

Gender-based violence

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Gender-based violence: A five country, cross-sectional survey of health and social care students' experience, knowledge and confidence in dealing with the issue

Key messages:

- Future generations of health and social care professionals are being insufficiently prepared to deal with GBV.
- Students indicated that they would like GBV learning to be practice-focused, patient-focused, inclusive and intersectional.
- Higher education institutions globally need to embed the subject of GBV in health and social care curricula, so that future professionals are sufficiently prepared to address this pervasive issue.

Background

Gender-based violence (GBV) has been defined as ‘the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between the two genders, within the context of a specific society’ (Bloom, 2008) (p. 14). It covers a range of harms, such as intimate partner violence (IPV), female genital mutilation (FGM), human trafficking and sexual abuse. Although men and boys can be victims of GBV, as can those who identify as lesbian, gay, bisexual, transgender or queer (LGBTQ), the majority of people affected are women and girls (World Health Organization, 2013b). Accurate figures for the extent of the problem are problematic because GBV is an obscured and under-reported issue, but it is estimated that globally, 35% of women have experienced some form of IPV – the most common form of GBV – or sexual violence by a non-partner during their lifetime (World Health Organization, 2017).

Health and social care professionals across a range of disciplines are well-placed to identify and respond to those affected by GBV, yet registered professionals often report a lack of confidence knowledge and experience of GBV (Taylor *et al.*, 2013). Consequently, many studies report that GBV is poorly recognised by professionals in practice (Hinderliter *et al.*, 2003; Kothari and Rhodes, 2006; Reijnders, Giannakopoulos and de Bruin, 2008; Cappon *et al.*, 2015). Furthermore, a study by Neale (2018) drew the conclusion that frontline practitioners use ‘cognitive masks’ (a concept proposed by Ash, 2013) to lessen the weight of their professional burden, and in so doing, hinder women’s decisions about remaining in, or exiting an abusive relationship. Some authors have referred negatively to the ‘clinicalisation’ of domestic violence, with some arguing that shifts in policy and funding have led to a reduction of specialist women’s services in favour of a more generalised statutory response (McDonald, 2005; Neale, 2018). While not denying the validity of these arguments, we argue that non-specialist health and social care practitioners should nevertheless be competent to recognise and address GBV, particularly as these frontline professionals will often be the first point of contact for many women who have not yet disclosed or even ‘named’ their abuse (Bradbury-Jones *et al.*, 2013).

We approach the issue of GBV as a public health issue. In other words, it is ubiquitous, having an impact at population-level, and therefore requires an upstream approach to tackle the problem at its routes (World Health Organization, 2019). We emphasise the importance of effective education at pre-professional-level for this reason. However, the literature on healthcare students’ experiences and understanding of the subject is sparse. These points indicate a need for further research on the nature and content of existing undergraduate curricula, allowing for any gaps in education to be identified and addressed early on in health and social care professionals’ careers.

Women and girls experiencing or surviving GBV suffer an array of impacts, ranging from financial and legal to social. However, it has particularly devastating and often long-term effects on women's physical and mental health. Women who have experienced GBV are significantly more likely to report overall poor health and suffer from chronic health co-morbidities than their non-abused counterparts (Garcia-Moreno, Guedes and Knerr, 2012). They are also at greater risk of depression, suicide attempts, post-traumatic stress disorder and psychosomatic disorders (World Health Organization, 2013a). Because of their greater health needs, women who have experienced GBV access health services more frequently than the general population (Garcia-Moreno, Guedes and Knerr, 2012). This provides ample opportunities for health and social care professionals to identify abuse and intervene. For example, those working in emergency departments (Wu, Huff and Bhandari, 2010) and dentistry (Nelms *et al.*, 2009) may see the acute aftermath of a violent episode, while those in mental health settings (Howard *et al.*, 2009) and maternity services (Bacchus, Mezey and Bewley, 2004) are likely to witness the long-term consequences. It is therefore important that future health and social care professionals are adequately prepared to recognise and respond to these issues *before* entering their respective fields of practice.

