

**Al-Quds University
Deanship of Graduate Studies**



**Exploring Palestinian Women's Experiences with Ectopic
Pregnancy in West Bank, Palestine: Aqualitative Study
Jihan Ramadan Abdel- Fatah Badaha**

M.Sc. Thesis

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Jerusalem-Palestine

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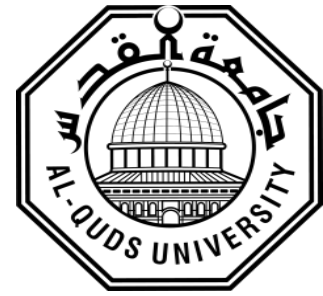
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Thesis Approval

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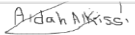

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Dedication

To my beloved family, who stood by me through every challenge and celebrated every triumph along this academic journey. To my cherished friends, whose laughter and encouragement lifted my spirits when the path seemed overwhelming. To my esteemed professors and mentors at the university, who nurtured my intellectual curiosity and guided me with wisdom and patience. Your collective support has been the foundation upon which this achievement stands.

To the resilient women who opened their hearts and shared their deeply personal experiences with ectopic pregnancy for this research. Your courage in revisiting painful memories to help others is truly inspiring. And to all Palestinian women navigating the complex terrain of reproductive health challenges within our unique cultural and healthcare context - may this work honor your experiences and contribute to meaningful improvements in care and support. This research is dedicated to your strength, your stories, and your healing journeys.

Jihan Ramadan Abdel- Fatah Badaha

Declaration

I certify that this thesis which is 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:*Jihan*

Jihan Ramadan Abdel- Fatah Badaha

Date: 29-5-2025

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Abstract

Background: Ectopic pregnancy is a serious health problem that might imply life-threatening complications among women in the reproductive stage. Despite the well-known implications of early diagnosis and surgical management of ectopic pregnancy, women's experience of ectopic pregnancy and its consequences is not well understood, particularly within the Palestinian context.

Aim and Objectives: This study aimed to explore the psychological, physical, and social dimensions of Palestinian women's experiences following an ectopic pregnancy.

Methodology: A qualitative phenomenological design was employed, using purposive sampling. Ten women who had experienced ectopic pregnancy at Ramallah Governmental Hospital and Al-Maqased Hospital in Jerusalem participated in depth isemi-structured interviews, which were conducted between February and June 2023. Thematic analysis was used to identify patterns in participants' narratives.

Main Findings: Five major themes emerged: (1) Psychological Impact, characterized by sadness, denial, guilt, fears about future fertility, and feelings of inadequacy; (2) Physical Impact, marked by severe persistent pain and difficulties related to medical procedures; (3) Social Impact, including inadequate support, stigmatization, and social isolation; (4) Marital Dynamics, ranging from blame and ignorance to support and care; and (5) Healthcare Provider Interactions, revealing lack of psychological support and unclear communication about treatments and prognosis.

Conclusion : The findings demonstrate that ectopic pregnancy profoundly affects women's psychological wellbeing, physical health, social relationships, and marital dynamics. Palestinian women face unique challenges influenced by cultural and healthcare system factors. This study highlights the need for integrated psychosocial support, clear communication from healthcare providers, holistic pain management, and enhanced post-treatment guidance. These insights can inform improvements in clinical practice and support systems for women experiencing this challenging reproductive health event.

Keywords: Ectopic pregnancy, Palestinian women, psychological impact, physical pain, social support, qualitative research, reproductive health.

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List of Abbreviation

Abbreviation	Full Form
ART	Assisted Reproductive Technology
EP	Ectopic Pregnancy
GA	Gestational Age
IRB	Institutional Review Board
IUCD	Intrauterine Contraceptive Device
IVF	In Vitro Fertilization
KSA	Kingdom of Saudi Arabia
NHS	National Health Service
PCBS	Palestinian Central Bureau of Statistics
PID	Pelvic Inflammatory Disease
RCOG	Royal College of Obstetricians and Gynecologists
UK	United Kingdom
US	United States
WHO	World Health Organization

Chapter one

1.1 Introduction

Ectopic pregnancy (EP) is a life-threatening gynecological emergency that may lead to maternal mortality and morbidity worldwide. EP accounts for 75% of maternal deaths in early pregnancy, and therefore in most developing countries, it is a common cause of maternal death in the first trimester of pregnancy. Every risk factor that has been found is maternal: endometriosis, smoking, tubal surgery, induced conception cycle, pelvic inflammatory illness, and Chlamydia trachomatis infection. These risk factors, however, differ from study to study and from location to location (Obeagu et al., 2023).

Ectopic pregnancy (EP) is defined as an implantation of the conceptus outside the uterine cavity. Around 98% of the ectopic pregnancy occurs in the fallopian tubes which means rupture possibility is greater than other rare sites (ovary, cervix, and abdominal) resulting in internal bleeding which leads to death or Salpingectomy (removal of fallopian tube or/and ovary) both threaten women's life and reproductive health. (Cunningham et al. (2018).

Ectopic pregnancy is a common condition among women of reproductive age, with a reported incidence of 1-3% in the Western world, and in the United States, 1 in 1,000 women aged 15 to 15 years annually (Ashshi et al., 2015), while in Saudi Arabia, the incidence was 1.13% (Turki, 2015).

This recent increase is mostly attributed to the increase of incidence of pelvic inflammatory disease (PID) as well as ART (Assisted Reproductive Technology). (Klinika, 2005). In Palestine, a previous retrospective cross sectional study which was conducted among 107 women regarding the incidence, risk factors and outcomes of ectopic pregnancy in Ramallah area, This study showed that the incidence of ectopic pregnancy was 3.53/1000 childbirth, The most common risk factors of EP were age, Pelvic inflammatory disease (PID), Intrauterine Contraceptive Device (IUCD), parity, smoking, history of abortions and history of abdominal surgery. (Haheer ,2005).

Early detection and management of ectopic pregnancies are crucial, as they represent one of the leading causes of maternal mortality during the first trimester. Advances in diagnostic techniques such as transvaginal ultrasound and β -hCG blood testing have significantly improved early diagnosis and timely intervention, contributing to a notable reduction in maternal deaths. However, despite these advancements, ectopic pregnancies continue to pose serious health risks (Mullany et al., 2023).

Despite the expanding global literature on the clinical characteristics, prevalence, and risk factors of ectopic pregnancy, there is a notable deficiency of qualitative research examining the personal, emotional, and social experiences of women, especially in the Palestinian setting. Most current research emphasizes epidemiological data or clinical outcomes, but the subjective experiences, physical, emotional, social and psychological impact on women are predominantly neglected. In Palestine, where sociocultural norms, healthcare accessibility,

and reproductive health awareness may significantly differ from other regions, it is crucial to comprehend how women perceive, manage, and get assistance during ectopic pregnancies. As of now, no qualitative research has investigated these lived experiences among Palestinian women. This study seeks to address a significant gap by offering a comprehensive examination of the emotional and experiential aspects of ectopic pregnancy, thereby guiding culturally sensitive healthcare practices and policy-making that more effectively meet the needs of women confronting this life-threatening condition.

1.2 1.2.Statement of the Problem

Despite the life-threatening risks and severe mental and physical stress faced by women experiencing ectopic pregnancy, their lived experiences are inadequately recognized and underrepresented in the literature.

EP represents one of the leading causes of first-trimester maternal mortality and a significant contributor to life-threatening obstetric complications, particularly in low- and middle-income settings such as Palestine. Despite its clinical severity and emotional toll, research on ectopic pregnancy has predominantly focused on medical aspects, including incidence rates, risk factors, diagnostic methods, and treatment outcomes, with limited attention given to the lived experiences of affected women.

There remains a notable gap in qualitative literature that explores the psychological, social, and emotional impact of ectopic pregnancy from the perspective of women themselves. While quantitative studies have provided valuable epidemiological insights, they often fail to capture the depth of personal suffering, fear, and distress experienced by women throughout diagnosis and treatment. As highlighted in global research, women frequently describe their experience with ectopic pregnancy as traumatic, marked by intense anxiety, fear of infertility, feelings of loss, and emotional isolation —yet these dimensions remain largely unexplored within Palestinian reproductive health contexts (Lasker & Toedter, 2010; Barnhart, 2009).

Moreover, existing studies tend to frame ectopic pregnancy as an alternative cause of early pregnancy loss, rather than treating it as a distinct and potentially fatal condition with profound biopsychosocial consequences. This marginalization contributes to a lack of holistic care strategies that address not only the physical but also the emotional and relational challenges faced by women after diagnosis.

The absence of qualitative inquiry into how Palestinian women perceive, interpret, and cope with ectopic pregnancy further limits the development of culturally responsive support systems and interventions. There is an urgent need for more patient-centered research that gives voice to women's narratives, enhances understanding of their psychological burden, and informs healthcare practices that extend beyond clinical management to include emotional and psychosocial care. This study focused into a woman's specific experience with an ectopic pregnancy, fears, anxiety and impact on women life. It also will reflects some of the Palestinian women suffering during their reproductive life and focus attention on this mysterious situation.

1.3 1.3.Significant of the study

This study is significant as it explores the lived experiences of Palestinian women with ectopic pregnancy and the multifaceted impact this condition has on their emotional, physical, and social well-being. Currently, there is limited qualitative research addressing how women in Palestine navigate the challenges associated with ectopic pregnancy within their unique cultural, societal, and healthcare context. Given that ectopic pregnancy remains a leading cause of maternal mortality in the first trimester globally, understanding the personal and contextual dimensions of this experience is essential for developing culturally sensitive and effective interventions tailored to the needs of Palestinian women.

This research provides foundational insights into the psychological suffering, changes in marital and social relationships, and the physical consequences women face following an ectopic pregnancy. These multidimensional perspectives are especially important in a context where reproductive health issues are often stigmatized and surrounded by silence. In the Palestinian setting, societal expectations around motherhood, stigma related to infertility or pregnancy loss, and traditional gender roles can intensify the emotional burden of ectopic pregnancy. Additionally, limited access to psychosocial support services and reproductive health counseling may leave many women to cope with their trauma in isolation, without adequate professional or familial support.

By shedding light on these culturally specific experiences, the study contributes not only to local healthcare practices but also to global understandings of how cultural norms shape responses to reproductive loss. It highlights the need for healthcare systems in Palestine to adopt a more holistic approach—one that integrates mental health care with medical treatment and addresses the broader relational and societal impacts of ectopic pregnancy. The findings offer valuable guidance for clinicians, particularly midwives and obstetricians, in providing empathetic, patient-centered care that acknowledges both the clinical and emotional realities faced by women in this region.

This study enhances worldwide comprehension of the impact of cultural factors on reproductive health experiences by emphasizing the experiences of Palestinian women. In the Palestinian context, social shame associated with infertility and pregnancy loss, conventional gender roles, and societal expectations regarding parenting might exacerbate the emotional and psychological distress of ectopic pregnancy. Moreover, restricted access to psychological support services and reproductive health counseling may result in numerous women managing their challenges in silence, devoid of sufficient professional or familial assistance. The culturally distinctive characteristics distinguish this study from others worldwide and emphasize the necessity for context-sensitive care strategies in the management of ectopic pregnancy.

Furthermore, this study serves as a foundation for future research and program development aimed at improving post-ectopic care, including psychosocial support systems and educational interventions for both women and healthcare providers. Ultimately, it underscores the importance of culturally responsive healthcare policies and practices that recognize and address the full spectrum of women's experiences following ectopic pregnancy.

1.4 Study aims and objectives

The purpose of the study was to explore the women's experiences with Ectopic pregnancy including psychological, physical, and social dimensions within the Palestinian cultural context. More precisely, it aims to achieve the following :

1. To explore Palestinian women's psychological experiences following an ectopic pregnancy diagnosis.
2. To understand the physical impacts and challenges women face during and after ectopic pregnancy.
3. To understand the social dimensions and support systems available to Palestinian women with ectopic pregnancy.
4. To explore the impact of ectopic pregnancy experience on women marital relationships
5. To explore women's experiences and interactions with healthcare providers during ectopic pregnancy management.

1.5 Research questions

1. How do Palestinian women describe their psychological experiences before, during, and after ectopic pregnancy?
2. What physical symptoms and challenges do Palestinian women experience with ectopic pregnancy?
3. How does the experience of ectopic pregnancy affect Palestinian women's social relationships and support systems?

4. How does ectopic pregnancy impact Palestinian women's marital relationships?
5. How do Palestinian women describe their interactions with healthcare providers during ectopic pregnancy management?

1.6 Definition of terms

Pregnancy: Pregnancy is a physiological state characterized by the implantation and development of one or more embryos in the uterus following fertilization of an ovum by a sperm. It typically lasts approximately 40 weeks from the first day of the last menstrual period until delivery, during which significant physiological and anatomical changes occur in the woman's body to support fetal growth and development (Cunningham et al., 2018).

Ectopic pregnancy: Ectopic pregnancy is a pathological condition in which a fertilized ovum implants outside the normal uterine cavity, most commonly (98% of cases) in the fallopian tube. Other potential implantation sites include the ovary, cervix, or abdominal cavity. This condition represents a serious and potentially life-threatening complication requiring prompt medical intervention, as the growing embryo can rupture surrounding structures, resulting in severe hemorrhage (Leziak et al., 2022).

Mortality: Mortality refers to the state of being subject to death or the incidence of death in a population. In obstetric contexts, maternal mortality specifically refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (WHO, 2018).

Morbidity: Morbidity refers to the state of being diseased or the incidence of disease in a population. In relation to ectopic pregnancy, morbidity encompasses the various physical and psychological complications that can arise from the condition or its treatment, including hemorrhage, pain, fertility impairment, emotional distress, and adverse effects on quality of life. Morbidity measures the burden of disease beyond mortality, accounting for both acute symptoms and longer-term consequences of health conditions (Berhe et al., 2021).

Chapter two

Literature review

2.1. Introduction

This chapter presents the literature review of the study includes ectopic pregnancy definition, Etiology, symptoms, treatment, complications and the previous studies on women ectopic pregnancy experiences

21.1. Definition of Ectopic Pregnancy

Ectopic pregnancy (EP) refers to the implantation of a fertilized ovum outside the endometrial cavity of the uterus. The most common location—accounting for approximately 98% of cases is the fallopian tube, particularly the ampullary region. Other less common sites include the ovary, cervix, or abdominal cavity (Leziak et al., 2022). This condition is considered a life-threatening obstetric emergency, as it can lead to tubal rupture, internal hemorrhage, and in severe cases, maternal death if not diagnosed and treated promptly (Cunningham et al., 2018).

