

Perinatal Intimate Partner Violence and Maternal Health Pathways in Nuwara Eliya, Sri Lanka: An Inductive Thematic Analysis of Case Study Interviews

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Original Article

Abstract

Introduction: Intimate partner violence (IPV) during pregnancy is a critical maternal health and safety concern. Beyond episodic assault, perinatal IPV may operate through coercive control that undermines women's autonomy, restricts access to essential resources, and disrupts engagement with antenatal care (ANC) and related maternal health services. This study aims to explore how pregnant women experience perinatal IPV in the Nuwara Eliya District, Sri Lanka, and how violence shapes maternal health pathways, including ANC engagement, disclosure, and help-seeking.

Methods: This paper reports a stand-alone qualitative component nested within an ongoing exploratory sequential mixed-methods study. Fifteen in-depth case-study interviews were conducted with pregnant and postpartum women who disclosed IPV during their most recent pregnancy. Interviews followed a case-narrative approach and were analysed using inductive thematic analysis under an interpretivist epistemological position. Data were managed and coded using NVivo (v15.3), progressing from free coding to codebook refinement and theme development.

Results: Four inter-connected themes were generated. Theme 1 showed perinatal IPV as a spectrum of abuse and coercive control, including physical, sexual, emotional, and economic abuse, with pregnancy-specific restriction of ANC access. Theme 2 highlighted a household "ecosystem" sustaining violence, commonly involving alcohol-linked escalation, in-law hostility, jealousy/suspected infidelity, and pregnancy-related role expectations. Theme 3 demonstrated that disclosure was strategic and selective; women navigated silence, concealment, reliance on trusted Public Health Midwives (PHMs), temporary separation, and crisis-driven engagement with hospitals or police/legal services. Theme 4 described significant maternal well-being and functional impacts, including disrupted sleep/appetite, reduced daily functioning, and severe psychological distress.

Conclusion: Perinatal IPV in this setting is experienced as sustained coercive control that directly shapes maternal health pathways. Strengthening confidential, survivor-centred IPV responses within routine ANC/PNC; particularly through PHM continuity, safe enquiry, and coordinated referral may improve protection and support for women during pregnancy.

Key Words: gender based violence, domestic violence, antenatal care, help-seeking pathways, coercive control, inductive thematic analysis

Introduction

Intimate partner violence (IPV) refers to physical, sexual, psychological, and controlling behaviours by a current or former intimate partner that cause harm to women's health, safety, and autonomy [1]. IPV is widely recognised as both a public health and human rights concern, with consequences that extend beyond episodic physical assault to include coercive control, fear, restricted mobility, economic dependence, and reduced access to support [1, 2]. Pregnancy and the postpartum period may heighten these vulnerabilities because women require regular health service contact, physical rest, nutrition, emotional support, and household cooperation [3, 4]. In this context, IPV may directly shape maternal health pathways by affecting women's ability to attend antenatal care (ANC), disclose violence, seek help, and maintain well-being during pregnancy and early motherhood [3-5].

Maternal health pathways, particularly antenatal care (ANC) and postnatal care (PNC), are central to this relationship between IPV and perinatal well-being [3]. In many settings, pregnancy may increase routine contact with health services, which positions ANC/PNC as a potential entry point for early identification, first-line support, and referral [5]. However, health system contact does not automatically translate into protection. For women experiencing IPV, maternal health services can become contested spaces where disclosure is shaped by fear of escalation, concerns about confidentiality, stigma, and the potential consequences of involving others [6]. In these circumstances, women may delay care, attend selectively, or develop cover stories to avoid raising suspicion at home [7]. The relationship

between IPV and maternal health pathways, therefore, requires attention not only to whether women access services, but also to how women navigate those services under coercive conditions, and when health services become helpful or insufficient within trajectories of violence.

Recent international evidence supports examining perinatal IPV as a pathway issue rather than only as a violence exposure. Qualitative evidence from perinatal care settings shows that disclosure is shaped by fear of retaliation, perceived confidentiality, family consequences, provider response, and the safety of the consultation environment [8]. Even when women have contact with health services, disclosure may remain difficult if they doubt that services can offer practical protection or if partner or family surveillance continues [6, 8]. Multi-country evidence also suggests that IPV is associated with maternal health service utilisation, reinforcing the need to understand not only whether women attend ANC/PNC, but how they navigate care under conditions of control, fear, and constrained autonomy [9].

Sri Lanka provides an important context for examining these dynamics. Despite its strong maternal health indicators and well established public health midwife (PHM) system, IPV during pregnancy remains under-researched and inadequately addressed within routine maternal healthcare services [10, 11]. Sri Lanka's policy and service frameworks increasingly support IPV enquiry and first-line response within antenatal and postnatal care, including guidance for PHMs to conduct sensitive enquiry, provide first-line support, and refer survivors to dedicated services such as Mithuru Piyasa/Natpu Nilayam [12, 13]. Yet, recent assessments highlight

persistent implementation gaps, including inconsistent application of protocols, limited integration of IPV screening into routine maternal and child health services, and missed opportunities for identification and support during ANC/PNC encounters [10]. These gaps are significant because women often have multiple points of contact with the health system throughout pregnancy and the postpartum period, and each interaction can either reinforce silence or provide a safe pathway to disclosure and support [14].

The Nuwara Eliya District was selected because it represents a setting where Sri Lanka's strong maternal health system intersects with estate-sector, rural, linguistic, and socio-economic vulnerabilities [13,15,16]. In this manuscript, the term "estate" refers to plantation-sector communities commonly associated with tea estates, characterised by plantation labour histories, estate-based settlement patterns, and distinct socio-economic and linguistic contexts. "Non-estate" refers to communities located outside the plantation estate structure, including rural, semi-urban, and other settlement types within the district. This distinction is analytically important because household structure, income security, mobility, language, social surveillance, and proximity to services may influence both IPV experiences and help-seeking options [15-17]. National evidence indicates that violence against women remains a significant concern in Sri Lanka, while district-level vulnerability evidence underscores the importance of examining how socio-economic conditions and service-access constraints operate in specific local contexts, rather than assuming that the benefits of national maternal health achievements are experienced equally across all communities [16,17].

