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**Title**

Educating university Allied Health students about gender based violence: report of a pilot study

**Short title:** Education about gender-based violence

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**Title**

**Educating university Allied Health students about gender based violence: report of a pilot study**

**Short Report Abstract**

**Introduction / Aim**

Sexual harassment, bullying and discrimination occur across a range of health care settings, with frequent complaints made to Health Professional Registration Boards of Australia. **H**ealth professional education provides an ideal opportunity to ensure students understand the nature of gender based violence, how to prevent and address such behavior.

The aim of this pilot project was to increase awareness and knowledge of pre-registration allied health students of the context of gender-based violence and for participants to learn bystander approaches to reduce violence.

**Innovation / Evaluation**

A primary prevention educational workshop was developed **as a key component of** curriculum for a single discipline cohort of health students. **Participants completed a survey pre and post the workshop where they provided responses to statements exploring attitudes, knowledge and behaviors in relation to behaviors that constitute gender-based violence.** Within-subject pre– and post–intervention statistical analysis was completed.

**Outcomes**

The results demonstrated several significant positive changes of knowledge and attitude of the participants in relation to gender-based violence.

**What next?**

The findings of the project can inform the development of integrated gender focused education as a core competency for preparing health professional students across a range of disciplines in clinical health and public health curricula.

**MANUSCRIPT**

**Introduction**

Sexual harassment, sexism and gender discrimination are common in workplaces including health care settings (Victorian Equal Opportunity and Human Rights Commission, [VEOHRC], 2020). Sexual harassment is more likely to occur in settings where stereotyped constructions of masculinity, sexism and gender discrimination are excused or tolerated (Our Watch, 2020). Gender based violence (GBV) is a major public health issue (World Health Organization [WHO], 2013) that occurs on a continuum (McMahon & Banyard, 2012) ranging from demeaning attitudes to women, sexist jokes (AHRC, 2020) to sexual harassment (Kabat-Farr & Crumley, 2019) and at its most severe, crimes against women such as rape, sexual assault and family and domestic violence (Flood, 2019; Our Watch, 2015). These are significant public health issues, with attention drawn recently to their prevalence and associated dire effects within work place settings, with the #Me Too movement and calls to end sexist attitudes and behaviours that condone violence against women (Fileborn, Loney-Howes, & Hindes, 2019; Jagsi, 2018).

Complaints about health professionals’ behavior are frequent to the national professional boards of registered health practitioners in Australia (Australian Health Practitioners Regulation Agency [AHPRA], 2019; Bismark et al., 2020). AHPRA received 92 notifications about “sexual misconduct” and 1167 about “boundary violations” in the 2018/19 year (AHPRA, 2019). Results of the first Medical Training Survey, with almost 10,000 doctors found more than one in three trainees experienced or witnessed bullying, harassment or discrimination (Medical Board of Australia and AHPRA, 2020). The report noted that bullying, harassment and discrimination negatively impact patient safety, constructive learning and the culture of health care and highlighted the needed to strengthen professional behaviour. Male health professionals are identified as the main perpetrators of gender-based violence (Our Watch, 2020) and key to engage in primary prevention programs (Wells & Fotheringham, 2021).

Each of the national boards of health practitioners in Australia require all registered health student practitioners to adhere to a Code of Conduct on professional behavior (AHPRA 2019). It is therefore essential that students as potential leaders understand professional boundaries, the prevalence of sexism, gender discrimination and harassment, how to avoid unprofessional behavior in workplace settings and how to take necessary action towards achieving gender equality (VEOHRC, 2020). Sexual harassment and gender-based violence are not women’s issues, they are societal issues (Australian Human Rights Commission [AHRC], 2020). Health care professionals have a key role in addressing these issues and influencing cultural change. Primary prevention education to address gender based violence within health professional curriculum is warranted.

