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ORIGINAL ARTICLE

Healthcare Students' and Educators' Views on the Integration of Gender-Based Violence Education into the Curriculum: a Qualitative Inquiry in Three Countries

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Abstract

Purpose Health and social care professionals are ideally placed to identify and address gender-based violence (GBV), yet research continues to demonstrate that the subject is being poorly covered at undergraduate level. This qualitative study explored health and social care students' and educators' views on GBV education, with a view to identifying 'best practice'. We aimed to capture students' and educators' experiences and perceptions of GBV education across participating countries; how participants thought GBV should be taught/learned within their curricula; and their views on how GBV education might be 'optimized'.

Methods We conducted nine focus group discussions and one semi-structured interview with 23 students and 21 academic staff across the UK, Australia and Chile.

Results Thematic analysis yielded three themes: (1) GBV addressed in all but name, (2) Introduce sooner, explore later and (3) A qualitative approach to learning. Educators and students indicated that GBV is largely being overlooked or incompletely addressed within curricula. Many participants expressed a wish for the subject to be introduced early and revisited throughout their study, with content evolving as cohorts mature. Lastly, our findings indicate that GBV education could benefit from adopting a 'qualitative' approach, prioritizing survivor narratives and incorporating dialogue to facilitate student engagement.

Conclusion Though time constraints and competing demands within undergraduate curricula are frequently cited as barriers to moving away from traditional didactic methods, our findings suggest that teacher-centered strategies are insufficient and, in some regards, inappropriate for GBV education. The need for a paradigm shift in GBV education is discussed.

Keywords Education · Gender-based violence · Healthcare · Students · Teaching

Internationally, women experiencing gender-based violence (GBV) experience a higher rate of physical and mental health issues than the general population (World Health Organization, 2021). GBV survivors are consequently more likely to access health services, particularly in sexual health, emergency care and maternity services (García-Moreno et al., 2015; Hooker et al., 2020). GBV also incurs social problems for survivors, including income and home instability (Daoud et al., 2016). Health and social care (HSC) professionals are therefore ideally placed to identify GBV and refer women on to appropriate support services. However, the problem continues to be under-recognized and poorly addressed by HSC professionals around the world (García-Moreno et al., 2015). A professional's response to disclosure is important, as women who receive positive reactions are more likely to accept help (New South Wales Government, 2019). While evidence for universal screening is mixed (O'Doherty et al., 2015), it is nevertheless essential for professionals to have the skills to ask about and respond to GBV. Since HSC students are based in patient-facing environments early on in their courses, inclusion of undergraduate education on GBV is key to equip them with the knowledge and skills to recognize and respond to GBV. As such, research is needed

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to explore both students' and educators' experiences and perceptions of GBV education in HSC, to identify potential barriers to effective education, and assess how learning in this subject area can be optimized.

Culture, Gender and Traditional Gender Roles

While individuals of any gender identity can experience violence, women are disproportionately victims of male-perpetrated violence. Women also experience a significantly higher rate of more serious, sustained, and repeated episodes of violence (Hester, 2013). Therefore, throughout this paper, the term 'GBV' will be used to refer to violence against women. Though GBV is a global problem, attitudes towards and perceptions of GBV vary globally. While many traditional cultural views and practices are not harmful to women, some perpetuate GBV by distorting views of women's sexuality and normalizing submission to men, such as traditional Latin American 'machismo' which emphasizes masculinity and female loyalty (Gonzalez-Guarda et al., 2011). In their qualitative study, Gonzalez-Guarda and colleagues found that participants often spoke of machismo and gender inequality as a singular issue, with the authors concluding that the former "shape[s] the context" of abuse for many Hispanic women (p. 52). Harmful attitudes regarding gender and gender roles are not exclusive to non-Western contexts: in an American study, Reidy et al. (2009) found that men were more likely to demonstrate aggression towards a woman who they perceived to violate feminine norms. In fact, there is strong evidence to suggest an association between non-conformity with traditional gender roles and poorer health outcomes globally (Weber et al., 2019).

Despite the links between some cultural traditions and violence, Walker (2020) argues that care must be taken to avoid the 'culturalisation of violence' – where culture is determined to be the main cause of GBV. Though a reasonable argument, we consider that the issues outlined here point to the importance of context. Kumagai and Lypson (2009, p. 782) describe the value of developing a 'critical consciousness' which "places [practice] in a social, cultural, and historical context and which is coupled with an active recognition of societal problems and a search for appropriate solutions". GBV is not only a pattern of behavior, but a multifaceted social problem underpinned and perpetuated by a number of structural factors. Structural inequalities – such as women's unequal access to resources and opportunities – often create the conditions for interpersonal violence, such as economic inequality increasing the likelihood of financial dependency. Similar arguments have been made for societal attitudes and ideologies that perpetuate these inequalities, which Montesanti and Thurston (2015) refer to as 'symbolic violence'. For many feminist theorists, these structural factors are not only a precursor to interpersonal violence, but a form of violence in their own right (Montesanti & Thurston, 2015). This paper therefore conceptualizes GBV widely, encompassing harmful attitudes to individuals or groups for reasons associated with gender, with repercussions manifesting on the macro- and micro-level. These include structural factors, such as distribution of resources and internalized beliefs in society, as well as abuse perpetrated directly by individuals or groups.

