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‘What do I do?’ A study to inform development of an e-resource for maternity healthcare professionals and students caring for people with lived experience of childhood sexual abuse

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ABSTRACT

Background: The impact of childhood sexual abuse can last a lifetime. It is more prevalent than many common complexities that require additional care during the childbirth cycle but is rarely part of the education of healthcare professionals and students. This study informed the development of an e-resource to support maternity healthcare professionals and students caring for people with lived experience of childhood sexual abuse.
Objectives: To identify any previous learning of pre-registration students and healthcare professionals in relation to care of survivors of childhood sexual abuse, explore their clinical experience in caring for survivors, identify related learning needs, explore what survivors of childhood sexual abuse would like healthcare professionals to know about their maternity care needs.
Design: A qualitative descriptive study using focus groups and interviews. Data derived qualitative content analysis was employed to address the objectives.
Setting: The study was designed in consultation with The Survivors Trust and took place in South London, UK
Participants: Thirty seven health care professionals and students participated, comprising 25 students of midwifery, health visiting and medicine; 9 midwives, health visitors and doctors with specialist obstetric training. Eight women with lived experience took part in focus groups.
Findings: Care of women and birthing people who have experienced childhood sexual abuse had not been part of the undergraduate/pre-registration curricula, nor in specialist training for obstetricians. Many practitioners felt unprepared to care for those with lived experience of abuse and their learning needs were wide-ranging. The need for a learning resource was acknowledged and the outline plan that had been produced following the focus groups was endorsed by participants with lived experience.
Conclusion: Care for women and birthing people with lived experience of childhood sexual abuse can be challenging for both personal and professional reasons. This study confirmed the need for a resource that could facilitate the classroom teaching of students and be used for the Continuous Professional Development of qualified practitioners.

Introduction

Statement of significance

Issue	What is already known	What this paper adds
The provision of trauma-informed maternity care to survivors of childhood sexual abuse.	Care of those who have experienced childhood sexual abuse has not been included in healthcare professional education. Healthcare professionals often feel uncomfortable dealing with disclosures of abuse.	Our work confirmed the need for a resource to support healthcare professionals and students in providing maternity care to those who have experienced childhood sexual abuse. It informed development of the resource. Our approach was supported by those

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Abbreviations: NHS, national health service; NMC, nursing and midwifery council; ONS, office for national statistics; TST, the survivors trust.

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(*continued*)

Issue	What is already known	What this paper adds
		with lived experience of abuse.

Care of women following sexual abuse was included in the Standards of Proficiency for Midwives by the Nursing and Midwifery Council (NMC) for the first time following the United Kingdom's (UK) most recent review (Nursing and Midwifery Council, 2019). As defined by the NMC, 'abuse' comprises both abuse that is still happening and non-recent abuse that occurred in the past. The widely acknowledged continuing harmful physical and psychological effects (Hughes et al., 2017; Itzin et al., 2010) that can impact adults who have experienced childhood sexual abuse are therefore recognised.

Childhood sexual abuse is more prevalent than many of the common medical complexities that increase risk for women during pregnancy (e.g. diabetes and hypertension) yet it has often been absent from the education of healthcare professionals (Bewley and Welch, 2014). The latest release on child abuse from the Office for National Statistics (ONS) for England and Wales (Elkin, 2020), suggests that at least 11.5% of women have experienced sexual abuse before the age of 16. However, the ONS acknowledges that there is currently no source that provides data on the prevalence of child sexual abuse. They indicate that the Crime Survey for England and Wales is the best available indicator, but that this underestimates the true prevalence. An international meta-analysis that included studies from 16 countries, reported a pooled prevalence of 24% for childhood sexual abuse (Pan et al., 2020). Although this meta-analysis did not include any studies from the UK, the rate in Europe was 17%. In her report 'Protecting Children from Harm', the Children's Commissioner (2015) estimated that in the UK, approximately 1.3 million children will have experienced sexual abuse by the time they are 18 years old but only one in eight are known to statutory bodies. Childhood sexual abuse has been described as one of society's most serious public health issues (Pereda et al., 2009). Survivors[1] are regular users of health services but frequently do not disclose their history of abuse to healthcare professionals.