A 2014 survey by the European Union Agency for Fundamental Rights (FRA) reported that much of the abuse against women in Europe remains unreported to authorities (FRA, 2014). This under-reporting may be partly attributable to victims' low confidence levels in authorities, which highlights the importance of educating future health and social care professionals to act and respond appropriately. Furthermore, a systematic review by Sprague *et al.* (2012) explored healthcare providers' perceived barriers to screening for IPV and found that lack of knowledge and comfort were the most significant factors. Doran and Hutchinson (2016) described a lack of clear and consistent approaches to the education of healthcare students on the subject of domestic violence, supporting earlier findings from Bradbury-Jones and Broadhurst (2015)

regarding failure of educational programmes to prepare nursing and midwifery students to deal with domestic violence. Our study contributes to the growing body of knowledge regarding healthcare students' knowledge and confidence on the subject of GBV, adding a further international and interdisciplinary focus. The aims of the study were to investigate healthcare students':

- i. Recollection of previous GBV education;
- ii. Experiences of encountering GBV in their clinical/experiential placements;
- iii. Perceptions of and confidence in their knowledge about GBV;
- iv. Perceptions of the importance of GBV learning;
- v. Views on the key requirements of future e-learning in GBV.

This study was part of a larger, funded study in which we undertook an international, systematic review [Sammut *et al.*, 2019] of effective GBV educational strategies and developed a GBV e-learning resource for health and social care students. The results from the present study were used to inform the development of the resource, which is freely available via the following link: <https://www.nottingham.ac.uk/helmopen/rlos/safeguarding/gbv/>

Methods

Study design and participants

We conducted a cross-sectional, international study of a purposive sample of health and social care students across six universities in five countries (Australia, Canada, England, New Zealand and Scotland). All participating universities are part of a network known as Universitas 21 Health Sciences Group. Our study population comprised undergraduate and postgraduate students in the disciplines of dentistry, medicine, nursing, pharmacy, physiotherapy, psychology, and social work.

Data collection instrument

While several survey tools evaluating health professionals' GBV knowledge and confidence exist, none of the available validated scales have been designed specifically for use with students. For example, the PREMIS instrument (Physician Readiness to Manage Intimate Partner Violence Survey) (Short *et al.*, 2006) has not been psychometrically evaluated for use in student populations. Moreover, this tool only addresses the issue of IPV, whereas our study explored more broadly the wider forms of GBV. To address this, we designed a new survey instrument. The research team included experts in GBV, experts in healthcare education and people with a range of professional backgrounds. Since co-design was important, four healthcare students were active members of the study team who contributed to development of the instrument.

The questionnaire collected data on the following: (1) students' demographic information, (2) recollection of previous GBV education, (3) GBV encounters whilst on placement, (4) self-reported knowledge of and confidence in responding to GBV, (5) perceived importance of GBV learning, and (6) views on the key requirements of future e-learning in GBV. Self-reported knowledge was captured quantitatively by the question 'How would you describe your knowledge about GBV?' rated on a 5-point Likert type scale (1=very poor, 2=poor, 3=average, 4=good and 5=excellent) followed by the opportunity to qualitatively expand answers in a free-text response. To find out about self-reported confidence, we asked participants 'How confident do you feel about dealing with the following in relation to GBV?' followed by six items exploring confidence, each rated on a 5-point Likert type scale (1=very unconfident, 2=unconfident, 3=neither confident nor unconfident, 4=confident and 5=very confident):

1. Identifying those experiencing GBV
2. Understanding barriers to disclosure of GBV

3. Asking a wide range of people about GBV
4. Discussing and responding to GBV
5. Knowing where to get advice if someone discloses GBV
6. Knowing about legal issues related to GBV

To find out about students' opinions on the importance of GBV learning, we asked: 'How valuable is it for students from your profession to learn about GBV?', with responses rated on a 5-point Likert type scale (1=not at all important, 2=of limited value, 3=average value, 4=highly valuable and 5=extremely valuable). The questions capturing students' experiences of formal GBV teaching and encounters of GBV issues whilst on placement, together with listed options, can be seen in Tables 2 and 3, respectively. Students' opinions regarding future GBV e-learning were captured in two questions: (1) 'What do you think may be important to include in any online or electronic resources on GBV?' and (2) 'Which of the following methods would you find effective in learning about GBV online or electronically?'. Both questions were followed by a number of options, with students using a 5-point Likert type scale to rate perceived importance (question 1; 1=unimportant, 2=slightly important, 3=important, 4=very important and 5=extremely important) and effectiveness (question 2; 1=very ineffective, 2=ineffective, 3=neither effective nor ineffective, 4=effective and 5=very effective). We piloted the questionnaire with five postgraduate students from one of the participating universities (University of Glasgow, Scotland).