2.1.2 Epidemiology

Globally, ectopic pregnancy occurs in 1–2% of all pregnancies, with its incidence rising over time (Basnet et al., 2015; Chowdhury & Chakraborty, 2017). Regional variations exist:

- In China, the prevalence reaches up to 7.93%, with the most common presenting symptoms being vaginal bleeding accompanied by abdominal pain (Fan, Liu, & Mao, 2021).
- In the Kingdom of Saudi Arabia (KSA), the prevalence ranges between 0.58% and 1.5% (Al-Turki, 2015; Ashshi et al., 2015).
- In Palestine, a retrospective study conducted in Ramallah found an incidence of 3.53 per 1000 live births, highlighting EP as a significant reproductive health concern in the region (Haheer, 2005).
- In the UK, around 1 in every 90 pregnancies is ectopic, amounting to roughly 11,000 cases annually (Spillane, 2018), and EP remains one of the leading causes of maternal mortality during the first trimester (Shadman & Vedadhir, 2022).

2.1.3 Risk Factors and Etiology

Several factors have been identified that increase the likelihood of ectopic pregnancy:

- **Maternal Age**: The risk increases significantly for women aged over 35 years, possibly due to chromosomal abnormalities in trophoblastic tissue and age-related changes in tubal motility that delay ovum transport (Zhang et al., 2022).
- **Smoking**: Cigarette smoking has been linked to nearly one-third of all EP cases, potentially affecting ciliary beat frequency and fallopian tube function (Rana et al., 2013).

- History of Pelvic Inflammatory Disease (PID) : PID and other infections such as sexually transmitted diseases are major contributors to tubal damage and scarring, increasing the risk of EP.
- Prior Ectopic Pregnancy: Women with a previous history of EP face an increased risk of recurrence, with the odds ratio reaching 12.5% after one prior episode and 76.6% after two episodes (Ashshi et al., 2015).
- Infertility Treatments : The use of Assisted Reproductive Technology (ART) , especially in vitro fertilization (IVF) , elevates the risk of EP, with a rate of 2–5% following IVF , compared to 1–2% in spontaneous pregnancies (Rana et al., 2013).
- Tubal Surgery History: Procedures such as salpingostomy, fimbrioplasty, or lysis of adhesions increase the risk of EP depending on the extent of tubal damage (Rana et al., 2013).
- Contraceptive Use: Although rare, progestogen-only contraception and intrauterine contraceptive devices (IUCD) may be associated with EP in cases of contraceptive failure, though they do not necessarily increase the overall absolute risk (Rana et al., 2013).

2.1.4 Clinical Presentation and Symptoms

Ectopic pregnancy may present asymptotically and be discovered incidentally during routine scans, or it may manifest with a variety of signs and symptoms, including:

- Missed menstrual period
- Vaginal bleeding or brownish discharge
- Unilateral lower abdominal pain
- Shoulder tip pain (due to hemoperitoneum)
- Discomfort during urination or bowel movements

These symptoms may overlap with those of early pregnancy or gastrointestinal disturbances, which can delay diagnosis and treatment. However, any combination of abdominal pain and vaginal bleeding in early pregnancy should raise suspicion of ectopic implantation (Spillane, 2018).

2.1.5 Treatment Options

Timely diagnosis and appropriate intervention are essential in managing ectopic pregnancy and reducing morbidity and mortality. The choice of treatment depends on the woman's clinical stability, gestational age, and fertility intentions:

- Medical Management: Methotrexate is often used in stable patients with unruptured EP to halt embryonic development and allow natural resorption.
- Surgical Intervention: Laparoscopic surgery is preferred for unstable patients or when rupture is suspected. Common procedures include salpingectomy (removal of the affected fallopian tube) and salpingostomy (making an incision to remove the embryo while preserving the tube).

Emergency Surgery : Required in cases of tubal rupture or hemodynamic instability to control bleeding and stabilize the patient (Barnhart & Sammel, 2020; Alkatout et al., 2013)

2.1.6 Complications

Ectopic pregnancy poses serious risks to women's health:

- Tubal Rupture: This is the most critical complication, potentially leading to severe intra-abdominal bleeding , shock, and even death if not managed urgently (Creanga et al., 2011).

- Fertility Loss: Salpingectomy or tubal damage may result in reduced fertility, a major concern in many cultures where motherhood plays a central role in female identity (Vulcanescu & Marintchev, 2014).
- Psychological Morbidity: EP is associated with long-term emotional distress, including grief, anxiety, and fear of future infertility.
- Infection and Organ Damage: Rare but possible complications include pelvic infection or injury to adjacent organs during surgical interventions.

2.1.7 Post-Treatment Monitoring and Support

Following treatment, close monitoring is essential to ensure complete resolution of the ectopic pregnancy and to assess future fertility potential. Equally important is the provision of psychosocial support to help women cope with the emotional trauma associated with EP. Healthcare providers must offer clear explanations about the condition, its implications, and future reproductive options to reduce fear and promote informed decision-making (Vulcanescu & Marintchev, 2014).

Previous qualitative studies on women who were experienced ectopic pregnancy

To better understand how women experience and cope with ectopic pregnancy, several qualitative studies have explored the perspectives of those who have undergone this condition. One such study, conducted by Spillane, Meaney, and Donoghue (2018), used indepth indepth semi-structured interviews to examine the experiences of seven women who had experienced ectopic pregnancy and were treated through expectant, medical, or surgical management.

The findings revealed that many women expressed hesitation about attempting future pregnancies, accompanied by heightened anxiety regarding their fertility. Participants also described difficulty accepting their diagnosis, which affected their emotional recovery and contributed to reluctance in pursuing future childbearing. These insights highlight the psychological burden associated with ectopic pregnancy and emphasize the importance of addressing emotional concerns throughout the care process.

This study has important implications for clinical practice, particularly in how healthcare providers communicate with women from the point of diagnosis through treatment. The way in which women are informed about their condition and supported during recovery significantly influences their emotional well-being and future reproductive decisions.

Norhayati, Hazlina, Asrenee, and Sulaiman (2017) investigated women's experiences with maternal near-misses and how they viewed the standard of treatment Malaysia by using depth interviews. The study comprised 30 women who had suffered maternal near-miss incidents. The four main themes that arose from the experiences and views of women with maternal near miss were their self-evaluation of their near miss as a mother, their assessment of the quality of treatment, their propensity to seek medical attention, and the social support they got. The ladies who encountered a maternal near-death experience described it as terrifying and said that they also felt other unfavorable feelings and a sensation of impending death. Those looking to enhance services at healthcare institutions should be concerned about the elements affecting women's opinions of the quality of treatment.

Another study was conducted to examine the long-term consequences and psychosocial impact of ectopic pregnancy on women by using a combination of quantitative and qualitative approach to follow-up women who had experienced ectopic pregnancies over a 16-year. This study assess various aspects of the women's lives, including their physical and emotional well-being, relationships, reproductive history, and overall quality of life.

The findings of the study revealed significant long-term consequences of ectopic pregnancy. Women who had experienced ectopic pregnancies reported persistent physical symptoms, such as chronic pelvic pain and fertility issues. The emotional impact was also evident, with

many participants expressing feelings of grief, loss, and anxiety related to their ectopic pregnancy experience. Furthermore, the study highlighted the impact on participants' relationships and reproductive decision-making. The women experienced strain in their intimate relationships and reported difficulties in planning future pregnancies due to concerns about the risk of recurrent ectopic pregnancies (Lasker & Toedter, 2003).

Another qualitative study conducted by Spillane et al. (2015), that aimed to explore and understand the experiences of women who had gone through ectopic pregnancies. This study conducted by using in-depth interviews with a group of women who had experienced ectopic pregnancies. The findings of the study highlighted the initial shock and emotional distress upon receiving the diagnosis such as expressed feelings of fear, confusion, and sadness, often struggling to come to terms with the loss of a pregnancy and the potential impact on their fertility. Moreover, the study revealed the physical and psychological challenges associated with ectopic pregnancies. Participants discussed the physical pain and discomfort they endured, along with the need for medical interventions, such as surgery or medication. The emotional toll was evident, with women expressing grief, anxiety, and a sense of isolation throughout their journey.

The article emphasizes the importance of support networks and healthcare providers in navigating the emotional and physical challenges of ectopic pregnancy. It suggests the need for improved communication and emotional guidance from healthcare professionals to help women cope with the diagnosis, treatment, and the subsequent impact on their reproductive choices (Spillane et al., 2015).

Moreover, a study was conducted by Lili Jia, Wenfei Li, Yue Liu, (2023) to explore the psychological effects experienced by women who encountered complications during early pregnancy. The study focused on understanding the emotional impact and psychological sequelae associated with these complications. The findings suggest that early pregnancy complications can lead to significant psychological sequelae. Women who experienced complications reported increased levels of stress, anxiety, and depression. The emotional distress was linked to the uncertainty and fear surrounding the well-being of the pregnancy, as well as concerns about the potential long-term effects on their reproductive health.

The article emphasizes the importance of recognizing and addressing the psychological sequelae associated with early pregnancy complications. It underscores the need for healthcare providers to offer appropriate emotional support and counseling to women during this challenging period. By addressing the psychological well-being of women experiencing early pregnancy complications, healthcare professionals can contribute to better overall patient care and improved mental health outcomes.

Another study conducted to examine the relationship between self-esteem, depression, and anxiety in women during the recovery process following an ectopic pregnancy. The findings suggest a significant association between low self-esteem and depression and anxiety symptoms in women recovering from an ectopic pregnancy. Women with lower self-esteem reported higher levels of depression and anxiety compared to those with higher self-esteem. The study indicates that self-esteem plays a crucial role in the psychological well-being of women during the recovery process (Hasani et al., 2021).

There are not enough previous studies about the impact of Ectopic pregnancy on diagnosed women with, so the researcher aims to discover more knowledge about the physical and psychological impact of EP on these women which exposed in such this case.

Ectopic pregnancy in Palestine

Research on ectopic pregnancy in Palestine remains limited, with few comprehensive studies dedicated specifically to this condition within the Palestinian context. However, several notable studies have provided insights into the incidence, risk factors, and management of ectopic pregnancy in Palestine.

A significant retrospective cross-sectional study conducted in the Ramallah area by Haheer (2005) examined 107 women diagnosed with ectopic pregnancy. This research revealed an incidence rate of 3.53 per 1,000 childbirths. The study identified several prevalent risk factors among Palestinian women, including age, pelvic inflammatory disease (PID), use of intrauterine contraceptive devices (IUCD), parity, smoking, history of abortions, and previous abdominal surgeries. These findings align with global risk factors while providing specific insights into the Palestinian context.

Shahawy and Diamond (2018) examined reproductive health in the occupied Palestinian territories, noting that cultural and religious factors significantly influence women's reproductive health experiences. While their study focused primarily on abortion, their findings suggest that cultural attitudes toward pregnancy loss and women's reproductive health may affect how women experience and seek care for conditions like ectopic pregnancy.

The limited available research points to a need for more comprehensive studies on ectopic pregnancy in Palestine, particularly those examining women's lived experiences with this condition. Such research could inform healthcare policy and practice to better address the specific needs of Palestinian women experiencing ectopic pregnancy, while accounting for the unique socio-political and cultural context in which they live.

Conclusion

The literature review reveals ectopic pregnancy as a significant and potentially life-threatening condition with growing global prevalence, including in Palestine. Research clearly establishes its medical aspects, while qualitative studies highlight profound psychological impacts including grief, guilt, and fertility concerns. Social dimensions are significant, with women reporting varied support experiences and often feeling isolated. Healthcare experiences differ considerably, with many women reporting insufficient emotional support and communication. A notable gap exists in research specific to the Palestinian context, where unique cultural, religious, and healthcare system challenges likely shape women's experiences differently. This study aims to address this gap by exploring Palestinian women's experiences with ectopic pregnancy, providing insights to inform more culturally responsive and holistic approaches to care that address both the physical and emotional needs of these women.

Chapter Three:

Theoretical framework

3.1 Introduction:

This chapter presents the theoretical background for the study of Palestinian women living with ectopic pregnancy. Since reproductive health crises have many aspects, this study uses behavioral and psychological theories to look at how women understand, interpret and cope with ectopic pregnancy on their own terms. The framework chosen helps to organize how we analyze women's distress, the way they are supported by their partner and their experiences with medical staff.

Settling the study's findings in the context of a theory helps make the data useful for developing approaches that are responsive to culture. What is presented here helps us understand ectopic pregnancy as a combined biological, psychological and social issue and prepares us for informing policies and practices for the benefit of Palestinian mothers.

3.1 Trauma theory

3.1.1 Trauma Theory: Overview

Trauma theory examines how overwhelming and distressing experiences—such as violence, loss, war, childbirth complications, or systemic oppression—impact individuals' mental health, behavior, identity, and memory. Central to trauma theory is the idea that trauma can disrupt normal cognitive and emotional functioning, leading to long-lasting psychological effects such as post-traumatic stress disorder (PTSD), anxiety, depression, dissociation, and altered self-perception (Caruth, 1996; Herman, 1992).

Trauma may be individual or collective and can be caused by both acute events (e.g., childbirth emergencies, natural disasters) and chronic conditions (e.g., ongoing poverty, occupation, or domestic violence). In healthcare and maternal health contexts, trauma theory is increasingly applied to understand the emotional and psychological aftermath of events such as emergency cesarean sections, stillbirth, or lack of respectful maternity care.

Judith Herman's foundational work *Trauma and Recovery* (1992) outlines a three-stage recovery process: establishing safety, reconstructing the trauma narrative, and reconnecting with community. Cathy Caruth (1996) emphasizes how trauma is not fully experienced in the moment but returns later in the form of intrusive memories or flashbacks. These insights inform trauma-informed care, an approach that emphasizes safety, empowerment, and trustworthiness in care provision.

