

# Barriers to disclosure of violence against women in health services in Palestine: qualitative interview-based study

maggie evans (✉ [m.a.evans@bristol.ac.uk](mailto:m.a.evans@bristol.ac.uk))

University of Bristol Medical School <https://orcid.org/0000-0002-2307-0584>

**Amira Shaheen**

An-najah National University Faculty of Medicine and Health Sciences

**gene feder**

University of Bristol Medical School

**loraine bacchus**

London School of Hygiene and Tropical Medicine Department of Population Health

**manuela colombini**

London School of Hygiene and Tropical Medicine Department of Population Health

**suzy ashkar**

An-najah National University Faculty of Medicine and Health Sciences

**abdulsalam alkaiyat**

An-najah National University Faculty of Medicine and Health Sciences

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## Research article

**Keywords:** Violence against women, barriers to help-seeking, health professionals' training, disclosure of violence, qualitative study, Palestinian women

**Posted Date:** June 5th, 2020

**DOI:** <https://doi.org/10.21203/rs.3.rs-32601/v1>

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**Version of Record:** A version of this preprint was published on November 26th, 2020. See the published version at <https://doi.org/10.1186/s12889-020-09907-8>.

# Abstract

## Background

Violence against women (VAW) damages health and requires a global public health response and engagement of clinical services. Recent surveys show that 27% of married Palestinian women experienced some form of violence from their husbands over a 12 month's period, but only 5% had sought formal help, and rarely from health services. Across the globe, barriers to disclosure of VAW have been recorded, including self-blame, fear of the consequences and lack of knowledge of services. This is the first qualitative study to address barriers to disclosure within health services for Palestinian women.

## Methods

In-depth interviews were carried out with 20 women who had experienced violence from their husbands. They were recruited from a non-governmental organisation offering social and legal support. Interviews were recorded, transcribed and translated into English and the data were analysed thematically.

## Results

Women encountered barriers at individual, health care service and societal levels. Lack of knowledge of available services, concern about the health care primary focus on physical issues, lack of privacy in health consultations, lack of trust in confidentiality, fear of being labelled 'mentally ill' and losing access to their children were all highlighted. Women wished for health professionals to take the initiative in enquiring about VAW. Wider issues concerned women's social and economic dependency on their husbands which led to fears about transgressing social and cultural norms by speaking out. Women feared being blamed and ostracised by family members and others, or experiencing an escalation of violence.

## Conclusions

Palestinian women's agency to be proactive in help-seeking for VAW is clearly limited. Our findings can inform training of health professionals in Palestine to address these barriers, to increase awareness of the link between VAW and many common presentations such as depression, to ask sensitively about VAW in private, reassure women about confidentiality, and increase awareness among women of the role that health services can play in VAW.

## Background

Violence against women (VAW) damages health, requiring a public health response and engagement of clinical services. It is estimated that 3% of women globally have experienced physical and/or sexual

violence from a partner during their lifetime (1). This prevalence is raised to 37% in Eastern Mediterranean countries (1)(2). A recent systematic review showed that a doubling of this lifetime prevalence (70%) was reported among Arab women attending health care settings in Arab countries (3).

Looking specifically at Palestine, a 2019 survey by the Palestinian Centre Bureau of Statistics (PCBS) found that 27% of currently married or ever married Palestinian women had at least one experience of some form of violence from their husbands in the 12 months preceding the interview (4). Psychological violence was the highest at 52%, economic 41%, social 33%, physical 17%, and sexual 7%. Sixty-one per cent of interviewed survivors had not disclosed violence either formally or informally. 24% of survivors took refuge on their parents' or siblings' homes and a further 20% did not leave their homes, but asked for help from either their parent or relative (4). Six per cent sought advice from a work colleague or a neighbour. Despite 40% of interviewed survivors reporting that they were aware of the existence of support services, only 5% had sought formal help, generally from the police or legal services (4).

The above figures make no reference to help-seeking via health services, despite the serious health consequences of VAW such as depression, sleep problems, abortion, pain, and hypertension (4),(5),(6),(7),(8),(9). VAW results in substantial social and economic costs related to treating the physical and psychological impacts on women, absence from work, reduced quality of life, and problems with integrating into society (10)(11). Eliminating VAW by 2030 is the second item of the UN 5th Sustainable Development Goals (SDGs), which would make a major contribution to women's health (12).

