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Intimate Partner Violence Against Women in the Arab Countries: A Systematic Review of Risk Factors

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Abstract

Intimate partner violence (IPV) profoundly damages physical, sexual, reproductive, and psychological health, as well as social well-being of individuals and families. We sought in this systematic review to examine the risk factors according to the integrative ecological theoretical framework for IPV for women living in the Arab countries. We searched Embase, PubMed, PsycINFO, and SCOPUS, supplemented by hand searching of reference lists. A research strategy was developed and observational studies were included if they considered female participants (age $\geq$13) in heterosexual relationships, estimates of potential risk factors of IPV, and IPV as a primary outcome. We conducted a narrative synthesis of the risk factors data from 30 cross-sectional studies. Factors associated with increased IPV against women were extracted and categorized into four levels according to the updated integrative ecological model. At the individual level, risk factors were either related to victims or perpetrators of IPV. Factors relating to marriage, conflict within the family, etc., were explored and included within the family level, whereas factors relating to the extended family and the nature of marriage were included in the community level. Finally, risk factors relating to the cultural context that are influenced by the political and religious backgrounds were included in the societal level. The complex structure of violence against women in the Arab world calls for socioculturally sensitive interventions, which should be accompanied by systematic and structured work aimed at improving Arab women's status at all levels.

Keywords

intimate partner violence, women, intimate partner violence and cultural contexts, predicting intimate partner violence, systematic review

Apart from it being a human rights violation, intimate partner violence (IPV) profoundly damages physical, sexual, reproductive, and psychological health, as well as the social well-being of its victims and their families (World Health Organization [WHO], 2010). The theoretical underpinnings of IPV have come from different disciplines, spanning the psychological (e.g., frustration-aggression theory, cognitive behavioral theory), biobehavioral (e.g., individualist theories), criminological, and sociological frameworks (Larsen, 2016). This article is focusing on the structuralist perspectives of the sociological theoretical framework, with the valuable standpoints of viewing IPV as a function of social structures, ranging from micro- to macrolevels, as opposed to viewing it as individual pathology (Levin & Rabreovic, 2007).

The two major structuralist theories are examined to understand IPV: (A) Family violence theories consider abuse within relationships as part of a more extensive violence that is intrinsic in social structures and view IPV as qualitatively equal to child abuse, elder abuse, or violence between siblings (Anderson, 1997; Gelles, 1993; Larsen, 2016; Lawson, 2012). IPV is viewed as a "stress reaction" to a domestic problem or circumstances, such as poverty, unemployment, rurality, and so on. However, studies indicate the widespread nature of IPV and its far-reaching consequences and have shown that it is not limited to those in particular social, geographical, cultural, or

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socioeconomic circumstances (Devries et al., 2011; WHO, 2005). Therefore, this standpoint is criticized for its limitation to acknowledge the violence perpetrated by the wealthy and socially privileged as well as the nonabusive behaviors of those less privileged or with poor socioeconomic status.

(B) Feminist theories view IPV as an issue fundamentally related to gender and patriarchal domination of men over women. They propose that this imbalance at the societal level is reproduced within the family unit when men exercise power and control over women, sometimes in the form of violence and abuse (Yllo, 2005). From this perspective, where the social system recognizes the subordination of women as normal, men are entitled to dominate and control. These theories also believe violence against women (VAW) is not episodic but rather an expression of systematic male control, with abuse being intentional, and abuse is in fact an assertion of control rather than a loss of it (Mankowski et al., 2002). Critics of the feminist theories challenge the ideas of the prevailing victimization of women by referring to the underreporting by victimized men in research. Even if reported victimization rates and injuries are far lower for men, there is also an inequity in attempts to reduce men's IPV victimization compared to women's (Dutton & Nicholls, 2005).

Given the complexity and diverse realities of IPV in different societies, integrative perspectives have been developed in order to better understand IPV (Lawson, 2012). An ecological approach can help to examine complex forms of violence from a public health standpoint (Dutton, 2006; Green et al., 1996; McLaren, 2005). Moreover, such an approach considers risk factors rather than causes at four different levels (individual, microsystem, exo-system, and macrosystem). The gender-related aspects that are essential in the ecological analysis of IPV (e.g., societal gender norms and male dominance within the family) are also considered (Ashcraft & Mumby, 2004; Heise, 1998). Given the special focus of this research on the unique context of the Arab world, this approach could offer a framework for conceptualizing the complex interplay between the many and varied factors that influence IPV in that region. It could also enable a more nuanced discussion on better ways to approach and acknowledge the hidden roles of cultural, legal, and organizational factors for better prevention and intervention for IPV, especially in such complex sociocultural contexts with variable dimensions of societal gender norms like the Arab countries. For all these reasons, this article is premised on an ecological model of IPV.

The Arab World Today

The Arab world is a geopolitically defined territory with about 350 million people living in what is presently known as the Arab countries or states that are situated in Western Asia, North Africa, the Horn of Africa, and Western Indian Ocean islands (United Nations Development Program [UNDP], 2014; Worlds Bank, 2019). The complex sociocultural contexts of the Arab countries reside in having a rich diversity of ethnic, linguistic, and religious communities. These include Kurds, Armenians, Berbers, Amazigh, indigenous Africans, and others. Today, the word *Arab* itself is a cultural and linguistic term and holds in it a shared identity. As language is important to any ethnic identity, Arabic has been the ethnic marker and the catalyst of a larger Arabic identity, with its spreading throughout the region during the early Muslim conquests of the seventh and eighth centuries and the subsequent Arabization of indigenous populations (Hourani, 1991; Mackintosh-Smith, 2019).

In terms of its cross-cultural aspects, this study situates its analysis of the risk factors for IPV within the overall socioeconomic and political environment that has defined the Arab region during the last 3 decades (United Nations [UN], 2016). Exploring such aspects could lead to recognizing the roles or expectations of behaviors and norms within the cultural and social group at hand that could influence the factors related to IPV. The Arab region encompasses 22 states with stark contrasts in the economic, social, and political realms. In particular, wide disparities exist among the Arab States in terms of geographical size, population, level of urbanization, and wealth. For example, the population of Egypt is almost 100 times larger than that of Comoros (United Nations Economic and Social Commission for Western Asia, 2013). Another aspect of the cross-cultural context of the Arab region is the existing social classism imposed by the gross division of communities in which they reside. Rural populations, in particular, remain at a significant disadvantage in accessing basic services such as health care, education, and other social infrastructure, as well as the lack of awareness in regard to their human and women's rights. The majority of people in Comoros, Somalia, the Sudan, and Yemen live in rural areas, whereas Lebanon and most of the countries that comprise the Gulf Cooperation Council (i.e., Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates) are highly urbanized (United Nations Population Division, 2014). While the average gross domestic product per capita stands at US$7,574, it ranges from US$128 in Somalia, which is one of the poorest countries in the world, to roughly US$94,000 in Qatar, which is one of the wealthiest (United Nations Population Division, 2014).

At the same time, the Arab countries share similar historical and linguistic features, producing similar cultural and societal features. Examples of these features are the set of laws adopted according to the dominating religions and norms, the authoritarian and fascist governments, as well as the ongoing implications of patriarchal male dominance, such as the minimal changes made to the discriminating temporary personal status laws, which governs issues such as marriage, divorce, and inheritance (Abadeer, 2015).

Gender Norms and IPV

In the Arab world, similar as in other collectivist societies in the world, inherited social norms (i.e., the shared understandings about actions that are obligatory, permitted, or forbidden, which are created, modified, sustained, and enforced by people) and traditions, in many cases, condone and even encourage VAW (Abadeer, 2015). According to Bourdieu (1998), collective expectations or collective privileges place male and female

spheres in opposition. The female sphere is one of fragility and frivolity while the male sphere is one of machismo and virility (Johansson-Nogués, 2013). The traditional often discriminating gender role definitions could intersect with other factors that drive inequalities, discrimination, and marginalization, such as ethnicity, socioeconomic status, disability, age, geographic location, and sexual orientation, among others (Manandhar et al., 2018).