Given the estimated prevalence, it is likely that every day, there will be women and birthing people within maternity services who were sexually abused in childhood (Gutteridge, 2009). Childbirth inevitably involves the crossing of body boundaries and can be a particularly traumatic time for those who have experienced childhood sexual abuse. Survivors report 're-enactment' of their abuse during pregnancy and birth in ways that they may not have anticipated and that may be very perplexing at the time (Montgomery et al., 2015a). Many survivors report guilt and shame in relation to their childhood history and although they feel scared and alone during their childbearing journey, they dare not ask for help from those providing their care because they fear judgement (Montgomery et al., 2015b). The specific needs of survivors are consequently often unrecognised and unmet. As a result, survivors may emerge from maternity care feeling very vulnerable and further traumatised. Although disclosure, and subsequent sensitive care, will not necessarily prevent women experiencing re-enactment of their abuse during pregnancy and birth (Montgomery et al., 2015a), if during their maternity care women retain control and forge positive, trusting relationships with healthcare professionals, they may experience healing in the process (Montgomery, 2013).

Although labour can be challenging for women who have experienced childhood sexual abuse (Leeners et al., 2016), inconsistencies in how abuse is measured and operationalised, highlighted in the systematic review by Brunton and Dryer (2021), mean that only tentative conclusions can be drawn regarding association between a history of childhood sexual abuse and adverse birth outcomes. From the perspective of the healthcare professionals caring for these women, there may be little to distinguish them from many other women. Without an awareness of childhood sexual abuse and its potential impact during pregnancy and birth, professionals may inadvertently cause trauma from the care they offer and may miss cues that could alert them to distress. There is evidence that healthcare professionals do not feel comfortable in dealing with disclosures of abuse (Jackson and Fraser, 2009; Montgomery, 2012). Caring for women and birthing people who have been sexually abused can be challenging on both a personal and professional level and staff may be reluctant to invite disclosures for fear of opening up 'a can of worms' for which they lack knowledge and skills (Montgomery, 2012).

Inclusion of the care of women who have experienced abuse in the NMC standards of proficiency (2019) is a positive step forward that will necessitate its inclusion in midwifery curricula in the UK. However, other maternity care professionals regularly encounter those with histories of abuse too. Resources to support education on the subject are lacking. This paper reports a study undertaken to inform the development of an e-resource to support healthcare professionals and students in caring for survivors of childhood sexual abuse during pregnancy, birth and beyond.

Objectives were as follows:

- Identify any previous learning of pre-registration students and healthcare professionals in relation to care of survivors of childhood sexual abuse.
- Explore clinical experience in caring for survivors of childhood sexual abuse among healthcare professionals and students.
- Identify the learning needs of healthcare professionals and students in relation to caring for survivors of childhood sexual abuse.
- Explore what survivors of childhood sexual abuse would like healthcare professionals to know about their maternity care needs.

Methods

Given the clear aim to develop an educational intervention, a qualitative descriptive approach that summarised the pertinent informational contents of the data was utilised (Sandelowski, 2000).

Setting

The study was designed in consultation with The Survivors Trust (TST, a national umbrella agency for 120 specialist organisations for support for the impact of rape, sexual violence and childhood sexual abuse throughout the UK and Ireland) and with key stakeholders in a South London National Health Service (NHS) Trust. Ethical approval was gained from the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee at the host university. In addition, Health Research Authority approval was gained for the data collection with healthcare professionals.

Data collection

Qualitative data collection methods, primarily focus groups, were utilised because the interaction that is a key aspect (Finch and Lewis, 2003; Wilkinson, 2004) can lead to a richness of data that may not be possible from individual interviews (Walsh and Baker, 2004). As care of women and birthing people following childhood sexual abuse is an issue for both pre-registration and post-qualifying education, focus groups were conducted with each of the following groups: midwives and health visitors from a local NHS Trust; students of midwifery (second and third year), health visiting and medicine (Phase 4) from the host university (University a). As midwifery students from this university have been taught by the first author (EM), their experiences may not reflect the

[1] We use the term 'survivor' as this was the preference of most of the participants in our study. We acknowledge that not all women who have experienced sexual abuse in childhood identify with this term as relevant or helpful.

experiences of midwifery students in general. To mitigate against this, a focus group was also conducted with second and third year midwifery students from another local university (University b). The focus groups were conducted face to face. Although a number of dates were set to conduct a focus group with doctors working in obstetrics at the local NHS trust, on each occasion the group had to be cancelled due to competing priorities. Because of funding deadlines, three individual interviews with doctors were conducted instead. One of these was face to face and two were by telephone. Focus groups, lasting approximately one hour, and interviews which lasted approximately 30 min, were conducted by the first author. The second author supported focus group facilitation and took field notes.