Health services could potentially play an important role in supporting women who are experiencing violence (13). This can be done within the clinical setting and through referral of identified women to specialist services (14). However, studies in the UK, India and Malaysia reveal that women experience barriers to help-seeking and disclosure of violence in the clinical setting. Barriers include self-blame, shame and embarrassment, prior negative experiences of help-seeking, fear of the consequences of disclosure, economic dependency on the perpetrator and lack of awareness about formal support services related to VAW (15)(16)(17). Similar barriers were identified among women from eastern Mediterranean countries (18).

Studies show that women who have experienced VAW are more likely to disclose to a health care provider if asked in an empathic, non-judgemental way (19). Little is known about how Palestinian women view the role of health professionals in responding to VAW, or how they feel about disclosing their experience of violence in health care settings. The study reported here aimed to articulate Palestinian survivors' of VAW attitudes towards and experiences of disclosure in a health setting. It is the first qualitative study to explore barriers to disclosure of VAW among Palestinian women survivors of violence.

## Methods

As a part of a larger mixed-method study aimed at enhancing the Palestinian primary health care response to VAW, we conducted 20 semi-structured interviews with Palestinian women survivors of violence. This article presents results from the qualitative interviews.

**Recruitment and sample** Women who had experienced violence were recruited from a non-governmental organization (NGO) that provides legal and social support services, free of charge, to survivors of domestic violence. A convenience sample of 20 women aged 18 and over, who had experienced domestic violence, were interviewed in Ramallah and Hebron in July through August 2017. The NGO contacted twenty women and explained the study to them. All the contacted women agreed to participate.

## **Interview Procedure**

After written informed consent, women were interviewed by one of two female researchers in a private room provided by the NGO. All women were given transport costs to attend the interview. Semi-structured interviews, using a piloted topic guide, were conducted to explore women's personal experiences with violence, influences on their decisions to disclose violence, and their experience of talking to health care providers (HCPs) about violence and abuse. Further information about the topics covered in the interview is given in the Topic Guide: [see Additional file 1]. Interviews were conducted in Arabic and lasted for 1 to 2 hours. A social worker was available on site for any women in need of support during or after the interview.

## **Qualitative Analysis**

Interviews were audio-recorded and were translated and transcribed verbatim into English. A sample of the transcribed interviews was checked against the Arabic recording, by the first author, to ensure accuracy. Data from transcripts were anonymised and analysed thematically following the method developed by Clarke and Braun (20). A coding framework was developed by ME, SA and AS and a sample of transcripts were double coded for verification. NVIVO 11 was used to facilitate the initial coding and analyses. Emerging themes were identified and discussed by ME, SA and AS.

## **Results**

### **Characteristics of participants**

Most of the women were in marriages arranged by their families and the majority were separated or divorced. The husband was identified as the main perpetrator by all the interviewed women. Three women also identified in-laws as secondary perpetrators. Further details are given in Table 1.

Table 1  
Socio-demographic characteristics of the study participants (N = 20)

<b>Characteristics</b>	<b>n</b>
<b>Age (years)</b>	
20–29	8
30–39	8
40–49	3
50–59	1
<b>Educational status</b>	
Primary	3
Secondary	7
University	5
Vocational education	5
<b>Employment status</b>	
Currently employed	3
Unemployed	17
<b>Marital status</b>	
Separated*	10
Divorced	7
Married	3
<b>Type of marriage</b>	
Traditional**	18
Modern	2
<b>Length of marriage</b>	
Less than 10 years	12
More than 10 years	8
*Separated: not officially divorced, **Traditional: family arrangement	

## Barriers to survivors disclosing VAW to health care providers

Eleven out of the twenty interviewed survivors said that they had disclosed violence to HCPs at some point. However, all the women encountered multiple barriers to talking to HCPs about their experiences that either prevented disclosure or made it difficult. Themes were identified by the authors that reflect the cultural barriers to talking about VAW that pervade all areas of women's lives and experiences.

## **Survivors' individual level barriers**

Two key individual barriers that were identified were women's sense of dependence on their husband and their fear of the consequences of disclosure.

### **Dependence on their husband**

Women described their dependence on their husbands, both financially and in terms of cultural expectations about how a married woman should behave. They were reluctant to talk about relationship difficulties, matters considered to be 'too personal', and likely to result in them being blamed, shamed or embarrassed.

