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Factors Associated with Intimate Partner Violence Among Women with Primary Infertility: An Etiology-Stratified Cross-Sectional Study from Egypt

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Abstract

Background: Infertility is a major reproductive health problem with psychological, social, and relational consequences, particularly in settings where childbearing is closely linked to marital stability and women's social status. Intimate partner violence (IPV) may be intensified by infertility-related stigma; however, limited evidence has examined whether IPV exposure and its predictors differ according to infertility etiology.

Aim of the work: To assess IPV exposure among women with primary infertility and identify sociodemographic and partner-related predictors across different infertility etiologies at the ART Unit, International Islamic Center for Population Studies and Research (IICPSR), Al-Azhar University, Cairo, Egypt.

Patients and Methods: This cross-sectional study included 390 married women with primary infertility, equally allocated into female-factor, male-factor, and combined/unknown infertility groups. Data were collected through structured face-to-face interviews covering sociodemographic characteristics, health status, infertility profile, and IPV exposure using the Infertile Women's Exposure to Violence Determination Scale (IWEVDS). Group comparisons and within-group predictor analyses were performed, with statistical significance set at $p < 0.05$.

Results: Marriage duration differed significantly across infertility groups ($p = 0.003$), with male-factor infertility more frequently presenting within 2 - 5 years of marriage. Reproductive disease adversely affecting pregnancy outcome was substantially more frequent in the female-factor group (53.9%) than in the male-factor (6.2%) and combined/unknown groups (15.5%) ($p < 0.001$). Total IWEVDS scores were highest in the female-factor group, although the between-group difference was not statistically significant. Item-level analysis revealed significant differences in physical abuse due to infertility (Q6, $p = 0.01$) and being taunted as the "childless woman" (Q10, $p = 0.02$). Husband's education was a consistent factor across all groups, while partner unemployment, partner drug/medication/sedative use, and prolonged infertility or treatment duration were associated with higher IPV exposure in selected etiologic groups.

Conclusion: IPV exposure among women with primary infertility is shaped by both sociodemographic vulnerability and infertility-related relational stress. An etiology-stratified approach may improve risk identification and supports integrating confidential IPV screening, psychosocial counseling, and referral pathways into infertility care.

Keywords: Infertility; intimate partner violence; sociodemographic predictors; IWEVDS; Egypt.

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Introduction

Infertility is a major global health condition with far-reaching medical, psychological, and social implications. Recent estimates from the World Health Organization indicate that approximately 17.5% of the global adult population will experience infertility during their reproductive lifetime, affecting individuals across diverse socioeconomic settings [1]. Although its prevalence appears relatively consistent worldwide, the lived experience of infertility is highly context-dependent and shaped by cultural norms, gender roles, and societal expectations.

In many Middle Eastern and North African societies, including Egypt, fertility is closely linked to marital stability, social identity, and family continuity. Within such contexts, infertility is often interpreted not only as a biomedical condition but also as a disruption of expected social roles, particularly for women. Even when infertility is medically attributed to male or combined factors, women frequently bear a disproportionate share of the social consequences, including stigma, blame, and marginalization within both marital and extended family structures. This imbalance reflects deeply embedded gender norms that continue to influence interpersonal dynamics and may increase vulnerability to coercive or abusive behaviors [6].

Intimate partner violence (IPV) is a pervasive public health and human rights issue, encompassing physical, psychological, sexual, and economic abuse within intimate relationships. Globally, approximately one in three women has experienced physical or sexual violence, most commonly perpetrated by an intimate partner [2]. Beyond its immediate physical consequences, IPV is strongly associated with long-term mental health morbidity, including depression, anxiety, and post-traumatic stress disorder, as well as adverse reproductive outcomes [7,9]. These impacts are often magnified in settings where gender inequality, economic dependency, and limited access to support services constrain women's ability to respond to or escape abusive relationships.