Engagement with Survivors

Health and social care professionals need to be trained to approach survivors with sensitivity (Tarzia et al., 2020). The practicalities of this are complex, and the consequences of poor engagement are significant. For example, evidence suggests that receiving a negative response from a professional following disclosure is likely to inhibit any future attempts to disclose (Mackenzie et al., 2019). Yet, as noted by Metzl and Hansen (2014), there is more to professional 'competency' in tackling complex social problems than simply acknowledging diversity and holding a non-judgmental attitude (although these are undoubtedly important, see Hegarty et al., 2020). Instead, an awareness of the structural factors which enable and perpetuate inequalities is integral to being able to address them.

Identification of GBV

Research into professionals' attitudes and behaviors has identified reluctance to enquire about GBV. In general, this is attributed to lack of training (Kirk & Bezzant, 2020), confidence (Tavrow et al., 2017) or fears of causing offence (Mauri et al., 2015). Unfortunately however, in a minority of cases, studies have attributed reluctance to professionals' endorsement of negative stereotypes surrounding GBV (Taylor et al., 2013). Additionally, evidence continues to highlight inconsistencies in the quantity and quality of GBV education across undergraduate HSC curricula (Bradbury-Jones et al., 2021). As such, many professionals are entering their careers unequipped with the skills required to identify and respond to GBV.

Research Questions

To identify 'best practice' in GBV education, we conducted a qualitative study to answer the following:

1. How do students' and educators' experiences and perceptions of GBV education compare across participating countries?
2. How do students and educators think GBV should be taught/learned in the curriculum?
3. How do students and educators think GBV education can be optimized in HSC?

As this was an exploratory study, our use of the word 'optimized' within the third question is intentionally broad, with the goal being to allow participants to describe what they believe constitutes 'good' education in their respective fields. This could include practically-driven outcomes such as attainment of professional skills, or more broadly, improving awareness and attitudes toward GBV.

Methods

Study Design

This article reports on the final part of a larger funded study, consisting of three prior phases: (1) a systematic review of effective educational strategies in GBV (Sammut et al., 2021); (2) a cross-sectional survey exploring HSC students' knowledge and confidence in addressing GBV (Bradbury-Jones et al., 2021); and (3) development of a GBV e-learning resource (available at: https://www.nottingham.ac.uk/helmopen/rlos/safeguarding/gbv/index.html). The present qualitative study reports the fourth and final phase.

We held focus groups with a purposive sample of HSC students and academic staff from three universities in Australia, Chile and the UK. Participating universities are members of the Universitas 21 network – a global network of research-intensive universities – with two contributing to earlier phases of this project. The third university was invited to participate to bring a non-Western perspective. Email invitations were sent to eligible student cohorts, while academic staff were approached via selected contacts within each school. In addition, each site independently used posters, digital notices, and snowball sampling through known networks. We purposively recruited students who met the eligibility criteria of being enrolled on a HSC programme at a participating university. Academic staff were required to be actively involved in teaching on any HSC undergraduate programme; this included junior and senior academic staff, as well as part-time educators with substantive clinical roles, to maximize the diversity of our sample. For the purposes of our study, HSC programmes included any undergraduate or postgraduate courses leading to a qualification required to register with a health or social care professional body (for example, doctors, nurses and social workers).

Participants

In total, we conducted nine focus group discussions and one semi-structured interview with 23 students and 21 academic staff. All students were enrolled in an undergraduate health or social care programme, with exception of one student studying law, who expressed interest and was permitted to participate. All academic staff taught on HSC undergraduate programmes, either full-time or part-time. Participant demographics are shown in Table 1.

Procedure

Data collection took place between July 2019 and March 2020. For convenience, sessions took place at selected

Table 1 Participant Demographics

	UK	Australia	Chile
Students			
Gender			
Male	0	0	2
Female	3	6	12
Discipline			
Medicine	0	2	0
Nursing	3	0	9
Midwifery	0	0	2
Dentistry	0	1	0
Social work	0	1	0
Physiotherapy	0	1	0
Nutrition	0	0	1
Biological sciences	0	0	1
Law	0	1	0
Speech pathology	0	0	1
Year of study			
1	0	3	2
2	1	1	3
3	2	0	3
4+	0	0	6
Unknown	0	2	0
Total	3	6	14
Faculty			
Gender			
Male	2	2	1
Female	2	6	8
Discipline			
Medicine	0	3	0
Nursing	4	1	5
Dentistry	0	2	3
Physiotherapy	0	1	1
Social work	0	1	0
Total	4	8	9