The key evidence gap extends beyond the limited documentation of IPV during pregnancy in Sri Lanka, to the lack of qualitative understanding of how women experiencing IPV navigate maternal healthcare pathways. While existing studies identifies IPV as an important maternal health concern and acknowledge the potential role of ANC/PNC services in addressing it, less is known about how pregnant and postpartum women in estate and rural settings manage clinic attendance, concealment or disclosure of abuse, interactions with PHMs, hospital encounters, and formal help-seeking, while living under conditions of coercive control [6,10,12,14]. This gap limits the development of survivor-centred IPV interventions within routine maternal healthcare, particularly in settings where privacy, mobility, and access to referral services may be limited [10-12].

This study aimed to explore how pregnant and postpartum women in the Nuwara Eliya District experience IPV during the perinatal period and how these experiences shape their engagement with maternal healthcare pathways, including ANC/PNC engagement, disclosure, and help-seeking. The study was guided by two research questions: (01) How do women experience IPV during pregnancy and the postpartum period within the estate and rural district context? (02) How does IPV influence women's engagement with maternal health services, decisions regarding disclosure, and help-seeking pathways?

Methods

Study design and epistemological position

This paper reports the qualitative component of an ongoing exploratory sequential mixed-methods study conducted in the Nuwara Eliya District, Sri

Lanka. The qualitative component was designed as a case-study-based inquiry to generate an in-depth understanding of how IPV is experienced during pregnancy and the postpartum period, and how these experiences shape maternal health pathways, particularly ANC/PNC engagement, disclosure, and help-seeking. The study was guided by an interpretivist epistemological position, which treats women's accounts as situated narratives shaped by household relationships, social norms, structural constraints, and interactions with health and support systems [16]. Inductive thematic analysis was selected because it allowed patterns to be generated from women's narratives while retaining attention to case context, meaning, and variation across participants [18,19].

Study setting

The study was conducted in the Nuwara Eliya District, a predominantly rural and estate-sector area with distinctive maternal health and social conditions relevant to perinatal IPV. Maternal health services in the district are delivered through routine ANC/PNC clinics and hospital pathways, supported by the PHM system [13]. Formal referral and support services for women experiencing IPV and other forms of gender-based violence include Mithuru Piyasa/Natpu Nilayam service points and a 24/7 hotline and referral network [12]. The district context is also characterised by estate/non-estate settlement patterns, constrained household resources, language diversity, and structural barriers [16] that may influence both IPV dynamics and access to care [17].

Participants, recruitment and sampling

Fifteen pregnant and postpartum women who disclosed IPV during their most recent

pregnancy were included. Participants were purposively selected to capture variation in estate and non-estate residence, perinatal stage, age, parity, living arrangement, type and severity of IPV, and type of help-seeking pathway. Recruitment took place through IPV-relevant health and community contact points, including FPA Sri Lanka Suwasewa Centre.

Recruitment was conducted with attention to participant safety. Participation was discussed privately where feasible. No identifying information was recorded in maternal health records for research purposes. Interview appointments were arranged at times and locations considered safe by participants, with careful attention to the risk of partner, in-law, or community surveillance. The sample size was justified by the qualitative component's purpose: to develop rich, information-dense case narratives rather than statistically representative estimates. Sampling continued until the research team judged that additional interviews no longer yielded substantially new insights into the central analytic domains: forms of IPV, pregnancy-specific control, ANC/PNC disruption, disclosure, PHM contact, hospital or legal encounters, and maternal well-being impacts. Saturation was assessed through iterative review of interview summaries, emerging codes, and cross-case comparison. The adequacy of 15 interviews was also supported by the principle of information power, which suggests that smaller qualitative samples may be sufficient when participants provide rich, specific, and highly relevant information for a narrowly focused study aim [20].

Data collection

Data were collected through individual in-depth interviews using an open-ended

case-narrative interview guide. Interviews explored women's pregnancy history, relationship context, forms and timing of IPV, perceived triggers or sustaining conditions, restrictions on movement or resources, ANC/PNC attendance, disclosure decisions, interactions with PHMs or other health workers, hospital encounters, police/legal or community help-seeking, and perceived physical and psychological impacts. Probing questions were used flexibly to allow participants to describe events in their own words and to preserve the sequence of pregnancy, violence, care-seeking, and support. This approach was consistent with qualitative interviewing standards that emphasise participant-led narratives, contextual detail, and transparent reporting of interview procedures [18,19,21].

Interviews were conducted in confidential locations selected in consultation with participants, including safe health or community settings where privacy could be maintained. Interviews lasted approximately 60–90 minutes, depending on participant comfort, narrative depth, and safety considerations. The interviewer used a non-judgmental approach, monitored distress, avoided pressuring participants to disclose details they did not wish to share, and provided information on available support services when needed [21].

Researcher reflexivity

Researcher reflexivity was incorporated throughout data collection and analysis. The interviewer was a female medical graduate with prior training in GBV/IPV-related service response, but she did not have a prior relationship with the participants. This reduced the likelihood that participants felt obliged to participate because of an existing clinical

or service relationship. During analysis, the research team discussed how their backgrounds in sexual and reproductive health, maternal health, public health, and service delivery could shape interpretation. Reflexive discussions focused on avoiding assumptions that contact with health services automatically equates to safety, avoiding victim-blaming interpretations of non-disclosure, and interpreting silence, concealment, and delayed help-seeking as contextually situated safety strategies [8, 18, 21].

