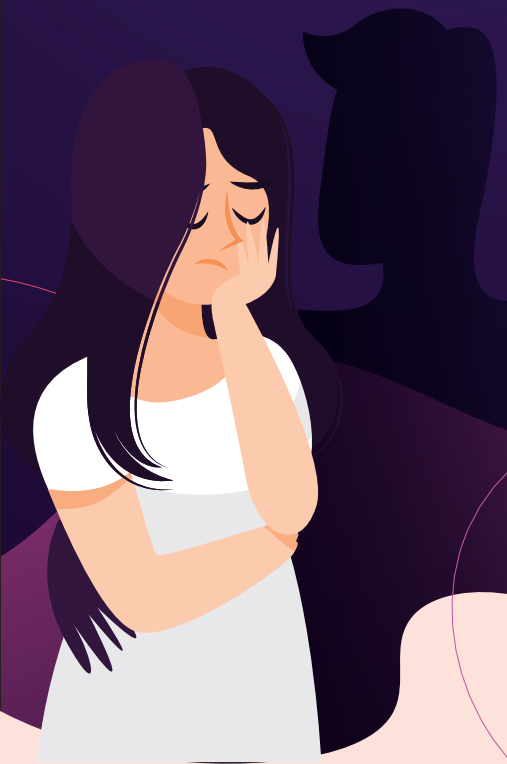
INTIMATE PARTNER VIOLENCE DURING PREGNANCY

A Qualitative Inquiry in the Nuwara Eliya District, Sri Lanka



The Family Planning Association of Sri Lanka

Intimate Partner Violence During Pregnancy: A Qualitative Inquiry in the Nuwara Eliya District, Sri Lanka

The Family Planning Association of Sri Lanka
Monitoring and Evaluation Unit
2026

Established in 1953, The Family Planning Association of Sri Lanka is a leading service provider and advocate of Sexual and Reproductive Health, Rights and Justice in Sri Lanka. The Association seeks to promote multiple aspects of reproductive health and improve the quality of life and well-being.

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All names, people, villages, and environments depicted in this book are hypothetical.

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This study was carried out in accordance with the ethical guidelines of the Ethical Review Committee of the Faculty of Medicine, General Sir John Kotelawala Defence University. The opinions, findings, and interpretations expressed in this report are those of the authors and do not necessarily reflect the official views of The Family Planning Association of Sri Lanka, the Embassy of the Kingdom of the Netherlands in Sri Lanka, or its donor organisations, except where explicitly stated.

Intimate Partner Violence During Pregnancy: A Qualitative Inquiry in the Nuwara Eliya District, Sri Lanka

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FOREWORD

It is my privilege to introduce this report, Intimate Partner Violence During Pregnancy: A Qualitative Inquiry in the Nuwara Eliya District, Sri Lanka, prepared by the Monitoring and Evaluation Unit of The Family Planning Association of Sri Lanka. This report addresses an issue of profound public health and social significance. Intimate partner violence during pregnancy threatens not only the safety, dignity, and well-being of women, but also the health of their unborn children and the effectiveness of maternal health systems. Pregnancy should be a period marked by care, protection, and hope. Yet, as this report demonstrates, for many women, it is also a period of fear, coercion, and vulnerability. Through the voices of pregnant and postpartum women in the Nuwara Eliya District, this study shows that intimate partner violence during pregnancy is rarely a single incident. Rather, it often takes the form of a continuing pattern of physical, emotional, sexual, and economic abuse, reinforced by control, silence, and structural disadvantage. These findings remind us that violence during pregnancy is not merely a private matter within the household. It is a serious maternal health concern and a reflection of wider inequalities and gaps in protection and support.

This report is especially important because it highlights women's lived experiences in a district marked by multiple vulnerabilities. Nuwara Eliya, with its estate-sector communities, poverty, service access barriers, and gendered inequalities, provides an important setting for understanding how violence intersects with maternal health pathways. The study shows how women's access to antenatal care, disclosure, help-seeking, and safety is shaped not only by intimate relationships, but also by poverty, household power dynamics, language barriers, and uneven access to services.

