Proceedings of the Estonian Academy of Sciences
2025, **74**, 3, 392–400

https://doi.org/10.3176/proc.2025.3.09

www.eap.ee/proceedings
Estonian Academy Publishers

ATTITUDES,
INTIMATE PARTNER VIOLENCE

RESEARCH ARTICLE

Received 17 December 2024
Accepted 18 March 2025
Available online 12 August 2025

Keywords:
attitude, knowledge, beliefs, behaviour, violence against women, first-year nursing students

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Citation:
Merits, M., Tupits, M. and Nool, I. 2025. Attitudes of first-year nursing students at Tallinn Health University of Applied Sciences towards violence against women. *Proceedings of the Estonian Academy of Sciences*, **74**(3), 392–400. https://doi.org/10.3176/proc.2025.3.09

Attitudes of first-year nursing students at Tallinn Health University of Applied Sciences towards violence against women

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ABSTRACT

Violence against women (VAW) is defined by the United Nations as any gender-based violence that causes mental, physical, or economic harm and restricts freedom. The topic has not been studied before in the context of the nursing curriculum in Estonia. The objective of the study was to investigate the attitude of first-year nursing students towards VAW and provide input to improve the quality of the nursing curriculum content when addressing the topic of violence. The study was conducted using a cross-sectional method. The study population consisted of the first-year nursing students at Tallinn Health Care College (now Tallinn Health University of Applied Sciences) during the period of 2022–2023. The online survey was distributed to 120 first-year nursing students of the college. The results of the study show that 96.00% of students have a generally negative attitude towards VAW, but this attitude contains certain limitations. Respondents know about the types of violence and have personal experiences with violence, but their knowledge of the impact of violence on women's health is limited. There are some negative beliefs and behavioural tendencies that indicate that less than half of the respondents would know how to help a woman as a victim. Based on the above, it is possible to gain input for addressing violence-related issues in the nursing curriculum. Violence-related topics should be included in the nursing curriculum, along with the development of practical skills that help shape the right attitudes.

1. Introduction

Violence against women (VAW) is defined by the United Nations as any gender-based violence that causes or is likely to cause mental, physical, or sexual harm, including acts of intimidation and coercion or deprivation of liberty, whether in public or private life. VAW can include mental/emotional, physical, sexual, cultural/spiritual, and financial violence, and a wide range of controlling, coercive, and intimidating behaviours [1]. A report compiled by the WHO, which analysed data from 161 countries from 2000 to 2018, found that globally 30.00% of women aged 15 to 50 have systematically experienced physical, mental, or sexual violence by an intimate partner or non-partner [2]. VAW is internationally described as a serious global public health problem with severe consequences, not only for the woman herself but also for her children. Besides individual suffering, VAW causes serious short- and long-term mental health, physical health, and sexual and reproductive health problems for victims [1,2]. In 2014, a survey was conducted among Estonian healthcare professionals, which revealed that 79.00% of respondents have a victim-blaming attitude, but the main problem is the lack of preparation in assisting victims of violence [3]. An individual's attitudes are a social psychological concept. Attitudes consist of three parts: knowledge, beliefs, and behaviour [4]. Knowledge that is not theoretical is often formed through personal experiences. Beliefs are ingrained misconceptions that have been socioculturally formed and lack evidence-based foundation [4,5]. Therefore, attitudes are based on a person's knowledge, beliefs, and, as a result, behavioural tendencies presented in relation to a phenomenon or a person [4–6]. More than 700 social psychological studies have confirmed that knowing people's attitudes can predict or influence their behaviour. It is known that changing wrong attitudes can be a long-term process that involves influencing a person's knowledge, beliefs, and behaviour. Even a single incorrect component of an attitude affects the attitude

as a whole [5]. A systematic review by Sammut et al. [7], which consists of 17 studies on violence against healthcare students, shows that knowledge, beliefs, and experiences of existing attitudes allow for more effective shaping of correct attitudes through educational interventions throughout the curriculum. Wrong attitudes and a lack of professional skills among healthcare professionals are serious obstacles to helping victims, which tend to perpetuate victim blaming rather than helping and supporting them [8,9]. However, health professionals, nurses, and midwives are in a unique position to identify and assist victims of VAW, as they are often their first point of contact in the health system [9–12]. The readiness of healthcare students to recognize signs of violence and help the victim is influenced by their attitudes and can be effectively shaped throughout the curriculum, starting from the first year of study [13–15]. Students may be aware of the importance of teaching about violence, but their attitudes and level of knowledge are not sufficient to help victims, so extensive preparation and training are necessary [16]. Several studies have shown that when healthcare students receive training on violence, their awareness and ability to spot a victim and help within the limits of their competence increases [12,17,18]. In Estonia, first-year nursing students' attitudes towards VAW have not been studied before, which is why this study is necessary to find out the primary results and, based on this, plan future actions.

