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Domestic violence in pregnancy: a systematic review of clinical guidelines

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Abstract

Background Domestic violence is a public health concern and human rights violation affecting more than one-third of all pregnant women globally. Abused pregnant women need several interventions to reduce domestic violence and its negative consequences on mother and child. The purpose of this study was to determine the quality, scope, and consistency of clinical guidelines for managing domestic violence during pregnancy.

Methods This systematic review was based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). Electronic databases of Scopus, PubMed, Embase, Web of Science, Up-to-date, Cochrane Library database, Google Scholar, and Guideline repositories, including NICE, SIGN, GAC, NHMRC, NGC, New Zealand Guidelines Group, TRIP, AHRQ, G-I-N, and MD Consult, using appropriate keywords were searched. Included studies were clinical guidelines containing recommendations about domestic violence in pregnancy and postpartum. Two reviewers used the AGREE II (Appraisal of Guidelines, Research, and Evaluation version 2) instrument to evaluate the quality of guidelines, and textual syntheses were used to appraise and compare the relevant recommendations. Out of 381 relevant published guidelines, 14 clinical guidelines were ultimately reviewed systematically.

Results Seven countries had a clinical guideline for domestic violence during pregnancy. None of the reviewed guidelines was rated > 75% across all domains of AGREE II while the highest-rated domains were scope, purpose, and clarity. Four related categories were recognized from the synthesis of recommendations within the appropriate guidelines. These consisted of an introduction, domestic violence in pregnancy, the role of health care professionals, and the resources. Recommendations for privacy and confidentiality, screening, identification, support, and documentation were the most commonly reported, which all of the guidelines advised them, suggesting the importance of identification of violence in pregnancy and support for abused pregnant women. 93% of the reviewed guidelines had recommendations on communication, support and building trust, child protection, and professional education and training.

Conclusion The study findings suggest that there are currently gaps in clinical guidelines in various areas, including patterns of violence, the cycle of violence, identifying risk factors for violence during pregnancy, providing medical care, implementing home visitation programs, promoting self-care and empowerment, preventing violence, offering follow-up support, and conducting community education programs. Therefore, it is crucial to develop or adapt clinical guidelines for abused pregnant women, emphasizing their needs to ensure their safety and well-being.

Keywords Clinical guideline, Domestic violence, Pregnancy, Systematic review

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Introduction

Domestic violence is a significant social and public health problem, which globally affects more than one-third of all women [1, 2]. The World Health Organization describes domestic violence as any violent and gender-based behavior causing damage or emotional, sexual, physical injury or distress for women [3]. Domestic violence and intimate partner violence that is perpetrated by a current or former partner are often used interchangeably in the literature [4]. The prevalence of domestic violence during pregnancy has been reported as high as 20% [5] and ranging from 15 to 71% in low and middle-income countries [6]. Estimations on rates of domestic violence in pregnancy amongst Iranian women vary significantly and range from 19.3 to 94.5% highlighting the extent of this problem [7]. Domestic violence has been associated with several adverse perinatal physical and mental health outcomes [8]. These perinatal effects include unplanned pregnancy, postponed entry to prenatal care, inadequate antenatal weight gain, several mental problems, miscarriage, vaginal bleeding, preeclampsia, preterm labor, dystocia, low birth weight infants, and postpartum depression [8–11]. Prenatal care is a chance for healthcare providers to recognize abused pregnant women and support them with appropriate counselling and programs to protect the health of both mothers and infants [12, 13].

Clinical Practice Guidelines (CPGs) are a progressively common component of clinical care worldwide. Clinical practice guidelines have the potential to develop the care received by patients by improving interventions of proven benefit and reducing ineffective interventions [14]. Clinical practice guidelines are systematically standardized, and scientifically developed statements, designed to help practitioners in decision-making about appropriate health care for specific clinical conditions or health care issues [15]. Evidence-based clinical practice guidelines (EBCPGs) are developed through a systematic review of high-quality research to provide the best scientific evidence for healthcare recommendations [16]. These guidelines aim to promote patient outcomes by improving healthcare practice for certain medical conditions, standardizing care, reducing variations in practice, and minimizing morbidity and mortality. While EBCPGs are crucial for unifying practices and enhancing patient care, their development requires significant expertise, resources, and time [16]. In some cases, the costs of creating and implementing guidelines may exceed their benefits. For resource-limited settings, adapting existing high-quality guidelines may be a more efficient solution [14] similar to other settings [17]. The results of the preliminary review have shown that the existing clinical guidelines on violence during pregnancy related to universities and health centres in Toronto-Ontario [18], British Columbia [19], England [20–26], Northern Ireland [27], and Queensland [28].