locations within each university. Facilitators included members of the research team and other individuals with expertise in GBV and/or qualitative methods, who were selected for their skills and knowledge. The rationale for appointing facilitators who were not part of the research team was pragmatic, enabling a wider range of sessions to be offered to would-be participants, while also providing a greater level of support and skill to the managing of the groups. Facilitators included individuals of various ages and levels of experience, and in some groups, facilitators were known to participants (Table 2). The implications of facilitators' characteristics and knowledge of participants are discussed further under the limitations section. Focus groups were chosen to enable us to explore agreements and differences of opinion in a setting where participants could engage with one another. Due to timetable conflicts, the three UK students who expressed interest in participating were unable to attend on the same day, and so were invited to participate in a group of two and one semi-structured interview. All three indicated they were happy to proceed, and though not conventional, it was decided that these students should nonetheless have the opportunity to participate.

Written consent was obtained prior to the sessions. Topic guides (see Online Resource 1) were developed by project leads in each participating country and reviewed by the wider team prior to use. Where required, team members amended the wording of certain questions to reflect local colloquialisms and terminology: for example, 'educators' became 'academics' in the Australian topic guide. Similarly, facilitators began each group with a brief explanation of what, for the purposes of our study, was meant by the term 'gender-based violence', followed by an invitation to answer any questions. In some groups, such as the Australian faculty session, this led to a discussion of the complexity of defining this concept, and a conversation about terminology such as 'family violence' (often used interchangeably with 'domestic violence' in Australia). In other groups, such as one Chilean student session, these concepts became the subject of discussion later on following the participants' reflections on the social implications of language.

All sessions were audio recorded and identical semi-structured focus group guides were used across each site (translated into Spanish for Chilean participants). Recordings were transcribed locally by facilitators (DS, JK, FL), with Spanish transcripts being translated into English by a research associate (FL). Throughout the process of transcribing, each transcriber checked their own transcription against the audio file to check for accuracy. Additionally, when writing up our thematic findings, all quotations from the Chilean transcripts

Table 2 Context of Data Collection

	Data collection method	Participants known to one another	Participants known to facilitator
UK			
Facilitator(s)	DS: female, aged 27, facilitated all groups (including interview)		
Students	Semi-structured focus groups ($n=1$) *Two participants*	Yes	No
	Semi-structured interview ($n=1$)	N/A	No
Faculty	Semi-structured focus groups ($n=1$) *Four participants*	Yes	DS known to all participants
Australia			
Facilitator(s)	JK: female, aged 25, facilitated both groups JC: female, aged 49, facilitated both groups		
Students	Semi-structured focus groups ($n=1$) *Six participants*	Three participants known to one another	JK known to two participants
Faculty	Semi-structured focus groups ($n=1$) *Eight participants*	Four participants known to at least one other person in the group	No
Chile			
Facilitator(s)	FL: female, aged 25, facilitated all groups LF: female, aged 47, facilitated two groups MB: female, aged 35, facilitated one group		
Students	Semi-structured focus groups ($n=3$) *Group 1: Six participants* *Group 2: Five participants* *Group 3: Three participants*	Group 1: Three participants known to one another Group 2: No information Group 3: Two participants known to one another	FL known to two participants in groups 1 and 3
Faculty	Semi-structured focus groups ($n=2$) *Group 1: Six participants* *Group 2: Three participants*	Groups 1 and 2: No information	LF known to two participants in group 2

were back-and-forward translated by two team members who are speakers of English and Spanish, in line with best practice.

Data Analysis

We undertook inductive thematic analysis (Braun & Clarke, 2006) within a contextualist epistemological framework. Given our study's GBV focus and our mixed gender sample, we chose to apply a gendered lens to our data. This involved bringing certain assumptions to the forefront of analysis: (1) gender is a social construct, (2) traditional gender norms result in power imbalances, and (3) expression of gender and attitudes towards traditional gender norms are highly context-dependent (Stark et al., 2020). An advantage of our international sample was that it allowed us to draw comparisons between the role of local socio-political contexts in shaping participants' views. This was accounted for through the process of analysis.

We utilized a combined inductive and deductive approach in our analysis, generating data-driven codes which related directly to our three research questions. This approach was chosen to enable us to produce a rich description of the data, without attempting to apply analytic preconceptions, while using the research questions to map our findings (Braun & Clarke, 2006). Data were coded by DS and JK, with each author independently coding a number of transcripts before coming together to discuss initial findings and to cross-check coding strategies. No revisions to the coding process were made, due to substantial agreement in approaches, and so independent coding continued until completion. Throughout this process, the authors acknowledged and discussed their positionality in relation to the research questions, including ideas about language, culture, and conceptualizations of GBV. Despite familiarity with the literature, both authors recognized that their understandings stemmed largely from Western academic discussion, and so time was taken to challenge one another's preconceived ideas in relation to our early findings. This was done by reading more extensively, with a focus on international literature, and debating fundamental GBV concepts. A meeting was then held with the wider team (all contributing authors) to share initial findings and to discuss patterns across the datasets. The final stages of analysis (reviewing, defining and naming themes) were undertaken independently by DS. The final thematic map illustrating the codes, themes and accompanying notes was then shared with the wider team for feedback, following which consensus was reached, before the final report was written up.