Data Analysis

Interviews were audio-recorded with consent, transcribed verbatim, and de-identified before analysis. Data were managed using NVivo version 15.3. Analysis followed an inductive thematic analysis process. First, transcripts were read repeatedly to develop case-level familiarity and to document the sequence of pregnancy, IPV experience, care-seeking, disclosure, and support. Second, free/open coding was conducted across the transcripts to capture descriptions of IPV forms, coercive control, household drivers, pregnancy-specific restrictions, ANC/PNC barriers, concealment, disclosure, PHM contact, hospital encounters, police/legal help-seeking, and maternal well-being impacts. Third, initial codes were reviewed, merged, renamed, and organised into broader analytic categories through constant comparison across cases. Fourth, candidate themes were developed by examining how categories explained the relationship between perinatal IPV and maternal health pathways [18, 19].

To strengthen transparency, the final coding structure is summarised in Annexure 1. Coding decisions were discussed within the research team, with attention to

whether themes were grounded in multiple cases, whether contradictory or less common cases were represented, and whether each theme directly addressed the research aim. This process was informed by qualitative reporting principles that encourage transparent description of the research team, coding process, analytic decisions, and interpretation [18, 21]. NVivo was used as a data management and analytical support tool, not as a substitute for interpretation. Query outputs and visualisations were used only to support reflection on coding patterns and case relationships. The final themes were generated through interpretive engagement with transcripts, case summaries, and team discussion, rather than solely from automated NVivo outputs [18, 19, 21].

Ethical Considerations

These procedures were consistent with established ethical principles for research and service engagement on violence against women, where privacy, confidentiality, voluntary participation, and non-maleficence are central safeguards. Ethical approval for this study was obtained from the Ethical Clearance Committee of the Faculty of Medicine, General Sir John Kotelawala Defence University, Sri Lanka. The application (Reference No: RP/2025/09) was reviewed and approved at the ERC meeting held on 23rd April 2025, and the official approval letter was issued on 25th April 2025.

Results

Participant Profile

The analysis draws on 15 case-study interviews with pregnant and postpartum women who disclosed IPV during their most recent pregnancy. Most participants

were from estate-sector communities (11/15), with ages ranging from 19 to 41 years. Women were interviewed across the perinatal period, including pregnancy (12–34 weeks' gestation) and postpartum (approximately 3 weeks to 6 months). Reported violence commonly included physical and psychological abuse, with several accounts also describing sexual and economic abuse (Table 01).

Figure 01 illustrates the distribution and overlap of IPV forms reported across the 15 case-study interviews. Most participants described psychological abuse occurring alongside physical violence, reflecting the frequent co-occurrence of emotional harm with bodily assault during pregnancy. A smaller number of cases also reported sexual violence in addition to physical and psychological abuse. Economic abuse was less frequently reported and tended to occur in combination with other forms of violence, rather than as an isolated experience. Overall, the visual highlights that perinatal IPV in this sample commonly involved multiple, overlapping forms of violence, reinforcing an analytic framing of IPV as a spectrum of coercive control rather than a single-event exposure.

Theme 1: Perinatal IPV as a spectrum of abuse and coercive control that restricted safety, resources, and antenatal care

Women described IPV during pregnancy and postpartum as layered and cumulative, where physical assaults often occurred alongside sexual coercion, intimidation, emotional degradation, mobility restriction, and financial control. Pregnancy was repeatedly framed as a period when women required care, rest, and consistent maternal health follow-up, yet many

Table 1. Socio-demographic and pregnancy characteristics of participants

	Estate or Non-estate	Age	Marital Status ¹	Pregnancy status	Number of pregnancies ²	Number of living children	Education
01	Estate	21	2	04 WPP	2	1	Grade 10
02	Estate	38	2	03 WPP	3	2	O/L
03	Estate	19	2	23 WOG	1	0	O/L
04	Non-estate	33	4	12 WOG	1	0	A/L
05	Estate	24	2	20 WOG	1	0	O/L
06	Estate	29	2	20 WOG	3	2	Grade 9
07	Estate	41	2	12 WOG	2	1	O/L
08	Non-estate	36	2	19 WOG	3	2	O/L
09	Estate	29	2	20 WOG	3	1	A/L
10	Non-estate	20	2	24 WOG	1	0	O/L
11	Estate	28	2	32 WOG	1	1	A/L
12	Non-estate	20	2	23 WOG	1	0	Grade 12
13	Estate	33	2	34 WOG	3	2	O/L
14	Estate	41	2	24 WPP	4	3	O/L
15	Estate	23	2	24 WPP	1	1	O/L

Note: Marital Status = 1. Never married, 2. Currently Married – First Marriage, 3. Currently Married – Remarried (second or later marriage), 4. Divorced or Separated, 5. Widowed.

WOG = weeks of gestation; WPP = weeks postpartum; O/L= GCE Ordinary Level, A/L= GCE Advance Level.

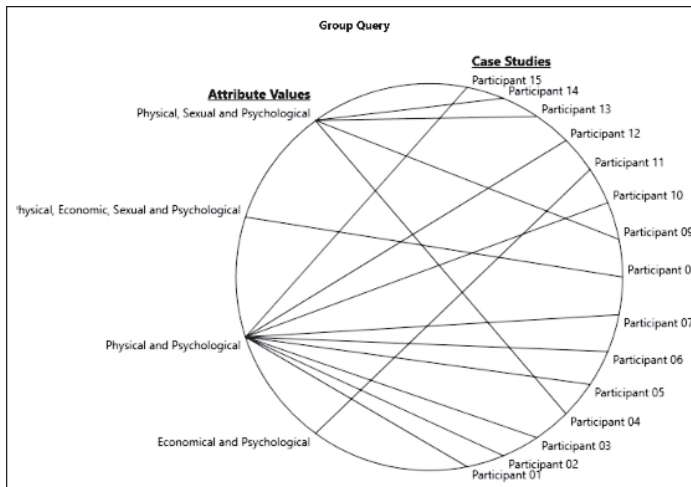


Figure 1. Distribution and co-occurrence of violence types across participants (NVivo group query).

