Interventions for preventing or reducing domestic violence against pregnant women

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RHL summary

Key Findings

- Interventions included were: single brief individualized consultation, case management and referral to a social care worker, and multiple therapy sessions during pregnancy and after birth.
- There was limited evidence to signify reduction in episodes of violence (physical, sexual, and/or psychological), and prevention of violence during and up to one year after pregnancy.
- In only one study (N=306 women), women who received the intervention had fewer episodes of partner violence during pregnancy and in the postpartum period.
- No significant difference in low birth weight was observed with violence reduction interventions.

Evidence included in this review

Ten trials with 3417 women were included, but only seven trials with 2629 women contributed data for the review.

Quality assessment

The quality of evidence using GRADE varied from very low (Conflict Tactics Score, Current Abuse Score for partner abuse and partner abuse) to low (low birthweight) to moderate (episode of partner violence).

Clinical implications

There is currently insufficient evidence available to assess interventions to prevent or reduce domestic violence against pregnant women.

Further research

More randomised controlled trials are needed to evaluate the effectiveness and safety of interventions to prevent or reduce violence against pregnant women. Studies reporting results for outcomes such as stillbirth, neonatal death, miscarriage, maternal deaths, antepartum haemorrhage, and placental abruption are also lacking and should be conducted.

Cochrane review
Abstract

Domestic violence during pregnancy is a major public health concern. This preventable risk factor threatens both the mother and baby. Routine perinatal care visits offer opportunities for healthcare professionals to screen and refer abused women for effective interventions. It is, however, not clear which interventions best serve mothers during pregnancy and postpartum to ensure their safety.

To examine the effectiveness and safety of interventions in preventing or reducing domestic violence against pregnant women.

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (31 July 2014), scanned bibliographies of published studies and corresponded with investigators.

We included randomised controlled trials (RCTs) including cluster-randomised trials, and quasi-randomised controlled trials (e.g. where there was alternate allocation) investigating the effect of interventions in preventing or reducing domestic violence during pregnancy.

Two review authors independently assessed trials for inclusion and risk of bias, extracted data and checked them for accuracy.

We included 10 trials with a total of 3417 women randomised. Seven of these trials, recruiting 2629 women, contributed data to the review. However, results for all outcomes were based on single studies. There was limited evidence for the primary outcomes of reduction of episodes of violence (physical, sexual, and/or psychological) and prevention of violence during and up to one year after pregnancy (as defined by the authors of trials). In one study, women who received the intervention reported fewer episodes of partner violence during pregnancy and in the postpartum period (risk ratio (RR) 0.62, 95% confidence interval (CI) 0.43 to 0.88, 306 women, moderate quality). Groups did not differ for Conflict Tactics Score - the mean partner abuse scores in the first three months postpartum (mean difference (MD) 4.20 higher, 95% CI -10.74 to 19.14, one study, 46 women, very low quality). The Current Abuse Score for partner abuse in the first three months was also similar between groups (MD -0.12 lower, 95% CI -0.31 lower to 0.07 higher, one study, 191 women, very low quality). Evidence for the outcomes episodes of partner abuse during pregnancy or episodes during the first three months postpartum was not significant (respectively, RR 0.50, 95% CI 0.25 to 1.02, one study with 220 women, very low quality; and RR 0.60, 95% CI 0.35 to 1.04, one study, 271 women, very low quality). Finally, the risk for low birthweight (< 2500 g) did not differ between groups (RR 0.74, 95% CI 0.41 to 1.32, 306 infants, low quality).

There were few statistically significant differences between intervention and control groups for depression during pregnancy and the postnatal period. Only one study reported findings for neonatal outcomes such as preterm delivery and birthweight, and there were no clinically significant differences between groups. None of the studies reported results for other secondary outcomes: Apgar score less than seven at one minute and five minutes, stillbirth, neonatal death, miscarriage, maternal mortality, antepartum haemorrhage, and placental abruption.

There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy
outcomes. There is a need for high-quality, RCTs with adequate statistical power to determine whether intervention programs prevent or reduce domestic violence episodes during pregnancy, or have any effect on maternal and neonatal mortality and morbidity outcomes.

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