Recruitment

A survey link, including the participant information sheet, was distributed via the research leads for each university to all students studying on dentistry, medicine, nursing, pharmacy, physiotherapy, psychology, and social work programs. We do not know with certainty how many students received the invitation to participate and therefore cannot provide an accurate

response rate. However, we estimate that it was no more than 10%. Each research lead sent one reminder.

Data collection

The survey was generic in the sense that it was relevant for use in each participating university. There were some details, however, that were context specific, and where necessary individual universities modified the introductory page to the survey to reflect the different ethical and procedural preferences of the university. Similarly, the contact and support details for students detailed at the end of the survey were also modified to meet local contexts.

The survey was live from 9th April to 15th June 2018 and took approximately 10 minutes to complete.

Data analysis

We undertook descriptive statistical analysis to examine data distributions. Self-assessed knowledge (single question, range 1-5) and confidence (mean score of the six confidence questions calculated to give confidence score, range 1-5) were analysed by profession, gender, age and year of study. To ensure internal consistency of the confidence items, Cronbach's alpha was calculated for the six confidence questions and was .87, suggesting high consistency. We tested data (knowledge, confidence, age, year of study) for normality of distribution using the Shapiro-Wilk test, and corresponding parametric and non-parametric bivariate tests were run. For confidence by profession, a one-way between-subjects ANOVA was run, and for knowledge by profession a Kruskal-Wallis test was run. To identify any differences between professional courses, pairwise comparisons were run using Dunn's (1964) procedure with a Bonferroni adjustment. Gender was treated as a dichotomous variable, comparing males and females. Mann-Whitney U tests were run to examine the relationship between

knowledge/confidence and gender. Spearman's rho correlations were calculated to examine knowledge and confidence by age and year of study. We used IBM SPSS Statistics version 24.0 to support our analyses.

Content analysis was used to evaluate free-text responses and these are presented to support the quantitative survey responses. The data were derived from two main open-ended questions in the questionnaire, seeking students' comments on their perceived own GBV knowledge, and thoughts about what would be useful to include in a GBV e-learning resource. In addition, a third free-text comment box invited students to add any further comments at the end of the questionnaire. As the free-text data were brief and descriptive in nature, our approach to analysis was similarly descriptive. After initial reading of and familiarisation with the data, semantic codes were identified and grouped together based on similarity of meaning: for example, the codes 'importance of a multicultural approach', 'need for consideration of different gender identities' and 'inclusion of violence against men and boys' were grouped together under the category *Inclusiveness and Intersectionality*. One researcher undertook the initial analysis, with a second researcher cross-checking the existing coding process and final categories to ensure accuracy in reporting and representation of the data.

Ethical considerations

Given the sensitive nature of the study, as well as being mindful that some students may themselves have personal experiences of GBV, additional features were added to the survey design to optimise the safety and welfare of the student participants. For example, it was possible to 'quick exit' the survey at any point and all questions were voluntary. At the end of the survey students could opt to receive further information on support services which were local to them. This was dependant on them working through to the end of the survey. All participating universities gained institutional ethical approval prior to distributing the survey,

with University of Birmingham, England being the first and lead university and therefore repository of data (reference number ERN_17-0402). Written informed consent was obtained from all study participants.

Results

Three hundred and seventy-seven students from six universities in five countries (Australia, Canada, England, New Zealand, Scotland) completed the questionnaire. This was a purposive sample and we did not undertake a power calculation to determine the sample size.

Sample profile

As shown in Table 1, the sample includes participants from seven health and social care disciplines. They were mainly female (81.7%, n=308), with 53 male students and two students who identified as transgender. This was a relatively young sample, with just under 60% falling between the 20-25 age range. Nursing students comprised the largest group of the seven represented disciplines (31.0%, n=117), followed by medicine (26.8%, n=101) and dentistry (11.9%, n=45). Lengths of programmes were discipline and country specific, but just over half of the students who participated in this study (54.2%) had been on their course for three years or more.