Two focus groups were held with women with a history of childhood sexual abuse who had experienced maternity care. The purpose of these groups was to check that the issues we had identified for inclusion in the educational resource via our work with healthcare professionals and students were recognised as important by the service users too. This study ran in parallel with a separate study (Montgomery et al., 2021), during which an e-resource to help prepare survivors for pregnancy, birth and parenthood was co-produced. The decision to conduct these studies together was taken to respect the time and commitment required from survivors who would be participating in both. For the other study, data were collected via an on-line survey with open questions in addition to the focus groups. Many of the responses to open questions were relevant to the current study and are reported in this paper.

Initial contact was made with participants via gatekeepers (relevant academic staff for students, staff with managerial or leadership roles for clinicians, The Survivors Trust for survivors of childhood sexual abuse). Face to face meetings were arranged to introduce the study where possible. When this was not possible, communication took place by email. On introduction to the study, potential participants were provided with a Participant Information Sheet and a reply slip. Those interested in participating sent their contact details to EM. Focus groups took place at either the host university or the health professionals' workplace. Students and survivors were offered a £20 High Street voucher as a token of appreciation for attending the groups. Written consent from participants was obtained before the focus group discussion or face to face interviews began. A consent form was sent electronically to the doctors who were interviewed by telephone and verbal consent obtained before the interviews began. A leaflet containing Sources of Support was distributed to each participant. EM conducted the interviews. She led the facilitation of the focus groups, supported by YSC. A semi-structured topic guide was used for both the interviews and focus groups.

Dr Elsa Montgomery is a senior lecturer in midwifery with extensive experience in research and teaching on the maternity care experiences of women who have experienced childhood sexual abuse. Dr Yan-Shing Chang is a lecturer in maternal, child and family health, and has extensive experience of conducting research on sensitive topics including domestic violence. Together with survivors they co-produced the resource hosted on The Survivors Trust website.

Data analysis

Focus groups and interviews were digitally audio recorded and transcribed verbatim by a transcription service who had signed a confidentiality agreement. Data were managed using NVivo software. Drawing on the principles of naturalistic enquiry, data-derived qualitative content analysis was undertaken (Sandelowski, 2000). The authors initially analysed the data individually and then reached agreement through discussion. In keeping with our methodology, a pragmatic approach has been taken to presentation of our findings below, which have been organised in line with the objectives of the study.

Findings

Overall, 34 healthcare professionals and students participated in 6 focus groups as shown in Table 1. Focus groups with healthcare professionals and students took place between November 2016 and January 2018. In addition, three doctors were interviewed in September 2018. We met with survivors in March 2017 and September 2018. Data were received from a further 29 survey responses.

Demographic details of healthcare professionals and students are presented in Tables 2 and 3 respectively.

The learning of pre-registration students and healthcare professionals in relation to care of survivors of childhood sexual abuse

The only students who had learned anything specific about caring for women who have experienced childhood sexual abuse were the midwifery students who had been taught by EM. None of the other students had received any education on the subject and a number stated that they felt unprepared to care for these women. Of the qualified practitioners, one midwife was a graduate who had been taught by EM but none of the others had received any input on the subject. It was neither part of the undergraduate/pre-registration curricula, nor in specialist training for obstetricians.

Clinical experience in caring for survivors of childhood sexual abuse among healthcare professionals and students

Of those who took part in focus groups or interviews, only three had received direct disclosures of childhood sexual abuse from women; one doctor, a health visitor, and a health vising student. The Health Visiting student reported receiving a disclosure that came as a shock because it was not written in the woman's records:

> *…she hadn't mentioned it to the midwife who had booked her appointment. That's why it wasn't written in the notes. We were really taken aback by that, because we weren't expecting to hear that.*

Doctors tended to learn of a woman's history because it was previously written in the notes. One recognised that women do not readily disclose and will often not respond to direct questions. However, several participants had cared for women in whom they suspected a history of abuse. Examples included when women were very upset about vaginal examinations or could not tolerate them. One midwifery student had cared for a woman who wanted a general anaesthetic for a cervical smear and several participants reported that they sensed women were holding something back. The atmosphere in a consultation sometimes led to suspicion:

> *…there have been a few consultations where I've thought the vibe has been a bit fraught, and I've wondered if I was missing something.* (Medical student)

One midwife recounted her experience with a woman who was part of her caseload:

Table 1
Healthcare professional and student participation.