Trauma Theory In Maternal and Postnatal Contexts

In maternal health, trauma theory is used to analyze how experiences such as difficult childbirth, neglect in healthcare settings, or postpartum depression may lead to emotional trauma. For example, women who feel powerless or disrespected during labor may carry psychological trauma into the postnatal period, affecting mother-infant bonding and long-

term mental health. Trauma-informed postnatal care is therefore essential, particularly in high-risk settings such as conflict zones or under-resourced health systems.3.2.2 Applying Trauma Theory to Women's Experiences of Ectopic Pregnancy

Trauma theory offers a comprehensive framework for understanding the multifaceted impact of ectopic pregnancy on women's psychological, social, and physical well-being. An ectopic is not only a medical emergency but often a traumatic reproductive loss. Women's lived experiences in this context reflect the core dimensions of trauma as described by theorists such as Herman (1992), who emphasized the disintegration of normal coping mechanisms, disruption of meaning, and the need for safety and psychological reconstruction following trauma.

3.2.3 Psychological Impact

Women who experience ectopic pregnancy often go through profound emotional reactions that align with trauma responses. Common reactions include denial, persistent crying, guilt, and overwhelming grief—symptoms that reflect the acute psychological disorientation trauma can cause (Brier, 2008). Many women also report anxiety and deep-seated fears regarding future fertility, which can challenge their sense of self, bodily integrity, and reproductive identity (Anderson et al., 2014). According to trauma theory, such responses are expected when individuals face a sudden and uncontrollable event that threatens their physical and emotional security (Herman, 1992; Caruth, 1996).

3.2.4 Social Isolation and Stigmatization

The social impact of ectopic pregnancy can further compound trauma. Many women report feeling isolated or unsupported by their social circles. In contexts where reproductive loss is poorly understood or stigmatized, women may be discouraged from expressing their grief, leading to silence and emotional suppression (Wallace et al., 2010). Trauma theory posits that recovery is hindered when individuals lack validation or support, making social isolation a significant barrier to healing (Herman, 1992). Stigmatization, especially in cultures that associate childbearing with female identity and social status, can lead to internalized shame and further marginalization.

3.2.5 Physical Trauma and Medical Consequences

The physical impact of ectopic pregnancy—often involving emergency surgery, internal bleeding, and possible removal of a fallopian tube—adds a visceral layer of trauma. These events not only threaten a woman's life but can permanently affect her fertility, reinforcing fears of future pregnancy loss or childlessness (Jurkovic et al., 2013). Trauma theory recognizes that the body becomes a site of memory, where physical pain can trigger emotional flashbacks or feelings of helplessness (Caruth, 1996). The physical aftermath is thus inseparable from psychological recovery.

3.2.6 Marital Dynamics and Emotional Disconnect

The trauma of ectopic pregnancy can strain marital or intimate relationships. Women often report changes in communication, a lack of empathy, or emotional distancing from their partners. While some partners may respond with increased care, others may withdraw or be unable to understand the depth of the loss (Van den Akker, 2011). Trauma theory underlines that unresolved trauma can alter interpersonal relationships, making emotional reconnection and mutual understanding difficult without external support or intervention (Herman, 1992).

3.2.7 Healthcare Interactions and Institutional Trauma

Interactions with healthcare providers also play a critical role in shaping the trauma experience. Numerous women describe poor communication, lack of emotional support, and clinical detachment during and after diagnosis and treatment (Wallace et al., 2010). When healthcare workers fail to provide empathetic care or adequate information, women may feel

dehumanized, confused, and abandoned—experiences that reinforce feelings of powerlessness. Trauma theory emphasizes that how an institution responds to a traumatic event can either support healing or deepen the trauma (Seng et al., 2011). Therefore, the adoption of trauma-informed care in reproductive health services is essential to address this gap.

3.3.Conclusion

Through the lens of trauma theory, ectopic pregnancy is not only a medical event but a deeply disruptive emotional and social experience. Women's responses—ranging from psychological distress and social withdrawal to relational strain and dissatisfaction with care—reflect the layered and lasting impact of trauma. A trauma-informed approach, emphasizing compassionate communication, psychosocial support, and validation of grief, is essential to help women process their loss and recover meaningfully.

Chapter Four

Methodology

4.1 Introduction

This chapter presents the research design adopted for the current study, which investigates the lived experiences of Palestinian women diagnosed with ectopic pregnancy and received treatment at two main sites: Ramallah Governmental Hospital in the middle of West Bank and Al-Maqased Hospital in Jerusalem. The research design and its justification are first provided. The study settings, population, methods for sampling, tools for data collection, and the procedures followed in data collection are then outlined. Further, the next section describes how the data were analyzed and discusses some relevant ethical issues and issues about trustworthiness. A qualitative descriptive design has been adopted for this study to gather in-depth narratives related to the complex journey and experiences that women undergo when being diagnosed, treated, and dealing with the consequences of ectopic pregnancy.

4.2 Study Design

A **Qualitative phenomenological research design** was adopted to capture the richness and depth of women's personal experiences with ectopic pregnancy. Qualitative descriptive methods focus on uncovering the "what" and "how" of participants' experiences rather than testing hypotheses or determining causal relationships (Remler & Van Ryzin, 2021). For this study, this study aimed to explore the experiences of Palestinian women following ectopic pregnancy, with a focus on the emotional, psychosocial, and life-altering dimensions of their journey.

Rationale for Qualitative Inquiry

Ectopic pregnancy is a serious health issue that can bring physical, emotional, and social consequences to the affected women. While quantitative research can measure incidence rates, risk factors, and treatment outcomes, it often cannot put in words the depth of women's subjective experiences (Hendriks et al., 2020). Therefore, a qualitative design was considered most appropriate to:

- Elicit personal narratives that offer insight into how women navigate the diagnosis and treatment process.
- Understand the psychological, social, and cultural contexts surrounding ectopic pregnancy.
- Explore coping mechanisms and support systems utilized by women throughout their experience.
- The majority of the previous studies regarding ectopic pregnancy concentrating on the medical issues and ignoring the psychosocial aspect of the ectopic pregnancy and its impact on women. Phenomenological Approach

- The phenomenological approach is a qualitative research design aimed at exploring and understanding individuals' lived experiences from their own perspectives (Moustakas, 1994). This approach seeks to capture the depth and meaning of participants' subjective experiences by setting aside the researcher's biases through a process called "bracketing" or epoche (Moustakas, 1994). Phenomenological research typically involves collecting data through in-depth interviews, personal narratives, or observations, allowing participants to describe their experiences in rich detail. The researcher then analyzes the data to identify common themes that reveal the core meaning of the phenomenon under study (van Manen, 1990). This design is particularly useful in fields such as nursing, psychology, and education, where understanding how people perceive and make sense of their experiences is essential

4.3 Study Setting

The reference hospitals for the data collection were Al-Maqased and Ramallah medical complex at the middle of West Bank, Palestine.

a) Ramallah Governmental Hospital – West Bank

- The Ramallah Governmental Hospital is one of the foremost public health facilities in the city of Ramallah and environs. It has a wide range of obstetric and gynecological services, offering an immense influx of cases relating to pregnancy and childbirth.
- It has separate maternal health units, including emergency obstetric services, where ectopic pregnancy cases are diagnosed and managed.

b) Al-Maqased Hospital – Jerusalem

- Al-Maqased is a highly regarded charitable medical center in Jerusalem, vastly known for offering state-of-the-art medical treatment, in addition to well-planned and separated departments.
- Obstetrics and gynecology are considered the foremost department in this hospital, which has been providing complete reproductive health services to women from Jerusalem and neighboring West Bank regions. Ectopic pregnancy cases are immensely welcomed here, hence being a perfect venue for recruiting participants who have gone through EP.

The present study is thus better placed to capture a range of experiences from women across different geographic areas, Ramallah in the West Bank and Jerusalem, sharing a cultural and linguistic background but perhaps very different in the healthcare pathways due to variations in the resources of hospitals and their accessibility.

4.4 Study Duration

The overall timeframe of the research spanned from February 2023 to June 2023. This period was sufficient for obtaining ethical approval, recruiting participants, collecting in-depth interview data, and initiating preliminary data analysis.

1.7 4.5 Study Population

The **target population** for this study consisted of **women in the middle of the West Bank** region who had experienced an ectopic pregnancy (EP) at some point in their reproductive lives. However, to ensure practical feasibility, the accessible population was defined as women diagnosed with and/or treated for ectopic pregnancy at:

- Ramallah Governmental Hospital, and
- Al-Maqased Hospital in Jerusalem.

Rationale for Selecting This Population

- **Medical Relevance:** As the incidence of ectopic pregnancy continues to rise globally, and given the limited body of qualitative literature on women's experiences specifically in Palestine, focusing on this group helps fill a critical gap in local and regional research.

- **Diversity of Cases:** Both hospitals manage cases that vary in severity, from expectant management of early-detected EP to emergency interventions for ruptured ectopic pregnancies. This diversity ensures a richer dataset of experiences.
- **Regional Representation:** Ramallah and Jerusalem represent distinct socio-political and demographic contexts within Palestine, potentially influencing healthcare access and personal coping strategies.

4.6 Eligibility Criteria

4.6.1 Inclusion Criteria

- Women who have been diagnosed with an ectopic pregnancy and received care at Ramallah Governmental Hospital or Al-Maqased Hospital.
- Aged 18 years or above (to ensure legal consent).
- Able to speak Arabic fluently (the interview language).
- Willing to provide informed consent and participate in an in-depth interview.

4.6.2 Exclusion Criteria

- Women with documented psychiatric disorders that could limit their ability to give informed consent or engage in an in-depth qualitative interview.
- Women physically or emotionally unfit to participate (e.g., currently hospitalized with complications or in acute distress) as assessed by the hospital staff.
- Women unable to communicate in Arabic (e.g., foreign nationals or those with severe communication impairments).

The criteria above were designed to ensure that participants could provide rich, firsthand insights into the phenomena under investigation, while also safeguarding their well-being.

4.7 Sampling Method and Sample Size

4.7.1 Sampling Method

A **purposive sampling** method was employed to select participants who could provide the richest possible data related to the aims of this study. Purposive sampling is widely recognized in qualitative research for facilitating the selection of “information-rich cases” (Mason, 2017). This approach ensures that participants meet specific criteria and, in turn, can share in-depth perspectives on the phenomenon under study—in this case, ectopic pregnancy (EP).

a) Identification of Potential Participants

- **Medical Records:** The researcher liaised with the obstetrics and gynecology departments in Ramallah Governmental Hospital and Al-Maqased Hospital. Hospital records were reviewed to identify women who had been diagnosed or treated for an ectopic pregnancy in the past 6 to 12 months.
- **Health Professionals’ Referrals:** Obstetricians, midwives, and nurses were informed about the study and asked to refer potential participants who met the inclusion criteria.

b) Contact and Recruitment

- **Initial Contact:** After obtaining permission from the hospitals, potential participants were contacted by phone or approached in person (during scheduled follow-up visits) to gauge their interest in participating.
- **Study Explanation:** The researcher explained the study’s purpose, procedures, and voluntary nature in Arabic, addressing any questions about confidentiality and the interview process.

This multi-channel recruitment strategy helped maximize the likelihood of reaching a diverse set of participants who had direct experience with an ectopic pregnancy, thus enriching the data collected.

4.7.2 Sample Size

Determining sample size in qualitative research is primarily governed by the concept of **data saturation** rather than statistical power (Xie & Chen, 2021). Saturation is achieved when no new themes or insights emerge, indicating that additional interviews would yield repetitive data (Alordiah & Oji, 2024). Consequently, the final number of participants was not predetermined but evolved as the study proceeded.

- **Anticipated Range:** Based on prior qualitative studies on sensitive reproductive health topics, the researcher initially anticipated interviewing approximately 10–15 women.
- **Saturation Point:** Interviews continued until the researcher perceived that recurrent themes were well-established and that subsequent interviews no longer contributed substantially new information. In the present study, saturation was reached after 10 indepth interviews.

4.8 Data Collection

4.8.1 Data Collection Tools

1. Semi-Structured Interview Guide

A **semi-structured interview guide** was developed in English and translated into Arabic by professional translator (see annex B)

The interview guide consisted of open-ended questions to explore the women's experience with an ectopic pregnancy, and their views on the impact of that experience on women's emotional, physical and social health, future reproductive life and coping mechanism.

- . Moreover, the guide also included introductory questions related to socio-demographic and obstetric characteristics of the interviewed women. The interview guide was developed based on the objectives of the study and guided by literature review on ectopic pregnancy and its psychosocial impacts (Spillane et al., 2018; Smith, 2007).

The guide included open-ended questions covering:

- a) Initial Reaction and Diagnosis**
 - “Could you describe your feelings when you first heard the term ‘ectopic pregnancy’ applied to you?”
- b) Medical Care Journey**
 - “How was your experience interacting with healthcare providers, from diagnosis to treatment?”
- c) Psychological and Social Impact**
 - “How did this experience affect your psychological status, fears, feelings about your self. impact on social relationships and family relationships
- d) Future Reproductive Decisions**
 - “How has this experience shaped your thoughts on pregnancy going forward?”

The open-ended format allowed participants to convey their narratives in their own words, giving the researcher opportunities to probe for further details. Moreover, the guide also included introductory questions related to socio-demographic and obstetric characteristics of the interviewed women.

4.9 Data Collection

The data collection process was conducted primarily through interviews at the participants' homes. Interviews were scheduled at times that were convenient for the participants. Prior to beginning each interview, participants received a comprehensive explanation of the study, including its purpose, potential risks and benefits, and confidentiality measures. They were

assured of their right to withdraw from the study at any point. Written consent was requested before recording, though in cases where participants were uncomfortable with signing documents, verbal consent was documented instead.

Interview sessions typically lasted between 50 to 80 minutes, though some extended up to an hour depending on the participant's willingness to share detailed information. Upon receiving consent, interviews were recorded using a digital audio device to ensure accuracy and completeness of data collection. Throughout the interviews, the researcher maintained detailed field notes to record the sociodemographic and obstetric data.

At the end of each interview, the main researcher thanked the participants for their time and information. They were provided with information about counseling services in West Bank, to ensure they had access to support beyond the research context if needed. Following the interviews, all conversations were transcribed verbatim in Arabic. All the interviews' data were saved in one file named interviews file.