The Universal Declaration of Human Rights affirms the principle of the inadmissibility of discrimination and proclaims that all human beings are born free and equal in dignity and rights, without distinction of any kind, including the distinction based on sex in order to achieve gender equality and justice (United Nations General Assembly, 1948). In the Arab countries, the acknowledgment of such a declaration is highly limited. In the case of women, they are burdened with domestic roles and responsibilities while having limited influence over resources within the household and in society, whereas obstacles still hinder their fulfillment in political and nondomestic roles. Moreover, the historically rooted, socially constructed norms according to these gender role definitions and expectations can lead to permanent gender discrimination in societies that still seek to sanction such behaviors and expectations (Abadeer, 2015). Such norms are converted to formal rules, which adopt more violent attitudes against women. If not obeyed, disapproval ranging from raised eyebrows to social ostracism is very likely to occur. For example, in countries like Iraq, Egypt, and the Palestinian Territories, norm-based laws exist granting justifying or mitigating excuse when a man commits a crime against his wife, sister, or daughter (known as *honor crimes*) under the pretext that the woman violated his honor by *committing* what is perceived as behaviors contrary to the prevailing moral norms (women's virginity and fidelity), including *honor crimes* committed against rape victims (Abu Odeh, 2010). Furthermore, the female genital mutilation/cutting practices that are common in countries like Somalia, Sudan, Djibouti, Mauritania, Yemen, Oman, and Egypt are a reflection of the attempts for preserving women's chastity and family honor. Such systematic norm-based laws and practices are cyclic and intergenerational in their nature, where violent attitudes affect women from an early age (United Nations International Children's Emergency Fund [UNICEF], 2013).

Moreover, many women, not only in Arab countries, are reluctant to report or disclose their experiences of abuse (Walker, 2016). The fear of possible and grave consequences from perceived disloyalty to the victims' families and/or spouses and the lack of personal resources to leave or change the situation could lead to a sense of entrapment and isolation of the victims (Usta et al., 2006). On the other hand, victimized women may not recognize their marginalized status and are taught to accept it, others may not have the notion that they have been wronged (McKinney et al., 2008). Consequently, accepting and normalizing attitudes toward IPV are among the many significant factors associated with exposure to IPV. A review article about women's attitudes regarding IPV found that women from Africa and South Asia were even more likely to justify IPV compared to men from the same regions. Four Arab countries (Lebanon, Tunisia, Sudan, and Iraq) were included. Around 20%–30% of women in Lebanon and Tunisia and about 50% of women in Iraq and Sudan had accepting attitudes of IPV (Tran et al., 2016). The existing and undeniable societal indifference to IPV could also influence social and health care institutions' measurements to deal with IPV victims and survivors. For instance, health care providers often fail to ascertain, or in many cases, lack the desire to acknowledge IPV (Stam et al., 2015). Women's report of violence by their partners is denied, minimized, or ignored, and the knowledge of assaults and rape is not addressed in individual treatment and family interventions or discharge plans (Douki et al., 2003). This results in further underreporting of IPV which leads to more serious negative health implications for IPV victims.

Societal Factors and IPV

Multiple factors such as the difficult economic context, rurality, unemployment, armed conflicts, and current legislation in addition to persistent elements of gender-discriminating norms in the unique cultural settings might accumulate and prevent women and their families from seeking help and increase the incidence of IPV. Violence against women exacerbates in countries where there is no law against domestic violence (DV) or where there is a lack of effective enforcement of laws against offenders (UN, 2013). Nowadays, new legislation has afforded better protection of women and children in some of the Arab countries (Arfaoui & Moghadam, 2016; Cohran, 2009; Tonnessen, 2016). According to the UN, several states withdrew some or all of the reservations they had made upon accession to the Convention on the Elimination of All Forms of Discrimination Against Women. These withdrawn reservations addressed the applicability of particular articles of the convention that were deemed subject to compatibility with tenets of Islam and/or constitutional law[1] (UN, 2016). However, these borderline positive developments sharply contrast with a reality in which the victimization of IPV and the adverse consequences for women's health are not declining and the fact that discrimination against women and girls still persists at all levels of society and is being institutionalized by national law (UN, 2016).

National Laws and IPV

National family laws of the respective Arab states are known to be norm-based laws. They are very much unique and distinctive factors to the Arabian cultural context. They are mostly governed by religion-based personal status codes (Skaf, 2013), which guarantee an inferior legal status for women living in those countries. Among these laws is the *maintenance in return for obedience* law, that is, the husband's demand for complete obedience from his wife in return for the woman's claim for financial support before (as dowry) and during marriage (Skaf, 2013). Such law guarantees the manipulation, control, and the discrimination against women in terms of male guardianship

that treats women as minors, unequal access to divorce, child guardianship, and their rights for legal protection against violence in countries like Saudi Arabia, Sudan, Yemen, Egypt, and Jordan (Haj-Yahia, 2000b; Skaf, 2013; Tonnessen, 2016; Würth, 2008).

Furthermore, the legal protection of women is dependent on the legislative and judiciary organs of the respective state—in the case of the modern Arab state, dependent on patriarchal institutions—making, for example, the definition of VAW and its types based on the prevalent and dominant political climate (Würth, 2008). For instance, the Islamic law in Sudan's Criminal Act of 1991, *zina* (i.e., adultery), is defined as unlawful sexual intercourse between two consenting individuals who are not married to each other. Rape, however, is categorized as *zina* without consent, where the strict rules of evidence used for *zina* are also applied to rape. In addition, rape victims can be convicted of *zina* and punished (Tonnessen, 2014). The legal reference to adultery (*zina*) entails that if rape cannot be proved, a woman filing a complaint about rape may be prosecuted either for adultery (punishable by the death penalty for married women or a whipping of hundred lashes for unmarried women) or for wrongful accusation of adultery (punishable by a whipping of eighty lashes; REDRESS Organization, 2008). Similarly, in Saudi Arabia, regulations concerned with IPV define violence as physical, psychological, or sexual mistreatment. However, the regulations regarding sexual mistreatment do not explicitly make marital rape a crime (Tonnessen, 2016). Such vague interpretations of criminality participate in creating loopholes within the justice system and further ignore IPV committed against women in that society. In other cases, when rape is proved, victims could be forced to marry their rapists. The logic behind this law is not to protect women from further harm but rather to salvage her *wounded* reputation or honor in the society where she lives. Hence, a marriage to her rapist is perceived as a less shameful and stigmatizing solution to the problem, that is, premarital sex (Haddad, 2017). The legal loopholes that let perpetrators escape the consequences of their crimes and the criminalization of rape victims by society and judicial systems are strong implications of how gender-discriminating norms and societal factors could interplay. They are also among many reasons for the underreporting of violence committed against women, especially sexual violence such as rape.

IPV in Political Conflicts

In many countries of the region, the newly internationally submitted measures and the improved national laws have not yet proven to have any meaningful impact, and the legal and institutional safeguards to protect women and girls from abuse have yet to materialize. The advancement of women's rights and better protection from violence and abuse in the Arab region in the last 30 years is complicated by the ongoing political instability, as well as the resulting mass displacements internally, or in neighboring countries. Many Arab countries have suffered and still are suffering the aftermath of anti-regime uprisings (the Arab Spring) and wars (Wachter et al., 2018). On the surface, the conflict caused by these events appears to be damaging to the infrastructure and economics of society, yet it was and still is a step to establish and expand human and women's rights. In such conflict settings, it is therefore imperative to analyze IPV and its occurrence within the context of intersecting gendered oppressions and social norms at hand.