Note: Chord diagram from NVivo group query showing the combination of IPV types coded within each case study participant. Lines indicate the co-occurrence of physical, sexual, psychological, and economic violence within individual narratives, demonstrating that most women reported multiple overlapping forms of abuse rather than a single isolated type.

¹1. Never married, 2. Currently Married – First Marriage, 3. Currently Married – Remarried (second or later marriage), 4. Divorced or Separated, 5. Widowed.

²Number of pregnancies before this pregnancy.

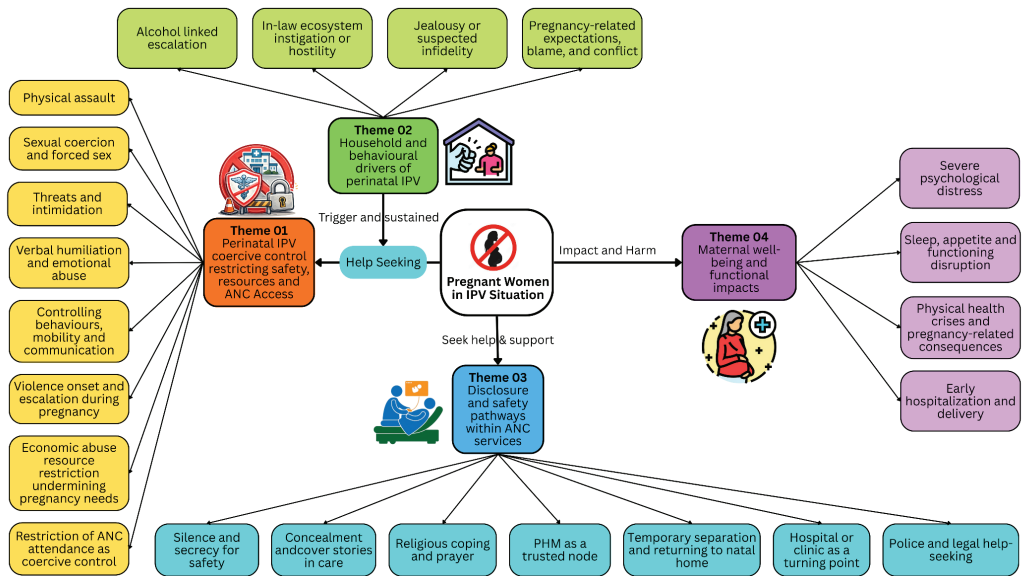


Figure 2. Conceptual overview of thematic findings linking perinatal IPV, sustaining household drivers, help-seeking pathways, and maternal well-being impacts.

Note: The arrows indicate perceived linkages across four domains based on participants' narratives, and should be interpreted as relational pathways rather than evidence of causality.

experienced a tightening of control instead. Rather than reducing violence, pregnancy sometimes intensified surveillance and conflict, positioning the perinatal period as a time when both bodily vulnerability and dependence on the household increased.

Physical violence during pregnancy was frequently narrated as occurring despite foetal vulnerability, with women describing assaults even after explicitly stating they were pregnant. One woman recalled, "When he started hitting me, I reminded him that I'm pregnant... then he pulled my hair and dragged me on the ground and beat me." Several accounts conveyed that violence was not limited to one episode but repeated across pregnancy, contributing to fear about harm to the baby and on-going instability. A participant explained, "Throughout my pregnancy, I have been

admitted to the hospital around four or five times... even now, I still have bruises and scars all over my body from being beaten." Another participant explained, "I remember that I fainted once while he was hitting me, and I had to get admitted to the hospital for 8 days as I had severe back pain and was not able to stand or do regular activities. My husband did not even visit me during my hospital stay or even provide me with the necessary expenses needed". In these narratives, pregnancy was not protective; instead, it became the context in which violence was endured while women simultaneously attempted to safeguard the foetus. "When I was pregnant with my first child, he tried to kill me by squeezing my neck. He tried to hit my stomach. But as my child was inside me, I protected my stomach by defending myself and making sure he didn't hit it."

Sexual coercion during pregnancy was described as forced compliance within a climate of fear and power imbalance. Women spoke about refusal being unsafe or impossible, and some narrated forced sex as part of a broader system of domination rather than an isolated incident. One participant stated, *"He will not listen to my refusals... When I say no, he would force me."* Another described compliance as a strategy to avoid further assault: *"If I don't want to have sex with him, he hits me. When he asks, I'm expected to say yes. Most of the time, it starts with a fight."* These experiences highlight how pregnancy did not reduce sexual entitlement, but instead positioned women to negotiate bodily autonomy under heightened dependence and threat. *"My husband never really cares; he only wants sex. After getting me pregnant, he always leaves. He comes and goes whenever he wants and sexually abuses me. Sometimes, he even accuses me of carrying someone else's child."*

Threats and intimidation operated as a constant backdrop that amplified women's fear during pregnancy, shaping daily decisions and limiting perceived options for resistance or disclosure. Women described being frightened not only for themselves but also for the unborn baby and other family members. One woman noted, *"He threatened to kill me... another time, he said he would kill our child."* Such intimidation extended the violence beyond physical injury into a pervasive atmosphere of fear, where women remained alert to escalation and weighed the risks of "speaking out" during pregnancy.

Verbal humiliation and emotional abuse were described as continuous forms of harm that eroded dignity during pregnancy, often intensifying when women

were physically constrained and more dependent. Participants described insults, accusations, and harsh language that undermined their sense of self and security. One woman explained, *"He uses bad words... I don't fight back because of the child."* Another reflected how repeated degrading comments shaped her emotional state across pregnancy, describing the home as a space of constant criticism rather than support. These accounts show emotional abuse functioning as an everyday form of violence that accompanied pregnancy, making the perinatal period psychologically burdensome even when physical assault was not occurring.

