PREGNANCY RISK ASSESSMENT MONITORING SYSTEM
A survey for healthier babies in New Jersey

Intimate Partner Violence During Pregnancy in New Jersey

Intimate partner violence (IPV) has been recognized as an important public health issue by organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the Centers for Disease Prevention and Control (CDC). IPV is defined by Healthy People 2010 as physical assault by a current or former intimate partner. IPV during pregnancy can lead to adverse health outcomes such as serious physical injury to the mother or fetus, premature delivery, miscarriage, or even death of the mother. Although IPV is likely to be under-reported, surveys such as PRAMS that solicit self-reports by victims are usually more comprehensive than arrest reports and other administrative sources. NJ PRAMS provides our best opportunity to examine the risk of IPV during pregnancy for different groups of women.

In 2002-2003, 2.9% of New Jersey women reported being physically hurt by their husband or partner during pregnancy, about 3,000 per year. Women who report IPV come from all social backgrounds. While 45% of IPV victims were poor and unmarried, 19% were neither. Nonetheless, only 30% of women recall being asked about potential abuse by their prenatal care provider.

Figure 1 illustrates significant variations in IPV. African American and Hispanic women were almost 5 times more likely to report IPV than white women. Teens and young women were almost 5 times more likely to report being victimized than women over 30. Women with higher education were less likely to report IPV.

Although Figure 2 shows there was similarity between those most at risk and those who recall being asked about IPV, there is no guarantee that selective screening captures those at highest risk. Both women whose prenatal care was paid for by Medicaid and those receiving some type of

NJ-PRAMS is a joint project of the New Jersey Department of Health and Senior Services and the Centers for Disease Control and Prevention (CDC). Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants—such as improving access to high quality prenatal care, reducing smoking, and encouraging breastfeeding. ▫ One out of every 33 mothers are surveyed each month, when newborns are 2-6 months old. Survey questions address their feelings and experiences before, during and after their pregnancy. ▫ In 2002 and 2003, 3,121 mothers were interviewed with a 72% response rate. (For more information about PRAMS and its operations, see **Contact PRAMS** ***below.)***

Figure 1. IPV Incidence by Select Demographic Characteristics

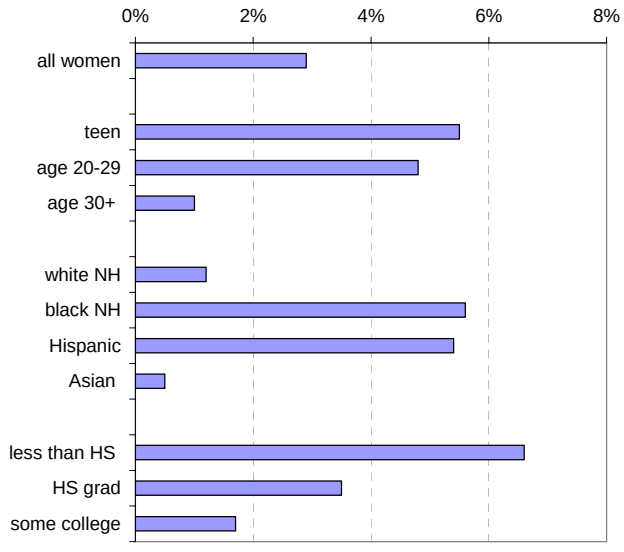
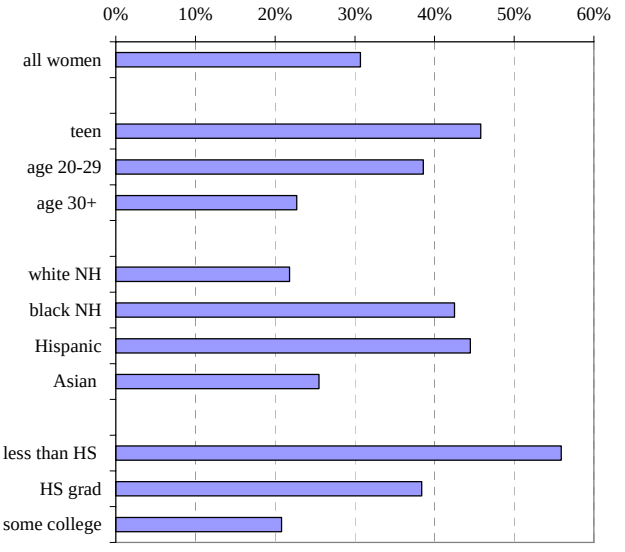


Figure 2. Talk About IPV with PNC Provider



income assistance were twice as likely to be asked about IPV than their non-Medicaid, and non-assistance receiving counterparts. Women with less than a high school education, previously indicated as being high-risk, were also more likely to be asked about IPV by their prenatal care provider.

