Ethnic-specific prevalence rates of intimate partner violence against women in New Zealand

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Abstract

Objective: This study presents age-standardised ethnic-specific prevalence rates of intimate partner violence against women in New Zealand, by physical and/or sexual intimate partner violence, psychological intimate partner violence, controlling behaviours and economic abuse.

Methods: Data are from 1,431 ever-partnered women in the representative and cross-sectional He Koiora Matapopore, the 2019 New Zealand Family Violence Study.

Results: High lifetime prevalence of intimate partner violence is present across all ethnic groups in NZ, with over half of all women reporting any intimate partner violence (55.8%). Substantial ethnic disparities exist in intimate partner violence rates, with Māori women reporting the highest prevalence of intimate partner violence (64.6%), followed by NZ European women (61.6%).

Conclusions: Intimate partner violence prevention and intervention services are needed at the population-level, and services must be culturally responsive and attuned to the needs of communities that bear the greatest burden.

Implications for Public Health: Ethnic differences in intimate partner violence prevalence likely contribute to health disparities at the population-level, reinforcing calls for prevention and necessitating healthcare systems to be culturally informed and mobilised to address intimate partner violence as a priority health issue.

Key words: intimate partner violence, ethnicity, prevalence

Introduction

International evidence suggests that intimate partner violence (IPV) is a serious public health issue that is associated with a wide range of long-term physical and mental health consequences.[1,2] Substantial ethnic disparities exist for IPV victimisation in New Zealand (NZ). Previous findings indicate that 57.6% of Māori women reported experiencing lifetime physical and/or sexual IPV, followed by 34.3% of NZ European/other women, 32.4% of Pacific women and 11.4% of Asian women.[3]

Understanding disparities in violence experience across population groups can help to signal that underlying inequities may be contributing to the problem and can be used to inform policy and practice decisions (e.g. ensure that resourcing is appropriately allocated and responses are designed to meet the needs of those who bear the greatest burden).

This brief report updates and extends ethnic-specific prevalence rates of IPV (physical and/or sexual IPV, psychological IPV, controlling behaviours and economic abuse) for women in NZ using best-practice data collection methods from the population-based He Koiora Matapopore | 2019 New Zealand Family Violence Survey.

Methods

Methods for the cross-sectional He Koiora Matapopore | the 2019 New Zealand Family Violence Survey have been detailed elsewhere.[4] Respondents in the present study were ever-partnered women (n=1,431) aged over 16 years.

Participants were counted as experiencing each type of IPV (physical and/or sexual, psychological, controlling behaviours, economic abuse) if they responded yes to at least one act inflicted by any current or previous partner. Survey questions for measuring IPV acts are provided in Supplementary Table 1.

Survey-weighting functions in Stata were used to account for sampling methods. Ethnicity was categorised according to Ministry of Health protocols.[5] Prevalence rates were directly standardised using the 2001 World Health Organization Age Standard Population to

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Table 1: Age-standardised lifetime intimate partner violence prevalence rates for women in the 2019 New Zealand Family Violence Study, stratified by ethnicity.

	Women (n=1,431)				
	Māori (n=183)	Pacific (n=66)	Asian (n=152)	NZ European (n=1006)	Total (n=1,407)
Lifetime IPV	W%				
Physical and/or sexual	48.98%	26.28%	17.38%	30.75%	30.66%
Psychological	56.20%	27.38%	30.82%	55.54%	48.87%
Controlling	35.11%	22.37%	13.88%	22.86%	23.12%
Economic	20.94%	14.10%	13.12%	14.03%	15.14%
Any IPV	64.61%	42.78%	35.86%	61.63%	55.76%

Note. W% = weighted percentage.
Total ever-partnered and total ethnicity are different as Middle Eastern/Latin American/African participants were excluded due to low cell counts.
Abbreviations: IPV = intimate partner violence; NZ = New Zealand.

enable comparability and ensure prevalence rates were not attributable to the age structure of population subgroups.[6]

Results

Lifetime experience of IPV was reported by over half (55.8%) of ever-partnered women in the sample. Māori women presented the highest prevalence for all IPV types, with 64.6% experiencing any lifetime IPV (Table 1). NZ European women reported the next highest prevalence for each IPV type, excluding economic IPV, for which Pacific women had comparable rates (14%) (Table 1). Asian women presented the lowest prevalence for experiencing all IPV types aside from psychological IPV, for which, the lowest prevalence was reported by Pacific women (30.8%) (Table 1).