Controlling behaviours were described as particularly prominent during pregnancy and the postpartum period, when women's mobility and communication were closely monitored. Women described being restricted from leaving the home, from visiting family, or from speaking freely with trusted people. One participant reported, *"I can't speak with even my mother... he checks my phone."* For some women, control over communication meant that pregnancy follow-up and help-seeking were navigated in isolation, increasing dependence on the partner and reducing access to protective social ties. *"My husband always tries to control me. He does not like me talking to anyone else, and he won't let me go out alone. The only time he allows me to go alone is when I go to the clinic, as once the PHM shouted at him for not allowing me to visit the clinic."*

Several women described violence as beginning for the first time or escalating after pregnancy was recognised, framing pregnancy as a turning point in relationship power dynamics. A participant described her experience: *"He first hit me when I*

was two months pregnant. During an argument, he hit and slapped me several times and also pushed me down more than once. I hit the oil lamp once and fell down. But even then, they didn't take me to the hospital or allow me to go". Women spoke about changes in behaviour where conflict became more frequent, control became stricter, or assaults became more severe as pregnancy progressed. In these accounts, escalation was experienced as both physical and relational. Women described a shift from "arguments" to fear, surveillance, and repeated harm, particularly when household pressures increased.

Economic abuse was repeatedly framed in relation to pregnancy-related needs; with food, transport, medicines, and clinic-related expenses becoming sites through which control was exercised via denial and deprivation. Women described asking for basic pregnancy necessities and facing anger or refusal. A participant explained, *"He doesn't buy medicines... milk... I had to work even when I was pregnant."* Another linked financial deprivation to conflict and intimidation: *"He keeps talking about money... if I ask for something, he gets angry."* Another participant described that *"He doesn't take care of me, sometimes he doesn't even provide food. There have been days when I haven't eaten properly. I often survive on just one meal per day, as my husband does not give me money."* In these narratives, withholding resources was not only an economic constraint but a mechanism that undermined maternal well-being and reinforced dependency during pregnancy.

A particularly pregnancy-specific dimension was the restriction of antenatal care, where clinic attendance was regulated, delayed, or made conditional on surveillance by others.

Women described needing permission, accompaniment, or oversight, limiting their autonomy in seeking care. One participant stated, *"He does not allow me to go to the clinic alone... only my mother-in-law takes me."* For these women, ANC was not simply a health service; it became a contested space shaped by coercive control, with clinic access reflecting relational power dynamics rather than maternal need.

Theme 2: Household and behavioural drivers that intensified IPV during pregnancy and postpartum

Women consistently situated perinatal IPV within a broader household "ecosystem" where alcohol use, jealousy, in-law dynamics, and pregnancy-related role expectations interacted to heighten tension and escalate violence. Participants rarely presented these conditions as single causes; rather, they described predictable patterns in which certain triggers intensified assaults, threats, and control during pregnancy and the postpartum period.

Alcohol use was frequently described as a catalyst that escalated violence, with women reporting that intoxication changed men's behaviour and increased the likelihood of assault. One woman explained, *"When he drinks alcohol, he will hit... other times he is good."* Another described alcohol-related conflict spilling into clinical spaces, showing how pregnancy did not protect women even in healthcare environments: *"He visited the hospital drunk and again fought there."* Women's narratives often reflected anticipation; pregnancy was lived with the fear of what would happen "when he drinks," indicating that alcohol contributed to cyclical and predictable violence patterns. *"If he didn't have enough money for alcohol, he used the little money*

kept aside for food. When I objected, he manhandled me and threatened me with daggers".

In-law involvement was described as an enabling environment where violence was legitimised, reinforced, or intensified, particularly for women living in the partner's household during pregnancy. Some participants described hostility from mothers-in-law and sisters-in-law, where blame and insults accompanied or escalated abuse. One woman stated directly, *"His mother also hit me... they all blame me."* Others described pregnancy as a period when they were expected to endure mistreatment silently within the household hierarchy, with limited protection from elders. In such contexts, violence was not contained within the couple but embedded within extended family relations that shaped women's isolation and reduced their capacity to seek support. *"My partner and I always had to listen to his parents' comments as they would insult me, saying that I don't have parents or an identity of my own".*

Jealousy and suspected infidelity emerged as common drivers of conflict and control during pregnancy, with women describing accusations that justified monitoring and restrictions. One participant explained, *"He thinks I have another man... that's why he fights."* These suspicions often fuelled surveillance of phones, restrictions on movement, and increased intimidation, reinforcing the controlling dynamics described in Theme 1. One participant explained that her husband would repeatedly question her, *"You didn't answer my phone; were you with another man? Were you pregnant by him?"* This shows how pregnancy did not reduce the IPV; for some women, it intensified conflict,

positioning pregnancy within a broader context of mistrust and coercion.

Pregnancy-related expectations and blame also contributed to violence escalation, with women describing being held responsible for household stability while physically constrained. Some women described being pressured to continue heavy domestic tasks, manage finances, and meet relationship expectations despite pregnancy-related fatigue and health needs. One woman expressed the strain clearly: *"I have to take care of him, right? But I don't have money, and I do not take care of the household work."* These accounts reveal a "double vulnerability" in pregnancy; women were more physically limited, yet more harshly judged, with conflict emerging when expectations were not met. *"Two months ago, when I was pregnant. I didn't go to work for one month, I didn't get paid, and they told me to come back only after I gave birth. Then, my sister's husband went to speak to my husband about it. But my husband blamed me, saying it was all my fault because of that conversation. And then he hit me."*

Theme 3: Selective disclosure, concealment, and help-seeking within pregnancy and postpartum constraints

Women's responses to IPV during pregnancy were shaped by fear of escalation, stigma, social consequences, and concerns about the unborn baby. Disclosure was not described as a simple "yes/no" act, but as a strategic process in which women assessed what could be safely shared, with whom, and at what moment. Maternal health pathways were sometimes opportunities for limited help-seeking, yet they could also be navigated through silence, concealment, and controlled communication.