At The Family Planning Association of Sri Lanka, we believe that sexual and reproductive health and rights cannot be realised without safety, dignity, bodily autonomy, and freedom from violence. This report reinforces that commitment. It also reminds us that maternal health services should function not only as clinical spaces, but also as points of recognition, support, referral, and protection. The findings underscore the importance of strengthening survivor-centred and confidential responses within routine antenatal and postnatal care, particularly through the trusted role of Public Health Midwives and the wider community health system.

I commend the research team for conducting this important inquiry with scientific rigour, ethical care, and compassion. Most importantly, I wish to acknowledge with sincere respect the women who shared their experiences for this study. Their courage has made this report possible, and their voices call on all of us to respond with greater commitment and responsibility.

It is my hope that this report will not only be read, but also acted upon. May it strengthen our collective resolve to ensure that every woman is able to experience pregnancy in safety, dignity, and care.

Dr Ruchitha Perera
Executive Director
The Family Planning Association of Sri Lanka

ACKNOWLEDGEMENT

"Intimate Partner Violence During Pregnancy: A Qualitative Inquiry in the Nuwara Eliya District, Sri Lanka" is more than a research report. It reflects the difficult realities many women endure in silence and stands as a tribute to their courage. The stories presented in this qualitative inquiry bear witness to the profound and enduring effects of intimate partner violence during pregnancy, a period that should instead be marked by safety, care, and support. This report is the result of a collaborative and compassionate effort to document and amplify the lived experiences of women affected by violence during pregnancy. The authors extend their sincere appreciation to the Board of Directors, the Executive Director, and the Senior Management Team of The Family Planning Association of Sri Lanka for their guidance, encouragement, and institutional support throughout the study. The authors further acknowledge, with gratitude, the contributions of the FPA Sri Lanka team, especially Ms. Jayamini Priyangika and Ms. Zaroosha Farook, for their support in implementing this study.

This study was supported through a grant from the Embassy of the Kingdom of the Netherlands in Sri Lanka (Grant No. E10000086/HR-ODA/2024/FPASL), together with internally generated funds from The Family Planning Association of Sri Lanka. The authors gratefully acknowledge this generous support, which made the study possible. The authors also wish to place on record their sincere appreciation to Mr. Namal Perera, Senior Policy Advisor at the Embassy of the Kingdom of the Netherlands in Sri Lanka, for his valuable support and encouragement. Appreciation is also extended to the technical experts who reviewed the protocol and study papers and provided valuable input that strengthened the scientific and practical quality of this work. In particular, the authors gratefully acknowledge Dr. Dinusha Perera, National Programme Manager, Gender and Women's Health, Family Health Bureau; Dr. Nishanjali Mapitigama, Consultant Community Physician; Dr. Ataur Rahman, Director, Centre for Professional Skills Development, BRAC James P Grant School of Public Health, BRAC University; Prof. Manoj Samarathunga, Rajarata University of Sri Lanka; Dr. Meenakshi Rai, Programme Director, RENEW, Bhutan; and Dr. Hariyot Khosa, Regional External Relations Director, International Planned Parenthood Federation.

The protocol of this study was reviewed and approved by the Ethical Review Committee of the Faculty of Medicine, General Sir John Kotelawala Defence University, ensuring that the research was conducted with due respect for the rights, safety, privacy, and dignity of all participants. The authors extend their sincere appreciation to the Chairperson, reviewers, and members of the Committee for their careful review and guidance.

Above all, the authors express their deepest gratitude to the women who courageously shared their experiences for this study. Their voices, strength, and honesty made this report possible. This report is dedicated to them, and it is their lived experiences that call all of us to respond with greater commitment, compassion, and responsibility.