Considering the high prevalence of domestic violence during pregnancy in Iran and its adverse maternal and fetal consequences, it is necessary to provide a culturally based supportive care program to help these abused women. Although Integrated Maternal Health Care in Iran (a guide for midwives and general practitioners in the health care centres providing healthcare services before pregnancy and continues during the pregnancy and postpartum periods) is a valuable step toward improving maternal health, it cannot provide comprehensive and complete care for abused pregnant women [29]. According to the Integrated Maternal Health Care, pregnant women are screened for domestic violence at four stages: pre-pregnancy, the first trimester, the second trimester, and the third trimester. If no physical harm is detected, women are advised to communicate effectively and may be referred to a psychologist. In cases of maternal or fetal physical injury, vital signs are monitored, fetal heart rate is checked, injuries are treated, and immediate referral to a specialist is made [29]. The lack of a specific supportive care program and clinical guidelines for abused pregnant women, which is based on the economic, social, political, cultural, and religious situation of the country, demonstrates the necessity of developing such a program. Domestic violence during pregnancy is a widespread problem in many countries, and establishing effective and culturally sensitive clinical guidelines is essential to providing optimal care for abused pregnant women worldwide. In the process of designing the supportive care program for abused pregnant women and adapting the related guidelines, it is helpful to review the relevant clinical guidelines available in other countries. Therefore, the present study was designed to systematically review the existing clinical guidelines for domestic violence during pregnancy to explore insights for developing clinical guidelines in Iran and offering valuable instructions for healthcare systems worldwide.

Methods

Identification and selection of guidelines

Inclusion criteria for guideline selection were clinical guidelines that focus on domestic violence or intimate partner violence during pregnancy, a national government organization endorsed them and guidelines published in English. Guidelines that do not address domestic violence or intimate partner violence in the context of pregnancy and documents not published in English were excluded.

Search for guidelines

Based on the PRISMA flowchart; academic databases such as Scopus, PubMed, Embase, Web of Science,

UpToDate, Cochrane Library database, and Google Scholar were searched until July 2022. Guideline repositories were also searched, including NICE, SIGN, GAC, NHMRC, NGC, New Zealand Guidelines Group, TRIP, AHRQ, G-I-N, and MD Consult. Keywords and Boolean combinations were used to identify related results. The search terms included guideline, guide, clinical guide, clinical recommendation, management, operational framework, good clinical practice, consensus, standard, procedure, instruction, principle, rule, maternal, antenatal, pregnancy, prenatal, perinatal, violence, domestic violence, intimate partner violence, victim, and abuse. Reference lists of comprised studies were also reviewed to ensure that all guidelines were found. Medical topic headings and Boolean terms were used to increase the precision of the search process. MAB screened titles and abstracts, and full-text articles were reviewed independently by two authors MAB and FSH. Disagreements were judged by the third reviewer RB.

Appraisal of guidelines

The AGREE (Appraisal of Guidelines, REsearch, and Evaluation) instrument is a tool that assesses the methodological rigour and transparency in which a guideline is developed. The original AGREE instrument was refined, which resulted in the AGREE II. The AGREE II instrument was used to evaluate the guidelines' methodological quality in six domains: scope and purpose, stakeholder involvement, rigor of development, clarity and presentation, applicability, and editorial independence [30]. The 23-item AGREE II tool uses a 7-point agreement scale, ranging from 1 for strongly disagree to 7 for strongly agree. Two authors, MAB and FSH, evaluated each guideline independently, and major disagreements in the scores were deliberated and independently checked by the third author RB. Domain scores were calculated, and a total quality score was achieved for each domain by summing the score of each item. The mean domain score between the two appraisers was used to standardize the domain score as a percentage. To assess agreement between two appraisers on the AGREE II grading, a weighted kappa was computed using SPSS V.24.0. The extent of variations among appraisers with less agreement on weight allocation was identified [31, 32], and a kappa value was calculated for all guidelines. A kappa value less than 0.2 indicates poor agreement, 0.21 – 0.4 fair, 0.41 – 0.6 moderate, 0.61 – 0.8 good, and 0.81 – 1.0 very good agreement [33]. Moreover, the appraiser assigned a total guideline assessment score, made a recommendation decision and provided options of Yes, Yes with modifications, or No.

