

Domestic abuse training for Nursing and Midwifery students: a quasi-experimental and focus group evaluation

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Abstract

Background: Gender based violence is now an urgent global public health issue. Domestic abuse (DA), one its most pernicious forms is consistently shown to be associated with multiple negative health outcomes. Despite nurses and midwives being perfectly positioned to identify and intervene effectively with victims/survivors, research indicates that nurses and midwives often lack the knowledge, skills and confidence to support victims/survivors.

Method: This was a mixed method study incorporating a quasi-experimental pre and post-cross sectional survey and qualitative focus groups used to explore the acceptability and feasibility of the domestic abuse training. Measures of knowledge of domestic abuse and an adapted inventory on beliefs and attitudes towards DA were administered to students pre and post training. Two focus groups (n=19) explored aspects of the educational intervention including content, delivery, what students found useful/not useful and ways to improve the training.

Results: Students showed significant change in knowledge and awareness of DA post training, in addition to positive improvement in attitudes towards gender-based violence. Three themes were generated from the qualitative data; unprepared to feeling scared; barriers to implementation and bridging the skills gap; and awareness, myths, beliefs and blaming. In line with previous research, students reported feeling ill prepared to support victims/survivors and lacked confidence when asking routine enquiry safety questions. Students also expressed concern around some workplace practices that they described as 'workplace culture' where victim blaming was widespread and preconceived assumptions influenced whether and how safety questions were asked.

Conclusion: These findings reiterate the urgent need for more structured education on gender-based violence throughout undergraduate training. At the point of registration, students should feel prepared and ready to identify and escalate domestic abuse cases where necessary. The findings also point to the need for cultural shift interventions at the organisational level, extending beyond university-based education. Workplace culture that minimises or dismisses domestic abuse requires urgent attention. In conclusion, gender-based violence remains a global crisis that needs to be addressed across healthcare settings.

Background

Gender based violence (GBV) is a significant public health problem [1]. Approximately one in three women will experience GBV in their lifetime [2] and this can cause an array of short and long term emotional, psychological, and physical harms [3]. The United Nations have explicitly called for an end to all forms of violence against women and girls in both public and private spheres in SDG Target 5.2. One of the most prevalent forms of GBV occurring within the private sphere is domestic abuse (DA), which Women's Aid defines as "an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-

partner, but also by a family member or carer is also common". It is estimated that one in four women will experience domestic abuse in their lifetime [4].

Healthcare professionals, in particular nurses and midwives, are uniquely positioned to play a key role in recognising, responding to and supporting survivors of domestic abuse [5]. However, research consistently shows that many healthcare professionals (including registered nurses and midwives) lack the knowledge and confidence to identify and manage domestic abuse effectively [6, 7]. Significant gaps in DA knowledge and understanding, in addition to low levels of self-efficacy in supporting women who disclose DA are regularly identified [8]. A scoping review of domestic abuse education/training highlighted the paucity and inadequacy of educational training about DA in pregnancy for midwives/student midwives [9]. A recent comparison of both British and Australian Nursing and Midwifery students indicated that students reported minimal training, in addition to a limited knowledge and skills around DA [6]. Findings from a recent systematic review [10] demonstrated that frontline professional responses to DA are shaped by a complex interaction of knowledge, attitudes, training, and organisational context. Their review highlighted that limited training and gaps in knowledge contribute to reactive or disengaged practices, whereas increased preparedness and understanding promote more proactive, trauma-informed responses.

This research points to a significant lack of training on DA throughout students' undergraduate education on a global scale [6, 7]. Thus, whilst international bodies such as the World Health Organization (WHO), have issued formal guidance for healthcare professionals on identifying and responding to abuse in clinical settings [11], training and preparation of future professionals remains limited, inconsistent and sporadic across disciplines, institutions and countries. Despite the need, there is no national/universally agreed commitment to integrate DA training into healthcare curricula in a meaningful way, to ensure that at the point of registration, nurses and midwives are effectively prepared to identify, escalate and respond to victims/survivors. As a consequence, there is inconsistency in the extent to which nursing and midwifery students feel able to effectively respond to domestic abuse [6].

Doran, & van de Mortel, [12] note that this lack of preparation can undermine confidence, reduce empathy, and affect students' mental resilience when managing such cases in clinical practice. This is important for a number of reasons, not least because the decision to disclose abuse is never easy, making the initial response following disclosure crucial as it influences whether victims are likely to seek further support [13]. If victims disclose and are met with judgement, disapproval, disbelief or general uncertainty, it can impact on their likelihood to disclose again.

