Improving learning in the management of gender violence. Educational impact of a training program with reflective analysis of dramatized video problems in postgraduate nurses.

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This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declarations of interest: none

1 **Improving learning in the management of gender violence. Educational impact of a**
2 **training program with reflective analysis of dramatized video problems in**
3 **postgraduate nurses.**

4 **Abstract**

5 Background: Most gender-based violence victims who sought help in Spain did so
6 through health services. Training on gender-based violence with active learning
7 methodologies promotes the management of knowledge, reflection, and adaptation to
8 change. Nurses, along with an educator, can construct knowledge with the same strategies
9 they will use professionally.

10 Purpose: To evaluate the knowledge, skills, and attitudes associated of postgraduate
11 nurses on gender-based violence before and after a reflection-based training program with
12 dramatized problem-videos. The secondary objectives were to evaluate the knowledge in
13 the activation of protocols, skills, and attitudes in the management of women who are
14 victims of gender-based violence, the consolidation of learning, and the applicability to
15 the workplace.

16 Methods: Pre-post quasi-experimental study without a control group. A specifically
17 validated and designed instrument was utilized to evaluate the dimensions of knowledge,
18 skills, and attitudes when facing gender-based violence, before and after the training
19 sessions, along with additional questions to assess if the participants possessed better
20 tools to address gender-based violence.

21 Results: The difference between the pre and post-tests was statistically significant for the
22 dimensions knowledge, skills, and attitude ($p<0.05$), with a smaller effect size in the
23 dimensions skills and attitude. Also, high scores were observed in the consolidation of
24 learning and applicability to the workplace.

25 Conclusion: Reflection-based training with dramatized problem-videos improved the
26 acquisition of tools necessary for the detection and management of gender-based violence
27 of nurses.

28 **Keywords:** Education Nursing; Gender-Based Violence; Active Learning; Online
29 Learning; Quantitative Evaluation.

30

31 ## 1. Introduction.

32 Gender-based violence (GBV) is violence directed against a person because of that
33 person's gender, or violence that affects individuals of a particular gender
34 disproportionately. It can include violence against women, men, or children. Although
35 women are the main victims of GBV, it also causes severe harm to families and
36 communities (European Commission, 2021). Women suffer from violence for the mere
37 fact that they are women, from any social, cultural, educational, or economic status in the
38 world (Akhmedshina, 2020).

39 In many cases, the violence against women is perpetrated by those who are or have been
40 linked to them through romantic relationships in the present or past. The aggressor seeks
41 to damage, obtain control, and maintain authority in the relationship with the woman, so
42 that GBV continuously and systematically occurs (Martínez Ortega, 2019). Violence
43 against women is sustained, in part, by models of male domination due to culturally-
44 established roles (Herrero Olaizola et al., 2017).

45 The United Nations General Assembly (UNGA) defined violence against women as "any
46 act of gender-based violence that results in, or is likely to result in, physical, sexual or
47 psychological harm or suffering to women, including threats of such acts, coercion or

48 arbitrary deprivation of liberty, whether occurring in public or in private life" (United
49 Nations. Human Rights, 1993).

50 Violence against women is present in different ways; objectively, through physical and
51 sexual aggressions, to subjectively, through social control or discrimination. The origin
52 of this behavior towards women is found in the cultural values which have historically
53 been granted to each gender, and which have lacked social reproach, thus providing some
54 impunity to the aggressor (Ozaki and Otis, 2017).