Data saturation was reached after conducting 8 in-depth interviews, at which point no new themes or codes emerged during the analysis process. This was determined through continuous review and coding of interview transcripts, where the researcher observed repetition and consistency in the identified themes, including psychological distress, physical pain, social stigma, and variations in spousal support. Another two interviews were conducted to be sure about the saturation issues. By the 10th interview, all key themes had been fully developed and validated across participants, indicating sufficient depth and richness in the data. This aligns with accepted qualitative standards, where saturation is defined as the point at which no additional meaningful information is obtained, and further data collection no longer contributes to the understanding of the phenomenon under study.

4.10 Data Analysis

Method of Analysis: Thematic Analysis

Thematic analysis was employed to analyse the data collected from the in-depth semi structured interviews. Thematic analysis is suitable for uncovering recurrent subjects in qualitative data, particularly in health research contexts (Braun & Clarke, 2023). The researcher followed Braun and Clarke's six-step framework as below. Thematic analysis derives meaningful patterns (themes) and subthemes from the interview transcripts. Data analysis started parallel with the data collection and after copying the first three interviews. All interviews were transcribed, and coded in English. Then the similar coded copined together under suitable and meaningful themes and subthemes.

a) Familiarization with Data

- Re-reading transcripts and listening to audio recordings to deeply immerse in the data.
- Making initial notes and observations.

b) Initial Coding

- Systematic line-by-line coding using open codes.
- Codes capturing key ideas, emotions, actions (e.g., "fear of infertility," "emotional distress," "support from spouse").

c) Searching for Themes

- Grouping related codes into broader categories or themes (e.g., "Psychological Turmoil," "Social Isolation," "Coping and Resilience").

d) Reviewing Themes

- Checking each theme against the dataset to confirm consistency and meaningfulness.
- Eliminating or merging themes as necessary.

e) Defining and Naming Themes

- Clearly defining what each theme encompasses.

- Assigning names that reflect participants' voices (e.g., "Fear of the Unknown," "Healthcare Experiences").

f) Producing the Final Report

- Selecting rich excerpts from interviews to illustrate each theme.
- Contextualizing findings within existing literature on ectopic pregnancy and women's health.

Example of Coding Table

All interviews were done in Arabic and recorded verbatim to maintain the participants' authentic expressions. The transcripts were subsequently transcribed into English by a bilingual researcher adept in both languages and knowledgeable in medical and qualitative research terms. A back-translation technique was utilized to guarantee that the translated information adequately represented the original meaning. An independent translator, lacking prior familiarity with the source transcripts, retranslated the English version into Arabic. The back-translated material was subsequently compared with the original Arabic transcripts to detect any discrepancies or loss of meaning. Upon discovering inconsistencies, the research team collectively examined and amended the English translation to ensure conceptual, semantic, and cultural fidelity. To enhance the credibility of essential quotations, a third bilingual expert evaluated specific extracts to verify that the emotional tone, context, and intent of participants' experiences were accurately represented in English. This multi-step validation approach safeguarded the integrity of participants' experiences and verified that the translated data accurately reflected their voices.

Below is a simplified example of how the researcher moved from raw data to codes and then to themes. Table 4.1 illustrates excerpts from participants.

Table 4.1 Quotation, Codes, Subthemes, and Themes

This table provides direct quotations from the interviews that illustrate each theme and subtheme, capturing the emotional, physical, and social experiences of women with ectopic pregnancy.

Theme	Sub-theme	Code	Quotations
Psychological Impact of Ectopic Pregnancy	Sadness, denying, and tearful	Emotional breakdown	
	Fears especially from infertility	Fear of pregnancy	future loss "I was afraid it would happen again. I was never at ease. I kept imagining: what if I have to go through this nightmare another time? ... I worried I wouldn't be able to become a mother again."
Marital dynamics	Social Isolation and Limited Social Interactions		My life was restricted to the my home and my bed room (Interview 4, 27)
	Blaming ignorance and	Blame	shifting my husband preferes to stay at her mother and his father home long time."(Interview 6, 20)
	Avoiding intimate relationship	Emotional distancing	There was no sexual relationship for more than 3 months (Interview 6, 20)

Ethical Considerations

a) Ethical Approval

- Institutional Review Board (IRB) and Ethical clearance was obtained from the from ethical committee at Al- at Al-Quds University in the West Bank. All procedures complied with the ethical guidelines, including respect for privacy, confidentiality, and informed consent. (appendx 2, 3, and 4 illustate approval from (Al Quds University, Al-Makassed Islamic Charitable Society Hospital, Ministry of Health)

b) Informed Consent

- Participants received a thorough explanation of the study purpose and procedures, potential benefits, and risks.
- All were assured they could withdraw at any point without any repercussions and voluntary participation reassured.
- Given the sensitive nature of ectopic pregnancy and its potential emotional distress, participants were also informed about avenues for counseling and support.

c) Confidentiality and Anonymity

- All identifying information was removed or replaced with pseudonyms/codes during transcription.

- Transcripts and audio files were stored on password-protected devices accessible only to the principal investigator and academic supervisors.
- Participants' personal details (e.g., names, addresses) were not disclosed in any publication or presentation.

d) Participant Well-Being

- Since recounting an ectopic pregnancy can elicit emotional stress, the researcher ensured the availability of psychosocial support referrals if a participant exhibited signs of distress.

4.11 Trustworthiness and Rigor

Establishing trustworthiness in qualitative research involves four critical criteria: credibility, dependability, transferability, and confirmability (Guba, 1981; Schwandt et al., 2007). The study instrument was validated by expert assessment of the interview and open-ended questions by three supervisors at al Quds University and Bethlehem university, all of whom had substantial expertise in qualitative research. The questions were further revised through collaborative talks between the researcher and the research supervisor.

Credibility was established through many means. Qualitative research seeks to describe and comprehend phenomena, with the trustworthiness of results primarily evaluated from the participants' viewpoint. Consistent consultations with the academic supervisor were held during the data gathering and analysis stages. Transcript evaluations were conducted to uphold objectivity and reduce bias, concurrently assessing novel designs and hypotheses to guarantee research integrity (Lincoln et al., 1985). To augment credibility, transparency, and reliability, three interviews were independently coded by both the researcher and the supervisor, succeeded by comparison analysis. Alternative viewpoints were examined during code review meetings with supervisors at Al-Quds University. The researcher utilized participant validation by directly confirming codes with participants, assuring consistency with the original meaning in the raw data. In accordance with Strauss's (1990) guideline, the researcher employed participants' verbatim expressions during the coding process.

Confirmability in qualitative research recognizes the distinct perspective of each researcher while guaranteeing that results can be validated by others (William, 2006). The study's confirmability was enhanced by systematic documenting of data verification processes and consistent presentation of findings to supervisors for analysis and assessment. The researcher offered a cogent rationale for using interviews as the principal data gathering method and augmented data diversity by interviewing both victims and professional colleagues.

Concerning dependability, the researcher implemented explicit, replicable protocols and upheld reflexivity throughout the technique (Gasson, 2003). This encompassed comprehensive documentation of the research design, execution strategy, and data collection processes, along by meticulous explanations of both the intended and executed components of the study.

Transferability, akin to generalizability, denotes the potential applicability of study findings across diverse contexts or situations (Bitsch, 2005; Tobin & Begley, 2004). Bitsch (2005) asserts that transferability assessments are enhanced by "thick description" and intentional sample methods, both of which were utilized in this research.

4.12 Summary

This chapter presented the detailed methodology used to explore the experiences of Palestinian women diagnosed with ectopic pregnancy. A qualitative descriptive design was adopted to capture the richness and diversity of women's narratives. Two major hospitals—Ramallah Governmental Hospital in the West Bank and Al-Maqased Hospital in Jerusalem—served as the study settings, facilitating a diverse recruitment of participants via

purposive sampling. Data were collected using indepth interviews, transcribed verbatim, and analyzed through thematic analysis. Ethical protocols were observed meticulously, ensuring respect for participants' privacy and welfare. Finally, the rigor of the study was maintained through established measures of credibility, transferability, dependability, and confirmability, underscoring the robustness and ethical integrity of the research process

Chapter Five:

Results

5.1 Introduction

This chapter presents the findings of a qualitative study among 10 women experienced ectopic pregnancy. The study explored the Palestinian women's experiences with ectopic pregnancy (EP). The findings include Sociodemographic and obstetric Characteristics of the Participants as well as the five interrelated themes were emerged from the qualitative thematic data analysis; Psychological Impact of Ectopic Pregnancy, Physical Impact to Ectopic Pregnancy, Social Impact of Ectopic Pregnancy and Variation in Husband's Reaction to Ectopic Pregnancy and Health Care Providers Treatment. Each theme and subthemes are illustrated with direct participant quotes (English translations). These quotes are followed by a detailed interpretation, linking participants' narratives to broader research findings.

5.2 Sociodemographic Characteristics of the Participants

A total of ten women participated in the study, each bringing her unique perspective and life context to the discussion of ectopic pregnancy.

In reviewing the characteristics of the participants, the majority of participants were relatively young, with half of them falling between 20 and 29 years old. This age profile is reflective of the early childbearing period commonly seen in Palestinian society, where marriage and family formation often begin at younger ages. While two participants were in their early thirties, the overall impression is one of a predominantly youthful sample still in a crucial period of family building.

Education levels were split as four women reported holding a bachelor's degree in various fields, while one woman had a two-year college diploma. Despite some having tertiary degrees, most participants described themselves as housewives, reflecting social norms in some parts of Palestine, where married women may leave formal employment to focus on household responsibilities and childrearing. One participant was a teacher, another a student, and the remainder occupied roles within the home or as a kindergarten teacher.

Place of residence varied, with the majority of the participants living in Ramallah City, while 3 of them resided in Jerusalem. This diversity indicates that the participants were drawn from multiple geographic contexts, each with its own cultural and infrastructural nuances.

Table 4.1 presents these participants' characteristics in terms of age, education, occupation, place of residence, and number of children. The summary of these characteristics is provided in narrative form, ensuring a cohesive understanding of the sample composition.

Table 5.1. Sociodemographic Characteristics of the Participants (n = 10)

Demographics	Classification	N (%)
Age	20-29 Years	8 (80%)
	30- 40 Years	2 (20%)
Education	Bachelor degree	4 (40%)
	Diploma	1 (10 %)
	School	5 (50%)
Occupation	Teachers	4 (40%)
	Housewives	6 (60%)
Residency	Ramallah	7 (70%)
	Jerusalem	3(30%)

5.3 Obstetric Characteristics of the Participants

In addition to their sociodemographic features, participants also displayed a range of obstetric histories. The number of children each participant had ranged from zero to four, Table 4.3 highlights the number of children each woman had, her abortion history, the gestational age at which the ectopic was discovered, the type of pregnancy (e.g., IVF vs. spontaneous), and the intervention or complications that arose. All these factors shape a woman's prior understanding of obstetric risks and her emotional reaction to discovering she had an ectopic pregnancy.

To enhance the credibility and accuracy of the data collected during interviews, each participant's obstetric history was verified by reviewing her medical records prior to conducting the interview. This included confirming details such as the gestational age at diagnosis, type of treatment received (e.g., surgical or medical management), previous pregnancy outcomes, and any associated complications . By cross-referencing self-reported experiences with documented clinical information, this approach helped minimize recall bias , particularly for events that occurred several months or even years before participation in the study. While the primary focus of the research was on women's lived experiences rather than clinical accuracy, this step ensured that personal accounts aligned with verifiable medical facts , thereby strengthening the trustworthiness and rigor of the qualitative data. This method also supported more accurate interpretation of how women understood and described their experiences in relation to actual medical events.

Table 5.2. Obstetric Characteristics of the Participants (n=10)

Interviews	No. of Children	Abortion	Period After Previous Ectopic	GA of Ectopic	Pregnancy Type	Complications of Ectopic
Interview 1	1	4	18 months	8 Wks	IVF	Salpingectomy
Interview 4	1	1	9 months	8 Wks	Normal	Salpingectomy
Interview 3	2	No	7 months	10 Wks	Normal	Salpingectomy
Interview 2	0	No	11 months	11 Wks	Normal	Medical management
Interview 5	1	1	10 months	9 Wks	Normal	Salpingectomy
Interview 6	0	0	12 months	12 Wks	Normal	Salpingectomy
Interview 7	3	1	16 months	7 Wks	Normal	Salpingectomy
Interview 8	2	0	12 months	9 Wks	Normal	Salpingectomy
Interview 9	3	0	18 months	7 Wks	Normal	Salpingectomy
Interview 10	4	1	11 months	10 Wks	Normal	Salpingectomy

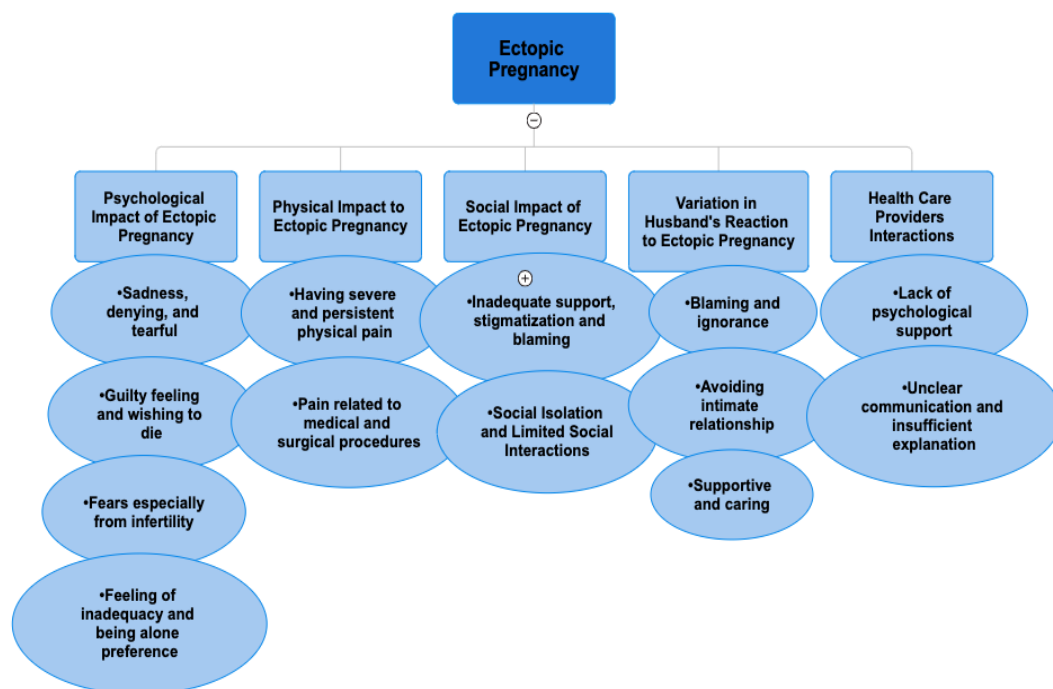
Analysis of the obstetric characteristics reveals that 5 participants (50%) had previously undergone spontaneous abortions. This finding suggests that some participants had already experienced reproductive losses, which may have heightened their anxiety upon being diagnosed with another complicated pregnancy. Additionally, the gestational age at which ectopic pregnancy was discovered varied, with most detected in the early weeks of the first trimester. Nine of the participants (90%) required surgical salpingectomy, indicating a likely advanced or ruptured state. One participant (Interview 2) underwent a medical management regimen. Nine of the participants (90%) had ectopic pregnancy post spontaneous pregnancy and one (10%) of the ectopic pregnancy occurred after IVF.