The objective of the study is to investigate the attitude of first-year nursing students towards VAW and provide input to improve the quality of the nursing curriculum content when addressing the topic of violence.

Based on the objective, the following questions are of interest:

1. What are the first-year nursing students' personal experiences with violence, knowledge about the types of violence, the impact of violence on women's health, and VAW-related legislation in Estonia?
2. What are the first-year nursing students' beliefs about VAW?
3. What are the behavioural tendencies of the first-year nursing students related to helping victims, to provide input into the nursing curriculum?

2. Materials and methods

2.1. Study design

A quantitative method was used in this cross-sectional study. Cross-sectional studies are characterized by the collection of relevant information (data) at a given point in time. A cross-sectional design is relevant when assessing the prevalence of traits, attitudes, and knowledge [19]. For the quantitative questionnaire data, relative frequencies (%) were calculated for Tables 1 and 4. The results are presented as frequency tables. For Table 2, the mean, standard deviation, and minimum/maximum were calculated based on the Likert scale data. Table 3 shows that the internal consistency of the questionnaire's Likert scale was acceptable. The Likert scale consisted of 16 items, and the value for Cronbach's alpha was $\alpha = 0.61$. Item-total correlations were calculated, where an item's Cronbach's alpha varied from $\alpha = 0.57–0.64$. The results showed that if any of the items had been deleted, the internal consistency of the whole scale would not have changed. Statistical Package for the Social Sciences (SPSS) was used for quantitative analysis.

2.2. Subjects

The study population consisted of 120 first-year nursing students of Tallinn Health Care College (now Tallinn University of Applied Sciences) during the period of 2022–2023. An online questionnaire was sent to all first-year nursing students. Everyone had an equal opportunity to respond to the questionnaire, and 62.50% of the nursing students completed the online survey. There were 75 respondents, of whom 70 were female and 5 were male. The average age of the participants in the study was 32.04 years (SD = 11.90, min 18, max 67).

2.3. Ethics

To carry out the research, an approval was obtained from Tallinn Health Care College (No. 1-16/238, 21.04.2020) and the Research Ethics Committee of the National Institute for Health Development of Estonia (No. 2725, 19.04.2020). All study data were collected using an online survey and stored on a private, password-protected computer, accessible only by the principal investigator. Subjects were informed about the study method, purpose, and significance for the quality of the nursing curriculum before the study began. A written informed consent form preceding the questionnaire informed subjects that they could refuse to participate in the study either at the beginning or at any stage. It was further informed that a scientific article would be written based on the results of the study, using the respondents' comments as examples. Subjects were also informed that their IP addresses and account details would not be recorded when answering the questionnaire and that their responses would be anonymized.

2.4. The online survey

The online survey was prepared by the authors of the study and is based on the basic social psychology model of attitudes (knowledge, beliefs, behaviour tendencies) and related research. The questionnaire was created in the Connect Environment, which is an online survey platform (https://www.connect.ee). The online questionnaire consisted of 26 questions structured into three topic blocks. The results of this study do not present an analysis of all the questions but rather highlight the most important components of the respondents' attitudes. There are questions where the respondent can select multiple answer options and questions where only one answer option can be selected. The first topic block included four open-ended questions about types of VAW, the respondents' exposure to and/or experiences with violence, and asked about general attitudes towards VAW. The second topic block was based on a 5-point Likert scale [20]. On the Likert scale, statements can be rated from 1 to 5, where 5 represents 'do not agree at all', 4 'do not agree', 3 'cannot say', 2 'mostly agree', and 1 'completely agree'. The questionnaire contained 16 questions about respondents' beliefs (sociocultural mis-

Table 1. Respondents' experiences with and exposure to different types of violence (n = 75)

