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Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes: A Cross-Sectional Study in Bethlehem and Hebron Areas.

Shahd Issam Ahmad Ashour

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Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes: A Cross-Sectional Study in Bethlehem and Hebron Areas.

Prepared by:

Shahd Issam Ahmad Ashour

B.Sc. Al-Quds University (Palestine)

Supervisor

Dr. Salam Al-Khatib

A thesis submitted in partial fulfillment of requirements for the degree of Master of MCH, Nursing Department, Faculty of Health Professions, Al-Quds University.

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Al-Quds University

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MCH/ Faculty of Health Professions

Thesis Approval

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Prepared by: Shahd Issam Ahmad Ashour

Registration No: 22312449

Supervisor: Dr. Salam Al-Khatib

Master thesis submitted and accepted, Date: 20/12/2025 The names and signatures of the examining committee members are as follows:

1. Head of Committee: Dr. Salam Al-khatib Signature:

2. Internal Examiner: Dr. Abdallah Alwawi Signature:

3. External Examiner: Dr. Eman Shaweesh Signature:

Jerusalem-Palestine

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Dedication

To Gaza

To my country “Palestine”

To my dear parents

To my husband's parents

To my children

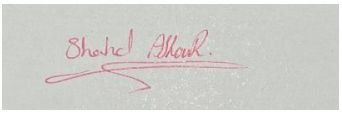
To all my teachers

To my colleagues

Shahd Issam Ahmad Ashour

Declaration

I Certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed: 

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With all my respect and gratitude,

Shahd Issam Ahmad Ashour

Abstract

Introduction: Domestic violence refers to physical, sexual, or psychological abuse inflicted by one spouse or partner upon the other, with women constituting the majority of victims (Rakovec-Felser, 2014). In 2002, the WHO recognized domestic violence as a public health crisis due to its significant impact on the well-being of victims and its associated societal implications.

Approximately 30% of women globally face physical or psychological violence during marriage, with heightened risks during pregnancy, affecting both maternal and fetal health (WHO, 2024). During pregnancy, victims may experience adverse outcomes like miscarriage and preterm labor (Ayele et al., 2023). In the Palestinian Territories, about 29% of women are impacted with a prevalence of 24% in the West Bank (OCHA, 2019), reinforcing the need for focused intervention. Various predictors of pregnancy-related domestic violence include low education, history of violence, and socioeconomic status (Mahapatro et al., 2022). International studies back the negative consequences of intimate partner violence (IPV) on pregnancy, including increased risks of preterm birth and low birth weight. Despite existing research, gaps remain in understanding the specifics within Palestinian society.
Aim: The aim of this study is to assess the prevalence of domestic violence, identify the risk factors among pregnant women and its effects on maternal and fetal outcomes in the Bethlehem44 and Hebron areas.

Methodology: This study employed a cross-sectional design and was conducted in seven governmental and private hospitals and clinics in the Hebron and Bethlehem districts. The sample included 360 mothers who delivered, and the data was collected from them within six weeks postpartum. Data was collected using a structured questionnaire that had been tested for validity and reliability. Ethical approval was obtained from the Ethics Committee of Al-Quds University (part of this questionnaire was designed by me based on the results of previous studies, and the section measuring violence used an existing, validated, and used Revised Conflict Tactics Scale previously employed in several studies), along with permissions from the Palestinian Ministry of Health and the administrations of private hospitals. Verbal consent was also obtained from all participating mothers. The data collection process lasted approximately four months, and the data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 27.

Results: About one-third of women (33.4%) reported exposure to domestic violence, with psychological violence being the most prevalent form. Lower educational level and having a middle-aged or older husband were associated with a higher likelihood of violence. Exposure

to violence was significantly associated with psychological distress, including anxiety, stress, and PTSD. Pregnancy complications and psychological symptoms were common, particularly infections, hyperemesis, stress, and severe anxiety. Adverse fetal outcomes, such as low birth weight and preterm birth, were frequently reported, and many newborns required special medical care.

Conclusions: This study highlights that domestic violence during pregnancy is a common problem in the Southern West Bank, with psychological violence being the most prevalent form. Lower maternal educational level and having an older husband were identified as significant risk factors for exposure to domestic violence. Exposure to violence was significantly associated with adverse maternal psychological outcomes, including anxiety, stress, and post-traumatic stress disorder. Pregnancy-related complications were also frequently reported among exposed women. In terms of fetal outcomes, domestic violence was associated with adverse outcomes such as low birth weight and preterm birth, and a considerable proportion of newborns required special medical care. Overall, the findings emphasize the importance of addressing educational and social risk factors and integrating mental health screening and support into antenatal care services.

Keywords: Domestic violence, Pregnant women, Risk factors, Maternal outcomes, Fetal outcomes, psychological distress.

Table of Contents

Declaration i
Acknowledgments ii
Abstract iii
List of Figures ix
List of Tables x
List of Annexes xii
List of Abbreviation xiii
Chapter One 1
1.1 Background 1
1.2 Statement of the problem 2
1 .3 Significance of the study 3
1.4 Study aim 3
1.5 Study Purpose\ objective 4
1. 6 Study questions 4
1.7 Null Hypothesis 4
Chapter Two 6
Literature Review 6
2.1 Introduction 6
2.2 Prevalence of Domestic Violence 6
2.2.1 In Western Countries 7
2.2.2 In Arabic Countries 8
2.2.3 In Palestine 9
2.3 Factors Increasing the Risk of Domestic Violence During Pregnancy 10
2.4 Receiving Support of Pregnant Women Exposed to Domestic Violence 12
2.5 Effects of Domestic Violence on Pregnant Women 12
2.6 Effects of Domestic Violence on Maternal and Fetal Outcomes: 14
2.7 Summary 16
Chapter Three 17

Conceptual framework 17
3.1 Introduction 17
3.2 Study variables Operational and Conceptual definitions 17
3.3 Study conceptual framework 22
3.4 Independent and Dependent Study variables relationship 23
3.4.1 Independent Variables 23
3.4.2 Dependent Variables 23
3.5 Proposed Relationship 23
Chapter Four 25
Research Methodology 25
4.1 Introduction 25
4.2 Study Design 25
4.3 Study settings 25
4.4 Study Population and sampling 26
4.5 Instruments of the Study 28
4.5.1 Section One: Sociodemographic and Economic Information 29
4.5.2 Section Two: Assessment of Domestic Violence 29
4.5.3 Section Three: Receiving Support 29
4.5.4 Section Four: Maternal and Fetal Health Outcomes 29
4.7 Reliability of the study questionnaire 31
4.8 Ethical Considerations 33
4.9 Data Collection 33
4.10 Data Analysis 33
4.11 Summary 34
Chapter Five 35
Results 35
5.1 Introduction 35
5.2 Socio-demographic data among participants: 35
5.3 Reproductive & Family-related Characteristics 36
5.4 The Prevalence of Domestic Violence Among Women 37
5.5 Percentages Distribution Toward Domestic Violence Subdomains Among Women 38

5.4 Receiving Support Among Women 40
5.7 Maternal and Fetal Outcomes Among Participants 40
5.8 Fetal Outcome Among Participants 42
5.9 Associated Factors Between Study Variables and Exposure to Violence 43
5.9.1 Demographic Characteristics 43
5.9.2 Reproductive & Family-related Characteristics 44
5.9.3 Help-Seeking Behavior 45
5.9.4 Pregnancy-Related Health Complications 46
5.9.5 Psychological and Emotional Symptoms 47
5.9.6 Labor, Delivery, and Postpartum Outcomes 48
5.9.7 Fetal Outcome Among Participants 49
5.10 Factors Predicting Exposure to Violence 50
Summary 52
Chapter six 53
Discussion 53
6.1 introduction 53
6.2 Domestic Violence Among Women 53
6.3 Receiving Support Among Participants 55
6.4 Associated Factors Between Study Variables and Exposure to Violence 56
6.4.1 Demographic Characteristics 56
6.4.2 Reproductive & Family-related Characteristics 57
6.4.3 Pregnancy-Related Health Complications 58
6.4.4 Psychological and Emotional Symptoms 59
6.4.5 Labor, Delivery, and Postpartum Outcomes 60
6.4.6 Fetal Outcome Among Participants 61
6.5 Factors Predicting Exposure to Violence 61
6.6 Conclusion 62
7.6 Strengths of the study 63
8.6 Limitations of the study 63
9.6 Recommendations 63
9.6.2 recommendations for professionals 64

References 66
الملخص 96

List of Figures

No	Figures	Page
1.3	Conceptual Frameworks Diagram	23
1.5	The prevalence of Domestic Violence Among women	38

List of Tables

No	Tables	Page
4.1	Names of the selected study sites and the number of participating women in each location	28
4.2A	Cronbach's Alpha for each domain of the questionnaire	32
4.2B	Cronbach's Alpha for each domain of the questionnaire	33
5.1	Socio-demographic data among participants	36
5.2	Reproductive & Family-related Characteristics	37
5.3.A	Domestic Violence Subdomains Assessment	38
5.3.B	Domestic Violence Subdomains Assessment	39
5.4	Receiving Support Among Women	40
5.5.A	Maternal and Fetal Outcomes Among Women	41
5.5.B	Maternal and Fetal Outcomes Among Women	42
5.6	Fetal Outcome	43
5.7	Association Between Demographic Characteristics of Women and Exposure to Violence	44
5.8	Association Between Reproductive and Husband-related Characteristics and Exposure to Violence	45
5.9	Association Between Help-Seeking Behavior and Exposure to Violence	46
5.10	Association Between Pregnancy-Related Health Complications and Exposure to Violence	47
5.11	Association Between Psychological and Emotional Symptoms and Exposure to Violence	48
5.12	Association Between Labor, Delivery, and Postpartum Outcomes and Exposure to Violence	49

5.13 Association Between Fetal Outcomes and Exposure to Violence 50

5.14 Binary Logistic Regression Predicting Exposure to Violence 51

List of Annexes

No	Annex	Pages
A.	Questionnaire (English)	77
B.	permission letters	92
C.	Ethical approval letter	95

List of Abbreviation

Abbreviation	Explanation
DV	Domestic violence
IPV	intimate Partner Violence
VIF	Variance Inflation Factor
UN	United Nations
MOH	Ministry of Health
WHO	World Health Organization
UNFPA	United Nations Population Fund
SPSS	Statistical Package for Social Sciences
SD	Standard Deviation
OR	Odds Ratio
COVID	Coronavirus Disease
AJSP	American Journal of Social Psychology
OCHA	Office for the Coordination of Humanitarian Affairs
Kg	Kilogram
No.	Number
AOR	Adjusted Odds Ratio
NICU	Neonatal Intensive Care Unit)
PTSD	Post-Traumatic Stress Disorder
PROM	Premature Rupture of Membranes

Chapter One

Introduction

1.1 Background:

According to the World Health Organization (WHO, 2024), approximately 30% of women worldwide experience some form of physical or psychological violence during their married lives, with an elevated risk during pregnancy. This period is a critical phase in a woman's life, where external factors like domestic violence can have profound effects on both maternal and fetal health.

Domestic violence refers to physical, sexual, or psychological abuse inflicted by one spouse or partner upon the other, with women constituting the majority of victims (Rakovec-Felser, 2014). In 2002, the WHO recognized domestic violence as a public health crisis due to its significant impact on the well-being of victims and its associated societal implications. Although violence against women can occur at any stage of life, pregnancy is a period of heightened vulnerability (Nasir & Hyder, 2003), making the effects of domestic violence during this time particularly concerning.

Domestic violence during pregnancy has been linked to adverse maternal and fetal outcomes, such as intrauterine growth retardation, preterm labor, miscarriage, and perinatal death (Ayele et al., 2023). The psychological impact is equally concerning, with studies associating domestic violence with depression, anxiety, suicidality, substance abuse, and sleep disturbances (Mahapatro et al., 2022).

In the Palestinian Territories, domestic violence affects approximately 29% of women, with a prevalence of 24% in the West Bank (United Nations Office for the Coordination of Humanitarian Affairs - Occupied Palestinian Territory, 2019). These rates highlight the significance of the issue within the region, underscoring the urgent need for targeted research and intervention.

Various risk factors have been identified as predictors of pregnancy-related domestic violence. For instance, low educational attainment, previous experiences of domestic violence, marital status, socioeconomic status, and unplanned pregnancy have been shown to increase the risk of domestic violence among pregnant women(James et al., 2013). Furthermore, victims of domestic violence during pregnancy may suffer from diminished maternal-fetal attachment, potentially resulting in postpartum rejection of the infant and diminished productivity during labor(Zare et al., 2022).

Consistent findings have been reported globally. For instance, Berhanie et al. (2019) showed that women exposed to Domestic Violence (DV) were significantly more likely to experience preterm birth and low birth weight. Guo et al. (2023), in a meta-analysis, confirmed that IPV during pregnancy increases the risk of preterm delivery by 30–40% and doubles the likelihood of delivering a low-birth-weight infant. Furthermore, Lin et al. (2022) explained that domestic violence can trigger elevated maternal stress hormones (such as cortisol and adrenaline), which may impair placental function and fetal growth. They also reported that abused women often suffer from poor nutrition, delayed antenatal care, and higher levels of psychological distress, all of which further contribute to negative maternal and fetal outcomes. Despite the extensive research on domestic violence, a significant gap remains in understanding its specific effect on Maternal and Fetal Outcomes, particularly within Palestinian society in the West Bank. This study aims to investigate the risk factors and effects of domestic violence on maternal and Fetal Outcomes in the Bethlehem and Hebron areas, offering insights that could enhance support and intervention efforts for affected women.

1.2 Statement of the problem:

Despite extensive research on domestic violence and its harmful impact on maternal and fetal health, a significant gap remains in understanding its specific effect on maternal and fetal outcomes, especially in regions with unique social and cultural contexts, such as Palestine. The impact of domestic violence during pregnancy extends beyond physical and psychological risks that threaten the health of mothers, involving serious complications during labor, such heightened psychological distress during childbirth (Taillieu et al., 2010).

Multiple recent studies and reviews indicate that DV increases maternal psychological distress and trauma-related responses during labour, which can manifest as difficulties with cooperation, impaired ability to follow instructions, or dissociative/fear responses during childbirth (Agarwal et al., 2023).

In Palestine, where approximately 29% of women experience some form of domestic violence, with a prevalence of 24% in the West Bank (United Nations Office for the Coordination of Humanitarian Affairs, 2019)., This issue becomes even more pressing. The likelihood of

domestic violence negatively affecting the labor process adds complexity to maternal and fetal health challenges in this region (Devries et al., 2019).

However, there is still a lack of local studies focusing specifically on the effect on maternal and fetal outcomes, leaving an important knowledge gap. Understanding these effects is essential for developing effective support and intervention strategies to mitigate the adverse consequences of domestic violence for mothers and newborns.

1 .3 Significance of the study:

This study holds significant value for public health and social interventions, especially in addressing the link between domestic violence and complications on maternity and fetal. It offers a unique opportunity to explore the effects of domestic violence on maternal and fetal, a largely underexplored area in Palestine, where rates of domestic violence are notably high.

The findings of this study will shed light on how domestic violence affects the physical and psychological health of pregnant women, including an increased risk of pregnancy and delivery complications, as well as psychological effects and mental disorders. The study will also clarify how domestic violence can influence the health and development of the fetus, and the mother–infant relationship after birth, highlighting the importance of raising awareness and promoting early intervention to protect the health of both mother and child.

This research will provide critical insights for healthcare professionals, policymakers, and social workers regarding the specific needs of pregnant women who experience domestic violence. The study's insights can contribute to the development of support systems prioritizing safety, mental health, and empowerment, ensuring compassionate and effective care during a highly vulnerable time.

By focusing on the Bethlehem and Hebron areas, this research adds to the evidence specific to Palestinian society, offering culturally sensitive recommendations that can enhance maternal health and newborn well-being.

1.4 Study aim:

The aim of this study is to identify and analyze the risk factors of domestic violence among pregnant women and its effects on maternal and fetal outcomes in the Bethlehem and Hebron areas.

1.5 Study Purpose\ objective:

1. To assess the sociodemographic and family-related risk factors associated with women's exposure to domestic violence in Bethlehem and Hebron areas, including marital status, educational level of both mother and father, monthly household income, place of residence, and living arrangements (whether residing with the husband's family).
2. To assess the reproductive and husband-related risk factors associated with women's exposure to domestic violence in Bethlehem and Hebron areas, including number and gender of children, maternal employment status and working hours, number of pregnancies and abortions, husband's age and employment status, duration of marriage, and the mother's age at marriage.
3. To determine the prevalence of domestic violence among women in Bethlehem and Hebron areas and its subdomains (psychological, physical, severity of physical violence and sexual).
4. To assess the reasons for not seeking help, and sources of support among women exposed to domestic violence.
5. To assess the maternal outcomes associated with women's exposure to domestic violence during pregnancy, labor, and the postpartum period, such as vaginal bleeding, infections, psychological distress, type of delivery, preterm birth, and readiness for labor, as well as breastfeeding practices (particularly direct breastfeeding).
6. To assess the fetal outcomes associated with women's exposure to domestic violence during pregnancy and after labor, including birth weight, congenital anomalies, preterm delivery, and neonatal intensive care unit (NICU) admission.

1. 6 Study questions:

1. What sociodemographic, reproductive, and husband-related factors are associated with women's exposure to domestic violence?
2. What is the prevalence of domestic violence among women, and what are the most common subdomains (psychological, physical, severity of physical violence, and sexual)?
3. What are the reasons for not seeking help and the main sources of support among women exposed to domestic violence?
4. What maternal and fetal outcomes are associated with women's exposure to domestic violence?

1.7 Null Hypothesis:

1. H_0: Sociodemographic, reproductive, and husband-related factors are not significantly associated with women's exposure to domestic violence at ($p=>0.05$).

2. H_0: There is no significant association between exposure to domestic violence and help-seeking behavior, reasons for not seeking help, or sources of support at ($p=>0.05$)
3. H_0: Exposure to domestic violence is not significantly associated with maternal and fetal outcomes at ($p=>0.05$).

1.8 Definitions of Terms

1.8.1 Domestic violence (DV): Violence committed by an individual inside the victim's home is termed domestic violence. This includes partners, former partners, immediate family members, other relatives, and family friends.

When the offender and the victim have a close connection, it is termed "domestic violence." They often possess varying degrees of power. The victim depends on the offender. Physical, sexual, or psychological abuse may be classified as domestic violence (Ministerie van Algemene Zaken, 2016).

1.8.2 Pregnant women: Pregnancy refers to the duration during which a fetus grows inside a woman's uterus.
Gestation typically last around 40 weeks, or slightly more than 9 months, calculated from the last menstrual cycle until parturition. Healthcare expert's categories pregnancy into three divisions known as trimesters.

Pregnancy is divided into trimesters. The significant occurrences in each trimester include: First Trimester (Weeks 1 to 12), Second Trimester (Weeks 13 to 28) and Third Trimester (Weeks 29 to 40) (*About Pregnancy*, 2024).

1.8.3 Maternal outcomes: Maternal outcomes pertain to a mother's health during and after pregnancy, which may be classified as either favorable or negative (adverse). Negative outcomes include disorders such as postpartum hemorrhage, eclampsia, infection, severe lacerations, and maternal mortality, impacted by variables like age, socioeconomic level, healthcare accessibility, and chronic stress (Leta et al., 2025).

1.8.4 Fetal outcomes: Fetal outcomes refer to the health and viability consequences of a pregnancy, including a spectrum from healthy development to negative outcomes such as miscarriage, preterm delivery, low birth weight, and stillbirth. Maternal health, lifestyle choices, and pregnancy problems may profoundly influence fetal outcomes (Zhan et al., 2017).

