The impact of domestic violence upon default from colposcopy services

Rachael R. Collier

University of Notre Dame Australia

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Appendix
Appendix 1 Approval letters

University letter for ethical approval
Hospital letter for ethical approval
5 July 2010

Ref: 010125S

Julie Quinlivan
School of Medicine
The University of Notre Dame Australia
Fremantle Campus

Dear Julie,

I am writing to you in regards to your Low Risk Application for Ethics Clearance for your proposed research project, to be undertaken as a staff research project at The University of Notre Dame Australia

The title of this project is: “Impact of Domestic Violence upon Default from Colposcopy Services at Sunshine Hospital”

I am pleased to advise that your proposal has been reviewed by the University’s Human Research Ethics Committee and approval has been endorsed conditional on addressing the following:

- The old “ Expedited Review” checklist and form have been used for this application and we require applications to be submitted in the latest format which can be found on the Research Office website. Please re-submit your application on the new form.
- In regards to the Checklist it is noted that no box is ticked for Section 1: please tick the appropriate box.
- Section 1.1 and 1.2 of the application form: the dates of the project listed here need to relate to the specific research described in this application and not to anything in the past.
- Section 2.2/2.3: please advise how many cases of DV you expect to get out of the study cohort of 550 women. Please also advise whether this is enough for the study to have sufficient statistical power.
- Ms Rachael Collier will need to be listed as a researcher in Section 0.4 and will also need to sign the application on page 9.

Please respond to above by e-mailing me at nvandijk@nd.edu.au by Thursday 29 July 2010. Failure to respond and/or communicate by this time could result in a suspension of the approval and/or endorsement of ethical review of the project.

Should the design of the study, the choice of instrument, or its manner of administration be altered in any significant way as the study progresses, you will be required to provide an amendment to your clearance application for fresh consideration by the University.

On behalf of the University and the Human Research Ethics Committee, I wish you well with what promises to be a most interesting and valuable study.

Yours sincerely,

Nicolette van Dijk
Executive Officer, Human Research Ethic Committee
Research Office

cc. Rachael Collier, School of Medicine
13 December 2010

Julie Quinlivan
School of Medicine
The University of Notre Dame, Australia
Fremantle Campus

Ref: 0101258

Dear Julie,

I am writing to you in regards to the proposed amendment(s) to your ethics application.

The title of the project is: "Impact of Domestic Violence upon Default from Colposcopy Services at Sunshine Hospital"

Your amendments have been reviewed by the University’s Human Research Ethics Committee, and based on the information provided the project has been assessed as meeting all the requirements as mentioned in the National Statement on Ethical Conduct in Human Research (2007). I am therefore pleased to advice that ethical clearance is now unconditional for this proposed study.

Please note the following conditions of approval which apply to your research project:

- Ethics approval for this project is valid for 3 years. Under the National Statement you are required to report on the project’s progress on an annual basis and the first annual report is therefore due in December 2011. Once your project is completed you are required to complete the Annual Report as a Final Report on your project. You are also required to notify the HREC Executive Officer in writing if this project is abandoned. The Annual Report form can be found at: [http://www.nd.edu.au/research/hrec/apply.shtml](http://www.nd.edu.au/research/hrec/apply.shtml).

- As a researcher you are required to immediately report to the HREC Executive Officer anything which might warrant review of ethical approval of the project, including unforeseen events that might affect continued ethical acceptability and any complaints made by participants regarding the conduct of the project.

- If the design of the study, the choice of instrument, or its manner of administration is altered in any significant way as the study progresses, you are required to submit an amendment in regards to the changes for ethical consideration to the HREC. The Amendment Form can be found at: [http://www.nd.edu.au/research/hrec/apply.shtml](http://www.nd.edu.au/research/hrec/apply.shtml).

On behalf of the Human Research Ethics Committee, I wish you well with what promises to be a most interesting and valuable study.