Discussion

This report provides estimates of ethnic-specific IPV victimisation rates among women in NZ using specialised population-based data. This study reports on a number of IPV types and is the first to include NZ women over 65 years of age. These findings indicate high IPV rates among women from all ethnic groups in NZ, with lifetime prevalence of any IPV type ranging from over 2 in 3 for Māori, to almost 2 in 3 for NZ European women, 2 in 5 for Pacific women and 1 in 3 for Asian women.

Differences in IPV rates cannot be wholly attributed to differences in socioeconomic status.[7,8] As with many Indigenous communities internationally,[9,10] structural inequities and the ongoing impact of colonisation contribute to high rates of violence among Māori women.[7,11] Included amongst these factors are patriarchal societal structures that disrupted the traditional balance in Māori society which were introduced through colonisation.[7,11] Disruption of collective childrearing practices place Māori women at greater risk for exposure to violence in childhood (including sexual abuse), which is a risk factor for IPV.[12] Furthermore, exposure to different forms of violence across the life course is posited to have a cumulative effect on health outcomes and likely contribute to health disparities at the population-level.[13,14] The structural inequities that create these disparities can have tragic consequences; Māori women are at a three-times greater risk of intimate partner homicide than non-Māori women.[7] Given the intergenerational impacts of violence on Māori wellbeing,[11] it is imperative that substantial and sustained efforts are made to rectify these inequities.

Ethnic disparities in violence prevalence emphasise the need for targeted and culturally responsive initiatives that meet best-practice standards, including expanded kaupapa Māori (by Māori, for Māori) family violence services and integrated approaches across sectors.[15,16] Initiatives to address violence also need to acknowledge cultural diversity among ethnic groups (such as Pacific and Asian communities) and incorporate cultural norms.[3,17,18] Rates of IPV among European women (NZ's largest ethnic group) are also high, indicating that prevention efforts and services are needed for all groups. These findings emphasise the need to allocate resourcing to establish and support ongoing IPV prevention and intervention approaches for women in NZ as a population issue.[3] NZ's National Strategy to Eliminate Family Violence and Sexual Violence is well-positioned to address many of the sociocultural issues underlying violence; however, sufficient resourcing and collective buy-in and implementation are necessary to achieve this much-needed societal change.[19]

Limitations

Due to low cell counts, prevalence rates could not be reported for Middle Eastern/Latin American/African ethnic groups or based on respondents' migrant status. Further research is needed among ethnic and migrant groups to understand the unique challenges and needs of these communities.[18,20]

IPV prevalence was likely underreported as sampling excluded residential facilities and prisons, and those currently in abusive relationships or engaging with IPV services may be less likely to participate in surveys.

Conclusion

Given the high prevalence of IPV experienced by women in all ethnic groups, population-level IPV prevention and intervention efforts are needed. Culturally responsive initiatives must be developed, implemented, supported and sustained. Further research to understand ethnic-specific needs and to determine the effectiveness of existing prevention and intervention responses for all groups within the population are warranted.

Ethics statement

Ethics approval was granted by the University of Auckland Human Participants Ethics Committee (Reference 2015/018244).

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Conflicts of interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Janet Fanslow, Pauline Gulliver, Tracey McIntosh report that financial support was provided by New Zealand Ministry of Business, Innovation and Employment, contract number CONT-42799-HASTR-UOA. Pauline Gulliver reports a relationship with New Zealand Health Quality and Safety Commission that includes: employment.

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Appendix A Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.anzjph.2023.100105.