The relationship between infertility and IPV has gained increasing attention in recent years. Infertility may function as a significant relational stressor, intensifying existing vulnerabilities and altering power dynamics within the couple. A systematic review and meta-analysis reported a pooled prevalence of domestic

violence among infertile women of approximately 47.2%, with psychological violence representing the most frequently reported form [3]. However, despite growing recognition of this association, most studies have treated infertility as a homogeneous condition, without adequately accounting for differences in underlying etiology.

The attribution of infertility, whether to the female partner, the male partner, or both, may play a critical role in shaping relational dynamics and patterns of violence. In many sociocultural contexts, female-factor infertility is more likely to be associated with direct blame and stigmatization, thereby increasing vulnerability to IPV. In contrast, male-factor infertility may introduce different relational tensions, including threats to masculinity, concealment, or delayed disclosure. Existing studies have documented high levels of psychological distress and violence among infertile women; however, few have systematically examined how these outcomes vary according to infertility etiology, representing a critical gap in the literature [3,5].

To further contextualize this relationship, infertility and IPV can be understood within an integrated conceptual framework linking sociocultural, relational, and psychological mechanisms. In this model, infertility acts as an initial stressor that triggers stigma and social pressure, particularly in settings where fertility is closely tied to female identity. This stigma often leads to attribution of blame, most commonly directed toward women, which subsequently alters power dynamics within the relationship. Reduced autonomy and increased dependency may predispose women to emotional or physical abuse. At the same time, exposure to IPV exacerbates psychological distress and may negatively influence reproductive outcomes through both behavioral and stress-related physiological pathways. This bidirectional interaction suggests that infertility and IPV may operate as mutually reinforcing conditions rather than independent phenomena [3,7,9,18–20].

In addition to sociocultural influences, ethical and religious frameworks play a key role in shaping perceptions of infertility and IPV in Islamic societies. Contemporary Islamic bioethics permits the use of assisted reproductive technologies within marriage while prohibiting third-party involvement in order to preserve lineage and family integrity [13]. At the same time, Islamic teachings explicitly condemn injustice and violence within marital relationships and emphasize mutual respect and compassion between spouses. Within this framework, infertility is recognized

as a medical condition rather than a moral failing and therefore cannot justify abusive behavior [13].

Taken together, these considerations highlight the need for a more nuanced and context-sensitive understanding of the relationship between infertility and IPV, one that integrates biomedical, sociocultural, and relational dimensions and accounts for the heterogeneity of infertility.

Therefore, the present study aimed to assess exposure to intimate partner violence among women with primary infertility and to identify key sociodemographic and partner-related predictors across different infertility etiologies at the ART Unit of the International Islamic Center for Population Studies and Research (IICPSR), Al-Azhar University, Cairo, Egypt.

Patient and Methods

Study Design and Setting

This cross-sectional analytical study was conducted at the Assisted Reproductive Technology (ART) Unit of the International Islamic Center for Population Studies and Research (IICPSR), Al-Azhar University, Cairo, Egypt, over a three-year period from May 2022 to May 2025.

Sample Size Estimation

The sample size was calculated using the standard formula for estimating a population proportion at a 95% confidence level and a 5% margin of error. A conservative prevalence estimate of 50% was used to maximize the required sample size in the absence of reliable etiology-specific prevalence estimates. The minimum required sample size was calculated to be 384 participants. To facilitate equal allocation across infertility etiologies and compensate for potential incomplete data, the final sample size was set at 390 women, with 130 participants included in each group.

Study Population and Sampling

A total of 390 women with primary infertility were enrolled and equally allocated into three groups according to infertility etiology ($n = 130$ per group):

- Group I: Female-factor infertility
- Group II: Male-factor infertility
- Group III: Combined or unexplained infertility

Equal group allocation was applied to enable balanced comparison across infertility etiologies and to improve the analytical power of both between-group and within-group comparisons.

A pilot study was conducted on 10 infertile women to assess the clarity, feasibility, and acceptability of the study instrument. These participants were excluded from the final analysis.