Synthesis of guideline recommendations

The scope, content, and consistency of guideline recommendations were analyzed by textual descriptive synthesis [34]. At first, each guideline was read to obtain a general knowledge of the content, and then MAB and FSH coded the guidelines to recognize the categories/clinical content areas encompassed by the guidelines. Preliminary codes were identified and described by constant comparison of each guideline's recommendations as data collection progressed. For each domain, guideline recommendations were compared across other guidelines to identify similarities and inconsistencies. Within each category, the recommendations were further coded into separate subcategories where appropriate. MAB and FSH compared guidelines for consistency in content and recommendations and the level of underpinning evidence for each category. Finally, recommendations from the guidelines that were of the highest quality based on the AGREE II rating were synthesized to give an overview of all recommendations.

Results

Guideline selection and data extraction

381 publications came up in the initial search including 324 documents from academic databases, 32 from guideline repositories, and 25 from additional resources. After 125 duplicate studies were removed, 256 documents remained. The titles and abstracts of the 256 studies were screened according to the criteria for inclusion. A total of 219 documents were removed and 37 guidelines remained. The full texts of the 37 guidelines were assessed for eligibility, and 21 guidelines were excluded. The 21 excluded studies were those that were: incorrect population ($n=5$), not a clinical guideline ($n=8$), not endorsed by a national government organization ($n=5$), and no systematic literature search was conducted ($n=3$). 16 clinical guidelines remained and were reviewed for qualitative synthesis. Finally, based on the quality score of the clinical guidelines, the recommendations of 14 clinical guidelines were systematically reviewed. (Fig. 1)

General information about the guidelines

The fourteen guidelines assessed in this systematic review were published from 2003 to 2021. The guideline development group was from seven countries, including Canada ($n=1$), Finland ($n=1$), Queensland ($n=1$), Ireland ($n=1$), UK ($n=7$), Australia ($n=2$), and British Columbia ($n=1$). Table 1 shows general information about the guidelines.

Assessment of the quality of the reviewed guidelines

The quality of each guideline ($n=14$) was assessed using the AGREE II domain scores (Table 2). Each guideline was quality assessed by two independent researchers