Health professional curricula must encompass these higher order values-based content areas to ensure students have a good understanding of gender based violence and knowledge of how to stop disrespectful behavior (Fenton & Jones, 2017). To date, an integrated focus on gender has largely been overlooked or sparsely covered (Siller, Komlenac, Fink, Perkhofer, & Hochleitner, 2018; World Health Organisation, 2007) in health professional education within curriculum often densely packed and dominated by clinical skills and task-based learning outcomes (Lovi et al*.,* 2018). The challenge is to ensure this content is covered with appropriate pedagogies aimed at ethical and moral outcomes. The literature based on transformative learning focuses on this issue, and experiential learning and content delivery by workshop are both highly regarded methods to engage the student participant in deeper learning (Glisczinski, 2016).

Primary prevention education is key to creating culturally safe workplace and influencing individuals to address the ‘drivers’ of gender based violence (Our Watch, 2020). Though relatively new in Australia, these programs have a long history in the USA (Katz, 2018) commonly utlising workshops to incorporate bystander approaches. Bystander approaches seek to promote individual awareness of gender inequity and change the social norms, which condone and perpetuate violence against women (Katz, 2018). Bystander approaches focus on leadership and the development of skills and knowledge of bystanders to interrupt GBV. The approach encourages men to be agents of change alongside women. (Wells & Fotheringham, 2021) to advance gender equity (AHRC, 2020). This approach suits the role of health professionals, many of whom **have capabilities for practice that include patient advocacy, community leadership and acknowledgement of the right to be treated with respect (AHPRA, 2020)**.

**Innovation**

*Methods*

A pilot study primary prevention educational workshop was undertaken that aimed to increase awareness and knowledge of the context of GBV and for participants to learn about bystander approaches to intervene to reduce violence. All students enrolled in a core unit of study in the Master of Osteopathic Medicine (n = 57) at a regional Australian University in 2019 were eligible to participate.

**Osteopathy was deemed an appropriate professional training in which to deliver this content as unlike many other health professions, has an even gender mix (AHPRA, 2019) and presented a valuable opportunity to engage men. In addition, osteopaths (combined with chiropractors), are reported to have relatively high r**ates of notifications regarding sexual harassment or assault (Bismark et al., 2020)**.** Ethics approval was granted from Southern Cross University Human Research Ethics Committee (ECN-17-182).

A three hour workshop was designed and delivered by an expert in gender based violence (GBV) April, 2019. The workshop content covered behaviours that constitute GBV including harassment; attitudes, beliefs and behaviours that normalise GBV; stereotyped constructions of masculinity and femininity, leadership and bystander strategies to interrupt violence and challenge sexist behaviour. The delivery was through facilitated discussion, scenarios, whole of group interactive activities, and use of audio-visual material. Students were able to leave the workshop at any time without any repercussions and attendance at the workshop was not compulsory.Informed consent was gained.

As there were no appropriate or suitable validated instrument, a survey was developed through a review of key literature (Alegría-Flores et al., 2017; ANROWS, 2018; Hutchinson & Doran, 2017; McMahon, Palmer, & Banyard, 2017) **exploring attitudes, knowledge and behaviors in relation to gender-based violence**. **Participants completed the survey pre- and post- workshop where they provided responses to statements (25 questions) according to a 5 point Likert scale (1 = strongly agree to 5 = strongly disagree).** Students were instructed to create their own code using the last two years of their year of birth and the first two letters of their mothers first name. There were three open-ended questions at the end of the post survey: *What was the most valuable part of the workshop?* *What are your suggestions for improvement? And Do you have any further comments?*

***Data analysis***

Within-subject pre– and post–intervention statistical analysis was completed (IBM Corp. Released 2019. IBM SPSS Statistics for Windows, Version 26.0. Armonk, NY: IBM Corp). Differences across time were analysed using paired-samples *t*-tests, and significant differences considered when *p*<.05. The mean results indicate strength of agreement, with a score < 3 indicating agreement and > 3 indicating disagreement. Cross tabulations were performed for both age and gender effect on survey responses. The open-ended responses were collated.