Eligibility Criteria

Inclusion Criteria

Participants were eligible if they:

- Were married women aged 18–43 years
- Had primary infertility (failure to conceive after ≥ 12 months of regular unprotected intercourse)
- We're not using any contraceptive methods during the period of attempted conception
- Provided informed consent to participate

Exclusion Criteria

Participants were excluded if they had:

- Chronic medical conditions likely to affect pregnancy outcomes
- Use of medications known to impair sexual function
- Previously diagnosed psychiatric or psychological disorders

These criteria were applied to reduce potential confounding factors that could independently influence IPV exposure or reproductive outcomes.

Data Collection and Study Variables

Data were collected through face-to-face, interviewer-administered structured questionnaires conducted in a private setting to ensure confidentiality and encourage accurate disclosure.

The questionnaire comprised four main domains:

1. Sociodemographic characteristics (age, education, occupation, residence, and partner-related variables)
2. Medical and reproductive history (infertility duration, underlying cause, previous investigations, treatment duration, and ART attempts)
3. Partner-related factors (employment status, educational level, and reported substance or medication use)
4. Exposure to intimate partner violence (IPV), assessed using the Infertile Women's Exposure to Violence Determination Scale (IWEVDS)

Measurement Tool: IWEVDS

IPV exposure was assessed using the Infertile Women's Exposure to Violence Determination Scale (IWEVDS), a validated infertility-specific instrument developed and psychometrically validated by Onat and Beji (2014) [21] for the assessment of violence-related experiences among women with infertility.

The scale consists of 31 items rated on a 5-point Likert scale (1 = never, 5 = always), yielding a total score ranging from 31 to 155, with higher scores indicating greater exposure to IPV.

The IWEVDS includes five domains:

- Domestic violence (11 items)
- Social pressure (6 items)
- Punishment (7 items)

- Exposure to traditional practices (4 items)
- Exclusion (3 items)

Both domain-specific and total scores were calculated.

Outcome Measures

The primary outcome was the total IPV exposure score (IWEVDS total score).

Secondary outcomes included:

- Domain-specific scores
- Item-level differences between infertility etiologies
- Sociodemographic and partner-related factors associated with IPV exposure within each group

To comply with journal space limitations, item-level analysis in this manuscript focuses on variables demonstrating statistically significant differences, while the full item distribution is available in the thesis.

Statistical Analysis

Data were coded and analyzed using IBM SPSS Statistics (Version 26).

Categorical variables were presented as frequencies and percentages, while continuous variables were expressed as mean $\pm$ standard deviation (SD).

Comparisons between groups were performed using:

- Chi-square test
- Fisher's exact test
- Monte Carlo correction (when appropriate)

Between-group comparisons were conducted for sociodemographic variables and IWEVDS outcomes.

Within-group analyses were performed to identify factors associated with IPV exposure across each infertility etiology group, focusing on:

- Sociodemographic variables
- Partner-related characteristics
- Infertility duration and treatment timelines

A two-sided p -value < 0.05 was considered statistically significant.

Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of the ART Unit, IICPSR, Al-Azhar University.

All participants provided informed consent prior to inclusion. Interviews were conducted in a confidential setting, and participants were assured of privacy, anonymity, and their right to withdraw at any stage without consequence.

Results

Baseline Characteristics and Infertility Profile

A total of 390 women with primary infertility were included in the study and equally distributed across the three etiologic groups ($n = 130$ each).