In addition to enabling Nursing and Midwifery students to feel prepared, there is a need to challenge widespread and persistent myths, stereotypical and gendered attitudes and/or victim blaming which potentially impact the values, beliefs and hence the response of healthcare students to victims/survivors [14]. Research indicates that students' ability to recognise and/or respond to abuse is associated with broader attitudes held towards societal gender roles and norms. For example, [15] showed that as students' gender role attitudes towards violence became more traditional/patriarchal, their capacity to

recognise signs of violence decreased. Similarly, [16] highlighted the influence of myths and stereotypes on the decision to intervene. Therefore, there is an opportunity for education and training not only to increase knowledge and awareness of DA, but also to adopt a broader gender-based violence framework to challenge widespread myths and traditional gender role attitudes and beliefs across societies.

The Northern Ireland context

Northern Ireland (NI) is quite a conservative society, historically influenced by 2 predominant narrow religious traditions, ranging from Roman Catholic conservatism to Evangelical fundamentalism. It is argued that this backdrop has enabled an entrenched patriarchy framework, shaping societal attitudes which have minimised or institutionalised misogyny [17]. Whilst difficult to obtain exact figures, NI is one of the most dangerous places for women to live in the United Kingdom; 33 women have been killed since 2020. These are not isolated incidents but are most often the culmination of repeated and systematic abusive behaviours endured at the hands of a 'loved one'. Recent Police Service Northern Ireland (PSNI) data reveal that Domestic abuse is reported on average every 16 minutes, a sexual offence every two hours and that reported cases have been on the increase since 2004 [18]. Many domestic abuse cases remain unreported, so these figures underestimate the true extent of the problem. Monckton-Smith [19] outlines the stages of the homicide timeline clearly showing that in most cases of femicide there are many opportunities to intervene, dispelling the myth of the 'crime of passion'. Recognising the importance of early intervention, the NI Domestic and Sexual Abuse Strategy 2024–2031 emphasises the need to build the capacity of frontline professionals to identify and respond to domestic and sexual abuse at the earliest opportunity. Given that Nurses and Midwives are often the first point of contact for DA survivors, the importance of interventions that enhance their abilities to identify, intervene and support DA survivors is clear.

In recognition of this education practice gap, efforts to integrate domestic abuse training into nursing and midwifery student curricula over the past decade [20] are increasing. Research indicates that these findings are promising. Early exposure to DA education during undergraduate training has been associated with increased confidence, improved ability to identify DA and improved referral practices [21]. For example, [1] in a quasi-experimental design showed that after domestic violence (DV) training nursing students reported increased knowledge, recognition of the signs of DA and more positive attitudes towards DA. Various modalities have shown promising results, for example, virtual patients [22] virtual multidisciplinary gaming [23]; and high-fidelity videos [24, 25]. However, whilst it is acknowledged that the evidence base is growing and findings are promising, gaps remain which this research sought to address.

The Current Research

This research aims to further advance our understanding of the design and implementation of DA training for Nursing and Midwifery students and specifically address recent research calls:

Adopts a mixed method approach to specifically highlight areas for improvement and to explore different teaching strategies [26].

Examines actual knowledge rather than perception of knowledge as research indicates the two are not always aligned [27].

Explores cultural context, the research is the first of its kind in Northern Ireland, recognising the need to explore practices from a range of cultural perspectives [28].

Methodology

Aims

To compare Nursing and Midwifery student's knowledge and attitudes towards domestic abuse before and after DA training and,

To explore the students' views and perceptions of the training and explore the feasibility and acceptability of this training.

Research Design

This was a mixed method study incorporating a quasi-experimental pre and post test cross sectional survey and qualitative focus groups used to explore the acceptability and feasibility of the Domestic Abuse training.

Educational intervention

The educational intervention was an adaptation of the training provided by a Domestic Abuse Safety and Support (DASS) worker in a Health and Social Care (HSC) Trust in a region of NI. This training is provided as part of the DASS role to improve recognition and response to DA by registered nurses, midwives and other HSC staff.

The intervention consisted of a 2-hour interactive class delivered by a DASS worker with learning outcomes to increase knowledge of DA and CC; increase awareness of systems/processes, for e.g. DASH risk assessment and MARAC; increase understanding and confidence in creating the conditions to encourage/enable disclosure and increase their knowledge of support services to effectively intervene. Content included the complexity of Domestic Abuse and Coercive Control; legislation; helpful/unhelpful responses and identification of risk.

Recruitment

All students enrolled on Year 2 BSc Midwifery and Year 3 BSc Adult Nursing programmes were eligible to take part. Participant recruitment was coordinated by the School of Nursing and Midwifery using a purposive sampling strategy.