As noted in *paragraph 135* of the Beijing Platform for Action, "while entire communities suffer the consequences of armed conflict and terrorism, women and girls are particularly affected because of their status in society and their sex." Meaning that violence and discrimination against women that existed prior to conflict will be exacerbated during conflict (UN, 2002). In the Palestinian Territories, particularly in Gaza, women and girls suffer from increased violence by their family, including marital rape and incest (Abdo, 2000). In Lebanon, the most traumatic experiences that women reported during and after the war were dealing with the violence perpetrated by their husbands (United Nations Population Fund, 2007). Furthermore, since the anti-regime uprisings, the established women's rights have been increasingly under attack and VAW has been on the rise in countries like Egypt, Morocco, Tunisia, and Libya (Johansson-Nogués, 2013). Therefore, it is crucial to consider the changes and processes that took place during and after the revolutions and armed conflicts in the Arab region and how they are linked to IPV.

Legal Injustices

In 2009, the World Economic Forum highlighted some recommendations to address systemic problems related to VAW across the Arab states. However, the lack of government support and women's political participation and agency have undermined the efforts to tackle such issues. In some Arab countries, questioning what is considered in the respective cultural context as a private matter has put people who advocate for better policies in danger of being detained and their families socially ostracized (Skaf, 2013). In countries like Saudi Arabia, Sudan, Syria, Yemen, Egypt, Libya, and Iraq, men and women have been targeted for promoting women rights in their communities and are sometimes even detained and accused of undermining state security, defamation, or treason by partnering with foreign organizations (Amnesty International, 2019; Human Rights Watch, 2013, 2014, 2016, 2017, 2019a, 2019c). Their lack of subservience to the hypermasculine states and the fear of challenging the larger misogynistic patriarchal ideology of most Arab societies have led many of the Arab regimes to enact unfair treatment toward advocates, such as the imprisonment of those men and women, as well as the collective shaming and punishment toward IPV survivors.

Accordingly, it is evident that the development of research examining the contextual, structural, and gendered nature of factors related to women's IPV victimization has been insufficient and far less representative for women living in Arab countries. The purpose of this study, therefore, is to conduct a systematic review in order to effectively answer the following

questions: What are the risk factors for IPV for women living in Arab countries? and What are the potential cross-cultural aspects that could be related to IPV risk among women living in Arab countries?[2]

Method

Search Strategy

In this article, research articles were primarily obtained through electronic searches performed in four databases: Embase via Ovid, PubMed, PsycINFO via ProQuest, and SCOPUS. Reference lists of the existing reviews and included publications were searched for further articles. Other electronic databases (i.e., ASSIA and Google Scholar) were screened for gray literature. The search strategy was developed according to the population, intervention, comparison and outcomes (PICOs) scheme to determine search concepts and types of studies that were most appropriate to answer our research questions. The search was last conducted in May 2018 and had no date range restrictions because no information regarding when IPV studies first emerged in the Arab countries was found.

Separate searches for each primary database combined Medical Subject Subheadings terms and key text words with the Boolean operators (AND) and (OR), accordingly. Different terms for IPV and country names were used. The 22 Middle Eastern and African countries listed are the members of the Arab League,[3] a regional organization in the Arab world, which is located in Africa and Western Asia. The electronic search strategy used for the PubMed database is presented in Online Appendix A.

Eligibility Criteria

All studies had to be observational studies (i.e., cohort, case-control, and cross-sectional studies), measuring risk factors for IPV in the respective Arab countries. Due to the difficulty to collect representative data and to conduct research on population-based samples of women within the respective countries, we included clinic-based (nonpopulation) and nonclinic-based studies that applied convenience sampling of participants. We included studies considering the PICOs framework: Population was women, aged $\geq$ 13 years and living in one of the 22 Arab countries (i.e., Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, the United Arab Emirates, and Yemen). Estimates of potential risk factors for IPV (e.g., socioeconomic, mental health–related factors) were considered as interventions or exposure. No comparison was needed. IPV was considered as our main outcome. We originally planned to include only articles published in English or Arabic, but we diverged from the protocol and considered articles published in French for inclusion as well. We also lowered the age definition from 15 to 13 years old or older, since some eligible studies on IPV included females from that age.

Data Collection Process

This review followed the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines for the systematic review of nonrandomized studies (Liberati et al., 2009). All studies collected through the database searches were imported into the web-based, systematic review tool *Covidence* (2019). Titles and abstracts of these studies were screened independently by A.M. and N.A. to identify all citations that met the inclusion criteria. The full articles that appeared to match the inclusion criteria based on the title–abstract screening were then reviewed by the same reviewers independently. Disagreements between the two reviewers were resolved by discussion, with the involvement of a third reviewer (J.H.) when necessary.

We developed a data extraction form, based on the data extraction sheet used in Bargagli et al. (2007), and pilot-tested it on five randomly selected included studies, refining it accordingly. Data items included (1) characteristics of study (including its design, site, size and population, response rate, survey period, and data collection instruments), (2) type of intervention/exposure (gender of perpetrator should be defined as male and victim as female, age of victim, nature of relationship between the two should be defined as intimate or spousal) and number of exposed and nonexposed, and (3) type of outcome (risk factor estimates of IPV). A.M. extracted the data from included studies, and a second reviewer (N.A.) checked the extracted data. Discrepancies were resolved by discussion.

Quality of Included Studies

The methodological quality of all eligible studies was assessed using a checklist developed from the Methodological Evaluation of Observational Research tools (Shamliyan et al., 2011). A pilot trial on two included studies was performed in order to assess the feasibility of using this instrument. Items of the checklist were modified accordingly to suit the purpose of this review (Online Appendix B). Quality assessment was independently conducted by two reviewers (A.M. and N.A.), and disagreements were discussed to reach a consensus. We defined the overall scoring rules for the assessment of risk of bias as follows: Low risk of bias was defined as a low risk in at least four of the major domains and in at least one of the minor domains.

Data Analysis

Due to the numerous risk factor characteristics considered by the identified research studies, we decided post hoc to group risk factors according to the four concentric circles within the updated, integrative ecological framework suggested by Heise et al. (2002): (a) the innermost circle that represents the biological and personal history of the individuals, which we refer to as the individual level, (b) the second innermost circle (family level or *microsystem*) is the immediate context where abuse took place, (c) the third circle (community level or *exo-system*)