**Evaluation**

*Results*

Forty participants attended the workshop. There were 21 matched pre- and post-surveys. The matched respondents were 52.4% female; the median age category was 25-30 years (38.1%), with another 38% between 31-50 years. The group were all English speakers at home, and one student identified as Indigenous. Table 1 presents the pre-post survey results with significant results shaded.

**Table 1: Survey results Insert here**

* Key significant findings from this post survey were that after the violence prevention training, participants had significantly more agreement with the statements: "Men's violence against women is common in our community"; *t* (20) = 4.18, p <.001.
* “The majority of perpetrators of domestic violence are men”; *t*(19) = 3.58, p <.002
* “I have a good understanding of the non-physical types of men’s violence against women”; *t*(20) = 4.17, p <.001
* “I am confident to explain the types of men’s non-physical violence against women”; *t*(20) = 5.56, p <.001

Also, after the violence prevention training, participants had significantly more disagreement with the statement:

* “If a woman dresses in a sexy manner (wearing short skirts or tight clothes for example) she is asking for sexual attention” ; *t*(19) = 3.33, p <.004

There were no significant differences for age or gender.

Fourteen students provided written comments on the workshop. Students commented positively on content, resources, the facilitation process and the way the information could be applied as highlighted in comments below.

“Gender stereotype explanations and examples; learning all the different variation of violence”:

“Different ways I can act as a bystander”.

“Very important conversation for all age groups and walks of life”.

The benefit of peer engagement was reflected in several comments:

“Seeing the people I spend so much time with engage in such an important topic, especially the men in the room”.

“Hearing peers different opinions and views”.

Suggested ways to improve the workshop included a role play activity to explore the content more deeply, a broader spectrum of violence examples and compulsory attendance.

**Outcomes**

The results of this pilot educational workshop demonstrated several significant positive changes in this cohort. The students improved their knowledge of how common GBV is in the community, the gendered nature of violence and their understanding that most perpetrators of violence are men. Post workshop there was a significant shift in gender respectful attitudes in relation to not blaming women’s choice of clothing for perpetrators’ behaviour. This is important given attitude’s that excuse, blame, condone and minimise violence can contribute to a culture of support for violence (Our Watch, 2020). Whilst most Australians do not accept sexism and want to address it, nearly one quarter of Australians see no harm in telling sexist jokes (Webster et al., 2018). This is comparable to international estimates where 28% men around the world think it is acceptable to tell sexist jokes or stories at work (Global Institute for Women's Leadership, 2020). Participants in this study significantly improved in their understanding of what constitutes sexist behaviour, and there was a non-significant trend towards speaking out and taking action against sexist language. Violence prevention education needs to dispel myths in order to reduce the prevalence of sexual harassment in health care contexts where gender stereotypes remain unchallenged and sexism is excused or tolerated (AHRC, 2020). The results from this pilot intervention are encouraging as a way to dispel myths and promote understanding of the drivers of gender based violence which include gender stereotypes and sexism (Our Watch, 2020).

A clear understanding of the context and spectrum of violence is an important influence on any attitude and willingness to intervene to address the issue (Katz, 2018). Whilst this project did not directly assess behaviour, the findings demonstrate a positive trend for all participants to step up as bystanders and a willingness to intervene to address sexism and disrespectful attitudes.

Students in this study indicated support for gender based education within their undergraduate curriculum. An integrated curriculum to address GBV would assist health care students to meet professional requirements and equip them to become effective global citizens and agents of 'social good’ (VEOHR, 2020). Knowledge about the implications of behaviours that are unacceptable are a precursor to action. Whilst the benefit of the bystander approach is that all participants are engaged as pro-active bystanders to address GBV (Katz, 2018), it is particularly important to engage men as bystanders as they often hold positions of power, can influence culture and can advocate for change (Our Watch, 2020). A global study of almost three hundred men engaged in antiviolence work found that bystander willingness was supported with self-efficacy to engage in bystander behaviour, positive beliefs about the contributions of antiviolence involvement, and an awareness of male privilege (Casey et al., 2019).