Mental (emotional) violence	n (%)
Humiliation	60 (80.00)
Inducing guilt	59 (78.78)
Threatening	53 (70.66)
Scolding, nagging	52 (69.33)
Making comments about appearance (clothing, weight, etc.)	51 (68.00)
Commanding	40 (53.33)
Physical (including sexual) violence	
Pushing	49 (65.33)
Hitting with an open hand	42 (56.00)
Touching or groping of the intimate area	40 (53.33)
Dragging (of hair, clothes, etc.)	39 (52.00)
Throwing an object	39 (52.00)
Forcing sexual intercourse (rape)	39 (52.00)
Economic violence	
The partner (life partner) does not materially contribute to the household	35 (46.66)
The partner (life partner) controls economic expenses	24 (32.00)

Table 2. Mean, standard deviation, minimum and maximum of the statements' beliefs (sociocultural misconceptions) related to VAW (n = 75)

	Mean	SD	Min	Max
He who beats, loves	2.12	0.40	3	5
Being hit once is not yet violence	2.21	0.47	3	5
If a woman nags, a man can hit her	2.24	0.46	2	4
A woman's place is mainly at home (in the family)	2.40	0.68	2	5
The health risks to women associated with violence are not visible	4.81	0.49	3	5
Wearing a short skirt and/or a wide neckline is one of the causes of sexual violence	2.61	0.93	1	5
A woman's flirtatious behaviour means consent to sexual intercourse	2.43	0.70	1	5
Touching/groping a woman while dancing is acceptable	2.24	0.57	2	5
If during a sexual act a woman wants to interrupt (give up) the act and the man refuses, it is rape	4.43	1.00	1	5
A woman can be physically disciplined (beaten) if necessary	2.11	0.35	1	3
Educated men are not violent	2.29	0.73	1	4
Less educated men are more violent	2.41	0.95	1	5
A woman is to blame herself if a man has hit her	2.17	0.62	1	5
A woman has more responsibilities in life than a man	3.01	1.31	1	5
During a woman's pregnancy, a man is less violent towards her	1.89	1.01	1	5
Men are less violent towards women during the postpartum period	1.75	0.73	1	3

conceptions) related to VAW. The third topic block contained one open-ended question about knowledge regarding the impact of violence on women's health, one open-ended question about VAW-related legislation in Estonia, and four open-ended questions about future nurse's awareness and possible skills in assisting the victim. Respondents had the opportunity to clarify or comment on their answers if they wished, but this was not mandatory.

3. Results

The first question in the first topic block showed that 96.00% of the respondents have a generally negative attitude towards VAW. The results of the first topic block showed that the respondents know different types of VAW. The respondents of this study have had personal experiences with and exposure to different types of violence (Table 1). **The respondents admitted that they had experienced mental (emotional) VAW.** The most common forms of emotional VAW that the respondents had seen or experienced were humiliation (80.00%), inducing guilt (78.78%), threatening (70.66%), and scolding and nagging (69.33%).

Examples of comments:

'*My partner constantly mocked and humiliated me. He enjoyed dominating and bossing me.*'

'*I have suffered emotional abuse both as a child and as an adult. In childhood by parents, especially father. In my adult life, my boyfriend was the one who mentally terrorized me.*'

'*Feeling guilty and being constantly scolded and criticized by male colleagues is unfortunately a common phenomenon. I have experienced and witnessed it myself.*'

'*Constantly making me feel guilty that everything is my fault. Still guilty. Threats were also common with him.*'

The respondents' experiences with or exposure to physical violence (including sexual violence) were the following: The most frequent types of physical VAW seen

Table 3. Internal consistency coefficient (α) and item-total correlation of the statements' beliefs related to VAW (n = 75)