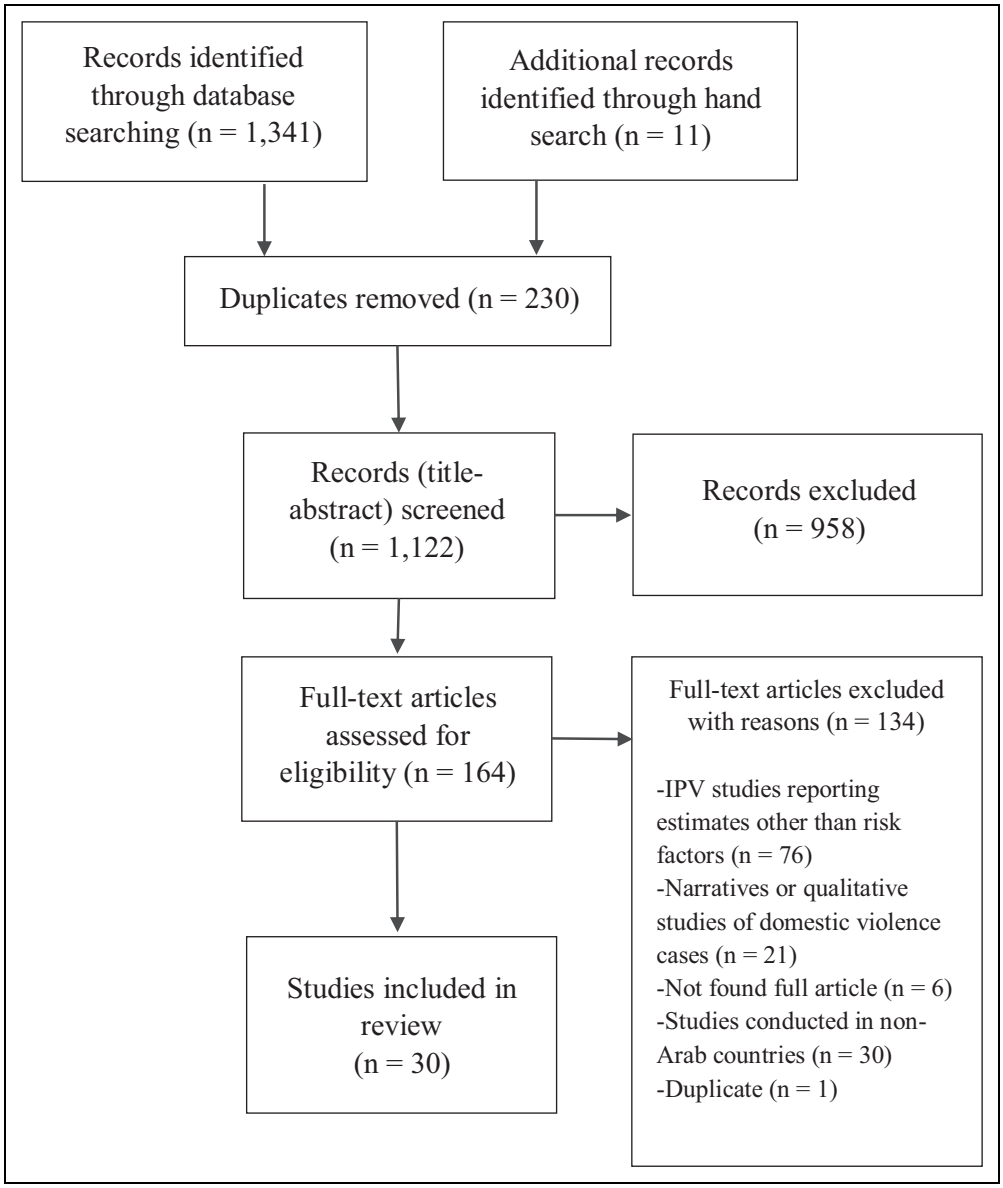

Figure 1. PRISMA flow diagram.

represents factors relating to the formal or informal social institutions or structures in which violent relationships are embedded, and (d) the fourth outermost circle (social level or *macrosystem*) represents factors that influence IPV such as gender inequality, religious or cultural belief systems, societal norms, and economic or social policies. If studies reported results with different effect measures, we converted the different indices (e.g., correlation values, F test and χ^2 test values, and β coefficient values) into a common effect measure (i.e., odds ratio [*OR*]) in order to combine them all in one meta-analysis (Borenstein et al., 2009; Cohen, 1988; Rosenthal, 1994). However, given that very few studies considered the same risk factors, the planned meta-analysis could not be performed. In order to understand the risk factors more effectively in the context of our review, we tabulated and summarized all findings with the measurement effects (such as *OR*s, regression coefficients, percentages, and p values or 95% confidence interval [CI]) and the converted effect sizes. The reported results were also considered qualitatively.

Results

Description of Studies

A total of 1,341 references were found through database searching and 11 studies through the hand search (Figure 1). After the title–abstract screening of 1,122 studies, full-text screening of the remaining 164 studies took place for assessing eligibility. Finally, 30 studies were included and reviewed (Akmatov et al., 2008; Al-Badayneh, 2012; Al-Faris et al.,

2013; Ali et al., 2014; Alsaleh, 2015; Al-Tawil, 2012; Alzahrani et al., 2016; Barnawi, 2017; Clark et al., 2010; Clark, Hill, et al., 2009; Clark, Silverman, et al., 2009; Eldoseri et al., 2014; Fageeh, 2014; Guimei et al., 2012; Haj-Yahia, 2000a; Haj-Yahia & Clark, 2013; Hammoury & Khawaja, 2007; Hammoury et al., 2009; Jellali & Jellali, 2015; Karadsheh & Al-Khatatneh, 2007; Lafta et al., 2009; Lenze & Klasen, 2016; Manoudi et al., 2013; Maziak & Asfar, 2003; Okour & Badarneh, 2011; Oweis et al., 2010; Safadi et al., 2018; Shiraz, 2016; Sousa & Haj-Yahia, 2015; Tashkandi & Rasheed, 2010).

Characteristics of Included Studies

All 30 studies included in this review were cross-sectional studies published in English ($n = 27$), French ($n = 2$), and Arabic ($n = 1$). The included studies involved 49,848 women (≥13 years old) living in Arab countries.

Seven of the included studies were conducted in Saudi Arabia (Al-Faris et al., 2013; Alzahrani et al., 2016; Barnawi, 2017; Eldoseri et al., 2014; Fageeh, 2014; Shiraz, 2016; Tashkandi & Rasheed, 2010), followed by eight studies in Jordan (Al-Badayneh, 2012; Clark, Hill, et al., 2009; Clark, Silverman, et al., 2009; Karadsheh & Al-Khatatneh, 2007; Lenze & Klasen, 2016; Okour & Badarneh, 2011; Oweis et al., 2010; Safadi et al., 2018); four studies in the Palestinian Territory (i.e., Gaza and the West Bank; Clark et al., 2010; Haj-Yahia, 2000a; Haj-Yahia & Clark, 2013; Sousa & Haj-Yahia, 2015); two studies in Egypt (Akmatov et al., 2008; Guimei et al., 2012), Syria (Alsaleh, 2015; Maziak & Asfar, 2003), and Lebanon (Hammoury & Khawaja, 2007; Hammoury et al., 2009); and one study in Sudan (Ali et al., 2014), the Kurdistan region in Iraq, Iraq (Lafta et al., 2009), Tunisia (Jellali & Jellali, 2015), and Morocco (Manoudi et al., 2013). Although all of the included studies investigated VAW, in which the perpetrators were their current or former intimate partners, various terms were used to describe this violence, that is, DV, IPV, VAW, wife beating/wife abuse/-and battering, family violence, spousal violence, gender-based violence, and intimate partner abuse. The term IPV is used from this point on to describe all the results. It should also be noted that if the analysis in this article at times referred to the situation of "Arab women," this is merely a shorthand to describe the region's many female inhabitants, which may come from various ethnic backgrounds.

As for the data collection settings, 11 studies were conducted in nonclinical settings. Studies conducted at universities utilized convenience sampling (Karadsheh & Al-Khatatneh, 2007), whereas household-based studies used representative populations (Akmatov et al., 2008; Al-Badayneh, 2012; Ali et al., 2014; Alsaleh, 2015; Clark et al., 2010; Haj-Yahia, 2000a; Haj-Yahia & Clark, 2013; Lafta et al., 2009; Lenze & Klasen, 2016; Shiraz, 2016). Sixteen studies were conducted in clinical settings, which are not necessarily representative of the general population. Clinical settings included primary health care centers (Alzahrani et al., 2016; Eldoseri et al., 2014; Hammoury & Khawaja, 2007; Maziak & Asfar, 2003; Tashkandi & Rasheed, 2010); hospitals (Al-Faris et al., 2013; Fageeh, 2014); public clinics, medical, or health centers (Barnawi, 2017; Guimei et al., 2012; Manoudi et al., 2013); family planning centers and reproductive health centers (Clark, Hill, et al., 2009; Clark, Silverman, et al., 2009; Jellali, & Jellali, 2015); antenatal clinics (Hammoury et al., 2009; Okour & Badarneh, 2011); and maternal and child health centers (Oweis et al., 2010). Three studies chose mixed settings, which are also considered to be unrepresentative (Al-Tawil, 2012; Safadi et al., 2018; Sousa & Haj-Yahia, 2015). Sousa and Haj-Yahia (2015) recruited participants from both universities and clinics. Al-Tawil (2012) initially recruited participants from a hospital and then recruited further participants from churches. Safadi et al. (2018) recruited participants from public and private health care clinics, general public service settings, schools, and women's union centers (Table 1).