Yours sincerely,

Nicole van Dijk
Executive Officer, Human Research Ethics Committee

[Signature]

Rachael Collier, School of Medicine
Western Health Office for Research

Research and Education Centre
Sunshine Hospital
176 Furlong Rd
St Albans 3021

27th March 2009

Associate Professor Michael Sedgley
Director of Clinical Services
Women’s and Children’s
Western Health
Footscray 3011

Re: Impact of Domestic Violence upon Default from Colposcopy Services at Sunshine Hospital (WHRP: 2009.05)

Dear Michael,

Thankyou for your quality assurance application. I am pleased to advise you that your application has been approved as of the 27th March 2009.

Regards

Louise Sillar
Manager, Office for Research
Western Health

Education and Research Centre
Sunshine Hospital
176 Furlong Rd
St Albans 3021
Ph: 61 3 83451504
Fax: 61 3 83184790
Email Louise.Sillar@wh.org.au
Appendix 2 Paper
Prevalence and Associations of Domestic Violence at an Australian Colposcopy Clinic

Julie A. Quinlivan, PhD, MBBS, FRANZCOG, Rachael R. Collier, and Rodney W. Petersen, FRANZCOG, MBBS, MBA

1University of Notre Dame Australia, Fremantle; 2Ramsey Healthcare Joondalup Health Campus; and 3Edith Cowan University, Joondalup, Western Australia, Australia

Abstract

Objective. Domestic violence is associated with significant mortality and morbidity including gynecological morbidity. We report the prevalence and associations of domestic violence in an Australian colposcopy service.

Materials and Methods. A prospective study was performed from consecutive patients attending colposcopy clinics at a major metropolitan hospital in Australia. Key outcomes were the prevalence of intimate partner violence and its key demographic associations.

Results. Consent was obtained from 574 and domestic violence status was ascertained in 566 of 581 women approached. Overall, 33% of respondents reported violence within 12 months, in 14.5%, the female reported being sole recipient of violence; in a further 16.6%, violence was bidirectional, and in 1.9% of cases, a woman was the sole perpetrator. Key associations of violence were younger age at presentation (30 vs 35 y; p = 0.1), higher rates of smoking (51.3% vs 38.2%; p = .0004), higher rates of housing instability (32.2% vs 12.2%; p < .0001), a positive Beck Depression Inventory screen (50.0% vs 24.9%; p < .0001), and higher rates of default to initial attendance (15.5% vs 4.7%; p < .0001).

Conclusions. Domestic violence is common in women presenting to colposcopy services and may be associated with poor housing stability and higher default rates.

Key Words: domestic violence, colposcopy, screening, default, homelessness

Domestic violence is associated with significant mortality and morbidity, especially among women [1–3].

Two large US government reviews have confirmed the lasting legacy of domestic violence across the life span of women and into the life span of any children they rear [1, 2]. Physical and psychological morbidities are common in both the woman and her offspring. A large Australian review has also confirmed the major morbidity associated with domestic violence in women and children [4].

Intimate partner violence is common. Statistics vary, but surveys place the lifetime prevalence of intimate partner violence against women at between 25% and 30% and the annual prevalence between 2% and 12% [2, 4–6].

Domestic violence is associated with significant gynecological mortality and morbidity. A large survey from the United States concluded that women who reported a history of physical or sexual abuse in the context of family violence were significantly more likely to have experienced a sexually transmitted disease. This included the high-risk human papillomavirus infections [7, 8].

We hypothesized that the prevalence of domestic violence in a colposcopy clinical service would be high. We planned to evaluate associations of domestic violence within this clinical service context to determine whether we could improve wider aspects of women’s health care.

Unlike previous prevalence studies, we utilized a prospective approach and specifically included all women, including those with English as a second language, to capture true prevalence rates.

MATERIALS AND METHODS

Institutional ethics committee and informed patient consent were obtained. A prospective cohort study was performed. The patient population consisted of all women booked to attend a colposcopy service at the...
Sunshine Hospital in western Melbourne, Australia, during a 12-month period. The study included all women, regardless of their primary language. Non-English speaking women and women in whom English was a second language were specifically included by the use of medical interpreters and appropriate information sheets. This was to ensure that the data reflected, as far as possible, an "all comers" approach to the prevalence of domestic violence in the attending population.