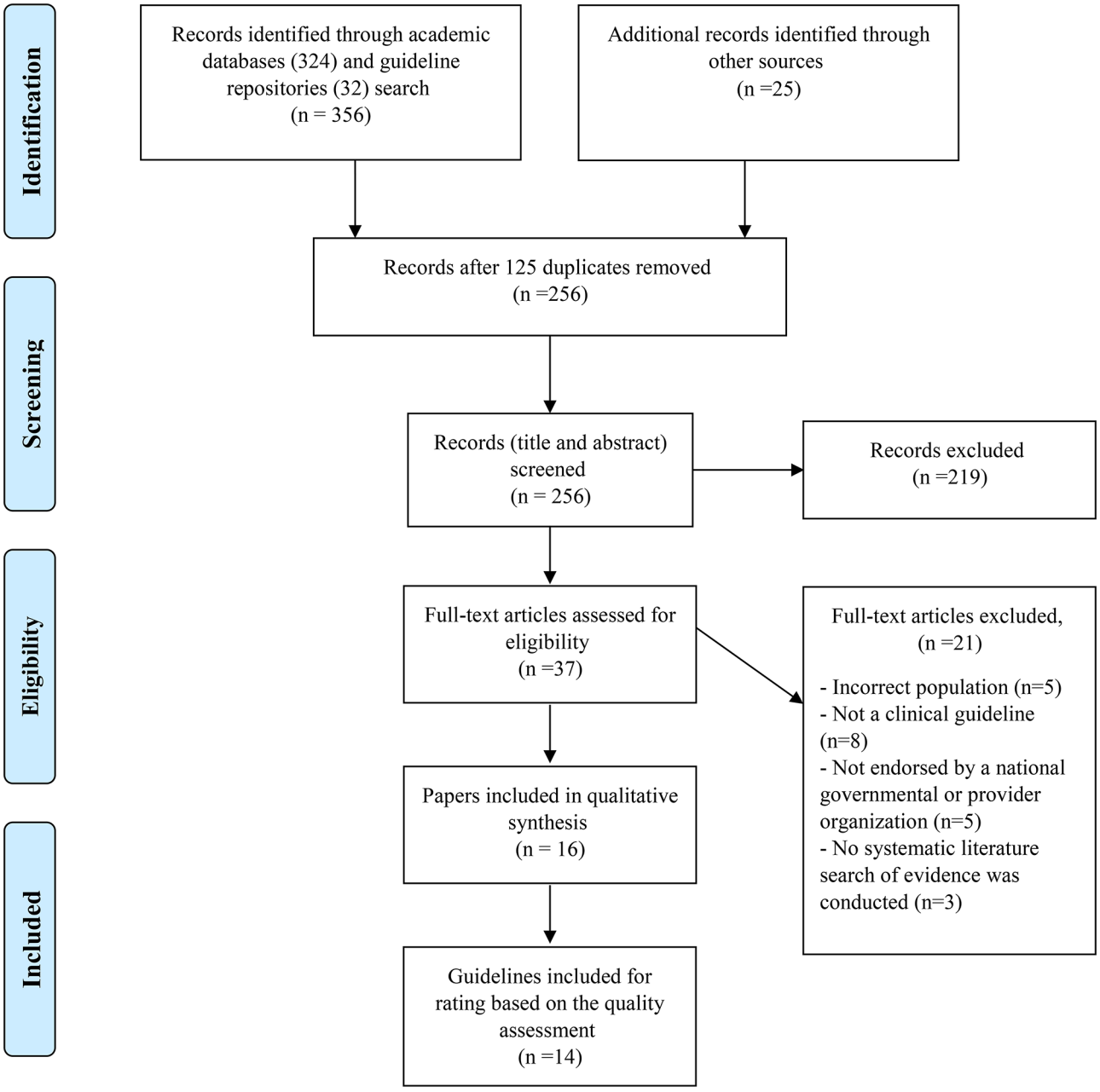

Fig. 1 Flow diagram of the search strategy

MAB and FSH with any disagreements resolved by a third reviewer RB. No guidelines were assessed as high. The domain score for purpose and clarity of presentation was good, while the score for editorial independence and rigor of development was poor. The mean scores (range; SD) for the domains were: scope and purpose 83.29% (63.80–100%; SD 12.53); stakeholder involvement 54.32% (38.80–75%; SD 11.83); rigor of development 31.93% (14.50–65.60%; SD 13.26); clarity of presentation 81.30% (69.40–97.20%; SD 10.30); applicability 51.15% (31.20–93.70%; SD 17.61) and editorial independence 13.39% (0–50%; SD 22.16). The kappa values ranged from fair kappa = 0.39 (95% CI 0.15 to 0.58) to 0.90 (95% CI 0.87 to 0.99). The overall inter-appraiser agreement was an inter-class correlation = 0.69 (95% CI 0.53 to 0.84), indicating good strength of the agreement.

Nine guidelines (64%) were assessed as 'recommended' for use since their quality score ranged between 5 and 7 representing good quality guidelines [35–43]. Five guidelines (36%) were 'recommended after modification' with an overall score of 4 to 5 representing moderate quality guidelines [44–48]. Three guidelines (21%) which updated more frequently had higher quality [39, 40, 45]. None of the 14 guidelines were assessed as high (> 75%)

Table 1 Characteristics of the included guidelines ($n=14$)