[Table 1 here]

Formal teaching of GBV on current course

Table 2 shows the extent of recall of formal teaching (i.e. a discrete, structured session or course) on GBV reported by students. Domestic violence/abuse and/or IPV was the most highly cited topic (n=216), followed by sexual assault (n=167) and FGM (n=104). One hundred and twenty-three students reported that they had received no formal teaching on the subject of GBV on their course.

[Table 2 here]

Encountering issues of GBV whilst on placement

Many students (62.1%, n=234) reported that they had encountered GBV in some form while on clinical placement (Table 3). Of this number, 31.2% (n=73) reported actively engaging in discussions about GBV with patients and clients, and 20.5% (n=48) stated they had taken an active role in providing support. A considerable number of students, however (37.9%, n=143), reported that they had never encountered the issue of GBV on placement.

[Table 3 here]

Self-assessed professional knowledge of GBV

A Kruskal-Wallis test was performed to determine whether there were differences in self-assessed knowledge between the students' professional groups. The distributions of knowledge scores were statistically significantly different between groups, $H(6) = 45.348, p = .000$. For pairwise comparisons, adjusted p-values are presented and values are mean ranks, with a higher mean rank indicating a higher level of self-assessed professional knowledge. This *post hoc* analysis revealed statistically significant differences between: physiotherapy (129.35), and nursing (215.85) and social work (235.34) ($p = .019$ and $p = .003$); pharmacy (146.69), and nursing (215.85) and social work (235.34) ($p = .031$ and $p = .004$); medicine (151.95), and nursing (215.85) and social work (235.34) ($p = .000$ and $p = .000$).

Gender and self-assessed knowledge of GBV

A Mann-Whitney U test was run to determine whether there were differences in self-assessed knowledge between males and females. Knowledge scores for females (mean rank = 182.84) and males (mean rank = 170.33) were not statistically significantly different, $U = 7596, z = -.872, p = .383$, using an exact sampling distribution for U (Dinneen and Blakesley, 1973).

Self-assessed professional confidence in dealing with GBV

A one-way between-subjects ANOVA was run to compare confidence in dealing with GBV issues between students' professional groups. There were outliers so analyses were run with and without the outliers; results were not materially affected by the outliers so they were retained. Data were normally distributed for each group as assessed by Shapiro-Wilk test ($p > .05$), except for nursing ($p = .02$); inspection of the histogram showed negative kurtosis. The ANOVA is a reasonably robust test and so the data were not transformed. There was homogeneity of variances, as assessed by Levene's test of homogeneity of variances ($p = .502$). Confidence scores were significantly different between professional groups, $F(6, 368) = 26.751, p < .000$. Physiotherapy students were the least confident, followed by pharmacy, medicine, dentistry, psychology, nursing and social work students, in that order.

Gender and self-assessed confidence in dealing with GBV

Data are mean \pm standard deviation, unless otherwise stated. An independent-samples t-test was run to determine whether there were differences in confidence in dealing with GBV between females and males. There were no outliers in the data, as assessed by inspection of a boxplot. Confidence scores for each gender were normally distributed, as assessed by Shapiro-Wilk's test ($p > .05$) and there was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .836$). Confidence scores were marginally higher for males ($2.70 \pm .89$) than females ($2.69 \pm .85$) but this difference was not statistically significant ($p = .943$; 95% CI $-.26$ to $.24$).

Age, number of years of study, and self-assessed knowledge and confidence

Spearman's rho correlations showed a statistically significant, but weak positive correlation between age and self-assessed knowledge ($r_s(371) = .206, p < .000$), and age and self-assessed confidence ($r_s(371) = .201, p < .000$). Number of years of study was very weakly negatively

correlated non-significantly with knowledge ($r_s(375) = -.054, p = .294$) and significantly with confidence ($r_s(375) = -.116, p = .024$).

