



Intimate partner violence during pregnancy

Information sheet

Violence against women, committed by an intimate partner, is an important public health and human rights issue. In recent years, attention has focused also on intimate partner violence during pregnancy due to its prevalence, adverse health consequences and intervention potential.

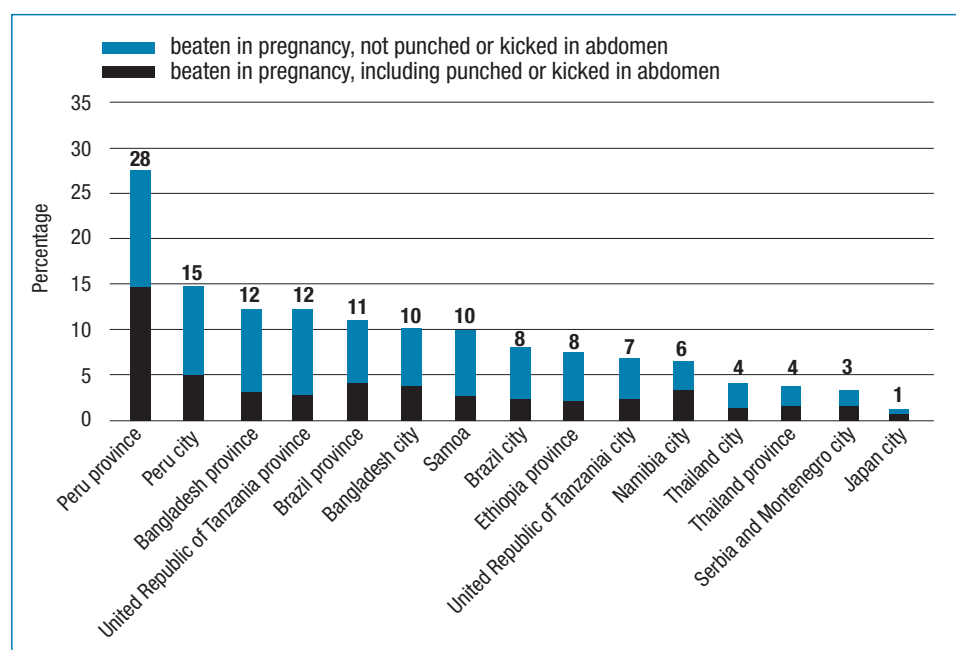
Intimate partner violence during pregnancy

Violence by an intimate partner is manifested by physical, sexual or emotional abusive acts as well as controlling behaviours. The majority of studies on intimate partner violence during pregnancy measure physical violence during pregnancy, although sexual and emotional abuse during pregnancy are also considered as detrimental for women's and their children's well-being. An especially concerning form of physical violence during pregnancy is when abusive partners target a woman's abdomen, thereby not only hurting the women but also potentially jeopardizing the pregnancy.

Global prevalence

The WHO multi-country study on women's health and domestic violence against women (Figure 1), which consists of population-based surveys conducted in various countries using the same methods and definitions, found the prevalence of physical intimate partner violence in pregnancy to range between 1% in Japan city to 28% in Peru Province, with the majority of sites ranging between 4% and 12% (1). This finding was supported by an analysis of Demographic and Health Surveys and the International Violence against Women Survey, which found prevalence rates for intimate partner violence during pregnancy between 2% in Australia, Denmark, Cambodia and Philippines to 13.5% in Uganda, with the majority ranging between 4% and 9% (2). Clinical studies around the world, which tend to yield higher prevalence rates but often are the only sources of information available, found the highest prevalence in Egypt with 32%, followed by India (28%), Saudi Arabia (21%) and Mexico (11%) (3). A recent review of clinical studies from Africa reports prevalence rates of 23–40% for physical, 3–27% for sexual and 25–49% for emotional intimate partner violence during pregnancy (4).

Figure 1. Prevalence of intimate partner violence during pregnancy.



Source: WHO multi-country study on women's health and domestic violence against women.

Health consequences

Intimate partner violence during pregnancy has been found to be associated with fatal and non-fatal adverse health outcomes for the pregnant woman and her baby due to the direct trauma of abuse to a pregnant woman's body, as well as the physiological effects of stress from current or past abuse on fetal growth and development (Figure 2).