	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Cronbach's alpha if item deleted
He who beats, loves	39.01	20.175	0.389	0.490	0.589
Being hit once is not yet violence	38.92	20.696	0.190	0.378	0.605
If a woman nags, a man can hit her	38.89	19.907	0.394	0.618	0.586
A woman's place is mainly at home (in the family)	38.73	19.955	0.219	0.212	0.600
The health risks to women associated with violence are not visible	36.32	21.788	0.063	0.303	0.629
Wearing a short skirt and/or a wide neckline is one of the causes of sexual violence	38.52	20.334	0.065	0.224	0.630
A woman's flirtatious behaviour means consent to sexual intercourse	38.71	18.670	0.426	0.562	0.569
Touching/groping a woman while dancing is acceptable	38.89	18.961	0.499	0.522	0.567
If during a sexual act a woman wants to interrupt (give up) the act and the man refuses, it is rape	36.71	36.710	0.031	0.183	0.640
A woman can be physically disciplined (beaten) if necessary	39.03	20.648	0.303	0.384	0.598
Educated men are not violent	38.84	18.515	0.428	0.526	0.568
Less educated men are more violent	38.72	18.042	0.349	0.393	0.576
A woman is to blame herself if a man has hit her	38.96	19.769	0.285	0.250	0.592
A woman has more responsibilities in life than a man	38.12	18.431	0.141	0.111	0.634
During a woman's pregnancy, a man is less violent towards her	39.24	18.482	0.259	0.490	0.595
Men are less violent towards women during the postpartum period	39.39	18.754	0.357	0.473	0.578

Table 4. Respondents' awareness of the impact of violence on women's health (n = 75)

Impact factors	n (%)
Miscarriage	73 (97.33)
Foetal injuries	68 (90.66)
Premature birth	70 (93.33)
Death of the foetus	68 (90.66)
Abortions	61 (81.33)
Bleeding	73 (97.33)
Bruises	69 (92.00)

or personally experienced by the respondents were pushing (65.33%), hitting with an open hand (56.00%), and touching or groping of the intimate area (53.33%). Forced sexual intercourse (rape) was indicated by 52.00 % of the respondents.

Examples of comments:

'*My boyfriend hit me and pulled my clothes when I refused to cook because I was tired.*'

'*You always see it in bars. I've experienced it myself. Men think they have the right to grope a woman if they want to. My previous relationship was sexually abusive.*'

'*I don't know a single female person who doesn't have a story to tell. Starting with the taxi driver's decision to drive to a completely different place and try something, ending with rape in the company of friends. I have had the experience of classmates simply lifting my dress so that my underwear was visible.*'

The form of economic violence that the respondents have encountered is the situation when the partner (life partner) controls economic expenses (46.66%) or the partner (life partner) does not materially contribute to the household (32.00%).

Examples of comments:

'*I don't have my own money; every purchase is controlled by my partner.*'

'*My partner controlled absolutely everything; I could not financially manage anything myself.*'

'*In my childhood home, my father did not financially support any of the children, although he would have had the opportunity to do so.*'

The results of the second topic block showed the respondents' beliefs (sociocultural misconceptions) related to VAW.

Respondents were presented with a statement to which they could respond using a Likert scale from 1 to 5, where 5 represented 'do not agree at all', 1 represented 'completely agree', and 3 'cannot say' (Table 2). Respondents also had the option to clarify their answers in words or add a comment.

The internal consistency of the questionnaire's Likert scale was acceptable. The Likert scale consisted of 16 items, and the value of Cronbach's alpha was α = 0.61. Item-total correlations were calculated, where an item's Cronbach's alpha varied from α = 0.57–0.64. The results showed that if any of the items had been deleted, the internal consistency of the whole scale would not have changed.

The mean, standard deviation, minimum, and maximum of the statements' beliefs were calculated, showing results for the questions where the respondents had written comments. In general, the respondents were unanimous regarding the given statements. The most agreement was with the state-

ments 'He who beats, loves' and 'Being hit once is not yet violence', for which 'do not agree at all' had the mean ratings of 2.12 and 2.21 points.

Examples of comments regarding the above statements:
'*When I was young, I thought so, now I see things differently.*'
'*This statement used to amuse me because I knew that it was circulating among the Slavs and seems to be accepted. Today I can't stand this sentence, I even physically resist it.*'
'*This is an outdated custom of the Russian nation.*'
'*Whoever hits once, will continue to do so.*'
'*Violence starts the first time.*'

There was slightly less consensus on the statements 'If a woman nags, a man can hit her' and 'Wearing a short skirt and/or a wide neckline is one of the causes of sexual violence'. Respondents generally disagreed with these statements, with the mean ratings of 2.21 and 2.24 points.