Eligible students were informed of the workshop via email by the School of Nursing and Midwifery gatekeeper(s), with details regarding the date, time, and location. The workshop was opt-in and was added to their academic timetables and delivered on-site at the usual setting for student teaching.

Data collection

Pre and post quantitative measures

Knowledge of Domestic Abuse was measured using nine items. The measure was comprised of knowledge-based questions such as “How many women aged 16–59 will experience domestic abuse in their lifetime?” and “On average, how often do the Police Service Northern Ireland (PSNI) attend a domestic abuse incident every day?”. Knowledge items were presented as multiple-choice questions and recoded into binary variables (1 = correct, 0 = incorrect). Internal consistency of the knowledge scale was modest (Cronbach’s $\alpha = .66$), which is consistent with the heterogeneous nature of factual knowledge items that assess discrete domains rather than a single underlying construct [29].

The Inventory on Beliefs and Attitudes towards DA [30] was adapted for the present study. This measure included 3 of the subscales; Subscale 1: Domestic Violence as verbal, financial and sexual abuse Subscale 3: Attitudes towards excusing DV and Subscale 5: Attitudes in Nursing and Midwifery students. Questions included “The majority of abusers of domestic abuse are men”; “Most abusers of domestic abuse are from lower income groups”; “Nursing and midwives have an important role in providing emotional and practical support to women who experience domestic abuse” [30, 31]. Scores were collated on a 5 point likert scale where 1 = strongly agree and 5 = strongly disagree. Initial Exploratory Factor Analysis (EFA) showed low commonalities for the subscale “Attitudes toward DA Prevalence”, resulting from its removal from the scale. For the remaining items, Cronbach’s Alpha was .81.

Qualitative Focus groups

Upon post-training survey completion, participants were asked if they would like to voluntarily take part in a follow-up focus group. The researchers contacted those willing to take part in the focus groups to arrange a suitable time. The focus group schedule was codesigned by the cross-disciplinary team and Women’s Aid. The focus group schedule explored aspects of the educational intervention including content, delivery, what students found useful, what they didn’t find useful, and ways to improve the training.

Data analysis

Survey data were analysed using SPSS. An exploratory factor analysis (EFA) using principal axis factoring was conducted on pre-test Likert-scale items to examine the underlying structure of attitudes toward domestic abuse and professional responsibility. Qualitative data

was analysed using reflexive thematic analysis [32].

Ethical considerations

The study received ethical approval from the Faculty of Engineering and Physical Sciences in Research Ethics Committee, Queen’s University, Belfast (EPS 24_273). Both the education and participation in the research were entirely voluntary. All participants provided informed consent prior to completion of the pre-education questionnaire and little to no demographic details were collected to preserve anonymity. Support was available to students throughout the research in recognition that students may have personal experience of DA.

Results

Quantitative

A total of 149 students took part in the pre-workshop survey, at post-workshop this number was 119, suggesting a 79.87% workshop attendance rate across student groups. Among the X undergraduate and postgraduate midwifery students invited to participate, 102 completed the pre-workshop survey, of whom 82 attended the workshop and completed the post-workshop survey. Of the 120 nursing students invited, 47 completed the pre-workshop survey, with 37 subsequently attending the workshop and completing the post-workshop survey. Sample population breakdowns at pre- and post- workshop can be found in Table 1.

Table 1
Student enrolment in midwifery and nursing programmes pre- and post-workshop

Student population	Pre-workshop		Post-workshop	
	N	%	N	%
Postgraduate Midwifery	38	25.5	28	23.5
Undergraduate Midwifery	64	43.0	54	45.4
Undergraduate Nurses	47	31.5	37	31.1
Total	149	100.0	119	100.0

Qualitative data collection

Two focus groups with BSc Midwifery students were also conducted [n = 19] to explore the feasibility, acceptability and perceived relevance of the training. The focus on Midwifery students only was due to non attendance of the Nursing students on the day.

Reflexivity

The cross disciplinary team brought a range of experience and perspectives to the study which helped shape the analysis and interpretations. In order to contain our potential biases and to uphold academic

rigour, we met regularly and engaged in reflective discussion throughout the analytical process.

Data Analysis

Quantitative data

Due to participant attrition between the pre-test and post-test, responses could not be matched at the individual level. Consequently, analyses were conducted treating pre- and post-test data as independent samples. Exploratory factor analysis (EFA: Items demonstrating low communalities ($< .30$) or poor factor loadings were removed iteratively to achieve a stable and interpretable factor solution. The final factor structure was used to create a composite scale, and internal consistency was assessed using Cronbach's alpha.

To examine differences across time (pre-test vs. post-test) and between student groups (MSc Midwifery, Undergraduate Midwifery, and Nursing), univariate general linear models (GLMs) were conducted for both the attitudinal composite score and self-reported knowledge. These models assessed main effects of time and group, as well as interaction effects.