Professional Group	Number	Mode of data collection
Midwifery students:		
University a (Host)	8	Focus Group
University b	7	Focus Group
Health visiting students	7	Focus Group
Medical Students	3	Focus Group
Midwives	2	Focus Group
Health visitors	4	Focus Group
Doctors	3	Individual interviews

Table 2
Demographic Details of healthcare professionals.

Profession	Years in Profession	Age	Gender	Ethnic group
Health visitor	NR	NR	Female	Black/African/Caribbean/ Black British
Health visitor	15	40–40	Female	White
Health visitor	15	50 - 59	Female	Black/African/Caribbean/ Black British
Midwife	2.5	20–29	Female	White
Midwife	1–5	50 - 59	Female	White
Obstetrician	6–10	50 - 59	Female	Black/African/Caribbean/ Black British
Obstetrician	6–10	30–39	Female	Mixed/multiple ethnic group
Obstetrician	NR	NR	Female	White

Key – NR – not recorded.

Table 3
Demographic details of students.

Student Programme	Age	Gender	Ethnic group
Midwifery	20–29	Female	White
Midwifery	20–29	Female	Black/African/Caribbean/Black British
Midwifery	20–29	Female	White
Midwifery	20–29	Female	Black/African/Caribbean/Black British
Midwifery	20–29	Female	White
Midwifery	20–29	Female	Black/African/Caribbean/Black British
Midwifery	30–39	Female	White
Midwifery	20–29	Female	White
Midwifery	20–29	Female	White
Midwifery	20–29	Female	White
Midwifery	20–29	Female	White
Midwifery	30–39	Female	White
Midwifery	40–49	Female	White
Midwifery	20–29	Female	White
Midwifery	30–39	Female	White
Health Visiting	30–39	Female	Black/African/Caribbean/Black British
Health Visiting	20–29	Female	Mixed/multiple ethnic group
Health Visiting	20–29	Female	White
Health Visiting	20–29	Female	White
Health Visiting	20–29	Female	Black/African/Caribbean/Black British
Health Visiting	20–29	Female	White
Health Visiting	50–59	Female	Black/African/Caribbean/Black British
Medicine	20–29	Male	White
Medicine	30–39	Male	White
Medicine	30–39	Female	Mixed/multiple ethnic group

Just the way she felt about being pregnant and the way she described her own concerns about her body image changing. Her fears for how that might impact on her relationship with her husband were very big for her, very important for her, and her absolute definite, unquestionable desire to not breast feed…

Participants generally reported feeling ill-prepared and this was an uncomfortable experience:

I was the first person she has ever told and that, to me, it felt like it was weighing a tonne on my shoulders. I wasn't prepared, I recognised my limitations in how much support I could give her. (Health visitor)

They expressed reluctance to broach the subject even if they suspected a history of abuse because they were concerned about what their response should be and felt that they lacked the knowledge to support women and birthing people appropriately:

I think the phrase 'can of worms' comes to mind, in that if you start to explore and open up something, you need to know that there's something you can do positive to help, rather than just stir up something that actually you might cause more trouble than you can help. So, that's the scary aspect of it, I think. (Midwife)

The perceived learning needs were consequently wide ranging as shown below.

Learning needs of healthcare professionals and students related to caring for survivors of childhood sexual abuse

There was general recognition of the need for background information such as prevalence that would raise awareness of the subject and provide context. How to recognise women and birthing people who have experienced childhood sexual abuse was a concern and participants wanted to find out about any cues that might be given, or signs and symptoms to look out for:

Certain responses or certain cues to maybe be aware of, rather than just - I feel like we're, sort of flying a bit blind on that - which might probe you to ask a question that you might not normally ask would be useful. (Medical student)

How to provide sensitive care and respond to the needs of individual women and birthing people was an important issue for many participants:

I would not have a clue. I would be trying to be as kind as I could be and listen and be sensitive, you know, I don't know what else I would do. So, I'd want to know what I could do to help it be less painful for them. (Midwifery student)

This included awareness of triggers, the importance of language and being aware of any procedures that might be particularly difficult. However, there was also a recognition of the need to make practitioners aware of the importance of individualised care:

but I think it's probably quite individual, in the sense of what one woman will want might be completely different for another woman that's gone through the same kind of thing. Equally, with language and things like that, I suppose, triggers for some people might be completely different to triggers for others. So, I guess it's probably more about individualising care, rather than having blanket rules. (Doctor)