55 Throughout history, violence against women has been present in a generalized manner,
56 and its beginning and maintenance has come from a series of economic, social, and
57 cultural influences (Bent-Goodley, 2007). The WHO calculates that 1 out of 3 women in
58 the world manifests having suffered physical and/or sexual violence from her partner or
59 ex-partner (World Health Organization, 2021). This is therefore a severe public health
60 problem, which violates their human rights. It is also the main obstacle with respect to
61 dignity and equality between men and women, and impedes women from reaching the
62 highest possible level of health (United Nations. Entity for Gender Equality and the
63 Empowerment of Women, 1995). A woman's health includes her physical, emotional,
64 and social health (World Health Organization, 2020), and these are determined by the
65 effects of violence against them. This violence not only affects the victims themselves,
66 but also their families, friends, and society. It is a matter that demands a critical view of
67 the institutions, in regard to the manner in which they provide an answer to this type of
68 violence (Council of Europe. Gender Equality, 2021; Council of Europe. Istanbul
69 Convention, 2021).

70 Among the measures for the prevention of violence against women in the European Union
71 (EU), we find the directive on victims of crime (2012/29/EU) and the European Council
72 Convention on action against violence against women and domestic violence (Istanbul

Convention) in 2011 (Council of Europe. Istanbul Convention, 2021). Aside from the judicial measures, the results from the European Union Agency For Fundamental Rights (FRA) on violence against women in an EU-wide poll in 2014, revealed that most of the GBV women victims did not report these types of crimes. As a result, they did not resort to the appropriate institutions, which demonstrates that the needs and rights of many women in the EU are not addressed, and that the data on the magnitude of the problem utilized, are not exact. Nevertheless, it is calculated that one in three women in the EU has experienced physical and/or sexual violence since the age of 15, one out of five has suffered bullying, and one out of two has had to face one or many types of sexual harassment (FRA – European Union Agency for Fundamental Rights, 2014).

In Spain, the total number of women killed as victims of GBV started to be counted in 2003, and as of April, 2021, this number had risen to 1,086 (Ministry of Equality, 2021). In 2015 and 2019, macro-surveys were conducted to analyze the prevalence of GBV and to study the consequences on the physical and psychological health of the affected women. Additionally, they sought to discover whether these women reported this situation or had asked for help, the impact of GBV on the victims' children, and how they had survived GBV (Government Office against Gender-based Violence, 2020, 2015).

Among the data from the 2019 survey, it is striking to find that 1 out of 2 women in Spain had suffered violence for being a woman, that 66.96% of the women who had suffered GBV had not sought formal help, and of those who did, 28.9% sought help from health services at some point (Government Office against Gender-based Violence, 2020).

2. Background

GBV is a public health problem that must be addressed from a multi-dimensional perspective. Different actions must be performed, from providing care to GBV women victims, to prevention programs oriented towards all levels of society. Thus, in the case of health services, an effort is needed to provide a comprehensive response.

The focus on violence against women from Spanish institutions has increased considerably (Autiero et al., 2020). Good public opinion of the Spanish public health system, has made it the entry point for women who have suffered from GBV (Alcaraz Lozano et al., 2014).

Nurses, when trying to manage violence against women, use certain psychological defense mechanisms, which impede them from recognizing and assisting the victims in an adequate manner (Autiero et al., 2020). Diverse studies have provided evidence on the difficulties experienced by health personnel when trying to detect cases of violence against women (Alcaraz Lozano et al., 2014; Alotaby et al., 2013; Autiero et al., 2020), especially with a backdrop of lack of training and lack of information with respect to the management and assessment of situations with women who are victims of GBV (Alcaraz Lozano et al., 2014; Baides Noriega, 2018; Calvo González and Camacho Bejarano, 2014). Nevertheless, the rate of abuse-related communication improves when the woman is questioned by nurses who are aware and/or trained in GBV (Macías Seda et al., 2009).

Nurses are a fundamental link in the detection of women who are victims of GBV, as they directly participate in their care (Carrilero López et al., 2012). Academic training and postgraduate courses are indispensable for high quality care of women who suffer from gender-based violence, although these are not always sufficient (Maquibar et al., 2019). It is thus necessary to continually address GBV in higher education to educate and train

nurses on the detection and adequate care of violence against women (Alshammari et al., 2018; Valdés Sánchez et al., 2016).