Objective knowledge was analysed separately. Knowledge items were coded dichotomously (1 = correct, 0 = incorrect) and summed to create a total knowledge score. This composite score was analysed using univariate GLMs to examine differences across time and between groups, including interaction effects. Where significant interactions were identified, simple effects analyses were conducted to explore differences within groups over time.

Descriptive statistics were used to summarise participants' post-intervention confidence and perceived preparedness to respond to domestic abuse.

Quantitative Results

An exploratory factor analysis identified a unidimensional structure underlying attitudes toward domestic abuse and professional responsibility. Items with low communalities ($< .30$) were removed iteratively, resulting in the exclusion of nine knowledge-based variables (which were explored separately) and one Likert-scale item. Initial extraction based on eigenvalues greater than 1 resulted in a Heywood case, indicating over-extraction.

A one-factor solution was retained as the most parsimonious and interpretable model following examination of communalities and the scree plot. A two-factor solution was also explored but demonstrated substantial cross-loadings, lacked conceptual clarity, and failed to converge efficiently. The second factor was defined by two stereotype-related items and reflected a contrast with professional responsibility items rather than a distinct construct. These items were therefore removed. The final factor solution demonstrated acceptable sampling adequacy ($KMO = .74$), with factor loadings ranging from .47 to .74. The factor represented *understanding and recognition of domestic abuse and*

professional responsibility and demonstrated good internal consistency (Cronbach's $\alpha = .81$). A composite score was created from the retained items (Table 2).

Table 2

The structure of understanding and recognition of domestic abuse and professional responsibility resulting from factor analysis and reliability analysis

Factor	Sub-Scale	Item Number and Exact Wording	Factor Matrix Loading
Understanding and Recognition of Domestic Abuse and Professional Responsibility	Understanding and Recognition of Domestic Abuse	<i>Please rate your agreement levels with the following statements:</i>	.47
			.72
		7a. If a partner yells abuse this is a form of domestic abuse	.66
		7b. If a partner repeatedly criticises the other one to make them feel bad or useless, this is a form of domestic abuse	.56
			.68
		7c. If a partner tries to control the other partner by denying them money, this is a form of domestic abuse	
		8a. If a partner forces the other partner to have sex this is a form of domestic abuse	
	Understanding and Recognition of Professional Responsibility	8b. Slapping and pushing a partner to cause harm or fear is a form of domestic abuse	
		<i>Please rate your agreement levels with the following statements:</i>	.68
			.58
		14a. Nurses and midwives have an important role in providing emotional and practical support to women who experience domestic abuse	.74
		14b. Education on domestic abuse is an important part of the undergraduate nursing and midwifery curriculum	
		14c. Nurses and midwives have an important role in detecting domestic abuse through risk assessment and screening	

A univariate general linear model revealed a significant main effect of time on the attitudinal composite score, $F(1, 248) = 36.45, p < .001$, with higher scores observed post-intervention ($M = 4.32, SE = .04, 95\% CI (4.24, 4.40)$) compared to pre-intervention ($M = 3.98, SE = .04, 95\% CI (3.91, 4.06)$). A significant main

effect of student group was also observed, $F(2, 248) = 3.59, p = .029$. Estimated marginal means indicated that undergraduate midwifery students had the highest scores ($M = 4.23, SE = .04, 95\% \text{ CI } (4.15, 4.31)$), followed by MSc midwifery students ($M = 4.16, SE = .05, 95\% \text{ CI } (4.05, 4.27)$) and nursing students ($M = 4.06, SE = .05, 95\% \text{ CI } (3.97, 4.16)$). Post hoc comparisons (Bonferroni-adjusted) revealed a significant difference between undergraduate midwifery and nursing students ($M \text{ difference} = 0.18, SE = .06, p = .014$). The interaction between time and student group was not significant, $F(2, 248) = 0.57, p = .567$.

A composite knowledge score was created by summing correct responses across items (Table 3). Analysis revealed a significant main effect of time on knowledge scores, $F(1, 252) = 107.55, p < .001$, indicating higher knowledge post-intervention. There was no significant main effect of student group, $F(2, 252) = 0.37, p = .693$. However, a significant interaction between time and student group was observed, $F(2, 252) = 4.01, p = .019$.

Table 3
Knowledge Score Scale

Score	Item Number and Exact Wording
Knowledge	3. How many women aged 16–59 will have experienced domestic abuse across their lifetime?
	4. On average, how often do the PSNI attend a domestic abuse incident every day?
	5. Women with disabilities are how many times more likely to experience domestic abuse?
	6. When is the most dangerous time for a woman affected by domestic abuse?
	9. How many women have been killed in NI since March 2020 in a domestic homicide?
	10. What causes domestic abuse?
	11. How likely is a woman to be assaulted when she is pregnant?
	12. Domestic Abuse always involves physical violence?
	13. Children are not victims of Domestic Abuse until they are assaulted or witness an assault?