1.8.5 Risk factors: is a trait or state that elevates the probability of an unfavorable result, such as a disease, ailment, or negative occurrence. These variables may be biological, psychological, behavioral, or environmental, including aspects such as familial sickness history, chemical exposure, or individual lifestyle and habits (*Risk and Protective Factors*, 2021).

Chapter Two

Literature Review

2.1 Introduction

This chapter will review the literature on domestic violence and its impact on maternal and fetal. The review will begin with an introduction to domestic violence and its effect on pregnant women, focusing on factors that increase the risk of violence during pregnancy. The psychological and physical effects of domestic violence on pregnant women will be discussed, and how these effect different stages of pregnancy, with a particular focus on the effects of violence on maternal and fetal. We will also address the role of healthcare providers, including midwives and doctors, in recognising and managing domestic violence, focusing on the barriers they may face in providing appropriate support and treatment in healthcare settings.

In this review, Google schooler, PubMed, science direct, WHO site, Palestine MOH was used to find the knowledge frame. The keywords used in this review were The Risk Factors and Effects of Domestic Violence on maternal and fetal.

2.2 Prevalence of Domestic Violence

Domestic violence is a significant global public health issue that profoundly affects individuals across all social and demographic boundaries. Defined as acts of violence perpetrated by someone within the victim's domestic circle, it often involves a power imbalance where the victim is dependent on the offender (Stöckl & Sorenson, 2024).

Domestic violence refers to physical, sexual, or psychological abuse inflicted by one spouse or partner upon the other, with women constituting the majority of victims (Rakovec-Felser, 2014). The prevalence of domestic violence (DV) varies significantly between Western countries and Arab nations, reflecting cultural, social, and legal differences. The following sections provide a detailed comparison of the prevalence and implications of domestic violence in these regions.

2.2.1 In Western Countries

Worldwide, approximately one in three women worldwide, or 736 million, have experienced intimate relationship violence, non-partner sexual violence, or both at some point in their lives (30% of women aged 15 and older) (UN Women, 2023).

Research indicates a growing body of literature on domestic violence, with a notable increase in publications post-2013, highlighting its recognition as a critical public health issue (Neupane & Lourdusamy, 2024).

The prevalence of lifetime intimate partner violence varies globally, with estimates ranging from 20% in the Western Pacific to 33% in the WHO African, Eastern Mediterranean, and South-East Asia regions. Globally, 38% of all murders of women are committed by intimate partners, and 6% of women report sexual assault by someone other than a partner (Sardinha et al., 2022).

The European Union Agency for Fundamental Rights (FRA, 2024) conducted one of the largest surveys on gender-based and domestic violence across the European Union. The study aimed to assess the prevalence and nature of violence experienced by women within intimate relationships and its broader social implications. Findings revealed that approximately one in three women in the EU had experienced physical or sexual violence during adulthood, and one in five had suffered abuse from a current or former partner. The report emphasized that domestic violence remains a deeply rooted public health and human rights issue that transcends social and economic boundaries.

Also, The Office for National Statistics (ONS, 2024) in the United Kingdom released a national report examining the prevalence and demographic trends of domestic abuse. The report found that approximately 4.8% of adults equivalent to around 2.3 million people had experienced domestic abuse in the year ending March 2024. Women were found to be significantly more affected than men (6.6% compared to 3.0%), and younger women were identified as the most vulnerable group. The findings highlight the ongoing challenge of domestic violence in the UK and the need for continuous monitoring.

The Australian Bureau of Statistics (ABS, 2023) conducted a comprehensive national survey titled Personal Safety, Australia 2021-22, which examined experiences of violence and abuse among Australian adults. The survey reported that approximately 27% of women had experienced violence by a partner or family member since the age of 15, while 39% had faced physical or sexual violence in their lifetime. The report underscored that intimate partner violence remains a major public health concern in Australia, with substantial long-term physical and psychological consequences for women.

2.2.2 In Arabic Countries

The WHO multi-country study on women's health and domestic violence against pregnant women (WHO,2024) found that over 25% of women aged 15-49 have experienced physical and/or sexual violence by their intimate partner at least once in their lifetime.

Also, Elghossain et al. (2019) conducted a systematic review to examine the prevalence of intimate partner violence (IPV) against women across 22 Arab countries. The review analyzed data from 56 population-based studies and revealed that the lifetime prevalence of physical IPV ranged from 6% to over 59%, sexual IPV from 3% to 40%, and emotional/psychological IPV from 5% to 91%. The authors concluded that IPV represents a significant public health and human rights issue in the Arab region.

In addition, Abu-Elenin et al. (2022) conducted a national cross-sectional study in Egypt that included 2,068 married women to determine the prevalence of domestic violence before and during the COVID-19 pandemic. The study revealed a significant increase in violence rates after the pandemic, with physical violence rising from 32.8% to 75%, along with a marked increase in psychological abuse and domestic restrictions on women. These findings highlight that domestic violence in Egypt is a widespread problem, particularly during crises that heighten household tension.

And (Rohym et al., 2022) conducted a descriptive-analytical study titled "Domestic Violence During the Period from 2015 to 2020 in Fayoum Governorate, Egypt", which examined the prevalence of domestic violence among women. And a total sample of 100 participants. The study revealed that less than half of the married women in the sample had experienced some form of marital abuse, with emotional violence being the most prevalent, followed by physical violence.

There is another study that Wali et al. (2020) conducted a cross-sectional study among women attending the National Guard Primary Health Care Centers in the Western Region of Saudi Arabia. The study found that the lifetime prevalence of domestic violence was 33.2%, with psychological abuse being the most common type (48.5%), followed by physical (34.8%) and sexual violence (16.8%). These results indicate that domestic violence remains a significant public health and social concern in Saudi Arabia.

Moreover, a systematic review found that lifetime exposure to intimate partner violence (IPV) among women in Arab countries is alarmingly high, with a pooled prevalence of 73.3% (Hawcroft et al., 2019). Specific forms of IPV reported include physical violence (35.6%), sexual violence (22%), and emotional abuse (49.8%) (Hawcroft et al., 2019).

2.2.3 In Palestine

In Palestine, Data from a national survey conducted by the Palestinian Central Bureau of Statistics in the second quarter of 2019 indicated that approximately 29% of married Palestinian women experienced some form of psychological, physical, or sexual violence from their husbands during the previous 12 months. The prevalence was higher in the Gaza Strip (around 38%) compared to the West Bank (about 24%). The study highlighted that psychological violence was the most common type among the victims (OCHA, 2019).

(Heaney, 2022) Women and girls in the occupied Palestinian territory face widespread gender-based discrimination and violence, including early marriage, intimate partner violence, and sexual exploitation. These problems are exacerbated by the Israeli occupation, cultural norms, and the COVID-19 pandemic, which saw a 135 per cent increase in reported cases of gender-based violence in May 2021 compared to the previous year. Concerns about women's safety are particularly high in the West Bank (31%) and Gaza (19%), alongside a 24% increase in child marriage. Access to essential services related to gender-based violence is extremely limited in areas such as Gaza and East Jerusalem. Ongoing humanitarian efforts focus on health, economic development, and awareness-raising programs to combat gender-based violence.

Heba Jibbat, head of the Women and Gender Unit at the Palestinian Ministry of Social Development, points to an increase in cases of violence against women, despite the lack of accurate data on its prevalence. The ministry responded to 935 cases of violence in 2022 and 908 in 2023, with psychological violence being the most common. While laws such as the National Referral System for Abused Women exist, current legislation is insufficient to protect women, highlighting the need for a Family Protection Law. Women face challenges including fear of retaliation and social stigma, which prevent them from seeking help (*Ayham Abu Ghosh*, 2024).

Haj-Yahia and Clark (2014) conducted a nationally representative study including 3,500 married women in the West Bank and Gaza Strip to investigate the prevalence of intimate partner violence (IPV) during a 12-month period. The study found that minor psychological aggression occurred in 50% of women, while severe psychological aggression was reported by 12%. Physical violence occurred at rates of 17% for minor assault and 6% for severe assault, and sexual violence was reported at 4% for minor coercion and 6% for severe coercion. The study also identified that factors such as husband's controlling behavior, marital conflict, and societal acceptance of IPV were associated with higher likelihood of experiencing domestic violence.

A cross-sectional study published in 2019 in the Gaza Strip, including 517 previously married women, found that approximately 23% of participants reported experiencing some form of intimate partner violence. The study identified several significant risk factors, including

husband's substance use (OR = 27.58), husband's history of childhood violence (OR = 9.17), and having a child with special needs in the family (OR = 2.96).

Salameh. et al. (2025) reported that a substantial proportion of women in the Occupied Palestinian Territory experienced intimate partner violence (IPV). The study highlighted that IPV prevalence was particularly high among women whose husbands had been directly exposed to political violence, reflecting the compounding effect of socio-political stressors on domestic violence. Although exact percentages were not the main focus, the findings indicate that exposure to structural and interpersonal stress significantly increases the likelihood of IPV, demonstrating a widespread presence of domestic violence in conflict-affected areas of Palestine.

2.3 Factors Increasing the Risk of Domestic Violence During Pregnancy

A study conducted in the Islamic Republic of Iran by Gharacheh et al. (2015) identified several risk factors for domestic violence among pregnant women. The research highlighted that emotional, sexual, and physical abuse were prevalent, and that most participants were unemployed. The study emphasized that domestic violence can affect women across different social and economic backgrounds, regardless of sociodemographic characteristics.

In Gaza, the study employed a descriptive cross-sectional design and included a sample of 400 pregnant women from five governorates. The results indicated that psychological abuse was more prevalent among women residing in refugee camps compared to women in urban or rural areas, particularly among women aged 36 and older, those with limited education, those married to illiterate husbands, and those with eight or more children. The rate of physical abuse was higher among illiterate women and families with eight or more children, while physical injuries were more common among women married to illiterate husbands and in large families (Thabet, 2017).

The literature indicates that violence against women in Palestine is influenced by complex structural and social factors, with the occupation being one of the most prominent factors that increases pressure on families. Patriarchal norms and traditional culture also contribute to reinforcing the power imbalance between the sexes, which legitimizes some forms of violence. Legislative gaps and weak enforcement of laws also contribute to reducing the protection of women, in addition to the limited availability of support services. Poverty and economic dependence on men increase women's vulnerability to violence, while social conditions designed to discourage reporting of violence increase women's vulnerability, especially during pregnancy (Economic and Social Commission for Western Asia, 2020).

In Egypt, Abu-Elenin et al. (2022) found that low educational attainment, early marriage, poor socioeconomic status, the husband's smoking habits, and reduced family income during the

COVID-19 pandemic were associated with higher risks of domestic violence. These findings suggest that economic hardship and social inequalities play a major role in increasing vulnerability to violence among married and pregnant women.

Research in Saudi Arabia by Wali et al. (2020) indicated that employed, highly educated, or financially independent women were more likely to report domestic violence. The authors suggested that evolving social dynamics and women's empowerment within traditional family structures may paradoxically increase vulnerability to violence, highlighting the need for further investigation.

Usta et al. (2017) conducted a cross-sectional study in Lebanon, revealing that low education, verbal and physical abuse, and general marital tensions were important risk factors for domestic violence among 1,418 women. The study underscored domestic violence as a serious public health concern in Lebanese communities.

In urban communities of Hengyang City, China, Zheng et al. (2020) identified middle- and low-income families, medium household debt, and conflicts between the mother-in-law and family members as factors increasing the risk of domestic violence, particularly among women in late pregnancy.

In the United States, Kyriacou et al. (2017) reported that women with partners who abuse alcohol or drugs, are unemployed or work part-time, have low education, or are former intimate partners are at the highest risk of domestic violence-related injuries.

At Deakin University, Australia, Wong and Mellor (2014) found that cultural factors including tolerance of violence, maintaining family reputation, resistance to divorce or separation, and control over women's freedom alongside abusive relationships and childhood sexual abuse, significantly increased the likelihood of intimate partner violence.

A meta-analysis in Ethiopia by Alebel et al. (2018), covering eight studies with 2,691 pregnant women, showed that low educational attainment of the mother or her partner and alcohol use were key risk factors for intimate partner violence during pregnancy. Women or partners with lower education levels were more likely to experience or perpetrate IPV.

Finally, Antoniou and Iatrakis (2019) in Greece highlighted that certain vulnerable groups were at higher risk, including women originating from abroad or with foreign partners, those living in precarious conditions such as unemployment, being housewives, or university students, and women with low educational levels. These factors consistently increased the incidence of violence during pregnancy.

2.4 Receiving Support of Pregnant Women Exposed to Domestic Violence

In the Occupied Palestinian Territories, specifically in the Gaza Strip, less than 1% of women who experienced intimate partner violence (IPV) sought formal help. Employment, education, and political and sociocultural barriers were identified as significant factors affecting women's ability to access support (Fitzgerald & Chi, 2020). This limited access to assistance perpetuates violence and increases the risk of adverse outcomes for both mother and fetus.

Similarly, Fekadu et al. (2018) conducted research at the University of Gondar Referral Hospital in Northwest Ethiopia, emphasizing that many pregnant women face substantial barriers to seeking help, particularly those who are economically dependent or have limited autonomy. The study highlighted the urgent need for targeted support mechanisms, including accessible counseling, empowerment programs, and safety interventions, to ensure that pregnant women can obtain appropriate assistance.

In Iran, Barez et al. (2022) explored strategies used by pregnant women in Mashhad to manage domestic violence. The qualitative study included 13 women who had experienced domestic violence, interviews with 24 healthcare and social service professionals, and two focus groups with 20 women. Two main themes emerged: "escape strategies" (such as concealment and passive behaviors) and "situation improvement strategies" (including self-regulation, protecting privacy, and seeking help). Understanding these coping mechanisms is crucial for designing effective violence prevention programs and encouraging women to access support, ultimately reducing maternal and fetal complications.

Also, Babaheidarian et al. (2021) investigated the effect of family-based counseling on reducing domestic violence against pregnant women in Sahneh, Iran. The intervention, involving three counseling sessions for pregnant women and their spouses, led to a significant decrease in mental, verbal, physical, and sexual violence, although emotional violence was not significantly reduced. The findings indicate that family-based counseling can effectively mitigate violence and its associated complications during pregnancy, thereby improving maternal and fetal outcomes.

2.5 Effects of Domestic Violence on Pregnant Women

Domestic violence, which includes physical, sexual, psychological, and financial coercion against partners, is a common health problem among expectant mothers and presents serious risks to the health of both the mother and the unborn child (UCSF Health, 2024).

Globally, nearly one in three women have experienced physical or sexual violence from an intimate partner or non-partner in their lifetime. Such violence has far-reaching consequences,

including mental health issues like depression and anxiety, and physical health problems such as unintended pregnancies and sexually transmitted infections (WHO, 2023).

In Palestine, the situation mirrors global trends, with significant numbers of women reporting psychological, physical, and sexual violence, particularly in the West Bank. These figures underline the pervasive nature of domestic violence in the region and its various manifestations ((Palestinian Central Bureau of Statistics, 2024).

Research has consistently shown that intimate partner violence (IPV) negatively impacts women's physical and mental health. Findings from the World Health Organization's Multi-Country Study emphasize that all forms of IPV-especially when combined-are associated with severe health outcomes, including depression, suicidal ideation, and hospitalizations (Potter et al., 2020).

Pregnancy introduces additional risks, as both the mother and unborn child are vulnerable to the consequences of domestic violence. Violence during pregnancy has been linked to complications such as premature labor, fetal health issues, and maternal mental health challenges. Moreover, the lack of emotional support further exacerbates these outcomes, underscoring the need for early intervention and support systems (Manongi et al., 2017).

According to the survey, emotional violence was the most prevalent form of domestic abuse, affecting nearly one-third of pregnant women (35.2%). Women who experienced violence had a lower physical health quality of life score than women who did not, but their mental health quality of life score was noticeably worse (Naghizadeh et al., 2021).

Pregnancy-related decisions and care-seeking may be restricted for women who are victims of domestic violence, which could have a negative impact on the course of the pregnancy.

Non-fatal health outcomes associated with domestic violence during pregnancy include maternal and newborn health outcomes. Specifically, previous research has found that women reporting domestic violence during pregnancy had higher rates of intrauterine growth retardation and preterm labor than women not experiencing violence. Experiencing domestic violence during pregnancy has also been associated with women's increased risk of miscarriage and abortion. Others have also found increased risk of antepartum hemorrhage, and perinatal death.

Domestic violence during pregnancy can also lead to short and long-term health consequences for pregnant women, including maternal mortality (Melaku et al., 2023).

2.6 Effects of Domestic Violence on Maternal and Fetal Outcomes:

Domestic violence during pregnancy has been consistently linked to adverse maternal and fetal outcomes, although some studies report conflicting findings. For instance, while James et al. (2013) and Zare et al. (2022) found no statistically significant association between domestic violence and labor complications, other research highlights clear negative effects on maternal and neonatal health.

In the United States, Levendosky, Bogat, and Huth-Bocks (2011) explored how domestic abuse affects the mother child attachment bond, beginning during pregnancy. They identified relationship-harming strategies such as dissociation, emotional dysregulation, projective identification, and maternal projection, which can indirectly influence maternal and fetal well-being.

In Nepal, Pun et al. (2018) found that exposure to domestic violence was significantly associated with pregnant women's unpreparedness for childbirth. Younger, uneducated women married to illiterate husbands, of lower socioeconomic status, attending fewer prenatal checkups, with limited income, or residing in rural areas were more likely to be unprepared. These findings underline the importance of addressing socio-demographic vulnerabilities alongside domestic violence to improve maternal readiness.

In the Middle East, studies demonstrate that domestic violence increases risks for pregnancy complications. Aldabbour et al. (2025) in Gaza reported higher rates of preterm birth, low birth weight, and stillbirth among women living in conflict-affected areas. Similarly, research on Palestinian refugee women in Lebanon (UN Women, 2025) linked exposure to violence with vaginal bleeding, anemia, preterm delivery, and low birth weight infants, emphasizing the need for antenatal screening and psychosocial support. In Minia, Egypt, Elkhateeb et al. (2021) found that domestic violence was associated with vaginal infections, bleeding, preterm labor, and premature rupture of membranes.

Other regional studies reinforce these findings. Faramarzi et al. (2005) in Iran observed that women experiencing physical, sexual, or emotional violence were more likely to undergo cesarean delivery, have abnormal labor progression, premature rupture of membranes, preterm birth, low birth weight, and hospitalization prior to delivery. Berhanie et al. (2019) in Ethiopia similarly reported that intimate partner violence increased the likelihood of preterm birth and low birth weight.

Systematic reviews and meta-analyses provide further support. Guo et al. (2023) reported that IPV during pregnancy raises the risk of preterm birth by 30–40% and doubles the likelihood of low birth weight, while Lin et al. (2022) highlighted biological and behavioral mechanisms,

such as elevated maternal stress hormones, poor nutrition, and delayed prenatal care, that mediate these adverse outcomes.

In Jordan, Abujilban et al. (2022) examined the effects of physical intimate partner violence (IPV) on maternal health outcomes among pregnant women attending a hospital-based clinic. The study found that women who experienced physical violence during pregnancy had significantly higher rates of obstetric complications, including antepartum hemorrhage, preterm labor, and cesarean delivery, compared with non-abused women. Moreover, victims of IPV reported greater psychological distress, sleep disturbances, and reduced antenatal care attendance.