As compared to traditional learning methodologies, training with active learning methodologies provides better results in regard to the assimilation of concepts and training in decision making (Konopka et al., 2015; Roca Llobet et al., 2015). In the university environment, the use of learning videos can improve the acquisition of knowledge and skills of health sciences students. With this learning method, the students, with the help from the professor, construct knowledge in a reflective manner and with the same strategies that must be utilized in their professions. It is a learning system that promotes the management of knowledge, the practice of reflection, and the adaptation to change, in a manner that is individual for each student (Coyne et al., 2018a, 2018b; Jiménez-Rodríguez et al., 2020; Stone et al., 2020).

The hypothesis of the present study is that a training program on GBV women victims with active learning methodologies, through the practice of reflection with dramatized problem-videos, will provide the nurses with greater knowledge, skills, and attitudes with respect to violence against women.

The general objective of the study was to evaluate knowledge, skills, and attitudes related to violence against women before and after a reflection-based training program with dramatized problem-videos, with nurses enrolled in a postgraduate master's program. The specific objectives were: a) to evaluate the knowledge associated to the protocols and GBV women victim care, b) to evaluate the skills in the management of women who suffered GBV, c) to evaluate the attitudes towards violence against women, and d) to evaluate the consolidation of learning and its applicability to their workplace.

145 **3. Method.**

146 *3.1 Design*

147 This is a quasi-experimental study with pre and post-test repeated measures with an
148 intragroup comparison of the measurements before and after the GBV training program.

149 *3.2 Participants*

150 The study population was composed by students enrolled in the "Health, Women, and
151 Care" Master's program at the [redacted] in the academic year 2020/21.

152 The inclusion criteria for taking part in the study were: 1) enrollment in the 2020/21
153 offering of the "Health, Women, and Care" Master's program from the Faculty of Nursing
154 at the [redacted], 2) participation in the active learning methodology training program on
155 addressing gender-based-violence, and 3) signing an informed consent form.

156 The exclusion criteria for the study were: 1) having suffered gender-based violence, and
157 2) not wanting to participate in the study.

158 The final number of participants was 23 nurses, with a response rate of 100%.

159 *3.3 Measurement instruments*

160 Sociodemographic (sex and age) and professional (months of experience and professional
161 category) variables were obtained from the participants.

162 To evaluate the active learning methodology training program on addressing gender-
163 based-violence, the "Questionnaire on knowledge, skills, and attitudes on gender-based
164 violence (CCHA-VioGen)" was utilized (Palacio Gaviria et al., 2021). All the items were
165 written in a positive sense, so that a greater score in the assessment indicated a higher
166 evaluation of the variable studied. The final instrument was composed of three

167 dimensions (knowledge, skills, and attitudes), and 17 items scored with a Likert-type
168 response scale (where 1 indicated complete disagreement, and 10 complete agreement).

169 The knowledge dimension (eight items) evaluated knowledge on the GBV health protocol,
170 on the possible actions when dealing with a GBV victim, on the screening questions to
171 identify a possible GBV victim, the risks of a woman who is a victim of GBV, how to
172 complete and what to do with the lesion report when dealing with a GBV victim, what
173 information and support could be offered to a female GBV victim, the consequences of
174 GBV on the woman's health, and an interview to be conducted with a possible GBV
175 victim. The score that could be obtained oscillated between 8 and 80. The dimension skill
176 (three items) evaluated aspects such as the ability of the participants to complete the lesion
177 report of women who suffered from GBV, to ask the GBV screening questions, and offer
178 the resources available. The scores for this dimension oscillated between 3 and 30. Lastly,
179 the dimension attitude (six items) evaluated the position of the professionals on GBV care,
180 the approach with colleagues from the point of view of health care, if they felt
181 uncomfortable, and if they experienced anxiety when attending a possible GBV victim
182 who did not want to report the aggressor. The mean score that could be obtained oscillated
183 between 6 and 60.