ABBREVIATION

A/L	GCE Advanced Level
ANC	Antenatal Care
APH	Antepartum Haemorrhage
CI	Confidence Interval
DCS	Department of Census and Statistics
DHS	Demographic and Health Surveys
FHB	Family Health Bureau
FPA Sri Lanka	The Family Planning Association of Sri Lanka
GBV	Gender-Based Violence
GLMM	Generalised Linear Mixed Model
IPPF	International Planned Parenthood Federation
IPV	Intimate Partner Violence
LBW	Low Birth Weight
M&E	Monitoring and Evaluation
MBBS	Bachelor of Medicine, Bachelor of Surgery
NGO	Non-Governmental Organisation
O/L	GCE Ordinary Level
OLE	Organisational Learning and Evaluation
OPD	Outpatient Department
PHM	Public Health Midwife
PI	Prediction Interval
PNC	Postnatal Care
PROM	Pre-labour Rupture of Membranes
PTB	Preterm Birth
SOP	Standard Operating Procedure
SPHM	Supervisory Public Health Midwife
SRH	Sexual and Reproductive Health
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization
WOG	Weeks of Gestation
WPP	Weeks Postpartum

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EXECUTIVE SUMMARY

Introduction: Intimate partner violence (IPV) during pregnancy is a serious public health and maternal health concern. It includes physical, sexual, and psychological abuse, as well as controlling behaviours that can undermine women's safety, autonomy, and access to care. Pregnancy and the postpartum period may heighten women's vulnerability to IPV, with important consequences for maternal well-being, foetal health, and continuity of antenatal and postnatal care. Although Sri Lanka has strong maternal health services and policy guidance for responding to gender-based violence, IPV during pregnancy remains under-researched and insufficiently addressed in routine maternal healthcare. This gap is especially important in the Nuwara Eliya District, a predominantly rural and estate-sector setting marked by poverty, structural disadvantage, limited health workforce availability, and the vulnerability of plantation-sector women.

Objectives: The overall objective of the study was to explore how pregnant and postpartum women in the Nuwara Eliya District, Sri Lanka, experience intimate partner violence during the perinatal period, and how these experiences shape maternal health pathways, particularly antenatal care engagement, disclosure, and help-seeking. The specific objectives were to: explore the forms and manifestations of IPV during pregnancy and the postpartum period; examine the household, relational, and contextual factors that trigger, sustain, or intensify IPV; understand how IPV affects maternal health pathways, including access to antenatal and postnatal care and women's disclosure and help-seeking practices; and assess the perceived impacts of IPV on maternal wellbeing, psychological health, and daily functioning.

Literature Review: A narrative literature review was undertaken to establish the conceptual and empirical context for the study. Relevant peer-reviewed and grey literature published between 2000 and 2025 were searched using PubMed, Google Scholar, Lens.org, and Dimensions, together with national and institutional sources. The search initially identified 828 records; following deduplication and screening, 27 studies were included in the final synthesis. The review found that the prevalence of IPV during pregnancy varies substantially across Asian settings. In Sri Lanka, current pregnancy prevalence ranged from 4.7% to 15.9%, while across the wider Asian region the pooled prevalence of IPV during the current pregnancy was estimated at 14.4% (95% CI: 10.3–19.9) based on 23 studies comprising 52,072 pregnancies and 5,448 IPV events. The literature further showed that IPV during pregnancy is associated with low education, low income, low socioeconomic status, younger age, early marriage, patriarchal decision-making, poor relationship quality, and partner alcohol or substance use. It is also linked with adverse maternal and

pregnancy outcomes, including psychological distress, miscarriage, stillbirth, preterm birth, low birth weight, and other maternal complications. However, the Sri Lankan evidence base remains limited, especially with regard to emotional abuse, sexual violence, coercive control, estate-sector populations, and women's lived experiences of navigating maternal care and help-seeking.