All women were provided with an information sheet by a research assistant, and after informed consent were obtained, were invited to complete a short screening questionnaire. The process of obtaining informed consent and completion of the questionnaire were obtained only when the women were able to be spoken to privately without a partner being present. The interviews were conducted in a room adjacent to the clinical service room to ensure privacy. All women who made a disclosure of domestic violence were referred to ongoing counseling and social support services. The clinic had a safe back exit.

The completion of the questionnaires was undertaken by questions being read to the patient in her primary language by the research assistant or via a qualified medical interpreter if required. If the patient gave consent, information in relation to the domestic violence was also disclosed to the woman's attending doctor. However, if a woman wished this information to remain confidential, this information was not disclosed. Likewise, all women were offered the opportunity to have the information disclosed to the hospital social support services. In only 2 cases of positive disclosure did the patient decline to have the information transmitted to her doctor and to the hospital social support services.

A demographic questionnaire was also used to collect and complete. This included questions on age, race, parity, housing stability, associated gynecological symptoms, and the Beck Depression Inventory (9).

Statistics were obtained on the prevalence of domestic violence, and this was broken down into subtypes. Data are represented as number and percentage for discrete data and as mean and SD for continuous data that were normally distributed. χ² tests were undertaken to compare discrete data and Student t tests for continuous data. A multivariate analysis of variance was performed in a model that included all factors found to have an association with the outcome of domestic violence at a univariate level with a p < .1. Factors assessed for inclusion in the model were age, smoking, alcohol or illicit drug use, marital status, gravidity, parity, housing status, associated symptoms, educational level, Beck Depression Inventory score, and socioeconomic status, which was assessed using the postal code of the home address as a surrogate measure. A p = .05 was considered significant.

RESULTS

Of 581 women approached to participate in the trial, 574 women (99%) provided consent. One woman subsequently withdrew while completing the questionnaire. In 6 cases, a partner came into the room during the process of completing the questionnaire, and in this scenario, the research assistant had been advised to stop and charge to another activity because of issues of female safety were paramount. In these cases, ascertainment of domestic violence was not able to be determined. One other woman gave ambiguous responses to domestic violence questions, and her data were also excluded. Thus, final outcome data were available in 560 women.

The demographics of the study cohort are summarized in Table 1. The mean age of the study population

Table 1. Demographics of the Study Cohort

<table>
<thead>
<tr>
<th>Variable</th>
<th>N = 566</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y</td>
<td>33.7 (10.9)</td>
</tr>
<tr>
<td>Race, n (%)</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>479 (84.5)</td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>4 (0.7)</td>
</tr>
<tr>
<td>Asian</td>
<td>48 (8.6)</td>
</tr>
<tr>
<td>Other</td>
<td>95 (16.9)</td>
</tr>
<tr>
<td>Gravidity, n (%)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>129 (22.7)</td>
</tr>
<tr>
<td>1</td>
<td>65 (11.7)</td>
</tr>
<tr>
<td>2</td>
<td>37 (6.6)</td>
</tr>
<tr>
<td>3 or more</td>
<td>207 (36.8)</td>
</tr>
<tr>
<td>Parity, n (%)</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>119 (21.0)</td>
</tr>
<tr>
<td>1</td>
<td>90 (16.1)</td>
</tr>
<tr>
<td>2</td>
<td>140 (24.4)</td>
</tr>
<tr>
<td>3 or more</td>
<td>117 (20.5)</td>
</tr>
<tr>
<td>Smoking status, n (%)</td>
<td></td>
</tr>
<tr>
<td>I have never smoked cigarettes</td>
<td>256 (45.2)</td>
</tr>
<tr>
<td>I used to smoke cigarettes but stopped more than a year ago</td>
<td>44 (7.7)</td>
</tr>
<tr>
<td>I used to smoke cigarettes but stopped in the last year</td>
<td>15 (2.7)</td>
</tr>
<tr>
<td>I still smoke cigarettes</td>
<td>245 (43.7)</td>
</tr>
<tr>
<td>Symptoms at time of screening, n (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>189 (34.0)</td>
</tr>
<tr>
<td>No</td>
<td>377 (66.0)</td>
</tr>
<tr>
<td>Current partner, n (%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>436 (77.8)</td>
</tr>
<tr>
<td>No</td>
<td>120 (22.2)</td>
</tr>
<tr>
<td>Perceiving Help from partner, n (%)</td>
<td></td>
</tr>
<tr>
<td>Low-grade abnormality</td>
<td>306 (54.2)</td>
</tr>
<tr>
<td>High-grade abnormality</td>
<td>173 (30.5)</td>
</tr>
<tr>
<td>Other</td>
<td>87 (15.5)</td>
</tr>
</tbody>
</table>
was 33.7 years, and the majority were white. A quarter had never been pregnant, and one third was nulliparous. Half was current or ex-smokers. Majority of the women reported having a current sexual partner. One third of the women had presented with Pap smears demonstrating a high-grade abnormality.

