Gender-Based Violence in Clinical Training: Insights Into and Call for Interventions in South African Higher Education Institutions

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Abstract

Gender-based violence remains a pervasive issue in South African higher education institutions, particularly in clinical training environments where hierarchical structures, power imbalances and high-stress conditions exacerbate vulnerabilities. Despite extensive research on gender-based violence, its occurrence within clinical training contexts remains underexplored. This review article examines the unique vulnerabilities of clinical students and the systemic factors that perpetuate gender-based violence. It draws on Crenshaw's intersectionality to explore the ways in which structural inequalities and overlapping identities exacerbate these challenges. It identifies key gaps in existing research and emphasises the need for comprehensive context-sensitive responses. The article advocates a multifaceted approach that includes structural reforms, such as survivor-centred grievance mechanisms, and cultural interventions, such as gender-transformative programmes that address harmful norms and foster equitable relationships. Institutional accountability through transparent policies and capacity-building initiatives is also emphasised. Recognising the diversity of South African higher education institutions, the article underscores the importance of tailored interventions that consider institutional disparities, such as rural–urban divides and historical inequities. By proposing actionable strategies, this study calls on higher education institutions to prioritise proactive sustainable measures to deal with GBV and create safer, more inclusive environments for clinical students. The findings contribute to ongoing scholarly debates and provide a framework for institutional transformation in addressing gender-based violence.

Keywords: gender-based violence; clinical training; higher education institutions; intersectionality; transformative interventions

UNISA university of south africa PRESS
Social and Health Sciences
Volume 24 | Number 1 | 2026 | #19997 | 20 pages
https://doi.org/10.25159/2957-3645/19997
ISSN 2957-3645 (Online)

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Introduction

Gender-based violence (GBV) represents a critical global health and human rights concern. It manifests in various forms, such as physical harm, psychological/emotional harm, sexual harassment, rape and economic harm rooted in unequal power relations and harmful gender norms (Krug et al., 2002; Republic of South Africa, 2007; 2011; UNICEF, 2017; United Nations, 1993; WHO, 2021). These manifestations differ by setting, but all reinforce unequal gender dynamics and undermine individual agency. In South Africa, GBV persists at alarming levels despite the presence of progressive legal frameworks (Arango et al., 2014; Magezi & Manzanga, 2019; Radzilani-Makatu & Chauke, 2019; South African Police Service [SAPS], 2020). These patterns are underpinned by cultural norms that valorise male dominance, which restrict women's ability to assert sexual and reproductive autonomy (Peacock, 2013; Van den Berg et al., 2013).

Critically, GBV is not only a societal problem but is also embedded in institutions, including higher education institutions (HEIs), where it often goes under-examined. In these settings, GBV is shaped by institutional hierarchies, systemic inequalities and normalised silences, which hinder reporting and accountability. Persistent structural patriarchy, reinforced by inadequate institutional responses and patriarchal culture, contributes to survivors' reluctance to report, thereby perpetuating cycles of violence (Enaifoghe & Idowu, 2021; Graaff & Heinecken, 2017; Treves-Kagan et al., 2020).

South Africa remains one of the most dangerous countries, with GBV consistently ranked among its most pressing public health and human rights crises (SAPS, 2020). The disconnect between legislative advances and the lived experiences of survivors suggests that policy alone is insufficient. Legal protections exist, but enforcement is inconsistent, and institutional accountability remains weak. Normative gender roles further entrench vulnerability. Male control over sexual and reproductive decision-making is sustained by cultural ideals of masculinity, while women face blame or shame when attempting to assert autonomy (Peacock, 2013; Van den Berg et al., 2013). The normalisation of violence sustains cycles of abuse, often beginning in childhood. Treves-Kagan et al. (2020) argue that early exposure to violence serves as a key predictor for perpetration later in life, particularly among men, which reinforces the intergenerational nature of GBV. Efforts to challenge GBV must confront both its cultural foundations and its institutional manifestations. Patriarchy is not only a societal system but is reproduced through the norms, structures and silence of institutions, including HEIs (Graaff & Heinecken, 2017; Enaifoghe & Idowu, 2021).