Guideline organization/society/ Authors	Guideline name(s)	Version	Years of publication	Country	Target users	Guideline writers	Search strategy for evidence	Level of evidence included
Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre [35]	Abuse in Pregnancy: Information and Strategies for Prenatal Education	1	2015	Canada Toronto, Ontario	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Sirkka Perttu Verena Kaselitz [36]	Addressing Intimate Partner Violence	1	2005/2006	Finland	Health Professionals in Maternity and Child Health Care	Multidisciplinary	Systematic literature review	Levels 1–4
Queensland Health [44]	Antenatal screening for domestic and family violence	1	2018	Queensland	midwives, obstetricians, nurses, and other health service professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Institute of Obstetricians and Gynecologists, Royal College of Physicians of Ireland, and Directorate of Quality and Strategy Health Service Executive [37]	Antenatal routine inquiry regarding violence in the home	1	2012	Ireland	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
NCT(England) [38]	NCT Policy Briefing: Domestic abuse during pregnancy and the postnatal period	1	2008	UK	NCT specialist workers, students, and volunteers providing parent support	Multidisciplinary?	Systematic literature review	Levels 1–4
Amanda Shearer NHS Royal Berkshire NHS Foundation Trust [45]	Domestic abuse in pregnancy guidelines (GL828)	7.1	2021	UK	Policy Hub/ Clinical/ Maternity/ Social Issues & Public Health	Multidisciplinary	Systematic literature review	Levels 1–4
Sandra Harrington Midwifery Development Officer, NHS Highland [39]	Domestic Abuse: Pregnancy and the Early Years	4	2015	UK	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
C Rogers, P Ryan – Updated by C. Robinson By: Maternity Service Governance Group University Hospital of Leicester NHS [46]	Domestic Violence Abuse in Maternity UHL Obstetric Guideline	2	2020	UK	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Australian Government Department of Health [47]	Pregnancy Care Guidelines 29 Family violence	1	2018	Australia	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Amanda Shearer NHS Royal Berkshire NHS Foundation Trust [40]	Domestic Abuse documentation and procedural framework policy (CG480)	6.1	2021	UK	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Diane Sawchuck [48]	Intimate partner violence during the perinatal period Obstetric Guideline 13	1	2003	British Columbia	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
NICE Pathways National Institute for Health and Care Excellence [41]	Pregnant women who experience domestic abuse: service provision	2	2021	UK	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4
Aneurin Bevan University Health Board (NHS) Maternity service [42]	Routine Enquiry into Domestic Abuse in the Antenatal Period	2	2015	UK	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4

Table 1 (continued)

Guideline organization/society/ Authors	Guideline name(s)	Version	Years of publication	Country	Target users	Guideline writers	Search strategy for evidence	Level of evidence included
Australian Institute of Health and Welfare (AIHW), Michelle Quee [43]	Screening for domestic violence during pregnancy Options for future reporting in the National Perinatal Data Collection	1	2015	Australia	healthcare professionals	Multidisciplinary	Systematic literature review	Levels 1–4

in all domains of AGREE II. Mean domain scores for the guidelines ranged from 41 to 66%. Six guidelines, which is 43%, were published in the UK and updated more frequently.

Synthesis of recommendations

The synthesis of related categories for each guideline is conducted in Table 3. Two reviewers MAB and FSH extracted all relevant recommendations from each included guideline. Four related categories were recognized within the appropriate guidelines. These consisted of Category 1: introduction, Category 2: domestic violence in pregnancy, Category 3: the role of health care professionals, and Category 4: the resources.

Category 1: introduction

All fourteen guidelines (100%) included relevant content in the introduction, which was categorized into purpose and scope, definition of violence, patterns of violence, and the cycle of violence.

The most common subcategory was for the definition of violence (93%), twelve of the fourteen guidelines contained relevant content on the purpose and scope (86%), three guidelines had relevant content on the patterns of violence (21%) and one guideline had relevant content related to the cycle of violence (7%).

Category 2: domestic violence during pregnancy

All fourteen guidelines (100%) had relevant content on domestic violence during pregnancy. There were four subcategories identified within this category such as the prevalence of violence during pregnancy, signs and symptoms of violence during pregnancy, risk factors of violence during pregnancy, and health consequences of violence during pregnancy.

The most common subcategories of the statements were the prevalence of violence during pregnancy (93% of the guidelines provided statements), health consequences of violence during pregnancy (71% provided statements), and signs and symptoms of violence during pregnancy (64%). Six guidelines made statements for the subcategories of risk factors of violence during pregnancy (43%).

Category 3: the role of healthcare professionals

All fourteen guidelines (100%) had recommendations about the role of healthcare professionals. There were 17 subcategories identified within this category. These categories were communication support and building trust, privacy, and confidentiality, screening, barriers to screening, identification, non-disclosure, psychological counselling, medical care, home visitation program, child protection, risk assessment, safety planning, self-care and empowering, prevention, support, documentation and follow-up.

Table 2 Guideline assessment according to the AGREE-II instrument ($n = 14$)

