Intimate partner violence and reproductive coercion: cross-sectional study of women attending a Perth sexual health clinic, 2019–20

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Intimate partner violence and reproductive coercion have important negative mental and physical health effects.[1] Without a standardised data collection system, ascertaining the prevalence of these forms of abuse is difficult in Australia, but this information is crucial for decision makers designing evidence-based measures at the national, state, and local levels.

We therefore undertook a cross-sectional study of relationships between selected demographic characteristics and reported exposure to violence, based on data collected in printed screening questionnaires (Supporting Information) and from patient electronic medical records for women (self-identified) aged 16 years or older who attended the Sexual Health Quarters clinic (SHQ; https://shq.org.au) between 1 March 2019 and 31 March 2020. We have described the development, implementation, and impact of the clinic screening program elsewhere.[2] Written informed consent was provided by each participant, and they completed questionnaires in a private area of the clinic waiting room. The following information was extracted from participants' medical records in the SHQ clinical database: age, country of birth, postcode, date of screening, Indigenous status, sex of intimate partners, SHQ attendances prior to screening, screening and brief risk assessment responses, and the date of any counselling appointments. Socio-economic status was based on the 2016 Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socioeconomic Disadvantage (IRSD) decile for residential postcode at the time of screening.[3] We summarise characteristics as descriptive statistics, and assessed relationships between these characteristics and reported exposure to intimate partner violence (lifetime or current exposure) in multivariate logistic regression analyses; we report prevalence odds ratios (PORs) with 95% confidence intervals (CIs). Statistical analyses were undertaken in Stata 15. The University of Western Australia Human Research Ethics Committee approved the study (RA/4/20/4896).

Of 3745 eligible women, 2623 (70%) participated in the study (Box 1); we regarded them as representative of all women who attended the clinic. In their screening questionnaires, 454 participants (17.3%) reported they had experienced intimate partner violence (427, 16.3%) or reproductive coercion (139, 5.3%) at some point in their life. Ninety-one participants (3.5%) reported abuse in their current relationship: 85 reported intimate partner violence (3.2%), 38 reproductive coercion (1.4%). The proportion of women who reported current intimate partner violence was larger for respondents who reported reproductive coercion than for those who did not (32 of 38 [84%] *v* 53 of 2585 [2.1%]; POR, 251 [95% CI, 96.7–754]).

Lifetime prevalence of intimate partner violence was higher among women born in Australia (POR, 2.85; 95% CI, 2.23–3.64), those with female partners (POR, 2.64; 95% CI, 1.48–4.70), and Aboriginal or Torres Strait Islander women (POR, 2.82; 95% CI, 1.24–6.43). The prevalence of current intimate partner violence was higher among women born in Australia (POR, 4.87; 95% CI, 2.67–8.92), women in IRSD quintiles 4 to 7 (POR, 7.70; 95% CI, 1.05–57.7), those with female partners (POR, 3.89; 95% CI, 1.57–9.65), and women aged 35–54 years (*v* under 25 years: POR, 2.25; 95% CI, 1.25–4.05) (Box 2).

We found that a large proportion of women who attended a sexual health clinic in Perth reported abuse by their partners. The reported proportion of women exposed to intimate partner violence or reproductive coercion (17.3%) was similar to the reported prevalence of physical and sexual abuse among Australian women (17%),[4] but the proportion who reported reproductive coercion (5.3%) was smaller than in a large United States survey (8.6%).[5] Information about reproductive coercion in Australia is limited. The high co-reporting of intimate partner violence and reproductive coercion we found is similar to the findings of overseas studies,[6,7] and should prompt doctors to ask about the different forms of abuse their patients may be experiencing.

We found that larger proportions of women born in Australia, aged 35–54 years, or living in areas of middle socio-economic status reported abuse. These findings differ from those of other studies,[8] and require further exploration. However, they indicate that clinicians should not assess the risk of violence on the basis of demographic characteristics alone; any woman they see could be experiencing abuse by their partners.