184 The instrument was created and designed by a panel of eight experts with more than ten
185 years of experience with GBV, and with training in active learning methodologies, to
186 create items based on the current recommendations for addressing women who suffered
187 from GBV. An adequate content validity index for all the items was obtained (CVI
188 between .87 and 1), as well as for the total CCHA-VioGen questionnaire (CVI = 0.97).
189 As for the reliability analysis, the internal consistency of the total scale based on the
190 participant's scores in the questionnaire was analyzed (Cronbach's α), with a value of α=
191 0.79 obtained (Palacio Gaviria et al., 2021).

Also, eight additional questions were added to this questionnaire to assess if the nurses possessed better tools for addressing GBV in health centers after the training. For this, the following aspects were measured: the consolidation of the learning (3 questions), the applicability to the workplace (3 questions), and the need for additional training (2 questions).

3.4 Data collection

The nurses enrolled in the “ ” Master’s program were contacted via the telephone in the month of February 2021, to explain to them the aim of the study, and to ask for their email for data collection.

A data collection form was created with the measurement instruments described in the previous section with Google Forms. At first, the form was sent with the CCHA-VioGen questionnaire through email, for the students to complete and send before taking part in the GBV training program with active learning methodologies. Later, 25 days after the end of the program, the CCHA-VioGen and the eight additional questions were once again sent.

Data collection took place between March 16 and May 5, 2021.

3.5 Training program

A training program was designed to address GBV with active learning methodologies. It took place on April 20th and 21st, 2021, within the “ ” Master’s program at the . The training was conducted online, and it was entirely practice-based, using Zoom tools, in two sessions lasting four hours each. The detailed content of the sessions can be found in Table 1.

-INSERT TABLE 1-

215 Different active learning methodologies were combined: group dynamics, learning
216 among equals, becoming emotionally aware about the basis of reflective analysis of the
217 dramatized problem-videos. There was a constant interaction between the students and
218 professors. The prior theoretical contents were available online before the class (with
219 reference documents available in the virtual classroom platform), so that during the
220 sessions, discussion and reflection tasks were undertaken with the focus placed on the
221 analysis of problem-videos.

222 To design the videos, a panel of two experts, who had more than ten years of GBV
223 experience and training on active learning methodologies was convened. These experts
224 selected situations that dealt with the most common dilemmas in the making of clinical
225 decisions.

226 Different stories from women were scripted and recorded in the clinical simulation rooms
227 at the ███ with the participation of professional actors and actresses. Two types of videos
228 were made; 1) "teaching videos", whose function was to illustrate the path or protocol
229 followed by the GBV victim when she seeks help from a health center, and the GBV
230 victim interview, a type of interview to which the efficient communication tools were
231 applied. 2) "problem-videos", where an unfinished situation was described, and in which
232 the student had to identify the problem, reflect, and search for solutions. For this, a
233 methodology based on clinical debriefing was utilized (Cheng et al., 2014). The student
234 takes on the role of one of the protagonists in the video, identifies the situation, raise
235 issues to resolve that are related to the case, and afterwards transfers them to a real
236 situation. At the end of each reflection session, a closing session takes place with
237 conclusions. The recording of the teaching and problem videos was performed with
238 funding from the Pact against gender-based violence from the Region of █████ (Region
239 of █████, 2018), and the Unit of professional development of the █████ Health System.

The content of the teaching and problem videos is outlined in Table 2.

-INSERT TABLE 2-

3.6 Ethical considerations

To conduct this study, approval was obtained from the Ethics Committee from the [redacted] (CEI) (Code 3258/2021). The confidentiality of the data and the anonymity of the participants was guaranteed according to the current legislation on protection of personal data. All the ethical principles of the Declaration of Helsinki were followed in this study (The Lancet, 2000), and the participants signed an informed consent form, which informed them about the object of study and through which they manifested their desire to participate in it.

3.7 Data analysis

To analyze the data, the SPSS® v.25 software (Statistical Package for the Social Sciences) was utilized. The statistical significance was set as p-value<0.05.