5.4 Emergent Themes from the thematic analysis

There are five interrelated themes were emerged from the qualitative thematic data analysis; Psychological Impact of Ectopic Pregnancy, Physical Impact to Ectopic Pregnancy, Social Impact of Ectopic Pregnancy and Marital Dynamics and Health Care Providers Treatment. Table 4.4 show the summary of these themes and their subthemes

Table 5.3 Summary of Themes and Subthemes

Theme	Subthemes
Psychological Impact of Ectopic Pregnancy	<ul style="list-style-type: none"> • Sadness, denying, and tearful • Guilty feeling and wishing to die • Fears especially from infertility • Feeling of inadequacy and being alone preference
Physical Impact to Ectopic Pregnancy	<ul style="list-style-type: none"> • Having severe and persistent physical pain • Pain related to medical and surgical procedures
Social Impact of Ectopic Pregnancy	<ul style="list-style-type: none"> • Inadequate support, stigmatization and blaming • Social Isolation and Limited Social Interactions
Marital dynamics	<ul style="list-style-type: none"> • Blaming and ignorance • Avoiding intimate relationship • Supportive and caring • Lack of psychological support
Health Care Providers Interactions	<ul style="list-style-type: none"> • Unclear communication and insufficient explanation



Fig(5.1) summary of themes and subthemes related Women's Experiences with Ectopic Pregnancy

5.4.1 Psychological Impact of Ectopic Pregnancy

All the participants women expressed their experience with ectopic pregnancy, five subthemes emerged from this theme Sadness, denying, and tearful, Guilty feeling and wishing to die, Fears especially from infertility and Feeling of inadequacy and being alone preference.

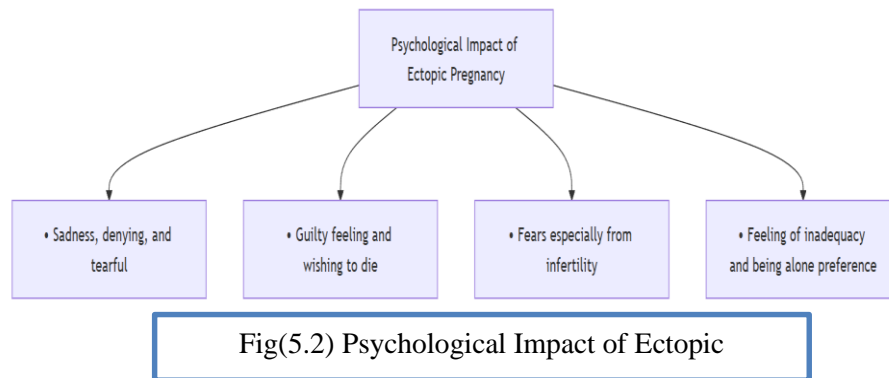


Figure 5.2. Psychological Impact of Ectopic Pregnancy

5.4.2 Sadness, Denying, and Tearful

Women across the sample recounted profound emotional distress, often marked by sadness, crying and denying. The majority of the women mentioned that they felt that Losing of hope and happiness to maintain pregnancy after discovering ectopic pregnancy and having Had bad memories, insomnia and discomfort Several participants described experiencing intense shock upon receiving the diagnosis, often followed by uncontrollable crying. One woman, Participant 3 (Age 26), expressed how overwhelming the news was:

"Once I heard there wouldn't be a baby and I'd be in even more pain, I completely fell apart. ... My husband tried to calm me, but I felt like my world just ended right there."

Participant 1 (Age 37) described a moment of overwhelming happiness initially, followed by intense sorrow:

"When I discovered I was pregnant, I can't describe my happiness. ... But it did not last long. Just a short time after finding out, I started experiencing a severe pain in my abdomen, shocked and I start crying ... I realized something was not normal."

She added:

"It was horrible, it was such a bad phase. My mental state was shattered."

"We welcomed the news of my pregnancy with happiness, especially since my previous pregnancy ended in miscarriage. Pregnancy is always good news for all mothers, even if she already has 10 children. It feels like a gift from God to the family. We were all happy - me, my husband, my family, and his family." (Interview 5, Age 28)

"The pregnancy experience itself was new to me because it was my first pregnancy after getting married 4 months earlier. I was happy, and so were my husband, my family, and his family. It was good news for everyone." (Interview 6, Age 20)

5.4.3 Guilty Feeling and Wishing to Die

Guilty feeling and wishing to die was heard from several participants due to ectopic and pregnancy loss. Several participants express their feeling of guilt because they lost the pregnancy and a wish to die because they unable to keep her pregnancy to term. One participant described:

"When they told me that the pregnancy could not continue, I fell into depression. It was a shock added to the feeling that, 'Oh Allah, let me die, I don't want to live anymore.'"

Participant 7 (Age 22) also talked about her sense of guilt and punishment:

"A couple of days after I started having pain... I cried and was afraid of God, as if He was punishing me because initially, I didn't want this gift from Him."

"When I found out I was pregnant, honestly, I didn't want this pregnancy because my children are still young and close in age. It had only been 3 months since I had a miscarriage,

and I was feeling that my body was tired. I didn't want this pregnancy." (Interview 7, Age 22)

5.4.4 Fears, Especially from Infertility and future pregnancy

Fear, particularly the fear of infertility, emerged as a dominant concern. The majority of the participants express their feeling about becoming infertile after ectopic pregnancy.

Participant 6 (Age 20) vividly stated:

"I was afraid it would happen again. I was never at ease. I kept imagining: what if I have to go through this nightmare another time? ... I worried I wouldn't be able to become a mother again."

Another participant expressed:

"At the hospital, during the examinations and procedures, they found that one of my tubes had ruptured because the pregnancy wasn't in the right place. I wasn't thinking so much about my body as I was about not being a mother anymore, about becoming infertile with lower chances than normal women." (Interview 6, Age 20)

Two of the participants had fears of recurrent ectopic pregnancy one of them mentioned:

"I was afraid it would happen again as ectopic pregnancy. I was never at ease." (Interview 10, Age 27)

A significant finding was that the experience of ectopic pregnancy often translated into fear about future childbearing because their ectopic pregnancies were not going easily and they experience complications.

Another one said:

"Of course it was painful. I was dying from pain, and it wasn't pleasant. I started thinking if pregnancy and pain are like this, how would birth and the next pregnancy be? I developed a fear of this experience." (Interview 6, Age 20)

The same participant continued: "I would cry a lot because I feel I'm still a bride and still too young for these pains. Since it was my first experience, I became afraid it would repeat because it was very painful."

"I was very scared and sad because I was no longer pregnant and had been living in the illusion of pregnancy. I was scared because I knew I would be in pain for nothing, for something that wasn't there. The pain of childbirth is bearable because there's a beautiful result waiting for you - a baby. But the pain of losing a baby is something else entirely. This would be my second time, and it was definitely painful. It was a painful experience and not pleasant." (Interview 5, Age 28)

5.4.5 Feeling of Inadequacy and Being Alone Preference

Beyond fear and guilt, some participants felt shame from husband, Feeling of Inadequacy was also expressed by three of the participants when they expressed their feeling about themselves after ectopic pregnancy, as they feel that something from their body was missed because they had salpingectomy as well as feeling of inadequacy because they feel that they themselves were the problem.

"One of them said:

I feel that I became an incomplete woman because I lost one tube" (Interview 5, Age 28)

The Participants also added that this inadequacy because of the tube loss make them feel shy and embarrassed from their husbands about their fertility future. She added:

"I was embarrassed to talk about fertility issues with my husband because I was ashamed that the problem was from me." (Interview 5, Age 28)

Almost all of the participants describe their experience as a bad experience and express their desire to be always alone with limited people contact after experience of ectopic. They added that unlike to communicate with people and prefer to be alone and in dark places most of the time.

One of them said:

"I didn't want to see anyone or speak to anyone; I just wanted to stay alone in a dark room."
(participant 1, Age 37)

My life has become just moving from the bedroom to the bathroom to the living room
Interview9, 30

"It was certainly a bad experience. I am socially by nature and I love visiting my family, my husband's family and our relatives, but during that period I did not want to contact any one
(Interview 1, Age 37)

5.4.5 Physical Impact to Ectopic Pregnancy

All the participants mentioned about having physical pain during ectopic pregnancy experience, two subthemes emerged from this point; Having severe and persistent physical pain and Pain related to medical and surgical procedures

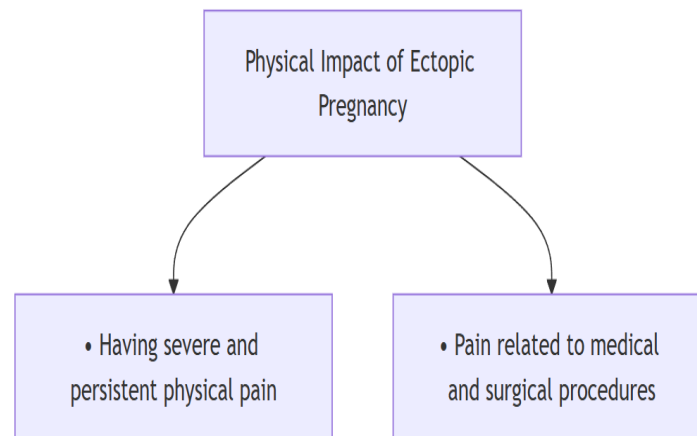


Fig (5.3) Physical Impact to Ectopic Pregnancy

Having Severe and persistent Physical Pain

Participants repeatedly emphasized the severe, continuous physical pain associated with ectopic pregnancy. The majority of the participants said that they have severe, continuous abdominal pain before and after surgery

Participant 4 (Age 27) described fainting from the intensity:

"Every moment was filled with extreme pain. I actually fainted once from how bad it was. Even after surgery, I was still in pain for two weeks at home."

Many participants reported that the physical impact of ectopic pregnancy extended well beyond the acute phase, affecting their bodies for months afterward:

"I experienced very strong pains throughout my entire body, and some days the pain was continuous even with painkillers; the pain wouldn't subside much." (Interview 1, Age 37)

Participant 3 (Age 26) shared her immediate experience: "From the first moment, I felt strong abdominal pain."

"Alhamdulillah's, it was an experience to remember but not repeat. An indescribable feeling of fear and sever pain too." (Interview 3, Age 26)

The chronic nature of this pain suggests that recovery from ectopic pregnancy is not just a short-term medical event but a prolonged physical ordeal that can disrupt daily functioning for extended periods. This ongoing physical suffering compounds the psychological distress, creating a cycle of pain and emotional turmoil that can be difficult to break.

5.4.6 Pain Related to Medical and Surgical Procedures

Pain due to treatment procedures was reported by most of the participants and they mentioned that their treatment of ectopic pregnancy was not easy.

One participant said: Treatment of ectopic pregnancy was not easy, it was painful, risky and take long time (interview7,22)

Moreover, the majority take about the pain mixed with fears that they experienced before and after surgery, medical or surgical procedures that they received during being under treatment. The participants express their feeling of severe pain mixed with fears from surgery and concerns about their health after ectopic pregnancy. One participant said

"It was an experience where every moment was filled with severe pain. I reached the point where I would faint from how intense it was. Even after surgery, with painkillers, the pain was still severe. When I went home, it continued for two weeks." (Interview 4, Age 27)

Participants also discussed the pain related to medical or surgical interventions. Meanwhile, Participant 6 (Age 20) highlighted her apprehension regarding surgery, especially the possibility of losing a fallopian tube:

"During the hospital tests, they found that one of my tubes had ruptured... I wasn't thinking so much about my body as I was about not being a mother anymore, about becoming infertile."

"They gave me medication to relieve the pain at the hospital and gave me an intramuscular injection. They kept me in the hospital under observation and then sent me home, telling me to come back after a few days to do the accumulative test." (Interview 5, Age 28)

"A few days later, we returned to the hospital, and the test was still high. They told me I needed to be formally admitted to the hospital. I became depressed and upset and told them to let me go home. I didn't want to do anything or stay there. I signed that I was leaving against medical advice because I wanted to go home." (Interview 5, Age 28).

The participants express that ectopic pregnancy experience was bad, complicated and unexpected because of pain, procedures, risk and fears associated.

5.4.7 Social Impact of Ectopic Pregnancy

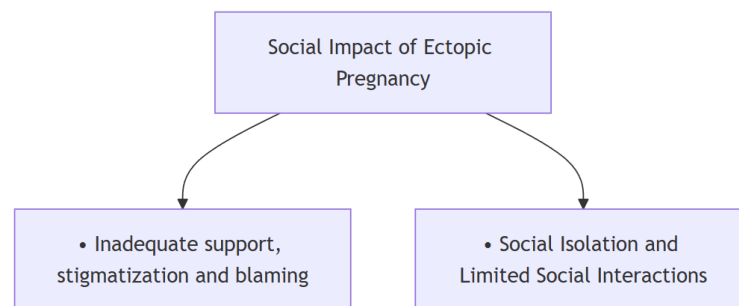


Fig (5.4) Social Impact of Ectopic Pregnancy

5.4.8 Inadequate Support, Stigmatization and Blaming

Several participants express that they receive inadequate support from their families because their family members unable to understand the extent of the participants losses.