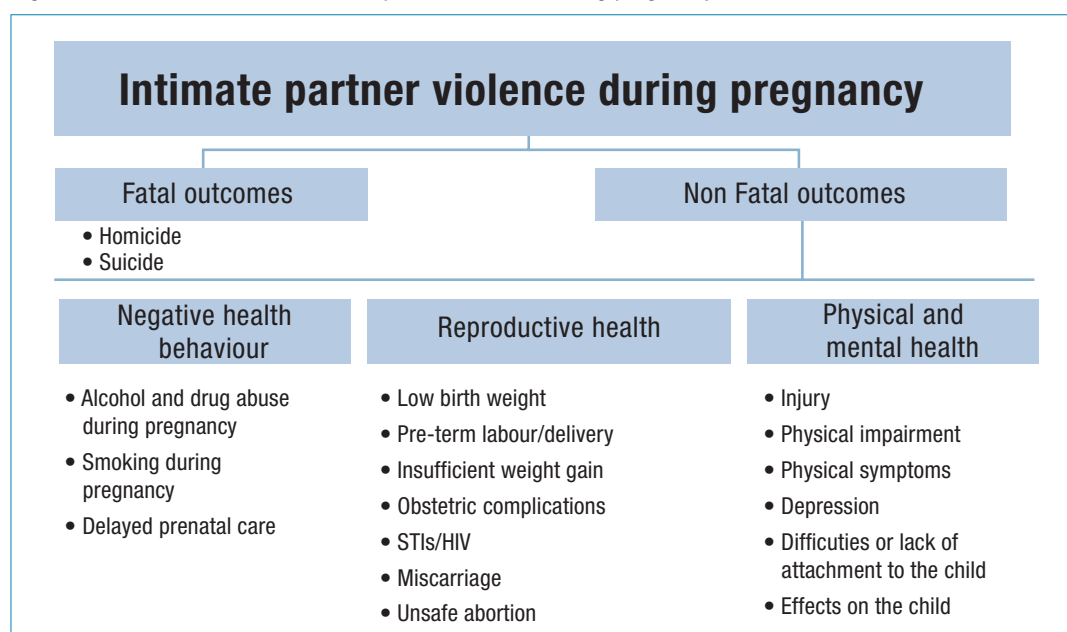
Homicide

Homicide is the most extreme consequence of intimate partner violence. Evidence from the USA suggests that intimate partner violence during pregnancy is a risk factor for women's increased risk of being killed by an intimate partner. For example, an examination of police and medical examiner records in 11 US cities showed that pregnancy significantly increased women's risk of becoming a victim of intimate partner homicide and that men who abuse their partners during pregnancy seem to be particularly dangerous and more likely to commit homicide (5). Still, the link between intimate partner homicide and pregnancy needs to be further explored.

Reproductive health

Non-fatal health outcomes associated with intimate partner violence during pregnancy include maternal and newborn health outcomes. Specifically, previous research has found that women reporting abuse during pregnancy had higher rates of intrauterine growth retardation and preterm labour than women not experiencing abuse, which can lead to low birth weight and other neonatal risks (6–8). Experiencing intimate partner violence during pregnancy has also been associated with women's increased risk of miscarriage and abortion (9,10). Others have also found increased risk of antepartum haemorrhage (11), and perinatal death (11,12). Abuse during pregnancy can also lead to short- and long-term health consequences for pregnant women, including maternal mortality (13). Suicide following pregnancy from sexual violence has also been documented (3).

Figure 2. Health outcomes of intimate partner violence during pregnancy.



Negative health behaviours

Intimate partner violence during pregnancy is significantly associated with a number of adverse health behaviours during pregnancy, including smoking, alcohol and substance abuse, and delay in prenatal care, even after controlling for other mediating factors (14). Possible explanations are that women smoke, drink or take drugs for self-medication to cope with the stress, shame and suffering caused by the abuse (14). Delays in prenatal care might be due to abusive partners preventing women from leaving the house or to abused women missing appointments because of injuries (15). More in-depth research is needed on how intimate partner violence during pregnancy affects health-seeking behaviour, especially in low-resource settings, since evidence

from population-based studies from Bangladesh, Kenya, Rwanda, and Zimbabwe shows that women who ever experienced intimate partner violence are less likely to deliver in a health facility (16).

Physical and mental health

Injuries resulting from intimate partner violence during pregnancy include broken bones, cuts, burns, haemorrhages, broken teeth and persistent headaches. While intimate partner violence may frequently be focused on the abdomen during pregnancy (see Figure 1), pregnant abused women also report that their partners targeted other body parts, such as their buttocks, breasts, genitals, head and neck and extremities (17). Direct blows into the

abdomen during pregnancy are especially concerning since they can cause some of the negative reproductive health outcomes outlined above (18,19).

Physical, sexual and psychological intimate partner violence during pregnancy are associated with higher levels of depression, anxiety and stress, as well as suicide attempts, lack of attachment to the child and lower rates of breastfeeding (20,21). Another indication that intimate partner violence during pregnancy has consequences into the postpartum and later periods is provided by studies that find increased levels of anxiety even six months after birth among babies whose mothers experienced partner violence during pregnancy (22). A longitudinal study shows that maternal antenatal stress predicts children's behavioural and emotional problems up to four years later, with the underlying mechanism including the effect of maternal mood on the fetal brain development, which affects the child's behavioural development (23).