A descriptive analysis of the study was performed. The mean and standard deviation were used for the quantitative variables, and frequencies and percentages for the categorical ones.

As most of the measurement results would not have a normal distribution, the pre- and post-data were subjected to Bootstrap analysis (Bland and Altman, 2015). The comparison of the pre and post intervention scores was performed with Student's t-test with the Bonferroni correction for multiple comparisons. For each variable, the effect size was calculated with Cohen's d to assess the magnitude of the effect of the intervention, with the use of values proposed by Ferguson (Ferguson, 2009), where 0.41 indicated a small effect, 1.15 a medium effect, and 2.70 a large effect.

4. Results.

4.1 Sociodemographic and professional characteristics

The final sample was composed by 23 nurses, with a mean age of 34.30 (SD=7.38), with 95.7% (n=22) being women. The professional experience was 74.13 (SD=74.52) months.

4.2 Effect of the Gender-Based Violence training program

After the analysis of the items from the knowledge dimension, we observed that the mean of the total score obtained by the participants in each item was greater after the training, with the differences being statistically significant in all the items, and with a medium effect size. As for the dimension skill, it was observed that the mean of the total score of the participants was also greater after the training, although these differences were only statistically significant in items 1 and 2, with a small effect size. Lastly, in the dimension attitude, it was observed that the mean of total score in each item provided by the participants was the same after the training, except for item 2, where statistically significant differences were observed, with a medium effect size (Table 3).

-INSERT TABLE 3-

Table 4 shows the scores of the dimension's knowledge, skills, and attitudes. A statistically significant ($p<0.05$) improvement was obtained in the scores after the training program, with medium effects sizes in the dimension knowledge d=2.39. However, we found small effects in the dimensions skills d=0.51, and attitude d=0.69.

-INSERT TABLE 4-

Lastly, after the training program, the participants were asked about the consolidation of learning (3 questions), the applicability to the workplace (3 questions), and the need for additional training (2 questions). As outlined in Table 5, the participants scored highly (9 out of 10) on the questions on consolidation of learning. As for the applicability to the

287 workplace, medium-high scores were obtained (7 out of 10). Lastly, the participants
288 provided a high score (8 out of 10) on the question "I have obtained enough with what
289 I've learned to be able to apply it to my workplace" and gave a low score (2 out of 10) to
290 the question "With what I've learned in the training, I have had to broaden/delve in the
291 contents for their practical application".

292 -INSERT TABLE 5-

293 **5. Discussion**

294 The training on GBV women victim care with active methodologies experienced by the
295 "[redacted]" Master's students was conducted through interactive group
296 dynamics. The reflection-based video-analysis of unfinished GBV cases enabled nurses
297 to reflect and engage with the teaching material. The students, in a reflective manner,
298 became aware of the causes and the origin of the GBV, acquired knowledge and skills
299 associated to GBV cases, with constant feedback provided by the professors, which
300 allowed them to become emotionally aware of the problem, as shown in the study results.
301 In comparison with traditional training on GBV received by nurses (Alcaraz Lozano et
302 al., 2014; Carrilero López et al., 2012; Macías Seda et al., 2009; Rojas Loría et al., 2015),
303 the reflection-based video-analysis of unfinished GBV cases improved the nurses´
304 knowledge, skills, and attitude related to violence against women, and the consolidation
305 of learning and its applicability to their workplace.

306 The reflection-based video-analysis of the unfinished cases (debriefing), allowed the
307 participants to develop critical thinking skills and become aware of the situation, and
308 improved the management of the interventions, thereby significantly contributing to the
309 acquisition of knowledge, skills, and attitudes of the nurses (Cheng et al., 2014) with
310 respect to how to address women GBV.

311 This great improvement in knowledge, and therefore the positive evaluation of this novel
312 method of training, could be due to the low percentage of nursing professionals who are
313 able to detect GBV cases, and the insufficient training received during their university
314 studies related to the detection and management of GBV victims, as corroborated in
315 national and international studies (Jiménez-Rodríguez et al., 2020; Macías Seda et al.,
316 2009; Rojas Loría et al., 2015; Valdés Sánchez et al., 2016).