While GBV is pervasive across HEIs globally, medical and health sciences students face distinct vulnerabilities owing to the structure and culture of clinical education. These students operate in environments characterised by entrenched hierarchies, prolonged physical and emotional demands, and a high degree of dependency on senior professionals for academic progression. These dynamics contribute to a culture where

GBV may be normalised or overlooked, particularly when power differentials limit the capacity to report violations (Fnais et al., 2014; Dzau & Johnson, 2018).

Despite being trained to care for survivors, healthcare students themselves are often unprotected. A meta-analysis found that nearly 60% of medical students reported harassment or discrimination during training (Fnais et al., 2014). Early studies, such as Komaromy et al. (1993), exposed the disproportionate targeting of female medical students, who were reported to be over twice as likely to experience harassment than their peers in non-STEM fields. The 2018 report by the National Academies of Sciences reinforced these concerns, which underscored the pervasiveness of faculty or staff-perpetrated harassment in clinical environments (National Academies of Sciences, Engineering, and Medicine et al., 2018).

These experiences are not isolated. They are embedded in the broader structure of HEIs in South Africa, where systemic gender inequality amplifies student vulnerability. Despite public discourse and activism, such as the #EndRapeCulture protests, limited research has specifically examined GBV in clinical training contexts. This represents a critical gap in scholarship, policy and institutional accountability.

Research Gaps and Rationale

Despite extensive research on GBV in South Africa, significant gaps persist in understanding the specific vulnerabilities of clinical students in HEIs. Much of the existing literature generalises findings from broader student populations, and overlook the unique contexts of clinical training. These environments are characterised by hierarchical structures, high stress demands and dual roles that position students both as learners and as providers of patient care. These dynamics foster distinct vulnerabilities that remain insufficiently explored (Dzau & Johnson, 2018; Fnais et al., 2014).

One critical gap is the lack of disaggregated context-specific data on the prevalence, forms and drivers of GBV in clinical settings. The entrenched hierarchies of clinical education often intensify risks of exploitation and abuse, yet these structures are rarely interrogated in empirical studies. Without targeted evidence, it remains challenging to design effective, contextually appropriate interventions (Fnais et al., 2014).

There is also a notable absence of intersectional analysis in existing research. Intersectionality, as theorised by Crenshaw (1991), offers a lens to examine the ways in which overlapping identities such as gender, race and socio-economic status shape individual experiences of GBV. For instance, a female student from a rural historically disadvantaged background may encounter compounded risks and additional barriers to seeking redress. Although some literature acknowledges this complexity, few studies apply intersectionality in a systematic way to clinical education settings, which limits the relevance and reach of proposed solutions (Treves-Kagan et al., 2020).

In addition, although the psychological and emotional effects of GBV are well documented in general populations (WHO, 2024), little is known about how GBV has an impact on clinical students' academic performance, career progression or professional identity formation. The high-pressure nature of clinical training – coupled with trauma from GBV – can erode confidence, impair focus and undermine students' ability to form mentoring and peer networks, all of which are vital to academic and professional success (Dzau & Johnson, 2018).

Institutional diversity in South Africa's higher education sector also presents a critical research gap. Universities vary widely in resources, infrastructure and social contexts. Urban HEIs may be better equipped with grievance procedures and reporting mechanisms, while rural or historically disadvantaged institutions may face resource constraints and institutional cultural resistance to addressing GBV. However, few studies assess contextually how these institutional contexts influence the forms and prevalence of GBV or the effectiveness of response mechanisms (Treves-Kagan et al., 2020). These gaps underscore the urgent need for research that is both context specific and analytically robust. Comprehensive studies that consider intersectionality, institutional diversity and the realities of clinical education are essential to inform policy and practice. Without this foundation, efforts to deal with GBV in clinical training environments risk being ineffective or misaligned with the lived experiences of students.

South Africa's broader GBV crisis further underscores the urgency of this focus. Despite legislative gains and international commitments, such as the SADC Protocol on Gender and Development, the country continues to record some of the highest rates of GBV globally. Approximately 60% of South African women report having experienced abuse and reported sexual offences rose from 52 420 in 2018/2019 to 53 293 in 2019/2020 (SAPS, 2020). These figures reveal the inadequacy of existing mechanisms and the persistent influence of cultural and structural factors that sustain violence.