*"I felt like I would be blamed for it and people might say; look, she let out secrets between her and husband. Why would she say that? So that would make me shy, embarrassed to talk about it" [39 year old woman, Hebron].*

*"Because I don't want to expose the secrets of my home and I want to stay protected (under husband) and live in comfort" [23 year old woman, Hebron].*

Feeling 'protected' by marriage was also financial. Exposing violence in the home might lead to separation and divorce, with no guarantee of financial support for the woman or her children. Fear of living apart from their children was a major barrier for women to disclosure.

*"Because my family, if I divorced, don't want me to keep his children and I don't want to lose my daughters. If I lose the children I will suffer" [34 year old woman, Hebron].*

The data highlighted the cultural taboo about women speaking out against their husbands and the stigma attached to those who do so, especially if they are separated or divorced. Most women found it hard to talk about VAW to family members or friends, as well as to HCPs, and they often hid their injuries, or their cause, from them, as well as from HCPs.

*"They asked me what happened. I didn't say it was done by my husband, I said it happened while I was cutting a piece of wood" [34 year old woman, Hebron].*

Staying in the abusive relationship and keeping quiet about the violence can be seen as active, calculated choices to protect themselves and their children, expressing agency in difficult circumstances, until an opportunity arose to take action.

### **Fear**

Women talked about their fear of escalation of the violence should they disclose.

*“because the violence would get worse and the problems would increase. The problems between my family and his would become worse and God forbid, if it got to the point where they might hurt each other, someone might get killed...that’s not a little issue.” [41 year old woman, Ramallah].*

Fear of what might happen if they left the house by themselves to seek help or if they talked about the violence, kept women at home, unable to access HCPs or other forms of help.

*“Researcher: you didn’t tell the doctor that you couldn’t go out? SW20: no. Researcher: why? SW20: honestly, I was very, very scared of him ... Researcher: you were scared of him? SW20: yes. My husband used to put his key in the door, and when I’d hear it, when I’d hear the key enter the door, I’d start shaking” [32 year old woman, Ramallah].*

Women were also reluctant to seek help, especially for psychological distress, for fear of being labelled ‘mentally ill’. Losing their credibility as a competent wife or mother might lead to them losing custody of their children.

*“Researcher: so you would like to see a psychologist but you’re worried your husband will find out and... SW14: he’d say, for example, ‘she’s mentally sick!’ He won’t say, ‘she wants to change her behaviour’, he’d say ‘this woman is mentally sick. I want to take the kids’.” [39 year old woman, Ramallah].*

*“Other than that, family, or society rather considers psychiatrists are only for crazy people. That’s their negative views on psychological treatment” [24 year old woman, Ramallah].*

## **Health care service level barriers**

### **Expectations of Health Care Providers’ (HCP) role**

Women varied in their views as to whether attending to the issue of VAW was within the remit of HCPs, and they had low expectations of getting help. Women saw the focus on physical health as the normative role of HCPs, and they were unwilling to take up HCPs’ time in busy clinics.

*“I don’t know. The idea never came to my mind. I don’t expect that they could help me with the situation” [19 year old woman, Ramallah].*

*“yes I had the potential to [disclose], but I didn’t feel like the doctor would listen to me if I did ... because there were a lot of people waiting for a turn and other than that, she works fast ... she doesn’t ask about the person’s state...it was just an exam for the fetus, and that’s it, work is done” [24 year old woman, Ramallah].*

Some women expressed personal ambivalence about the idea of HCPs probing into areas of their life they considered ‘private’, even when they had obvious bruising.

*"it was normal, anyway, he checked me out, put his stethoscope here. Examined my arms and said alright up, we are done ..... because maybe I want a doctor just to examine me, not to know everything about me" [30 year old woman, Hebron].*

*"honestly? I don't like them to get involved in my private life...I consider it my personal life. It's private" [32 year old woman, Ramallah].*

Others, however, said they would prefer HCPs to look beyond their physical health, show concern for women's psychological well-being and take the initiative to ask about violence.

*"maybe they could ask me questions, give me support ..." [24 year old woman, Hebron].*

*"Well, women feel that they don't care. I don't feel like they care about these things at all. So at least they should ask those that he feels something might be wrong." [23 year old woman, Hebron].*

Most women were clear that the initiative must come from the HCP asking direct questions, even repeatedly, in order to overcome their initial reluctance to disclose.

*"Researcher: in a case where a woman refused to talk about, what should the doctor do? SW03: ask the first time, and second time, third time" [30 year old woman, Hebron].*

## **Women's direct experiences of disclosure and non-disclosure to HCPs**

Missed opportunities for disclosure were described by women who presented with warning signs of abuse including low mood, bruising and poor nourishment, with no questions asked by HCPs.