Post- workshop comments reflected the value of the workshop for future health professionals with suggestions for more specific skills to address potential issues in clinical practice. Education about GBV with undergraduate health care students can provide practical tips to speak up against sexism, gender discrimination and gender inequality to positively influence the culture of health care (Hennelly et al., 2019), and challenge attitudes, norms and behaviours that drive GBV (Our Watch, 2020). This is crucial to address what has been described as “endemic unprofessional behaviour in health care” (Westbrook et al*.,* 2018) with the true prevalence of discriminatory behaviours such as gender harassment, offensive remarks and practices most likely to be under-reported. Our pilot study suggests the benefits of workshop format to stimulate discussion about GBV with peers in a safe context.

As a pilot study the outcomes of this brief educational intervention of a facilitated workshop are promising as a way to inform the development of GBV education within undergraduate health student curricula. A larger study based on this pilot could help build an Australian evidence-base for effective gender based education (Siller et al*.,* 2018) to address the prevalence of sexual harassment within health care and prepare health practitioners to meet professional standards of practice. As osteopaths and other disciplines are registered health practitioners that abide by ethical principles and capabilities that **include patient advocacy and community leadership,** it is essential they recognise GBV and act to support clients in both the clinical and community environment. The use of experiential and workshop based pedagogies appear promising to engage students at this level of knowledge and understanding.

***Limitations***

There were a number of limitations to the data including the small sample size from one discipline and the limitations of a pre-post design. A simpler coding system may have improved the rate of post workshop matching. Not all students attended the non-compulsory workshop and a few students left the workshop early without expressing their reasons.

**What next?**

Workshops in GBV delivered to pre-registration healthcare students can potentially enhance knowledge and skills in line with their graduate and professional attributes in practice and in the community. There were areas where the changes from the workshop were non-significant, and these could be emphasised more in future workshops. For example, a focus on the types and impacts of non-physical violence, and training in different ways people can take action to prevent or stop abusive behaviour towards a woman. Larger interventions could possibly show significant age and gender differences. A series of integrated workshops through curriculum with a focus on behavioural change may improve the results. However, this brief educational workshop intervention has demonstrated promising results from an innovative pedagogy that can be integrated into the core curriculum across a range of health disciplines.