Methods: This report presents findings from the qualitative component of an ongoing exploratory sequential mixed-methods study conducted in the Nuwara Eliya District. The qualitative inquiry adopted an interpretivist epistemological position and used an inductive thematic analysis approach to generate an in-depth, case-based understanding of women's experiences. Fifteen in-depth case-study interviews were conducted with pregnant and postpartum women who disclosed IPV during their most recent pregnancy. Participants were purposively selected to ensure diversity across estate and non-estate settings, perinatal stage, forms and severity of violence, and living arrangements. Data were collected through confidential, open-ended case-narrative interviews conducted by a trained MBBS-qualified female interviewer. Audio-recorded interviews were transcribed verbatim, de-identified, and analysed in NVivo using a staged inductive thematic analysis process involving familiarisation, free/open coding, codebook development, constant comparison, and theme generation. Ethical safeguards included private recruitment and interviewing, informed consent in preferred languages, confidentiality protections, and referral pathways for participants who required support.

Results and Discussion: The analysis generated four inter-connected themes. First, women described perinatal IPV as a spectrum of abuse and coercive control, comprising physical, sexual, emotional, and economic abuse, along with threats, surveillance, mobility restriction, and control over communication and finances. Pregnancy did not protect women from violence; rather, it often intensified dependence and created additional vulnerabilities. A particularly important finding was that antenatal care itself became a site of control, with some women needing permission, accompaniment, or supervision to attend clinics.

Second, women's experiences of violence were embedded in a wider household and social ecosystem. Alcohol use, in-law hostility, jealousy and suspicion, and pregnancy-related role expectations were repeatedly identified as factors that triggered or intensified violence. These findings are consistent with the literature review, which also identified partner alcohol use, low autonomy, poor family support, and patriarchal household dynamics as recurrent correlates of IPV during pregnancy in Sri Lanka and across Asia.

Third, disclosure and help-seeking were strategic rather than straightforward. Many women used silence, concealment, or partial

disclosure to protect themselves from escalation, stigma, or surveillance. Within this constrained context, Public Health Midwives emerged as trusted and potentially protective actors within maternal care pathways. Hospitals and police or legal services were usually approached only when violence became acute, medically urgent, or otherwise unmanageable. The discussion highlights that contact with services alone does not ensure protection; rather women require safe opportunities for confidential disclosure within systems that are equipped to respond effectively.

Fourth, perinatal IPV had substantial effects on maternal well-being and functioning. Women described disrupted sleep, poor appetite, emotional strain, reduced daily functioning, and pregnancy-related health crises within a context of chronic fear and instability. The discussion, supported by the literature review, reinforces that IPV during pregnancy is not merely a private or social matter, but a maternal health issue with implications for continuity of care, safety planning, psychosocial well-being, and pregnancy outcomes. Overall, the study demonstrates that perinatal IPV in Nuwara Eliya is shaped by the intersection of gender inequality, household power relations, economic vulnerability, and service access constraints, while existing policy and service provisions remain incompletely implemented in practice.

Conclusion: The report concludes that intimate partner violence during pregnancy in the Nuwara Eliya District is experienced as sustained coercive control rather than as isolated acts of abuse. Pregnancy creates distinct vulnerabilities, while maternal health pathways, especially ANC, PHM follow-up, and hospital care, become both contested spaces and critical opportunities for protection. Women's accounts show that perinatal IPV is shaped by structural disadvantage, household power imbalances, economic restriction, and fear of disclosure. Although Sri Lanka has policy guidance and service mechanisms for responding to IPV within maternal health services, important implementation gaps remain. Strengthening confidential, survivor-centred, and practically usable responses within routine maternal care is therefore essential, particularly in estate and rural settings.