Table 2 summarizes the prevalence of domestic violence in the study cohort. Overall, 33% of the study cohort reported intimate partner violence within 12 months of the survey. There were 3 types of violence patterns elicited within the cohort. Overall, 14.5% of the total cohort reported being the sole recipient of violence. A further 16.6% of the total cohort reported that they had been both the recipient and perpetrator of violence. Only 1.9% of the total cohort reported being the sole perpetrator of violence.

Table 3 summarizes demographic differences between women who reported domestic violence compared to those who did not. Women who reported violence were 3 years younger ($p = .01$). They were more likely to be current smokers (51.3% compared with 38.2%; $p = .0004$) and to report greater housing instability (32.2% compared with 12.2%; $p < .0001$) and have a positive Beck Depression Inventory screen based on symptoms in the past week of their life (50.6% compared with 24.6%; $p < .0001$).

Despite 36.9% having another symptom at the time of screening, women reporting exposure to domestic violence were significantly more likely to have defaulted from their first colposcopy appointment compared with women not exposed to violence (15.5% compared with 4.7%; $p < .0001$). These symptoms included vaginal discharge, abnormal vaginal bleeding, dyspareunia, pelvic pain, and vulval pain or itch. There were neither differences in the proportion of women with current partners nor significant racial, gravidity, or parity differences between the 2 groups of women.

In multivariate analysis, smoking status, housing instability, a positive Beck Depression Inventory, and

Table 3. Demographic Differences in Women Exposed to Domestic Violence and Those Who Were Not