How to approach the subject in the first place was a concern and how to 'ask the question'. The challenge that women and birthing people might face in disclosing, even when staff ask about a history of abuse, was recognised:

It takes a while, it takes that regular contact for them to trust you, to be able to disclose such sensitive information. (Health visitor)

Healthcare professionals and students were uncertain of the most appropriate response if disclosures were received. 'What do I do?' was a frequently asked question and there was also uncertainty about what women want from staff:

So, is it just that they want to be able to disclose it, just so that someone knows? What do they want from us? Or nothing at all, but to know that would be helpful. (Health visiting student)

The fact that women might not want a disclosure to be documented was acknowledged, but that was a source of anxiety for several participants. The provision of optimal care was a factor articulated by one of the doctors:

Some guidance on where to document and how to document would be, actually, really helpful. …because you want to do the best thing for the patient and you might not necessarily be able to do that if you're not conveying the information to the whole team that might need it.

There was an assumption that a referral would be needed but lack of knowledge about who to refer to. This is an important area that is related to practitioners' anxiety about legal aspects.

The need for access to resources for women and birthing people was recognised, but support for healthcare professionals was also flagged as important:

…background training for us to be able to absorb that information, deal with it, analyse. Also, how do you actually get rid of it, in a way, because you don't keep it with you … So how to become, yourself, a healthy practitioner. So you are ready for the next mother, to support her. (Health visitor)

The need for the proposed resource was acknowledged by many of the participants. Some of the students felt more prepared to care for women and birthing people with histories of childhood sexual abuse having been introduced to the subject and participated in the study. They felt that was due to the face-to-face discussions. Although several were positive about the production of an e-resource, concerns were also expressed and their attitude to e-learning was sometimes ambivalent:

…it's quite often click through, click through, click through, get the certificate, okay, I put it in my portfolio. (Midwifery student)

However, there was general approval for a resource that would address people's different learning styles. The idea of an interactive resource involving short films and animations, clinical scenarios and case studies was discussed.

What would survivors of childhood sexual abuse like healthcare professionals to know about their maternity care needs?

We met with women who had experienced childhood sexual abuse on two occasions. The first time, three survivors explored their experiences of pregnancy, birth and parenthood. The second time, we presented and discussed an outline plan of the resource to six survivors, one of whom had also been at the first meeting. Relevant useful information was also shared with us via the on-line survey for a project that ran concurrently. The outline plan had been developed following the focus groups and interviews with healthcare professionals and students.

On both the occasions we met with women, response to our work was very positive. This is summed up by a comment made by a participant from the second group that was supported by the other participants:

I think this is a great project actually because this is pushing this further forward. This is opening up the world that this actually happens. This is something that happens but there is somebody trying to change it for women, so I think it's brilliant.

Several of the areas of concern raised by healthcare professionals were recognised by survivors. Lack of education on the subject was one such concern. Women sense the discomfort that healthcare professionals report:

I'm amazed how uneducated people are about it so because they're so nervous of it they don't want to talk about it and you pick that up. (Survey participant)

Issues surrounding disclosure were also debated, for example, if and how women would like to be asked about experiences of childhood sexual abuse. Staff reluctance to 'ask the question' mirrors women's reluctance to disclose:

At the time, I could not and did not tell the healthcare professionals of my survivor status. I did not know how to say it and no one asked me. It felt like there was no way to bring it up easily and I was not confident enough to be able to say it for myself with no prompting. I had such bad experiences of telling trusted adults in the past, that I think I projected that into the relationship with health care professionals. (Survey participant)

Other women were also wary of telling staff of their history following previous responses to disclosure:

I really wanted to tell the midwife but I was scared so didn't. I think I felt infantilised by the medical profession so was scared I wouldn't be believed (again). (Survey participant)

Knowledge of potential triggers was a key issue that was linked to healthcare professionals being aware of how their behaviour might impact women:

If I feel like someone's trying to overpower me with their position or their voice or their presence, I will leave [dissociate] *and you know, it does cause a lot of triggers in that moment and in that situation.* (Focus Group 1)

The importance of empowerment and feeling in control was mentioned by nine of the survey participants in their free-text responses and discussed during both focus groups. Although there was general support for educating healthcare professionals and students about the impact of childhood sexual abuse and care of women who have experienced it, a note of caution was also raised in the first group:

I think there as well that's a lack of questioning, you know, it's going back to this 'oh we've done our training, we know what you as a survivor want' and actually they need to just ask.