Recommendations: The report recommends strengthening confidential IPV screening within routine antenatal and postnatal care by ensuring safe opportunities for women to speak alone during selected contacts. It further recommends strengthening the role of Public Health Midwives as frontline responders through practical training on safe enquiry, recognition of coercive control, first-line emotional support, safety assessment, confidential documentation, and referral follow-up. At district level, clearer referral pathways should be established linking maternal health services, hospitals, Mithuru Piyasa/Natpu Nilayam services, police/legal systems, and relevant social support mechanisms. Service responses should be tailored to the realities of estate-sector and Tamil-speaking

communities in Nuwara Eliya, with context-appropriate communication and outreach. The report also recommends safer dissemination of information on available support services, including helplines and referral options, through discreet channels that do not increase women's risk. Finally, it calls for stronger incorporation of IPV during pregnancy into district and national maternal health planning, along with further Sri Lankan research that goes beyond physical violence and facility-based samples to include emotional abuse, sexual coercion, controlling behaviours, and marginalised populations.

1. INTRODUCTION

1.1. IPV During Pregnancy

Intimate partner violence (IPV) refers to behaviours within an intimate relationship that cause physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours (WHO, 2024). IPV is widely recognised as one of the most common forms of violence against women, affecting women across socio-economic, cultural, and geographic boundaries(United Nations, 2020). While often framed as a "domestic" or private matter, IPV is increasingly understood as a public health and human rights concern with serious consequences for women's health, safety, and social well-being(WHO, 2024). Pregnancy and the postpartum period can represent a time of heightened vulnerability to IPV, including violence that begins for the first time, escalates in severity, or becomes more controlling in form (The American College of Obstetricians and Gynaecologists, 2012). In such contexts, women may experience IPV not only as episodic assaults but also as a spectrum of coercive control shaping everyday life, including restrictions on movement, communication, decision-making, and access to financial resources. This is especially important in perinatal contexts, where women's autonomy is central to maintaining safety and meeting pregnancy-related needs (WHO, 2024). Perinatal IPV is consistently associated with adverse maternal and pregnancy outcomes, including depression and psychological distress, miscarriage, preterm delivery, and low birth weight. These harms may accumulate over time, affecting both clinical outcomes and women's day-to-day functioning during a period when physical recovery, rest, and sustained health service contact are critically important (Donovan et al., 2016).

Globally, IPV affects an estimated 6–16% of pregnant women (Ma & zhang, 2025). A recent meta-analysis found an overall prevalence of 34% among pregnant women, and it identified multiple risk factors unique to this period (Ma & zhang, 2025). As the unique physical, emotional, and social practices and behaviours expected during the pregnancy can increase relationship stress, potentially triggering or escalating abusive behaviours from their partners, leading to an increase in IPV during the pregnancy. Although most studies on IPV during pregnancy capture physical violence, sexual and emotional abuse are also prevalent and have significant harmful effects on their health and well-being and that of their unborn foetuses (WHO, 2011).

Maternal health pathways, particularly Antenal Care (ANC) and Postnatal care (PNC), are central to this relationship between IPV and perinatal well-being (The American College of Obstetricians and Gynecologists, 2012). 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 (WHO, 2013). 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 (Heron & Eisma, 2021). In these circumstances, women may delay care, attend selectively, or develop cover stories to avoid raising suspicion at home (Silva et al., 2022). 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.

1.2. IPV During Pregnancy in Sri Lanka

Sri Lanka provides an important context for examining these dynamics. The country is recognised for strong maternal health indicators and an established Public Health Midwife (PHM) system; at the same time, IPV during pregnancy remains under-researched and under-addressed within routine maternal health practice (Senanayake, 2012a; Suranga et al., 2025). 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 (FHB, 2020, 2023). Yet recent assessments highlight persistent implementation gaps, including inconsistent application of protocols, limited integration of IPV screening into routine maternal and child health contacts, and missed opportunities across ANC/PNC encounters (Suranga et al., 2025). These gaps matter because women may have multiple points of contact with the health system across pregnancy and postpartum, and each contact can either reinforce silence or create a safe pathway for support (Moonesinghe et al., 2004a).