Examples of comments regarding the above statements:
'*Women, perhaps, are more emotional and express themselves more loudly, but that does not give them the right to hit.*'
'*This statement is childish, and nagging is still in the listener's ears. Not all sentences from women's mouths are mature yet – the woman nags.*'
'*Neither party has the right to beat the other.*'
'It's a dress not a yes. A woman has the right to wear what she wants, and no one can touch her if she doesn't want it.'
'*The more temptations you offer yourself, the more likely you are to fall victim.*'
'*Unfortunately, there are women who want such attention. This can contribute to unpleasant attention.*'

Another statement can be given as an example: 'If during a sexual act a woman wants to interrupt (give up) the act and the man refuses, it is rape', with the mean rating of 4.43 points.

Examples of comments:
'*Rather not because both started the intercourse. Rather, it is exploitation and disrespecting a woman.*'
'*Point of contention ... because who wants to interrupt.*'
'*You can certainly say so in part, but the male partner may not agree. We have many examples in society.*'
'*This is such a subtle ethical issue.*'
'*No is no. No matter at what stage it is said.*'

The third topic block contained questions about knowledge of the impact of violence on women's health, VAW-related legislation in Estonia and what the behaviour tendencies, awareness, and possible skills of future nurses should be when helping victims. The third block used open-ended questions. Knowledge of the impact of violence on women's health was assessed through an open-ended question that asked respondents to name various related factors (Table 4).

Respondents identified seven different risk factors that affect the health of a woman who is a victim of violence. The listed risks are related to pregnancy and childbirth.

To the closed-ended question 'Is VAW punishable by law in the Republic of Estonia?', 36.62% of the respondents answered 'Yes' and 14.82% of the respondents answered 'Do not know'. 48.61% of the respondents maintained that there is no law specifically regarding VAW in the Republic of Estonia.

Examples of comments:
'*It is not enough to change the legislation here; all members of society must be educated about violence. It starts from kindergarten, then elementary school, etc.*'
'*The punishments for the perpetrators of violence are so small that it does not motivate change. Rather, the finger is pointed in the direction of the victim, that it is your fault that it happened this way...*'
'*We have several anti-violence strategies in Estonian society, but women as victims continue to be unprotected. Everything starts with attitude.*'
'*Both legislation and people's attitude towards violence must be changed. It's a long process.*'

The open-ended questions asked what the behaviour tendencies, awareness, and possible skills of future nurses should be when helping victims.

Theoretical knowledge about violence was considered necessary by 30.33% of the respondents. How to empathically communicate with the victim, understand, support, and help her was considered important by 48.20% of the respondents. 37.51% of the respondents considered the right intervention (documentation of injuries, examination, victim assistance, network cooperation, legislation, etc.) necessary. 68.00% of the respondents stated that they would not be able to provide proper help to a woman as a victim, but they hoped that the topic of violence would be thoroughly covered in the nursing curriculum, both in theory and in practice, so that the future nurse would acquire the necessary knowledge and skills.

4. Discussion

VAW is a significant problem both in Estonia and around the world. In Estonia, the attitudes of first-year nursing students toward VAW have not been studied before.

Attitudes consist of three parts: knowledge, beliefs, and behaviour. It is known that a person's attitudes are formed from existing knowledge, experiences, and beliefs, and the resulting behaviour tendencies [4,5,7]. The results show that 96.00% of respondents have a general negative attitude towards VAW. Respondents have knowledge of types of violence and personal experiences with violence. Knowledge that is not theoretical is often formed through personal experiences; therefore, it is important to analyse the personal contacts of the respondents affected by violence. Respondents' comments indicate that mental violence has a long-term destructive effect and damages self-esteem. Similar studies in Turkey found that students in the healthcare curriculum had experienced mental VAW that had affected them. Mental violence was mostly perpetrated by a male family member or a loved one [13,21,22]. There is reason to assume that different forms of mental violence are either difficult to distinguish or so normalized that they go unnoticed. The study by White et al. [23] also confirms that lifetime mental violence is the most prevalent form of violence, and often the victim does not pay attention to its manifestations. For that

reason, this form of violence is being downplayed. An Estonian study by Pettai and Kase [3] showed that, according to healthcare workers, the most prevalent form of violence against women is mental violence, occurring in as many as 82.00% of cases. Mental violence seen or experienced personally, either in childhood or as an adult, affects various aspects of an individual's personal and professional life [22].