Quality of studies

Twenty studies scored high risk of bias (Al-Faris et al., 2013; Al-Tawil, 2012; Alzahrani et al., 2016; Barnawi, 2017; Clark, Silverman, et al., 2009; Eldoseri et al., 2014; Fageeh, 2014; Guimei et al., 2012; Hammoury & Khawaja, 2007; Hammoury et al., 2009; Jellali & Jellali, 2015; Karadsheh & Al-Khatatneh, 2007; Lafta et al., 2009; Manoudi et al., 2013; Maziak & Asfar, 2003; Okour & Badarneh, 2011; Oweis et al., 2010; Safadi et al., 2018; Sousa & Haj-Yahia, 2015; Tashkandi & Rasheed, 2010), while 10 studies scored low risk of bias (Akmatov et al., 2008; Al-Badayneh, 2012; Ali et al., 2014; Alsaleh, 2015; Clark et al., 2010; Clark, Hill, et al., 2009; Haj-Yahia, 2000a; Haj-Yahia & Clark, 2013; Lenze & Klasen, 2016; Shiraz, 2016). Twenty studies employed some form of random sampling and 23 studies had a nonresponse rate ≤30%. The remaining studies employed nonrandom ($n = 10$) and clinic-based sampling ($n = 16$) or did not clearly state their sampling methods ($n = 2$). Twenty studies provided unclear justifications of their sample size, while the remaining 10 studies calculated the power or sample size. Four studies did not define the exposure exclusively as IPV, which could mean additional violence perpetrated by others than intimate partners or husbands. Two studies did not provide any information regarding the validity or sources of tools used. Furthermore, 16 of the included studies failed to list potential confounders for their studies, and therefore, the statistical methods to reduce research-specific bias were inadequate. Twenty-seven studies used adequate statistical methods to measure their outcomes, providing adequate estimates with 95% CIs for risk factors. Twenty-two studies did not clearly report their funding sources. The quality scores of the included studies are shown in Appendix C.

Risk Factors

Fifty-five associated factors were reported in our included studies.

Table 1. Extraction Table for Individual Studies.

Country	Study ID	Study Setting	Sampling	Sample Size	Response (%	Instrument	Risk of Bias
Saudi Arabia	Shiraz (2016)	Nonclinic	Random	1,000	99	WHO Questionnaire	Low risk
	Al-Faris et al. (2013)	Clinic-based	Nonrandom	300	74	WHO Questionnaire	High risk
	Alzahrani et al. (2016)	Clinic-based	Random	500	99	HITS + WHO Questionnaire	High risk
	Barnawi (2017)	Clinic-based	Random	720	-	Self-developed	High risk
	Eldoseri et al. (2014)	Clinic-based	Nonrandom	230	87	WHO Questionnaire	High risk
	Fageeh (2014)	Clinic-based	Nonrandom	2,301	81	NorVold Domestic Abuse Questionnaire	High risk
	Tashkandi & Rasheed (2010)	Clinic-based	Random	1,034	67.5	CTS-R	High risk
Jordan	Al-Badayneh (2012)	Nonclinic (household-based)	Random	1,854	96.5	CTS2	Low risk
	Karadsheh & Al-Khatatneh (2007)	Nonclinic	Nonrandom	729	100	Self-developed	High risk
	Lenze & Klasen (2016)	Nonclinic (household-based)	Random	10,867	99	Women-only Questionnaire	Low risk
	Clark, Silverman, et al. (2009)	Clinic-based	Random	622	99	WHO questionnaire	High risk
	Clark, Hill, et al. (2009)	Clinic-based	Random	390	78	WHO Questionnaire	Low risk
	Okour & Badarneh (2011)	Clinic-based	Nonrandom	303	96.8	WHO Questionnaire	High risk
	Oweis et al. (2010)	Clinic-based	Nonrandom	316	83.2	Self-developed	High risk
	Safadi et al. (2018)	Mixed	Nonrandom	471	100	ABI	High risk
Palestinian Territory	Clark et al. (2010)	Nonclinic (household-based)	Random	3,815	92	CTS2	Low risk
	Sousa & Haj-Yahia (2015)	Mixed	Nonrandom	122	100	Self-developed	High risk
	Haj-Yahia (2000a) (1)	Nonclinic (population-based)	Random	2,800	86.7	CTS + MWA + ISA + ABI	Low risk
	Haj-Yahia (2000a) (2)	Nonclinic (population-based)	Random	1,500	88.9	CTS + MWA + ISA + ABI	Low risk
	Haj-Yahia & Clark (2013)	Nonclinic (population-based)	Random	3,815	91.7	CTS2	Low risk
Sudan	Ali et al. (2014)	Nonclinic	Random	1,009	100	Domestic Violence Questionnaire in Married Women	Low risk
Kurdistan region, Iraq	Al-Tawil (2012)	Mixed	Nonrandom	500	-	WHO Questionnaire	High risk
Egypt	Akmatov et al. (2008) (1)	Nonclinic	Random	7,122	99	DHS	Low risk
	Akmatov et al. (2008) (2)	Nonclinic	Random	5,612	99	DHS + WHO	Low risk
	Guimei et al. (2012)	Clinic-based	Random	450	100	Self-developed	High risk
Syria	Alsaleh (2015)	Nonclinic	Random	365	100	Questionnaire on the Phenomenon of Violence and Its Effects	Low risk
	Maziak & Asfar (2003)	Clinic-based	Random	423	97	Self-developed + SRQ-20	High risk
Lebanon	Hammoury et al. (2009)	Clinic-based	Nonrandom	349	99.4	AAS	High risk
	Hammoury & Khawaja (2007)	Clinic-based	-	351	99.4	AAS	High risk
Iraq	Lafta et al. (2009)	Nonclinic	Random	1,100	91	Self-developed	High risk
Tunisia	Jellali & Jellali (2015)	Clinic-based	Random	-	16	WAST	High risk
Morocco	Manoudi et al. (2013)	-	-	265	100	Self-developed	High risk

Note. WHO = World Health Organization; HITS = hurt, insult, threaten, scream; CTS-R = conflict tactics scale-revised; CTS2 = revised conflict tactics scale; ABI = abusive behavior inventory; MWA = measure of wife abuse; ISA = index of spouse abuse; DHS = demographic and health survey; SRQ = self-reporting questionnaire; AAS = abuse assessment screen. - indicates for unknown values or unprovided information by the individual studies.

Individual-level risk factors. At the individual level, risk factors were either related to victims or perpetrators of IPV (Online Appendix D). Eighteen studies examined victim-related risk factors. Young age of the victim was reported to be significantly associated with IPV by three studies (Barnawi, 2017; Maziak & Asfar, 2003; Safadi et al., 2018). Karadsheh and Al-Khatatneh (2007) and Safadi et al. (2018) reported an increased risk of IPV among women marrying at young age. Education was examined as a further risk factor for experiencing IPV. Three studies reported that women who had higher education were at risk (Al-Badayneh, 2012; Barnawi, 2017; Karadsheh & Al-Khatatneh, 2007), while two other studies found that women with more years of education were less likely to be at risk (Maziak & Asfar, 2003; Shiraz, 2016). One study reported that pregnant refugee women with secondary education were at higher risk (Hammoury et al., 2009). Eight studies reported on the relationship between women's employment status and experiences of IPV, with four studies reporting that employed women were significantly at risk (Al-Badayneh, 2012; Al-Tawil, 2012; Lenze & Klasen, 2016; Shiraz, 2016), while the other studies showed that women's unemployment could put them at higher risk of violence (Alsaleh, 2015; Fageeh, 2014; Jellali, & Jellali, 2015; Lafta et al., 2009). A study compared the level of violence among housewives, students, teachers, and clerks and found that the housewife group was significantly different from the other groups, suffering the highest level of violence (Shiraz, 2016). Similar findings were also reported in three other studies (Alsaleh, 2015; Fageeh, 2014; Lafta et al., 2009). There was also strong evidence from five studies examining the history of violence (defined as exposure to violence or maltreatment and/or witnessing marital violence during childhood) being significantly associated with women experiencing IPV later in life (Al-Badayneh, 2012; Al-Faris et al., 2013; Clark, Silverman, et al., 2009; Guimei et al., 2012; Tashkandi & Rasheed, 2010). One study reported that women having divorced parents could be associated with experiencing IPV (Alzahrani et al., 2016). Another study reported increasing risk of pregnant refugee women as they advance in their pregnancy (Hammoury et al., 2009), as well as for those who were subjected to lifetime physical violence, last-year sexual coercion, and pregnant women who feared their husbands (Hammoury & Khawaja, 2007).