Silence and secrecy were frequently framed as protective strategies to prevent further violence, avoid retaliation, and preserve pregnancy safety. *"I do not want to talk about this with anyone except my mother. I don't want anyone in the community to know what I am going through because I will feel ashamed of myself. That is why I do not want to speak to anyone in the clinic either."* Women described remaining quiet to avoid provoking partners and to prevent conflict from worsening. One woman explained, *"I did not tell him... because if he knows, he will do something. Only my child and I know."* For many participants, silence was not acceptance, but survival, pregnancy was managed alongside fear, and speaking openly was seen as risky when women remained dependent and closely monitored.

Concealment and cover stories were commonly used when women accessed maternal care or interacted with others, especially when visible injuries raised questions. Participants described hiding bruises, attributing harm to accidents, or minimising incidents to avoid disclosure. One participant narrated, *"I told the doctor I fell down... I did not say anything about what happened at home."* Such concealment reflected women's calculation of safety and the fear that disclosure could trigger escalation once they returned home. Even in care settings, women often managed disclosure carefully, balancing the need for help against the consequences of being "found out."

Religious coping emerged as an emotional response when women felt they had limited practical options for change. Women described prayer and faith as sources of endurance and hope during pregnancy, particularly when violence was ongoing and support systems were uncertain. For

some, religion offered a private space to express distress when speaking to others was unsafe. This form of coping did not replace formal support but functioned as a stabilising strategy within constrained circumstances.

The Public Health Midwife (PHM) was repeatedly described as a trusted and familiar node within women's maternal health pathways, where limited disclosure sometimes became possible. *"I had to face everything alone. Neither my parents nor my in-laws supported me. When I finally spoke to the PHM and told her what I was going through, she advised me how to protect myself and my unborn baby"*. Some women spoke about the PHM as someone who could notice distress or provide guidance, especially when pregnancy follow-up created repeated contact. Women described feeling safer sharing concerns when approached sensitively and when confidentiality felt credible. In these accounts, the PHM role was experienced not only as clinical follow-up but as relational trust within the maternal care system. *"I took his phone and gave it to the PHM to keep it. I didn't explain why, but I did it so he couldn't talk to that lady."*

Temporary separation; often returning to a natal home was described as a safety strategy used during pregnancy or postpartum when violence escalated. *"I always want to run away to my parents' house whenever he hits me. He always comes home drunk and gets angry at me for no reason. Even on the days he doesn't drink, he still abuses me."* Women described leaving temporarily to protect themselves and the baby, although these separations were often unstable due to dependence, childcare, social pressures, or continued intimidation. One woman reflected, *"When I was having my second baby, I stayed in*

my brother's place... sometimes he would come and shout at me." For some women, leaving created brief safety but did not end coercive control, as partners continued to monitor or threaten them across locations.

Hospital or clinic encounters sometimes functioned as turning points, particularly when violence resulted in physical harm, severe distress, or pregnancy complications that required care. Women described moments when health staff raised concerns or when the hospital environment temporarily reduced partner control. *"I once had a fit when my husband was hitting me, and I had to be admitted to the hospital because it affected my baby. The doctor warned me and advised me to be careful, saying that if it happens again, it could lead to serious problems for the baby."* However, women also remained cautious because clinics were not always safe spaces for open disclosure, especially when partners or in-laws accompanied them. Care settings could therefore represent both opportunity and constraint; women might receive support, but only within the boundaries of what could be safely said. *"I have been admitted to the hospital four or five times. He's even gone to jail because of it. The hospital staff said they would file a case, but I begged them not to. He promised me he would change. He said he would will take care of me."* Some women described receiving personal support from hospital staff, including one participant who recalled, *"A madam at the hospital told me, 'If something happens again, I will protect you and find a safe place for you and your children to stay.'"*

Police or formal legal help-seeking was described cautiously and often only under crisis conditions. Women's accounts reflected hesitation due to fear

of retaliation, stigma, and uncertainty about outcomes. Some women described approaching police when violence became unmanageable, while others explained why they avoided it, anticipating escalation or community consequences. Formal help-seeking was thus situated as a high-risk option, considered when safety threats outweighed fears of disclosure.

Theme 4: Maternal well-being and functional impacts of IPV during pregnancy and postpartum

Women's narratives highlighted that IPV during pregnancy affected both body and mind, disrupting sleep, appetite, emotional stability, and everyday functioning. Rather than being a period of protection and anticipation, pregnancy and the early postpartum period were described as periods of survival marked by chronic tension. Women's accounts conveyed that well-being impacts were not only psychological but also shaped by physical strain and pregnancy-related complications occurring in an environment of fear and instability.

Severe psychological distress was described through constant worry, fear, and emotional exhaustion, often intensified by concerns about the baby's safety and uncertainty about the future. One participant described severe psychological distress and suicidal thoughts despite being referred for counselling, stating, *"I was referred from the hospital for counselling, but my husband said I'm fine. Sometimes I have thoughts of ending my life, but when I look at my children, I feel a little better."* Another participant described, *"My son wants us to commit suicide together. He is very smart for his age, not like other children. He doesn't like me suffering, and he's also*

going through a difficult time. He thinks we should end our lives together." Women described pregnancy as emotionally heavy, with distress accumulating over time. In these accounts, distress was not separate from violence; it was understood as a consequence of living under coercion while trying to maintain pregnancy health and household stability.