In HEIs, institutional responses to GBV are often insufficient. Grievance mechanisms are poorly resourced, survivors face stigma, and institutional cultures frequently discourage reporting (Dzau & Johnson, 2018). For clinical students, these failures are compounded by the dependence on supervisors for evaluations and references, which makes it difficult to report abuse without fear of academic or professional retaliation. This review therefore focuses on GBV as experienced by clinical students in South African HEIs and aims to contribute to evidence-based strategies for creating safer, more equitable academic and clinical environments.

Theoretical Framework

This review is anchored in intersectionality as conceptualised by Crenshaw (1991). Intersectionality provides a useful analytical lens for understanding the ways in which multiple overlapping identities – such as gender, race, socio-economic status, language

and geographic location – interact to shape unique experiences of a phenomenon, usually one characterised by disadvantage, exploitation or discrimination. Adapted to this review, this framework is particularly relevant in the South African context, where structural inequalities and historical legacies continue to influence institutional culture, access to resources and students' lived experiences. Clinical students, especially those at historically disadvantaged institutions or rural campuses, often navigate environments marked by systemic under-resourcing, hierarchical supervision structures and limited reporting mechanisms. These structural and institutional conditions intersect with individual identities to create layered vulnerabilities to GBV – often without adequate redress.

Although intersectionality is widely acknowledged in global discourse, it remains underutilised in studies on GBV in HEIs. Many works treat students, and particularly women students, as a homogenous group, thereby overlooking the ways in which race, class or institutional context shape the form and impact of GBV. For instance, Black women from low-income or rural backgrounds may experience barriers not only in accessing support services but also in reporting incidents because of stigma, linguistic limitations or fear of institutional retaliation. These layered challenges are seldom disaggregated in current literature, despite their critical importance.

This framework is also used to highlight institutional dynamics – such as power asymmetries between clinical students and supervisors, unaccountable reporting mechanisms, and the bureaucratisation of redress – that perpetuate silence and inaction. These patterns are well documented in existing studies (for example, Fnais et al., 2014; Treves-Kagan et al., 2020), which note how students often calculate the risks of reporting based on perceived institutional inaction or fear of academic backlash. This review, therefore, adopts intersectionality not only as a tool for identifying disparities but also as a guide for designing interventions that respond to the differentiated needs of clinical students.

Methodology

This article adopts a narrative literature review approach to synthesise current knowledge on GBV in clinical training environments in South African HEIs while identifying research gaps and informing context-relevant interventions.

Search Strategy

A structured literature search was conducted from March to May 2025, using the following databases: Scopus, PubMed, Google Scholar, Web of Science, EBSCOhost, African Journals Online (AJOL). The search strategy combined medical subject headings and free-text terms. Boolean operators (AND/OR) were used to expand or narrow the results as necessary. The search followed general best practices for literature reviews as outlined by Green et al. (2006) and Munn et al. (2018).

Key terms included the following:

- "Gender-Based Violence" AND "Clinical Training";
- "Sexual Harassment" AND "Medical Students";
- "GBV" AND "Higher Education Institutions" AND "South Africa";
- "Power dynamics" AND "medical education"; and
- "Gender transformative interventions" AND "Gender Justice".

Inclusion and Exclusion Criteria

The included sources were the following:

- peer-reviewed articles;
- reports, policy briefs and book chapters relevant to GBV in HEIs, especially in clinical or health education contexts;
- studies written in English; and
- literature addressing GBV policy, prevalence, and interventions in South African, sub-Saharan African and other relevant contexts.

The exclusion criteria were the following:

- studies not focused on post-secondary education;
- articles with insufficient methodological transparency; and
- publications focused solely on general gender equality or empowerment without addressing GBV specifically.

Selection and Screening Process

The guidelines for Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021) were followed to retrieve an initial pool of 326 articles. After title and abstract screening, 94 articles were selected for full-text review. Based on relevance and inclusion criteria, 73 sources were included in the final synthesis. The selection process was carried out manually by the lead author and cross verified for accuracy.

Data Extraction and Analysis

The included articles were analysed using a thematic synthesis approach (Thomas & Harden, 2008). This involved the following:

- extracting descriptive data (author, year, study setting, population, type of GBV, outcomes);
- identifying emergent themes aligned with the guiding framework of intersectionality (Crenshaw, 1991); and
- categorising the findings into broad thematic areas:
  - GBV in South African HEIs and clinical training settings,

- oversight mechanisms, and
- the urgency of addressing GBV in clinical training.