In the Gaza Strip, a study on pregnant women attending primary health care clinics revealed that exposure to domestic violence was significantly associated with adverse maternal and fetal outcomes. Women who experienced physical or emotional violence during pregnancy were more likely to suffer from complications such as vaginal bleeding, anemia, premature rupture of membranes, preterm delivery, and low birth weight infants (Al Ghussain et al., 2017).
Moreover, Aldabbour et al. (2025) conducted a cross-sectional study in the Gaza Strip to examine maternal and neonatal health in a conflict-affected setting. The study revealed that pregnant women exposed to chronic stress and conflict-related challenges experienced adverse maternal and neonatal outcomes. Key findings included a high prevalence of maternal anemia, limited access to antenatal care, and a notable proportion of low birth weight (LBW) infants (10.8%).

Conducted a cross-sectional study in Hossana Town, Ethiopia, to assess the association between intimate partner violence (IPV) during pregnancy and adverse birth outcomes. The study found that exposure to IPV was significantly associated with low birth weight, as women who experienced violence were nearly fourteen times more likely to deliver low birth weight infants compared to those who were not exposed. However, no statistically significant relationship was observed between IPV and other outcomes such as preterm birth, stillbirth, or low Apgar scores. These findings indicate that IPV can negatively affect fetal growth through both physiological and psychological stress mechanisms. The study emphasizes the importance of early identification of violence during antenatal care and the implementation of targeted interventions to reduce the risk of adverse maternal and neonatal outcomes (Laelago et al., 2017).
Conversely, a study on Omani women (Shidhani et al., 2020) found no significant differences in childbirth outcomes between women exposed and not exposed to domestic violence, illustrating contextual variability.

Despite growing attention to domestic violence, there is a notable gap in understanding its specific impact on maternal and fetal outcomes. This study seeks to address this gap by exploring the risk factors and effects of domestic violence on maternal and fetal outcomes

among women in Bethlehem and Hebron, Palestine. By shedding light on this underexplored issue.

2.7 Summary

Domestic violence is a global public health issue affecting individuals across social and demographic boundaries. It involves physical, sexual, or psychological abuse, with women being most victims. The prevalence of domestic violence varies significantly between Western countries and Arab nations, reflecting cultural, social, and legal differences. In Western countries, approximately one in three women have experienced intimate relationship violence, non-partner sexual violence, or both at some point in their lives. In Arab countries, lifetime exposure to intimate partner violence is alarmingly high, with specific forms of violence reported.

Domestic violence during pregnancy poses significant risks to both mothers and unborn children. Approximately one in three women globally experience physical or sexual violence, leading to mental health issues such as depression and anxiety, as well as physical problems such as unintended pregnancies, sexually transmitted infections, miscarriages, preterm births, low birth weight, impaired fetal growth, and exacerbation of chronic conditions in the mother.

Domestic violence during pregnancy is influenced by various risk factors. These include emotional (88.4%), sexual (34.9%), and physical (26%) abuse, often linked to joblessness, low family income, and medium household debt. Partner-related factors, such as alcohol or drug abuse, unemployment, part-time work, lower education levels, and estranged relationships, significantly increase the risk. Cultural and social dynamics, including family tensions and in-law conflicts, further contribute. Regional variations show high prevalence rates in Ethiopia (26.1%), Iran (44.5%), and China (15.62%), while younger, urban-dwelling, and religious women are particularly vulnerable. Barriers like sociocultural, political, and economic factors prevent many women from seeking help, with less than 1% reporting violence in some regions.

Studies indicate varying impacts of domestic violence on maternal and fetal outcomes. Some research links domestic violence to complications such as delayed labor, cesarean deliveries, preterm births, low birth weight, and premature rupture of membranes, while other studies suggest no clear association. Exposure to violence has also been shown to disrupt the emotional bond between a mother and her child due to psychological factors like emotional detachment and maternal projection. Women unprepared for childbirth, often younger, from disadvantaged socioeconomic backgrounds, or uneducated, are at greater risk of experiencing violence. However, findings differ by context; for instance, a study in Oman found no significant connection between domestic violence and childbirth outcomes. These contradictions emphasize the need for further research to better understand the precise effects of domestic violence on maternal and fetal outcomes across different cultural and social settings.

Chapter Three

Conceptual framework

3.1 Introduction:

In this chapter, the operational definitions that were used, the determinates of the study and the conceptual framework will be presented.
The conceptual framework of this study aims to explain the relationship between domestic violence during pregnancy and its effects on maternal and fetal, to provide a comprehensive understanding of the main variables.

3.2 Study variables Operational and Conceptual definitions:

Domestic Violence
Conceptual Definition: Violence perpetrated by a member of the victim's household is referred to as domestic violence. Partners and ex-partners, close family members, other relatives, and family friends are all included in this.

When the perpetrator and the victim have a close relationship, it is referred to as "domestic violence." They often have different levels of power. The victim is
reliant on the perpetrator. Abuse that is physical, sexual, or psychological might be considered domestic violence (Ministerie van Algemene Zaken, 2016).

Operational Definition: In this study, domestic violence is measured through a questionnaire addressing the types of violence (physical, Severe Physical Violence, psychological and sexual), its duration, frequency, and the perpetrator's relationship with the victim (Ford-Gilboe et al., 2016).
Tool: A structured questionnaire with Likert-scale items for frequency and severity.

Risk factors associated with domestic violence (Socio-Demographical Factors):
Educational Level (Mother and Husband):
Conceptual Definition: The highest level of formal education completed by the individual (mother or husband) (Biology Online, 2021).

Operational Definition**:** Categorized as illiterate, primary education, secondary education, or higher education, based on survey responses (Abujilban et al., 2021).

Maternal Age
Conceptual Definition: The chronological age of the pregnant woman at the time of the study. (*Advanced Maternal Age*, 2024).

Operational Definition: Categorized into age groups: under 20, 20–29, 30–39, and 40+ years (Abujilban et al., 2021).

Economic Status:
Conceptual Definition: The household's financial condition, which may affect access to resources (*NCI Dictionary of Cancer Terms*, n.d.-b).

Operational Definition: Self-reported and categorized as low, medium, or high income (Abujilban et al., 2021).

Marital status:
Conceptual Definition: The legal and social condition that defines the relationship status of an individual, such as married, divorced, separated, or widowed (*Marital Status - Health, United States*, n.d.).

Operational Definition:
Self-reported and categorized as:
(Married, Divorced, Separated, Widowed) (Alzboon & Vural, 2019).

Employment status:
Conceptual Definition: Employment status refers to an individual's engagement in paid work or formal economic activity. It reflects whether the individual participates in the labor force and contributes to household income through employment (*Types of Employment Status - Employment Status - Acas*, 2024).

Operational Definition: Employment status is measured based on self-reported responses to the question:
For the mother: "Do you work outside the home?" and what are your working hours: Morning

Evening
Shifts (Abujilban et al., 2021).
For the husband: "Does your husband work?" (Abujilban et al., 2021).

Number of previous pregnancies:
Operational Definition: The total count of pregnancies a woman has experienced, regardless of their outcome, self-report (Alzboon & Vural, 2019).

Number of previous children:
Operational Definition: The total number of living children born to a woman, self- report (Alzboon & Vural, 2019).

Place of residence:
Conceptual Definition: The geographical and living environment where the individual resides, such as urban, rural, or camp settings (Medical-dictionary.com).

Operational Definition: Self-reported and categorized as:
Urban (city).
Rural (village).
Refugee camp (Abujilban et al., 2021).

Living with the husband's family:
Operational Definition: A living arrangement where the woman resides with her husband's immediate or extended family members.
Self-report and categorized as:
Yes (living with the husband's family).
No (not living with the husband's family) (Abujilban et al., 2021).

Mother's age at marriage and duration of marriage:
Operational Definition:
mother's age at marriage refers to the age (in years) at which the woman entered her marriage, as self-reported in the questionnaire.

Duration of marriage refers to the total number of years the woman has been continuously married to her current husband at the time of data collection.

Maternal Outcomes
Conceptual Definition: Maternal and fetal outcomes refer to the health consequences and medical conditions affecting both the mother and fetus during pregnancy, labor, and the postpartum period. These outcomes can be influenced by various factors, including maternal health status, prenatal care, and external stressors such as domestic violence. Maternal outcomes

include complications during labor, psychological well-being, and overall postpartum recovery, while fetal outcomes include birth weight, gestational age at birth, and neonatal health status (WHO, 2019).

Operational Definition: maternal outcomes will be measured based on recorded labor complications (e.g., prolonged labor, need for medical interventions), psychological assessments (e.g., levels of anxiety, depression, and fear based on standardized scales), and cooperation with the medical team (evaluated through clinical observations and patient feedback).

Physical and Psychological Health:

Conceptual Definition: Refers to an individual's overall mental and physical well-being, including safety, emotional stability, and psychological resilience (Khan et al., 2023).

Operational Definition**:** Physical and psychological health are measured using questionnaires that assess complications such as anxiety, stress, or physical injuries during pregnancy and labor.

Questions used in the study (Physical health):

- Did you experience any of the following health complications during pregnancy? (Vaginal bleeding in early pregnancy, Vaginal infections, Premature rupture of membranes (PROM), Preterm labor, Placental abruption and Hyperemesis, or Other)

Example from a study: Kang-Yi et al. (2017) found that women with psychiatric disorders were more likely to have pregnancy complications including vaginal bleeding.

Another example: Harris (2021) included vaginal bleeding and severe nausea/vomiting among complications.

- What type of delivery did you have? (options: vaginal without tears, vaginal with tears, C-section, assisted)

Example: Lilliecreutz et al. (2016) studied stress during pregnancy and delivery type as an outcome.

Questions used in the study (Psychological health):

- Did you experience any of the following psychological symptoms during pregnancy? (… options: severe anxiety, depression, stress, PTSD)

Example: Dawes et al. (2022) found high anxiety among women at high risk of preterm birth.

Another example: Wadhwa et al. (2011) reviewed maternal stress and risk of adverse outcomes.

Psychological Health During Labor:

Conceptual Definition: The emotional and mental state of the mother during childbirth, including anxiety, fear, or depression (Khan et al., 2023).

Operational Definition: Measured using survey responses and categorized into calm, anxious, fearful, or depressed.

Using the following question
- How was your emotional state during labor? (calm/anxious/fearful/depressed/other)
Example: Martín-de-las-Heras et al. (2022) reported associations between psychological intimate partner violence and preterm birth, capturing anxiety/fear during labor.
- If you were experiencing anxiety or emotional distress, did it impact your ability to focus or to cooperate with the healthcare team? (yes/no)
Example: Najjarzadeh et al. (2021) measured perceived stress in women with threatened preterm labor and its effect on cooperation.
- How prepared were you to welcome your newborn? (… very well prepared / well / moderately / poorly / not at all)
Example: General literature on psychological health and readiness shows relationship between maternal mental state and preparedness. (systematic review) (Zare et al., 2022).
Did you breastfeed your baby directly after birth (within the first hour)? (yes/no)
Example: The review by Wadhwa et al. (2011) covers maternal mental health and early breastfeeding initiation as outcome.

Support During Pregnancy:
Conceptual Definition: Pregnancy support provides practical, emotional, physical, and informational assistance to pregnant women and their unborn child, reducing stress, ensuring access to resources, and promoting a happy pregnancy experience (Bohren et al., 2017).

Operational Definition**:** Support is measured by exploring the types of assistance women received during pregnancy and their perceived effectiveness (Zhang et al., 2024).

Fetal Outcomes:
Conceptual Definition: Maternal and fetal outcomes refer to the health consequences and medical conditions affecting both the mother and fetus during pregnancy, labor, and the postpartum period. These outcomes can be influenced by various factors, including maternal health status, prenatal care, and external stressors such as domestic violence. Maternal outcomes include complications during labor, psychological well-being, and overall postpartum recovery, while fetal outcomes include birth weight, gestational age at birth, and neonatal health status (WHO, 2019)

Fetal outcomes will be assessed using neonatal records, including (Low birth weight < 2500 g, Growth or developmental problems, Congenital anomalies, Physical injuries, Preterm birth, Stillbirth (fetal death before delivery), Neonatal death (death shortly after birth) and or Other. (Kwok et al., 2016)

Did your baby require special medical care after birth? (Yes, No)
If yes, what type of care did they receive?

(Special care nursery, Neonatal Intensive Care Unit, Specific medical treatments and or Other) (Ford-Gilboe et al., 2016b).

3.3 Study conceptual framework:

The following Figure (3.1) shows the Conceptual Frameworks Diagram.

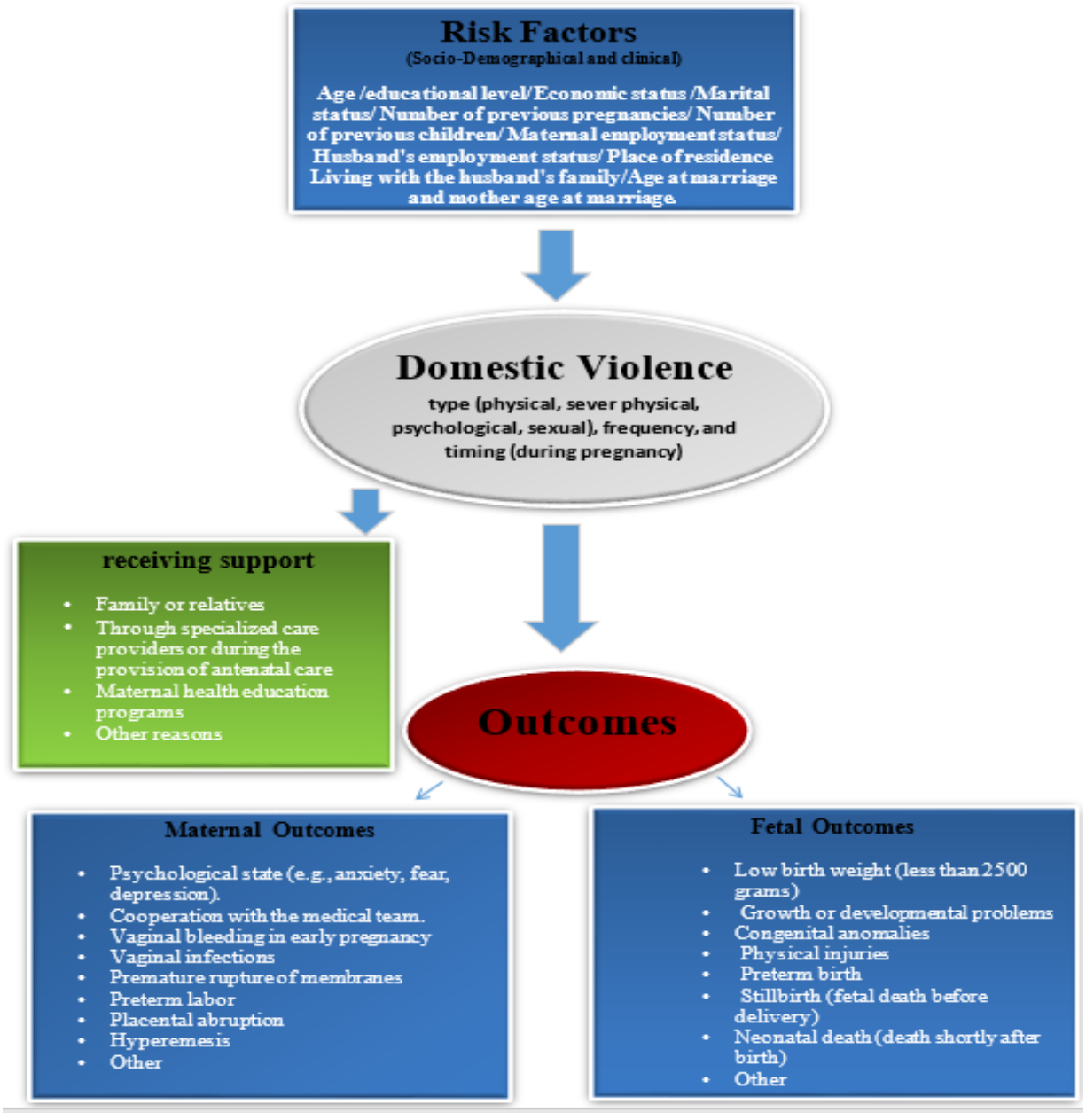

Figure (3.1): Conceptual Frameworks Diagram.

3.4 Independent and Dependent Study variables relationship:

3.4.1 Independent Variables

Domestic Violence Characteristics: Type (physical, psychological), frequency, timing (during pregnancy).
Socio-demographic and clinical Factors: Age, education, economic status, marital status, Number of previous pregnancies, number of previous children, maternal employment status, husband's employment status, Place of residence, living with the husband's family, age at marriage, mother's age at marriage.

These variables are critical as they directly relate to the study's hypothesis that domestic violence increases labor complications and adverse outcomes in maternity and fetal.

3.4.2 Dependent Variables

Receiving Support: Family or relatives, specialized care providers / antenatal care and maternal health education programs.
Maternal Outcomes: Prolonged labor, increased anxiety, reduced cooperation with medical staff, and emotional trauma during childbirth...

Fetal Outcomes: Preterm birth, low birth weight, and impaired mother-infant bonding...
These variables reflect the primary goal of the study, which is to evaluate the effects of domestic violence on the health of both the mother and the fetal, is reflected in these factors and assessment of the proportion of women exposed to violence who seek help and support, based on their surrounding circumstances.

3.5 Proposed Relationship:

The relationship between domestic violence and maternal and fetal outcomes is complex, influenced by various socio-demographic factors. Domestic violence during pregnancy can lead to significant maternal complications and adverse fetal outcomes, highlighting the need for effective interventions. The following sections outline the key aspects of this relationship.

Socio-Demographic Factors
Education Level: Higher maternal education correlates with lower instances of domestic violence, which in turn reduces complications during pregnancy (Ghotbizadeh et al., 2023).
Socio-Economic Status: Lower socio-economic status is associated with increased risk of domestic violence, leading to adverse maternal and fetal outcomes (Zaheen et al., 2020).

Age and Marital Duration: Younger age and shorter marriage duration are linked to higher rates of domestic violence (Zaheen et al., 2020).

Maternal Outcomes

Labor Complications: Domestic violence is significantly associated with preterm labor (34.2% incidence) and antepartum hemorrhage (Zaheen et al., 2020).

Psychological Conditions: Exposure to violence can lead to severe psychological distress, impacting maternal health (Jamali et al., 2019).

Fetal Outcomes

Premature Birth: Women experiencing domestic violence have a higher likelihood of preterm births and low birth weight infants (Lin et al., 2022).

Neonatal Health: Increased rates of neonatal complications, including NICU admissions, are observed in cases of domestic violence (Zaheen et al., 2020).

Mitigating Factors

Support and Interventions: Access to support systems and healthcare interventions can significantly mitigate the negative effects of domestic violence on maternal and fetal health (Ghotbizadeh et al., 2023) (Jamali et al., 2019).

Conversely, while domestic violence poses significant risks, some studies suggest that awareness and education can empower women, potentially reducing the prevalence of violence and its associated outcomes. This highlights the importance of community and healthcare interventions in addressing these issues.

Chapter Four

Research Methodology

4.1 Introduction:

This chapter aims to define and clarify the implemented methodology in this research. The researcher depends on several techniques to accomplish this study and achieve the stated goals. Ethical Consideration and permission, Study instrument, validity and reliability of Instrument Pilot study, Data collection, Data entry and analysis, and Summery.

4.2 Study Design:

This study used a quantitative, cross-sectional descriptive design to explore the risk factors of domestic violence among pregnant women and its effect on maternal and fetal outcomes in governmental and private hospitals and clinics located in the Bethlehem and Hebron areas.