Ethics

Gender-Based Violence Education

Separate groups were held for students and academic staff due to the potential impact of inherent power differentials on the quality of data obtained. Participant information sheets (PIS) were shared, advising that participation was voluntary and that consent could be withdrawn at any time. However, due to data anonymization, participants were made aware that their contribution could not be disaggregated following data collation. The PIS and consent forms made it clear that participation was strictly confidential, that no identifying information would be included in the study report or other publications, and that all data would be stored securely in accordance with local university policies. The PIS also provided a list of resources and local sources of support for those affected by the subject matter. At the end of each session, participants were given a card with the facilitator's contact information so that confidential support could be requested if needed. Institutional ethical approval was granted from each university, with the University of Birmingham holding overall responsibility as the lead university (University of Birmingham Ethical Review ERN_17-0402).

Results

Three overarching themes were identified: (1) GBV addressed in all but name, (2) Introduce sooner, explore later, and (3) A qualitative approach to learning. These themes correlate with our three research questions, respectively. Some quotations have been edited for readability.

GBV Addressed in all but Name

This theme considers participants' exposure to and perceived importance of GBV education. We explore how attitudes varied across countries and different professional groups, and the perceived impact of university culture.

Student participants from all three countries reported receiving inconsistent exposure to the subject of GBV. Many reported that GBV was not addressed at all (or rather, explicitly) within their curricula, while others suggested that coverage had been incomplete: "When entering the classroom, I think that there is education on gender-based violence in between the lines, but very implied. It's not like, explicitly, that they tell us what gender-based violence looks like, etc." (Chilean nursing student, fourth year).

Academic staff reported similar experiences: "I think I've touched on it [GBV] but probably not under that umbrella term" (UK nursing educator); "I believe that it's not a topic that we have approached directly, but intuitively" (Chilean educator, course unknown).

Students generally expressed the opinion that GBV is an important issue deserving explicit coverage in their curricula. However, a majority reported that they lacked knowledge about the subject and therefore would not feel confident to address GBV in practice. Two third-year UK

nursing students expressed their frustrations at being unprepared to encounter GBV on placement:

> P2: I was really shocked… We were eighteen, nineteen – how old were we?
> P1: Eighteen when we started.
> P2: Eighteen years old and seeing all these abused kids… And as an eighteen-year-old that was actually quite scary. (UK nursing students, third year)

Following this dialogue, both students asked the facilitator a number of practical questions about how to respond to GBV, before summarizing their concerns:

> P1: I think it's really important to learn about it [GBV] to be honest. Especially now we're gonna qualify, we hardly know anything about how to escalate the concerns…
> P2: People expect like… You're the nurse, that's your patient, you should kind of know. (UK nursing students, third year)

Not all participants attributed the same importance to GBV education. In the UK and Australia, many participants suggested that certain professional groups (often social workers) should receive more GBV training than others. Reflecting this, the only social work student in our sample was also the only student to indicate that she had received thorough coverage of GBV: "I think social work students definitely need to learn a lot about this. Every semester, there are at least one or two subjects that have included family violence in this course" (Australian social work student, year unknown).

In contrast, one physiotherapy student commented:

> I think it [GBV education] is something valuable. I think it would be worth having a broader understanding of, but whether they should give us the skills to really deal with it, I'm not sure. I think there is a reason why these kind of issues are handballed [handed over to others] and I don't necessarily think that's wrong. (Australian physiotherapy student, second year).

The issue was approached differently by Chilean participants, who seemed almost unanimously to have strong opinions about GBV and GBV education. Students and faculty talked about GBV as though it were something ubiquitous and universally relevant, with roots in religion, politics and Latin American culture:

> Sadly, I think that the generations before us normalized this… And I feel this is true for the professors in our faculty, mostly men, who are older and lived in that Chile, which was perhaps a bit more patriarchal. They never had the opportunity to really see the situation and reconsider. (Chilean nursing student, third year).

Other apparent influences on participants' attitudes included the wider culture within their universities. One Australian student noted that despite not receiving any coverage of GBV within her curriculum, the issue was being addressed in (non-academic) sessions provided by her department: "I've engaged with a few of the university's sessions […]. The university as a whole is looking at raising awareness for things like sexual assault, so that's where I've learnt it" (Australian medicine student, first year).

While this example may illustrate a shifting university culture, Chilean participants were frequently critical of what they perceived to be a restrictive culture within their university. A number of faculty indicated that strict expectations of 'professionalism' inhibited open dialogue between educators and students:

> The bad thing that I can say about my faculty, they are super restrictive about us getting close to the students. With those restrictions, how am I supposed to wait for a student to come to me and say, "Hey you know what, this happened to me," or, "Can I talk with you, tell you something"? (Chilean educator, course unknown).