Students' opinions about what would be useful to include in a GBV e-learning resource

In response to the question 'What do you think may be important to include in any online or electronic resources on GBV?', students overwhelmingly selected 'very important' or 'extremely important' for all eight listed options (Figure 1). Responses to the second question – 'Which of the following methods would you find effective in learning about GBV online or electronically?' – similarly favoured the two positive options of 'effective' or 'very effective' across the eight options, although overall opinions were more evenly distributed in comparison with responses to the first question (Figure 2). Collectively, students' responses indicate that they would prefer GBV learning to be focused on practical, professional and patient-centred issues (as opposed to having factual information given in isolation). For example, the options voted most 'important' (5=extremely important) were 'How to recognise GBV' and 'How to respond to GBV' (73.4% and 78.4% respectively). Similarly, students voted 'Personal accounts from people who have experienced GBV' and 'Personal accounts from professionals who have worked with GBV' as the most 'effective' (5=very effective) (46.2% and 53.1% respectively). These ideas are developed further within our qualitative findings.

[Figure 1 and Figure 2 here]

Qualitative findings from open-ended questions

Of the 377 students completing the questionnaire, 97 (25.7%) chose to provide one or more free-text responses. The questionnaire contained two main open-ended questions, seeking students' comments on (1) perceptions of their own GBV knowledge, and (2) thoughts about what would be useful to include in a GBV e-learning resource. A third free-text comment box

at the end of the questionnaire invited students to add any further comments. Content analysis identified three categories.

i. **The (in)adequacy of GBV learning at university**

Responding to the first question, the majority of students expressed the opinion that their current university course had *not* adequately addressed the subject of GBV. Some commented that the subject had been covered to an extent, but not sufficiently for them to feel knowledgeable or confident. Many students also indicated that they had undertaken independent reading on the subject and would be interested to learn more.

It [GBV teaching] has been very incidental, apart from a few tutorials in my psychiatry and gynaecology rotations. (Medicine, male, year 4)

I have a strong understanding of GBV from an interest in the topic in general, but not from any formal education within my program. (Physiotherapy, female, year 2)

Generally [my knowledge is] due to extra curricula reading. GBV was only covered from the perspective of safeguarding children, not adults. (Dentistry, female, year 4)

Many students commented that encountering GBV cases during practice placements had been a more valuable source of learning.

Limited teaching, however given good skills for dealing with DV[A] in a general practitioner setting during that rotation. (Medicine, gender not specified, year 4)

Until my most recent placement I knew very little about FGM, I have now come into contact with this but still feel I could be taught more. (Nursing, female, year 1)

I took the lead in two cases of domestic violence and one alleged rape case whilst on placement. (Social work, male, year 2)

However, as noted earlier, a considerable number of students (37.9%, n=143) reported never coming across GBV issues whilst on placement, highlighting that these experiences should not be considered a substitute for structured learning opportunities.

ii. **Practice-focused and patient-focused learning**

The students' comments made it clear that practice-focused learning was more sought-after and valued than strictly theoretical discussions of GBV. Many made reference to the disconnect between theory and practice, with some suggesting they felt professionally unprepared as a result of this.

I would say I have a good understanding of what constitutes GBV and how it can manifest, but not a good approach to discussing it with future patients or always knowing what resources may be available to them. (Medicine, female, year 2)

I know about it but I have no idea how to respond as a healthcare practitioner. (Pharmacy, female, year 1)

I don't want to learn about GBV, I want to know what to do – how to screen and what to do if GBV is encountered. (Psychology, female, year 4)

Responding to the second question about what would be useful to include in a GBV e-learning resource, many students expressed the opinion that GBV learning should be interactive and practical. For some, this would include simulation learning and interprofessional group work, while others indicated they would like a discussion of professional and legal obligations.

Simulations of GBV cases to give insight and help students identify characteristics of GBV victims. (Nursing, female, year 1)

Role-plays, video demonstrations, checklists, practical exercises, attitudes to adopt in relation to GBV might be additional methods to use. (Psychology, female, year 4)

I think it would be very important to discuss how patient confidentiality and professional responsibilities interact. For example, when is it appropriate to breach patient confidentiality to report GBV? (Pharmacy, female, year 1)

Many commented that GBV learning should seek to capture the voices of those who have experienced it.

I think the best learning methods are those where you get personal accounts from people who have experienced or been involved in helping people who have experienced GBV. (Medicine, female, year 2)

In relation to this, however, a number of students also noted that they had personal experiences of, or connections to GBV. Many commented that it would be important for educators to bear this in mind.