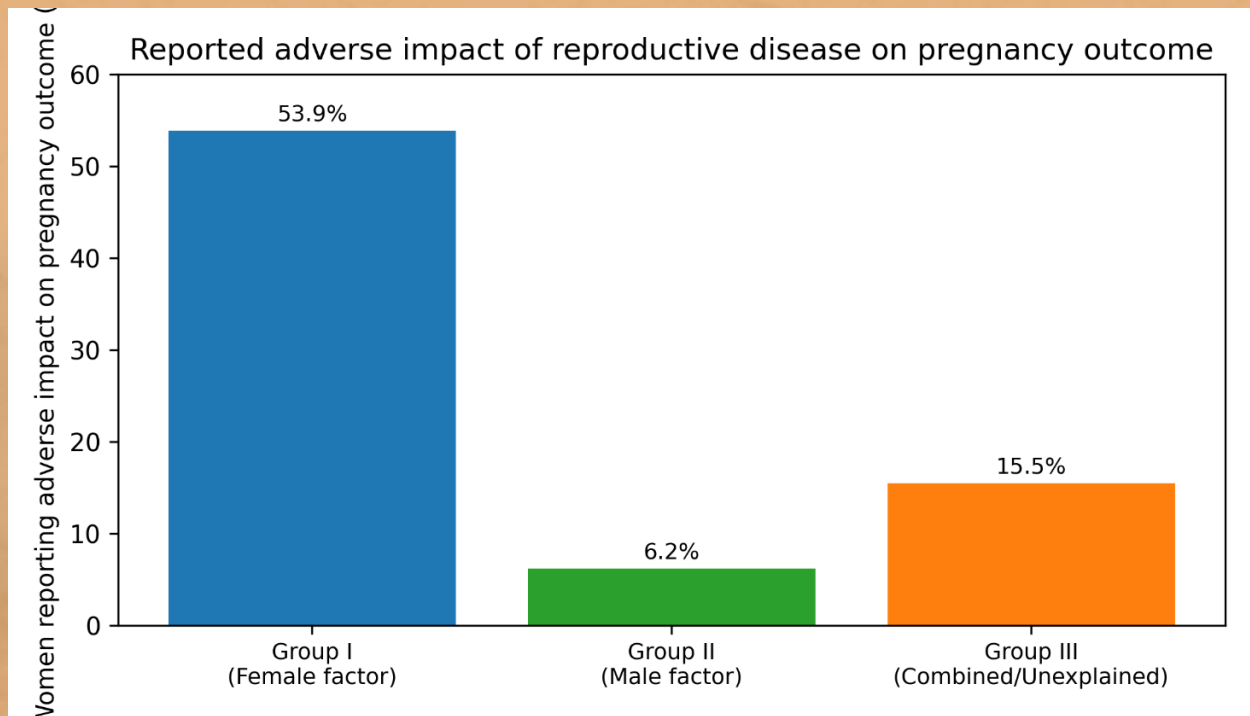
Marriage duration differed significantly across infertility etiologies ($p = 0.003$). Women in the male-factor infertility group were more likely to present within the early years of marriage (2 - 5 years), accounting for 54.6% of this group, compared with 33.1% and 37.7% in the female-factor and combined/unknown groups, respectively. In contrast, longer marriage durations (≥ 6 years) were more frequently observed in the female-factor and combined/unknown groups.

Table 1. Marriage duration by infertility etiology.

Marriage duration	Group I (female) (n=130)	Group II (male) (n=130)	Group III (combined/unknown) (n=130)	p value
< 2 years	8 (6.2%)	5 (3.8%)	2 (1.5%)	0.003*
2 - 5 years	43 (33.1%)	71 (54.6%)	49 (37.7%)	
6 - 10 years	45 (34.6%)	28 (21.5%)	50 (38.5%)	
> 10 years	34 (26.2%)	26 (19.2%)	29 (22.3%)	

Reproductive diseases adversely affecting pregnancy outcome were substantially more frequent in the female-factor infertility group (53.9%) compared with the male-factor (6.2%) and combined/unknown groups (15.5%) ($p < 0.001$), reflecting greater clinical burden in female-factor infertility.

Figure 1. Reported adverse impact of reproductive disease on pregnancy outcome by infertility etiology.