Chilean students similarly spoke of feeling confined by a culture of restrictiveness within the university. However, many also expressed the belief that this culture was endorsed and upheld by a number of academic staff (particularly male educators and/or those from older generations). It was apparent across the three student focus groups that participants were sensitive to their educators' biases, with some suggesting that their educators might be ill-suited to teach the subject of GBV:

> How are we going to ask them to teach it [GBV], or include it in their courses, their objectives, etc., if for them it may not be an issue, or perhaps they don't agree, they see it from another perspective? (Chilean nursing student, fifth year).

Overall, most participants reported that GBV had not been covered thoroughly or explicitly within their curricula. Students in particular were generally keen for the subject to be included within curricula, although we noticed differences across countries and professional groups.

Introduce Sooner, Explore Later

Under this theme we discuss participants' views on where and how GBV ought to be incorporated within their curricula.

Participants across all settings expressed varying opinions regarding the timing of GBV education. Students in the UK and Australia often talked about GBV learning in relation to their placement experiences, leading many to argue that GBV should be introduced early in the curriculum and revisited throughout. Some suggested that a lack of preparedness could have negative repercussions for the service users they encounter on placement:

> If a patient comes in and we don't know how to approach them or tackle these issues, I think that can cause major problems and cause major mistrust downstream. So I think it's something that needs to be taught from first year, absolutely. (Australian medicine student, first year).

While many academic staff agreed early coverage of GBV would be beneficial, some also commented on the challenges involved in teaching sensitive content to first year students: "The third years would probably be the best students. There has to be a certain amount of… a feeling that you're supported in the group, rather than just an anonymous student" (UK nursing educator).

This comment reflects similar ideas expressed across other focus groups, where participants indicated that different year groups would likely have different learning needs. Some Chilean participants suggested that first-year students might reject teaching on GBV due to its reputation as a 'taboo' subject. In many cases, this view coincided with suggestions that GBV is a 'fashionable' issue in Chile due to its perceived links with a growing feminist movement. Many participants indicated that diversity and equality trends in Chile are still in their infancy, and as a result, the issue of GBV might not resonate with younger students who have not yet had their 'minds opened' (or their prejudices challenged) by life as a university student:

> Perhaps introduce it [GBV education] gradually, because sadly if we incorporate it now, it may be rejected. People come with different mentalities from outside, and when you come to university, in my opinion you come to know a whole other world. (Chilean nursing student, fourth year).

Other Chilean students echoed this sentiment, with many suggesting that GBV teaching should evolve as the student cohort matures. Participants in the UK and Australia likewise indicated that GBV should be revisited throughout their undergraduate study, although views on how to best address and incorporate the subject varied. Many students expressed the opinion that passive learning strategies such as lectures were ineffective: "I forget everything I learn in lectures to be honest" (UK nursing student, third year); "Lecture slides and that kind of thing is a no. A lot of people don't learn much out of it" (Australian dentistry student, first year).

Suggestions for alternative approaches included use of role play, case studies, or facilitated small group discussions to encourage student engagement. Academic staff also commented on the feasibility of discussing sensitive issues with large cohorts: "I think it should be in smaller groups. I don't think it's a subject matter that you can talk about, not with say first year where there's 135 students… that's the wrong format" (UK nursing educator).

For some students, it was apparent that placement experiences had served as an opportunity to reflect on the complexities of GBV in real-world situations. However, others indicated that exposure to GBV during placement was not enough to guarantee learning, with one participant indicating that students often play the role of passive bystander: "When you're with your mentor you don't… like you don't have to actually think – your mentor is doing everything so like you don't really get to have much of an input" (UK nursing student, third year).

The majority of participants across all sites indicated a preference for active rather than passive approaches to learning. That being said, there were mixed opinions across the groups regarding the effectiveness of online learning. Some participants pointed out the benefits of being able to access sensitive subject matter in a comfortable space, while others described online material as being easily neglected, or alternatively, treated as a tick-box exercise: "I do feel like lectures are much more useful than doing the online – because sometimes, I'm not gonna lie, I don't even… I just wanna get it done, get my certificate sent off" (UK nursing student, third year).

A possible solution, discussed at length in the UK faculty focus group, was to combine in-person and online learning as a way of "hitting at multiple levels" (UK nursing educator). Many participants also suggested that GBV ought to be incorporated into various modules across curricula, in order to emphasize its relevance and transferability:

> It has links with substance use, it has links with suicide, it has links with safeguarding, which are all subjects we teach in the third and first year, and so it's useful for people to make connections between all of them. (UK nursing educator).

Overall, our participants indicated a preference for early and continuous education on GBV. However, some potential problems arising from early introduction were noted: for example, rejection from the cohort, or the pragmatic difficulty of teaching sensitive subject matter to large groups. The majority of students expressed a preference for active learning strategies.