Guideline organization/society/authors	Domain scores (%)						Mean domain scores (%)	Agreement between appraisers
	Scope and purpose [3]	Stakeholder involvement[3]	Rigor of development [8]	Clarity and presentation[3]	Applicability[4]	Editorial independence[2]		Weighted kappa coefficient (K,95%CI)
Best Start: Ontario's Maternal, Newborn and Early Child Development Resource Centre [35]	69.4%	75%	26%	77.7%	45.8%	50%	57.3%	0.75 (95% CI 0.64 to 0.88)
Sirkka Perttu Verena Kaselitz [36]	91.6%	63.8%	37.5%	83.3%	35.4%	12.5%	54%	0.62 (95% CI 0.38 to 0.84)
Queensland Health [44]	86.1%	55.5%	14.5%	69.4%	37.5%	0%	43.8%	0.88 (95% CI 0.79 to 0.94)
Institute of Obstetricians and Gynecologists, Royal College of Physicians of Ireland, and Directorate of Quality and Strategy Health Service Executive [37]	86.1%	58.3%	65.6%	69.4%	58.3%	25%	60.4%	0.84 (95% CI 0.62 to 0.91)
NCT(England) [38]	91.6%	38.8%	36.4%	77.7%	62.5%	0%	51.2%	0.71 (95% CI 0.62 to 0.91)
Amanda Shearer NHS Royal Berkshire NHS Foundation Trust [45]	63.8%	44.4%	27%	75%	39.5%	0%	41.6%	0.78 (95% CI 0.58 to 0.87)
Sandra Harrington Midwifery Development Officer [39]	94.4%	63.8%	23.9%	88.8%	56.2%	0%	54.5%	0.39 (95% CI 0.15 to 0.58)
C Rogers, P Ryan – Updated by C. Robinson By: Maternity Service Governance Group University Hospital of Leicester NHS [46]	88.8%	50%	18.7%	69.4%	35.4%	0%	43.7%	0.89 (95% CI 0.76 to 0.84)
Australian Government Department of Health [47]	69.4%	38.8%	29.1%	88.8%	54.1%	0%	46.7%	0.67 (95% CI 0.39 to 0.87)
Amanda Shearer NHS Royal Berkshire NHS Foundation Trust [40]	86.1%	50%	41.6%	97.2%	54.1%	0%	54.8%	0.71 (95% CI 0.68 to 0.89)
Diane Sawchuck [48]	66.6%	72.2%	33.3%	94.4%	31.2%	0%	49.6%	0.43 (95% 0.26 to 0.67)
NICE Pathways National Institute for Health and Care Excellence [41]	100%	61.1%	27%	97.2%	37.5%	0%	53.8%	0.90 (95% CI 0.87 to 0.99)
Aneurin Bevan University Health Board (NHS) Maternity service [42]	72.2%	41.6%	19.7%	72.2%	93.7%	50%	58.2%	0.48 (95% CI 0.33 to 0.69)
Australian Institute of Health and Welfare (AIHW), Michelle Quee [43]	100%	47.2%	46.8%	77.7%	75%	50%	66.1%	0.65 (95% CI 0.48 to 0.89)
Mean	83.27%	54.32%	31.93%	81.3%	51.15%	13.39%		

The most common subcategories of recommendation were privacy and confidentiality, screening, identification, support, documentation (100% of the guidelines provided recommendations), communication support and building trust, child protection (93% provided recommendations), risk assessment (86%), non-disclosure, safety planning (71% each), barriers to screening, psychological counselling (50% each), home visitation program (36%), and few guidelines made recommendations for the categories of medical care, prevention, follow up (26% each) and self-care and empowering (21%).

Category 4: the resources

All of the fourteen included guidelines (100%) contained recommendations related to the resources which were grouped into the following subcategories such as professionals' education and training, community education program, multi-professional co-operation, useful organization, sources of information, sources of support and list and number of local resources.

13 guidelines contained recommendations related to professionals' education and training (93%), 11 guidelines contained recommendations related to sources of information (79%), nine guidelines contained recommendations related to useful organization, sources of support (64%), seven guidelines contained recommendations related to multi-professional co-operation, list and number of local resources (50%), and two of them included recommendations about community education program (14%).

Discussion

This systematic review evaluates the quality of published clinical guidelines on domestic violence during pregnancy. It offers an overview of perinatal supportive care for abused pregnant women. The review includes international clinical guidelines to provide a global perspective. Fourteen guidelines were assessed in this systematic review. The results showed that the guideline development group was from seven high-income countries, and half were in the UK. The lack of guidelines from low and middle-income countries, and the cultural differences and different socio-economic statuses highlighted the importance of developing or adapting guidelines in these regions.

While the review highlights the importance of screening, identifying, and supporting women experiencing domestic violence [36, 37, 40, 42–44], the interpretation of the findings suggests that there are significant gaps and inconsistencies in the existing guidelines.

