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Racial/Ethnic Differences in Experiences of Intimate Partner Violence and Postpartum Abuse Screening Among Rural US Residents who Gave Birth 2016-2020

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Key Findings

- This analysis assessed racial/ethnic differences in rural US birthing people's experiences of physical intimate partner violence (IPV) before or during pregnancy, as well as differences in abuse screening at postpartum check-up visits.
- We found higher rates of IPV among multiracial and American Indian/ Alaska Native rural birthing people compared to non-Hispanic white rural respondents.
- Among all rural birthing people, and among rural IPV victims only, non-Hispanic white birthing people had higher rates of not being screened for abuse postpartum compared to Black, Indigenous, and People of Color (BIPOC) respondents.

Purpose

Intimate partner violence (IPV) is a serious health risk and a contributor to maternal mortality. Rates of IPV are elevated around the time of childbirth, and screening for abuse is recommended to ensure access to appropriate IPV-related services and supports. The goal of this analysis is to describe IPV among rural US residents who gave birth 2016-2020, with a focus on differences by race/ethnicity. We also describe the frequency by which different racial/ethnic groups are not screened for abuse postpartum, with the goal of informing efforts to improve detection of and interventions for IPV among rural residents and to improve racial equity in maternal health.

Background and Policy Context

Every year, more than 700 people in the US die from a pregnancy- or birth-related cause (maternal mortality),[1] and approximately 50,000 people experience severe complications other than death (severe maternal morbidity).[2] Certain communities experience an additional, disproportionate risk of maternal morbidity and mortality. Rural residents,[3–5] especially Black and Indigenous people,[4,6] have more limited access to pregnancy-related health care and are more likely to suffer illness or death around the time of childbirth compared to urban residents and non-Hispanic white people; this is due to complex factors,[4,7–10] including through additive and reinforcing social institutions and systems that perpetuate racial discrimination and inequities, known collectively as structural racism.[7,11,12]

Research has begun to explore the additive, intersectional risks of negative health outcomes for those who have multiple marginalized identities related to rurality and race/ethnicity, and whose health and well-being are shaped by systemic forces like structural racism and urban bias. Compared with majority-white rural counties, rural counties with majorities of residents who are Black, Indigenous, and/or People of Color (BIPOC) are less likely to have access to a hospital with an obstetric unit or to other supports associated with improved pregnancy-related health outcomes (e.g., doula care, nurse home visiting, perinatal mental health services).[9,10] BIPOC residents of rural areas suffer among the highest rates of maternal mortality in the US,[4] and Indigenous Medicaid beneficiaries living in rural areas

face the highest risks of poor pregnancy-related health outcomes.[3]

Violence is a contributor to severe maternal morbidity and mortality, with wide-ranging impacts on victims' physical and mental health,[13–15] as well as their infants' health and well-being.[16,17] Approximately half of homicides that occur during pregnancy are related to IPV.[13,18,19] Available data indicate that Black birthing people experience the highest risk of pregnancy-associated homicide.[20] However, American Indian/Alaska Native people experience the highest rates of IPV overall,[21] and data reporting practices frequently eliminate American Indian/Alaska Native as a racial/ethnic category,[22] suggesting a likely undercount of pregnancy-associated homicides among Indigenous birthing people.[22] Further, Indigenous people are more likely to live in rural US communities compared to other racial/ethnic groups,[23] heightening rural-related access barriers to pregnancy-related care for this group. Recent research has found that rural US residents are more likely than urban residents to experience IPV during the perinatal period, with 4.6% of rural and 3.2% of urban birthing people reporting physical IPV.[24]

IPV is a prevalent and preventable risk factor for negative pregnancy-related health outcomes that can be screened for in the health care setting; both the U.S. Preventive Services Task Force and American College of Obstetricians and Gynecologists recommend that pregnant and postpartum people be assessed for IPV at multiple visits.[25,26] Recent research suggests that overall rates of IPV screening during the perinatal period are low among rural and urban birthing people.[24,27] Recent research also indicates that rural birthing people who experience IPV are less likely to ever be screened for IPV during a health care visit before, during, or after pregnancy (20.8%) compared to their urban counterparts (16.0%).[24] Known inequities in access to health care services and supports in rural communities with a majority of BIPOC residents[9,10] could exacerbate barriers to IPV screening around the time of pregnancy for BIPOC residents in rural areas. To ensure equitable access to recommended screenings throughout the perinatal period, it is important to document differing risks of experiencing IPV and postpartum screening for rural birthing people by race and ethnicity.