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**Table 1 Survey results**

**(Data from five point Likert scale: 1 = strongly agree to 5 = strongly disagree)**

| **Statement**  | **pre M (SD)** | **95%CI** | **Post M (SD)** | **95%CI** | **M diff** | **SD** | **t** | **df** | **p** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Sexual harassment is common* | 1.95 (0.97) | -0.29 | 1.74 (1.10) | 0.71 | 0.21 | 1.03 | 0.89 | 18 | .385 |
| *Women often make false reports of sexual assault* | 3.52 (0.81) | -0.41 | 3.52 (0.93) | 0.41 | 0 | .89 | 0 | 20 | 1 |
| *Sexual assault and sexual harassment are not a big deal* | 4.90 (0.44) | -0.14 | 4.90 (0.30) | 0.14 | 0 | .32 | 0 | 20 | 1 |
| *Men’s violence against women is common in our community* | 2.29 (0.64) | 0.36 | 1.57 (0.75) | 1.07 | 0.71 | 0.78 | 4.18 | 20 | <.001 |
| *Attitudes about gender roles and relationships are contributing factors in men’s violence against women* | 2.14 (0.48) | -1.00 | 1.86 (0.79) | 0.67 | 0.29 | 0.85 | 1.55 | 20 | .137 |
| *The majority of perpetrators of domestic violence are men* | 2.75 (0.85) | 0.27 | 2.10 (0.79) | 1.03 | 0.65 | 0.81 | 3.58 | 19 | .002 |
| *If a woman dresses in a sexy manner (wearing short skirts of tight clothes for example) she is asking for sexual attention* | 4.05 (0.83) | -0.73 | 4.50 (0.61) | -0.17 | -0.45 | 0.61 | 3.33 | 19 | .004 |
| *When guys make suggestive comments about a woman’s body, she should take it as a compliment* | 4.20 (0.62) | 0.09 | 4.40 (0.75) | -1.45 | -0.20 | 0.62 | -1.45 | 19 | .163 |
| *It’s OK to call someone “slut”, “bitch”, and “ho” to refer to women as long as you are joking* | 4.76 (0.54) | -0.13 | 4.71 (0.64) | 0.22 | 0.05 | 0.38 | 0.57 | 20 | .576 |
| *Rape results from men not being able to control their need for sex* | 3.76 (1.09) | -0.16 | 3.62 (1.32) | 0.44 | 0.14 | 0.66 | 1.00 | 20 | .329 |
| *If a woman is raped while she is drunk or affected by drugs, then she is at least partly responsible* | 4.81 (0.40) | 0.15 | 4.71 (0.46) | 0.34 | 0.10 | 0.54 | 0.81 | 20 | .428 |
| *A person is not really abusive as long as they don’t physically harm someone* | 4.86 (0.36) | -0.15 | 4.90 (0.30) | 0.05 | -0.05 | 0.22 | -1.00 | 20 | .329 |
| *Intimate relationships between a man and a woman work best when the man is the leader* | 4.52 (0.68) | -0.06 | 4.19 (1.12) | 0.72 | 0.33 | 0.86 | 1.78 | 20 | .090 |
| *In some circumstances violence against women is justified* | 4.57 (0.98) | -0.26 | 4.38 (0.97) | 0.64 | 0.19 | 0.98 | 0.89 | 20 | .384 |
| *What happens between two people including a man and a woman physically fighting is none of my business* | 4.24 (0.83) | -0.28 | 4.05 (0.92) | 0.66 | 0.19 | 1.03 | 0.85 | 20 | .407 |
| *There are a number of different ways people can take action to prevent or stop abusive behaviour towards a woman* | 1.75 (1.02) | -0.46 | 1.70 (0.80) | 0.56 | 0.05 | 1.10 | 0.20 | 19 | .841 |
| *If I saw a man behaving abusively to a woman I would likely speak out or take action* | 2.05 (0.69) | -0.20 | 1.90 (0.45) | 0.50 | 0.15 | 0.75 | 0.90 | 19 | .379 |
| *If I saw a man using sexist language or calling women derogatory names I would likely speak out or take action* | 2.20 (0.52) | -0.04 | 1.90 (0.55) | 0.64 | 0.30 | 0.73 | 1.83 | 19 | .083 |
| *A bystander has the potential to prevent sexual assault and sexual harassment* | 1.70 (0.66) | -0.09 | 1.45 (0.61) | 0.59 | 0.52 | 0.72 | 1.56 | 19 | .135 |
| *I would be willing to speak out or take action if I saw anyone behaving abusively towards another* | 2.11 (0.57) | -0.05 | 1.89 (0.57) | 0.47 | 0.21 | 0.54 | 1.71 | 18 | .104 |
| *I would be willing to speak out or take action if I saw a friend behaving abusively towards another* | 1.67 (0.58) | -0.15 | 1.48 (0.51) | 0.53 | 0.19 | 0.75 | 1.16 | 20 | .258 |
| *I feel confident that I have the skills to speak out or take action if I saw anyone behaving abusively towards another* | 2.45 (0.69) | -0.04 | 2.05 (0.76) | 0.84 | 0.40 | 0.94 | 1.90 | 19 | .072 |
| *I have a good understanding of the non-physical types of men’s violence against women* | 2.57 (0.87) | 0.45 | 1.67 (0.66) | 1.36 | 0.91 | 1.00 | 4.17 | 20 | <.001 |
| *I am confident to explain the types of men’s non-physical violence against women* | 2.86 (0.79) | 0.74 | 1.67 (0.66) | 1.64 | 1.19 | 0.98 | 5.56 | 20 | <.001 |
| *I believe men’s violence against women is preventable* | 1.70 (0.47) | -0.42 | 1.65 (0.99) | 0.52 | 0.50 | 1.00 | 0.22 | 19 | .825 |

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***Conflicts of Interest***

No conflicts of interest exist.

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