Simple effects analyses indicated that knowledge scores increased significantly from pre- to post-test for all groups. Among MSc midwifery students, there was a significant increase, $F(1, 62) = 14.17, p < .001$ ($R^2 = .19$). Undergraduate midwifery students also demonstrated a significant increase, $F(1, 112) = 45.43, p < .001$ ($R^2 = .29$). The largest increase was observed among nursing students, $F(1, 78) = 67.26, p < .001$ ($R^2 = .46$). These findings indicate that, although knowledge improved across all groups, the magnitude of improvement was greatest among nursing students and smallest among MSc midwifery students.

Self-reported knowledge also increased significantly over time, $F(1, 253) = 89.82, p < .001$, with no significant differences between student groups.

Descriptive analyses indicated high levels of confidence and perceived preparedness following the intervention. The majority of participants reported that the session would increase their confidence in engaging in a “courageous conversation” ($N = 104$, 99.0%), improve their ability to identify red flags and indicators of domestic abuse ($N = 104$, 99.0%), and increase awareness of available support ($N = 103$, 98.1%). Positive responses were consistent across groups. All MSc midwifery and nursing students reported increased confidence across all domains, while a small number of undergraduate midwifery students ($N = 1$ per item) reported uncertainty.

Qualitative Findings

Three themes were generated from the data; Unprepared to feeling scared; Barriers to implementation and bridging the skills gap and Awareness, myths, beliefs and blaming.

The first theme included instances where the students revealed feeling ill prepared to identify or support victims/survivors. Worryingly along this continuum of ‘preparedness’, were cases where the students expressed genuine fear about responding to disclosures of domestic abuse. The second theme includes all of the perceived barriers/challenges that students identified around the implementation of this training, in addition to their suggestions to improve the training, including teaching methods, content and practical ideas. The third theme highlighted existing myths and beliefs and stereotypes that can influence clinical interactions with survivors.

Unprepared to feeling scared:

A key concern amongst students was the feeling of being unprepared and not knowing what to do if a woman disclosed abuse during a clinical interaction, or upon being asked if she felt safe. This specific concern was mentioned repeatedly throughout the focus groups, *“a challenge would be if, if she did say yes, because I don’t know what to do then. If a women came to me and said, ‘oh I feel unsafe’ I don’t know like what my reaction would be, but I suppose I haven’t seen that as a student.”* She continued, *I feel like I’d nearly be a bit feared [sic] like what do I do for this woman? Do I go get someone? Is there someone waiting outside for her, is he going to see? I think it’s just a lot of factors.*

For all of the students this lack of preparedness and uncertainty around what to do next was palpable, *“I dread the day somebody brings it [domestic abuse] up to me in practice ... You don’t know how it’s going to be brought up or how you’re going to deal with it or if anyone else is going to be there or if you’re going to be on your own”*

These extracts highlight a specific gap in midwifery training, so much so, that it left some of them fearful and dreading the day when they might face such a disclosure. They highlight a number of specific unknowns such as, not having a clear referral pathway, feeling unsure as to how to react following disclosure or how to manage a situation where a partner is waiting outside.

Students also expressed a lack of professional judgement and communication skills relating to the entire disclosure process and having to ask what they deemed to be ‘difficult’ questions. Whilst they

were very much aware of the sensitivity of these interactions, they don't feel equipped to convey genuine care and concern, whilst avoiding formulaic or tokenistic tone, *"Being able to just ask the questions, like doing it so it's not a tick box exercise or just reading off a page. We need more training on being able to ask these type of questions"*... Concern was also expressed around how the questions might be interpreted with findings revealing that many of the students felt uncomfortable having to ask them, *"I think it's like kind of trying to read the person too and asking them in a way that's not insulting. Some people could turn around and be like "what are you trying to say that my partner looks like?"*

Not knowing what to do often translated into a sense of hopelessness and a feeling of not being able to help, *"Mmm like even if she does like open up to you and say I don't feel safe at home, you can't really, what do you do for them? You just have to send them home? And then what do you do I've just sent a women home"*... This fear and uncertainty regarding risk and/or escalation of risk is a real concern and can result in moral injury for students/professionals. It is important that students understand that leaving is a process/journey and that they are trained to support women who remain in abusive relationships and can meet their unmet needs without judgement or disapproval, recognising the vital role they can play in ensuring women feel heard, believed, and supported.