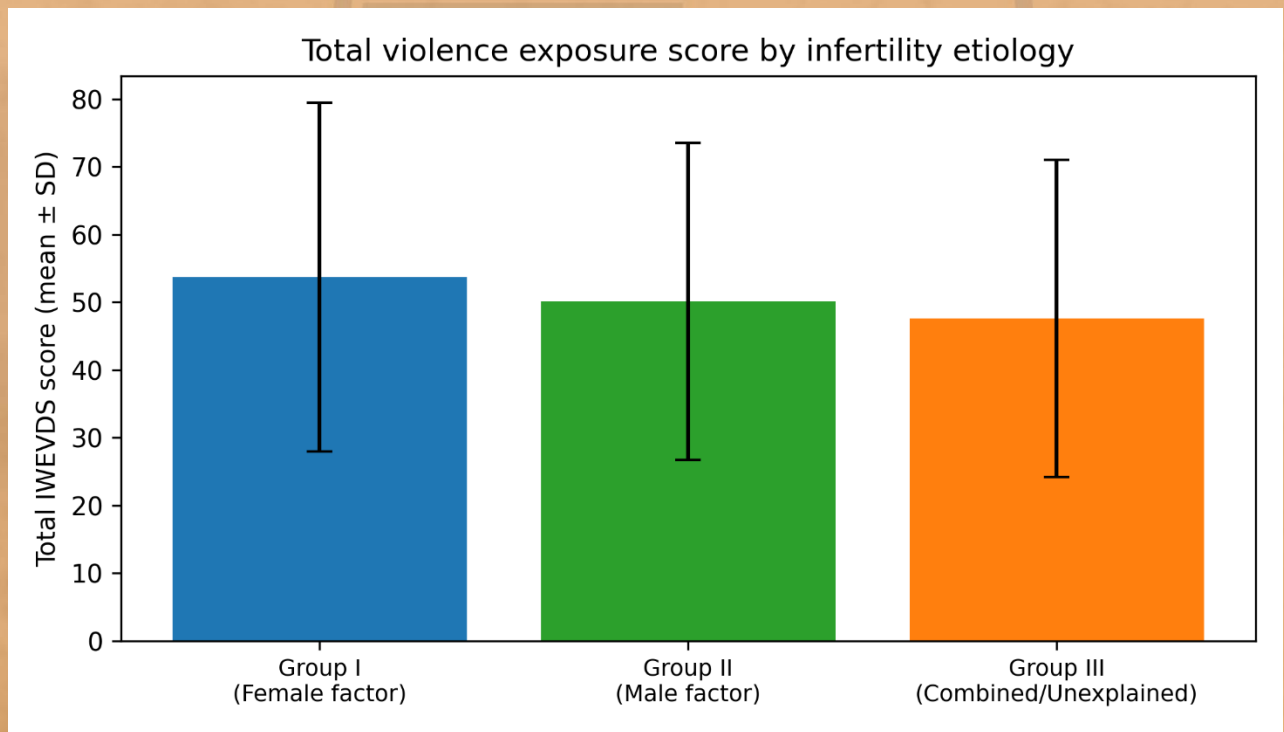
IWEVDS Domain Scores Across Infertility Etiologies

Mean IWEVDS domain scores did not differ significantly across infertility etiologies. However, a consistent pattern was observed, with higher mean scores in the female-factor group across all domains.

The total IWEVDS score was highest in the female-factor group (53.7 ± 25.7), followed by the male-factor group (50.08 ± 23.4) and the combined/unknown group (47.6 ± 23.4), although the overall difference was not statistically significant ($p = 0.21$).

Table 2. IWEVDS domain scores by infertility etiology (mean $\pm$ SD).

Domain	Group I	Group II	Group III	p value
Domestic violence domain	14.8 $\pm$ 7	14.02 $\pm$ 6.7	13.2 $\pm$ 6.5	0.22
Social pressure domain	14.1 $\pm$ 7.7	12.7 $\pm$ 7.1	12.1 $\pm$ 7.1	0.10
Punishment domain	9.9 $\pm$ 5.2	9.3 $\pm$ 4.5	8.9 $\pm$ 4.7	0.31
Exposure to traditional practice domain	9.3 $\pm$ 4.5	8.9 $\pm$ 4.2	8.5 $\pm$ 4.4	0.37
Exclusion domain	5.5 $\pm$ 3.2	5.1 $\pm$ 3	4.65 $\pm$ 2.7	0.09

Figure 2. Total violence exposure score by infertility etiology (mean $\pm$ SD).