One of the most important observations from this review is the variation in the methodological quality of the guidelines. While most clinical guidelines were of sufficient quality according to AGREE II ratings to be recommended [35–43], none of the reviewed guidelines achieved high ratings across all six AGREE II domains. This suggests that while some guidelines offer valuable recommendations, there is a lack of comprehensive, high-quality frameworks that can be universally applied to effectively address domestic violence during pregnancy. For example, although privacy, screening, support, and documentation were commonly addressed, several key elements, such as the patterns of violence [37–47] and the cycle of violence [35, 37–48], were largely underrepresented. This inconsistency reflects an overall gap in providing healthcare providers with the adequate information necessary to fully understand the basis complexities of domestic violence as a global health issue.

Clinical guidelines need to include information about recognizing signs and symptoms of violence during pregnancy, as well as the risk factors associated with violence during pregnancy. This is crucial for identifying and supporting pregnant women who may be experiencing abuse or hidden violence during pregnancy but some of the reviewed guidelines had no recommendations about them [37, 43–45]. This deficiency suggests that current guidelines may not fully equip healthcare professionals with the information necessary for early detection and intervention, particularly in settings where domestic violence is underreported. Furthermore, the result emphasizes the need for more practical training programs, particularly for midwives and other frontline healthcare professionals, to ensure they are equipped to handle the challenges of identifying and supporting women who are experiencing abuse.

The result of this study revealed that most of the reviewed guidelines explained the health consequences of violence during pregnancy [35–39, 41, 45–48]. Informing healthcare professionals about these consequences helps them to identify abused pregnant women and reduce the adverse effects of violence.

The most important part of reviewed clinical guidelines was the role of health care professionals. All of the guidelines had recommendations about privacy and confidentiality, screening, identification, support, and documentation. While these recommendations are crucial, they represent only the foundation of care. The last recommendations were about self-care and empowering [39, 41, 48], prevention [39, 41, 44, 48], medical care [36, 39, 41, 46], follow-up [39, 41, 43, 45], home visitation program [35, 39, 40, 43, 47], psychological counselling [35, 39, 41, 44, 46–48] and barriers to screening [38–42, 47, 48]. This highlights a significant area for improvement that guidelines should not only inform healthcare providers about recognizing violence but also about the broader systems of support that are necessary for long-term maternal and fetal well-being.

Table 3 Guidelines recommendation categories and subcategories

category & guidelines recommendation subcategory	1 [35]	2 [36]	3 [44]	4 [37]	5 [38]	6 [45]	7 [39]	8 [46]	9 [47]	10 [40]	11 [48]	12 [41]	13 [42]	14 [43]
Introduction														
Purpose and scope	+	+	+	+	+	-	+	+	-	+	+	+	+	+
Definition of violence	+	+	+	+	+	+	+	+	+	+	+	+	-	+
Patterns of violence	+	+	-	-	-	-	-	-	-	-	+	-	-	-
Cycle of violence	-	+	-	-	-	-	-	-	-	-	-	-	-	-
Domestic violence during pregnancy														
Prevalence of violence during pregnancy	+	+	-	+	+	+	+	+	+	+	+	+	+	+
Signs and symptoms of violence during pregnancy	+	+	-	-	+	-	+	+	-	+	+	+	+	-
Risk factors of violence during pregnancy	+	+	-	-	+	-	+	+	-	-	-	+	-	-
Health consequences of violence during pregnancy	+	+	-	+	+	+	+	+	+	-	+	+	-	-
The role of healthcare professionals														
Communication support and building trust	+	+	+	-	+	+	+	+	+	+	+	+	+	+
Privacy and confidentiality	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Screening	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Barriers to screening	-	-	-	-	+	-	+	-	+	+	+	+	+	-
Identification	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Non-disclosure	+	+	-	-	+	-	+	+	+	+	+	-	+	+
Psychological counseling	+	-	+	-	-	-	+	+	+	-	+	+	-	-
Medical care	-	+	-	-	-	-	+	+	-	-	-	+	-	-
Home visitation program	+	-	-	-	-	-	+	-	+	+	-	-	-	+
Child protection	+	+	+	-	+	+	+	+	+	+	+	+	+	+
Risk assessment	+	+	+	-	-	+	+	+	+	+	+	+	+	+
Safety planning	+	+	+	-	-	-	+	+	+	+	+	+	+	-
Self-care and empowering	-	-	-	-	-	-	+	-	-	-	+	+	-	-
Prevention	-	-	+	-	-	-	+	-	-	-	+	+	-	-
Support	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Documentation	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Follow up	-	-	-	-	-	+	+	-	-	-	-	+	-	+
The resources														
Professionals' education and training	+	+	+	+	+	+	+	+	+	-	+	+	+	+
Community education program	-	-	-	-	-	-	-	-	-	-	+	+	-	-
Multi-professional co-operation	-	+	+	-	-	-	+	+	+	-	-	+	+	-
Useful organization	+	-	+	-	+	-	+	+	+	-	+	+	+	-
Sources of information	+	-	+	-	+	+	+	+	+	-	+	+	+	+
Sources of support	+	-	+	-	+	+	+	+	-	-	+	+	+	-
List and number of local resources	+	-	-	-	+	-	+	+	-	-	+	+	+	-