*"There was an apparent thing on my arm, it was obvious that I had. When I get upset it's obvious, he didn't ask me about it or anything" [30 year old woman, Hebron].*

*"I was crying but, its normal, no one asked me about it. About anything!" [23 year old woman, Hebron].*

However, in spite of the barriers, just over half of these survivors had disclosed violence to HCPs.

*"no, she asked me. she asked me "what's going on? I feel like you're not all right?" I told her "I'm having some problems with my husband." [32 year old woman, Ramallah].*

Many of them, however, reported little benefit. Simply initiating a conversation was felt to be insufficient, some women felt that HCPs should make a full assessment of the violence.

*"What happened, why it happened. They should do a proper assessment about anything that looks like a case of abuse. It's obvious when something is normal and something is strange." [34 year old woman, Hebron].*

Women often said they wanted help to change their husband's behavior, so that they could preserve their marriage, and their social and financial survival. They did not know who to call on other than involving the police and filing a complaint.

*"SW15: yes. If I knew that there was someone that could talk to my husband and influence him to change his temper habits and such, then I would say something, but there is no one" [26 year old woman, Ramallah].*

They wanted HCPs to take responsibility for making a report of violence to the police, according to an unwritten and rarely followed mandate from the Ministry of Health.

*"[HCPs SHOULD]do what they're supposed to. For example, I reach out to them and they suspect that something is happen, they should immediately call the police. Even if I'm insistent upon not wanting to talk, from their report and their examinations, it's clear" [21 year old woman, Ramallah].*

*"They said the results show that nothing is broken there is only fracture. The Doctor asked me: "how this happened", and I said that it was from my husband". The Doctor then asked for the police. The police arrived and they asked me everything." [34 year old woman, Hebron].*

## **Privacy, confidentiality and trust**

Lack of personal privacy in health care consultations was another barrier to disclosure for the women, who were often accompanied by their husband or in-laws, making it impossible for them to talk about violence.

*"At the hospital they asked me what was wrong. My mother in law told me "if you tell them 'he hit me' we'll divorce you. Don't say that. We don't have women who complain about their husbands here." The doctor told me "I know you've been hit. I know it, but if you don't want to say something, I can't do anything." I went back home..." [24 year old woman, Ramallah]*

*"Researcher: did you have privacy when the doctor came to examine you? Were you by yourself with him, for example? I mean, could you have told him "honestly, doctor, I... SW11: No my mother in law was with me.... there's no privacy pause and even if I told him, the doctor how could he benefit me? He won't help me with anything" [23 year old woman, Hebron].*

Women did not trust patient confidentiality, and were anxious about disclosing in case 'domestic violence' appeared in writing in their medical report. They described overlapping social and professional networks in their communities. HCPs may know other family members, social ties and loyalties might outweigh concepts of confidentiality, and disclosure may not remain a private matter. For women, this risked an escalation of violence and other repercussions.

*"SW10: yes I was very scared. Researcher: why, what's he going to do to you? SW10: what do you mean? if he finds out that I told the doctor, I'm sure he wouldn't stay quiet. I mean, [the doctor] is going to say something. He's going to say "this girl gets hit while pregnant" and [word of] that gets to him, then he*

*would have hit me even more if my husband found out that I talked to the doctor about him.” [21 year old woman, Hebron].*

*“For example, if my medical record was with you, and your colleagues came along she’ll read the file and know about my life” [30 year old woman, Hebron].*

*“I didn’t want to make any problem. The Doctor is our family doctor and I was ashamed to talk about this” [34 year old woman, Hebron].*

*“No. I wouldn’t have trusted him because I’m living with people I don’t trust; he might be one of them. I mean, he’ll always side with them; he is still from their town. I wouldn’t have trusted him or told him. I’d be scared to go tell my husband, then he’d tell me why did you go tell him and the situation would be flipped against me.” [20 year old woman, Hebron].*

## **Societal level barriers to disclosure**

### **Normalization of violence**

Women described the cultural expectation that a wife should tolerate her husbands’ behavior, that it is ‘normal’ to be hit by him. An abusive husband should be given a ‘chance to change’.