PRAMS asks several questions about stressful life events that appear related to IPV but whose causal role is uncertain (see Figure 3). For example divorce increased the risk of IPV by a factor of six and a half. Furthermore, frequent arguments and financial difficulties also added substantially to the risk of IPV. Women were 7 times more likely to be abused if their partner did not want the pregnancy. Similarly, women who reported their own feeling that the pregnancy was unwanted or mistimed were also more likely to report IPV.

Married partners had lower rates of IPV, in part because marriage appears to moderate the effect of many of the IPV risk factors and stressors listed above (data available on request). This finding does not necessarily imply that encouraging all unmarried pregnant women to marry their current partner will reduce their risk of IPV. A large share of the effect of marriage we observe may instead reflect a number of preexisting protective factors: a longer and more stable relationship; desire for the pregnancy by each of the partners; established habits of problem solving; and a broader network of social support. Attempts to encourage marriage after a pregnancy occurs may have much smaller benefits, or in fact be counterproductive.

Agenda for Action

IPV during pregnancy affects a significant number of New Jersey women each year, and the risk varies widely across sub-populations. Due to social stigma and the risk of retaliation, IPV remains a hidden social problem for women in all walks of life.

Pregnancy enhances opportunities for women to interact with the healthcare and social support systems, especially those must vulnerable to IPV. Less than universal discussion about IPV between women and their prenatal care providers suggests that many opportunities are missed for prevention, screening and referral. Pediatric practices, WIC offices, family planning and sexually transmitted disease (STD) clinics are additional venues for intervention.

Contact NJ-PRAMS

http://www.nj.gov/health/fhs/pramsindex.shtml

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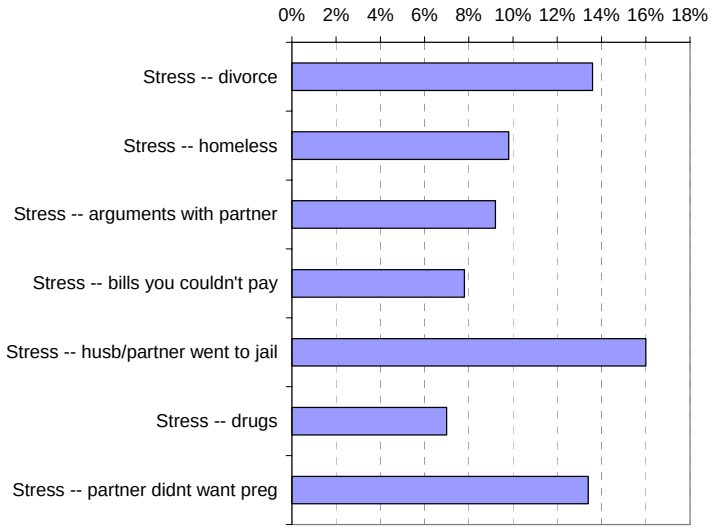
Figure 3. IPV Incidence by Potential Stressors



ACOG recommends that all health care providers screen all patients for violence at regular, ongoing intervals. Screening should occur:

- At routine annual examinations;
- At preconceptual visits;
- Once per trimester for pregnant patients;
- At post partum examinations.

Since these office visits have many priorities, IPV interventions must be efficient and tailored to providers' competencies. Several available intervention and referral strategies are described in some detail under ***Resources***, below.

Resources

www.acog.org/goto/noviolence - electronic resource guide on intimate partner violence intended for use by health professionals, administrators, etc..

www.cdc.gov/reproductivehealth/violence/IntimatePartnerViolence/ - a guide for clinicians that includes a screen show lecture presentation and selected bibliography on pregnancy and violence

www.cdc.gov/ncipc/factsheets/ipvoverview.htm - intimate violence fact sheet, CDC activities, publications and prevention strategies

www.nj.gov/dca/dow/dowprograms.shtml#dvhotline – listing of Division on Women programs that include the statewide domestic violence hotline and women's shelters

NJ Domestic Violence Hotline – 1-800-572-SAFE (7233)

H.I.T.S., a short domestic violence screening tool for use in family practice setting, (1998) Family Medicine, Volume 30, pp. 508-512.