Moreover, 10 perpetrator-related factors increased the risk of IPV violence for women. Among them was the educational level of the perpetrator, with Karadsheh and Al-Khatatneh (2007) finding that men with higher education were less likely to perpetrate any type of violence toward their female partners, while in another study, the association did not reach statistical significance (Al-Badayneh, 2012). Exposure to forms of political violence (PV) showed to be a statistically significant risk factor for perpetrating IPV in two studies (Clark et al., 2010; Sousa & Haj-Yahia, 2015). The three forms of PV were defined as follows: (a) perpetrator's direct exposure: being insulted or cursed, wounded, detained, or made a fugitive; (b) perpetrator's indirect exposure: characterized as exposures his wife, children, and/or close family members had had, such as home demolishment, land confiscation, or witnessing violence or death upon family members; and (c) the economic effect of policies restricting movement of goods and people which could lead to perpetrators losing their job, deterioration of economic status, and poverty. Further risk factors related to the perpetrator included unemployment (Al-Faris et al., 2013; Barnawi, 2017), use of drugs (Guimei et al., 2012; Tashkandi & Rasheed, 2010), alcoholism (Ali et al., 2014; Al-Tawil, 2012; Alzahrani et al., 2016; Jellali, & Jellali, 2015), smoking (Barnawi, 2017; Maziak & Asfar, 2003), mental distress (Maziak, & Asfar, 2003), and mood swings (Tashkandi & Rasheed, 2010). Three studies found perpetrator's exposure to childhood violence (Al-Faris et al., 2013; Alzahrani et al., 2016; Clark, Silverman, et al., 2009), witnessing marital violence and losing a parent to death as a child could lead to increased risk of IPV perpetration later in adulthood (Tashkandi & Rasheed, 2010). One study reported increased risk of pregnant refugee women whose husbands did not desire their pregnancy (Hammoury et al., 2009).

Family-level risk factors. Factors relating to marriage, family life, conflict within the family, family's living conditions, and so on are explored and included at this level (Online Appendix D). One study found that risk of violence increased with increased number of pregnancies (Okour & Badarneh, 2011) or by having unplanned pregnancies (Oweis et al., 2010). Another found that having more than three children could significantly increase the odds of experiencing IPV (Jellali, & Jellali, 2015), while another study observed the opposite (Barnawi, 2017). The pressure on pregnant women to have a male child (Okour & Badarneh, 2011), having female children (Karadsheh & Al-Khatatneh, 2007; Okour & Badarneh, 2011), and woman's inability to naturally conceive and reproduce could be predictive factors for experiencing IPV (Karadsheh & Al-Khatatneh, 2007). Moreover, one study found that women who lived with their families in rented spaces had higher odds of experiencing IPV (Al-Faris et al., 2013). Financial factors were explored in four studies. Barnawi (2017) and Lafta et al. (2009) found that the risk of experiencing IPV increased when the family income was insufficient. IPV was also increased when the husband was asked for money (Alsaleh, 2015; Manoudi et al., 2013) or when the husband had to give up a large sum of money (Manoudi et al., 2013). Further factors like polygamous marriages and longer duration of marriage were explored and found to be statistically significant (Ali et al., 2014; Barnawi, 2017).

Community-level risk factors. Factors relating to the extended family and the nature of marriage are explored and included at this level (Online Appendix D). Living in rural areas (Maziak & Asfar, 2003) and in cities were found to increase the odds of experiencing IPV (Lenze & Klasen, 2016; Okour & Badarneh, 2011). One study found consanguineous marriages (i.e., intrafamilial unions) to be associated with social IPV against women (i.e., isolating victims from their support networks in an attempt to assert power and control; Karadsheh &

Al-Khatatneh, 2007), while another study found that marrying a nonrelative increased odds of IPV (Clark, Hill, et al., 2009). Living with the husband's family (Clark, Silverman, et al., 2009; Tashkandi & Rasheed, 2010) and experiencing conflicts with them could increase the odds of IPV (Alsaleh, 2015), whereas the support and protection of the victims by their families could decrease that risk (Clark, Silverman, et al., 2009). Furthermore, pregnant women who communicated less with their natal family were at increased risk (Clark, Hill, et al., 2009).

Societal-level risk factors. Factors relating to the cultural context are heavily influenced by the social, religious, and political systems and should be included at this level (Online Appendix D). Studies found that women who endorsed justifications for IPV could be at higher risk (Al-Badayneh, 2012; Clark, Hill, et al., 2009; Haj-Yahia, 1998a, 1998b; Haj-Yahia & Clark, 2013). Two studies found that being Muslim could increase the odds of experiencing IPV for women when compared to being Christian (Al-Tawil, 2012; Maziak & Asfar, 2003).

Discussion

Our objectives for this article were to explore the risk factors for IPV among women living in the Arab countries and to examine potential cross-cultural aspects that could be related to perpetration of IPV within this context. Since the reporting of risk factors was very varied, the conduction of a meta-analysis therefore was not possible.

Individual-Level Factors

We found individual-related factors for both victims and perpetrators were reported to be associated with IPV (Table 2).

Studies included in this article found that young age of women, early marriages, women who had lower education, and women's and their partner's unemployment increased the odds of experiencing IPV. This is consistent with the findings in Boy and Kulczycki (2008) and Özcan et al. (2016). Being young, marrying before the age of 18, having no independent income, and the low probability to work in any job due to low educational level for women could cause them to accept violence and its continuity (Almiş et al., 2018). Perpetrator's unemployment has been described by Capaldi et al. (2012) as *deprivation*. Being unemployed could be interpreted as being deprived of social security, followed by acute stress that could fuel conflict and could lead to potential development of aggressive behaviors by the male partner (Capaldi et al., 2012). However, other studies found that women with higher education or who were employed were at increased risk; this may be due to women with higher education status being more likely to challenge male authority (Cwikel et al., 2003). Kishor and Johnson (2004) found a positive relationship between women's paid work and experiencing IPV in Iran. Similarly, Atkinson et al. (2005) found that employment of women is positively correlated with IPV if the husband has a *traditional ideology*. Both studies' findings support the male-backlash theory that suggests: "as women's wages increase, violence against them increases, since men feel their traditional gender role is threatened" (Lenze & Klasen, 2016, p. 3). In abusive households, 60% of the children living in the household were estimated to witness IPV directly through seeing or hearing or indirectly through seeing the chaos of the aftermath of IPV. Children's exposure to violence could lead them to suffer from post-traumatic stress disorder, anxiety, and depression symptoms and to exert IPV themselves as adults (transgenerational transmission of IPV; Cordero et al., 2012; Holt et al., 2008). Both women's and their intimate partner's exposure to violence and witnessing marital violence during childhood were found to be associated with women's exposure to IPV during adulthood. This result corresponds with research conducted in the United States (McKinney et al., 2008). From a social learning perspective, family violence is transgenerational and intertwined with IPV (Bandura, 1977). Losing a parent to death or to divorce as a child was also associated with experiencing IPV (Alzahrani et al., 2016). From a psychological perspective, all these factors could be interpreted as early traumatization that led to either experiencing or perpetrating violence later in life (Høeg et al., 2016, 2018; Luecken, 2008).