This design allowed data collection at a single point in time, providing insights into the prevalence, associated risk factors, and potential effects of domestic violence on maternal and fetal outcomes. This design was chosen due to its cost-effectiveness and ability to explore multiple variables simultaneously, despite inherent limitations such as recall bias and the inability to establish causal relationships.

4.3 Study settings:

The study was conducted in the Bethlehem and Hebron governorates, located in the southern part of the West Bank, Palestine. These regions are home to diverse populations and provide significant representation of the target study group. The research focused on governmental and private hospitals and clinics within these areas, as well as women from Al-Rashayda village in Bethlehem governorate, as they serve as primary healthcare providers for a large segment of the population.
The selection of these hospitals and communities was based on accessibility, their role in serving a diverse patient population, and alignment with the study objectives.

The selected hospitals and clinics in **Hebron** included:

- Alia **Governmental** Hospital (Hebron Governmental Hospital)
- Hebron Health (Vaccination Clinics)
- AL Malaki **private** Hospital

In **Bethlehem**:

- Beit Jala **Governmental** Hospital (Al-Hussein Hospital)
- Bethlehem Health (Vaccination Clinics)
- Holy Family **private** Hospital
- Women from Al-Rashayda village

The decision to include these specific hospitals, clinics, and the Al-Rashayda village community ensured geographic representation and facilitated access to a varied patient population. Furthermore, these sites were chosen because they are key providers of maternal healthcare services and represent diverse socio-demographic groups, which aligned with the focus of the study on maternal and fetal outcomes.

It should also be emphasized that the consistency in healthcare practices and the relatively homogeneous socio-cultural environment within the Bethlehem and Hebron governorates were facilitating factors for the study design. These factors supported the feasibility of implementing research across the selected hospitals, clinics, and communities, ensuring comprehensive coverage of the study population.

The study was designed to provide accurate and representative findings regarding the risk factors of domestic violence among pregnant women and its effects on both maternal and fetal outcomes.

4.4 Study Population and sampling:

A convenience sampling technique was employed to recruit participants from clinics and hospitals.
The target population in this study included all women who were pregnant and gave birth (within 6 weeks) during the data collection period, which started on June 1, 2025, and ended on August 1, 2025. Data were collected from the selected hospitals and clinics in the postpartum departments, postnatal clinics, vaccination clinics, and Al-Rashayda clinic in the Hebron and Bethlehem governorates, West Bank, Palestine.

A total of 360 mothers participated in the study, distributed across the seven selected sites. These participants represented diverse backgrounds and healthcare settings, ensuring comprehensive coverage of the study population and enhancing the generalizability of the findings

Table 4.1 shows the distribution of the participating mothers across the study sites.

Table (4.1): Names of the selected study sites and the number of participating women in each location

No.	Study sites name	sites Type	No. participated
1	Hebron Hospital (Alia)	Governmental	60
2	Hebron Health Clinics	Governmental	60
3	AL-Malaki Hospital	Private	40
4	Beit Jala Hospital	Governmental	65
5	Bethlehem Health Clinics	Governmental	75
6	Holy Family Hospital	Private	40
7	Al-Rashayda village	Private	20
Total		**7**	**360**

Sample Size

Determining the appropriate sample size was essential to ensure the reliability and validity of the study results. For this cross-sectional study, the sample size was calculated using an online sample size calculator (Raosoft, 2012). The following parameters were considered in the calculation:
The sample size was calculated through the following formula for a proportion-based sample size calculation:

$$\mathbf{n} = \frac{z^2.p.(1-p)}{e^2}$$

Where:
n = required sample size
Z = Z-value (standard normal deviate for the desired confidence level, e.g., 1.96 for 95% confidence),
p = estimated proportion of the population with the characteristic of interest (use 0.5 for maximum variability)
e = margin of error (precision level, e.g., 0.05 for 5%).
Using: Z = 1.96 (95% confidence level), p = 0.5 (maximum variability) and e = 0.05 (5% margin of error).

The required sample size for a study with an unknown population, at a 95% confidence level and a 5% margin of error**.**

$$\mathbf{n} = \frac{(1.96)^2.0.5\ .(1-0.5)}{(0.05)^2} = 364.16$$

are approximately 360 participants**.**

However, a total of 360 women were included in the final analysis. Forty (40) questionnaires were excluded for the following reasons:

1. Some responses were clearly random or inconsistent, making them unsuitable for inclusion in the study.
2. Several participants did not complete the entire questionnaire or failed to answer key questions.
3. A few questionnaires contained unclear or contradictory statements, suggesting that participants were unable or unwilling to respond accurately.

These exclusions were necessary to maintain the validity and credibility of the study results**.**

Inclusion criteria:

The mother who delivered and the data was collected from them within six weeks postpartum included the following:

1. Women aged 18–49 years who were in the postpartum period (within six weeks after delivery).
2. Women who attended governmental and private hospitals and clinics in the Bethlehem and Hebron governorates for maternal healthcare during the study period.
3. Women who consented to participate in the study and provided information regarding their experience of domestic violence.
4. Women who were free from communication problems that could interfere with data collection.

Exclusion criteria:

The following pregnant women were excluded to avoid confounders and mediators that could affect the study results:

1. Women who were unable to provide informed consent.
2. Women under 18 years of age.
3. Women with mental developmental problems.
4. Women with verbal communication problems that affected the research process.

4.5 Instruments of the Study

A self-reported questionnaire was employed in this study. The questionnaire consisted of four sections and was developed after an extensive literature review and consultations with experts in the field. The content validity of the questionnaire was reviewed by Dr. Salam Al-Khatib, Dr. Farid Grayeb, Dr. Ibtisam Dweikat, Dr. Khaled Nahal, and Dr. Nawaf Amro, who are specialists in maternal and child health, community health, and social sciences.

The questionnaire included the following sections:

4.5.1 Section One: Sociodemographic and Economic Information

This section included questions related to the mother's and father's background, covering variables such as:
marital status, educational level of both mother and father, monthly household income, number and gender of children, maternal employment status and working hours, living arrangements (whether residing with the husband's family), place of residence, number of pregnancies and abortions, husband's age and employment status, duration of marriage, and the mother's age at marriage.

4.5.2 Section Two: Assessment of Domestic Violence

This section used a standardized domestic violence revised conflict tactics scale (Abolmaali et al., 2014) (Wikipedia contributors, 2025) to assess different forms of intimate partner violence (IPV), including psychological, physical, severe physical, and sexual violence. The frequency of exposure to these forms of violence during the current pregnancy was measured using a four-point Likert scale (Never, Sometimes, Often, Always).

4.5.3 Section Three: Receiving Support

This section included questions regarding the participant's experience in seeking support during exposure to domestic violence, reasons for not seeking help, and sources of received support, such as family members or professional health services, this part of the questionnaire was designed by me based on the results of previous studies.

4.5.4 Section Four: Maternal and Fetal Health Outcomes

This section assessed the outcomes related to both maternal and fetal health during pregnancy, labor, and the postpartum period. It focused on maternal complications such as vaginal bleeding, infections, preterm birth, psychological distress, type of delivery, and readiness for labor, as well as breastfeeding practices (particularly direct breastfeeding).

Additionally, it evaluated fetal health outcomes during pregnancy and after labor, including birth weight, congenital anomalies, preterm delivery, and neonatal intensive care unit (NICU) admission.

The questionnaire was designed by Abolmaali et al. (2014) for the current study entitled "Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal

Outcomes." It was developed based on a review of previous literature on domestic violence during pregnancy, including The Construction and Standardization of a Domestic Violence Questionnaire (Abolmaali et al., 2014), to ensure the inclusion of relevant and validated items.

The instrument was translated into Arabic with the assistance of language and field experts to maintain the accuracy and clarity of the questions. It was piloted on a small sample of 30 pregnant women to assess its clarity and feasibility before the final distribution. The total sample initially consisted of 360 women, of which 40 incomplete questionnaires were excluded, resulting in a final sample of 320 participants.

4.6 Validity of the Study questionnaire

Content validity was established to determine the extent to which the questionnaire accurately measured the concepts it was intended to assess (Elshair et al., 2012; Thatcher, 2010). It also ensured that the questionnaire provided comprehensive coverage of the research objectives (Saunders et al., 2009).

The items of the questionnaire were developed based on an extensive review of previous international studies related to domestic violence among pregnant women (Abolmaali et al., 2014), which confirmed the validity and reliability of similar research tools.

To ensure cultural and contextual suitability, the questionnaire was reviewed and adapted by the researcher and her supervisor after several meetings to verify the clarity, relevance, and appropriateness of each item within the Palestinian context.

Subsequently, the questionnaire was reviewed by five experts in the fields of maternal and child health. Their feedback was incorporated, and necessary modifications were made to improve the clarity, accuracy, and comprehensiveness of the tool. After applying all recommended changes and obtaining expert approval, the final version of the questionnaire was validated and deemed ready for data collection.

The final version of the study questionnaire is included in Appendix (A).

Pilot Study

A pilot study was conducted on a group of 30 pregnant women who met the inclusion criteria and were selected from Beit Jala Governmental Hospital and Bethlehem Health Clinics. The pilot study aimed to confirm the clarity, feasibility, and validity of the questionnaire before starting the main data collection process.

It helped the researcher to test the comprehensibility and wording of the questions, assess the time required to complete the questionnaire, and identify any ambiguity or misunderstanding in the items presented.

The participants' feedback confirmed that the questionnaire was clear and understandable. Only minor modifications were made to improve the wording of some questions based on the pilot results.

The average time needed to complete the questionnaire was approximately 10 minutes, and the tool was then approved for use in the main study.

4.7 Reliability of the study questionnaire:

The reliability of the questionnaire was tested to ensure the consistency and stability of the responses across all items. Reliability refers to the degree to which an instrument consistently measures what it is intended to measure when administered under similar conditions (Polit & Beck, 2017).

To assess the reliability, a pilot study was conducted on a small sample of 30 women who had been pregnant and gave birth during the study period who met the inclusion criteria but were not part of the main study sample. The purpose of the pilot testing was to evaluate the clarity, feasibility, and internal consistency of the questionnaire.

The data collected from the pilot test were analyzed using Cronbach's Alpha coefficient, which is a commonly used measure of internal consistency. A Cronbach's Alpha value of 0.87 was obtained, indicating a high level of reliability of the questionnaire.
The reliability of each domain of the questionnaire was assessed using Cronbach's Alpha coefficient as follows:

Table (4.2A): Cronbach's Alpha for each domain of the questionnaire.

No	Domain	No. of Items	Cronbach's Alpha
1	Psychological Violence	5	0.82
2	Physical Violence	5	0.81
3	Severe Physical Violence	4	0.82
4	Sexual Violence	3	0.84

Table (4.2B): Cronbach's Alpha for each domain of the questionnaire.

5	Receiving Support	2	0.80
6	Maternal and Fetal Health Outcome.	9	0.88
Total		**0.869**	

4.8 Ethical Considerations:

The study was conducted following ethical guidelines and received approval from Research Ethics Subcommittee of the Faculty of Health Professions, reference number: C. A copy of the ethical approval letter is included in Annex C (page 75). Ethical approval was obtained from the participating mothers (who were pregnant and gave birth during the study period) through informed consent forms.

4.9 Data Collection:

The main researcher visited the selected hospitals and postnatal clinics in Bethlehem and Hebron governorates to obtain permission from the administrators and head nurses to conduct the study. The purpose and objectives of the study were explained in detail before starting data collection. After receiving approval, the researcher approached eligible women who were pregnant and had given birth during the study period. Each participant was verbally invited to take part in the study, and informed consent was obtained before distributing the questionnaire.
The self-administered questionnaire was provided with a cover letter explaining the purpose of the study, the confidentiality of responses, and participants' right to withdraw at any time without consequences. The average time required to complete the questionnaire was approximately 10 minutes.

Data collection took place from June 1st, 2025, to August 1st, 2025. During this period, the researcher was available to answer participants' questions and ensure clarity of all items in the tool. After completion, the questionnaires were securely collected and kept confidential for analysis purposes only.

4.10 Data Analysis:

Data was analyzed using the Statistical Package for the Social Sciences (SPSS) version 27. Data was cleared and double checked for errors and outliers. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were computed to summarize the sociodemographic characteristics of participants and the study variables. Chi-square tests were

initially conducted to examine associations between categorical variables and exposure to violence.

Variables showing statistical significance were subsequently entered into a binary logistic regression model to identify independent predictors of exposure to violence. Binary logistic regression analysis was conducted to identify predictors of exposure to violence. All relevant assumptions were checked and met. Linearity of continuous variables with the logit of the dependent variable was confirmed, and multicollinearity assessment using the Variance Inflation Factor (VIF) showed all values below 2, indicating no concern. The data were suitable for binary logistic regression analysis.

4.11 Summary:

This chapter gives a summary of the methodology employed in this research, including details on the study design, the specific population targeted, and the data collection and analysis procedures carried out using SPSS version 27.

Chapter Five

Results

5.1 Introduction:

This chapter presents the findings of the study based on the analysis of the data collected. The results are organized according to the research objectives and questions outlined in Chapter One. Descriptive statistics are first provided to summarize the demographic characteristics of the study participants, followed by analyses addressing each of the main study variables. Inferential statistics are then presented to examine associations between variables.

5.2 Socio-demographic data among participants:

The participants had a mean age of 28.34 years (SD = 5.5), ranging from 18 to 43 years. Regarding education, nearly half had university education (152; 47.5%), followed by secondary education (120; 37.5%), while fewer had primary (27; 8.4%) or no formal education (21; 6.6%). In terms of monthly income, most reported earning less than 2500 NIS (136; 42.5%) or between 2500–5000 NIS (129; 40.3%), with smaller proportions earning 5000–7500 NIS (42; 13.1%) or more than 7500 NIS (13; 4.1%). Most participants had between 2–5 children (211; 65.9%), while (92; 28.7%) had one child and (17; 5.3%) had more than five. When asked about the sex of their children, (124; 38.8%) reported having both male and female, (102; 31.9%) had only male, and (94; 29.4%) only female. Most participants were not employed outside the home (219; 68.4%), while (101; 31.6%) reported working, mainly in the morning (55; 17.2%), with smaller proportions working shifts (37; 11.6%) or evenings (9; 2.8%). Concerning residence, almost half lived in villages (150; 46.9%), followed by cities (135; 42.2%), and (35; 10.9%) in refugee camps. As shown in Table 5.1.

Table 5.1 Socio-demographic data among participants (n=320)

Socio-demographic data		**N**	**%**
Age (Years)	Mean: 28.34, SD: 5.5, Min: 18, Max:43		
Educational Level	Illiterate	21	6.6%
	Primary Education	27	8.4%
	Secondary Education	120	37.5%
	University Education	152	47.5%
Monthly Income	< 2500 NIS	136	42.5%
	2500 – 5000 NIS	129	40.3%
	5000 – 7500 NIS	42	13.1%
	> 7500 NIS	13	4.1%
Current Number of Children	One	92	28.7%
	2-5	211	65.9%
	>5	17	5.3%
Are the children	Female	94	29.4%
	Male	102	31.9%
	Both male & female	124	38.8%
Do you work outside the home?	Yes	101	31.6%
	No	219	68.4%
If yes, what are your working hours	Morning	55	17.2%
	Evening	9	2.8%
	Shifts	37	11.6%
Place of Residence	City	135	42.2%
	Village	150	46.9%
	Refugee Camp	35	10.9%

5.3 Reproductive & Family-related Characteristics

The mean age of participants' husbands was 35.33 years (SD = 6.7), ranging from 22 to 62 years. Regarding education, nearly one-third had university education (96; 30.0%) or secondary education (95; 29.7%), while others had primary (63; 19.7%) or no formal education (66; 20.6%). Most husbands were employed (210; 65.6%), while (110; 34.4%) were not. Concerning living arrangements, (130; 40.6%) of participants lived with their husband's family, compared to (190; 59.4%) who did not. For number of pregnancies, the majority had between 1–3 (168; 52.5%), followed by 4–5 (81; 25.3%), 6–10 (38; 11.9%), and only the current pregnancy (33; 10.3%). Regarding miscarriages, most had none (200; 62.5%), while (110; 34.4%) reported 1–3, and few reported >3 (10; 3.1%). The mean duration of marriage was 7.25 years (SD = 5.0; range 1–22), and the mean age at marriage was 21.05 years (SD = 3.3; range 2–35). As seen in Table 5.2

Table 5.2 Reproductive & Family-related Characteristics (n=320)

Reproductive & Family-related Characteristics		**N**	**%**
Husband's Current Age	Mean: 35.33 SD: 6.7 Min: 22, Max:62		
Husband's Educational Level	Illiterate	66	20.6%
	Primary Education	63	19.7%
	Secondary Education	95	29.7%
	University Education	96	30.0%
Does your husband work?	Yes	210	65.6%
	No	110	34.4%
Do you live with your husband's family?	Yes	130	40.6%
	No	190	59.4%
Number of Pregnancies	Only the current pregnancy	33	10.3%
	1 – 3	168	52.5%
	4 – 5	81	25.3%
	6 – 10	38	11.9%
Number of Miscarriages	None	200	62.5%
	1 – 3	110	34.4%
	>3	10	3.1%
How long have you been married/together?	Mean: 7.25, SD: 5.0, Min:1, Max:22		
How old were you when you were married?	Mean: 21.05, SD: 3.3, Min: 15, Max:35		

5.4 The Prevalence of Domestic Violence Among Women

The bar chart illustrates the prevalence of women who reported exposure versus non-exposure to violence. As shown, the majority of women n=213, 66.6% were not exposed to violence, while n=107, 33.4% reported being exposed to violence. As seen in Figure 1.5.

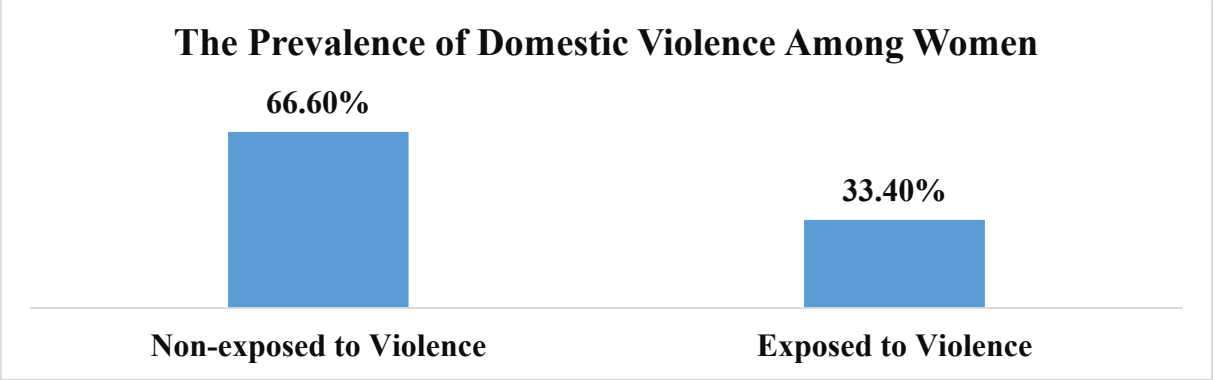

Figure 1.5 *The Prevalence of Domestic Violence Among Women (n=320). Cut-off point ≤1.50 =non-exposed to violence, >1.50= Exposed to violence (Min=1 and Max=4).*

5.5 Percentages Distribution Toward Domestic Violence Subdomains Among Women

The assessment revealed varying patterns of violence among participants. Overall, across all 17 items, the average prevalence showed that most participants never experienced violence (71.32%), while (17.91%) reported sometimes, (7.32%) often, and (3.47%) always, with an overall mean score of 1.42 (SD = 0.308). For psychological violence, the majority reported never experiencing it (60.76%), while (22.44%) reported sometimes, (11.38%) often, and (5.46%) always, with a mean score of 1.61 (SD = 0.477). Regarding physical violence, most participants reported never (72.50%), compared to (18.52%) sometimes, (6.32%) often, and (2.68%) always, with a mean of 1.39 (SD = 0.436). Severe physical violence was least reported, with the majority answering never (86.33%), while (9.30%) reported sometimes, (3.13%) often, and (1.28%) always; the mean score was 1.19 (SD = 0.297).
For sexual violence, two-thirds reported never (66.97%), while (20.83%) reported sometimes, (7.80%) often, and (4.40%) always, with a mean score of 1.49 (SD = 0.597). As shown in Table 5.3.