317 As for the dimension skills, the improvement was smaller than in the previous dimension.
318 Although this improvement was significant, the effect size was small. One of the items in
319 which a statistically significant improvement was not observed in this dimension, was
320 knowing how to offer the available institutional resources. As described by other authors,
321 the limited training received during the formative period of the degree creates a lack of
322 confidence in the nurses when offering resources (Alshammari et al., 2018; Baides
323 Noriega, 2018).

324 Lastly, in the dimension attitude, a statistically significant improvement was observed,
325 with a smaller effect size. If we focus on the items in this dimension, we observe a
326 statistically significant improvement only in the item related to talking about GBV with
327 colleagues, from the healthcare point of view, during the month before the training
328 session. The debate that could be generated by knowing the data from GBV studies
329 worldwide, either due to the severity, or the high incidence found, could be associated to
330 this result. On the contrary, the rest of the items assessed in the attitude dimension did not
331 show statistically significant differences after the training.

332 The nurses in the group had a proactive attitude towards women's health, and therefore,
333 the items in the attitude dimension were already high even before starting the training
334 session. This makes us think about what other actions could be performed so that this type
335 of training precisely reaches the professional groups that are less aware about this

336 problem. The lack of time and the deficiencies shown by the health professionals for
337 creating a safe environment where women are treated with respect, and where they feel
338 listened to and safe, makes difficult the change in this dimension, as shown by studies
339 from different continents in different cultures and periods of time (Alotaby et al., 2013;
340 Dorrego et al., 2020). The women who are GBV victims must be cared for in a specific
341 manner, and the personnel who care for them must have available the resources necessary
342 to guarantee the safety of the patients.

343 According to the literature, all studies that have been conducted reinforce the need for
344 continued training and education of health professionals, given the difficulty in the
345 comprehensive care of these women (AbuTaleb et al., 2012; Alshammari et al., 2018;
346 Calvo González and Camacho Bejarano, 2014; Jiménez-Rodríguez et al., 2020).

347 In view of the results, the training with reflection-based video-analysis of unfinished
348 GBV cases (debriefing), helped nurses to increase their knowledge and to obtain the
349 necessary skills for the adequate management of women who are victims of GBV. This
350 training could also facilitate the creation of feelings of empathy with the women who
351 suffer GBV and with the health professionals who care for them. Our results are similar
352 to those found with other students, where authors identified that the active learning
353 methodologies increase awareness and knowledge about GBV (Alcaraz Lozano et al.,
354 2014; Di Giacomo et al., 2017; Sis Çelik and Aydın, 2019) and results in an improvement
355 in the learning process, which could fill the existing gap associated with GBV (Angelini
356 and García-Carbonell, 2015; Jiménez-Rodríguez et al., 2020; Roca Llobet et al., 2015).

357 As a result, it should be pointed out that health professionals are frequently the first formal
358 contact when the victims seek help and must therefore be adequately educated and trained
359 to support them. Therefore, we recommend the inclusion of training with the reflection-
360 based analysis of dramatized and unfinished problem-videos in the teaching of

361 undergraduate and postgraduate nursing students, as it has been demonstrated that the
362 care provided by the health professionals who are aware about this subject, improves the
363 care of the victims (Macías Seda et al., 2009).

364 *5.1 Limitations*

365 The study had many limitations. There was no control group, as none of the nurses were
366 excluded from training, as this would be unethical, given that the program could be
367 beneficial for the care of women who suffer from GBV. A total of 95.7% of the
368 participants were women, and this could have influenced the participant's responses, as
369 they could have identified more with the topic and been more aware. The size of the
370 sample was small, which limited the extrapolation of the results. Nevertheless, the pre
371 and post data were subjected to Bootstrap analysis based on a simulation with 1000
372 participants, which would increase the external validity of the study. Finally, the time
373 transpired for the re-test was 25 days. In future research, more follow-ups should be
374 performed to ensure that the knowledge, skills, and attitudes acquired by the nurses are
375 long lasting.