A Qualitative Approach to Learning

When describing her positive and negative experiences of university education, one Chilean student suggested that an

optimized approach to GBV education ought to be 'more qualitative'. This succinct but salient point stood out to us, and went on to shape our final theme. Here we explore the value of hearing lived experiences; the importance of dialogue and reflexivity; and issues of power and empowerment.

In the same way that qualitative research is powered through individuals' stories and experiences, a number of students indicated that hearing the lived experiences of GBV survivors would provide an impactful learning experience:

> We had a class on Indigenous people, so a lot of guest lecturers in that course are Indigenous people who have gone through Stolen Generation and a lot of trauma. They are really powerful in terms of talking about their experience, and it's really a good experience for us, as well, because you've got to know how those people really feel. (Australian social work student, year unknown).

Similarly, many students and educators emphasized the importance of dialogue in the educational setting. As discussed under our first theme, a perceived culture of restrictiveness at university was seen by many Chilean participants as inhibiting open dialogue between students and faculty. Yet beyond this, some educators also expressed apprehension about openly acknowledging their feelings and biases among colleagues for fear of condemnation. One educator admitted feeling uncomfortable when they first encountered openly homosexual students, before recounting the impact of their colleagues' response to this admission:

> When I saw that they were my students I felt a little uncomfortable. It struck me… Then I remember speaking about it with my colleagues, and my colleagues scolded me. But I was not saying… What I wanted to say, in an environment of trust – I wanted to express that it was hard for me as a professor […]. And in return I get that response. Then, what motivation do you have [to speak honestly] afterwards? They'll accuse you of discrimination, but I am not discriminating; I am just saying that in my inner self it's hard to accept this situation. (Chilean educator, course unknown).

Under our first theme we explored how Chilean students were cognisant of their educators' biases (and indeed wanted their educators to acknowledge these biases), yet this account illustrates the repercussions of feeling unable to engage in an honest dialogue with colleagues. As though in response to the above account, one Chilean student expressed a desire to use dialogue as a way of finding common ground for understanding and mutual respect:

> I believe that always being clear and having respect for others, and saying like… before starting a conversation with someone you don't know […], you would clarify certain things which maybe I don't see as being violent [referring to 'gender violent' language], and say like: "If this makes you uncomfortable, let me know". (Chilean nursing student, fourth year).

These accounts speak to the importance of reflexivity, which is another fundamental tenet of the qualitative paradigm. The issue of reflexivity was also alluded to in our Australian focus groups, with many participants exploring this concept in relation to the inherent power dynamics in patient-professional relationships. Students demonstrated a critical awareness of their own power as would-be professionals and reflected on this in relation to GBV:

> The dental chair… the patients see it as a very powerful position. The way we approach it, especially, because we've got our arms around them and they're completely lying flat, so – we're in a position of power, in that sense. So I guess it could trigger something and it's really important to know how to make them feel comfortable. (Australian dental student, first year).

The same student later reflected on the problem of medical paternalism and its implications for service users with a history of abuse. Again, these critical reflections on power resonate with many of the fundamental conceptions of qualitative inquiry. Bringing these ideas back to the educational setting, some faculty spoke of the need to 'empower' students to recognize their role in addressing GBV as soon-to-be professionals. Educators in the UK and Australia recalled instances where students seemed to take a limited view of their ability to address GBV: "I think that when we use the term 'gender-based violence', I can almost see already children's nursing students thinking 'that sounds like an adult [field of practice] term'" (UK nursing educator); "I think the nurses, they often don't feel that they're authorized to do that and so empowering them would be important" (Australian nursing educator).

In contrast, Chilean students seemed to acknowledge and embrace their role in addressing GBV. This was often implied to be a civic as well as professional duty, with many students referencing the evolving social and political context in Chile:

> For medicine, nursing, kinesiology, all health careers basically – on the basis that we're the ones who see the most people [in professional contexts] – there should be a course in first year that opens your eyes and says, "Guys, we have to spark change in Chile". (Chilean nursing student, second year).

In contrast to our second theme, which considered the issue of how, this theme has illustrated a more nuanced view on how education on GBV might be optimized. As a problem which is inherently social and political at its roots, it can be argued that GBV education ought to utilize the same critical and reflexive techniques employed by the academics who seek to understand its dynamics.