Table 5.3.A Domestic Violence Subdomains Assessment (n=320)

Item	Never	Sometimes	Often	Always	Mean	SD
Psychological Violence						
1. Has he told you that you are ugly or (not beautiful)?	67.5%	22.5%	6.3%	3.8%	1.46	0.775
2. Has your partner shown jealousy or expressed suspicion towards your friends?	59.70%	20.60%	13.10%	6.60%	1.67	0.939

Table 5.3.B Domestic Violence Subdomains Assessment (n=320)

3. **Item**	**Never**	**Sometimes**	**Often**	**Always**	**Mean**	**SD**
4. Has he rejected you or avoided you?	66.90%	19.70%	9.70%	3.80%	1.50	0.819
5. Has he insulted you verbally?	54.40%	24.40%	13.40%	7.80%	1.75	0.964
6. Has he disparaged you in front of others?	55.30%	25.00%	14.40%	5.30%	1.70	0.906
Average Psychological Violence (5 items)	*60.76%*	*22.44%*	*11.38%*	*5.46%*	*1.61*	*0.477*
Physical Violence						
1. Has he kicked you?	70.90%	19.40%	8.40%	1.20%	1.42	0.867
2. Has he pushed you intentionally?	73.80%	18.80%	5.90%	1.60%	1.35	0.665
3. Has he slapped your face or punched you?	69.10%	20.30%	6.60%	4.10%	1.46	0.791
4. Has he twisted your arm?	70.60%	19.70%	6.60%	3.10%	1.42	0.751
5. Has he jerked you violently?	78.10%	14.40%	4.10%	3.40%	1.33	0.714
Average Physical Violence (5 items)	***72.50%***	***18.52%***	***6.32%***	***2.68%***	***1.39***	***0.436***
Severe Physical Violence						
1. Has he burned you with a cigar or other substances?	86.30%	9.70%	2.80%	1.30%	1.19	0.535
2. Has he threatened you with a firearm or other?	87.80%	8.10%	2.50%	1.60%	1.18	0.539
3. Has he threatened you with a knife?	87.80%	8.10%	2.50%	1.60%	1.23	0.554
4. Has he tried to drown or suffocate you?	83.40%	11.30%	4.70%	0.60%	1.19	0.497
Average severs physical violence (4 items)	***86.33%***	***9.30%***	***3.13%***	***1.28%***	***1.19***	***0.297***
Sexual Violence						
1. Has he demanded you to have sex?	65.00%	20.30%	9.70%	5.00%	1.55	0.862
2. Has he used physical force to have sex?	70.30%	20.00%	5.90%	3.80%	1.43	0.769
3. Has he threatened to leave you or have relations with other women if you refuse sex?	65.60%	22.20%	7.80%	4.40%	1.51	0.819
Average sexual violence (3 items)	***66.97%***	***20.83%***	***7.80%***	***4.40%***	***1.49***	***0.597***
Average violence (17 items)	***71.32%***	***17.91%***	***7.32%***	***3.47%***	***1.42***	***0.308***

Higher mean score means higher violence, (Min=1, Max=4).

5.4 Receiving Support Among Women

Nearly half of the participants (47.2%) reported attempting to seek help during their experience of violence, while a slightly higher proportion (52.8%) did not seek any assistance. Among those who did not seek help, the main reasons were lack of knowledge about specialized services (13.1%), fear (10.9%), lack of support (9.1%), and other unspecified reasons (19.7%).
For those who sought help, the most common sources of support were family or relatives (16.3%), followed by specialized care providers or assistance during antenatal care (10.9%), maternal health education programs (9.7%), and other sources (10.3%).
Overall, the results indicate that more than half of the participants faced barriers to help-seeking, primarily due to fear, limited awareness of available services, and insufficient social support. As shown in Table 5.4.

Table 5.4 Receiving Support Outcomes *(n=320)*

Receiving Support		**N**	**%**
Did you attempt to seek help during exposure to violence?	Yes	151	47.2%
	No	169	52.8%
If no, what were the reasons?	Lack of support	29	9.1%
	Fear	35	10.9%
	Receiving Support	**N**	**%**
	Other reasons	63	19.7%
If yes, what was the source of help you received?	Family or relatives	52	16.3%
	Through specialized care providers or during the provision of antenatal care	35	10.9%
	Maternal health education programs	31	9.7%
	Other reasons	33	10.3%

5.7 Maternal and Fetal Outcomes Among Participants

During pregnancy, participants reported several health complications, including vaginal infections (166; 51.9%), hyperemesis (144; 45.0%), other complications (137; 42.8%), vaginal bleeding in early pregnancy (132; 41.3%), placental abruption (127; 39.7%), preterm labor (124; 38.8%), and premature rupture of membranes (96; 30.0%). Psychological symptoms were also common, with stress or nervousness reported by (191; 59.7%), severe anxiety (161; 50.3%), depression (131; 40.9%), and PTSD (113; 35.3%). Emotional states during labor varied, with participants reporting feeling fearful (172; 53.8%), anxious (147; 45.9%), calm (121; 37.8%), other feelings (116; 36.3%), and depressed (111; 34.7%). Nearly half indicated that anxiety or

emotional distress affected their ability to cooperate with the healthcare team (156; 48.8%), while slightly more than half said it did not (164; 51.2%). Regarding preparation for welcoming the newborn, some felt very well prepared (97; 30.3%) or well prepared (76; 23.8%), while others reported being moderately prepared (66; 20.6%), poorly prepared (43; 13.4%), or not prepared at all (38; 11.9%). Concerning delivery, (99; 30.9%) had vaginal delivery with perineal tear, (90; 28.1%) had a cesarean section, (73; 22.8%) delivered vaginally without perineal tear, and (58; 18.1%) had assisted vaginal delivery. More than half of the mothers breastfed their newborn within the first hour after birth (184; 57.5%), while (136; 42.5%) did not. As seen in Table 5.5.

Table 5.5.A *Maternal and Fetal Outcomes Among Women (n=320)*

Maternal and Fetal Outcomes		**n**	**%**
Did you experience any of the following health complications during pregnancy? *	Vaginal bleeding in early pregnancy	132	41.3%
	Vaginal infections	166	51.9%
	Premature rupture of membranes (PROM)	96	30.0%
	Preterm labor	124	38.8%
	Placental abruption	127	39.7%
	Hyperemesis (Severe nausea and vomiting)	144	45.0%
	Other	137	42.8%
Did you experience any of the following psychological symptoms during pregnancy? *	Severe anxiety	161	50.3%
	Depression	131	40.9%
	Stress or nervousness	191	59.7%
	Post-traumatic stress disorder (PTSD)	113	35.3%
How was your emotional state during labor? *	Calm	121	37.8%
	Anxious	147	45.9%
	Fearful	172	53.8%
	Depressed	111	34.7%
	Other feelings	116	36.3%
If you were experiencing anxiety or emotional distress, did it impact your ability to focus or to cooperate with the healthcare team?	Yes	156	48.8%
	No	164	51.2%

Table 5.5.B *Maternal and Fetal Outcomes among Women (n=320)*

Maternal and Fetal Outcomes		**n**	**%**
How prepared were you to welcome your newborn?	Very well prepared (I planned ahead and was fully ready)	97	30.3%
	Well prepared (I made some preparations but faced some difficulties)	76	23.8%
	Moderately prepared (I managed to prepare but encountered several challenges)	66	20.6%
	Poorly prepared (I was not ready due to stress and obstacles)	43	13.4%
	Not prepared at all	38	11.9%
What type of delivery did you have?	Vaginal delivery without perineal tear	73	22.8%
	Vaginal delivery with perineal tear	99	30.9%
	Cesarean section (C-section)	90	28.1%
	Assisted vaginal delivery using vacuum or forceps	58	18.1%
Did you breastfeed your baby directly after birth (within the first hour)?	Yes	184	57.5%
	No	136	42.5%

**Possible more than one answer*

5.8 Fetal Outcome Among Participants

Several adverse fetal outcomes were reported. Low birth weight was the most frequent (125; 39.1%), followed by other complications (130; 40.6%), preterm birth (114; 35.6%), physical injuries (113; 35.3%), neonatal death (111; 34.7%), growth or developmental problems (106; 33.1%), congenital anomalies (100; 31.3%), and stillbirth (100; 31.3%). Almost half of the newborns required special medical care after birth (148; 46.3%), while (172; 53.8%) did not.

Among those who required care, the most common types included admission to a special care nursery (129; 40.3%), neonatal intensive care unit (NICU) admission (113; 35.3%), and specific medical treatments (126; 39.4%). As shown in Table 5.6.

Table 5.6 Fetal Outcome *(n=320)*

Fetal Outcome		**n**	**%**
Was your fetus diagnosed with any of the following conditions during pregnancy or after birth? *	Low birth weight (less than 2500 grams)	125	39.1%
	Growth or developmental problems	106	33.1%
	Congenital anomalies	100	31.3%
	Physical injuries	113	35.3%
	Preterm birth	114	35.6%
	Neonatal death (death shortly after birth)	111	34.7%
	Other	130	40.6%
Did your baby require special medical care after birth?	Yes	148	46.3%
	No	172	53.8%
If yes, what type of care did they receive? *	Special care nursery	129	40.3%
	Neonatal Intensive Care Unit (NICU)	113	35.3%
	Specific medical treatments	126	39.4%

**Possible more than one answer*

5.9 Associated Factors Between Study Variables and Exposure to Violence

5.9.1 Demographic Characteristics

Table 5.7 presents the association between women's demographic characteristics and their exposure to violence. The results of the Chi-square tests revealed that educational level was significantly associated with exposure to violence, χ^2 (3, n = 320) = 16.06, p = <.001. Women with secondary education (49.5%) were more likely to report exposure compared with those holding university degrees (31.8%).

In contrast, age group, economic status, number of children, children's sex, employment outside the home, and place of residence were not significantly associated with violence exposure (all p > .05). Overall, only educational level demonstrated a significant relationship with exposure to violence among the studied participants.

Table 5.7 Association Between Demographic Characteristics of Women and Exposure to Violence *(n = 320)*

Variable	Categories	Non-exposed to Violence n (%)	Exposed to Violence n (%)	χ^2	p-value
Age group	21–30 years	142 (66.7)	69 (64.5)	0.151	.698
	> 30 years	71 (33.3)	38 (35.5)		
Educational level	Illiterate	12 (5.6)	9 (8.4)	**16.058**	**.001***
	Primary education	16 (7.5)	11 (10.3)		
	Secondary education	67 (31.5)	53 (49.5)		
	University education	118 (55.4)	34 (31.8)		
Economic status (monthly income)	< 2500 NIS	83 (39.0)	53 (49.5)	4.004	.261
	2500–5000 NIS	89 (41.8)	40 (37.4)		
	5000–7500 NIS	32 (15.0)	10 (9.3)		
	> 7500 NIS	9 (4.2)	4 (3.7)		
Number of children	One child	61 (28.6)	31 (29.0)	3.177	.204
	Two children	144 (67.6)	67 (62.6)		
	Three or more	8 (3.8)	9 (8.4)		
Children sex	Female	65 (30.5)	29 (27.1)	659	.719
	Male	65 (30.5)	37 (34.6)		
	Both Male and Female	(83 39.0)	41 (38.3)		
Work outside the home	Yes	62 (29.1)	39 (36.4)	1.777	.183
	No	151 (70.9)	68 (63.6)		
Place of residence	City	92 (43.2)	43 (40.2)	0.458	.795
	Village	97 (45.5)	53 (49.5)		
	Refugee camp	24 (11.3)	11 (10.3)		

**Sig value; χ^2: Chi square value*

5.9.2 Reproductive & Family-related Characteristics

Table 5.8 summarizes the association between reproductive and husband-related characteristics and women's exposure to violence. A significant association was found between husband's age and exposure to violence, χ^2 (2, n = 320) = 6.63, p = .036. Women whose husbands were older than 45 years reported higher exposure (27.1%) compared with those whose husbands were younger (13.1%).

No significant associations were found for husband's educational level, employment status, co-residence with the husband's family, number of pregnancies, number of miscarriages, marriage duration, or age at marriage (all $p > .05$). Overall, the husband's age was the only factor significantly related to women's exposure to violence.

Table 5.8 Association Between Reproductive and Husband-related Characteristics and Exposure to Violence *(n = 320)*

Variable	Categories	Non-exposed to Violence n (%)	Exposed to Violence n (%)	χ^2	p-value
Husband's age (years)	Younger group (17-30)	54 (25.5)	14 (13.1)	**6.631**	**.036***
	Middle age (31-45)	112 (52.8)	64 (59.8)		
	Older age (>45)	46 (21.7)	29 (27.1)		
Husband's educational level	Illiterate	48 (22.5)	18 (16.8)	5.265	.153
	Primary education	35 (16.4)	28 (26.2)		
	Secondary education	67 (31.5)	28 (26.2)		
	University education	63 (29.6)	33 (30.8)		
Husband's employment	Yes	140 (65.7)	70 (65.4)	0.003	.956
	No	73 (34.3)	37 (34.6)		
Living with husband's family	Yes	90 (42.3)	40 (37.4)	0.700	.403
	No	123 (57.7)	67 (62.6)		
Number of pregnancies	Only current	23 (10.8)	10 (9.3)	2.838	.417
	1–3 pregnancies	116 (54.5)	52 (48.6)		
	4–5 pregnancies	53 (24.9)	28 (26.2)		
	6–10 pregnancies	21 (9.9)	17 (15.9)		
Number of miscarriages	None	137 (64.3)	63 (58.9)	0.900	.343
	One or more	76 (35.7)	44 (41.1)		
Marriage duration	≤5 years	14 (6.7)	6 (5.6)	1.044	.593
	6–10 years	85 (40.5)	38 (35.5)		
	>10 years	111 (52.9)	63 (58.9)		
Age at marriage	≤20 years	97 (45.5)	48 (44.9)	0.013	.908
	>20 years	116 (54.5)	59 (55.1)		

**Sig value; χ^2: Chi square value*

5.9.3 Help-Seeking Behavior

Table 5.9 presents the association between help-seeking behavior and women's exposure to violence. The Chi-square analysis showed no statistically significant associations between exposure to violence and attempts to seek help, χ^2 (1, N = 320) = 0.13, p = .720. Overall, the

findings indicate that help-seeking patterns and sources of assistance did not differ significantly between women exposed and not exposed to violence.

Table 5.9. Association Between Help-Seeking Behavior and Exposure to Violence *(n = 320)*

Item		**Non-exposed to Violence n (%)**	**Exposed to Violence n (%)**	**χ^2**	**p-value**
Did you attempt to seek help during exposure to violence?	Yes	99 (46.5)	52 (48.6)	0.128	.720
	No	114 (53.5)	55 (51.4)		
If not, what were the reasons?	Lack of support	15 (13.2)	14 (25.5)	6.394	.094
	Fear	21 (18.4)	14 (25.5)		
	Lack of knowledge about specialized services	31 (27.2)	11 (20.0)		
	Other reasons	47 (41.2)	16 (29.1)		
If yes, what was the source of help you received?	Family or relatives	35 (35.4)	17 (32.7)	1.934	.586
	Through specialized care providers or during the provision of antenatal care	20 (20.2)	15 (28.8)		
	Maternal health education programs	20 (20.2)	11 (21.2)		
	Other reasons	24 (24.2)	9 (17.3)		

**Sig value; χ^2: Chi square value*

5.9.4 Pregnancy-Related Health Complications

Table 5.10 summarizes the association between pregnancy-related health complications and women's exposure to violence. The Chi-square analyses revealed a significant association between exposure to violence and PROM, χ^2 (1, n = 320) = 4.17, p = .041. Women who experienced violence were more likely to report PROM (37.4%) compared with those who were not exposed (26.3%).

However, no significant associations were found between exposure to violence and other pregnancy-related complications, including vaginal bleeding in early pregnancy, vaginal infections, preterm labor, placental abruption, hyperemesis, and other health complications (all p > .05). Overall, only PROM demonstrated a statistically significant relationship with exposure to violence among pregnant women in this study.

Table 5.10 Association Between Pregnancy-Related Health Complications and Exposure to Violence *(n = 320)*

Maternal outcome		**Non-exposed to Violence n (%)**	**Exposed to Violence n (%)**	**χ^2**	**p-value**
Vaginal bleeding in early pregnancy	Yes	86 (40.4)	46 (43.0)	0.201	.654
	No	127 (59.6)	61 (57.0)		
Vaginal infections	Yes	107 (50.2)	59 (55.1)	0.687	.407
	No	106 (49.8)	48 (44.9)		
Premature rupture of membranes (PROM)	Yes	56 (26.3)	40 (37.4)	4.173	**.041***
	No	157 (73.7)	67 (62.6)		
Preterm labor	Yes	79 (37.1)	45 (42.1)	0.740	.390
	No	134 (62.9)	62 (57.9)		
Placental abruption	Yes	80 (37.6)	47 (43.9)	1.206	.272
	No	133 (62.4)	60 (56.1)		
Hyperemesis (severe nausea & vomiting)	Yes	89 (41.8)	55 (51.4)	2.662	.103
	No	124 (58.2)	52 (48.6)		
Other health complications	Yes	84 (39.4)	53 (49.5)	2.965	.085
	No	129 (60.6)	54 (50.5)		

**Sig value; χ^2: Chi square value*

5.9.5 Psychological and Emotional Symptoms

Table 5.11 shows the association between psychological and emotional symptoms and women's exposure to violence. The analyses indicated that severe anxiety, stress or nervousness, and post-traumatic stress disorder (PTSD) were all significantly associated with exposure to violence. Women exposed to violence reported higher levels of severe anxiety (59.8%) than non-exposed women (45.5%), χ^2 (1, n = 320) = 5.80, p = .016. Similarly, stress or nervousness was more frequent among exposed women (67.3%) compared with non-exposed women (55.9%), χ^2 (1, n = 320) = 3.86, p = .049. The strongest association was observed for PTSD, reported by 48.6% of exposed women and 28.6% of non-exposed women, χ^2 (1, n = 320) = 12.42, p < .001.

In contrast, no significant associations were found between exposure to violence and other psychological or emotional indicators, including depression during pregnancy, and emotional states during labor such as calmness, anxiety, fear, depression, or other feelings (all p > .05). Overall, these results highlight that exposure to violence during pregnancy was significantly linked with higher levels of anxiety, stress, and PTSD symptoms among participants.