Despite growing recognition of IPV within maternal health guidelines, there remains limited qualitative evidence in Sri Lanka connecting women's lived experiences of perinatal IPV to the practical realities of ANC/PNC engagement, disclosure, and help-seeking navigation (Suranga et al., 2025). This gap is especially important in settings such as Nuwara Eliya, where structural barriers and service constraints may further complicate women's choices (FPA Sri Lanka, 2024/2024; UNDP, 2023).

1.3. Nuwara Eliya District

The Nuwara Eliya District provides a particularly important setting in which to examine perinatal intimate partner violence and maternal health pathways (Figure 1.1). The district is characterised by a large estate-sector population, predominantly from the minority Indian Tamil community, and is marked by limited infrastructure and restricted access to health facilities. In FPA Sri Lanka's district prioritisation exercise, Nuwara Eliya was ultimately included among the final priority districts specifically because of the recognised vulnerability of the plantation-sector female labour force to sexual and gender-based violations. The district also has a relatively high population density, with 417 persons per square kilometre, further underscoring the pressure on local services and resources (FPA Sri Lanka, 2024/2024).

These structural vulnerabilities are compounded by severe socio-economic deprivation and health-system constraints. Nuwara Eliya records the highest multidimensional poverty rate in Sri Lanka (44) and 4.6% of households are classified as poor. The district also has one of the weakest public health workforces in the country, including the lowest number of medical officers per 100,000 population (36) and only 38 Public Health Midwives/Supervisory Public Health Midwives per 100,000 population. Although the district reports a relatively high modern contraceptive prevalence rate (62.7%), unmet need for family planning remains 6.7%, the fourth highest nationally.



Figure 1.1: Nuwara Eliya District, Sri Lanka.

In addition, Nuwara Eliya records the highest cervical cancer incidence in Sri Lanka, at 14 cases per 100,000 population, while nearly one quarter of women in the 35-year age cohort have not undergone cervical cancer screening (FPA Sri Lanka, 2024/2024). Taken together, these features make Nuwara Eliya a highly relevant context for understanding how poverty, service constraints, and gendered vulnerability may shape women's exposure to violence, access to care, and maternal health experiences during pregnancy.

1.4. Objectives of the study

The overall objectives of this study is to explore how pregnant and postpartum women in the Nuwara Eliya District, Sri Lanka, experience intimate partner violence during the perinatal period, and to understand how these

experiences shape maternal health pathways, particularly antenatal care engagement, disclosure, and help-seeking.

The specific objectives are

1. To explore the forms and manifestations of intimate partner violence experienced by women during pregnancy and the postpartum period, including physical, sexual, emotional, and economic abuse, as well as coercive control.

2. To examine the household, relational, and contextual factors that trigger, sustain, or intensify intimate partner violence during pregnancy and the postpartum period.

3. To understand how intimate partner violence affects maternal health pathways, particularly women's access to and engagement with antenatal and postnatal care, as well as their disclosure and help-seeking practices.

4. To assess the perceived impacts of intimate partner violence on women's maternal well-being, psychological health, and daily functioning during the perinatal period.

2. LITERATURE REVIEW

This chapter presents a review of the literature on intimate partner violence (IPV) during pregnancy, with particular attention to evidence from Sri Lanka and the broader Asian region. The purpose of this review is to establish the conceptual, empirical, and contextual foundation for the present study by summarising what is currently known about the prevalence, nature, associated factors, and maternal consequences of IPV during pregnancy. A narrative literature review approach was adopted to guide this chapter. This approach was considered appropriate because it allows the integration and interpretation of evidence drawn from diverse study designs, data sources, and contextual settings. IPV during pregnancy is a complex public health and social issue shaped by cultural norms, gender relations, health system factors, and variations in measurement and study design. In such a context, a narrative review offers greater flexibility to synthesise qualitative, quantitative, and institutional evidence in a way that supports conceptual understanding rather than statistical pooling.