Our large sample size and the confirmation that women attending the clinic were willing to participate in our study

1 Reported intimate partner violence and reproductive coercion by 2623 women attending the Sexual Health Quarters clinic, Perth, 1 March 2019 – 31 March 2020

Reported abuse	Lifetime exposure*	Current exposure
Intimate partner violence or reproductive coercion	454 (17.3%)	91 (3.5%)
Intimate partner violence and reproductive coercion	112 (4.3%)	32 (1.2%)
Intimate partner violence (all)	427 (16.3%)	85 (3.2%)
Intimate partner violence only	315 (12.0%)	47 (1.8%)
Reproductive coercion (all)	139 (5.3%)	38 (1.4%)
Reproductive coercion only	27 (1.0%)	6 (0.2%)

* In the past (before the time of screening) or currently (at time of screening). ◆

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2 Demographic characteristics of 2623 women attending the Sexual Health Quarters clinic, Perth, 1 March 2019 – 31 March 2020, and intimate partner violence and reproductive coercion: multivariable logistic regression analysis*

Characteristic	Participants	Prevalence odds ratio (95% confidence interval)	
		Intimate partner violence: lifetime	Intimate partner violence: current
Age group (years)			
Under 25	880 (33%)	1	1
25–29	655 (25%)	0.92 (0.48–1.74)	0.93 (0.49–1.75)
30–34	424 (16%)	1.14 (0.56–2.30)	1.15 (0.57–2.32)
35–54	664 (25%)	1.90 (1.07–3.39)	2.25 (1.25–4.05)
Indigenous status			
Aboriginal	25 (1.0%)	2.82 (1.24–6.43)	1.21 (0.29–7.59)
Non-Indigenous	2519 (99.0%)	1	1
Not stated	79	—	—
Country of birth			
Australia	1410 (54.5%)	2.85 (2.23–3.64)	4.87 (2.67–8.92)
Other	1175 (45.5%)	1	1
Not stated	38	—	—
Socio-economic status (IRSD decile)[3]			
1–3 (most disadvantage)	198 (7.6%)	1	1
4–7	835 (31.8%)	1.37 (0.86–2.19)	7.70 (1.05–57.7)
8–10 (least disadvantage)	1574 (60.4%)	1.00 (0.63–1.60)	6.21 (0.85–45.4)
Missing data	16	—	—
Sex of partner			
Same sex	61 (2.4%)	2.64 (1.48–4.70)	3.89 (1.57–9.65)
Different sex	2508 (97.6%)	1	1
Not stated	54	—	—

IRSD = Index of Relative Socioeconomic Disadvantage. * Adjusted for all other characteristics in table and client status (new or repeat).

were study strengths. However, we relied on self-reports by participants, and their lack of anonymity possibly caused recall and social desirability biases. Few participants were Aboriginal women or had female partners, limiting the interpretation of our findings for these two groups, but our finding of higher prevalence of abuse in these two groups was consistent with other reports about LGBTIQ people[9] or Indigenous women in Australia.[10] Finally, the external validity of our single centre study is limited.

Our findings provide an insight into the exposure of women attending a metropolitan sexual health clinic to violence. They indicate that inferring the risk of abuse from demographic characteristics should be cautious; clinicians should have an open mind about people and their risk of abuse. Effective screening programs, such as ours, are needed to recognise, respond to, and refer for support people at risk.

Acknowledgements: This study was supported by the Australian Department of the Prime Minister and Cabinet. The funding source had no role in the design, data collection, analysis, interpretation, reporting, or publication of this study. We thank Michael Phillips (Harry Perkins Institute for Medical Research, University of Western Australia) for assistance with the statistical analysis.

Open access: Open access publishing facilitated by The University of Western Australia, as part of the Wiley – The University of Western Australia agreement via the Council of Australian University Librarians.

Competing interests: No relevant disclosures.

Data sharing: The data underlying this study will not be available for sharing. ■

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Supporting Information

Additional Supporting Information is included with the online version of this article.