Table 5.11 *Asso*ciation Between Psychological and Emotional Symptoms and Exposure to Violence *(n = 320)*

Psychological and Emotional Symptoms			**Non-exposed to Violence n (%)**	**Exposed to Violence n (%)**	**χ^2**	**p-value**
Psychological symptoms during pregnancy?	Severe anxiety	Yes	97 (45.5)	64 (59.8)	5.804	**.016***
		No	116 (54.5)	43 (40.2)		
	Depression	Yes	84 (39.4)	47 (43.9)	0.593	.441
		No	129 (60.6)	60 (56.1)		
	Stress or nervousness	Yes	119 (55.9)	72 (67.3)	3.861	**.049***
		No	94 (44.1)	35 (32.7)		
	Post-traumatic stress disorder (PTSD)	Yes	61 (28.6)	52 (48.6)	12.421	**<.001***
		No	152 (71.4)	55 (51.4)		
Emotional state during labor	Calm	Yes	81 (38.0)	40 (37.4)	0.013	.911
		No	132 (62.0)	67 (62.6)		
	Anxious	Yes	101 (47.4)	46 (43.0)	0.562	.453
		No	112 (52.6)	61 (57.0)		
	Fearful	Yes	121 (56.8)	51 (47.7)	2.395	.122
		No	92 (43.2)	56 (52.3)		
	Depressed	Yes	75 (35.2)	36 (33.6)	0.077	.781
		No	138 (64.8)	71 (66.4)		
	Other feelings	Yes	75 (35.2)	41 (38.3)	0.297	.586
		No	138 (64.8)	66 (61.7)		

5.9.6 Labor, Delivery, and Postpartum Outcomes

Table 5.12 presents the association between labor, delivery, and postpartum outcomes and women's exposure to violence. The analyses revealed no statistically significant associations between exposure to violence and any of the examined outcomes (all $p > .05$). Overall, exposure to violence did not demonstrate a significant association with labor, delivery, or postpartum outcomes in this study.

Table 5.12 Association Between Labor, Delivery, and Postpartum Outcomes and Exposure to Violence *(n = 320)*

Maternal outcome		**Non-exposed to Violence n (%)**	**Exposed to Violence n (%)**	**χ^2**	**p-value**
Emotional distress impact on cooperation with healthcare team	Yes	102 (47.9)	54 (50.5)	0.190	.663
	No	111 (52.1)	53 (49.5)		
Type of delivery	Vaginal delivery without perineal tear	44 (20.7)	29 (27.1)	7.160	.067
	Vaginal delivery with perineal tear	76 (35.7)	23 (21.5)		
	Cesarean section (C-section)	55 (25.8)	35 (32.7)		
	Assisted vaginal delivery (vacuum/forceps)	38 (17.8)	20 (18.7)		
Breastfeeding within first hour after birth	Yes	117 (54.9)	67 (62.6)	1.722	.189
	No	96 (45.1)	40 (37.4)		

5.9.7 Fetal Outcome Among Participants

Table 5.13 presents the association between fetal outcomes and women's exposure to violence. The analyses revealed a significant association between exposure to violence and fetal growth or developmental problems, χ^2 (1, N = 320) = 4.52, p = .034. Women exposed to violence were less likely to report fetal growth or developmental problems (25.2%) compared with non-exposed women (37.1%).

However, no significant associations were found for congenital anomalies, physical injuries, preterm birth, neonatal death, other fetal or neonatal conditions, or the need for special medical care after birth (all p > .05). Overall, the findings indicate that exposure to violence during pregnancy was significantly related only to an increased likelihood of fetal growth or developmental problems.

Table 5.13 Association Between Fetal Outcomes and Exposure to Violence *(n = 320)*

Fetal Outcome Among Participants			**Non-exposed to Violence n (%)**	**Exposed to Violence n (%)**	**χ^2**	**p-value**
Fetus diagnosed during pregnancy or after birth	Low birth weight (<2500 g)	Yes	76 (35.7)	49 (45.8)	3.060	.080
		No	137 (64.3)	58 (54.2)		
	Growth or developmental problems	Yes	79 (37.1)	27 (25.2)	4.519	**.034***
		No	134 (62.9)	80 (74.8)		
	Congenital anomalies	Yes	65 (30.5)	35 (32.7)	0.160	.690
		No	148 (69.5)	72 (67.3)		
	Physical injuries	Yes	76 (35.7)	37 (34.6)	0.038	.846
		No	137 (64.3)	70 (65.4)		
	Preterm birth	Yes	74 (34.7)	40 (37.4)	0.217	.642
		No	139 (65.3)	67 (62.6)		
	Neonatal death (shortly after birth)	Yes	75 (35.2)	36 (33.6)	2.045	.360
		No	138 (64.8)	70 (65.4)		
		Missing / Other	0 (0.0)	1 (0.9)		
	Other fetal/neonatal conditions	Yes	86 (40.4)	44 (41.1)	0.016	.898
		No	127 (59.6)	63 (58.9)		
Baby requires special medical care after birth		Yes	95 (44.6)	53 (49.5)	0.697	.404
		No	118 (55.4)	54 (50.5)		

5.10 Factors Predicting Exposure to Violence

A binary logistic regression was performed to determine the factors associated with women's exposure to violence. The overall model was statistically significant, χ^2 (10) = 59.05, p < .001, indicating that the included predictors reliably differentiated between women who were and were not exposed to violence. The model explained approximately 23.4% of the variance in exposure status (R^2 = .234) and correctly classified 71.8% of cases.

Women with primary education (OR = 2.73, 95% CI [1.05, 7.08], p = .040) and secondary education (OR = 3.23, 95% CI [1.81, 5.77], p < .001) had significantly higher odds of experiencing violence compared with those holding a university education. Similarly, women whose husbands were middle-aged (30–45 years) (OR = 2.76, 95% CI [1.33, 5.72], p = .006) or older than 45 years (OR = 2.89, 95% CI [1.26, 6.64], p = .013) were more likely to be exposed to violence than those with younger husbands aged 17–30 years.

Regarding psychological factors, women reporting severe anxiety (OR = 1.78, 95% CI [1.06, 3.00], p = .029), stress or nervousness (OR = 1.96, 95% CI [1.14, 3.38], p = .016), and post-traumatic stress disorder (PTSD) (OR = 2.56, 95% CI [1.46, 4.47], p = .001) had significantly higher odds of being exposed to violence compared with those who did not report these symptoms. Conversely, women whose fetuses had growth, or developmental problems had significantly lower odds of violence exposure (OR = 0.34, 95% CI [0.19, 0.62], p < .001). Experiencing premature rupture of membranes (PROM) was not significantly associated with exposure (p = .231).

In summary, lower educational attainment, older husband's age, and the presence of psychological distress (anxiety, stress, and PTSD) were significant predictors of violence exposure. As seen in Table 5.14

Table 5.14 Binary Logistic Regression Predicting Exposure to Violence *(n = 320)*

Predictor Variable	B	S.E.	Wald	Exp(B) (OR)	95% CI for OR	p-value
Educational level (Ref. University education)						
Illiterate	1.020	.545	3.504	2.772	0.953–8.063	.061
Primary education	1.003	.487	4.238	2.725	1.049–7.078	**.040***
Secondary education	1.173	.295	15.786	3.232	1.812–5.765	**<.001***
Husband's age category (Ref. Early adult (17-30 years))						
Middle age (30-45 years)	1.016	.371	7.483	2.762	1.334–5.720	**.006***
Older age (>45 years)	1.061	.425	6.237	2.888	1.256–6.641	**.013***
PROM (Ref. No)	.347	.289	1.434	1.414	0.802–2.494	.231
Severe anxiety (Ref. No)	.578	.265	4.742	1.782	1.059–2.997	**.029***
Stress/nervousness (Ref. No)	.672	.278	5.833	1.958	1.135–3.376	**.016***
PTSD (Ref. No)	.939	.285	10.835	2.557	1.462–4.471	**.001***
Fetal growth problems (Ref. No)	–1.072	.305	12.353	0.342	0.188–0.622	**<.001***

Note. OR = Odds Ratio; CI = Confidence Interval. Model χ^2 (10) = 59.05, p < .001; R^2 = .23.
**Sig at p= ≤0.05*

Summary

The findings indicated that although most women did not experience domestic violence, a significant percentage did report experiencing some form of it, primarily psychological, followed by sexual and physical violence, with severe physical abuse being the least common. According to regression analysis, women who had less education and those whose husbands were older were more likely to experience violence. While fetal developmental issues seemed to lower the risk, psychological factors like anxiety, stress, and post-traumatic stress disorder were also associated with increased exposure. In conclusion, women's psychological distress, older husbands, and lower levels of education were the main predictors of domestic violence.

Chapter Six

Discussion

6.1 introduction

This chapter presents an interpretation and critical analysis of the study's findings in relation to the existing body of literature. It aims to explain the meaning and implications of the results rather than simply restating them. The discussion highlights how the findings address the research objectives and questions, comparing them with previous studies to determine areas of agreement or contradiction.

6.2 Domestic Violence Among Women

The proportion of women in our sample of 320 mothers who reported experiencing violence (33.4%) is considerable and significant from both health and social standpoints. This estimate, derived from meta-analysis, indicates that the prevalence of violence during pregnancy is approximately 34%, aligning with figures reported in the pertinent literature (Ma & Zhang, 2025).

More broadly, thousands of international studies and reports show that about one-third of women will experience some kind of sexual or intimate violence at some point in their lives. So, the 33.4% number fits with this worrying global trend and shows that violence against women is a big problem all over the world. This supports several conclusions: that violence is not an exception in our society, and that early detection and social health interventions are essential (WHO, 2024).

Research conducted in the region and adjacent countries has revealed discrepancies, yet the majority suggest elevated or comparable rates. For instance, Palestinian studies and research institutions in Gaza and the West Bank have documented disparate rates of violence against women, with certain samples indicating comparable or marginally reduced rates, illustrating the impact of local social, political, and economic conditions on the incidence of violence. Certain

regional studies have noted elevated levels of violence in the Eastern Mediterranean compared to other areas (Farahani et al., 2019b).

Regarding the subtypes of violence, the results showed that psychological violence was the most common among participants (approximately 39.24% had experienced at least one), followed by sexual violence at 33.03%, then physical violence in general at 27.50%, while severe physical violence was the least prevalent at 13.67%. These findings are consistent with studies conducted in other Arab countries, which have shown that psychological violence is the most common form of violence among women compared to physical or sexual violence. For example, a comprehensive study covering North Africa and the Middle East found that psychological/emotional violence often outweighs other forms of violence (Kisa et al., 2021). also, these findings are consistent with the Palestinian Violence Survey (2019), which also reported psychological violence as the most prevalent form among Palestinian women, followed by physical and then sexual violence.

This is often attributed to cultural and social factors that make psychological abuse more acceptable or harder to recognize and report compared to other forms of violence, such as social norms, the normalization of male dominance, fear of social stigma and shame, and a lack of awareness that psychological violence is a form of violence.

When compared with Arab and Asian countries, a study conducted in Egypt during the COVID-19 pandemic (2022) reported an overall prevalence of about 31%, which is relatively close to our findings. Emotional violence was the most common (43.5%), followed by physical violence (38.9%), while sexual violence was less common (17.5%). In contrast, a large national survey in India (NFHS-5, 2024) reported a lower overall prevalence (26.2%); however, among abused women, physical violence was the most dominant form (60%), whereas sexual violence was reported by only 2.1%. These differences reflect cultural and social variations in the definition of violence and in women's willingness to disclose their experiences.

In India, in many regions, marital sex is not considered refuseable because it is culturally viewed as a husband's right, also in some rural areas of India, physical abuse is seen as a socially acceptable form of discipline. Women, and even men, do not perceive it as real violence but rather as normal family behavior. Therefore, women in traditional societies are more afraid to speak about sexual abuse than physical abuse due to shame or fear of blame from family and society. Consequently, physical violence is more easily reported than sexual violence.

At the global level, a Lancet study (2018) reported that about 27% of women aged 15–49 years had experienced physical or sexual violence from an intimate partner at least once in their lifetime, which is comparable to our local findings. On the other hand, the rates were lower in some Western countries. For example, a study in England (2025) showed that 7.2% of women reported any form of intimate partner violence during the past year, while data from New York

(2018) indicated that about 12.4% of women had experienced physical violence from an intimate partner at least once in their lifetime.

It is clear that the prevalence of domestic violence varies significantly across different cultural and social contexts. While the Palestinian situation resembles that of some Arab countries such as Egypt, sexual violence appears to be relatively higher in our study compared with India and Western countries. This may point to particularities in the local context, including the nature of family relationships, social challenges, the level of disclosure regarding such sensitive issues, and community perceptions of violence.

6.3 Receiving Support Among Participants

In this study, a significant proportion of participants who experienced domestic violence did not seek help. The reasons were distributed as follows: lack of knowledge about specialized services (13.1%), fear (10.9%) and lack of support (9.1%). Additional barriers included fear for family members and concerns about social stigma.

On the other hand, among the participants who sought help, the most common source of support was family and relatives (16.3%), followed by healthcare providers during antenatal visits (10.9%), and health education programs for mothers (9.7%). Other sources included the internet, social media, religious leaders, and neighbors.

These findings are consistent with previous studies conducted in Palestine. For instance, a study on women in Nablus governorate highlighted that limited social support and lack of awareness of available services were among the main reasons for not seeking help (Ministry of Women's Affairs, 2019). Similarly, the report Spotlight: Support Services for Women Survivors of Violence in Palestine emphasized the role of family and relatives as the primary source of support for women survivors (UN Women & UNFPA, 2020).

In addition, the Response to Violence Against Women and Girls in the State of Palestine report analyzed gaps in the national system and found that reliance on informal sources of support, such as family, remains prevalent due to limited access to specialized services. The report further emphasized that organizations both governmental and non-governmental have the potential to play a crucial role in providing protection, psychological support, legal aid, and empowerment programs for abused women. However, their impact remains limited due to insufficient resources, weak intersectoral coordination, cultural barriers, and inadequate enforcement of protection policies (Ministry of Women's Affairs, 2021). Another study on The Role of Safe Houses in Supporting Abused Women in Palestine further confirmed that many women tend to approach family members first before seeking institutional assistance (AJSP Journal, 2018).

Our findings therefore align with the broader literature, which indicates that family support is the most common, yet not always sufficient.

We must also consider the woman's fear of societal judgment, where she is often perceived as weak and where it is believed that a man has the right to control her.

6.4 Associated Factors Between Study Variables and Exposure to Violence

6.4.1 Demographic Characteristics

The study results showed that educational level was the only demographic factor with a statistically significant association to exposure to domestic violence. Women with a secondary education (49.5%) were found to be more likely to experience violence than women with a university degree (31.8%), suggesting that higher education levels may act as a protective factor against violence. This aligns with the findings of numerous studies conducted in Arab and other developing countries, such as Al-Modallal et al. (2023) in Jordan, which found that women with university education were less likely to experience physical and psychological violence than those with lower levels of education. Similarly, Abujilban et al. (2019) indicated that increased awareness of women's rights and improved decision-making abilities reduce their likelihood of experiencing violence from their partners.

Also, a recent study from Sri Lanka (2024) demonstrated that higher education and social empowerment had a protective effect against intimate partner violence,
On the other hand, the results did not show a significant relationship between exposure to violence and age, economic status, number of children, gender of children, work outside the home, or place of residence, which is consistent with the study by Kishor & Gupta (2022) within the Demographic and Health Survey of India (NFHS-5), which showed that socioeconomic factors were not always consistent indicators of violence, as they can interfere with cultural norms and societal expectations about the role of women within the family.

Similar results were reported in Palestine during the COVID-19 pandemic, where these variables did not show a consistent association with violence exposure (Mahamid & Veronese, 2022). Supporting evidence also comes from a study conducted in Jordan, Economic Abuse of Women in Amman, Jordan (2020), which found no clear relationship between the husband's income, children's sex composition, or couples' age and the levels of economic violence, emphasizing that these factors are not always strong predictors of violence in certain socio-cultural contexts. This aligns with feminist theories that view domestic violence as a universal phenomenon rooted in gender inequality and patriarchal power structures, where all women regardless of their socioeconomic status or cultural background remain vulnerable to various forms of abuse (Beasley, 1999).

The weak correlation between these factors and violence in the study population can be explained by the fact that domestic violence in the studied area (Bethlehem and Hebron) may be more closely linked to cultural values and patriarchal beliefs that still grant men social authority over women, regardless of their age or economic status. Furthermore, social stigma and fear of family disintegration may prevent educated or working women from disclosing the violence they experience, thus reducing the apparent differences between various social groups.

6.4.2 Reproductive & Family-related Characteristics

The study results showed a statistically significant relationship between the husband's age and women's exposure to domestic violence. The rate of exposure was higher among women whose husbands were over 45 years old (27.1%) compared to those whose husbands were younger (13.1%). This finding can be explained by the fact that older husbands are often associated with more traditional thinking patterns and authoritarian notions about gender roles, which increases the likelihood of using violence as a means of control or enforcing obedience within the family (Azm et al., 2024). This result may also reflect a communication gap between spouses in relationships where the husband is older, leading to tensions and conflicts that sometimes translate into aggressive or controlling behavior towards the wife.

This finding is consistent with the findings of Hassan et al. (2022) in Egypt, which indicated that older husbands were more likely to use psychological and physical violence than younger husbands, due to their adherence to social beliefs that justify "disciplining" or controlling the wife. As demonstrated by Mahmoud & Kamel's (2021) study in Jordan, an older husband is often associated with weaker emotional communication skills and a higher likelihood of resorting to violence in managing marital conflicts.

In contrast, the current study did not show any significant relationship between violence and the education level, employment status, cohabitation with the husband's family, number of pregnancies or abortions, length of marriage, or the wife's age at marriage. The absence of such relationships can be explained by the fact that domestic violence is a complex, multifactorial phenomenon that is not solely dependent on demographic or economic variables but is also influenced by deeper factors such as patriarchal culture, power dynamics within the family, and socialization. In some environments, women may experience violence regardless of the husband's educational or economic status due to the persistence of the view that the man is the "decision-maker" in the marital relationship (Mutanawwi'a, 2006).

Furthermore, the lack of a relationship between living with the husband's family and violence may indicate that the primary source of violence is the marital relationship itself, and not necessarily the extended family, which aligns with the findings of Al-Modallal et al. (2020) In the West Bank, a study found that most cases of violence against women were perpetrated directly by husbands, not other family members.

Overall, these findings confirm that the husband's age can be an important indicator in understanding the dynamics of domestic violence, and that prevention programs should focus not only on empowering women but also on educating older men and modifying traditional notions of power and marital relationships through awareness programs and family interventions aimed at promoting communication and mutual respect within the family.

6.4.3 Pregnancy-Related Health Complications

Our studies results showed that exposure to violence was statistically significantly associated only with PROM (Premature Rupture of Membranes), with 37.4% of women who experienced violence reporting PROM compared to 26.3% of non-violent women. This finding can be explained by several potential biological and psychological mechanisms:
Psychological and physical violence generates psychological and hormonal stress in women, increasing cortisol and adrenaline levels, which may weaken the membranes surrounding the fetus and lead to premature rupture (La O et al., 2022).
Physical violence, including abdominal blows or trauma, increases the risk of prenatal rupture (Abdollahi et al., 2015).

Women who experience violence may have poor dietary habits, lack of medical follow-up, or engage in smoking/risky behaviors, all of which increase their risk of PROM (Steele-Baser et al., 2024).
We can say psychological violence is the highest and usually the effect of physical violence on women health is more.

Conversely, the study did not show any statistically significant relationship between exposure to violence and other complications such as early vaginal bleeding, vaginal infections, preterm birth, placental abruption, excessive vomiting, or other health problems. This aligns with some studies suggesting that the effects of violence on pregnancy may be specific to certain complications and depend on the type and severity of the violence, as well as the level of psychological and social support available to the woman.