Domain-specific scores, including domestic violence, social pressure, punishment, exposure to traditional practices, and exclusion, showed a gradual decline from female-factor to combined/unknown infertility, without reaching statistical significance.

Item-Level Differences in IPV Exposure

Item-level analysis revealed that most IWEVDS items did not differ significantly across infertility etiologies. However, two items demonstrated statistically significant differences:

- Physical abuse due to infertility (Q6) ($p = 0.01$)
- Being taunted as the “childless woman” (Q10) ($p = 0.02$)

Women in the female-factor infertility group reported higher frequencies of both physical abuse and verbal stigmatization compared with the other groups.

Across all infertility etiologies, IPV exposure demonstrated a consistent, though statistically non-significant, trend toward higher levels in the female-factor group. While overall IWEVDS scores did not differ significantly, specific forms of violence, particularly physical abuse and verbal stigmatization, were more pronounced in this group.

Table 3. Selected IWEVDS items with significant differences between etiologic groups.

Item	Response	Group I	Group II	Group III	p value
Q6. Physical abuse due to infertility	Always	0 (0%)	4 (3.1%)	2 (1.5%)	0.01
	Often	2 (1.5%)	2 (1.5%)	3 (2.3%)	0.01
	Sometimes	17 (13.1%)	12 (9.2%)	7 (5.4%)	0.01
	Rare	8 (6.2%)	0 (0%)	3 (2.3%)	0.01
	Never happened	103 (79.2%)	112 (86.2%)	115 (88.5%)	0.01
Q10. Taunted as the “childless woman”	Always	20 (15.4%)	13 (10%)	9 (6.9%)	0.02
	Often	0 (0%)	1 (0.8%)	5 (3.8%)	0.02
	Sometimes	28 (21.5%)	17 (13.1%)	17 (13.1%)	0.02
	Rare	4 (3.1%)	3 (2.3%)	4 (3.1%)	0.02
	Never happened	78 (60%)	96 (73.8%)	95 (73.1%)	0.02

Factors Associated with IPV Exposure Within Infertility Etiology Groups

Analysis of factors associated with IPV exposure demonstrated both shared and etiology-specific patterns across infertility categories.

The husband's level of education emerged as a consistent factor associated with IPV exposure across all infertility etiologies (Group I: $p = 0.008$; Group II: $p = 0.02$; Group III: $p = 0.02$).

Within the female-factor infertility group, additional factors associated with higher IPV exposure included:

- Husband non-working status ($p = 0.03$)
- Husband drug/medication/sedative use ($p = 0.006$)
- Longer infertility duration ($p = 0.03$)
- Prolonged treatment duration ($p = 0.01$)

Within the male-factor infertility group, IPV exposure was primarily associated with:

- Delayed pregnancy duration ($p = 0.02$)
- Longer treatment duration ($p = 0.03$)

In the combined/unknown group, fewer significant associations with IPV exposure were identified.

Table 4. Factors significantly associated with IPV exposure within infertility etiology groups (within-group analysis).

Predictor	Group I (female)	Group II (male)	Group III (combined/unexplained)
Husband education level	$p = 0.008^*$	$p = 0.02^*$	$p = 0.02^*$
Husband employment (working vs. not working)	$p = 0.03^*$	NS	$p = 0.05^*$
Husband drug, medication, or sedative use	$p = 0.006^*$	NS	NS
Duration of infertility	$p = 0.03^*$	$p = 0.02^*$	NS
Infertility treatment duration	$p = 0.01^*$	$p = 0.03^*$	NS

Summary of Key Findings

Across all infertility etiologies, IPV exposure demonstrated a consistent, though statistically non-significant, trend toward higher levels in the female-factor group. While overall IWEVDS scores did not differ significantly, specific forms of

violence, particularly physical abuse and verbal stigmatization, were more pronounced in this group.