*“Yes, we are afraid of the society, we always give a chance that maybe things will change. Unfortunately, it is the opposite, it will carry on and on until it becomes serious.” [34 year old woman, Hebron].*

*“Listen, a divorced woman is always the one blamed. No matter what. They don’t say that the man was no good, no it’s the woman fault. You should have been patient. You should have tolerated it. What am I supposing to tolerate more than I have endured?” [20 year old woman, Hebron].*

### **Expectations of women’s role**

Women described their society as ‘repressive’ and they were fearful of being judged if they talked about VAW or left their husbands.

*“Honestly no, because I never thought I’d ever file a complaint against him in my life. Firstly, for the sake of my kids and then because women are always violated. No matter what you say, your name and subject is going to be on the tip of everyone’s tongues” [36 year old woman, Hebron].*

One woman whose husband was in prison for violence felt she was being watched by the community and always had to be on her best behavior, as if she were the guilty party. Others echoed this experience of being abandoned by society for speaking out. Fear of being blamed and being seen as a ‘home-wrecker’ stopped some women from filing for divorce.

*“I think it’s more the nature of our society. Our society abandons a woman who speaks out about her circumstances, even when they are bad” [36 year old woman, Hebron].*

*“Like I said before they put all the blame on the woman and it’s because of you, like how they’ve already put all the blame on me. The closest people to you; you’re the reason, you’re the home wrecker” [30 year old woman, Hebron].*

One woman regretted not having spoken out sooner, since she now recognized how her rights had been taken away since marriage.

*“no, now I would have talked. I would have talked then because I’ve given up so many things in my life, from the day I married [perpetrator] until now, there are a lot of rights that he’s denied me from” [36 year old woman, Hebron].*

## **Stigma**

Women’s fear of being stigmatized for their actions was a strong theme in their accounts. They described their fear of the stigma of a ‘mental health label’ or of being a ‘home-wrecker’, and of being ostracized by society for speaking out against their husband, separating from or divorcing him. After leaving a violent relationship, women continued to feel stigmatized and faced barriers to getting support for themselves or their children, such as attending counselling sessions alone or getting psychological help for themselves or their children.

*“Even for my son and his sessions, in the beginning I told her even if you need to put two sessions a week, do it. I wanted my son to get better, but I felt that it was unaccepted” [45 year old woman, Hebron].*

## **Discussion**

The recognition that women face multiple barriers to disclosure of abuse at all levels of their personal, social and cultural life echoes Heise’s ecological model of the multiple levels of influence on the perpetration of abuse. Integrating results from international and cross-cultural research, Heise identified the predictive factors of abuse as being “grounded in an interplay among personal, situational, and sociocultural factors” (21). This study shows that the same factors that render women vulnerable to abuse are also limiting their ability to seek help.

Although the majority of the women in the study had left their abusive relationship, their pathways to support had been through legal channels rather than health care. Having found freedom, some women regretted not having challenged cultural norms sooner and taken opportunities to disclose, for example when presenting to HCPs with injuries caused by violence. However, women’s agency to be proactive in help-seeking or trying to change their situation, is clearly limited. Women felt disempowered in their marriages, and the only answer was for their husband’s behaviour to somehow change. Meanwhile, their own actions were often tactical, motivated to ensure damage limitation for them and their children.

The context of women’s lives was the largely patriarchal and hierarchical structure of the Palestinian family, with its hegemonic masculinity (22), where men expect their wives and children to respect them, and comply with their roles and demands. In this context there are many examples of the normalisation

of VAW, and few opportunities are available for women to talk about VAW either in their informal networks or to professionals (23), (24). These difficulties were compounded by overlapping social and professional networks and the custom of family members accompanying women to healthcare appointments, leading to a lack of trust in disclosure to HCPs and a lack of the privacy to do so. Family members, HCPs and other members of the community might all subscribe to a 'conspiracy of silence' around such uncomfortable issues. Fear of making matters worse, being subjected to even more abuse, of being ostracised by society and losing their children were all significant barriers to women speaking out about abuse.

Women described feelings of embarrassment and shame from disclosure, reflecting that VAW is perceived as a private issue, and that sharing experiences with others would not be accepted (25)(26). Lack of awareness of possible help that can be obtained from health care services was a further constraint on survivor disclosure. This is perhaps not surprising given the findings of a companion study interviewing HCPs and health officials in Palestine, carried out alongside the current study. This revealed the lack of clear VAW guidelines for HCPs, and protocols for how to respond to disclosure, which were recognized as challenges to the health service's response to VAW (27). However, all the women who were interviewed had found a way to get help from a professional agency, although the role of HCPs was limited. The determination of the women to break free meant that the majority were living apart from their perpetrator at the time of interview. In spite of the barriers highlighted in this study, a systematic review (3) suggests that Arab women still view visiting the health care setting as socially acceptable, and once trust is gained, and confidentiality is granted between them and their health care provider, disclosure will follow.