Sleep, appetite, and daily functioning were commonly disrupted, with women describing reduced food intake and a diminished capacity to complete daily tasks. One participant stated, *"Yes, I don't get much sleep. Sometimes I don't feel like eating, either."* Another linked emotional distress to physical weakness and lack of support during pregnancy: *"I have even fainted thinking about this, as I couldn't eat properly... no one ever came to see me or take care."* Women also described how persistent rumination interfered with routine activities: *"I sometimes don't eat... and I find it hard to do daily activities. I just keep thinking about these things."* These accounts illustrate the experience of pregnancy lived under chronic stress, where basic functioning became difficult.

Physical health crises and pregnancy-related consequences were described as occurring within the context of violence and distress, with women expressing fear that conflict and harm could affect the baby. Some women reported episodes of collapse or acute illness during pregnancy, while others described being warned by clinicians about risks associated with stress or injury. In these narratives, the pregnant body was experienced as fragile, and violence created uncertainty about the safety of the foetus and the stability of the pregnancy. Early hospitalisation and delivery were described by some women as part of pregnancy trajectories

shaped by stress, conflict, and declining health. One participant linked pregnancy complications to the broader context of distress and instability: *"I got pressure in that pregnancy, so I had to get admitted early for the delivery."* Such accounts illustrate how IPV during pregnancy was not only a safety concern but also a factor shaping maternal health trajectories, increasing the likelihood of crisis-driven care and heightened vulnerability during late pregnancy.

Discussion

This qualitative analysis of 15 case-study interviews with pregnant and postpartum women in the Nuwara Eliya District provides an in-depth account of how IPV is experienced, sustained, and navigated during the perinatal period, with particular attention to maternal health pathways. Rather than presenting violence as a series of isolated incidents, women's narratives portrayed pregnancy as a time when abuse often intensified into a spectrum of coercive control, shaping bodily safety, emotional well-being, household resources, and critically, women's ability to access ANC and other maternal healthcare services.

These findings are consistent with recent international qualitative evidence showing that perinatal IPV disclosure is often constrained by fear, concerns about confidentiality, family consequences, and uncertainty about whether services can offer meaningful protection [8]. Similar to findings from antenatal and perinatal care settings, women in this study did not experience disclosure as a simple individual decision, but as a safety calculation shaped by partner surveillance, family dynamics, stigma, and perceived responses from services [6, 8]. The findings also align with broader multi-country evidence

that IPV can influence maternal health service utilisation, although the present study extends this evidence by showing how service contact may be strategically negotiated rather than simply delayed or missed [19].

A central contribution of this study is the way women described IPV during pregnancy as layered and cumulative, with physical assault, sexual coercion, intimidation, emotional degradation, restrictions on mobility and communication, and economic restriction operating together as an interlocking system. Importantly, pregnancy did not simply occur “alongside” violence; instead, it appeared to reshape the terrain of control. Women spoke of being assaulted while pregnant despite foetal vulnerability, being coerced into unwanted sex while carrying a pregnancy, and living under persistent threats that made everyday life; including sleep, eating, and rest feel unsafe. What is particularly pregnancy-specific in these accounts is the way maternal health needs became part of the control strategy. Women described a loss of autonomy not only in home settings but also in their ability to attend clinics, communicate freely with providers, or disclose safely. This positions ANC access not merely as a service utilisation issue, but as an element of coercive control embedded in the lived experience of perinatal IPV. In this way, the study extends typical descriptions of “violence in pregnancy” beyond incident-based harm, highlighting how pregnancy-related vulnerabilities such as dependence, health needs and mobility constraints may be used to tighten control and isolate women at the very time they require additional care and support.

The findings can be interpreted through a coercive control lens, in which violence operates not only through discrete acts

of physical harm but through repeated restrictions on autonomy, mobility, resources, communication, and decision-making [1, 3, 5]. This framing is particularly useful in the perinatal period because pregnancy can increase women’s dependence on household support, transport, nutrition, and access to health services [3, 4, 8]. In this study, ANC attendance, communication with PHMs, hospital care, and disclosure were not neutral health behaviours; they were embedded in household power relations and shaped by safety calculations. This helps explain why women may attend services but remain silent, disclose partially, or seek help only when violence escalates to a crisis [6-9].

Women consistently located perinatal IPV within a broader household context; a set of interacting stressors and power relations that helped explain why violence escalated or persisted. Alcohol use emerged as a common escalation context, with women describing predictable patterns in which drinking preceded intimidation or assault. In parallel, in-law influence appeared in women’s narratives not simply as “background family dynamics” but as an active social force that could legitimise or amplify abuse, leaving women with limited protection within the household during pregnancy. Jealousy and suspected unfaithfulness also featured as recurring drivers, sometimes intensifying controlling behaviours and restrictions on communication and mobility. These suspicions often carried heightened consequences in pregnancy, as women’s physical limitations and dependence increased, making resistance or escape more difficult. In addition, women described pregnancy-related expectations; regarding domestic labour, obedience, and perceived “role” fulfilment as creating conflict when

women were physically unwell, required rest, or could not meet household demands.

A second major contribution is the study's detailed portrayal of how women managed disclosure strategically rather than following a simple "disclose versus do not disclose" pattern. Silence and concealment were frequently described as safety-preserving decisions made under fear of escalation, economic dependence, social consequences, and concerns about confidentiality. For many women, the risks of being "found out" were perceived as immediate and severe, particularly during pregnancy when physical vulnerability was heightened. Within maternal health settings, women sometimes used cover stories or partial disclosure to access care while avoiding escalation at home. This highlights ANC/PNC not only as opportunities for support, but also as contested spaces where women must actively negotiate safety. In this context, the PHM emerged as a critical trusted actor. Women's narratives suggested that the relational continuity of PHM contact (home visits, routine clinic follow-up, familiarity with families) can provide a rare entry point for recognition and support, especially when trust and confidentiality are experienced as credible. At the same time, women's accounts caution against assuming that service contact automatically ensures protection. Even when healthcare providers identified abuse or made referrals, women described situations where partners minimised concerns, restricted follow-through, or monitored interactions. These findings underscore that effective responses require more than the availability of services; they depend on whether care environments are safe, private, and equipped with viable referral pathways that protect women from retaliation and further control.