IPV exposure was influenced by a combination of sociodemographic, partner-related, and infertility-related factors, with distinct patterns of association observed across infertility etiologies.

Discussion

The present study provides an etiology-stratified perspective on intimate partner violence (IPV) among women with primary infertility, underscoring the importance of conceptualizing infertility as a heterogeneous and socially mediated condition rather than a uniform clinical entity. Although overall IWEVDS scores did not differ significantly across infertility etiologies, a consistent directional trend toward higher exposure was observed among women with female-factor infertility. While not statistically significant, this pattern remains clinically meaningful and reflects underlying sociocultural dynamics shaping women's lived experiences.

A central finding of this study is that both the determinants and expression of IPV vary according to infertility etiology. In many sociocultural contexts, infertility is implicitly attributed to the female partner, irrespective of the underlying medical cause. This attribution bias is deeply rooted in gender norms that equate female identity with reproductive capacity, thereby increasing vulnerability to blame, stigma, and psychological pressure [6]. These dynamics likely contribute to the higher IPV exposure observed in female-factor infertility, particularly in forms of emotional abuse such as labeling, humiliation, and social marginalization.

From a mechanistic perspective, infertility can be conceptualized as a chronic relational stressor that disrupts established interpersonal dynamics. The inability to conceive may trigger cycles of frustration, disappointment, and blame, which can escalate into controlling or abusive behaviors. Importantly, this relationship appears to be bidirectional. Infertility-related stress may increase susceptibility to IPV, while exposure to IPV may exacerbate psychological distress and negatively influence reproductive outcomes through both behavioral and physiological pathways, including stress-related endocrine dysregulation [3,9]. This bidirectional interaction reinforces the need to consider infertility and IPV as interconnected rather than independent conditions [3,7,9,18–20].

An important consideration in interpreting these findings is the distinction between statistical significance and clinical relevance. Although differences in total IWEVDS scores did not reach statistical significance, consistent directional trends and significant item-level findings suggest the presence of clinically meaningful variation. In socio-behavioral research, aggregate scores may obscure context-specific manifestations of violence, particularly those influenced by cultural norms and gender expectations. The higher frequency of stigmatization and physical abuse indicators in the female-factor group reflects not only individual vulnerability but also broader sociocultural narratives surrounding fertility. Therefore, interpretation of IPV in infertility settings should extend beyond total scores to include domain-specific and item-level patterns.

The etiology-specific findings of this study extend existing literature by highlighting the role of attribution dynamics in shaping IPV risk. While previous studies have consistently reported high prevalence rates of IPV among infertile women, particularly in Middle Eastern and South Asian settings [3,5], they have largely treated infertility as a homogeneous condition. The current findings suggest that discrepancies between studies may, in part, be explained by differences in how infertility etiology and sociocultural attribution are accounted for. By incorporating an etiology-stratified analytical approach, the present study provides a more nuanced and context-sensitive understanding of IPV risk.

This distinction is particularly important in reconciling inconsistencies across the literature, where variations in IPV prevalence may reflect differences in sociocultural context and the extent to which infertility etiology is explicitly considered.

These findings can also be interpreted within a broader sociocultural framework. In many traditional societies, fertility is not solely a private matter but a collective expectation reinforced by extended family systems. External pressures from family and community may intensify emotional strain and contribute to conflict within the couple. The persistence of gendered expectations, even in cases of male-factor infertility, reflects a disconnect between biomedical knowledge and social perception. This misalignment likely perpetuates the disproportionate burden placed on women and contributes to IPV vulnerability [6,18].

