**Introduction**

  Violence against women was defined by the Declaration on the Elimination of Violence against Women (1993) , as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (1,2). Intimate husband violence (IPV), defined as actual or threatened physical, sexual, psychological, and emotional abuse by current or former husbands is a global public health concern. When stress and violence increase in developing societies, women’s safety in the home, workplace and community is often seriously affected (1). According to the Egypt Demographic and Health Survey (2005), one-third of Egyptian women have been physically abused by their husbands, and seven percent said they are beaten “often.” These women mostly suffered silently and did not seek help (3). The study conducted by Kharboush et al. (4) concluded that nearly three-quarters of women visiting family health centers in the Alexandria Governorate have experienced spousal violence in their lifetimes. About one-half of the women who reported ever experiencing spousal violence were subject to two to three types of violence, with emotional abuse and physical violence being the most common.

 Pregnancy is supposed to be a time of peace and safety where the family turns its thoughts towards raising the next generation and growing a healthy baby. But, according to Faramarzi et al., (5), the prevalence of physical, emotional or sexual violence during pregnancy was high and was associated with adverse fetal and maternal conditions .Violence during pregnancy poses a threat to health and at its extreme can result in the death of the mother and her unborn child (6). Violence tends to worsen during pregnancy and has been associated with miscarriage, premature labor, low birth weight, fetal injury and death (7, 8). Adverse pregnancy outcomes could also be the result of associated factors such as smoking, illicit drug use, alcohol use, late initiation of antenatal care, rapid repeat pregnancy, a lack of social support, low socio-economic status, anxiety and depression (9).

 Intimate partner violence is a major public health problem in Africa and internationally (10). Abuse of women during pregnancy is a health problem that is receiving increased attention in both research and clinical practice. (11) When violence is experienced during pregnancy; it not only affects the health and well-being of the mother but is also associated with adverse health outcomes for the fetus (12). This has significant ramifications because negative birth outcomes (as low birth weight and pre-term infants) represent a significant cost to society, in addition to contributing disproportionately to neonatal morbidity and health care costs (13, 14). A better understanding of the epidemiology of abuse during pregnancy, including its frequency, risk factors, adverse maternal conditions and birth outcomes, could have important clinical and public health implications. This basic epidemiology can help in reducing the adverse outcomes through early identification of pregnant women at risk. . So, the researchers conducted the current study to investigate the impact of husband violence during pregnancy on maternal and fetal outcomes.

**Aim of the study:**

 The aim of current study is to explore the association between exposing to husband violence during pregnancy and adverse maternal and fetal outcomes

**Research hypotheses:**

1. Violenceduring pregnancy will worse the maternal and fetal outcomes.
2. Physical violence is more strongly correlated to maternal and fetal complications than others types.

1. **Materials & Methods**

**1- Technical Design:** A correlational design was used.

 **Setting:** The study was carried out at the labor ward in Suez Canal University Hospital – Ismailia

 **Sampling:**

A convenient sample collected within a period of 6 months (from July 2011 to December 2011). Laboring women who attained the above mentioned setting at the predetermined period (total of 280 women) were recruited in the study by researchers or research assistant (who trained for data collection). The sample was classified into study and control groups based on modified Woman Abuse Screening Tool. Women exposed to any type of husband violence were recruited as study group (n= 147), and women didn’t expose to husband violencewere recruited as control group (n= 133).

**Exclusion criteria:** High risk group including: primipara over 35 years, multiple pregnancy, and pregnancy complicated with medical diseases.

**Tools of data collection:** Data collection was obtained by using the following tools:

**1) A structured interviewing questionnaire:** Developed by the researchers and included two parts: **Part A**: Included sociodemographic data as: women age, level of education, occupation, family income, residence, and their husband's age, and level of education. **Part B:** Asked aboutthe history of pregnancy, obstetric profile such as gravida and para as well as obstetrical complains during pregnancy

**2) Abuse Assessment Screen Tool:** Of the 3 abuse screening tools (4, 15, 16), this tool developed and modified by the researchers to be suitable for Egyptian culture. It was used to identify the abused women and to determine the types (physical, emotional, sexual, or economical), forms, frequencies of violence attacks before pregnancy and during pregnancy.

 **3) Assessment sheet:**

 This tool was developed by the researchers depending on related literatures. It used to collect data about the labor and neonatal conditions. It included: weeks of gestation, membranes condition, any complications developed during labor, andmode of delivery. Also, birth weight, and any neonatal complication arises.