These findings are partially consistent with global studies, such as Silverman et al. (2006) in the United States, which demonstrated that domestic violence increases the risk of PROM and preterm birth, while not always being associated with other complications. In the Arab context, Nasrullah et al. (2014) in Pakistan indicated that psychological and physical violence during pregnancy is associated with an increased incidence of PROM, but the relationships with preterm birth or bleeding were not always statistically significant.

In contrast, a Spanish study conducted in Andalusia with a larger sample size (779 women) found a significant relationship between violence during pregnancy and certain complications,

particularly psychological violence, which was associated with genitourinary infections and, in some cases, preterm birth. This difference can be explained by our smaller sample size (320) and by social and economic contextual differences. In Spain, broader healthcare and social services and greater support were available, whereas in our community access to care and reporting of violence may be more limited.

The Jordanian study (Abujilban et al., 2022) similarly found no significant association between violence and certain outcomes such as preterm birth and miscarriage, though it did report associations with other variables, including elevated blood pressure and cesarean delivery. These results are consistent with ours and suggest that the relationship between violence and pregnancy outcomes is complex and influenced by multiple mediating factors.

6.4.4 Psychological and Emotional Symptoms

The study results showed that exposure to violence during pregnancy was statistically significantly associated with increased levels of severe anxiety, stress or nervousness, and post-traumatic stress disorder (PTSD) among women. Specifically, 59.8% of abused women reported severe anxiety compared to 45.5% of non-abused women. Stress or nervousness was also more prevalent among abused women (67.3%) compared to non-abused women (55.9%), while the strongest association was with PTSD, reported by 48.6% of abused women compared to 28.6% of non-abused women.

Exposure to violence creates a persistent feeling of threat and fear, leading to elevated levels of anxiety and nervousness, negatively impacting women's overall mental health, and causing chronic psychological stress (Alhusen et al., 2015). Repeated violence creates an environment conducive to the development of post-traumatic stress disorder (PTSD), where women experience recurring traumatic memories, nightmares, or physical symptoms related to the experience, exacerbating ongoing psychological trauma and stress (Pill, 2017).
Chronic anxiety and stress during pregnancy can lead to hormonal changes that affect a woman's mental and physical health and may increase the risk of premature birth or pregnancy complications (Agarwal, 2023).

This study, conducted in the United States in 2019 by Pill et al., involved 159 pregnant women and aimed to examine the impact of psychological and physical violence on mental health during pregnancy, such as anxiety, stress, and PTSD. It found that women who had experienced violence exhibited higher levels of anxiety, stress, and PTSD compared to those who had not experienced violence.

Conversely, the study did not show a significant relationship between exposure to violence and other psychological and emotional indicators such as depression during pregnancy or emotional states during labor. This aligns with some studies indicating that psychological symptoms vary

depending on the type and severity of violence, as well as the level of social and psychological support available to the woman.

Studies that align with our findings support this observation. For example, Smith et al., 2020 in Canada also found no significant association between violence and maternal complications or psychological symptoms. The study attributed this to factors such as strong social support and effective psychological support programs, which reduced the impact of violence on health outcomes.

6.4.5 Labor, Delivery, and Postpartum Outcomes

The study results showed that exposure to violence was not statistically significantly associated with any of the outcomes of labor, delivery, or the postpartum period. In other words, women who experienced violence did not differ from non-violent women in terms of birth complications or maternal health outcomes after childbirth.

This finding can be explained by several possible factors. Medical intervention during labor and postpartum care may be sufficient to offset some of the negative effects of violence, especially if regular follow-up and comprehensive healthcare are provided. The type and severity of violence may also play a role; as psychological or mild violence alone may not have a direct impact on the physical outcomes of labor or delivery.

These findings are partially consistent with some studies that found no direct association between exposure to violence and labor or delivery outcomes, but they differ from other studies indicating that severe or persistent physical violence during pregnancy may increase the risk of preterm birth, low birth weight, or postpartum complications (Alhusen et al., 2015).
Such a study, a contrasting study supporting a link between intimate partner violence and adverse birth outcomes, titled "Intimate partner violence among Egyptian pregnant women: incidence, risk factors, and adverse maternal and fetal outcomes" (Egypt), was conducted by researchers led by Amal E. El-Gibaly et al. and published around 2015. In this study, approximately 44.1% of pregnant women reported experiencing violence, and a significant association was found between exposure to violence and pregnancy complications such as preterm birth, rupture of membranes, low birth weight, and even fetal death.

The Jordanian study (Abujilban et al., 2022) similarly found no significant association between violence and certain outcomes such as preterm birth and miscarriage, though it did report associations with other variables, including elevated blood pressure and cesarean delivery. These results are consistent with ours and suggest that the relationship between violence and pregnancy outcomes is complex and influenced by multiple mediating factors also immediate breastfeeding practices were not significantly associated with violence.

6.4.6 Fetal Outcome Among Participants

According to the study's findings, there is a statistically significant link between fetal growth or development issues and exposure to violence during pregnancy. Compared to those who did not, women who had experienced violence were more likely to report issues with the growth or development of their fetus. Through intricate biological and psychological mechanisms, such as prolonged stress, hormone imbalances, and decreased placental blood flow (Alhusen et al., 2014), this research illustrates the possible effects of both physical and psychological violence on fetal health.

These findings are in line with a study by Silverman et al. (2006), which was carried out on a large sample of pregnant women in the United States. The study showed that exposure to physical or psychological violence was linked to a higher risk of low birth weight and fetal growth retardation because of elevated cortisol levels and their detrimental effects on fetal development. Pregnant women who experienced violence were 30% more likely to give birth to infants with intrauterine growth retardation or neurodevelopmental disability, according to research by Devries et al. (2011) that included 19 low- and middle-income nations.

In contrast, there was no discernible link between fetal developmental outcomes or birth abnormalities and violence during pregnancy, according to research by Yanikkerem et al. (2017) carried out in Turkey. Most reported violent incidents were probably psychological in character or intermittent, which reduced their direct physical effect on the fetus, the researchers said.

Cultural and societal variables, the intensity of violence, and the quality of care given to expectant mothers may all account for the differences across the studies. The detrimental biological consequences of abuse on the fetus may be lessened by family support and regular medical checkups. However, the results of this study and others like it highlight the fact that violence against pregnant women is a danger to the growth and development of the fetus, which calls for improved early diagnosis and psychosocial intervention in prenatal care programmes.

6.5 Factors Predicting Exposure to Violence

The logistic regression findings revealed several meaningful predictors related to violence exposure among pregnant women. Interestingly, a low level of education appeared to be one of the main contributing factors. Women who had completed only elementary or secondary schooling were found to be more vulnerable to abuse compared with those holding a university degree. This observation is in line with earlier research conducted in Egypt (Elghossain et al., 2021) and Jordan (Al-Natour et al., 2019), where inadequate education was linked to limited awareness of women’s rights, reduced financial independence, and a greater risk of remaining in abusive relationships. Similarly, a study from Ethiopia (Gebrezgi et al., 2017) reported that

women with lower educational levels were almost twice as likely to experience domestic violence.

Another important factor was the husband's age. Having a spouse aged over 30 appeared to increase the likelihood of violence. This could be related to unequal power dynamics, pressures tied to financial or social responsibilities, and traditional gender expectations that are often more pronounced in older age groups. A comparable pattern was noted by Khairuddin et al. (2020) in Malaysia, where older partners tended to show a stronger tendency toward intimate partner violence, possibly due to accumulated stress and rigid beliefs regarding gender roles.

Psychological factors also played a considerable role. Symptoms such as anxiety, stress, or post-traumatic stress disorder (PTSD) were found to be strongly associated with exposure to violence. These conditions may both contribute to and result from violent experiences, suggesting a two-way relationship. Evidence from Palestine (Hamdan & El-Sheikh, 2020) and Turkey (Yildiz et al., 2022) supports this finding, as both studies emphasized that pregnant women showing psychological distress faced higher risks of domestic abuse. This highlights the importance of integrating psychological assessment into routine prenatal care.

Interestingly, fetal growth or developmental complications showed what appeared to be a protective association against exposure to violence. One possible explanation is that families and healthcare providers might offer greater attention and care in such cases, reducing the chance of violence. Another possibility is that women experiencing violence may underreport fetal concerns. However, this outcome contrasts with studies such as Alhusen et al. (2015), which found that intimate partner violence was associated with adverse fetal outcomes, including growth restriction. Further research is clearly needed to explore this unexpected relationship.

Overall, the model underscores the importance of social, educational, and psychological factors in predicting women's vulnerability to domestic abuse during pregnancy. Efforts to strengthen women's empowerment, mental health support, and healthy partner dynamics could play a vital role in reducing such violence.

6.6 Conclusion

The research investigated domestic violence risks and effects on pregnant women throughout the West Bank territory with special focus on Hebron and Bethlehem governorates. The research results showed that domestic violence occurs frequently in the region where psychological abuse occurs most often followed by sexual and physical abuse. The research results demonstrate that violence against pregnant women continues to be a significant public health issue throughout Palestine.

The majority of survivors chose to avoid formal institutions for help because they turned to family members for support which resulted from cultural traditions and insufficient support from available institutions.

The research delivers its primary value by showing how Palestinian women experience domestic violence through the combination of cultural expectations and gendered power relations and social roles. The study demonstrates that education and financial stability do not guarantee protection from abuse because it reveals the necessity to tackle the fundamental patriarchal systems. The research demonstrates that institutional support remains insufficient, which requires government agencies and non-profit organizations to establish accessible confidential services that respect cultural backgrounds. The research provides essential information which helps develop maternal health programs and gender equality initiatives for Palestine.

7.6 Strengths of the study

1. The focus is on an important and sensitive segment of society: women who have become pregnant and given birth, thus integrating maternal and fetal health.
2. The diversity of factors studied allows for a more comprehensive view of the factors influencing domestic violence, rather than focusing on only one aspect in a limited way.
3. The results of our study will serve as recommendations to promote and empower women during the most important stage of life (pregnancy) and all other stages.

8.6 Limitations of the study

1. Relying solely on self-assessment questionnaires can lead to bias in responses or underreporting due to fear and sensitivity surrounding the topic of violence.
2. The sample is geographically limited, and this limits broader generalization.
3. Given the complex and multifactorial nature of domestic violence, It is likely that there were several factors that were not assessed in this study and may have affected the findings, such as the partner's substance use, mental health status, controlling behaviors, family support, cultural beliefs, economic stress, and women's previous exposure to violence.

9.6 Recommendations

9.6.1 recommendations for policy makers

1. The government needs to create countrywide awareness initiatives and premarital and antenatal education programs which teach about domestic violence origins and effects.

2. The government should create new specialized centers and expand existing shelters which offer protected spaces with cultural understanding and complete confidentiality to victims of domestic violence.
3. The community needs to understand domestic violence as a severe issue which affects women and their families and the entire society. Educational programs and media campaigns will help transform public opinions about domestic violence.
4. The government needs to improve preventive measures through better access to counseling and protection services and legal assistance for women who face domestic violence.

9.6.2 recommendations for professionals

Screening:

1. Integrate routine violence screening into prenatal visits using standardized and approved screening tools.
2. Ensure confidentiality during interviews and examinations, without the presence of a partner or any companion who might influence the woman's responses (e.g., fear).
3. Educate healthcare personnel to identify indirect indicators of violence, such as stress, recurrent bruising, or pregnancy complications.

Protection:

1. Provide individualized safety plans tailored to each woman's specific situation.
2. Accurately and legally document injuries and medical reports for use when needed.
3. Refer women directly to social, legal, and psychological support services through defined referral channel.
4. Organize regular training for professionals to improve their skills in handling cases of violence.

9.6.3 recommendations for women

- Use social media platforms like Facebook to raise women's awareness of their legal rights and how to seek assistance from relevant authorities.
- Provide community awareness programs about signs of violence and self-protection methods during pregnancy.
- Promote efforts that empower women economically through vocational training programs.
- Encourage women to discuss their safety concerns during prenatal visits with healthcare providers.
- Distribute information about the locations of shelters and specialized hotlines.

9.6.4 recommendations for future research

- Studying the ongoing effects of violence during pregnancy on the health of mothers and newborns.
- Studying the cultural and societal barriers that prevent women from reporting abuse or seeking help.
- Evaluating the effectiveness of standardized screening tools in Palestinian and Arab communities.
- Conducting research on culture-specific intervention programs and their effectiveness in reducing violence rates.
- Conducting longitudinal and mixed-species research to enhance understanding of the processes and variables that influence violence.
- Evaluating the impact of national reforms and policies on strengthening the protection of women, particularly during pregnancy.

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Appendix

A. Instruments used in the study

1. Questionnaire to identify Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes

Self-administration questionnaire

Dear Participants:

I am Shahd Issam Ashour, a student in the master's Program in Maternal and Child Health at Al-Quds University -Abu Dis-.

I am conducting a study titled **Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes**, as part of the requirements for obtaining my master's degree. Which aims to identify and analyze the risk factors of domestic violence among pregnant women and its effects on maternal and fetal outcomes in the Bethlehem and Hebron areas.

I kindly request your participation in filling out this questionnaire. Please be assured that all information collected will be treated with complete confidentiality, and your identity will not be disclosed.

Your participation in this study is entirely voluntary, and you have the right to refuse participation or withdraw at any time without affecting the health services you receive. The information you provide will be used solely for research purposes, and there are no direct risks associated with participating in this study.

By signing below, you confirm that you have read and understood all the information mentioned above and voluntarily agree to participate in this study.

Prepared by: Shahd Issam Ashour

Supervised by: Dr. Salam Al-Khatib

With sincere thanks and appreciation,

Signature: .....

Date: .....

Section One: (Socio-demographic data)

1. **Current Age:** ----------

2. **Marital Status:**

   o Married
   o single
   o Divorced
   o Widowed

3. **Your Educational Level:**
   o Illiterate
   o Primary Education
   o Secondary Education
   o University Education

4. **Economic Status (Monthly Income):**

   o Less than 2500 NIS
   o 2500 – 5000 NIS
   o 5000 – 7500 NIS
   o More than 7500 NIS

5. **Current Number of Children:** ----------
   Are the children:

   o Female
   o Male
   o Both Male and Female

6. **Do you work outside the home?**
   o Yes
   o No

If yes, what are your working hours:
o Morning
o Evening
o Shifts

7. Husband's Current Age: ----------

8. Husband's Educational Level:

o Illiterate
o Primary Education
o Secondary Education
o University Education

9. Does your husband work?

o Yes
o No

10. Do you live with your husband's family?

o Yes
o No

11. Place of Residence:

o City
o Village
o Refugee Camp

12. Number of Pregnancies:

o Only the current pregnancy
o 1 – 3
o 4 – 5
o 6 – 10

13. Number of Miscarriages:
o None
o 1 – 3
o 4 – 5
o 6 – 10

14. **How long have you been married/together? .....**

15**. How old were you when you were married? .....**

Section Two: (Domestic Violence Assessment)

Please answer the following questions by placing a mark (X) according to whether your husband has committed any of the following acts during the current pregnancy.

husband has committed any of the following acts during the current pregnancy.

Psychological Violence		**Never**	**Sometimes**	**Often**	**Always**
	1. Has he told you that you are ugly or (not beautiful)?				
	2. Has your partner shown jealousy or expressed suspicion towards your friends?				
	3. Has he rejected you or avoided you?				
	4. Has he insulted you verbally?				
	5. Has he disparaged you in front of others?				
Physical Violence	6. Has he kicked you?				

	7. Has he pushed you intentionally?				
	8. Has he slapped your face or punched you?				
	9. Has he twisted your arm?				
	10. Has he jerked you violently?				
Severe Physical Violence	11. Has he burned you with a cigar or other substances?				
	12. Has he threatened you with a firearm or other?				
	13. Has he threatened you with a knife?				
	14. Has he tried to drown or suffocate you?				
Sexual Violence	15. Has he demanded you to have sex?				
	16. Has he used physical force to have sex?				
	17. Has he threatened to leave you or have relations with other women if you refuse sex?				

Section Three: (Receiving Support)

1. Did you attempt to seek help during exposure to violence?

If not, what were the reasons?

- Lack of support
- Fear
- Lack of knowledge about specialized services
- Other reasons (please specify): _____

If yes, what was the source of help you received?

- Family or relatives
- Through specialized care providers or during the provision of antenatal care
- Maternal health education programs
- Other reasons (please specify): _____

Section Four: (Maternal and Fetal Outcomes)

<u>Maternal Outcomes</u>

1. **Did you experience any of the following health complications during pregnancy? (You can select more than one option)**

- Vaginal bleeding in early pregnancy
- Vaginal infections
- Premature rupture of membranes (PROM)
- Preterm labor
- Placental abruption
- Hyperemesis (Severe nausea and vomiting)
- Other (please specify): _____

2. **Did you experience any of the following psychological symptoms during pregnancy? (You can select more than one option)**

- Severe anxiety
- Depression
- Stress or nervousness
- Post-traumatic stress disorder (PTSD)

3. **How was your emotional state during labor? (You can select more than one option)**

    - Calm
    - Anxious
    - Fearful
    - Depressed
    - Other feelings (please specify): _____

4. **If you were experiencing anxiety or emotional distress, did it impact your ability to focus or to cooperate with the healthcare team?**

    - Yes
    - No

5. **How prepared were you to welcome your newborn?**

    - Very well prepared (I planned and was fully ready)
    - Well prepared (I made some preparations but faced some difficulties)
    - Moderately prepared (I managed to prepare but encountered several challenges)
    - Poorly prepared (I was not ready due to stress and obstacles)
    - Not prepared at all

6. **What type of delivery did you have?**

    - **V**aginal delivery without perineal tears
    - Vaginal delivery with perineal tears
    - Cesarean section (C-section)
    - Assisted with vaginal delivery using vacuum or forceps

7. **Did you breastfeed your baby directly after birth (within the first hour)?**

    - Yes
    - No

Fetal Outcomes

8. **Was your fetus diagnosed with any of the following conditions during pregnancy or after birth? (You can select more than one option)**

    - Low birth weight (less than 2500 grams)
    - Growth or developmental problems
    - Congenital anomalies
    - Physical injuries
    - Preterm birth

- Neonatal death (death shortly after birth)
- Other (please specify): _____

9. Did your baby require special medical care after birth?

- Yes
- No

If yes, what type of care did they receive? (You can select more than one option)

- Special care nursery
- Neonatal Intensive Care Unit (NICU)
- Specific medical treatments (please specify): _____

نموذج موافقة

عوامل الخطر للعنف الأسري بين النساء الحوامل وأثرها على نتائج الأم والجنين في بيت لحم والخليل.

اسم الباحث: شهد عاشور

اسم المشرف: د. سلام الخطيب

حضرة السيدة المحترمة،

أنا الطالبة شهد عصام عاشور، طالبة في برنامج ماجستير صحة الأم والطفل في جامعة القدس – أبو ديس.

أقوم بإجراء دراسة بعنوان: عوامل الخطر للعنف الأسري بين النساء الحوامل وأثرها على نتائج الأم والجنين، وذلك كجزء من متطلبات الحصول على درجة الماجستير. والتي تهدف إلى تحديد وتحليل عوامل الخطورة للعنف الأسري بين النساء الحوامل وأثره على نتائج الأم والجنين في منطقتي بيت لحم والخليل.

أطلب من حضرتك التكرم بالمشاركة في تعبئة هذا الاستبيان، مع العلم أن جميع المعلومات التي يتم جمعها ستكون سرية تمامًا ولن يتم الكشف عن هويتك.