Approach

Data for this brief came from the Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance survey of people who recently gave birth that is administered by the Centers for Disease Control and Prevention, in partnership with states, to collect data about pregnancy- and childbirth-related risk factors and health outcomes.

We used 2016-2020 PRAMS data to describe experiences of physical violence by an intimate partner before or during pregnancy among rural residents in the US who gave birth 2016-2020. We measured the proportions of rural birthing people who reported experiencing IPV during these time periods, as well as the proportions of rural birthing people who were not screened for abuse at a postpartum check-up visit, by race and ethnicity. We calculated 95% confidence intervals (CIs) to compare these outcomes by race/ethnicity. This analysis includes individuals who gave birth at the start of the COVID-19 pandemic but does not assess pandemic impacts on outcomes.

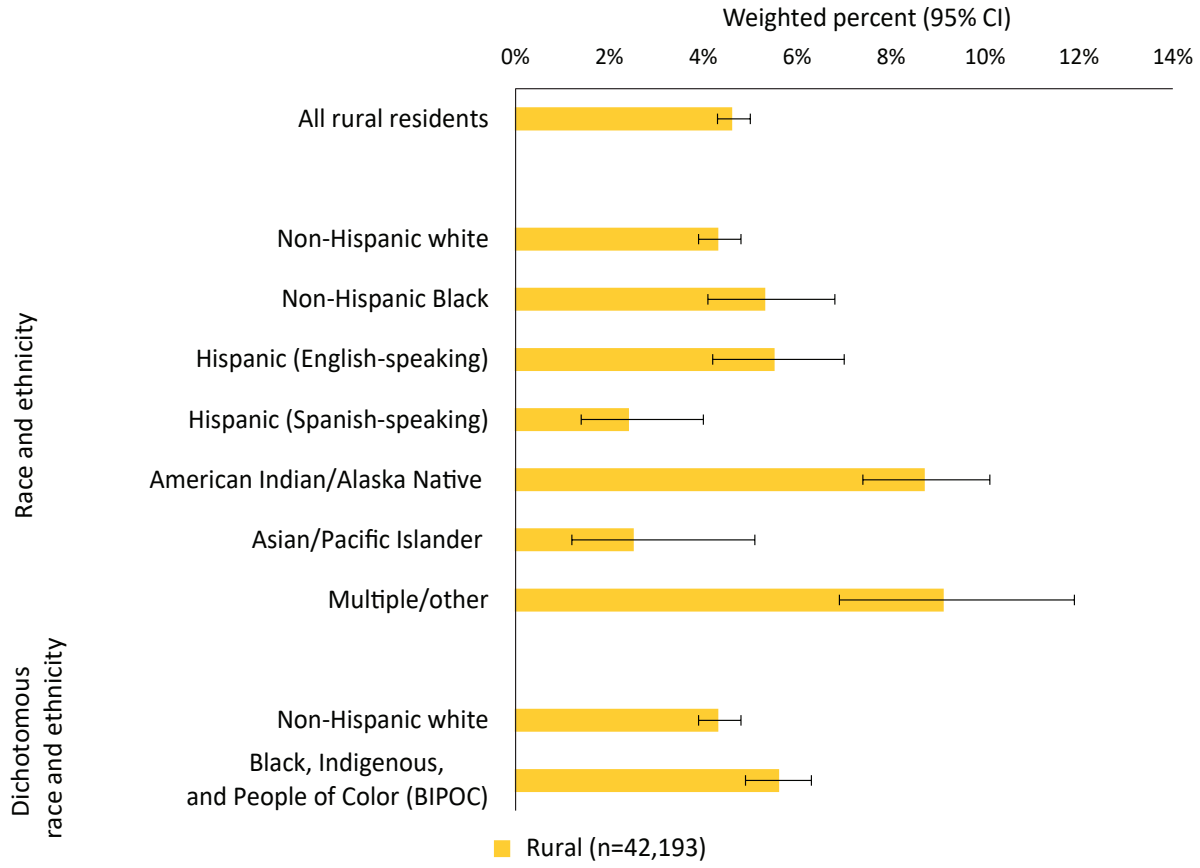
Among all respondents, the survey asked: "Did any of the following people push, hit, slap, kick, choke, or physically hurt you in any way?" This question had yes/no answer choices for both "my husband or partner" and "my ex-husband or ex-partner." This question was asked separately about the year before pregnancy and the time during pregnancy. Among respondents who had a postpartum check-up visit, the survey asked: "During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things?" Respondents could answer yes or no to multiple options, including whether a health care worker "asked me if someone was hurting me emotionally or physically."