The reviewed guidelines noted the importance of training programs in improving the confidence and competency of health professionals in identifying and caring for women experiencing domestic violence. For successful screening, there should be a greater focus on training health professionals who conduct the screening; this may require comprehensive educational efforts, rather than just producing and distributing guidelines [43]. Training and support for midwives must be included to provide clinicians with the skills they need to identify and respond effectively to domestic violence. All of the guidelines except one [40] had recommendations on professional education and training. However, the training described often focuses on recognizing signs of violence and offering basic support, rather than equipping health providers with the comprehensive knowledge needed to address the complexity of domestic violence during pregnancy. Similarly, community awareness, and education programs, along with an appropriate response to domestic violence can play an important role in reducing violence, especially during pregnancy, but only two guidelines had recommendations for them [41, 48]. Community-based approaches, which are instrumental in reducing stigma and providing resources for at-risk individuals, should be incorporated into guideline frameworks, particularly in regions where domestic violence is prevalent but underreported.

The results showed that the guideline development group was from seven high-income countries, and half were in the UK. The study highlights a significant gap in the availability of domestic violence guidelines for pregnant women in low- and middle-income countries (LMICs), where the prevalence of domestic violence is high and healthcare infrastructure is often inadequate. While the absence of these guidelines is a significant concern, the study suggests that adapting existing guidelines, rather than creating new ones, could be more effective. The focus should not be on the urgent development of new frameworks, but on adapting and strengthening existing ones to suit the specific cultural, socio-economic, and healthcare contexts of LMICs. The study advocates for research and collaboration to develop contextually relevant, culturally sensitive guidelines, involving localized studies and engagement with local healthcare providers to address the needs of these populations effectively.

In conclusion, while the review offers valuable insights into the current state of clinical guidelines for domestic violence during pregnancy, it also highlights the need for critical improvements in both the content and implementation of these guidelines. Greater attention must be given to training, the provision of detailed, actionable information, and the contextualization of guidelines to ensure their relevance and effectiveness in diverse healthcare settings.

This is the first study that systematically reviewed guidelines in the field of domestic violence during pregnancy. The use of a standardized method and rating tool AGREE II was one of the strengths of the present study. Screening the title and abstract by one reviewer was the limitation of the study.

Conclusion

This study reviewed clinical guidelines for managing domestic violence during pregnancy, highlighting the essential role of healthcare professionals in identifying and supporting pregnant women affected by violence. Although many guidelines included recommendations on privacy, screening, and medical care, significant gaps remain, particularly in addressing the full range of healthcare needs—such as psychological counseling, prevention strategies, and follow-up support. Moreover, professional training and community education, which are critical for effective intervention, are insufficiently addressed in many guidelines.

The findings underscore the need for enhancing existing guidelines rather than creating entirely new ones. Efforts should focus on strengthening the current framework by incorporating more comprehensive recommendations on preventing violence, improving follow-up care, and addressing the barriers to screening. This is especially pertinent for low- and middle-income countries, where the burden of domestic violence during pregnancy is often under-recognized, and clinical guidelines are lacking. These countries should focus on adapting international guidelines to their specific contexts, ensuring that healthcare providers are equipped with the necessary knowledge and resources to support pregnant women experiencing domestic violence.

Supplementary Information

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Supplementary Material 1

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Author contributions

MAB designed the study. MAB and FSH were involved in data collection. MAB and FSH contributed to data analysis and interpretation. MAB wrote the manuscript draft and RB did an extensive review. MAB and RB reviewed and approved the final version of the manuscript.

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Data availability
No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate
The study was approved by the Local Research Ethics Committee of Mashhad University of Medical Sciences and the Ethics Code was IR.MUMS.NURSE.REC.1399.047.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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