<table>
<thead>
<tr>
<th>Variable</th>
<th>Domestic violence, n (%)</th>
<th>No domestic violence, n (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, mean (SD), y</td>
<td>33 (9.7)</td>
<td>35 (11.0)</td>
<td>.01</td>
</tr>
<tr>
<td>Gravidity, n(%)</td>
<td>83 (17.6)</td>
<td>96 (23.3)</td>
<td>.09</td>
</tr>
<tr>
<td>0</td>
<td>30 (15.0)</td>
<td>65 (18.2)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>44 (23.3)</td>
<td>87 (23.8)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>80 (42.8)</td>
<td>127 (33.5)</td>
<td></td>
</tr>
<tr>
<td>Parity, n(%)</td>
<td>59 (31.4)</td>
<td>140 (36.4)</td>
<td>.56</td>
</tr>
<tr>
<td>0</td>
<td>3 (1.8)</td>
<td>16 (4.3)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5 (2.8)</td>
<td>16 (4.3)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>39 (21.4)</td>
<td>77 (20.3)</td>
<td></td>
</tr>
<tr>
<td>Race, n(%)</td>
<td>162 (86.6)</td>
<td>317 (83.6)</td>
<td>.35</td>
</tr>
<tr>
<td>White</td>
<td>51 (27.3)</td>
<td>79 (20.9)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>25 (13.4)</td>
<td>62 (16.4)</td>
<td></td>
</tr>
<tr>
<td>Have a violent partner, n(%)</td>
<td>118 (63.1)</td>
<td>259 (68.3)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>116 (61.4)</td>
<td>255 (67.7)</td>
<td>.21</td>
</tr>
<tr>
<td>No</td>
<td>72 (37.3)</td>
<td>104 (27.2)</td>
<td></td>
</tr>
<tr>
<td>Other current gynecological symptoms, n(%)</td>
<td>69 (36.2)</td>
<td>129 (34.7)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>118 (63.1)</td>
<td>259 (66.3)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>51 (27.3)</td>
<td>79 (20.9)</td>
<td></td>
</tr>
<tr>
<td>Smoker, n(%)</td>
<td>68 (35.3)</td>
<td>200 (51.9)</td>
<td>.009</td>
</tr>
<tr>
<td>Never smoked</td>
<td>25 (13.4)</td>
<td>54 (14.5)</td>
<td></td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>96 (51.9)</td>
<td>145 (38.2)</td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>73 (42.0)</td>
<td>239 (61.8)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Housing instability, n(%)</td>
<td>45 (23.3)</td>
<td>85 (23.0)</td>
<td></td>
</tr>
<tr>
<td>Very stable</td>
<td>11 (2.2)</td>
<td>25 (6.2)</td>
<td></td>
</tr>
<tr>
<td>Unstable</td>
<td>54 (29.3)</td>
<td>101 (27.2)</td>
<td></td>
</tr>
<tr>
<td>Did not answer</td>
<td>18 (10)</td>
<td>18 (10)</td>
<td></td>
</tr>
<tr>
<td>Beck Depression Inventory positive screen, n(%)</td>
<td>88 (56.0)</td>
<td>150 (42.6)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Yes</td>
<td>118 (63.1)</td>
<td>259 (68.3)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>51 (27.3)</td>
<td>79 (20.9)</td>
<td></td>
</tr>
<tr>
<td>Did not complete</td>
<td>150 (94.5)</td>
<td>150 (94.5)</td>
<td></td>
</tr>
<tr>
<td>Did not complete</td>
<td>108 (64.5)</td>
<td>108 (64.5)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Prevalence of Domestic Violence in the Previous 12 Months by Subtype in Study Cohort

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>279 (67)</td>
</tr>
<tr>
<td>Domestic violence where female subject was the perpetrator</td>
<td>11 (2.9)</td>
</tr>
<tr>
<td>Domestic violence where female subject was the recipient of violence</td>
<td>88 (20.3)</td>
</tr>
<tr>
<td>Domestic violence where female subject was both perpetrator and recipient of violence</td>
<td>94 (16.6)</td>
</tr>
<tr>
<td>Total</td>
<td>465 (100)</td>
</tr>
</tbody>
</table>

Table 3. Demographic Differences in Women Exposed to Domestic Violence and Those Who Were Not.

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default from first clinical attendance were significantly associated with a positive screen for domestic violence (all $p < .01$).

**DISCUSSION**

There was a disclosure of domestic violence in one third of the cohort. In half of these cases, the violence was unilaterally directed by the male partner toward the woman, but in the remaining cases, violence was bidirectional. In only 1.9% of the cohort was the woman the sole perpetrator of violence.

The questionnaire utilized in the study has been well validated and has been implemented into public obstetric practice in many Australian hospitals [11]. The questionnaire focuses on reports of physical abuse and safety rather than psychological abuse. Research has concluded that disclosures to health services can link
women into community support and improve health care outcomes [11, 12]. Given this, the prevalence of exposure to domestic violence reported in this study would seem to justify a policy to implement routine screening.

Women exposed to intimate partner violence may be at an increased risk of developing precancerous or cancerous lesions of the cervix. There is evidence that they are at an increased risk of acquiring sexually transmitted infections, including high-risk human papillomavirus, a mandatory precursor for such lesions [8, 13, 14]. In a study of 375 women attending a sexually transmitted disease clinic, 37.6% reported ever having experienced physical assault by an intimate partner and 32.8% reported verbal threats [14]. A study of 774 women attending a prenatal clinic found that women who reported exposure to intimate partner violence were more than twice as likely to have been diagnosed with a sexually transmitted infection [13]. An Australian study in a teenage pregnancy population reported that teenagers exposed to domestic violence were at 7-fold risk of having an abnormal Pap smear compared with those teenagers not exposed to partner violence [8].