The participants reported they feel that they just were receiving empathy from their families more than the needed support at that time. Their family members especially the mothers, sisters stay with them at hospital, though this often came with a sense that no one truly understood the extent of their loss and the needed support. The participants added that their families try to support us but their support level was not reaching our sadness level.

One Participant remarked:

"My sisters and mother kept telling me 'It's okay, your situation is better than others. May Allah reward you.' But they didn't really grasp the sadness I was in. I felt alone."

(Interview 1, Age 37)

"My mother definitely didn't fall short and kept staying with me the whole time while I was in the hospital and at home after the hospital. She stayed by my side." (Interview 6, Age 20)

Stigmatization and Blaming was also emerged as subtheme, Some of the Participants mentioned that they had strained relationships with their husband's family and they did receive blaming because of having ectopic pregnancy. Three of the participants mentioned that they were stigmatized and blamed from their family in law.

Participant 6 (Age 20) encountered blame from her mother-in-law:

"My mother-in-law and my sisters-in-law blamed me and burden me with guilt because of ectopic pregnancy and my husband stopped caring for me because of what they were saying."

One of the participants revealed that her predecessor was insulted and stigmatized her because she had ectopic and did not have children.

"My predecessor was insulted me and said you didn't tolerate my children play and their sound because you don't have children and you lost your pregnancy as well" (Interview 1, Age 37)

5.4.9 Social Isolation and Limited Social Interactions

The experience of ectopic pregnancy often led women to withdraw from social interactions, creating a sense of isolation that exacerbated their emotional distress: The majority of the participants mentioned that they prefer limited social life just with their families and close friends

"My biggest challenges were social because my family was in another country. Both my family and my husband's family were far from us, and my relationships were limited since I was new to the country with my husband. My social life was restricted to my female colleagues, and beyond that, just video calls with my sisters, mother, and father." (Interview 4, Age 27)

5.4.10 Marital Relationship (Variation in Husband's) Reaction to Ectopic Pregnancy

The participants revealed variation in reaction of their husbands towards the ectopic pregnancy experience ranged from Blaming, ignorance, avoiding intimate relationship and Supportive and caring

Blaming and Ignorance

Marital dynamics emerged as a critical factor, with some husbands reacting by blaming or showing ignorance. One participant revealed that his husband blamed her when having ectopic because she was not like her pregnancy from the beginning. Participant 7 (Age 22) recalled:

"my husband loves having children. The first thing he told me was, 'Aren't you the one who didn't want this pregnancy? Look what happened now?' He made me feel it was all my fault."

Three of the participants mentioned that their husband ignored them and prefers to be away from them and their husband was not cooperative and they were disappointed from them.

. One participant said:

"The first days after I returned from the hospital, my husband would sleep and eat at his mother's house. He only came home to get his things. He didn't even come with me for hospital follow-ups---my mother went with me instead. He wouldn't call me, and if I called him, he would barely answer my questions and seemed like he couldn't stand me." (Interview 6, Age 20).

Several participants described a profound emotional dryness and lack of emotional contact that developed between them and their spouses following the occurrence of ectopic pregnancy.

"My husband didn't help me get through this phase. He didn't try to get close to me or show compassion. It was like he chose for each of us to heal separately on our own." (Interview 1, Age 37).

Avoiding Intimate Relationship

Avoiding Intimate Relationship is another issue that reported by some of the participants Participant 6 (Age 20) shared:

"We didn't have any sexual relations for over three months, and it really affected me emotionally."

This avoidance reflects the deep psychological toll that ectopic pregnancy can impose on marital relations, intensifying the woman's sense of isolation.

Supportive and Caring

The husband reaction was varied through the participants interviews, not all husbands reacted negatively towards their wife. Some of the participants said that the ectopic pregnancy experience was a cause to make their husband very close to them, they added that their husband offered empathy and encouragement, providing a vital source of support and being calm and strong even they feel sad.

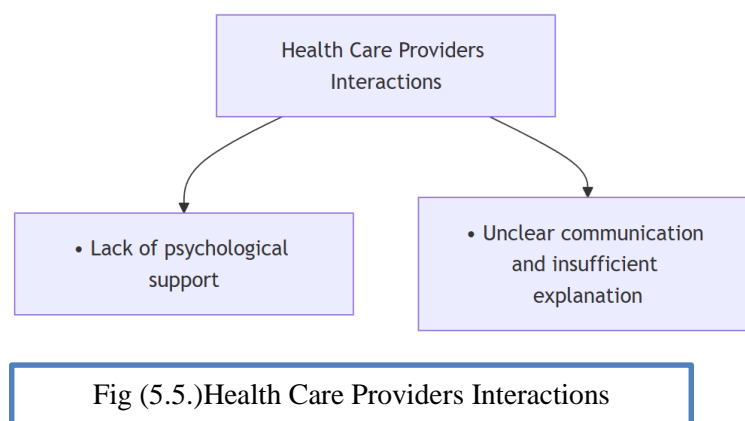
Participant 5 (Age 28) noted:

"my husband was sad, but he tried to remain stronger than me. He would reassure me, support me all the time and was more optimistic than I was, even though we both faced the same shock."

"This experience made me and my husband very close together, and he was the main source of support and encouragement". (Interview 4, Age 27)

Health Care Providers Interactions

The participants revealed that Health Care Providers interaction was not as they expected. Two subthemes were emerged from this theme; Lack of psychological support and Unclear communication and insufficient explanations



5.4.11 Lack of Psychological Support

The participants said that they also encountered lack of psychological support from Health care providers because they just want to provide the necessary care to the participants.

. Participant 6 (Age 20) stated:

'The medical staff did not take my psychological state into their considerations. They were only telling me that I am in need for emergency operation and then they would explain it to

me later. I was looking for anyone to show some care for my emotional well-being. So, the situation was not comfortable at all”.

She added that she received poor treatment from the healthcare team during hospitalization “The medical staff treated me very badly. I have had enough of my own worries and bad moods, and I am looking for someone to care about me and reassure me”. Interview 6.20

Another participant added that there was no qualified professional person available to provide psychological support in such cases

“I did not receive any psychological or social support from any specialized person in the hospital in this field.” interview 4,27

Unclear Communication and insufficient explanation

Participants also reported that healthcare professionals offered insufficient explanation about their conditions, care provided and procedures conducted and they added that they did not understand what happening to them because of no accurate explanation from the health care providers sites and this make them afraid and confued. Participant 1 (Age 37) highlighted:

"Neither I nor my husband or family knew what was happening. Every time we asked someone at the hospital, they gave us explanations, but we still left feeling confused."

Chapter Six

Discussion

6.1 Introduction

This chapter presents an in-depth discussion of the themes that emerged from the qualitative analysis of Palestinian women's experiences with ectopic pregnancy. Framed through Trauma Theory, the findings highlight how ectopic pregnancy is not only a medical emergency but also a reproductive trauma that disrupts women's physical, emotional, and social well-being. The sudden and life-threatening nature of this condition, coupled with its impact on fertility and identity, aligns with established trauma responses such as grief, guilt, fear, and isolation—particularly within conservative cultural settings.

By interpreting the lived experiences of these women through a trauma-informed lens, this study contributes to both theoretical understanding and practical approaches to post-ectopic care. It emphasizes the need for integrating psychosocial support into reproductive healthcare policies in Palestine and tailoring clinical practices to better address emotional distress, improve communication, and reduce stigma. These insights are essential for informing culturally relevant, patient-centered interventions that go beyond medical treatment to include holistic recovery and long-term mental health support.

The results revealed five overarching themes: Psychological Impact of ectopic pregnancy, Physical Impact of ectopic pregnancy, Social Impact of ectopic pregnancy, Marital Relationship Reaction to ectopic pregnancy, Health Care Providers' Interactions. These themes demonstrate that ectopic pregnancy is far more than a medical condition; it is a deeply personal event shaped by cultural, familial, and healthcare factors.

6.2 Psychological Impact of Ectopic Pregnancy

6.2.1 Sadness, Denying, and Tearful

The most exciting issue was that the majority of the women were described the rapid shift from the excitement of learning about a pregnancy to the sudden devastation of an ectopic diagnosis. Participants frequently mentioned shock, describing how their joy evaporated once they realized the pregnancy could not continue safely. This was often accompanied by denial, with women hoping that perhaps the diagnosis was incorrect, and episodes of intense crying that sometimes persisted for days or weeks. This initial grief reactions were also reported in other previous studies related to pregnancy loss, where women experience overwhelming sadness upon realizing their anticipated motherhood is threatened (Lasker & Toedter, 2010; Shahawy & Diamond, 2018). According to the Palestinian community According to the Palestinian society where early childbearing is often socially expected and very basic; pregnancy loss intensifies emotional distress (Shahawy & Diamond, 2018). Moreover, ectopic pregnancy is unfamiliar experience and this increase women fears, shock and interactions. Most of the participants had a feeling of loss leading to persistent sorrow

and difficulties in accepting reality. This emotional upset emphasizes the need for early psychological intervention, care and support, as prolonged denial or unresolved grief can develop into more severe mental health issues such as depression or anxiety disorders as reported in a previous study (Cordova-Pozo et al., 2018). The emotional and psychological turmoil induced by abrupt and life-threatening health occurrences such as ectopic pregnancy parallel with the trauma theory explanation. The paradigm affirms that experiences of loss, solitude, and dread are trauma responses. From the perspective of trauma theory, ectopic pregnancy represents a reproductive trauma that undermines both physical health and the woman's sense of bodily autonomy and reproductive identity. The persistent emotions of guilt, anxiety, and self-isolation align with established trauma responses, particularly in culturally conservative environments.

6.2.2 Guilty Feeling and Wishing to Die

Another major psychological burden involved self-blame and guilt, with some participants expressing a desire to die. Several women believed they were being “punished by Allah” for either not wanting the pregnancy initially (due to health or personal reasons) or for perceived personal shortcomings. These internalized feelings of guilt and shame can be exacerbated by cultural narratives, which often hold women responsible for reproductive outcomes (Lok & Neugebauer, 2007). Guilty feeling and self-blaming are deeply affecting the women and delay their recovery from the pregnancy loss and may affect their psychological status especially in conservative community like Palestinian one because women also face a lot of stressors from their families, husband and community. This was also supported by previous study which indicated that the severity of the self-blame after a pregnancy loss can hinder emotional recovery and increase the risk of prolonged grief or suicidal ideation (Farren et al., 2018). Moreover, the spiritual dimension—where some women interpret ectopic pregnancy as divine punishment—compounds these feelings, making psychological support from husband, family and healthcare providers particularly crucial because if the women's emotions left unaddressed, such as guilty feeling, this may lead to persistent isolation, heightening the risk of clinical depression as this reported in a previous study (Geller et al., 2010).

6.2.3 Fears Especially from Infertility

One of the ectopic pregnancy complications is infertility because of the risk of losing fallopian tubes. Infertility is one of the major women's concern in the Palestinian community because it affects their future marital life. Fear of future infertility emerged as a dominant concern of women, reflecting the central role that childbearing plays in participants' social and familial identities. The physical consequences of ectopic pregnancy—especially salpingectomy—intensified these fears, as women worried their fertility might be permanently compromised (Barnhart, 2009). In Palestinian culture, where motherhood is strongly valued, even the possibility of reduced fertility can trigger long-lasting psychological distress (Shahawy & Diamond, 2018).

Beyond fertility itself, a few participants voiced concerns about recurrent ectopic pregnancy, underscoring how one traumatic experience can alter perceptions of subsequent pregnancies. The emotional toll of ectopic pregnancy thus becomes cyclical: women fear both the loss of future pregnancies and the prospect of reliving a physically and emotionally painful ordeal. When healthcare providers do not adequately explain future fertility prospects or address these anxieties, fear may escalate, hindering women from seeking timely medical follow-up (Practice Committee of the American Society for Reproductive Medicine, 2013).

6.2.4 Feeling of Inadequacy and Being Alone Preference

A further psychological thread concerned women's sense of inadequacy and shame which frequently led them to self-isolate. Some of the women reported feeling of inadequate as other women because of losing their fallopian tube. So, most of the participants express their preference of being alone and sometimes sitting in dark rooms and withdrawing from social or familial circles. In a conservative culture, where extended family interactions are typically supportive, this withdrawal signals the severity of their distress, shame and the sensitivity of the subject. This was also mentioned in a previous study (Cordova-Pozo et al., 2018). A previous study in similar cultural contexts showed that stigma and fear of being judged from others especially about pregnancy loss drive women to internalize blame and avoid social contact (Kelly-Harrington et al., 2024; Lok & Neugebauer, 2007).

Another study added that without providing interventions such as counselling or psychoeducation, women internalized feelings of stigma, fear and inadequacy can persist and exacerbate marital tension (Lok & Neugebauer, 2007).

6.3 Physical Impact to Ectopic Pregnancy

6.3.1 Having Severe and Persistent Physical Pain

All participants described acute and unrelenting pain, with some fainting from its intensity. This aligns with global data, showing that ectopic pregnancy, particularly when ruptured, can be a leading cause of first-trimester maternal morbidity (Royal College of Obstetricians and Gynaecologists [RCOG], 2016). For many women, the severity of pain extended beyond the initial emergency, requiring extended rest and pain management at home.

As noted in other regions, prolonged physical discomfort can compound psychological stress, with persistent pain serving as a continual reminder of the lost pregnancy (Farren et al., 2018). Participants emphasized how daily life activities, including household chores or childcare, became difficult, thereby adding practical challenges to their already strained emotional state.

6.3.2 Pain Related to Medical and Surgical Procedures

Treatment for ectopic pregnancy often involves urgent surgical intervention (e.g., salpingectomy) or, in some cases, pharmacological management (e.g., methotrexate). Participants who underwent invasive procedures described not only severe post-operative discomfort but also intense anxiety about the procedure itself—especially the loss of a fallopian tube (Practice Committee of the American Society for Reproductive Medicine, 2013).

the majority of the women in this study, hospital stays were marked by fear and confusion, as they received minimal explanations about the necessity and implications of surgical versus medical treatment, as well as the pain they felt from the medical or surgical procedures they faced during receiving treatment. Women feeling of fear, powerlessness they felt with lack of accurate explanation from the healthcare providers showed that the physical aspect of ectopic pregnancy is inseparable from emotional turmoil.