In order to decrease VAW, a focus group of young Palestinians from Gaza recommended raising awareness among Palestinian women toward their legal rights and the available services (28). Awareness raising must, however, go alongside measures to address societal norms towards women and gender roles. Other studies also indicate the importance of awareness campaigns in introducing available services to women victims of violence and their communities in an attempt to raise the level of help seeking (23)(24).

This Palestinian study adds to the findings of previous qualitative studies that highlight the importance of sensitivity in the timing and questioning about violence by HCPs, who must be alert to windows of opportunity. A conceptual framework for understanding the processes of help-seeking among survivors of intimate partner violence, taking into account individual, interpersonal, and sociocultural factors was developed by Liang et al (29). This work was developed in further studies that stress the importance of a woman's personal 'readiness' to disclose VAW, at a time that is right for her (30)(31). The health system itself must also be 'ready' to take on responsibility for helping women survivors of VAW, with suitable infrastructure, training and referral pathways. A recent study in Lower and Middle Income countries (LMIC) explores the concept of health systems 'readiness' and corroborates many of the findings in the present study as regards health service barriers to disclosure (27).

The role of health care systems in responding to violence against women and in facilitating access to support services has been demonstrated worldwide (19). Our findings can inform training of HCPs in Palestine to facilitate asking about VAW and responding appropriately.

### Strengths and Limitations

This is the first study to investigate barriers to the disclosure of violence among Palestinian women exposed to VAW. The use of thematic analysis that starts with coding, grouping of codes under specified themes, investigating and defining these themes by more than one researcher, gives an in-depth view of the survivor experience that reflects on their collective experience rather than an individual one. Data for this study were collected by interviewing women in two legal centres, who had successfully sought help, hence the results might not reflect all the barriers that are experienced by women. Women who visited these legal centres may have been more severely affected by violence. As the recruitment of participants were at voluntary basis, it is possible that those who agreed to be interviewed were the more comfortable with the topic being investigated, or that those who refused to participate were more severely affected and scared.

## Conclusions

Training of Palestinians HCPs on response to VAW should be tailored to address the barriers to disclosure experienced by survivors, for example, how to ask sensitively about VAW in private, the importance of reassuring women about confidentiality, and increasing awareness of the link between VAW and many common presentations such as depression. Actions such as securing private spaces in clinics, for women to feel safe to disclose, and increasing awareness among women of the role that health services can play in VAW is crucial.

## Abbreviations

**VAW** Violence Against Women

**HCP** Health Care Professional

**PCBS** Palestinian Central Bureau of Statistics

**SDG** Sustainable Development Goals

**NGO** Non-Governmental Organisation

**LMIC** Lower and Middle Income Countries

## Declarations

**Availability of data and materials**

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### **Competing interests**

The authors declare that they have no competing interests.

### **Funding**

AS, SA ....., ME are funded by the HERA project, supported by the Medical Research Council grant MR/P025102/1. (<http://www.bristol.ac.uk/primaryhealthcare/researchthemes/hera/>)

AS is supported by a grant in connection to her “OWSD-Elsevier Foundation Award for Early-Career Women Scientists in the Developing World”, for her work investigating health care system responses to gender-based violence in primary health services in Palestine.

### **Authors contributions**

AS (collected the data, participated in the analysis, and wrote the first draft). SA (translated and transcribed interviews, participated in the analysis and critically commented on the manuscript), ME (participated in the analysis, critically commented on the manuscript and wrote subsequent drafts), (AA, LB, MC and GF) critically commented on the manuscript.

### **Acknowledgment**

The authors wish to thank the Women’s Centre for Legal Aid and Counselling (WCLAC) for recruiting women and providing their premises to conduct the interviews. We would like to thank Rania Abu-Aaita for interviewing some of the survivors, and the women survivors of violence for agreeing to participate in the study.

### **Consent for publication**

Not applicable

### **Ethics approval and consent to participate**

The study received ethical approval from An-Najah National University (ANNU), London School of Hygiene and Tropical Medicine (LSHTM), and the University of Bristol (UoB). Written informed consent was obtained from all participants.

### **Additional Material**

Additional File 1.doc

Topic Guide for Interviews with Women Survivor

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