Limitations of Existing Literature

This review identified the following limitations in the body of literature:

- a lack of studies that focus explicitly on GBV among clinical or health sciences students in South Africa (Duba et al., 2020; Dzau & Johnson, 2018);
- underreporting and lack of prevalence data for violence in clinical settings;
- a focus on general campus-based GBV without attending to clinical training hierarchies or mentor–student dynamics;
- insufficient intersectional analysis that incorporates race, socio-economic status or rural–urban divides in GBV experiences; and
- a lack of longitudinal studies, especially those assessing long-term intervention outcomes.

These gaps highlight the urgent need for more context-specific, disaggregated and gender-sensitive research.

Findings

GBV in South African HEIs and Clinical Training Settings

GBV remains a pervasive and under-addressed issue in South African HEIs. Protests across campuses have brought public attention to the deep frustration among students regarding the inadequacy of institutional responses (Department of Higher Education and Training [DHET], 2019). While a few cases gain media attention, the majority go unreported, which masks the true scale of the problem (Phipps et al., 2018). This invisibility is not incidental but results from systemic barriers that inhibit survivors from speaking out and institutions from taking meaningful action.

The social dynamics in university settings play a central role in reinforcing these silences. Studies suggest that in 80–90% of GBV cases on campus survivors know their perpetrators – often as friends, acquaintances or romantic partners (Fisher et al., 2010; Rennison & Addington, 2014). Alcohol-fuelled social environments further complicate reporting, with survivors fearing blame or disbelief, particularly in the absence of physical evidence (Fisher et al., 2010). Such dynamics are compounded by institutional practices that prioritise image management over accountability. Some universities have reportedly discouraged survivors from pursuing formal complaints to avoid reputational damage (Rentschler, 2015). In many cases, survivors are advised to remain silent to avoid jeopardising academic relationships with influential mentors (Ahmed, 2015). These practices contribute to an institutional culture where GBV is normalised, and accountability is elusive.

A significant obstacle in addressing GBV in HEIs is the lack of comprehensive data on its prevalence. Although consensus exists regarding widespread underreporting (Swartz et al., 2017), the absence of reliable data weakens efforts to develop effective institutional responses. Survivors often face emotional and logistical barriers to reporting, including confusion over procedures and a lack of institutional support (Adams et al., 2013). Feelings of shame, fear of judgement and social stigma further discourage disclosure (Ahmed, 2015; Chauke et al., 2015). These factors create isolating environments where survivors may feel unsupported and silenced.

Institutional responses to reported cases are frequently inadequate. Studies indicate that poor reporting mechanisms, weak follow-up processes, and minimisation of GBV claims are widespread across South African universities (Chauke et al., 2015; Rennison & Addington, 2014). Such practices reinforce a culture of tolerance and impunity. Evidence suggests that GBV incidents on campuses are not only underreported but are also increasing in frequency (Beyene et al., 2019; Swartz et al., 2017). Addressing this crisis requires systemic reform, proactive institutional accountability, and the implementation of survivor-centred grievance procedures.

In this broader university landscape, clinical training settings introduce an even more complex set of vulnerabilities. Clinical students operate in entrenched hierarchies that distinguish them from students in other faculties. They must navigate dual roles as learners and quasi-professionals, often under the scrutiny and control of academic and clinical supervisors (Dzau & Johnson, 2018; Fnais et al., 2014). The constant performance pressure, fear of clinical error, and emotionally demanding environments diminish autonomy – particularly for female and marginalised students – and create conditions that are ripe for abuse.

Power asymmetries are particularly rigid in clinical education. Supervisors often hold sway over evaluations, reference letters and career trajectories, thereby increasing students' dependency and reducing their ability to speak out against misconduct (Best et al., 2010; Fnais et al., 2014). Unlike in other academic disciplines where hierarchical relations may be more diffuse, clinical training embeds them structurally and culturally, which creates environments where faculty misconduct is often minimised or silenced (Broad et al., 2018; Henning et al., 2017).

Peer-to-peer GBV also features prominently in clinical contexts, and is often disguised as academic banter or initiation. These incidents, while sometimes dismissed as trivial, can be equally harmful, especially when they intersect with power-driven faculty abuse (Duba et al., 2020; Fnais et al., 2014; Frajerman et al., 2022). Institutional silence, coupled with unclear reporting structures, exacerbates these risks. The lack of clear boundaries, competitive cultures and inadequate safeguards allow GBV to thrive across multiple levels of the clinical training ecosystem.