State-level PRAMS sites identify whether to oversample certain subpopulations, and states commonly oversample underrepresented populations on maternal race and ethnicity.[28] Race/ethnicity data for this analysis were collected by PRAMS from self-reports on birth certificates. For this analysis, race/ethnicity was categorized as white, non-Hispanic; Black, non-Hispanic; Hispanic [primarily English-speaking] or Hispanic [primarily Spanish-speaking]; American Indian/Alaska Native; Asian/Pacific Islander; and Multiple/Other. In addition, race/ethnicity data were collapsed into two categories for certain analyses – white non-Hispanic respondents and BIPOC respondents – and these groupings were used for analyses of racial/ethnic differences among rural IPV victims because of small sample sizes. PRAMS respondents were identified in the dataset as rural residents using the National Center for Health Statistics Urban-Rural Classification Scheme for Counties.[29]

Results

Figure 1 shows rural birthing people's reports of experiencing physical violence by an intimate partner before or during pregnancy, by race/ethnicity. Overall, 4.6% of rural birthing people experienced IPV before or during pregnancy. Reports of physical IPV varied by race/ethnicity for rural birthing people. Highest rates of IPV were seen among respondents identifying as Multiple/Other race (9.1%) and as American Indian/Alaska Native (8.7%). Lowest rates were seen among respondents identifying as Hispanic and primarily Spanish-speaking (2.4%) and as Asian/Pacific Islander (2.5%). Overall, a higher proportion of BIPOC respondents reported IPV (5.6%) compared to non-Hispanic white respondents (4.3%).

Figure 1. Reports of physical violence by an intimate partner among rural residents who gave birth 2016-2020, by race/ethnicity