When the outline plan was presented, we were clear that we are not aiming to create 'experts' but to raise awareness of the issue and help practitioners to develop the skills needed to respond to individuals with sensitivity. This was met with approval.

Discussion

In common with the findings of Choi and Seng (2014), our study confirmed that care of women and birthing people who have experienced childhood sexual abuse has not generally been part of either the pre-registration education of healthcare professionals or their continued professional development. That situation will change for midwifery students now that the care needs of women who have experienced abuse is included in the Standards of Proficiency (NMC 2019). The need for a resource to support learning was recognised by healthcare professionals and students, and the women with lived experience of childhood sexual abuse welcomed efforts to raise awareness of the issue.

Some key concerns have emerged from our data that we address in the resource. 'Can of worms' is a phrase that has been used in this and other studies (Montgomery et al., 2015b). It reflects circumstances in which clinicians fear being confronted with situations which they feel need a definite response, but they do not know what it should be. This is a source of anxiety and participants in our study indicated that specific guidance on how to respond would be welcome, which was also a need identified by Choi and Seng (2014). However, learning how to respond risks a reductionist approach that fails to address the individual needs of women and challenges their agency and control. As recognised by one of the doctors in our study, what is needed is individualised care rather than blanket rules. Asking the woman or birthing person what they would find most helpful lessens the chance of disempowerment and reassures them that their view matters. Being aware of potential triggers is important, but these will vary between women even when they have apparently had similar experiences. Triggers can sometimes take survivors themselves by surprise (Montgomery et al., 2015b). Unexpected responses from women and birthing people can be perplexing, and staff need support too. As recognised by de Klerk et al. (2022) rates of sexual violence among healthcare professionals are at least similar to those in the general population, if not higher. Caring for those who have experienced childhood sexual abuse may therefore be challenging on both a personal and professional level (Choi and Seng, 2014). A trauma-informed approach, in which the widespread impact of trauma is recognised, is essential (Chapman, 2022). The resource incorporates principles that minimise the risk of re-traumatisation, whether or not abuse has been disclosed, and that consider the wellbeing of both service users and staff (Long et al., 2021).

In building the resource for healthcare professionals and students, our experience of co-producing a resource to help women who have experienced childhood sexual abuse prepare for pregnancy, birth, and parenthood (Montgomery et al., 2021) has been helpful. The resource

for women has received positive feedback. Some of those who have accessed it to date, have been healthcare professionals. Their feedback indicates that the resource provides a helpful insight into the maternity care experiences of survivors and confirms the need for an evidence-based resource for healthcare professionals and students. Although there is little available literature on trauma-informed education for healthcare professionals (Long et al., 2021), the need for interactive resources has been recognised in both our feedback and the work of Choi and Seng (2014). Our interactive e-learning product is in the final stages of development by the learning technology team at the host university and has been well evaluated by the Project Advisory Group. The final product will be available for the continuing professional development of qualified practitioners but will also be designed for use in classroom sessions to facilitate student education.

The involvement of The Survivors Trust in the creation of both resources was an important and welcome aspect of our work. The survivors who participated were from across England and they have endorsed our approach and the outline content we propose. However, the limitations of our work need to be recognised. This was a small-scale study based in one South London Trust. Although our work was multidisciplinary, it did not include all maternity care workers (e.g. maternity care assistants). As far as we are aware, all the survivors in our study identified as women. This is reflected in the language we use when referring to our participants. We did not ask the sexuality of our participants, so we do not know if our work addresses the needs of LGBTQIA+ people who have experienced childhood sexual abuse. Most of the survivor participants of our study were white, and global majority populations are under-represented in our work. We cannot therefore currently be sure that the resource we are developing will reflect the needs of all populations who access health services.

Conclusion

Caring for women and birthing people in whom a history of childhood sexual abuse is either known or suspected can be challenging for both personal and professional reasons. This is compounded by lack of education on the subject. Survivors often sense the discomfort felt by HCP, which reinforces their reluctance to disclose. Inclusion in the NMC Standards of Proficiency for Midwives (2019) will ultimately reduce the lack of education and our resource will support learning on the subject.

Ethical approval

King's College London Psychiatry, Nursing and Midwifery Research Ethics Subcommittee (HR-15/16–3250), Health Research Authority (17/HRA/0016)

Credit author contributions

EM and YSC conceptualised the study and facilitated focus groups. EM conducted the interviews. EM and YSC independently analysed the data and agreed on the final themes. EM wrote the first draft of the paper and YSC commented on drafts. She approved the final manuscript.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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