Is pregnancy a trigger for IPV?

Research clearly shows that pregnancy does not prevent the occurrence of intimate partner violence, but conflicting evidence exists about whether intimate partner violence increases or decreases during pregnancy (24). In the WHO multi-country study on women's health and domestic violence against women, the majority of women who reported physical abuse during pregnancy have also been beaten prior to getting pregnant, although around 50% of women in three sites stated that they were beaten for the first time during a pregnancy (7).

Risk factors

Risk factors for intimate partner violence during pregnancy are often similar to risk factors for intimate partner violence in general. Given that pregnancy is a time that may demand increased relationship commitment and increase the resources needed, some risk factors are likely to be more important during pregnancy. One potential risk factor significantly associated with intimate partner violence during pregnancy is having an unwanted or unplanned pregnancy, as numerous population-based studies in Bangladesh, Plurinational State of Bolivia, the Dominican Republic, Kenya, Malawi, Moldova, New Zealand, Rwanda, and Zimbabwe show (16, 25). A US population-based survey also showed that women who had mistimed or unwanted pregnancies reported significantly higher levels of abuse during pregnancy compared with those with intended pregnancies (15% versus 5%) (26).

Interventions

Antenatal care provides a window of opportunity for identifying women who experience intimate partner violence. Not only is it often the only point of contact for women within a health-care setting, but also provision of health services and support through the duration of a pregnancy, and the possibility for follow-up, make antenatal care a suitable setting for addressing issues of abuse. The most frequently tested intervention in antenatal care is a short 'empowerment counselling' intervention, which provides information about the types of abuse and the cycle of violence, conducts a danger assessment to assess risks and preventive

options women might consider, and develops a safety plan with the woman. Being tested in several antenatal and postnatal care clinics in the USA and Hong Kong Special Administrative Region, China, the intervention showed a decrease of psychological and physical violence as well as improvements in women's physical and mental health (27–29). A recent review of violence reduction interventions states that the evidence for effectiveness of advocacy/support interventions is growing, and that psychological interventions may be effective, but that more research is needed, especially since no trials of screening programmes measured morbidity and mortality (30).

What research is needed?

Despite increasing research on the prevalence and health effects of intimate partner violence during pregnancy from numerous countries around the globe, several gaps in knowledge still exist, especially in low- and middle-income countries. These include a need for:

1. Systematic reviews of the evidence on health consequences of intimate partner violence during pregnancy.
2. In-depth studies about the role of pregnancy on the evolution of intimate partner violence and how pregnancy influences strategies women use to deal with the violence.
3. Intervention research on the feasibility and effectiveness of integrating an intimate partner violence intervention into antenatal care in resource-poor settings.
4. Development and testing of alternative modes of intervention to reach women in low-resource settings with poor antenatal care services.

What are the policy and programme implications?

1. Efforts to address maternal and newborn health need to include issues of violence against women since evidence from many countries shows that partner violence is common during pregnancy and is associated with adverse health outcomes for the mother, the pregnancy and the newborn.
2. Sexual and reproductive health, adolescent health, and HIV/AIDS prevention policies and programmes should address issues of violence, sexuality, and power dynamics in gender relations systematically as key elements.
3. Information on violence against women, its health consequences and an appropriate response needs to be integrated into the curriculum and training of health-care providers working in family planning, prenatal and postnatal care and delivery. At a minimum, health-care providers should be informed and aware of the possibility of violence as an underlying factor in women's ill-health during pregnancy and postpartum, especially in resource-poor settings where these are the most common points of contact with the health service for women.
4. Development of interventions to prevent violence against women from happening in the first place, including those that promote gender equality and safe and responsible relationships is also a critical need.