I think it would be good for any teaching to consider that some students themselves are likely to have been victims of GBV. Sadly, I've felt in my course that when discussing topics that "hit close to home" (mental health etc.), there is little consideration of the lived experience of students. (Nursing, female, year 1)

iii. **Inclusiveness and intersectionality**

The final category relates to GBV learning including a focus on intersectionality (that is, the existence of and interaction between diverse social and cultural identities).

Discussion of patriarchy, misogyny, transmisogyny, intersectional analyses are key. (Social work, female, year 1)

Education on GBV must be intersectional (e.g. inclusive of persons with a variety of gender identities, sexualities, cultures, ages, etc.) rather than just taking a

binary/western/white-as-normative approach to instruction. (Psychology, female, year 4)

Clients' cultural and spiritual backgrounds should be taken into account. (Social work, male, year 3)

Many students also commented that they felt violence against men and boys should not be overlooked in discussions of GBV.

I think it's really important to discuss violence against males and boys – particularly in a family setting. It is disheartening that every time I see information/surveys regarding DV they are deliberately excluding this group of individuals. Whilst not minimising the truthfulness of the statement that females are more likely to suffer, it's a shame that such attitudes may make men/boys feel prohibited from speaking up in the ways in which we encourage females to. (Medicine, gender not specified, year 4)

I know that the majority of cases are against women/females, but I think that it would be a good idea to learn about it in the context of male victims as well, so that we can provide support and care to all of our patients. (Pharmacy, female, year 1)

Discussion

This study aimed to explore the knowledge and confidence of students around GBV. We also explored student encounters with GBV in practice and examined their views on the key requirements of future e-learning on the subject of GBV. Our study found that students were underprepared in their professional programmes, indicating a lack of knowledge and confidence. However, approximately 62.1% had some encounters with GBV issues in their clinical placements or practice, and qualitative data indicate that students found these practical encounters to be a valuable source of learning.

To an extent, our findings are not surprising. Previous studies (Aluko, Beck and Howard, 2015; Bradbury-Jones and Broadhurst, 2015) have indicated that students feel underprepared and lack confidence in dealing with GBV in practice. Our study adds support to these findings. We found a self-perceived lack of knowledge, which was consistent with low levels of recall of receiving education on many areas of GBV. Indeed, only 57% recalled any teaching on IPV and/or domestic violence/abuse. Students also indicated low levels of confidence, which may partly be explained by a lack of practice experience by a large proportion of our sample – around half of our sample were in years 1 or 2 of their programmes, and of these, a significant minority had not encountered GBV issues whilst on clinical placement or in practice.

What our study adds though, is a multidisciplinary view in which nursing and social care students reported a higher level of self-assessed knowledge and confidence than other disciplines. In trying to understand these differences, we might consider that the fields of nursing and social care education have a highly humanistic approach to learning and content, and may perhaps take a broader view of the patient or client in their social context than some other programmes (Chu, Tsui and Yan, 2009; McCaffrey, 2019). Furthermore, both disciplines are likely to have students gaining practical experience in the workplace earlier in the curriculum than might be the case with the other disciplines. Conversely, disciplines such as medicine and pharmacy have traditionally focused more on diagnosis, treatment, and pharmacotherapy, with humanistic areas often taking a back seat (Gaufberg *et al.*, 2010; Whitehead, 2012; Kostriba Jan, Alwarafi and Vlceka, 2014). These interpretations are tentative and warrant further investigation.

Whilst we found some student groups had greater levels of self-reported knowledge and confidence, our findings show that regardless of this, there was a general perception across the disciplines of a need for more education on GBV. When exploring what students indicated would be important to include in an electronic or internet-based curriculum, the quantitative

and qualitative data are consistent. Data in Figure 1 show that students placed a greater importance on domains with practical application, when compared with domains of knowledge. This is reflected also in the free-text comments from participants. This is unsurprising, given the nature of GBV and context in which students are likely to experience GBV issues in practice – as future health and social care professionals they will be interested in gaining an understanding of the issues and gaining confidence in how to respond (McGarry *et al.*, 2015; Sammut *et al.*, 2019). Similarly, when asked about methods they would find effective in learning about GBV online or electronically, they rated personal accounts from survivors and professionals, interviews with experts and interactive written resources over factual context. Indeed, students expressed a desire for “personal accounts” as part of the new learning tool. These findings echo conclusions drawn by Turner *et al.* (2017) in their systematic review of evidence on interventions aimed at improving professionals’ responses to domestic violence and abuse (DVA). Specific elements of effective training programmes included “drawing from a clear and well-articulated protocol for intervention” (p. 35) and involving experienced DVA specialists within training.