376 **6. Conclusion**

377 Online training with reflection-based video-analysis of unfinished GBV cases is adequate
378 for training health personnel on the care of GBV in a healthcare environment. This
379 methodology allows the acquisition of the tools necessary for the detection and
380 management of GBV, as the knowledge, skills, and attitudes of the nurses increased.

381 Given the complexity of caring for victims, training with reflection-based video-analysis
382 could be a useful learning approach to fill the gaps in knowledge found in traditional GBV
383 training, as it would allow the nurses to reflect and develop critical thinking skills and
384 awareness of the situation, and to improve the management of interventions.

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Table 1 Click here to access/download;Table;Table 1.docx

Table 1. Contents of the sessions from the training program on how to address GBV.

CONTENT
Dynamics and presentation
Awareness. Causes. Origin
Gaining emotional awareness
Communication and active listening
Viewing and debriefing problem-videos
Closing and conclusions

Table 2 Click here to access/download;Table;Table 2.docx

Table 2 Clinical situations.

Teaching video	**Clinical situations**	**Learning objectives**
“Path /protocol”	A woman arrives at Emergency Services to be attended due to GBV	Knowledge and practical application of the GBV protocol
“Interview with GBV victim”	Doctor-patient interview during consultation, with a GBV victim	Application of efficient communication elements. Sections of the clinical interview Detection of GBV
Problem-video	**Clinical situations**	**Learning objectives**
“Resistance is among us”	Debate between two colleagues when one resists attending a GBV victim	Identify situations in which resistance is observed and develop arguments to help the woman
“If I dared”	Suspicion of GBV in a woman who does not want an intervention	Assessment of risk Offer resources
“The moment of greatest risk”	Care for a pregnant GBV victim	Identify pregnancy as a situation of high vulnerability Know protocols and resources
“The need to act”	Caring for a woman victim with severe lesions	Know the protocol when faced with a high-risk situation Know and offer resources
“It is a suspicious situation”	Suspicion of human trafficking	Identify the situation Know protocol and resources
“Leave my phone”	Suspicion of adolescent abuse	Raise awareness about the problem of abuse of adolescents

Table 3. Scores obtained in the items from the questionnaire pre and post training.