6.4 Social Impact of Ectopic Pregnancy

6.4.1 Inadequate Support, Stigmatization, and Blaming

According to the Palestinian community, having children is a drive and power for the women in front their family in law and husband too, so losing pregnancy is a stigma. In this study, although some participants received sympathy and help from close family members, they consider it as inadequate to felt supported. Moreover, other women reported encountered insensitivity or blaming particularly from the husband family members. In some cases, women reported that their family members lessen the woman's grief or implied she was at

fault for the ectopic pregnancy. This results was also aligned with the results of previous study that showed where cultural expectations of motherhood can lead relatives to assign responsibility for reproductive outcomes to the woman alone and burden her with all consequences (Kelly-Harrington et al., 2024). The huge psychological burden including stigmatization and physical burden on women and lack of empathetic support, can exacerbate psychological distress and hinder emotional healing of the women whom experiencing ectopic pregnancy. This indicates that women often felt misunderstood, as though their relatives acknowledged only the physical events and disregarded the deep emotional suffering. This is consistent with a previous study result that concluded blame and stigma around pregnancy loss can magnify feelings of shame, leading women to isolate themselves further (Lasker & Toedter, 2010).

6.4.2 Social Isolation and Limited Social Interactions

Beyond familial relationships, the majority of the participants reported withdrawing from broader community engagement and social interactions after encountering ectopic pregnancy experience such as workplace interactions, and friendships. This isolation was sometimes geographic, as some families lived far away from the women place of living, but it was more commonly self-imposed. Women either felt uncomfortable sharing their experiences or feared judgment for a “failed” pregnancy.

This trajectory resembles patterns documented in other collectivist societies, where family networks typically serve as a buffer against stress (Cordova-Pozo et al., 2018). When women voluntarily cut themselves off, they forfeit potential avenues of support, which can prolong or intensify emotional distress.

6.5 Marital dynamics

The experience of ectopic pregnancy significantly impacts marital relationships, as evidenced by the diverse reactions of husbands toward their wives' condition. In this study, responses ranged from blame and emotional withdrawal, where some men attributed the pregnancy loss to personal failings or remained indifferent, to avoidance of intimacy, which contributed to women's sense of isolation. For instance, one participant described how her husband emotionally distanced himself, leaving her to cope alone, while another reported a prolonged absence of physical intimacy that deepened her emotional distress. These patterns suggest that Palestinian men's responses are shaped by cultural expectations of masculinity, where vulnerability and emotional expression are often discouraged.

Globally, studies such as those by Spillane et al. (2018) and Cordova-Pozo et al. (2018) have similarly documented the influence of spousal support—or lack thereof—on women's recovery after reproductive loss. However, unlike Western settings where couple-based counseling is more common, Palestinian women face additional barriers due to limited awareness and openness around infertility, resulting in fewer opportunities for shared emotional processing. Norhayati et al. (2017) found that supportive husbands can enhance resilience among women following maternal near-misses, a finding echoed in this study when participants described their husbands as sources of strength. Yet, in the Palestinian context, male partners often lack access to information and culturally appropriate guidance, contributing to confusion and disengagement during critical times.

This relationship responses highlights the urgent need for partner-inclusive approaches to reproductive health care in Palestine. The findings indicate that husbands' behavior is not inherently negative, but rather influenced by gaps in knowledge, cultural norms, and emotional preparedness. Integrating male partners into reproductive health education and psychosocial support systems could help reduce stigma, improve communication, and promote shared coping strategies. At the policy level, there is a strong case for developing interventions that address gender-specific challenges and provide couples with tools to

navigate reproductive trauma together. Culturally sensitive programs that encourage open dialogue and emotional engagement may ultimately lead to better psychological outcomes for women and stronger relational dynamics post-ectopic pregnancy.

6.5.1 Blaming and Ignorance

Some women recounted how their husbands attributed fault to them, echoing the larger cultural narrative that holds women accountable for reproductive outcomes. This blame was often reinforced by in-laws, creating a trifecta of guilt, shame, and isolation. For instance, several participants shared that their husbands distanced themselves—sleeping at their mothers' homes or refusing to attend post-operative checkups.

Such emotional neglect or blame can amplify self-blame and threaten marital stability (Geller et al., 2010). When husbands fail to offer reassurance or practical help, women feel not only bereft of a hoped-for child but also of the marital support that is typically crucial for psychological coping.

6.5.2 Avoiding Intimate Relationship

A related issue was avoidance of marital intimacy, with some husbands ceasing sexual relations for extended periods. This avoidance can stem from multiple factors, including misplaced fear of harming the woman physically, emotional discomfort around the trauma, or miscommunication about medical precautions (Farren et al., 2018).

For women already grappling with guilt or fear of infertility, this avoidance can reinforce feelings of inadequacy. Some participants indicated that this prolonged lack of intimacy deepened their sense of isolation and self-doubt, potentially straining the relationship further.

6.5.3 Supportive and Caring

Conversely, a subset of husbands emerged as emotionally supportive, reassuring their spouses through optimism and empathy. Participants described feeling validated in their grief and worry, noting how spouses reminded them of future possibilities rather than immediate loss. This emotional buffering aligns with studies showing that partner support is a key determinant of resilience after pregnancy loss (Voss et al., 2020).

Such supportive dynamics can mitigate blame from extended families, strengthen marital bonds, and reduce the psychological toll (Geller et al., 2010). Indeed, participants who experienced caring behaviors from their husbands reported a shorter duration of acute psychological distress and greater willingness to explore medical follow-up or counselling services.

6.6 Health Care Providers Interactions

6.6.1 Lack of Psychological Support

According to the study results, some of the women felt that healthcare providers focused solely on clinical interventions, medical and surgical issues but neglecting emotional and psychological care at the time women were in need for psychological support. Actually, in the high-pressure environment of emergency rooms and surgical wards, this can be somewhat expected but always happen unintentionally however, the absence of systematic psychosocial support was notable.

The participants reported no inquiries about their emotional well-being during hospitalization and they mentioned that there was no special qualified person to provide psychological support for them, leaving them feeling distressed and alone. This lack of psychological support from the healthcare providers sites is critical for the women experiencing ectopic pregnancy because women had mixture of fears of unknown, complications, sadness and shock. Incorporating brief psychosocial interventions or even just empathetic communication can alleviate immediate anxiety and encourage women to follow up on their emotional health post-discharge. This was also

reported in previous literature which emphasize the need for psychological support for the patients as a part of their care (Practice Committee of the American Society for Reproductive Medicine, 2013).

6.6.2 Unclear Communication and Insufficient Explanation

A further problem that appeared according to the participants was inadequate information and explanation about the diagnosis and treatment resulting in confusion and fear during hospitalization and afterward. Research consistently emphasizes that clear, culturally sensitive communication in acute reproductive health issues is paramount, as it helps reduce anxiety and fosters trust (Cordova-Pozo et al., 2018).

Insufficient counselling about the possibility of future ectopic pregnancies or fertility challenges left some women reluctant to seek timely care in subsequent reproductive events. Hence, enhanced communication is vital to ensure that the physical and psychological aspects of ectopic pregnancy are managed comprehensively, improving women's overall experiences and outcomes. During receiving care; women have the right to receive clear, adequate information and appropriate counselling according to her needs and circumstances.

6.7 Summary

Overall, the findings reveal ectopic pregnancy to be a biopsychosocial crisis for Palestinian women, shaped by cultural expectations of early motherhood and constrained by limited psychosocial support systems. The psychological ramifications (sadness, guilt, fear, and isolation) are deeply intertwined with the physical challenges (severe pain, invasive procedures) and social pressures (inadequate family support, stigmatization). Husbands' responses range from neglect or blame—amplifying women's distress—to empathy and reassurance that help foster resilience. Compounding these issues, healthcare providers often focus on immediate medical interventions, neglecting emotional care and leaving women uninformed about potential fertility consequences or risks of recurrence.

These findings are congruent with wider international research on pregnancy loss and align with specific studies on ectopic pregnancy management (Barnhart, 2009; Lasker & Toedter, 2010; Farren et al., 2018). However, they also highlight the unique cultural context of Palestinian society, where motherhood holds a deeply rooted social significance and extended families play a critical role in shaping women's experiences.

Implications include the urgent need for holistic, culturally sensitive care that addresses both the clinical and psychosocial dimensions of ectopic pregnancy. This entails providing accurate, accessible information on fertility and treatment, offering psychological counseling or referral services, and engaging family and spouses in supportive interventions. By recognizing the full scope of ectopic pregnancy's impact, healthcare systems and policymakers can develop protocols that not only save lives but also support emotional healing, protect marital relationships, and foster healthier, more informed communities.

6.8 Conclusion and Recommendations

This study's findings indicate that ectopic pregnancy significantly affects women's psychological health, social relationships, marital dynamics, and interactions with the healthcare system. Participants reported experiencing persistent emotional distress, apprehension regarding future pregnancy loss, societal shame, and insufficient sympathetic communication from healthcare professionals. These insights underscore the necessity for comprehensive treatment strategies that encompass not just prompt medical intervention but also psychosocial and emotional assistance. This study emphasizes women's voices within a culturally unique framework, establishing a basis for enhancing therapeutic practices and policies that address women's lived experiences. Additional research is advised to investigate long-term coping mechanisms and to create support programs specifically designed for women's reproductive and mental health requirements post-ectopic pregnancy.

6.9 Strength of the study:

- **Qualitative Depth:** The study employed a qualitative descriptive design, providing rich, in-depth insights into Palestinian women's lived experiences with ectopic pregnancy, which is underrepresented in existing literature.
- **Cultural Context:** Focused on the unique socio-cultural and healthcare challenges faced by Palestinian women, filling a gap in region-specific research.
- **Diverse Sample:** Purposive sampling ensured participation from women treated at two major hospitals (Ramallah Governmental Hospital and Al-Maqased Hospital), capturing varied perspectives.
- **Thematic Rigor:** Thematic analysis followed Braun and Clarke's framework, ensuring systematic identification of patterns and validation through supervisor cross-coding.
- **Practical Implications:** Findings highlight actionable recommendations for healthcare providers, policymakers, and support systems to improve holistic care.

6.10 Limitation of the study

- The study included the central region of the West Bank and did not include the southern and northern regions.
- Focus on two hospitals may not reflect experiences in lower-resource settings or private clinics.
- **Scarcity of Literature:** The limited existing literature on ectopic pregnancy, particularly within the Palestinian context, poses a challenge for comparison and contextualization of the findings. This scarcity can hinder the ability to draw broader conclusions or to benchmark the results against other studies, reducing the robustness of the research outcomes. The lack of previous qualitative studies specifically addressing Palestinian women's experiences with ectopic pregnancy further emphasizes the need for more comprehensive research in this area.
- **Self-Reporting Bias:** Participants' accounts may be influenced by their current emotional state or social desirability, potentially affecting the authenticity of their narratives.

6.11 Recommendations

5.11.1 Recommendations for Healthcare Practice

a) Integrated Psychosocial Support

- **Introduce Screening for Emotional Distress:** Implement routine mental health screening for women diagnosed with ectopic pregnancy, using brief, validated questionnaires or interviews.
- **Onsite Counseling Services:** Ensure availability of psychosocial support—either through in-house mental health professionals or through referral pathways—to address immediate emotional needs during and after ectopic pregnancy management.
- **Training Healthcare Providers:** Equip obstetricians, gynecologists, and nurses with basic skills in psychosocial care (e.g., empathetic communication, grief counseling) so they can better recognize distress signals and refer patients appropriately.

b) Clear and Compassionate Communication

- **Patient-Centered Explanations:** Develop standard protocols for explaining ectopic pregnancy, its treatment options, and potential fertility implications in clear, culturally sensitive language.
- **Family Involvement:** Where appropriate, encourage patient-approved involvement of partners or family members in counseling sessions. This can

help reduce blame, misunderstanding, and stigma, creating a support network for the woman.

c) Holistic Pain Management

- **Customized Pain Plans:** Provide detailed guidance on pain management strategies, including medication schedules, follow-up appointments for reassessment, and advice on safe, culturally acceptable home remedies where available.
- **Follow-Up for Chronic Pain:** Recognize that pain may persist after surgery or medical treatment. Ensure that follow-up care addresses chronic pain management, physiotherapy (if indicated), and referral for further specialty care when needed.

d) Enhanced Discharge and Post-Treatment Guidance

- **Comprehensive Discharge Summaries:** Supply detailed discharge instructions that outline physical care, signs of complications, emotional well-being checklists, and recommended follow-up visits.
- **24/7 Helpline:** Establish or promote an accessible hotline for urgent questions. This helps reduce anxiety by ensuring quick communication with healthcare professionals during recovery.

6.11.2 Recommendations for Policy and Institutional Framework

a) Policy on Integrated Women's Health Services

- **Multi-disciplinary Teams:** Encourage hospitals to formalize policies that mandate the involvement of mental health professionals (psychologists, social workers) in obstetrics and gynecology departments.
- **Standardized Protocols:** Advocate for standardized guidelines on ectopic pregnancy management that explicitly address mental health and social support, ensuring uniform care across various facilities.

b) Awareness Campaigns and Community Education

- **Reducing Stigma:** Launch education campaigns that challenge misconceptions around ectopic pregnancy. Community dialogues or media outreach can highlight the need for compassion and support.
- **Empowering Women:** Promote awareness sessions aimed at women and families regarding early detection of ectopic pregnancy, seeking prompt medical attention, and understanding emotional repercussions.

c) Support Systems for Spouses/Partners

- **Family-Centered Health Services:** Incorporate husband or partner counseling into maternal health policies so couples can face the crisis together. Emphasize communication strategies, shared decision-making, and emotional coping within the family setting.

d) Resource Allocation and Infrastructure

- **Equip Rural and Peripheral Clinics:** Invest in diagnostic tools (e.g., transvaginal ultrasound machines) and essential emergency services in peripheral health centers to reduce delays in diagnosis and treatment, especially for at-risk women in remote areas.
- **Continuous Training and Professional Development:** Foster ongoing programs that train medical and nursing staff in advanced diagnostic techniques, emotional first aid, and handling complications swiftly.