Barriers to Implementation and Bridging the Skills Gap:

Students also discussed some of the barriers or logistical challenges that they envisaged when discussing these sensitive topics or asking safety questions. One of the main challenges repeatedly mentioned was resources, for e.g. the lack of time, *"I think no time as well because once you start having that conversation you could be there for an hour but like the midwives on wards don't even have time to go on their lunch most days, how do you find the time to even have a conversation about it?"*

In addition to a lack of time, more practical challenges were also apparent, *"Maybe getting a quiet space, I feel like on the wards it could be, sometimes it's not the appropriate place to be asked the question"*.

Another barrier reported around being able to handle these conversations in a professional manner was of a systemic nature involving a lack of continuity of care, *"It's so difficult to get that continuity of care as you say, so this is going to be just a new healthcare professional coming in stonecold to a woman they may never have met asking these really difficult questions. How can we get around that?"*

Participant 16 also explained that within the midwifery curriculum, the students have been taught that ordinarily it takes "10 to 15 times" of being questioned before a victim will disclose abuse. She identified the lack of continuity of care as preventing these disclosures: *"I don't know what the statistics are now but it's something like 10 to 15 times you get asked before you open up. But you don't see that midwife that many times even though in hindsight, why would I open up to a complete stranger even if there's evidence there"?*

While participants generally felt the training prepared them "to a certain extent", there was also a consensus that one session wasn't enough, *"It shouldn't just be a one-off topic it should be spoken about*

more often so even if a woman does come to us and says she isn't safe and even if we're constantly thinking about it, the woman will know she can trust us". Students want to see domestic abuse training embedded into their curriculum and becoming an integrated component across their programme; "having it like more integrated in our modules like even in our women's health module. Having it tied into our classes more like one class a year where it just gets brought up and you get statistics and refreshed and all. I don't feel like once a year is enough".

Students put forward some very useful ideas around mode of delivery, "Some online resource that say if you think 'oh I'm not sure about that women...' it's just a resource of where to refer or sign posting, even just a one pager just to refresh". There was unanimous recognition of the value in the training interactive components. Despite this recognition, it was suggested that the training could be more scenario-based, with quizzes that incorporate real-life examples to facilitate decision-making skills, "Even when it came to the quizzes ... it would be helpful to have a scenario and some answers and you pick what you think is the best and then come back and this is why you picked it."

Echoing this, all participants noted a gap in their current curriculum and expressed a strong desire for more hands-on activities, especially role-playing and practical scenarios, to enhance their confidence in responding to domestic abuse disclosures, "I think scenarios would be good like fake videos or whatever or what you should say or how you should react because you know yourself, you're not going to go (gasps)".

"Maybe do like a tutorial class, you know the way we had scenarios but like actually give them to us in groups. Like 'how would you deal with this: You're in a room with a first time mummy and she says she has to disclose something' so you think 'ok I'll do this and this'.

Finally, suggestions for improving practice included incorporating more practical tools, such as visual cues in patient notes to discreetly indicate domestic abuse, similar to how group B strep is flagged,

"Do you know what have those stickers on the notes for group B strep and all? There needs to be some sort of thing that can be put into women's notes that obviously it's not written in bold "domestic violence" or whatever, but it needs to be more recognizable for midwives so it's not always being brought up in such a like, nonchalant way where they know that it's happening".

Awareness, Myths, Beliefs and Blaming:

Participants noted that the training encouraged them to reflect on the experiences of domestic abuse survivors, something that they may not have done readily before. One participant acknowledged that, without personal experience, she might not have considered abuse as a potential factor in her clinical assessments, something the workshop prompted her to reevaluate; "Like you were asked the question, what do you think domestic abuse is? It kind of made you think about what other people, you don't always think about it if you haven't experienced it so when you see other ones who have, you kind of know because it's not something you would've thought of".

Assumptions were also made by the students themselves, centering around norms and behaviours expected when a couple are expecting a baby. Students expressed shock at hearing how pregnancy was a dangerous time for a woman, *"I was shocked during the workshop that pregnant women are more likely to experience it because in your eyes could you ever harm a pregnant woman especially when they're carrying your child? It doesn't even come to mind"*. Students also discussed the complexity of disclosure and consent and the challenges that present themselves working in a multidisciplinary environment, *"There's nothing you can do like if that woman's not disclosed anything. I've said to a midwife before 'that's not right' and she said 'there's nothing you can do, she hasn't disclosed anything'".* These systemic constraints often led to feeling of hopelessness limiting their ability to intervene. Findings also highlighted tensions between disciplines leading students to remark that, *"Social workers don't want to know"*. The decision making process around escalating cases on and whether consent was gained or not, caused considerable tension, *"Unless there's a physical sign of abuse, unless there's a mark there, they don't want to know. Like making a referral, I'm making this referral because I know that something has gone on but she cannot say something to me about it. You could have it so she's black and blue all over and she's saying 'I'm fine' but I'm not being funny, you're looking at her and you know. This whole consent thing like I've had it in practice where the social worker is looking at me and said 'I've not had consent' so they're not going to do anything and you're like 'but how can you sit there morally and type that email knowing there's a woman present...'"?*