Items	Pre-training (*n* = 23)	Post-training (*n* = 23)	Bootstrap analysis*			Pre—Post training		
	M (SD)	*M (SD)*	*M*	*95% CI*		*t*	*p*	*d*
Knowledge								
1. I know the gender-based violence health protocol.	3.78 (2.37)	8.70 (0.82)	4.913	3.895	5.931	10.013	<0.001	2.09
2. I know how to act when I find a possible victim of gender-based violence during my work hours.	4.43 (2.11)	8.57 (0.94)	4.130	3.206	5.055	9.263	<0.001	1.93
3. I know the screening questions to identify a possible victim of gender-based violence.	3.96 (2.25)	8.22 (0.99)	4.261	3.310	5.212	9.290	<0.001	1.94
4. I know the risks of a woman who is a victim of gender-based violence.	5.87 (1.22)	9.22 (0.95)	3.348	2.688	4.008	10.523	<0.001	2.19
5. I know how to complete and what to do with the lesion report when dealing with a gender-based violence victim.	3.70 (2.24)	7.61 (1.53)	3.913	2.965	4.861	8.556	<0.001	1.78
6. I know which information and support resources I can offer to a woman who is a victim of gender-based violence.	4.26 (2.01)	8.48 (1.31)	4.217	3.287	5.148	9.397	<0.001	1.96
7. I know the consequences of gender-based violence on a woman's health.	6.13 (1.22)	9.35 (0.71)	3.217	2.566	3.869	10.244	<0.001	2.14
8. I know the interview I have to give to a possible victim of gender-based violence.	3.57 (2.39)	8.26 (1.42)	4.696	3.657	5.734	9.378	<0.001	1.96
Skills								
1. I am able to complete GBV lesion reports.	1.57 (0.99)	2.61 (2.54)	1.043	0.046	2.041	2.170	0.041	0.45
2. I am able to ask GBV screening questions when providing care to a woman.	2.43 (1.97)	3.87 (3.00)	1.435	0.119	2.750	2.262	0.034	0.47
3. When I am done providing care to a victim of GBV, I am able to offer available resources.	4.57 (2.97)	5.22 (3.20)	0.652	-0.504	1.808	1.170	0.255	0.24
Attitudes								
1. I try to have another colleague provide care to a gender-based violence victim.	2.57 (2.74)	2.00 (1.95)	-0.565	-2.112	0.982	-0.758	0.457	-0.16
2. In the last month, I have spoken with my colleagues about the subject of gender-based violence from the health care point of view.	2.35 (1.90)	6.52 (3.30)	4.174	2.684	5.664	5.808	0.000	1.21
3. It is difficult for me to speak to my colleagues about gender-based violence.	2.00 (2.41)	2.39 (2.74)	0.391	-1.155	1.938	0.525	0.605	0.11
4. I think that addressing gender-based violence should be done in an interdisciplinary manner.	10 (0)	9.30 (1.92)	-0.696	-1.525	0.133	-1.740	0.096	-0.36
5. I feel uncomfortable when I'm providing care to a possible victim of gender-based violence.	2.57 (2.42)	3.29 (2.17)	0.714	-0.525	1.954	1.202	0.243	0.26
6. I become anxious knowing that a woman suffers abuse but does not want to report it.	8.29 (1.43)	8.43 (1.43)	-0.143	-1.101	0.815	-0.311	0.759	-0.07

* The Bootstrap results are based on a simulation with 1000 participants
M = man; *SD* = standard deviation; *CI*= Confidence interval; *d* = Cohen's effect size

Table 4 Click here to access/download;Table;Table 4.docx

Table 4. Pre and post training scores obtained in the questionnaire for the dimensions knowledge, skills, and attitudes

Dimensions	Pre-training (n = 23)	Post-training (n = 23)	Bootstrap analysis*			Pre—Post training		
	M (SD)	*M (SD)*	*M*	*95% CI*		*t*	*p*	*d*
Knowledge	35.69 (7.04)	68.39 (7.04)	32.69	29.78	38.62	11.45	<0.001	2.39
Skills	8.56 (4.63)	11.70 (7.49)	3.13	0.50	5.77	2.46	0.022	0.51
Attitudes	28.05 (5.01)	32.29 (3.77)	4.24	1.44	7.04	3.16	0.005	0.69

* The Bootstrap results are based on a simulation with 1000 participants

M = man; *SD* = standard deviation; *CI*= Confidence interval; *d* = Cohen's effect size

Table 5. Descriptive statistics of the questions on consolidation of learning, applicability at the workplace, and the need for additional training.

Questions		
The training of how to address gender-based violence with active learning methodologies, has allowed me to:		
	M	***SD***
Know key aspects of the matter in question.	8.91	0.95
Discover useful tools and techniques for my work.	8.65	1.34
Acquire/reinforce my professional competences.	9.00	1.04
Applicability to the workplace		
About the training of how to address gender-based violence with active learning methodologies:		
	M	***SD***
From the training received, I have applied theoretical aspects in my workplace.	7.70	0.93
From the training received, I have applied practical aspects in my workplace.	7.04	1.19
I have habitually applied the training received at my workplace.	7.13	1.01
Need for additional training:		
	M	***SD***
I have obtained enough with what I've learned to be able to apply it to my workplace	7.87	1.91
With what I've learned in the training, I have had to broaden/delve in the contents for their practical application	2.35	0.78