6.11.3 Recommendations for Future Research

a) Longitudinal Studies

Conduct extended follow-ups examining how women's physical, emotional, and relational well-being evolves in the months and years after an ectopic pregnancy. This approach can shed light on longer-term fertility concerns, marital stability, and psychosocial adjustments.

b) Comparative Analysis

Compare experiences of women in different regions of Palestine (e.g., rural vs. urban, areas with better resourced hospitals vs. more limited facilities) to understand if and how healthcare delivery and social support networks shape outcomes differently.

c) Interventional Research

Investigate the effectiveness of targeted interventions—such as group counseling sessions, online peer support forums, or family-inclusive workshops—on improving women’s psychological well-being and social support systems following ectopic pregnancy.

d) Partner-Focused Research

Although this study sheds some light on husbands’ roles, there is a need for focused research on male partners’ emotional experiences and coping strategies. Such findings could inform couple-based interventions that improve shared resilience.

e) Health Systems Research

Examine the systemic and logistical factors within Palestinian healthcare—like referral pathways, availability of mental health resources, and coordination between public and private facilities—that influence timely, holistic care for ectopic pregnancy.

6.12 Final Reflection

Ectopic pregnancy remains a life-threatening obstetric challenge that encompasses far more than physical health risks. The emotional turmoil, social isolation, marital stress, and deep-seated fears about future fertility underscore the complexity of women’s experiences. This study highlights the urgent need for more integrated, human-centered care—where psychological, social, and relational dimensions receive the same attention as clinical management.

By promoting better communication strategies, strengthening psychosocial support, and fostering culturally sensitive healthcare policies, Palestinian women can receive more compassionate and effective care during and after ectopic pregnancy. The recommendations provided here aim to guide clinicians, policymakers, researchers, and communities toward a comprehensive approach that respects both the medical realities and the profound personal journeys of women facing ectopic pregnancy.

Through collective efforts and informed interventions, it is possible to transform the care environment for women experiencing ectopic pregnancy in Palestine, ultimately enhancing their health outcomes, emotional resilience, and overall well-being.

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Appendix 1 : interview questions form :

السلام عليكم

التعريف بالباحث / اسئلة المقابلة:

انا الطالبة جيهان بدحة طالبة، ماجستير صحة الام والطفل في جامعة القدس أبو ديس ، أقوم بدراسة نوعية كمتطلب للتخرج تحت إشراف د. ابتسام دويكات بعنوان **تجربة النساء الفلسطينيات مع الحمل خارج الرحم: دراسة نوعية في منطقة وسط الضفة الغربية**

إنّ مشاركتك والمعلومات التي ستزونا بها من خلال المقابلة التي سنجرىها معك مفيدة جداً لتحقيق الهدف الأساسي من هذه الدراسة، لذا، يرجى منك تحريّ الدقة والمصداقيّة في الإجابة عن الأسئلة، لتعكس حقيقة رأيك بشكل سليم، وسيكون رأيك محلّ التقدير والاعتبار، **قد يكون سبب في تحسين الخدمات المقدمة للسيدات اللواتي مررن بنفس التجربة.**

مشاركتك في هذا المشروع البحثي تطوعية تماماً مبنية على مشاركتك في المقابلة التي سيجريها الباحث ويمكنك الانسحاب من المقابلة في أي وقت تختارينه ولن تؤثر مشاركتك بأي شكل من الأشكال على حياتك الشخصية أو المهنية. ستبقى ردودك سرية ومجهولة الهوية؛ لن يطلع أي شخص آخر غير الباحثين على الإجابات الفردية ولن يستطيع أي شخص الربط بين هويتك وإجاباتك الفردية على هذا المقابلة، سيتم الاحتفاظ بالبيانات الواردة من هذا البحث في مكان سري. إذا كنت توافقين على المشاركة في هذه المقابلة، فيرجى التوقيع على النموذج المخصص لذلك والمرفق

إذا كان لديك أي أسئفسار حول هذا الموضوع أو فيما يتعلق بالدراسة أو حول حقوقك كمشاركة في الدراسة فلا تتردد بالسؤال عبر البريد الإلكتروني jehanbadha@gmail.com أو من خلال رقم الهاتف **00972542348218**

المعلومات الديموغرافية

العمر

القسم 1: البيانات الديموغرافية:

أ. العمر

ب. الحالة الاجتماعية

ج. مستوى التعليم

د. الوظيفة

عدد مرات الحمل والولادات

هل انجبت اطفال بعد تجربة الحمل خارج الرحم؟ لماذا لا ؟

القسم 2: التجربة مع الحمل خارج الرحم

أ. هل يمكنك التحدث عن تجربتك مع الحمل خارج الرحم/ خوف / صعوبات / تحديات/ ايجابيات

ب. كيف عرفتني بموضوع الحمل

ج هل يمكنك وصف شعورك وردة فعلك الأولى عندما علمتي بأن حملك خارج الرحم؟

هل كنتي تمتلكين أي معرفة سابقة أو فهم حول الحمل خارج الرحم قبل تجربتك الشخصية؟

القسم 3: اثر تجربة الحمل خارج الرحم على صحة الام

أ. كيف أثرت تجربة الحمل خارج الرحم على صحتك الجدية / العاطفية/ النفسية ؟

ب. هل واجهتي أي عواطف معينة أو تحديات نفسية خلال هذا الوقت؟

القسم 4: الخصوبة

أ. صفي لي كيف أثرت تجربة الحمل خارج الرحم على أفكارك واهتماماتك بشأن الانجاب اي الحمل بعد هذه التجربة؟

هل كان لديك خوف من الحمل بعد هذه التجربة

ج. كيف أثرت تجربة الحمل خارج الرحم على اتخاذك للقرارات المتعلقة بالحمل المستقبلي؟

د. هل كان لديك أي قلق أو مخاوف معينة بشأن إمكانية حدوث حمل خارج الرحم آخر في المستقبل؟

كيف اثرت تجربة الحمل خارج الرحم على علاقتك الزوجية؟

كيف اثرت تجربتك على حياتك الاجتماعية؟ ماهي الصعوبات التي واجهتها؟

من اين حصلت على الدعم لمواجهة التحديات والصعوبات ان وجدت؟

هل هناك أي شيء آخر ترغبين في مشاركته عن تجربتك مع الحمل خارج الرحم لم يتم تناوله في الأسئلة السابقة؟

شكرًا لمشاركتك في هذه الدراسة. ستساهم إجاباتك في تقديم رؤى قيمة لفهمنا لتجارب النساء مع الحمل خارج الرحم.

Appendix 2 :

Al- Quds University
Faculty of Health professions
Nursing Department
Jerusalem-Abu Dies

بسم الله الرحمن الرحيم



جامعة القدس
كلية المهن الصحية
دائرة التمريض
القدس-أبوديس

التاريخ : 25/9/2023

حضرة الدكتور عبد الله القواسمة المحترم / مدير عام وزارة الصحة
وزارة الصحة الفلسطينية

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

تحية طيبة وبعد ،،،

يرجى من حضرتكم تسهيل مهمة طالبة الماجستير " جهان رمضان عبد الفتاح بدحة" ورقمها الجامعي (22111395)، وهي طالبة ماجستير تمريض الام و الطفل / كلية المهن الصحية / جامعة القدس في جمع بيانات المعلومات اللازمة من ملفات السيدات اللواتي لديهن تجربة بالحمل خارج الرحم في اقسام النسائية في المستشفى (مجمع فلسطين الطبي) لديكم من اجل تسهيل الوصول للسيدات واجراء مقابلات معهن ، وذلك لغرض اجراء دراسة بحثية لرسالتها الماجستير بعنوان (تجربة النساء الفلسطينيات مع الحمل خارج الرحم: دراسة نوعية في منطقة وسط الضفة الغربية) باشراف الدكتور ه ابتسام دويكات ، وذلك في الفترة الواقعة ما بين 30/9/2023 حتى 30/11/2023 .

وتفضلوا بقبول فائق الاحترام والتقدير،،،

منسفة برنامج الماجستير/ دائرة التمريض

د . كفاح زين كحلح
مرفق: اسئلة المقابلات ونموذج الموافقة المستتيرة

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Appendix3 :



Ρεειαρχη Ετηιχσσυβχομ μ ιττεε οφ ΦαυλταυοφΗεολτη Προφειαιονσ
Λεττεροφαιπροααλ

Θυνε 4τη, 2023
Ρεφ Νο.: ΡΕΣΧ/2023-41

Dear Applicants, (Δρ Ιβτααμ Δωεικαα, Μα Θειαν Βοδηα)

Program: ΜΣχ Νυραιαυ Δεπαρτι εντ

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled (Εξπλοριαυ τηε εχποτιχ πρεγνααυαυ εξπεριενχεσ αμ οαυ Πολεσαιαυ αομ εν: α θυαοιτααε σαυδψ) submitted by (Δρ Ιβτααμ Δωεικαα). 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.

Ηυσειν ΑΛΜααρι, ΠηΔ
Ασσυααε Προφειασορ οφΜεδιχαλιμ ααιναυ
Ρεειαρχη Ετηιχσσυβχομ μ ιττεε Χηαυρ
ΦαυλταυοφΗεολτη Προφειαιονσ

Hussein AlMarr

CC: File
CC: Committee members

Appendix4

Al- Quds University
Faculty of Health professions
Nursing Department
Jerusalem-Abu Dies

بسم الله الرحمن الرحيم



جامعة القدس
كلية المهن الصحية
دائرة التمريض
القدس-أبوديس

التاريخ : 25/9/2023

حضرة السيد مدير التعليم المستمر / مستشفى جمعية المقاصد الخيرية – القدس

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

تحية طيبة وبعد ،،،،

يرجى من حضرتكم تسهيل مهمة طالبة الماجستير " جهان رمضان عبد الفتاح بدحة" ورقمها الجامعي (22111395)، وهي طالبة ماجستير تمريض الام و الطفل / كلية المهن الصحية / جامعة القدس في جمع بيانات المعلومات اللازمة من ملفات السيدات اللواتي لديهن تجربة بالحمل خارج الرحم في اقسام النسائية في المستشفى (المقاصد) لديكم من اجل تسهيل الوصول للسيدات واجراء مقابلات معهن، وذلك لغرض اجراء دراسة بحثية لرسالتها الماجستير بعنوان (تجربة النساء الفلسطينيات مع الحمل خارج الرحم: دراسة نوعية في منطقة وسط الضفة الغربية) باشراف الدكتور ايتسام دويكات ، وذلك في الفترة الواقعة ما بين 30/9/2023 حتى 30/11/2023 .

وتفضلوا بقبول فائق الاحترام والتقدير،،،،

منسق برنامج الماجستير/ دائرة التمريض

د . كفاح زين
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فاكس : 2791243

عنوان الدراسة: استكشاف تجارب النساء الفلسطينيات مع الحمل خارج الرحم في
الضفة الغربية، فلسطين:

دراسة نوعية

الباحث: جيهان رمضان عبدالفتاح بدحة

المشرفة: د. ابتسام دويكات

الملخص

مقدمة: الحمل خارج الرحم (EP) هو مضاعفة تهدد الحياة تحدث عندما يتم زرع بويضة مخصبة خارج تجويف الرحم، وغالبًا ما يكون في قناتي فالوب. على الرغم من أن الأبحاث الطبية قد تناولت الجوانب السريرية للحمل خارج الرحم بشكل موسع، إلا أن الأبحاث المتعلقة بتجارب النساء الحياتية، خصوصًا في السياق الفلسطيني، ما زالت محدودة.

الهدف: يهدف هذه الدراسة إلى استكشاف تجارب النساء الفلسطينيات مع الحمل خارج الرحم عبر الأبعاد النفسية والجسدية والاجتماعية. تشمل الأهداف المحددة فحص التجارب النفسية بعد التشخيص، والتحقيق في الآثار الجسدية والتحديات، وفهم الأبعاد الاجتماعية وأنظمة الدعم، وتحديد التأثيرات على العلاقات الزوجية، واستكشاف التفاعلات مع مقدمي الرعاية الصحية خلال إدارة الحالة.

المنهجية: تم استخدام تصميم بحث وصفي نوعي. شاركت عشر نساء عانين من الحمل خارج الرحم في مستشفى رام الله الحكومي ومستشفى المقاصد في القدس في مقابلات شبه منظمة، والتي أجريت بين فبراير ويونيو 2023. تم استخدام تحليل الموضوعات لتحديد الأنماط في روايات المشاركات.

النتائج: ظهرت خمسة مواضيع رئيسية: (1) التأثير النفسي، الذي يتميز بالحزن، الإنكار، الشعور بالذنب، المخاوف بشأن الخصوبة المستقبلية، ومشاعر العجز؛ (2) التأثير الجسدي، المتمثل في الألم الشديد المستمر والصعوبات المتعلقة بالإجراءات الطبية؛ (3) التأثير الاجتماعي، بما في ذلك الدعم غير الكافي، الوصم، والعزلة الاجتماعية؛ (4) تباين ردود أفعال الأزواج، التي تتراوح بين اللوم والجهل إلى الدعم والرعاية؛ و(5) تفاعلات مقدمي الرعاية الصحية، التي تكشف عن نقص الدعم النفسي وعدم وضوح التواصل بشأن العلاجات والتوقعات.

الخاتمة: تظهر النتائج أن الحمل خارج الرحم يؤثر بشكل عميق على الصحة النفسية للنساء، وصحتهن الجسدية، وعلاقاتهن الاجتماعية، وديناميكيات الزواج. تواجه النساء الفلسطينيات تحديات فريدة تتأثر بالعوامل الثقافية ونظام الرعاية الصحية. تسلط هذه الدراسة الضوء على الحاجة إلى دعم نفسي اجتماعي متكامل، وتواصل واضح من مقدمي الرعاية الصحية، وإدارة شاملة للألم، وتعزيز الإرشادات بعد العلاج. يمكن أن تسهم هذه الرؤى في تحسين الممارسات السريرية وأنظمة الدعم للنساء اللواتي يواجهن هذه الحالة الصحية الإنجابية الصعبة.

الكلمات المفتاحية: الحمل خارج الرحم، النساء الفلسطينيات، التأثير النفسي، الألم الجسدي، الدعم الاجتماعي، البحث النوعي، الصحة الإنجابية.