The respondents of this study have experienced various manifestations of physical violence, including sexual violence. A study conducted by Pettai in Estonia in 2022 [24] shows that 54.00 % of women have experienced some form of physical violence, but there is a widespread opinion in society that VAW is overemphasized. The position of this study is that nursing students are both members of society and future healthcare workers, so it is unfortunate that they have experienced physical (including sexual) violence. Several studies show that the academic results of female students who have experienced violence, including physical violence, are affected by it as is their self-esteem, which also has an impact on their professional life [24–26]. Pereira et al. [27] emphasize that any VAW affects a women's ability to cope, undermines her self-esteem, and poses a serious threat to her mental and physical health.

Economics is not the first association that comes to mind when thinking or talking about VAW [26]. Respondents' experiences with economic violence involving a parent or a current or previous life partner related to expenditure control or economic non-contribution. The FRA survey [28] sees economic violence as part of psychological violence, but separates it out, matching the concept with the following behaviour on the part of the respondent's partner: '*Preventing the respondent from making decisions on family finances or shopping independently, or forbidding her to work outside the home*'. Economic VAW suppresses a woman's self-esteem, decision-making ability, and access to both education and the labour market [29]. Although the prevalence of economic violence against students is estimated to be low – lower than among working women – it still has psychological impacts and negative consequences [28]. Several studies confirm that healthcare professionals who have experienced violence themselves are more supportive and empathetic towards victims [13,27]. Based on the study by Hegarty et al. [11], it can be confirmed that more than 20 scientific studies show that a health worker's personal experience of violence has a greater impact on their commitment, understanding, and willingness to help victims. However, these studies also emphasize that violence does not necessarily have to be experienced – evidence-based training provides the necessary skills and an empathic attitude.

The results of the second topic block show respondents' beliefs related to VAW and their knowledge about the impact of violence on women's health. Over 90.00% of respondents do not agree or do not agree at all with the beliefs as negative stereotypes prevalent in society regarding VAW. At the same time, the authors of the study emphasize that even a small percentage of the wrong beliefs that appeared in the study need attention and attitude change. The sociocultural statement 'If during a sexual act a woman wants to interrupt (give up) the act and the man refuses, it is rape' needs special attention. Estonian society has debated about this statement, but so far it has not been stipulated in the legislation. Although Pettai's study [24] highlights this regarding VAW, wrong attitudes continue to prevail. The literature has largely shown that incorrect beliefs about violence are strongly linked to the gender stereotypes and ambivalent sexist attitudes that contribute to the prevalence and perpetuation of VAW [17,30,31]. Social myths and negative stereotypes about abused women encourage the justification of violence [17].

Respondents' knowledge of the impact of violence on women's health is limited. The respondents did list some risks to a woman's health caused by violence, but the percentage representation of specific risks was quite limited. Respondents identified seven different risk factors that affect the health of a woman who is a victim of violence. The listed risks are mainly related to pregnancy and childbirth. Several representative studies confirm the negative impact of VAW on women's mental and physical health [32–34]; therefore, nursing students' knowledge of the impact of violence on women's health is crucial. Limited knowledge of VAW among future healthcare workers is an obstacle to helping victims [35,36]. Less than half of the respondents of this study were aware that VAW is punishable by law, which shows that first-year nursing students are not sufficiently familiar with the legislation in force in Estonia. The authors of the study are convinced that education on legislation must be included in the curriculum – it is a prerequisite for providing help to victims of violence.

Respondents' behavioural tendencies show that more than half of the respondents are not able to provide proper help to a woman as a victim (68.00%). Less than half of the respondents mention empathy, victim awareness, and intervention. The authors of the study emphasize that since they are first-year students, they lack the knowledge and skills to help the victim. The respondents, however, believe that they can acquire the necessary theoretical and practical skills in the nursing curriculum. The study by Simsek and Ardahan [21] found that although final-year nursing and midwifery students can recognize the signs of VAW, they lack the skills to help the victims. A pilot study of final-year nursing students at Tallinn Health Care College also revealed that nurses who have already completed their training do not know how to adequately help victims of violence [37]. Several authors also emphasize that a lack of knowledge is a key factor, recognized as the main barrier to care, inquiry, and diagnosis of VAW by healthcare professionals [9,35]. At this point, the authors are convinced that providing content into the nursing curriculum on the topic of violence is essential. The authors of the current study are of the opinion that topics related to violence need to be addressed in the nursing curriculum throughout the study period, giving students both knowledge and practical skills for providing the best possible help to the victim. Several authors are of the same opinion and consider the undergraduate courses as ideal means for changing nursing students' attitudes toward VAW, as undergraduate courses