إن مشاركتك في هذه الدراسة طوعية بالكامل، ويمكنك رفض المشاركة أو الانسحاب في أي وقت دون أن يؤثر ذلك على أي من الخدمات الصحية التي تتلقينها. سيتم استخدام المعلومات التي تقدمينها لأغراض البحث العلمي فقط، ولن تكون هناك أي مخاطر مباشرة مرتبطة بالمشاركة في هذه الدراسة.

من خلال توقيعك أدناه، فإنك تؤكدين أنك قرأتِ جميع المعلومات المذكورة أعلاه، وفهمتها بشكل واضح، وأنك توافقين طوعياً على المشاركة في هذه الدراسة.

مع خالص الشكر والاحترام،

التوقيع.....

التاريخ.....

القسم الأول (المعلومات الاجتماعية، الاقتصادية، والديموغرافية):

1. **العمر الحالي: ----------**

2. **الحالة الاجتماعية:**

   - متزوجة
   - منفصلة
   - مطلقة
   - أرملة

3. **المستوى التعليمي لديك:**

   - اعدادي
   - اعدادي فما اقل
   - تعليم ثانوي
   - تعليم جامعي

4. **المستوى الاقتصادي (الدخل الشهري):**

   - اقل من 2500 شيكل
   - 2500 – 5000 شيكل
   - 5000-7500 شيكل
   - أكثر من 7500 شيكل

5. **عدد الأبناء الحالي: ----------**
   هل الأبناء هم؟

   - اناث
   - ذكور
   - ذكور واناث

6. **هل تعملين خارج المنزل؟**

   - نعم
   - لا

إذا كانت الإجابة نعم. ما هي ساعات العمل:

- صباحا
- مساءا
- ورديات

7. هل تسكنين مع عائلة زوجك؟

- نعم
- لا

8. مكان الإقامة:

- مدينة
- قرية
- مخيم

9. عدد مرات الحمل:

- فقط الحمل الحالي
- 1 - 3
- 4 - 5
- 6 - 10

10. عدد مرات الإجهاض:

- لا يوجد
- 1 – 3
- 4 – 5
- 6 – 10

11. عمر الزوج الحالي: ----------

12. المستوى التعليمي لدى الزوج:

- اعدادي
- اعدادي فما اقل
- تعليم ثانوي
- تعليم جامعي

13. هل يعمل الزوج؟

- نعم
- لا

14. منذ متى وأنتما متزوجان/معًا؟ .....

15. كم كان عمرك عندما تزوجت؟ .....

القسم الثاني (تقييم العنف المنزلي):

يرجى الإجابة على الأسئلة التالية بوضع إشارة (X) وفقًا لما إذا كان زوجك قد قام بأي من الأفعال التالية خلال فترة الحمل الحالية.

العنف النفسي: -		أبدًا	أحيانًا	كثيرًا	دائمًا
	1. هل أخبرك أنك قبيحة (لست جميلة)؟				
	2 . هل أصبح غيورًا أو شك في أصدقائك؟				
	3. هل قام بالابتعاد عنك أو تجنبك؟				
	4. هل أهانك لفظيًا؟				
	5. هل قلل من شأنك أمام الآخرين؟				
العنف الجسدي: -					
	6. هل قام بركلك؟				
	7. هل قام بدفعك عمدًا؟				
	8. هل صفعك على وجهك أو لكمك؟				
	9. هل قام بلوى ذراعك؟				
	10. هل قام بهزك بعنف؟				
العنف الجسدي الشديد: -	11. هل قام بحرقك بسيجار أو مادة أخرى؟				
	12. هل هددك بسلاح ناري أو غيره؟				
	13. هل هددك بسكين؟				
	14. هل حاول خنقك أو إغراقك؟				
العنف الجنسي: -	15. هل طلب منك ممارسة الجنس بالإجبار؟				
	16. هل استخدم القوة الجسدية لإجبارك على ممارسة الجنس؟				
	17. هل هددك بتركك أو إقامة علاقة مع نساء أخريات إذا رفضت ممارسة الجنس؟				

القسم الثالث (تلقي الدعم):

1. **هل حاولت طلب المساعدة أثناء التعرض للعنف؟**

- نعم
- لا

إذا كانت الإجابة لا. ما الأسباب؟

- الخوف
- عدم توافر الدعم
- عدم معرفة بالجهات المختصة
- أسباب أخرى (يرجى التوضيح): ----------

إذا كانت الإجابة نعم. ما هو مصدر المساعدة الذي تلقيته؟

- من الأسرة أو أحد الأقارب
- جهات الرعاية المتخصصة أو خلال تلقي رعاية الحمل
- التثقيف الصحي للأمهات
- مصادر أخرى (يرجى التوضيح): ----------

القسم الرابع (النتائج التي تترتب على صحة الأم والجنين):

نتائج صحة الأم

1. **هل عانيتِ من أي من المضاعفات الصحية التالية أثناء الحمل؟ (يمكنك اختيار أكثر من إجابة)**

- نزيف مهبلي في الأشهر الأولى من الحمل
- التهابات مهبلية
- تمزق مبكر للأغشية(PROM)
- ولادة مبكرة
- انفصال المشيمة
- غثيان وقيء مفرط (Hyperemesis)
- أخرى ----------

2. هل شعرتِ بأي من الأعراض النفسية التالية أثناء الحمل؟ (يمكنك اختيار أكثر من إجابة)

- قلق شديد
- اكتئاب
- توتر أو عصبية
- اضطراب ما بعد الصدمة (PTSD)

3. كيف كانت حالتكِ النفسية أثناء المخاض؟ (يمكن اختيار أكثر من إجابة).

- هادئة
- قلقة
- خائفة
- مكتئبة
- مشاعر أخرى (يرجى التوضيح) ----------

4. أذا كانت حالتك النفسية قلقة أو ما شابه، هل أثرت على قدرتكِ على التركيز أو التعاون مع الفريق الطبي؟

- نعم
- لا

5. كيف كان استعدادك لاستقبال طفلك المولود؟

- جيد جدا (خططت مسبقا وكنت مستعدة تماما)
- جيد (قمت ببعض التحضيرات لكنني واجهت بعض الصعوبات)
- متوسط (لم أتمكن من التحضيرات لكنني واجهت بعض الصعوبات)
- ضعيف (لم أكن مستعدة بسبب الضغوط والعوائق)
- لم أكن مستعدة على الاطلاق.

6. كيف كانت ولادتك؟

- ولادة طبيعية دون حدوث تمزق مهبلي
- ولادة طبيعية مع حدوث تمزق مهبلي
- ولادة بعملية قيصرية
- ولادة عن طريق الشفط او استخدام الملاقط

7. هل قمت بإرضاع طفلك مباشرة بعد الولادة (خلال الساعة الأولى)؟

- نعم
- لا

نتائج صحة الجنين:

8. هل تم تشخيص جنينكِ بأي من الحالات التالية أثناء الحمل أو بعد الولادة؟ (يمكنك اختيار أكثر من إجابة)

- نقص الوزن عند الولادة (اقل من 2500 كغم)
- مشاكل في النمو أو التطور
- تشوهات خلقية
- إصابات جسدية
- ولادة مبكرة
- وفاة المولود بعد الولادة بفترة قصيرة
- أخرى ----------

9. هل احتاج جنينكِ أو مولودكِ إلى رعاية طبية خاصة بعد الولادة؟

- نعم
- لا

إذا كانت الإجابة نعم، ما نوع الرعاية التي تلقاها؟ (يرجى التوضيح)

- حضانة خاصة
- وحدة العناية المركزة لحديثي الولادة(NICU)
- علاجات طبية محددة ----------

B. permission letters

State of Palestine
Ministry of Health
Education in Health and Scientific
Research Unit

دولة فلسطين
وزارة الصحة
وحدة التعليم الصحي
والبحث العلمي

Ref.: .....
Date:.....

الرقم: ٢٠٢٠/١٠٢٦/١٢٤
التاريخ: ٢٠٢٠/١٠/١٣

الأخ مدير عام الادارة العامة للمستشفيات المحترم،،،

عطوفة الوكيل المساعد لشؤون الصحة العامة وصحة الاسرة المحترم،،،

تحية واحترام،،

الموضـــوع: تسهيل مهمة بحث

يرجى تسهيل مهمة **الطالبة: شهد عصام عاشور– ماجستير تمريض الام والطفل/ جامعة القدس**، وباشراف د. سلام الخطيب، في عمل بحث بعنوان:

"Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes: A Cross-Sectional Study in Bethlehem and Hebron Areas,"

من خلال السماح للطالبة بجمع معلومات عن طريق تعبئة استبانة من قبل السيدات بعد اخذ موافقتهن، وذلك في:

- **مستشفى عالية – مستشفى بيت جالا**
- **مراكز الصحة الأولية في محافظتي: – الخليل – بيت لحم**

على ان يتم الالتزام باساليب واخلاقيات البحث العلمي، وعدم التعرض للمعلومات التعريفية للمشاركين.

على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر لحين الحصول على موافقة الوزارة على نتائج البحث.

مع الاحترام،،

د. عبد الله القواسمي
رئيس وحدة التعليم الصحي والبحث العلمي

دولة فلسطين وزارة الصحة
وحدة التعليم الصحي والبحث العلمي

نسخة: منسقة برنامج الماجستير/ دائرة التمريض المحترمة/ جامعة القدس

Telfax.:09-2333901 scientificresearch.dep@gmail.com تلفاكس: 09-2333901

Al- Quds University
Faculty of Health professions
Clinical training unit
Jerusalem-Abu Dies

جامعة القدس
كلية المهن الصحية
وحدة التدريب العملي
القدس-أبوديس

التاريخ :2025/3/13

حضرة الدكتور غسان القواسمي المحترم / المستشفى الملكي التخصصي

الموضوع : تسهيل مهمة طالبة ماجستير في جمع بيانات لغرض البحث العلمي

تحية طيبة وبعد ،،،،

يرجى من حضرتكم تسهيل مهمة طالبة الماجستير " شهد عصام عاشور " ورقمها الجامعي (22312449) ، وهي طالبة ماجستير صحة الام والطفل/ كلية المهن الصحية / جامعة القدس في جمع بيانات المعلومات اللازمة عن طريق توزيع استبيان على التمريض في مستشفاكم ، وذلك لغرض اجراء دراسة بحثية لرسالتها الماجستير بعنوان (عوامل الخطر للعنف الأسري بين النساء الحوامل وأثرها على نتائج الأم والجنين) بإشراف الدكتورة سلام الخطيب ، وذلك في الفترة الواقعة ما بين 2025/3/18 حتى 2025/5/20

وتفضلوا بقبول فائق الاحترام والتقدير،،،

منسقة برنامج الماجستير/ دائرة التمريض

Salam al Khatib

د. سلام الخطيب

مرفق: استبانة الدراسة ونموذج الموافقة المستنيرة وموافقة لجنة البحث العلمي

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جامعة القدس
كلية المهن الصحية
وحدة التدريب العملي
القدس-أبوديس

التاريخ :2025/3/13

حضرة الدكتور سابا أبو فرحة المحترم / المدير الإداري لمستشفى العائلة المقدسة \ بيت لحم

الموضوع : تسهيل مهمة طالبة ماجستير في جمع بيانات لغرض البحث العلمي

تحية طيبة وبعد ،،،،

يرجى من حضرتكم تسهيل مهمة طالبة الماجستير " شهد عصام عاشور " ورقمها الجامعي (22312449) ، وهي طالبة ماجستير صحة الام والطفل/ كلية المهن الصحية / جامعة القدس في جمع بيانات المعلومات اللازمة عن طريق توزيع استبيان على التمريض في مستشفاكم ، وذلك لغرض اجراء دراسة بحثية لرسالتها الماجستير بعنوان (عوامل الخطر للعنف الأسري بين النساء الحوامل وأثرها على نتائج الأم والجنين) بإشراف الدكتور ة سلام الخطيب ، وذلك في الفترة الواقعة ما بين 2025/3/18 حتى 2025/5/20

وتفضلوا بقبول فائق الاحترام والتقدير،،،

منسقة برنامج الماجستير/ دائرة التمريض

د. سلام الخطيب

مرفق: استبانة الدراسة ونموذج الموافقة المستنيرة وموافقة لجنة البحث العلمي

C. Ethical approval letter

Al Quds University
Faculty of Health Professions
Jerusalem –Abu Dis

جامعة القدس
كلية المهن الصحية
القدس – أبو ديس

Research Ethics Subcommittee of Faculty of Health Professions
Letter of approval

March 7, 2025
Ref. No.: RESC/2025-34

Dear Applicants, (**Dr. Salam Khatib, Ms. Shahd Ashour**)

Program: **MSc Nursing Department**

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled (**Risk Factors of Domestic Violence Among Pregnant Women and Its Effect on Maternal and Fetal Outcomes: A Cross-Sectional Study in Bethlehem and Hebron Areas**) submitted by (**Dr. Salam Khatib**). Your proposal is deemed to meet the requirements of research ethics at Al-Quds University, but further assessment is required by the Central Research Ethics Committee of Al-Quds University. We wish you all best for the conduct of the project.

Hussein ALMasri, PhD
Associate Professor of Medical Imaging
Research Ethics Subcommittee Chair
Faculty of Health Professions

Hussein ALMasri

CC: File
CC: Committee members

Tel. Fax: 02 2791243 Email: dean@hpro.alquds.edu تلفاكس: 02 2791243

عوامل خطر العنف الأسري بين النساء الحوامل وأثره على نتائج الأم والجنين في منطقتي بيت لحم والخليل.

إعداد: شهد عاشور

إشراف: د. سلام الخطيب

الملخص

المقدمة: يشير العنف المنزلي إلى الإساءة الجسدية أو الجنسية أو النفسية التي يرتكبها أحد الزوجين أو الشريكين ضد الآخر، حيث تشكل النساء غالبية الضحايا (راكوفيتش–فيلسر، 2014). في عام 2002، اعترفت منظمة الصحة العالمية بالعنف المنزلي كأزمة صحية عامة نظرًا لتأثيره الكبير على رفاهية الضحايا وتداعياته المجتمعية المرتبطة به.

ووفقًا لمنظمة الصحة العالمية 2024، تتعرض حوالي 30% من النساء حول العالم لشكل من أشكال العنف الجسدي أو النفسي خلال حياتهن الزوجية، مع ارتفاع خطر التعرض له أثناء الحمل. حيث تُعد هذه الفترة مرحلة حرجة في حياة المرأة، وبالتالي يمكن أن يكون للعنف المنزلي، آثار عميقة على صحة الأم والجنين.

ووفقًا لمنظمة الصحة العالمية 2024، تتعرض حوالي 30% من النساء عالميًا عنفًا جسديًا أو نفسيًا أثناء الزواج، مع تزايد المخاطر أثناء الحمل، مما يؤثر على صحة الأم والجنين (منظمة الصحة العالمية، 2024). خلال فترة الحمل، قد تتعرض الضحايا لعواقب وخيمة مثل الإجهاض والولادة المبكرة (أيلي وآخرون، 2023). كما أن الأراضي الفلسطينية، تتأثر حوالي 29% من النساء تحديدا تبلغ نسبة انتشاره 24% في الضفة الغربية (مكتب تنسيق الشؤون الإنسانية، 2019) وهي نسبة كبيرة، مما يعزز الحاجة إلى تدخل مُركز. تشمل العوامل المُتنبئة المختلفة للعنف المنزلي المرتبط بالحمل (انخفاض مستوى التعليم، وتاريخ العنف، والوضع الاجتماعي والاقتصادي (ماهاباترو وآخرون، 2022). كما تؤكد الدراسات الدولية الآثار السلبية لعنف الشريك الحميم على الحمل، بما في ذلك زيادة مخاطر الولادة المبكرة وانخفاض وزن

المولود. ورغم وجود أبحاث، لا تزال هناك فجوات في فهم تفاصيل المجتمع الفلسطيني. وبالتالي تهدف هذه الدراسة إلى استكشاف هذه العوامل في منطقتي بيت لحم والخليل، وآثارها على صحة الأم والجنين، بهدف تحسين الدعم المقدم للنساء المتضررات.

الهدف: تهدف هذه الدراسة إلى تحديد وتحليل عوامل الخطر المرتبطة بالعنف الأسري بين النساء الحوامل وآثارها على النتائج الأمومية والجنينية في منطقتي بيت لحم والخليل.

المنهجية: استخدمت هذه الدراسة تصميمًا مقطعيًا، وأُجريت في سبعة المستشفيات وعيادات الحكومية والخاصة في محافظتي الخليل وبيت لحم. بلغ حجم العينة 360 أُمًا أنجبن، وجُمعت البيانات منهن في غضون ستة أسابيع بعد الولادة. جُمعت البيانات باستخدام أداة الاستبيان التي تم التحقق من صلاحيتها وموثوقيتها حيث صممتُ جزءًا من هذا الاستبيان بناءً على نتائج دراسات سابقة، كما تم الحصول على الموافقة الأخلاقية من لجنة الأخلاقيات في جامعة القدس، إضافةً إلى الحصول على إذن من وزارة الصحة الفلسطينية وإدارات المستشفيات الخاصة، وكذلك الموافقة الشفوية من جميع الأمهات المشاركات في الدراسة. استمرت فترة جمع البيانات نحو أربعة أشهر، وتم تحليلها باستخدام الحزمة الإحصائية للعلوم الاجتماعية (SPSS)الإصدار 27.

النتائج: أفادت نحو ثلث النساء (33.4%) بتعرضهن للعنف الأسري، وكان العنف النفسي هو الشكل الأكثر شيوعًا. وارتبط انخفاض المستوى التعليمي وكون الزوج في منتصف العمر أو أكبر بزيادة احتمالية التعرض للعنف. كما وُجد ارتباط ذو دلالة إحصائية بين التعرض للعنف والاضطرابات النفسية، بما في ذلك القلق، والتوتر، واضطراب ما بعد الصدمة. وكانت مضاعفات الحمل والأعراض النفسية شائعة بين المشاركات، خاصة الالتهابات، والقيء الحملي الشديد، والتوتر، والقلق الشديد. كما تم الإبلاغ بشكل متكرر عن نتائج جنينية سلبية، مثل انخفاض وزن المولود والولادة المبكرة، مع حاجة عدد كبير من حديثي الولادة إلى رعاية طبية خاصة.

الخلاصة: تُظهر هذه الدراسة أن العنف الأسري أثناء الحمل يُعد مشكلة شائعة في جنوب الضفة الغربية، حيث كان العنف النفسي هو الشكل الأكثر انتشارًا. وقد تم تحديد انخفاض المستوى التعليمي للأم وكون

الزوج أكبر سنًا كعوامل خطورة مهمة للتعرض للعنف الأسري. كما ارتبط التعرض للعنف بآثار نفسية سلبية على الأم، بما في ذلك القلق، والتوتر، واضطراب ما بعد الصدمة. إضافةً إلى ذلك، كانت مضاعفات الحمل شائعة بين النساء المتعرضات للعنف. وعلى صعيد النتائج الجنينية، ارتبط العنف الأسري بحدوث نتائج سلبية مثل انخفاض وزن المولود والولادة المبكرة، مع حاجة نسبة ملحوظة من حديثي الولادة إلى رعاية طبية خاصة. وتؤكد هذه النتائج أهمية معالجة العوامل التعليمية والاجتماعية المرتبطة بالعنف، ودمج فحوصات الصحة النفسية والدعم النفسي ضمن خدمات رعاية الحوامل.

الكلمات المفتاحية: الأمهات، الحوامل، الجنين، العنف المنزلي، العوامل المساعدة على حدوث العنف، المضاعفات المترتبة على صحة الأم والجنين.