In South Africa, where GBV is already pervasive and gender inequality remains deeply embedded, the risks in clinical environments are even more pronounced. Historical accounts such as De Klerk et al. (2007) and the 2016 national anti-GBV protests serve as reminders of the long-standing and unresolved nature of this crisis in HEIs. Despite periodic mobilisation, institutional responses often fall short of transformative change.

The psychological and academic consequences of GBV in clinical settings are far-reaching. Survivors report heightened rates of trauma, anxiety, depression and PTSD – outcomes that disproportionately affect women (Frajerman et al., 2022; Mayekiso & Bhana, 1997; Street & Arias, 2001). These impacts compromise academic performance, erode professional confidence, and diminish retention in health professions. Over time, such attrition threatens the diversity and resilience of the healthcare workforce, which makes it not only a student welfare issue but also a public health and workforce development concern.

Oversight Mechanisms

GBV in South Africa is embedded in structural inequalities, patriarchal systems and sociocultural norms that perpetuate gendered power asymmetries. HEIs are not immune to these dynamics; rather, they often mirror and reproduce the societal conditions that enable GBV. Campus-based mobilisations – such as the "Silent Protest" at Rhodes University, which drew over 1 700 participants, and the "My Body, My Choice" campaign – have illuminated the prevalence of rape culture in academic spaces, while simultaneously challenging both institutional inertia and the societal scripts that normalise sexual violence (Garcia & Vemuri, 2017). These movements have been instrumental in foregrounding the urgency of institutional accountability and the dismantling of harmful cultural norms.

Nationally, the DHET introduced the Policy Framework to Address Gender-Based Violence in the Post-School Education and Training System (2020). The framework promotes a zero-tolerance stance towards GBV and emphasises preventive measures, survivor-centred responses and the setting up of accountability structures. Its underlying rationale is the recognition that GBV undermines the dignity, well-being and academic attainment of students and staff, thereby eroding the transformative potential of higher education. Some HEIs, such as the Nelson Mandela University, have aligned their interventions with the DHET framework, and implemented multipronged strategies. These strategies include policy reforms, awareness campaigns, psychosocial support services, training initiatives and external partnerships, which have been commended by the Commission for Gender Equality (Nelson Mandela University Communication and Marketing, 2024; Walker, 2025). Comparable efforts have been observed in initiatives such as "WITS Against GBV" and NGO-led programmes such as the "Sonke Gender Justice's One Man Can" campaign, which engage men in gender-transformative dialogue (Singh et al., 2016; Van den Berg et al., 2013). However, independent evaluations indicate that, although such interventions may catalyse attitudinal change, their effects are frequently short-lived and insufficient to dismantle entrenched

institutional hierarchies or reduce GBV incidence (Hewett et al., 2023; Van den Berg et al., 2013).

Institutional culture significantly shapes both the incidence and normalisation of GBV. Empirical evidence from the Quality of Residence Life survey at Rhodes University (2010–2013) documents persistent safety concerns among female students that constrain autonomy and participation (Sexual Violence Task Team, 2016). National statistics and campus studies likewise demonstrate that women experience higher levels of fear and vulnerability than men, with attendant consequences for well-being and academic engagement (Bryden & Fletcher, 2007; Makhaye et al., 2023; STATS SA, 2018). Survivors commonly report psychological harms – anxiety, depression, low self-esteem and post-traumatic stress – that impede concentration, diminish performance and precipitate withdrawal from institutional life (Gouws & Kritzinger, 2007). Institutional shortcomings compound these effects: grievance mechanisms are frequently perceived as inaccessible, inconsistently applied or retraumatising, and fear of retaliation, disbelief or reputational harm discourages reporting (Larkin, 1994; Magudulela, 2017; Mdletshe & Makhaye, 2025). The persistence of everyday sexist practices – dismissive banter, unsolicited sexualised comments, sexist jokes and trivialisation of harassment – further evidences a campus climate permissive of GBV (Wear & Aultman, 2005).