Whilst the training clearly was of benefit to them in practice, some of the students alluded to the fact that the training was also of benefit in general to them in their personal life. Students remarked upon how it should be offered earlier and more widespread; *"I definitely think it should be something taught and spoken about earlier rather than waiting until you're in your adult life and maybe something has already happened and you don't realise what it was"*. It's worth noting that given the highly gendered nature of GBV and the fact that the majority of nurses and midwives are women, it's important to remember that they themselves can be victims of GBV and any training needs to incorporate a component of self care, *"It was really upsetting, very very triggering for me personally...its more common than you think"*.

The training also helped form a broader understanding of GBV. During the focus groups many of the participants expressed anger and questioned typical norms, behaviours and expectations around accountability and victim blaming; *"but like why should us as females have to be constantly aware of everything? It's always put on women, like, oh she's wearing a short skirt, she asked for it, she dressed that way, she said this, she said that, when is it ever going to be turned on the men to say, you shouldn't be drinking like that, you should keep your hands to yourself"* and like it's just a lot is put onto the women instead of men".

The students also reflected on midwifery practice that they have experienced or witnessed on placement. One issue that came up on a number of occasions was that the midwives tended to make assumptions around the safety of women based on little to no evidence, which impacted on how or indeed whether they asked the women if they were safe, *"I've heard midwives going 'oh there's no issues that we can see and we know how good he is, but we have to ask this question"* Assumptions were also

made “*when they know them from having previous kids or they know someone who knows them*” and these circumstances were reported to prompt midwives to assume that “everything is fine”, but the students challenged this assumption and expressed concern around these practices and questioned “*but is it?*”

Students also pointed out experiences of victim blaming within midwifery practice, “*You need to change work culture for it to work because there’s even still midwives out there where if someone does make a disclosure, I’ve seen it in practice myself, like, nobody has disclosed to me but they talk in the tearoom like, ‘I wouldn’t be letting a man hit me’, that’s not ok*”.

Discussion

This study highlights the importance of Gender Based Violence training for Nursing and Midwifery students. In line with previous research, students showed significant change in knowledge and awareness of DA post training [1], in addition to positive improvement in attitudes towards gender-based violence. Differences pre and post training were also observed between the Nursing and Midwifery students with Midwifery students being more knowledgeable at baseline, which accurately reflects the difference in curriculum and placement experience between Nursing and Midwifery students. Focus group findings also made clear that students understand and appreciate the importance of this education and were able to identify some of the myths and victim blaming that are readily apparent in the workplace and wider society.

Students expressed concern around some workplace practices that they described as ‘workplace culture’ where assumptions were made around the likelihood of a partner being abusive and the perceived need to ask the screening questions. These assumptions coloured how and whether women were asked if they felt safe or not. It was reported that some midwives felt they didn’t need to ask these questions based on their impressions of the partner or if they were familiar to them. The findings clearly indicate that attitudes need to be addressed not only within the student population but across practitioners also. Education and training is needed for students and practitioners alike, to challenge assumptions made around the need to ask safety questions in the first place. Misconceptions about perpetrator attribution and the belief that abusive individuals conform to a specific profile can act as barriers to identification. Perpetrators are often individuals known and trusted by those around them, including respected professionals, family members, and friends. The ongoing presenting of abusers as monsters facilitates the actions of abusers in families and affords them the freedom ‘to act with impunity and in plain sight’ [33]. Making assumptions such as these may lead to opportunities to intervene being missed. The students also reported that victim blaming was commonplace ‘in the tearoom’. This victim blaming points to a lack of knowledge of the complexities and dynamics of a coercive relationship and a lack of empathy and understanding of the impact of being in such a relationship can have on a victim/survivor’s self-esteem. They pointed out how this victim blaming narrative shifts accountability, normalises control and creates a ‘culture of fear’. These attitudes and behaviours can also serve to retraumatise the victim-survivor and is known as secondary victimisation [34]. This is also important because workplace norms and stigma may significantly shape the practices

of newly qualified staff, often constraining the application of knowledge gained during training. Students credited the training with increasing their awareness of DA and questioned the narrative around the fact that the responsibility of preventing GBV is placed on the women, shifting accountability from the preparator to the victim.