Further, alcoholism was positively linked to perpetrating IPV against women. A recent systematic review highlighted that epidemiological data on alcohol use behaviors and alcohol consumption in Arab countries have long been scattered and remain unclear (Ghandour et al., 2016). In our context, societal factors such as religious beliefs deem any alcohol drinking a sin and is illegal in several Arab countries (Alhashimi et al., 2018). This could indicate an improper measurement of this potential risk factor in our reviewed studies, which was also found in the systematic review of African studies (Shamu et al., 2011). For instance, the terms "alcohol addiction" and "alcoholic husbands" were reported by the victims in the included studies for this article; yet, these terms were not further explored. Although harmful use of alcohol is defined by the National Institute on Alcohol Abuse and Alcoholism (2013), as when a person drinks in large amounts, over a long time period and has difficulty cutting down, resulting in not being able to fulfill responsibilities, having social and health problems, as well as being involved in risky situations, some of the surveyed women might consider any consumption of alcohol to be problematic. This could raise issues of measurement bias. Questions regarding frequency and the effects of consuming alcohol need to be used to avoid the underestimation of this factor's association with IPV. In our review, we found indications that a form of collective violence (i.e., PV) was positively associated with male-to-female IPV. This is consistent with studies conducted in Sri Lanka, Afghanistan, and the United States (Catani et al., 2008; Gupta et al., 2009).

Contributing crisis-related factors could be the perceived threat to men's traditional role of power, a lower threshold at which men resort to violence, and disruption of women's resources for IPV intervention and protection (Humanitarian Response, 2019). This relation between IPV and exposure to

Table 2. Associated Factors Related to IPV.

Ecological Model		Associated Factors	Risk Factor	Protective Factor
Individual level	Victim-related factors	Young age	☒	☐
		Age at marriage	☒	☒
		Marital status	☒	☐
		Higher education	☒	☒
		Secondary (or less) education	☒	☒
		Employment	☒	☒
		Unemployment	☒	☒
		Childhood violence	☒	☐
		Witnessing IPV as a child	☒	☐
		Divorced parents	☒	☐
		Women in their second trimester	☒	☐
		Women in their third trimester	☒	☐
		Women subjected to lifetime physical violence	☒	☐
		Women who experienced sexual coercion last year	☒	☐
		Women who fear their husbands	☒	☐
	Perpetrator-related factors	Higher education	☐	☒
		Direct exposure to political violence	☒	☐
		Indirect exposure to political violence	☒	☐
		Economic effect of political violence	☒	☐
		Unemployment	☒	☐
		Use of alcohol	☒	☐
		Use of drugs	☒	☐
		Smoking	☒	☐
		Mental distress and mood swings	☒	☐
		Childhood violence	☒	☐
		Witnessing IPV as a child	☒	☐
		Widowed parents	☒	☐
		Undesired pregnancy	☒	☐
Family level		Gravidity (two to five pregnancies)	☒	☐
		Gravidity (more than six pregnancies)	☒	☐
		Had unplanned pregnancy	☒	☐
		Number of children (more than three)	☒	☐
		Number of children (fewer than three)	☐	☒
		Having female children	☒	☐
		Pressure to have a male child	☒	☐
		Inability to naturally conceive	☒	☐
		Household size	☒	☐
		Living in rented houses	☒	☐
		Polygamy	☒	☐
		Longer duration of marriage	☒	☐
		Asking perpetrator for money	☒	☐
		Giving a large sum of money by perpetrator	☒	☐
		Nonsufficient family income	☒	☐
Community level		Consanguinity	☒	☐
		Married to a nonrelative	☒	☒
		Living in the country side	☒	☐
		Living in the city	☒	☒
		Residence in perpetrator's family building	☒	☐
		Conflict with perpetrator's family	☒	☐
		Perpetrator's family interference	☒	☐
		Violence perpetrated by husband's family	☒	☒
		Women's family support	☐	☒
		Women's less frequent communication with their families	☒	☐
Societal level		Being Muslim	☒	☐
		Endorsed justification of IPV by victims	☒	☐

Note. IPV = intimate partner violence.

PV draws attention to the wide-ranging implications of PV toward men and women. Further research in that area is needed. Furthermore, odds of violence against pregnant refugee women were found to be increasing as the women advanced in their pregnancy and whose husbands did not desire the pregnancy. This might be due to the fact that the pregnancy became harder to ignore by husbands who did not desire the pregnancy. Also increased odds were found for pregnant refugee women who were subjected to physical or sexual violence during their lifetime or past year and feared their husbands. All these factors are distinctive to the context of this pregnant population. Arab refugees displaced in neighboring countries have been living under precarious conditions characterized by patriarchy, economic and social hardship, and future uncertainty. Camp residents experience extreme poverty and relatively high levels of war-related disabilities. They are largely isolated from the host society and are therefore denied access to national education and health care. The dire living conditions women face in this unusual context are more than likely to have a direct bearing on violence, particularly IPV.

Family-Level Factors

At the following level of the family, male control of income, such as asking the husband for money and him giving up a large sum of it, decision making within the family, marital conflict that could occur through having more than one wife, and low socioeconomic status (insufficient family income and living in rented houses) were found to be strong predictors of abuse (Table 2). Having an unplanned pregnancy or having more than three children could add to the complexity of a marital relationship by increasing stress and conflicts within the family, resulting in increased risk of experiencing IPV. However, previous research in Jordan and Nicaragua found that women who were abused were more likely to report experiencing interference in their attempts to control their fertility. This could mean that large family sizes could be a consequence and not a risk factor for IPV (Clark et al., 2008; Ellsberg et al., 2000; Haj-Yahia & Clark, 2013). Women's inability to naturally conceive was another risk factor, which could be interpreted—in light of what women's ability to conceive and reproduce may represent—as women being unable to provide social security for their family and it being considered a lack of an important and valuable *tool* to prove her female identity in order to be socially accepted and recognized as a viable entity within a traditional family context (Salman, 2000).

Further predictive factors were the pressure on pregnant women to have male children and ultimately having female children. The husband's attitude related to seeking and favoring a son could turn into pressure on the wife to have a male child before and during pregnancy. Individuals, extended families, and the surrounding communities who behave in such a manner falsely believe that wives are responsible for determining the baby's gender (UNDP, 2008). Such attitudes could lead to blaming and perpetration of VAW for giving birth to daughters. A large, international study found that low-income families perceived female children as vulnerable and male children as strong and independent (known as *the hegemonic myth*; Blum et al., 2017). The gender-based restrictions produced by such hegemonic masculinity's ideals could be rationalized, implicating any actions conducted by wives who could fail to protect female children and emphasize their subservience as deserving of physical abuse for violating such norms. The contempt held toward the wives for having female children (translated into increased risk of IPV victimization) could go back to the pre-Islamic history in the Arab world, when female infanticide (i.e., burial of daughters alive) was common (Douki et al., 2003).

