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Current Evidence on Perinatal Home Visiting and Intimate Partner Violence

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ABSTRACT

Objective: To describe current evidence on home visiting interventions for pregnant or postpartum women with specific intimate partner violence assessment and content.

Data Sources: Online bibliographic databases including PubMed, CINAHL Plus, and Web of Science and a hand search of bibliographies of relevant articles.

Study Selection: Original research and intervention studies were included that contained (a) a well-described prenatal and/or postpartum home visitation; (b) an assessment of perinatal intimate partner violence; and (c) quantitative data describing health outcomes for the women and their infants.

Data Extraction: The search yielded 128 articles, and 8 relevant articles met all of the inclusion criteria. Nonresearch, nonintervention, and international articles were excluded.

Data Synthesis: No perinatal home visiting interventions were designed to address intimate partner violence. Programs that screened for intimate partner violence found high rates, and the presence of intimate partner violence limited the ability of the intervention to improve maternal and child outcomes.

Conclusions: Perinatal home visitation programs likely improve pregnancy and infant outcomes. Home visiting interventions addressing intimate partner violence in nonperinatal population groups have been effective in minimizing intimate partner violence and improving outcomes. This suggests that perinatal home visiting programs adding specific intimate partner violence interventions may reduce intimate partner violence and improve maternal and infant health. Continued rigorous research is needed.

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Intimate partner violence (IPV) continues to be a major public health problem that affects the health and well-being of women and children. Pregnant women are not protected from IPV. Perinatal home visiting (HV) interventions have been used to reduce risks for poor pregnancy outcomes, improve parenting skills and enhance infant development, and they may have potential to reduce the harms of IPV. The purpose of this article was to conduct a comprehensive review of the literature specific to HV interventions for pregnant or postpartum women, with a focus on IPV assessment and content.

Violence Against Women

The National Violence Against Women Survey documents that one in four women are raped and/or physically assaulted by a current or former spouse, cohabitating partner or date at some point in their lifetime (Tjaden & Thoennes, 2000). Two recent (2003-2005) surveys, one of 3,568 women in a large HMO in Washington and Idaho and the other a population-based survey of 3,637 women from 12 U.S. cities, found IPV prevalence of just under 8% for the past year and 9.8% for the past 2 years, respectively (Thompson et al., 2006; Walton-Moss, Manganello, Frye, & Campbell, 2005). The abuse of women by intimate partners has been associated with traumatic injuries, long term physical health consequences (including headaches, sexually transmitted infections, and chronic backaches) and long term mental health consequences (including depression, low self-esteem, and posttraumatic stress disorder [PTSD]) (Campbell, 2002; Humphreys & Campbell, 2004; Walton-Moss et al., 2005). Given the significant magnitude and impact of IPV, preventing violence against women has become a national health priority, as addressed in Healthy People 2010 (U.S. Department of Health and Human Services, 2000; DHHS 2001).

Pregnant women also experience IPV. Recent studies estimate that 3% to 19% of women report being

abused during the childbearing year—that is in the year before, during, or after a pregnancy (Campbell, Garcia-Moreno, & Sharps, 2004). Rates vary depending on how women are asked (one-one interview, questionnaires, computer assisted), the setting in which women are asked (i.e., alone in a private location place, at triage in an office setting), at what point during the pregnancy they are asked, and which questions they are asked.

Intimate partner violence during pregnancy has been associated with poor health outcomes for mother, fetus, and neonate. Poor maternal outcomes include late entry into or no prenatal care, poor maternal weight gain, and traumatic injuries that may cause premature termination of the pregnancy. Similar to abused nonpregnant women, abused pregnant women experience poor mental health including low self-esteem, substance abuse (including smoking), depression, and PTSD (Bullock, Mears, Woodcocock, & Record, 2001; Martin, Kilgallen, Dee, Dawson, & Campbell, 1998). Intimate partner violence has also been associated with poor fetal and neonatal outcomes such as preterm delivery and low birth weight (Murphy, Schei, Myhr, & Du Mont, 2001). Abuse during pregnancy is also a risk factor for intimate partner homicide of women, both during and after the pregnancy (McFarlane, Campbell, Sharps, & Watson, 2002).

Intimate partner violence continues to negatively affect children throughout childhood. Research in the past 20 years documents that children exposed to IPV are at risk for a host of poor social-emotional and physical health outcomes including depression, anxiety, poor self-esteem, aggression, poor peer relations, poor school performance, physical health symptoms, under-immunization, and adolescent risk behaviors (Bair-Merritt, Blackstone, & Feudtner, 2006; Baldry, 2003; Holden, 2003; Fantuzzo et al., 1991; Fredland, Han, & Campbell, in press; Kernic et al., 2002; Polillo, 2003).

Despite the documented poor pregnancy and child outcomes associated with IPV, there have been few systematic or evidence-based intervention strategies specifically targeting the reduction or prevention of IPV against pregnant women. Commonly used strategies to address the health issues related to perinatal IPV include early case-finding to get women into prenatal care, provision of nutritional support, and programs to decrease substance use, including smoking cessation.

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Nurse HV: A Strategy for Preventing Perinatal IPV

Home visiting historically has been an essential component of public health/community health nursing practice. Perinatal HV interventions have been used to reduce risks for poor pregnancy outcomes, improve parenting skills, and enhance infant development (Gomby, 2000; Hahn et al., 2003). The Olds nurse HV intervention (Nurse-Family Partnership) has been recognized as the one intervention with evidence for decreasing child maltreatment (Chalk, 2003; Chalk & King, 1998; Olds et al., 2004b). Yet current economic slowdowns and under funding of a variety of health initiatives and interventions have forced many public health departments to eliminate HV interventions.

The core content of most perinatal HV programs includes the following: (a) delivery of anticipatory guidance; (b) implementation of a prespecified curriculum to enhance parenting and/or child development; (c) provision of social support and practical assistance to caregivers; and (d) referrals to community resources. The prior education and training of home visitors varies between programs; some home visitors are paraprofessionals, while others are nurses, social workers, or health educators. Some literature suggests that community/public health nurses are uniquely suited to be home visitors because of their advanced training in maternal and infant health and parenting and their ability to gain insight on family functioning (Tandon, Parillo, Jenkins, & Duggan, 2005).

This comprehensive review of the literature specific to HV interventions for pregnant or postpartum women was designed with a focus on IPV assessment and content. The overall goals of this work were to benchmark current knowledge and establish a foundation on which to develop future interventions for abused pregnant and/or postpartum women. The article concludes with a discussion of important implications for evidence-based clinical practice, and directions for future research and policy development for abused pregnant and/or postpartum women and their infants.

Methods

To examine the literature for this critique and synthesis, a computerized literature search was