Sociodemographic factors further modulate IPV risk. The husband's level of education emerged as a consistent factor associated with IPV exposure across all

infertility etiologies, suggesting a cross-cutting socioeconomic influence. Lower educational attainment may reflect limited awareness of healthy relationship dynamics, reduced communication capacity, and stronger adherence to traditional norms that may implicitly tolerate coercive behaviors [8,10]. These findings are consistent with global evidence identifying socioeconomic disadvantage and gender inequality as key drivers of IPV [2]. Additional factors, including unemployment and substance use, may further amplify relational stress and reduce adaptive coping capacity.

The temporal dimension of infertility represents another critical factor. Longer duration of infertility and prolonged treatment trajectories were associated with increased IPV exposure in certain groups, suggesting that cumulative stress may erode relational resilience over time. In the context of assisted reproductive technologies, repeated treatment cycles, financial burden, and uncertainty regarding outcomes may intensify emotional strain. Without adequate psychosocial support, such prolonged stress may increase the likelihood of maladaptive coping responses, including aggression and withdrawal [16,19,20].

From a clinical perspective, these findings support the integration of routine IPV screening into infertility care. Fertility clinics represent a unique setting for identifying psychosocial vulnerabilities, given the repeated and prolonged patient-provider interactions. A targeted screening approach, informed by infertility etiology and sociodemographic risk factors, may be more effective than a universal model. Multidisciplinary care pathways incorporating psychological support, social counseling, and referral mechanisms are essential for addressing the complex needs of this population [11,12].

Incorporating IPV assessment into infertility care pathways may also improve treatment adherence and overall reproductive outcomes. Early identification of psychosocial risk factors allows for timely intervention, including counseling, partner engagement strategies, and referral to specialized support services. Such integrated approaches align with emerging models of patient-centered reproductive care [12,16].

At the public health level, the intersection between infertility and IPV underscores the need for integrated strategies addressing both conditions within a unified framework. Reducing infertility-related stigma, promoting gender equity, and recognizing IPV as a health issue rather than a private matter are essential steps.

Community-based interventions and policy-level initiatives aimed at improving access to reproductive healthcare and social support services may contribute to mitigating the burden of both conditions [10,15].

An additional strength of this study lies in its consideration of the religious and ethical context. Within Islamic frameworks, infertility is recognized as a medical condition rather than a moral failing, and assisted reproductive technologies are permitted within marriage to preserve lineage and family integrity [13]. At the same time, Islamic teachings explicitly condemn injustice and violence, emphasizing mutual respect, compassion, and equity between spouses. This perspective provides a culturally grounded basis for addressing IPV and may enhance the acceptability and effectiveness of intervention strategies [13].

Several limitations should be acknowledged. The cross-sectional design precludes causal inference between infertility and IPV. Self-reported data may be subject to underreporting, particularly in socially sensitive contexts. Additionally, the single-center setting may limit generalizability. However, the use of a validated instrument and the etiology-stratified analytical approach strengthen the validity and relevance of the findings.

Conclusion

Intimate partner violence among women with primary infertility represents a clinically relevant and context-dependent phenomenon influenced by both sociodemographic vulnerability and infertility-related relational stress.

While overall IPV exposure did not differ significantly across infertility etiologies, consistent trends and item-level differences suggest that female-factor infertility is associated with greater sociocultural burden, particularly in the form of stigmatization and emotional abuse. These findings highlight the importance of moving beyond aggregate measures of IPV toward a more nuanced, etiology-informed understanding of risk.

The identification of both universal predictors, such as the husband's level of education, and etiology-specific factors, including infertility duration, treatment trajectory, and partner-related characteristics, underscores the multifactorial nature of IPV in this population.

From a clinical perspective, these findings support the integration of confidential IPV screening and psychosocial assessment into infertility care, particularly for women with prolonged infertility and socioeconomic vulnerability. Tailored, multidisciplinary approaches incorporating counseling, social support, and referral pathways are essential to address both the reproductive and psychosocial dimensions of care.

Future research should prioritize longitudinal designs to clarify causal pathways between infertility and IPV, as well as intervention-based studies aimed at reducing stigma, improving couple dynamics, and integrating mental health support within reproductive healthcare services.



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