Critical analyses of institutional frameworks reveal substantive gaps in policy scope, awareness and implementation. Many HEI policies remain narrowly framed with regard to sexual harassment or misconduct and do not provide comprehensive definitions or recognition of the broader spectrum of gendered harms (Davids, 2019a; 2019b; Gordon & Collins, 2013). Awareness of existing protocols is uneven – Gouws and Kritzinger (2007) reported that a substantial proportion of departmental heads and governance actors were unfamiliar with sexual harassment policies and that staff training on policy implementation is inconsistent (Joubert et al., 2011; Mahlori et al., 2018). In several cases, institutional instruments are outdated or poorly aligned with national legislation and best practice guidance, and reporting pathways are under-resourced or ambiguous (Abrahams et al., 2013; Adams et al., 2013; DHET, 2017). Coordination deficits among campus actors similarly impede effective responses: reviews (for example, Abrahams et al., 2013; Bennet et al., 2007) have highlighted unclear mandates, fragmented roles and limited monitoring and evaluation of prevention and response programmes. In addition, while awareness campaigns – including those intensified during the COVID-19 period – have increased visibility, they have sometimes focused disproportionately on women as potential victims, thereby risk-shifting responsibility onto survivors rather than addressing institutional or perpetrator-centred reforms (Davids, 2020).

Despite isolated examples of good practice, oversight mechanisms in South African HEIs remain fragmented and inadequate. The persistence of deeply embedded institutional cultural norms, coupled with limited institutional will and resource constraints, continues to undermine the development of effective comprehensive

responses. Addressing GBV in higher education requires a systemic survivor-informed approach that integrates gender-transformative interventions into enforceable accountability structures, sustained training and cultural change initiatives. Such a reorientation would move institutions beyond a reactive compliance-driven stance towards a proactive values-based ethos in which the eradication of GBV is a foundational non-negotiable priority.

The Urgency of Addressing GBV in Clinical Training

GBV in clinical training demands urgent attention because its consequences in these settings extend beyond individual harm to impair professional formation and public health. National and international data underscore the scale of GBV. South Africa's high GBV prevalence (SAPS, 2020; STATS SA, 2018; WHO, 2021) means that clinical students are training against a backdrop of pervasive societal violence, which interacts with the specific risks of clinical education to produce heightened vulnerability.

Clinical training amplifies risk through several distinctive features. The entrenched hierarchies and dependency relations – where supervisors control assessments, placements and references – create power asymmetries that can be exploited (Dzau & Johnson, 2018; Fnais et al., 2014). Practical elements of training (intimate examinations, repeated close-contact procedures), extended hours and high-stress clinical rotations further blur professional boundaries and increase vulnerability for harassment. These contextual factors differentiate clinical students' experiences and cannot be neglected.

Underreporting in clinical contexts, such as in the broad HEIs, is pervasive and, crucially, often deliberate. Empirical studies document that students frequently abstain from reporting because they anticipate ineffective responses, retaliation or reputational damage (Adams et al., 2013; De Klerk et al., 2007). Institutional cultures that normalise sexist conduct, lack clarity on reporting pathways or present opaque grievance procedures compound silence (Ahmed, 2015; Chauke et al., 2015; Gouws & Kritzinger, 2007). Where survivors learn, directly or vicariously, of mishandled cases, the signal sent to peers is that disclosure entails risk rather than remedy (Larkin, 1994; Rentschler, 2015).

The effects of GBV in clinical training are both immediate and longitudinal. Exposure is associated with measurable declines in mental health (anxiety, depression, PTSD), reduced academic engagement, impaired clinical confidence and attrition – outcomes that can persist into professional practice and compromise the quality and safety of care (Best et al., 2010; Duba et al., 2020; Frajerman et al., 2022; Gouws & Kritzinger, 2007). Tolerating GBV in clinical education therefore poses risks to students and future patients.

Given these stakes, institutional responses must be proportionate and context specific. Generic policy statements are insufficient: clinical settings require confidential and independent reporting channels, rapid and impartial investigations, survivor-centred

supports, formal protections against retaliation, and formal links between HEIs and clinical sites to ensure policy alignment (DHET, 2019; Treves-Kagan et al., 2020). Equally important is explicit curricular engagement – integrating professional ethics, boundary management and bystander training into clinical education – to address both prevention and cultural change (Fnais et al., 2014).

This urgency derives from the compounded harms and systemic risks unique to clinical training. Addressing these requires immediate operational reforms, sustained resourcing and dedicated research into context-sensitive interventions that can protect students and safeguard the integrity of healthcare professions.