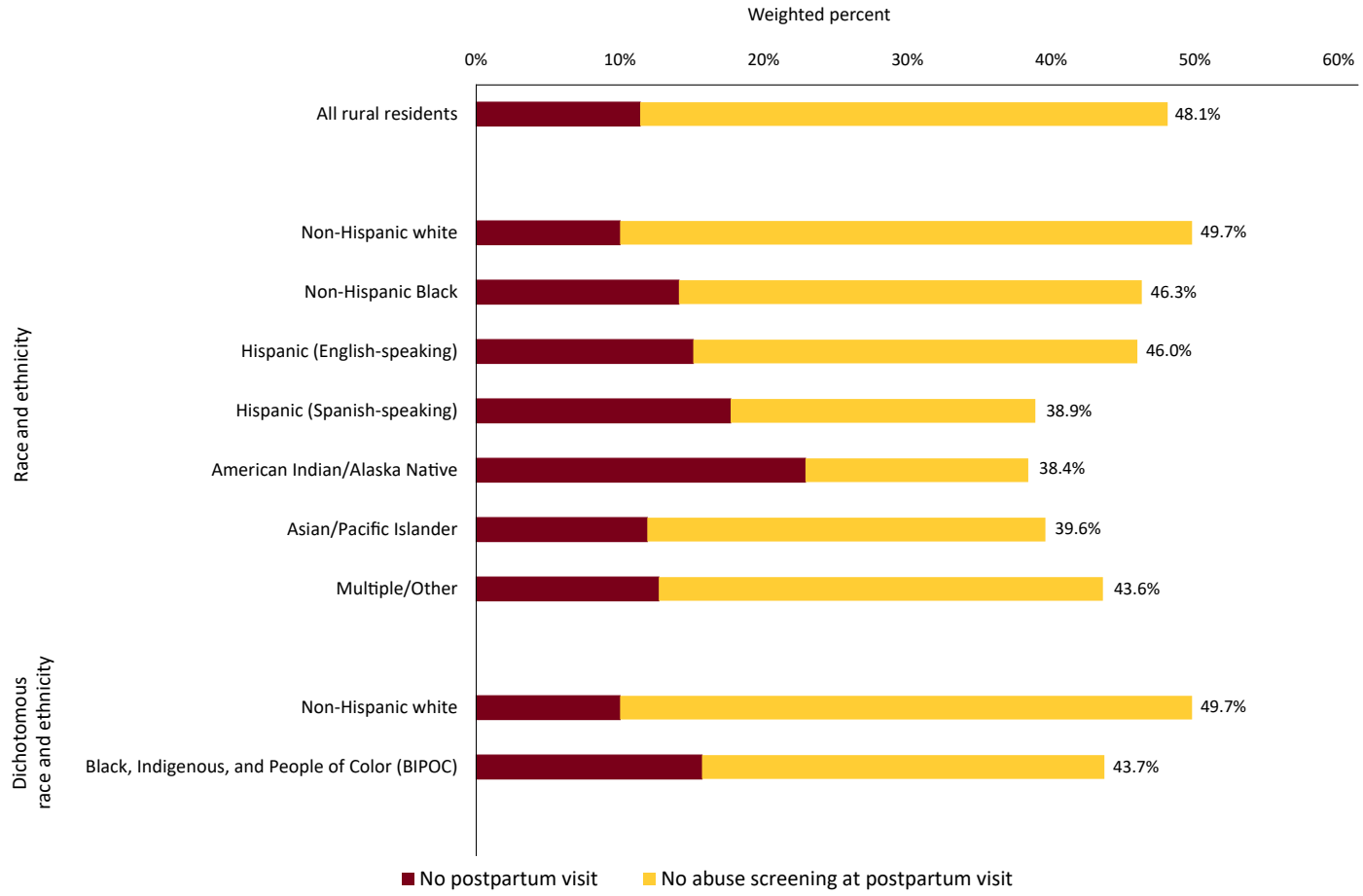


Source: Pregnancy Risk Assessment Monitoring System, 2016-2020 (n=42,193)

Figure 2 shows the proportions of rural birthing people who were not screened for abuse in the postpartum period, by race/ethnicity. Overall, 48.1% of rural respondents were not screened for abuse postpartum, either because they did not have a postpartum visit or because they were not screened at a postpartum visit they did have. The rate of not being screened for abuse among non-Hispanic white respondents (49.7%) was higher than the rate among respondents who identified as Hispanic and primarily Spanish-speaking (38.9%), American Indian/Alaska Native (38.4%), and Asian/Pacific Islander (39.6%). Non-Hispanic white respondents had a higher rate of not being screened for abuse (49.7%) compared to BIPOC respondents (43.7%).

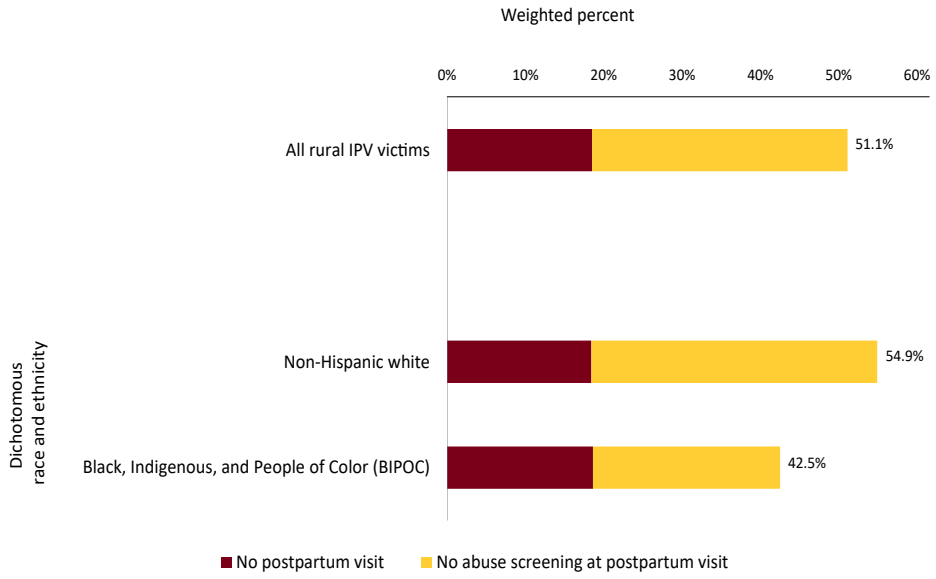
Figure 3 shows the proportions of rural IPV victims who gave birth who were not screened for abuse postpartum, by race/ethnicity. Overall, 51.1% of rural IPV victims were not screened for abuse during the postpartum period. Non-Hispanic white IPV victims had a higher rate of not being screened for abuse (54.9%) compared to BIPOC victims (42.5%).