Women's narratives also suggest that hospital admissions and police/legal services were most commonly engaged under conditions of escalation, acute harm, or crisis; rather than early in the violence trajectory. Hospitals were sometimes described as rare spaces where women were temporarily separated from the perpetrator or encountered compassionate staff support, creating moments where women could reflect, disclose, or be referred onward. However, these "turning points" were not consistently protective; they were fragile, dependent on staff discretion, and often undermined by fear of consequences once women returned home. Similarly, police/legal help-seeking appeared to be shaped by ambivalence and constraint: women described weighing the possibility of protection against risks of escalation, stigma, or community exposure. This indicates that formal services may be perceived as high-stakes options rather than routine supports, particularly within rural/estate contexts where women may fear social repercussions and have limited alternatives for safe housing or financial security.

Finally, the study shows how perinatal IPV undermined well-being in ways that were both psychological and physical. Women described disrupted sleep, appetite, and daily functioning, alongside experiences of severe distress. In some accounts, psychological suffering extended to thoughts of ending one's life, illustrating the intensity of entrapment and despair that can accompany sustained coercive control in pregnancy. In a perinatal context, these harms are particularly consequential because they occur alongside heightened physiological demands and the need for consistent care, nutrition, rest, and emotional safety. The findings therefore

reinforce that perinatal IPV is not only a social problem but a maternal health concern with implications for continuity of care, safety planning, and integrated mental health support within ANC/PNC systems.

These findings carry several practice-relevant implications for maternal and community health systems in Sri Lanka. First, ANC/PNC services should be positioned not only as routine clinical care but as protection-sensitive entry points, with staff trained to recognise coercive control patterns, not only physical injury. This includes strengthening privacy during consultations, improving confidential enquiry processes, and ensuring women have safe opportunities to speak alone. Second, the PHM system appears pivotal for early identification and relational support. Strengthening PHM capacity with practical tools for first-line response, safety planning, and referral coordination could be a high-impact investment, particularly in rural and remote communities where specialist services may be limited. Third, hospitals and police/legal mechanisms should be linked through clearer, survivor-centred referral pathways so that crisis points can become genuine opportunities for sustained protection rather than temporary interruptions. Finally, because economic restriction emerged as part of coercive control during pregnancy, responses must extend beyond counselling and referral alone. Where feasible, linkages to social protection, emergency support, and safe accommodation pathways can reduce women's dependency-driven entrapment, particularly when pregnancy increases the costs of care and transport.

Limitations

This study has several limitations. First, the sample was small and purposively

selected, and the findings are intended to provide in-depth qualitative insight rather than statistical generalisability. Second, the study was conducted in one district with a substantial estate-sector population; therefore, the findings may not fully represent women's experiences in other Sri Lankan settings. Third, the analysis is based on women's accounts and does not include the perspectives of partners, in-laws, PHMs, hospital staff, police officers, or other service providers. Fourth, because IPV is a sensitive and potentially dangerous topic to disclose, some participants may have under-reported certain experiences or avoided details that felt unsafe or distressing to discuss. Finally, although the study identified important service pathways, it did not evaluate the effectiveness, quality, or safety of specific IPV response services.

Conclusion

Overall, this study demonstrates that perinatal IPV in Nuwara Eliya is lived as a spectrum of coercive control, with pregnancy creating distinct vulnerabilities and service-related stakes. Maternal health pathways, especially ANC, the PHM system, and hospital care, can serve as vital entry points for protection, yet women's engagement is shaped by fear, surveillance, and strategic disclosure. Strengthening confidential, integrated, and survivor-centred IPV responses within routine maternal care is therefore essential to protecting both women's wellbeing and the continuity and safety of perinatal health pathways in estate and rural Sri Lankan settings.

Ethical Approval

Ethical approval for this study was obtained from the Ethical Clearance Committee of the Faculty of Medicine, General Sir John

Kotelawala Defence University, Sri Lanka. The application, Reference No. RP/2025/09 was reviewed and approved at the ERC meeting held on 23 April 2025. The official approval letter was issued on 25 April 2025. Written or documented informed consent was obtained from all participants before data collection. Confidentiality, voluntary participation, the right to withdraw, and referral information for participants requiring support were incorporated into the study procedures.

Author Contributions

MSS contributed to conceptualisation, study design, qualitative analysis, interpretation of findings, and drafting of the manuscript. LS led the overall study conceptualisation, provided technical guidance on maternal health and IPV response, and critically reviewed the manuscript. PK contributed to qualitative interpretation, literature integration, and critical review of the manuscript. JD, CB, AD, PS, and CR contributed to study design, field coordination, interpretation of findings, and critical review. All authors reviewed and approved the final manuscript.

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Conflict of Interests

The authors declare that there are no conflict of interests.

Data availability Statement

The de-identified case-study narratives underpinning this qualitative analysis are publicly available in the report *Voices of Mothers in Shadow: Intimate Partner Violence during Pregnancy*, published by The Family Planning Association of Sri Lanka, available at:

<https://www.fpasrilanka.org/sites/default/files/2026-03/Voices%20of%20Mothers%20in%20Shadow%20Intimate%20Partner%20Violence.pdf>

The full interview transcripts are not publicly available due to the sensitive nature of the data, the risk of deductive identification, and the ethical obligation to protect participant confidentiality and safety. Any further use of the underlying qualitative data would require appropriate ethical approval and permission from the

corresponding author and the relevant institutional authorities.

Use of Artificial Intelligence Assisted Technologies

During the preparation of this work, the authors used OpenAI (version GPT-5.2) to improve the language and readability. The authors reviewed and edited the content as needed and take full responsibility for the final publication.

Disclaimer

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