Discussion

Our findings were grouped thematically as follows: (1) GBV addressed in all but name, (2) Introduce sooner, explore later, and (3) A qualitative approach to learning. Students and academic staff across all three countries indicated that GBV had been insufficiently or incompletely addressed within their curricula. This finding mirrors conclusions from our previous research (Bradbury-Jones et al., 2021) and other international studies (Bradbury-Jones & Broadhurst, 2015; Doran & Hutchinson, 2017; Valpied et al., 2017). All participants agreed that GBV ought to have a place on their curricula, although some suggested that the subject has greater importance for certain professional groups. Importantly, we discovered a significant difference in attitudes between participants from the UK and Australia compared with those from Chile. While participants in the UK and Australia generally agreed on the importance of GBV education, they were more likely to frame GBV as a clinical issue, with GBV largely being conceptualized as a problem occurring between individuals. This framing reflects the following summarization by Walker (2020, p. 379): "[violence against women] in Western communities is largely attributed to an individual's desire for power and control", suggesting a fundamental cultural difference in conceptualization. This conceived 'distance' between GBV and the social context within which it occurs is perhaps evidenced by the still-prevalent perception that gender inequalities are a nonissue in Western societies. For example, a recent national survey found that two in five Australians believe women exaggerate their unequal treatment in Australia (Australia's National Research Organisation for Women's Safety, 2018), while 29% of UK respondents in a global survey indicated believing that their country had gone 'far enough' in giving women equal rights with men (Ipsos, 2019). In contrast, Chilean participants in our study were more likely to frame GBV as a global social problem. When considering their role in addressing GBV, students talked about the power they would have as professionals to enact social and political change on a wider scale in Chile. To an extent, this may reflect the theme of gender inequality which dominated many Chilean participants' conversations. Many discussions included explicit consideration of the social construction of abuse, with issues such as language subtleties being seen as a form of GBV in their own right. In an analysis of the terminology used in Spanish media, Vidal (2015) argued that discussing GBV without appropriate political contextualization obscures the structural nature of the phenomenon. Again, this perspective resonates with our Chilean participants', and explains what might appear at first glance to be a conflation of different issues (misogyny, homophobia, violence, etc.); in fact, this apparent conflation represents a valid and important perspective of GBV.

It is possible that UK and Australian participants' more limited framing of GBV impacted the importance they assigned to the subject. If so, this could be important to address in raising the profile of GBV as a universally relevant subject, rather than 'just another topic' to fit into a crowded curriculum. That said, we are not suggesting that this framing of GBV is unhelpful; we are, fundamentally, looking to view GBV as an academic/clinical issue. An 'optimized' approach might instead emphasize the social dynamics and systemic power imbalances which underpin GBV (particularly for Western audiences who may minimize this perspective) while also highlighting professionals' roles as individual responders to GBV. This combined focus reflects a key principle of Warshaw's (1997, p. S28) advocacy-based model of medical education, which emphasizes the importance of "analyzing the social construction of [violence against women]" while also locating this perspective within the clinical context. She proposed the following to which our findings attest:

(1) **A safe and supportive learning environment** provides learners with opportunities to explore their internal responses to any issues raised by discussions.
(2) Hearing **survivors' narratives** helps to sensitize students to the complexity of abuse and the ways in which it manifests. **Interactive formats** such as role play or faculty modeling (educator demonstration of skills, behaviors and concepts), where students variably empathize with perspectives of patient and clinician, provide an opportunity to bridge social and clinical perspectives.
(3) On **empowerment**, Warshaw wrote: "In order for students to learn to create empowering interactions with patients, they must have some experience of those interactions themselves" (p. S30).

These principles of empowerment also apply to educators. As Worrell et al. (1996) argued, if an empowered clinician is better able to create empowering interactions with service users, the same will be true for faculty with their students. Many models of empowerment emphasize the role of reciprocal interaction in facilitating empowerment in education. Yet, as one of our participants noted, this is not easily achievable with large cohorts. Furthermore, there is ample evidence supporting the effectiveness of interactive learning strategies which require collaboration between faculty and students (for example, behavior modelling or active listening exercises; Hegarty et al., 2008). This was explored under our second theme, with some students also highlighting the importance of being taught sensitive subjects by educators with whom they feel safe. Many of these issues point to the inadequacy of the lecture theatre as a learning environment for comprehensive GBV education.

Turner et al. (2017) argued that dichotomously categorizing educational approaches as 'active/passive' is over-simplistic, as many programmes identified in their systematic review adopted a multidimensional approach. This approach might be more easily incorporated within dynamic and time-constrained curricula, and may present a more feasible means of early and continuous coverage of GBV. For example, use of online platforms for early introduction to basic concepts, followed by more in-depth and interactive coverage at a later stage. Our participants almost unanimously agreed that GBV education should be revisited throughout curricula, with some participants suggesting that content complexity should increase as the cohort matures. Again, there is evidence to suggest that courses of longer duration, or multiple sessions, are more effective in instilling outcomes such as attitudinal change (Anderson & Whiston, 2005) or perceived competence (Turner et al., 2017).