Figure 2. Proportions of people who were NOT screened for abuse during the postpartum period among all rural US residents who gave birth 2016-2020, by race/ethnicity



Source: Pregnancy Risk Assessment Monitoring System, 2016-2020 (n=42,193)

Figure 3. Proportions of people who were NOT screened for abuse during the postpartum period among rural US IPV victims who gave birth 2016-2020, by race/ethnicity



Source: Pregnancy Risk Assessment Monitoring System, 2016-2020 (n=2,184)

Discussion and Implications

This study identified differences in experiences of perinatal IPV and postpartum abuse screening among rural residents who gave birth 2016-2020, by race/ethnicity. The highest rates of IPV were among rural birthing people who identified as Multiple/Other race and as American Indian/Alaska Native, similar to results from prior literature showing high rates of IPV among American Indian/Alaska Native populations.[21] In general, BIPOC rural respondents had a higher rate of perinatal IPV compared to non-Hispanic white rural respondents. Among all rural residents who gave birth, and among rural birthing people who experienced IPV before or during pregnancy, non-Hispanic white respondents were more likely to lack postpartum abuse screening compared to rural residents in other race/ethnicity identity groups. Overall, this analysis showed that a lack of abuse screening postpartum was a common problem for rural birthing people, as nearly half of all rural respondents (48%) and over half of rural IPV victims (51%) lacked postpartum abuse screening. Recent research found that 48% of urban birthing people who experienced IPV were not screened for abuse postpartum,[24] indicating that a lack of abuse screening postpartum is also a common problem for urban birthing people.

Reasons that rural birthing people lacked postpartum abuse screening varied by race/ethnicity. BIPOC rural birthing people had lower rates of attending postpartum health care visits (where screening might occur) than non-Hispanic white respondents, but BIPOC respondents were more likely to be screened for abuse at the visits they attended. This resulted in higher rates of non-screening for abuse at postpartum visits among non-Hispanic white birthing people compared to BIPOC birthing people. Among rural birthing people who experienced IPV, non-Hispanic white respondents were screened for abuse postpartum at a lower rate than BIPOC respondents, even though similar proportions of both groups attended postpartum check-ups. Potential contributing factors to the higher likelihoods of BIPOC birthing people being screened for abuse at postpartum visits include implicit racial bias among clinicians about who is at risk for IPV, as well as health care system biases such as through a greater prevalence of universal abuse screening policies at facilities that disproportionately serve racially minoritized people, such as community health centers. One important limitation of this analysis was a lack of sufficient sample size to assess the risks of non-screening for abuse postpartum among rural IPV victims by race/ethnicity, beyond the analysis that compared the risk of non-screening for abuse postpartum by groupings of non-Hispanic white and BIPOC IPV victims.

The results of this study can inform policy discussions on addressing IPV among pregnant and postpartum rural US residents, and these results may be of special relevance to public health and clinical initiatives aimed at addressing racial inequities in pregnancy-related health. For example, as part of the White House Blueprint for Addressing the Maternal Health Crisis, the U.S. Department of Health and Human Services is developing a state-based pilot program to improve IPV screening rates in the perinatal period.[30] These findings provide important data to inform the implementation of this and other IPV screening initiatives about differing rates of experiencing IPV among rural birthing people, and differing reasons for not being screened for IPV around the time of childbirth (not attending postpartum check-ups vs. not being screened at postpartum check-ups that are attended). Further, given findings that American Indian/Alaska Native and multiracial rural birthing people experienced perinatal IPV at higher rates than non-Hispanic white rural respondents, IPV prevention and intervention programs in rural communities should account for the racial/ethnic, language, and cultural diversity of rural people. Rural clinicians and IPV service providers could consider modeling or utilizing resources available from culturally-centered IPV organizations and services, including those doing work in rural tribal communities.[31] Policymakers should also consider racial and cultural inclusivity when planning and funding IPV initiatives serving rural communities.[32]

Being hurt by an intimate partner is a risk for maternal morbidity and mortality. Rates of IPV among birthing people in rural communities vary by race/ethnicity, with American Indian/Alaska Native and multiracial people at greatest risk. Screening for abuse is universally recommended as a strategy for detecting IPV, but many rural residents who give birth are not screened for abuse postpartum, with the highest risk for non-screening occurring among non-Hispanic white rural birthing people. In research and clinical initiatives aimed at reducing risks for IPV and enhancing detection of IPV in rural communities, it is important to take into account the diversity of rural communities in order to support health and equity for all rural birthing people.

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