References

- García-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts C. *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.
- Devries KM, Kishor S, Johnson H, Stöckl H, Bacchus L, Garcia-Moreno C, et al. Intimate partner violence during pregnancy: prevalence data from 19 countries. *Reproductive Health Matters*, 2010, 18(36):1-13.
- Campbell J, Garcia-Moreno C, Sharps P. Abuse during pregnancy in industrialized and developing countries. *Violence Against Women*, 2004, 10(7):770-789.
- Shamu S, Abrahams N, Temmerman M, Musekiwa A, Zarowsky C. A systematic review of African studies on intimate partner violence against pregnant women: prevalence and risk factors. *PLoS One*, 6(3):e17591.
- Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, et al. Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study. *American Journal of Public Health*, 2003, 93(7):1089-1097.
- Altarc M, Strobino D.. Abuse during pregnancy and stress because of abuse during pregnancy and birthweight. *Journal of American Medical Women's Association*, 2002, 57(4):208-214.
- Bullock LF, McFarlane J. 1989. The birth-weight/battering connection. *American Journal of Nursing*, 1989, 89 (9):1153-1155.
- Valladares E, Ellsberg M, Pena R, Hogberg U, Persson LA. Physical partner abuse during pregnancy: a risk factor for low birth weight in Nicaragua. *Obstetrics and Gynecology*, 2002, 100(4):700-705.
- Fanslow J, Silva M, Whitehead A, Robinson E. Pregnancy outcomes and intimate partner violence in New Zealand. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 2008, 48(4):391-397.
- Pallitto CC, Campbell JC, O'Campo P. Is intimate partner violence associated with unintended pregnancy? A review of the literature. *Trauma, Violence, and Abuse*, 2005, 6(3):217-235.
- Janssen PA, Holt VL, Sugg NK, Emanuel I, Critchlow CM, Henderson AD. Intimate partner violence and adverse pregnancy outcomes: a population-based study. *American Journal of Obstetrics and Gynecology*, 2003, 188(5):1341-1347.
- Jejeebhoy SJ. Associations between wife-beating and fetal and infant death: impressions from a survey in rural India. *Studies in Family Planning*, 1998, 29(3):300-308
- McFarlane J, Campbell JC, Sharps P, Watson K. Abuse during pregnancy and femicide: urgent implications for women's health. *Obstetrics and Gynecology*, 2002, 100(1):27-36.
- Campbell JC. Health consequences of intimate partner violence. *Lancet*, 2002, 359(9314):1331-1336.
- Parker B, Bullock L, Bohn D, Curry M. Abuse During Pregnancy. In: Campbell JC, Humphreys J, eds. *Family violence and nursing practice*. Philadelphia, Lipincott, 2003, p. 77-94.
- Hindin MJ, Kishor S, Ansara DL. *Intimate Partner Violence among Couples in 10 DHS Countries: Predictors and Health Outcomes*. Calverton, MD, USA, Macro International; 2008.
- Thananowan N, Heidrich SM. Intimate partner violence among pregnant Thai women. *Violence Against Women*, 2008, 14(5):509-527.
- El Kady D, Gilbert WM, Xing G, Smith LH. Maternal and neonatal outcomes of assaults during pregnancy. *Obstetrics and Gynecology*, 2005, 105(2):357-363.
- Bacchus L, Bewley S, Mezey G. Domestic violence in pregnancy. *Fetal and Maternal Medicine Review*, 2001, 12(4): 249-271.
- Martin SL, Li Y, Casanueva C, Harris-Britt A, Kupper LL, Cloutier S. Intimate partner violence and women's depression before and during pregnancy. *Violence Against Women*, 2006, 12(3):221-239.
- Zeitlin D, Dhanjal T, Colmsee M. Maternal-foetal bonding: The impact of domestic violence on the bonding process between a mother and child. *Archives of Women's Mental Health*, 1999, 2(4):183-189.
- Bergman KBA, Sarkar PMD, O'Connor TG, Modi NMD, Glover V. Maternal stress during pregnancy predicts cognitive ability and fearfulness in infancy. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2007, 46(11):1454-1463.
- O'Connor TG, Heron J, Golding J, Beveridge M, Glover V. Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years. Report from the Avon Longitudinal Study of Parents and Children. *British Journal of Psychiatry*, 2002, 180(6):502-508.
- Jasinski JL. Pregnancy and domestic violence: a review of the literature. *Trauma, Violence, and Abuse*, 2004, 5(1):47-64.
- Fanslow J, Silva M, Robinson E, Whitehead A. Violence during pregnancy: Associations with pregnancy intendedness, pregnancy-related care, and alcohol and tobacco use among a representative sample of New Zealand women. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 2008, 48(4):398-404.
- Goodwin MM, Gazmararian JA, Johnson CH, Gilbert BC, Saltzman LE. Pregnancy intendedness and physical abuse around the time of pregnancy: findings from the pregnancy risk assessment monitoring system, 1996-1997 [PRAMS Working Group. Pregnancy Risk Assessment Monitoring System]. *Maternal Child Health Journal*, 2000, 4(2):85-92.
- Tiwari A, Leung WC, Leung TW, Humphreys J, Parker B. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *International Journal of Obstetrics and Gynaecology*, 2005, 112(9):1249-1256.
- Parker B, McFarlane J, Soeken K, Silva C, Reel S. Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing and Health*, 1999, 22(1):59-66.
- Kiely M, El-Mohandes A, El-Khorazaty M, Gantz M. An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial. *Obstetrics & Gynecology*, 2010, 115(2):273-283.
- Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 2009, 13(16), 1-347.

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