In exploring and interpreting our findings, we need to take note of the gender imbalance of our sample, which was predominantly female. This could be reflective of the gender balances within the disciplines, or may alternatively indicate gendered differences in level of interest in the subject. In a systematic review (author's own., 2019) of university-level educational strategies in GBV, only one primary study (Haase *et al.*, 1999) out of seventeen reported disproportionate female interest in elective GBV learning opportunities. However, a number of studies have reported gendered differences in healthcare students’ attitudes towards GBV (Sivagnanam, Bairy and D’Souza, 2005; Anderson and Quinn, 2008; Can and Edirne, 2011). In addition, there is some evidence that those with an interest in or experience of a subject are more likely to respond to surveys on that subject matter (Sheridan and Strang, 1998; Kotaniemi

et al., 2001), and international data clearly show GBV against females is greater than that against males.

We have considered that the terms ‘unprepared’ and ‘underprepared’ are not equivalent in this discussion. The former implies an absolute lack of preparation, while the latter more likely refers to an overall lacking of preparedness (which may also persist despite efforts to address it). While many students in our study did report feeling absolutely unprepared in their professional programmes, others indicated that GBV had been covered *to an extent*, but not sufficiently for them to feel knowledgeable or confident. The term ‘preparedness’ in this context has previously been explored in a qualitative study by Po-Yan Leung *et al.* (2017), with a group of family doctors describing the concept as “having adequate IPA [intimate partner abuse] knowledge and good communication skills” (p. 521). This definition fits well with our use of the term in the context of the present study.

Recommendations for research

Our study’s relatively small sample size, together with the fact that 45.8% of respondents had not yet reached their third year of study, makes it difficult to argue conclusively that GBV is not addressed well enough in pre-qualifying healthcare courses. However, our findings do point towards this conclusion. This apparent paucity of GBV preparation within educational programmes is an issue, although we acknowledge that university-level healthcare curricula have competing demands for content coverage and a limited time in which to deliver core material. To our knowledge, there is currently no research addressing the question of *when* GBV content should be introduced to programmes. Our qualitative findings in particular indicate that students from *all* years of study are keen to learn and apply knowledge about various forms of GBV. Future studies might consider the practical issues and outcomes

associated with introducing GBV content at an early stage (i.e. year one) in pre-qualifying healthcare programmes. Comparative studies across disciplinary groups may also be useful.

Limitations

This study focused on the confidence, experience and recall of teaching of health and social care students in relation one aspect of demanding programmes of study. Without supporting data on the provision of GBV content in the respective curricula, generalisability is limited by potential recall bias. Likewise, generalisability is also problematic due to the small sample size. Data were gathered from a diverse student group through purposive sampling. Whilst most participants were in the later stage of their programme, many were in the first years and may not have encountered the relevant course content or been at a stage of learning where they recognised or assimilated relevant content. However, responses indicate that the prevalence of GBV observed in practice, and consequences relevant to these areas of study, are such that there is a need to introduce the issue of GBV explicitly early in programmes. Lack of representation from some geographic regions is acknowledged, particularly the global south, and is a further limitation which will be addressed in future phases of this work.

While the present study collected some qualitative data, the cross-sectional study design and data collection tool limited the richness and therefore quality of this data. Future research in this subject area should consider adopting a qualitative or mixed-methods approach to strengthen the confirmability of findings.

Conclusions

GBV remains a significant public health problem, the nature and extent of which requires an inter-professional, inter-agency and international response. This study found similar student experiences as regards lack of confidence, knowledge and preparedness across disciplines and

countries, demonstrating the need for higher education institutions globally to embed the issues of GBV in health and social care curricula. This will be crucial to enable future professionals to effectively recognise and address this pervasive health and social issue. Importantly, this study that was conducted by an interdisciplinary, international research team drawn from diverse geographical and professional settings, models how this might be achieved.

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Conflict of interest statement

The Authors declare that there is no conflict of interest.

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