Conclusion

This review examined the persistent and underexplored issue of GBV in clinical training environments in South African HEIs. Clinical students face distinct vulnerabilities shaped by hierarchical structures, institutional cultures and systemic inequalities – yet these are inadequately addressed in both policy and research. Despite the existence of legislation and university-level interventions, GBV continues to be underreported, poorly monitored and insufficiently theorised, particularly within clinical education contexts. A key finding of this study is the lack of disaggregated context-specific data on the forms and drivers of GBV affecting clinical students. This gap limits the design of effective evidence-based responses. In addition, the normalisation of abusive power dynamics, coupled with weak oversight and survivor distrust in institutional processes, reinforces a cycle of silence and impunity.

Addressing GBV in this context requires more than advocacy; it demands sustained research-driven institutional change. Integrating intersectional frameworks enables a deeper understanding of how violence is experienced differently. These insights must guide comprehensive reforms that include structural accountability, cultural transformation and survivor-centred care. Ultimately, transforming clinical training spaces into environments of safety, equity and dignity is essential not only to student well-being but also to producing healthcare professionals capable of upholding those same principles in broader society.

Recommendations and Call for Comprehensive Interventions

Effectively addressing GBV in clinical training environments requires interventions that comprehensively target structural, cultural and institutional roots. These interventions should be informed by a robust theoretical framework which emphasises dismantling systemic inequalities and addressing overlapping oppressions that perpetuate GBV (Crenshaw, 1991). Structural reforms must prioritise the development and enforcement of policies that explicitly address all forms of GBV in clinical settings. Such policies should include mandatory reporting mechanisms, protections against retaliation and survivor-centred support systems. Institutions should establish safe physical and

emotional spaces for students, such as counselling centres and secure grievance reporting hubs, to ensure a supportive environment for survivors.

Cultural interventions play an equally critical role in combating GBV by challenging harmful gender norms. Educational campaigns should target both students and faculty to address power dynamics, toxic masculinities and bystander intervention strategies. These initiatives aim to build a culture of mutual respect and accountability. At the institutional level, capacity building is essential. This includes regular training for faculty, supervisors and students on recognising and addressing GBV. Institutions should also set up oversight committees to monitor GBV cases, ensure transparent reporting processes, and maintain institutional accountability.

Specifically, the following are suggested:

- In-depth research and data collection: Current literature often generalises findings from broader student populations without capturing the layered experiences of clinical students who operate in high-stakes hierarchical environments. Research must disaggregate data and examine the ways in which power relations, clinical obligations and dual learner–practitioner roles shape exposure to GBV. Context-specific evidence is essential to developing responsive and relevant policies. Without such data, institutions risk implementing ill-fitted solutions.
- Contextualised prevention efforts: Prevention strategies should move beyond generic awareness campaigns, which are often favoured but show limited evidence of sustained impact on institutional cultures resistant to change. Interventions must instead deal with GBV manifestations specific to clinical environments, including harassment by supervisors, peer intimidation, and intimate partner violence linked to institutional stressors.
- Institutional strengthening: Reporting structures are often bureaucratic or misaligned with clinical realities. Policies should clarify reporting procedures, ensure confidentiality and protect against retaliation. Survivor support must go beyond formal services to include safe, accessible and stigma-free environments. Failure to address institutional norms that normalise misconduct undermines formal policies. This is particularly vital in clinical spaces where power asymmetries and silence are entrenched.
- Accountability and feedback mechanisms: Institutions should go beyond declarations of zero tolerance by embedding accountability into routine operations – through transparent reporting, regular audits of GBV cases, and student involvement in evaluating response systems. Transformation requires not only policy but also a cultural shift, sustained by transparency and critical reflexivity.
- Tailored interventions for diverse HEIs: HEIs are not monolithic. Urban and privileged institutions may implement digital tools and training with relative ease while rural or historically disadvantaged universities face infrastructural and

institutional cultural constraints. Successful interventions in resource-limited contexts often depend on community engagement and culturally sensitive approaches. This diversity must shape both policy design and implementation.

- Monitoring and evaluation: Claims of progress must be substantiated through systematic tracking of GBV trends, service utilisation and student perceptions. Relying on awareness metrics or policy existence is insufficient. Instead, interventions should be judged by measurable improvements in safety, well-being and academic outcomes.

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