In this study, we found that women exposed to violence were slightly younger than those who were not; however, the difference of 2 years is of doubtful clinical significance. However, they were also more likely to be current smokers. Numerous studies have reported an association between domestic violence and cigarette smoking. One of the largest studies involved a survey in the United States of 13,494 adults who reported a 2-fold to 4-fold increase in risk of smoking in women exposed to family violence [15].

Women exposed to violence were more likely to be depressed as measured by the Beck Depression Inventory. This finding has also been reported elsewhere [16]. In a study of 65 women were living in sanctuary houses as a result of violence and who were screened with the Beck Depression Inventory [10], every woman interviewed was found to score above the cutoff recommended for treatment. Women were also found to have high rates of menstrual irregularities, genital tract infections, and premenstrual syndrome symptomatology [16].

Perhaps the most important association was between the observation of housing instability and default from the first clinic attendance. A recent Indian study of 2435 women, which focused on the interplay of life facets involved in women's reproductive health experiences, documented a link between violence and homelessness [17]. An Australian study of teenage mothers also reported an association among domestic violence, homelessness, and sexually transmitted infections [18]. In the United States, the Violence Against Women Act of 2005 was passed to help create safe and independent housing for survivors of violence [19]. Housing instability can result in women moving address and missing hospital appointments that are routinely sent through the postal service. This can lead to higher rates of primary default from care.

These linkages and associations may explain why women exposed to domestic violence have poorer health care outcomes compared with other subgroups of women. We have previously explored reasons for default at colposcopy clinics and reported that the routinely collected demographic variables did not identify a subgroup of women at risk for default [20]. However, these routine variables do not include domestic violence and housing stability, which would need to be captured using a specific screening protocol in colposcopy clinics.

The high rates of domestic violence and associated levels of housing instability may partially explain the high rates of default from colposcopy clinics. If these defaults persist, this could be one of the mechanisms behind the poorer cervical screening and treatment outcomes observed in women exposed to domestic violence.

We have now recommended the introduction of screening into colposcopy services at our hospitals. Future directions for research include following up this cohort of women to determine if the issue of default at primary attendance persists following treatment and extends into other women's health services and to determine whether routine screening can improve quality of life and health care outcomes in other areas of health.

REFERENCES


Appendix 3  Conference presentation
Abstract

Introduction: Domestic violence is common in women and is associated with poorer healthcare outcomes. However, no causal pathway has been identified to explain this observation. We have followed a cohort of women to determine whether poorer outcomes can be explained by high rates of default and loss to follow up.

Methods: A prospective cohort study was performed. Institutional ethics approval was obtained. Participants were consecutive patients attending colposcopy clinics at a major metropolitan hospital in Australia. Following ascertainment of domestic violence status, appointment outcomes for colposcopy and women’s health services were tracked for a three year period. Multivariate analysis was undertaken to determine demographic factors associated with default from care.

Results: Of 581 women approached, consent was obtained from 574 women (99%). Ascertainment of domestic violence status was obtained from 566 women, of whom 187 (33%) had a recent history of exposure. Women exposed to violence were more likely to default from colposcopy once (26.2% vs 7.4%; p<0.0001), twice (11.2% vs 3.2%, p<0.0001), or twice (10.7% vs 2.4%, p<0.0001). They were more likely to be lost to follow up (8.0% vs 1.1%, P<0.0001). They were more likely to change appointments (10.2% vs 6.6%, p=0.0xx). They were also more likely to be referred to other women’s health services (50.3% vs 32.2%, p<0.0001) and to default from attendance at these services once (14.9% vs 3.3%, p=0.003), twice (11.7% vs 0.8%, p=0.001) or twice (9.6% vs 0%, p<0.0001) and be lost to follow up (9.6% vs 0%, p<0.0001). They were also more likely to rebook appointments (13.8% vs 4.9%, p=0.029).
Conclusion: Domestic violence is a risk factor for default from attendance and loss to follow up at women’s health services. This may explain the mechanism behind adverse healthcare outcomes seen. Screening and targeted appointment intervention programs may improve clinical compliance.