Community- and Society-Level Factors

At the community-level interfamilial marriage, residence with women's marital family that could predict instigation of conflict in the couple's relationship or direct violence by the women's marital family and living in rural areas that could increase women's isolation and lack of social support were found to be predictive factors of IPV (Table 2). These factors highlight the persistent role of extended families (i.e., natal or marital families) within marital relationships in the Arab world that could either be protective or harmful. The protective role was investigated in a survey included in our review and found that women who reported that they could count on their natal family for informal help were significantly less likely to report physical IPV, whereas pregnant women who communicate less with their natal family were at higher risk of IPV. The latter could be a form or a consequence of the controlling behavior victims may suffer rather than a risk factor (Sigalla et al., 2017). Women who reported violence from other family members (marital family) had a threefold higher risk of reporting IPV. These findings resonate cross-culturally with other qualitative research conducted in Afghanistan, Mexico, and Trinidad and Tobago (Agoff et al., 2007; Hadeed & El-Bassel, 2006; Hyder et al., 2007), as well as with quantitative research from Hong Kong (Chan et al., 2008). In rural regions, the difficulty shielding one's personal life from public scrutiny, the physical isolation and distance of women from support networks and social services, and the patriarchal views of the family, including traditional roles regarding gender relations that are commonly held, could explain why rural women are at greater risk of IPV (Riddell et al., 2009). However, living in modern urban areas is also positively linked with IPV (Lenze & Klasen, 2016); this may emphasize the still distinct patriarchal and traditional norms of the Arab society, regardless of women's residence. In one of the studies, consanguineous marriages appeared to be positively linked with social IPV. Its association with other types of IPV was found insignificant. This might reflect higher family control and sanctions facing the husband in case he commits violence toward his wife (Lenze & Klasen, 2016).

Religion could be considered as a factor that closely relates to the microsystem of the ecological framework. However, the cultural context (i.e., the macrosystem) of the Arab world is

heavily influenced by religious norms and beliefs (Table 2). The impact of these religious influences can extend to define a common identity, heritage, and value (e.g., the importance of preserving the honor of the family and the inherited male dominance and supremacy). In this context, abusers, victims, police, and health care professionals may use religious justifications to condone some acts of violence perpetrated against women (Douki et al., 2003; Haj-Yahia, 2000b) as it is found in this review, where women endorsed justifications for IPV perpetrated by husbands. Other studies showed similar findings, which is the greater victimization of Muslim women compared to their Christian counterparts (Feseha et al., 2012; Oyediran & Isiugo-Abanihe, 2005).

In the light of our included sample of women of 13 years of age and older, the implications of all the reported factors are of evident developmental nature, in which IPV could start from a young age as forced child or minor marriages where girls under 18 years of age could more likely suffer from violence and injuries compared to women who married after the age of 18 (UNICEF, 2019b). Factors from the different levels and their gendered aspects which influence the extent of experiencing IPV from such an early age still continue and persist throughout the time of marriage and pregnancy. The cyclic nature of violence is emphasized by its transmission to generations to come, where accepting attitudes of IPV and the gender-discriminating ideology still remain.

Cross-Cultural Aspects Related to IPV in the Arab Region

Apart from the socioeconomic aspects (social classes, rural vs. urban areas), further cross-cultural aspects in our context are the collectivist attitudes the included Arab countries have come to persistently maintain. Across cultures, attitudes toward gender are likely to affect how male–female relationships are viewed and subsequently how the violence perpetrators and the victims are viewed. Cultural definitions of appropriate gender roles within relationships and the belief of inherent superiority of males highlight some of the factors found in our review. A study in our review found that 50% of Jordanian women believed that men have the right to physically hurt and sexually desert a rebellious wife (Al-Badayneh, 2012). In the Palestinian territories, studies found that the wife's acceptance of IPV was one of the most consistent factors associated with women's reports of IPV (Haj-Yahia & Clark, 2013), and 60% of men and 50% of women agreed that wives are responsible for the violence conducted against them (Haj-Yahia, 1998a, 1998b). Similar to our findings is a study conducted in the rural regions of Egypt; 80% of the surveyed women said that physical IPV against females is justified, especially if they refused sexual interactions with their husbands, but also if the women interfere with husbands' social life or if they talk or complain too much (El-Zanaty et al., 1996). These attitudes reflect the patriarchal hegemony that is deeply ingrained into many of the Arab societies and shaped by social norms and cultural beliefs about traditional gender roles.

Limitations

While we have followed a rigorous protocol in the conduct of this systematic review, it still remains subject to some limitations. Among them, the fact that the planned meta-analysis could not be performed and the cross-sectional designs of the included studies not allowing us to determine any causal conclusions, that is, to distinguish whether IPV consequently leads to some of the factors we found in our review or whether these factors rather serve as causes for IPV. Moreover, in a context as large and as culturally and socially diverse as the Arab region, we attempted to collect and include studies from all 22 Arab state members. However, our search came up with studies from 12 countries only. Further, our ability to assess the quality of the studies that we identified was limited by the methodological limitations found in the published articles. Those limitations showed that our review could be subject to publication and reporting bias. Therefore, it is important to note that this systematic review does not attempt to make general claims about the female Arab population as a whole and that any generalizations made are only referred to in our sample.

Conclusion and Implications for Practice, Policy, and Research

After qualitatively analyzing the available data and discussing them at the different levels of the integrative ecological model, they have revealed a complex structure of VAW in the Arab world, whose composition comprises many overlapping psychological, demographic, societal, legal, and political variables. This sociocultural complexity of the issue calls for sociocultural sensitive interventions. Their preventive measures should be more structural and situational rather than individualistic only, where the focus of change would be on the behavior of individuals, as well as the real ecological and contextual structure of IPV. Not to mention that those very interventions should be accompanied by systematic, structured work aimed at improving Arab women's status at all levels. Increasing national and international efforts, as well as improving victims' access to effectively coordinated assistance by the police and justice system, health and social services could build a protective system for combating IPV. But in order to do so, the actual scale of this issue needs to be understood first. The standardized data on IPV against women need to be of sufficient quality in order to monitor trends on national and international levels. The enhanced value of the collected data could also allow more room for thorough analysis as well as offer a comparable system of data collection across countries and on a broader regional level.

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Supplemental Material

The supplemental martial for this article is available online.

Notes

1. What is meant by the tenets and/or laws are the ones that grant women equal rights as men with respect to freely choose a spouse and to enter marriage with their free and full consent; to have equal rights and responsibilities during marriage and its dissolution; to acquiring, changing, or retaining their nationality in the case of marriage to a foreigner and with respect to granting nationality to their children; and being equal parents in all matters relating to their children with regard to guardianship, trusteeship, and adoption of children. Also, the illegalization of betrothal and marriage of children, as well as taking necessary action to determine and apply specifications of minimum age for marriage and its compulsory official registration (Human Rights Watch, 2019b; United Nations Office of Legal Affairs Treaty Collection, 2011; United Nations International Children's Emergency Fund, 2019a).
2. The aims and methods of our systematic review were published a priori in a PROSPERO protocol that can be accessed at http://www.crd.york.ac.uk/PROSPERO/ under the registration number (CRD42018094200; Mojahed et al., 2018).
3. It is also a political organization that tries to help integrate its members economically and solve conflicts involving member states without asking for foreign assistance. It possesses elements of a state representative parliament while foreign affairs are often conducted under United Nations supervision (League of Arab States, 1945).

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Nada Alaidarous, MN-ANP, is a research assistant and a PhD student at the University of Western Ontario, Canada. Her research focuses on mental health promotion among ethnic minority youth, families, and communities. Her investigation of challenges is grounded in the social determinants of health framework that shed light on access barriers to existing health services and systemic risks to mental and psychosocial well-being.

Hanade Shabta, DipIT, is a student at the Faculty of Social and Behavioral Sciences at the University of Utrecht. Her political and feminist activism focuses on the Syrian civil society, where she has been working for nongovernmental organizations as a trainer and project assistant for women's participation in security and peace programs.

Janice Hegewald, MS, is a scientific researcher and the head of the Research Unit for Occupational, Social and Environmental Epidemiology at the Technical University of Dresden's Institute and Policlinics of Occupational and Social Medicine. Her main research interests are the nonauditory health effects of environmental and noise and all aspects of occupational epidemiology.

Susan Garthus-Niegel, PhD, Dipl.-Psych, is a psychologist and a professor at the Medical School Hamburg and the Norwegian Institute of Public Health. She is also the research unit head at the Technical University of Dresden's Institute and Policlinic of Occupational and Social Medicine. She and her team conduct studies on women's mental health and well-being, both via epidemiological cohort studies and systematic reviews and meta-analyses.