Our final theme explored the ways GBV education might be optimized by employing a qualitative approach. By this, we primarily mean powering education through stories, rather than simple facts and statistics, to encourage students to develop in-depth insights. Many participants emphasized the importance of narrative and dialogue, framing education in the context of survivors' stories, and exploring sensitive GBV issues in an interpersonal and cooperative way. There is a growing body of literature supporting the value of incorporating the lived experiences of service users into HSC education. Studies have concluded benefits include improved attitudes and self-awareness (Byrne et al., 2013) and an increased desire to challenge 'dehumanizing' practices and cultures (Ridley et al. 2017). In the latter study, after receiving education which prioritized service users' narratives, social work students demonstrated a critical awareness of the harmful impacts of biomedical discourses which they considered to be disempowering. This sentiment was echoed by a number of our participants, with many reflecting on the harms of exerting power over service users who have experienced disempowerment at the hands of abusers. Our participants' desire for open dialogue in GBV education links closely with these arguments, and mirrors findings in the literature. Grant (2014) highlighted that encouraging students to empathize with service users' traumatic experiences can also result in empathic distress (which paradoxically, if not addressed, can result in erosion of one's ability to empathize). To mitigate this, Grant emphasized the need for open communication between educators and students to facilitate reflection and healthy emotion regulation. Techniques such as facilitated group discussions and debrief have been shown to have a positive impact on students' handling of emotional distress (Chow et al., 2011), provided these interactions take place in an environment students perceive to be safe.

Much of this research exploring the incorporation of narrative, reflexivity and principles of anti-oppressive practice into education has been undertaken by social work academics. Given the discipline's sociological and political roots, this speaks to the importance of acknowledging and critically considering pedagogical paradigms when designing, implementing and evaluating education on complex social problems such as GBV. While our final theme draws parallels between some of the broader philosophical underpinnings of the qualitative paradigm and our participants' ideas, we also noted that many of their perspectives resonated with Freire's (1970) philosophy of critical pedagogy and other student-centered pedagogies. And, though many academics have proposed utilizing these pedagogies within HSC education (Blanchet Garneau et al., 2018; Cavanagh et al., 2019), it seems there is little research reporting on implementation of such approaches. Indeed, many authors are critical of the superficial attention given to social perspectives in undergraduate healthcare curricula. As Sharma et al. (2018) argued, teaching students about social injustice does not mean those students will take action in their future careers; instead, a cultural shift is needed within HSC education.

Limitations

Our study has some limitations. First, as a result of self-selection bias, our sample may consist of participants who are particularly interested in GBV and therefore more likely to have positive attitudes towards the subject. Second, power differentials may have impacted on students' accounts and similarly, faculty may have provided socially acceptable responses. However, this limitation was mitigated somewhat by conducting separate focus groups for students and faculty. Where possible, efforts were also made to have certain facilitators take on a leading role in groups where they shared more characteristics with the participants. For example, in the Australian focus groups, JK took the lead in the student focus group due to her younger age, while JC led the educator group. While this was not always possible – for example, within the UK groups – facilitators always took steps to try to make the sessions a more reciprocal experience. This included explaining their roles and reasons for involvement in the project (personal disclosure) and offering snacks and refreshments to help participants feel welcome. While some authors have argued that strategies such as these heighten the risk of boundary blurring (Dickson-Swift et al., 2006), others have challenged this idea, with Oakley (2016, p. 209) calling it "patronizing", and Braun and Clarke (2013, p. 93) advocating the use of such strategies provided they happen "in the framework of a professional interview".

Facilitator characteristics may have influenced the data in certain ways: for example, some data from groups led by younger and less experienced facilitators might have resulted from prompting, rather than a natural flow of discussion as is

ideal for focus groups. However, these facilitators' age may have helped them to build rapport with the younger student participants, which in turn may have aided the quality of data. The same may also have been true for groups where facilitators were known to participants.

Conducting research across countries also presents unique challenges. It is possible that our recruitment strategies and data collection processes varied across countries. Further, as five of our focus groups were translated from Spanish to English, subtle meanings may have changed or become lost in the process. However, our data analysis was led by a speaker of both Spanish and English, which allowed for comparisons to be made across transcripts. Lastly, there are inevitably challenges in 'comparing' cultures across different countries. By using a contextualist epistemological framework we sought to bring context to the forefront of our analysis. While we are not seeking to generalize, we consider that our findings can be carefully transferred to other settings.

Conclusion

Health and social care professionals are well placed to identify and respond to GBV, with their role often being integral to supporting women's help-seeking efforts. Yet, as our study illustrates, many professionals are entering the workforce with little to no structured education on GBV. Our findings build upon previous evidence to describe student and educator perspectives on how GBV might best be integrated into undergraduate curricula. In addition to exploring pragmatic considerations, we have also described the need for a wider paradigm shift in GBV education. A greater focus on empowerment, survivor narratives, open dialogue, and reciprocal interaction will be important to bridging the gap between social and clinical perspectives. Though time constraints and competing demands within undergraduate curricula are frequently cited as barriers to moving away from traditional didactic methods, our finding suggest that teacher-centered strategies are insufficient and, in some regards, inappropriate for GBV education. We argue that a new approach is needed if we are to best prepare tomorrow's professionals to tackle this pervasive problem.

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Declarations

Conflict of Interest We declare no conflicts of interest.

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