can equip students with a comprehensive understanding of VAW. Undergraduate nursing education must continually emphasize the relationship between exposure to violence and poor health; this will allow students to recognize exposure to violence and respond appropriately when they treat patients in clinical settings in the future. There is strong evidence that violence-related training increases confidence and skills in aiding a victim of violence in a clinical setting [12,16,36,38]. The authors of this study emphasize that changing attitudes is a long-time process. To provide broad-based knowledge and gain practical experience, it is necessary to introduce qualitative changes in the nursing curriculum to ensure the best possible help for victims of violence. Several studies confirm that evidence-based theory learning, simulations, workshops, etc. could be suitable methods. Therefore, the topic of violence should be included in the curriculum by integrating it into existing courses or including it as a separate course in each academic year [16,31]. Health educators should be strongly encouraged to provide nursing students with simulations and collaborative activities in addition to theory training on violence to gain practical experience in dealing with VAW.

Limitations. The present study has several limitations. The main limitation is the small number of respondents, which does not permit statistical generalizations or correlations, but allows for a preliminary analysis of the attitudes of first-year nursing students towards VAW and highlights emerging bottlenecks. The small number of male respondents, which does not allow analysing their attitudes, can be pointed out as a limitation. It is possible that male respondents should have been singled out to make their attitudes and comments more visible. An important limitation is that the survey did not ask about the nationality or cultural beliefs of the respondents. Several aspects of attitudes may stem from the wrong cultural beliefs and norms of the respondents. The strength of the study, however, can be highlighted as the first important insight into VAW, which allows for increasing the content quality of the nursing curriculum.

5. Conclusion

Even though 96.00% of respondents have a generally negative attitude towards VAW, the present study showed that first-year nursing students' attitudes towards VAW need improvement. Respondents do know about the types of violence and have personal experiences with violence, but their knowledge of the impact of violence on women's health is limited. There are some negative beliefs, and the respondents' behavioural tendencies indicate that less than half of them would know how to help a woman as a victim. Based on the above, it is possible to gain input for addressing violence-related issues in the nursing curriculum. Topics related to violence should be included in the nursing curriculum along with the development of practical skills. Issues related to violence should be addressed throughout the nursing curriculum – from the first year to the end of the studies – because changing attitudes is a long-term process. This approach equips students with both the theoretical knowledge and practical skills needed to provide the best possible care to victims and shape right attitudes.

Data availability statement

All research data are contained within the article and can be shared upon request from the authors.

Acknowledgements

This study received no specific grant from any funding from the public or commercial sectors. The publication costs of this article were partially covered by the Estonian Academy of Sciences.

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Tallinna Tervishoiu Kõrgkooli esimese kursuse õendusüliõpilaste hoiakud naistevastase vägivalla suhtes

Marika Merits, Mare Tupits ja Irma Nool

Ühinenud Rahvaste Organisatsioon määratleb naistevastast vägivalda kui igasugust soolist vägivalda, mis põhjustab vaimset, füüsilist või majanduslikku kahju ja piirab vabadust. Eestis ei ole teemat varem käsitletud õenduse õppekava kontekstis. Uuringu eesmärk oli analüüsida esimese kursuse õendusüliõpilaste hoiakuid naistevastase vägivalla suhtes, et saada sisendit õenduse õppekava sisu täiustamiseks. Selleks kasutati läbilõikeuuringut, mille populatsiooniks oli 120 esimese kursuse õendusüliõpilast ajavahemikul 2022–2023. Andmete kogumiseks kasutati veebiküsitlust. Tulemused näitasid, et 96,00% vastajatest suhtub naistevastasesse vägivalda üldiselt negatiivselt. Üliõpilased teavad vägivalla liike ning neil on isiklikke kokkupuuteid vägivallaga, kuid nende teadmised vägivalla mõjust tervisele on piiratud. Esineb üksikuid negatiivseid uskumusi. Alla poole vastanutest teavad, kuidas vägivalla ohvriks langenud naist aidata. Uuringu tulemused osutavad vajadusele täiendada õenduse õppekava naistevastase vägivalla teemade käsitlemisega. Ühtlasi tuleb rõhku panna praktiliste oskuste arendamisele, mis võimaldavad pakkuda ohvritele asjakohast ja tõhusat abi.