The findings corroborate previous research which indicates that Gender based violence training should include exploration of harmful and widespread beliefs, myths and stereotypes [26]. Training needs to show that leaving an abusive relationship is a complex and protracted process often compounded when children are present. The findings highlight an additional gap in knowledge and understanding of the complexities of being in an abusive relationship. Training also needs to address the language, attitudes and behaviours that help shift the accountability from the perpetrator to the victim. The research highlights the need for cultural shift interventions at the organisational level, extending beyond university-based education.

In some instances, students worried about offending the women or their partners, so training needs to make clear that protocols around safety questions are routine and standardised and make explicit that that they are acting as midwives following protocol consistent for everyone. However, students also cautioned against routine enquiry becoming a 'tick-box' exercise, highlighting the need for training that balances consistent safety assessment with meaningful, person-centred engagement. Students also reported being shocked that one of the most dangerous times for a woman is when they are pregnant questioning how someone could harm a pregnant woman especially when they are 'carrying your child'. This violation of norms and behaviours associated with being the father of an unborn child and 'someone who is supposed to look after you' was repeatedly referred to as a source of disbelief. This is another important knowledge gap that should be addressed in training; students should be aware that pregnancy is recognised as a period of 'high risk'. Research indicates that 30% of domestic abuse cases begins in pregnancy [35] and if the relationship is already abusive, then oftentimes the abuse becomes more severe.

The challenges that come with multi-disciplinary team working were also apparent, including negotiating ethical dilemmas around disclosure and consent that are often encountered. These issues were a cause of concern for the students who reported feeling guilty after certain decisions were made. Effective intervention and safeguarding of victims/survivors requires constant professional collaboration [5]. Thus, training should address the skills gap around interprofessional collaboration, cooperation and communication, shared responsibility and understanding of professional boundaries. Training needs to focus on these challenges and equip students with the skills to negotiate cross profession tensions whilst at the same time keep the trust and safety of the victim-survivor to the forefront. Training also needs to help students support women in abusive relationships that may not be ready to leave the relationship or support/refer whilst they make a safety plan.

The findings make clear that students want more education on GBV and wish to see it fully integrated into their curriculum. This is similar to previous research showing ongoing training is preferable and

rated more valuable, rather than once only [36]. They commented positively on the interactive element of the training, the thought provoking and interesting content and the engaging facilitators. They were also forthcoming on how it could be improved calling for simulations and role plays which they believe will help with decision making around those sensitive and difficult conversations. They also wanted a practical/accessible resource that they could refer to and use in practice.

Limitations

The research suffers for a number of limitations for example, the use of self-reported measures and the lack of demographic data (e.g. background or prior experience). Having no long term follow up also means it is impossible to ascertain whether the effects of the training are sustained over time. Future research should explore longer-term impacts, such as whether students apply these skills in practice placements or after graduation, as well as comparisons between different training approaches to identify what is most effective.

Conclusion

The findings align with the guidelines put forward by WHO outlining the importance of Gender based Violence training for Healthcare students and professionals [26]. However, despite the urgency, training is still not a priority for Nursing, Midwifery and other Healthcare professions worldwide. When training is delivered, it is often piecemeal and on an ad hoc basis with little evaluation and monitoring. The current research points to specific training gaps including; protocol around asking safety questions, knowledge of referral pathways, decision making processes around barriers/ethical dilemmas, challenges encountered through multi-disciplinary working and the observing of negative and harmful workplace culture. The research also highlights that efforts to establish, standardise and embed gender based training within the educational curriculums of all healthcare professions need to be made a priority. Institutional policies committed to the ongoing training and monitoring of healthcare professionals must be an urgent course of action.

In conclusion, it is crucial that these training gaps are addressed otherwise victims who need support and intervention may be missed, dismissed or blamed for the violence [12]. Failure to intervene means that victims may not get the support that they need, and some may pay the ultimate price for this.

Declarations

Ethics approval and consent to participate

The study received ethical approval from the Faculty of Engineering and Physical Sciences in Research Ethics Committee, Queen's University, Belfast (EPS 24_273). Both the education and participation in the research were entirely voluntary and all participants provided informed consent prior to completion of the pre-education questionnaire.

Consent for publication

Not applicable.

Competing interests

The authors report no competing interests.

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Author Contribution

Conceptualization: KML (lead), LL, CH, HC; Methodology: KML, RM, LL; Formal Analysis: KML, RM; Investigation (Data Collection): KML, RM; Writing – Original Draft Preparation: KML; Writing – Review & Editing: LL, RM, CH, AA, HC.

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Data Availability

The datasets and materials used in the study are available from the corresponding author on reasonable request.

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