To inform this review, relevant peer-reviewed and grey literature published between 2000 and 2025 was identified through a structured search of multiple electronic sources, including PubMed, Google Scholar, Lens.org, and Dimensions. To strengthen contextual relevance, additional national and institutional sources were also consulted, including Demographic and Health Surveys, publications of the Family Health Bureau, and reports produced by governmental and non-governmental organisations. Unpublished reports and other grey literature were reviewed where they provided primary data or substantive evidence relevant to the topic. The search process combined key terms related to intimate partner violence, domestic violence, pregnancy, maternal outcomes, Asia, and Sri Lanka using Boolean operators. A summary of the search and selection process is presented in Figure 2.1.

Studies were considered eligible for inclusion if they addressed IPV or domestic violence during pregnancy, were conducted in Sri Lanka or elsewhere in Asia, employed qualitative or quantitative methods, and were published in English. National survey reports and institutional publications were also included where they provided primary evidence relevant to the objectives of the review. Opinion papers, editorials, reviews, single-case reports, and studies not directly focused on IPV during pregnancy were excluded. The search process initially identified 828 records. After the removal of duplicates, 379 unique records remained for screening. Title and abstract screening resulted in 21 articles being selected for full-text assessment. A further six studies were identified through citation tracking and review of reference lists. In total, 27 studies were included in the final narrative synthesis. These studies provide the basis for the discussion that follows in this chapter, which examines the available evidence on IPV during pregnancy and identifies the key knowledge gaps that justify the present qualitative inquiry in the Nuwara Eliya District, Sri Lanka.



Figure 2.1: Methodological Framework of the Narrative Review on Intimate Partner Violence during Pregnancy in Asia and Sri Lanka with Aspecial Focus on Sri Lanka.

A thematic analysis framework was employed to guide both data extraction and synthesis. The extracted data were organised across three overarching analytical domains. The first domain focused on prevalence, which included assessments of overall IPV during pregnancy as well as its specific forms: psychological violence, physical violence, and sexual violence. The second domain examined associated factors, comprising socio-demographic and economic characteristics, reproductive and biological determinants, partner-related and behavioural influences, and marital and psychosocial contributors. The third domain addressed pregnancy outcomes, categorised into loss of pregnancy, foetal and neonatal consequences, maternal health and clinical complications, and psychological and behavioural effects. The synthesis process involved iterative reading, coding, and interpretation of findings across the selected studies, which were then clustered thematically.

The primary synthesis estimated the pooled prevalence of IPV during the current pregnancy using a random-effects generalised linear mixed model (GLMM) with a logit link. Individual-study confidence intervals were computed with Clopper–Pearson; between-study variance τ^2 was estimated by maximum likelihood. Heterogeneity was estimated using I^2 (with 95% CIs), τ^2, and the Q test. Because true prevalence plausibly varies across countries, settings, instruments, and timing of assessment, the Prediction Interval (PI) was reported to convey the range expected for a new, similar study.

2.1. Prevalence of Intimate Partner Violence during Pregnancy

The prevalence of intimate partner violence (IPV) during pregnancy demonstrates marked variability across Asian countries. As summarised in Table 2.1, the lifetime prevalence of IPV among women in Asian studies ranges from 18.3% in Sri Lanka (Moonesinghe et al., 2004b) to 52.8% in Bangladesh (Islam et al., 2021), while the current pregnancy prevalence varies from as low as 1.6% in Oman (Al Shidhani et al., 2020) to as high as 41% in Pakistan (Shahmir et al., 2023). This wide variation likely reflects differences in study design, measurement tools, socio-cultural contexts, and women's willingness to disclose violence during pregnancy. Overall, the evidence reveals that South Asian countries, including Sri Lanka, Bangladesh, Nepal, and Pakistan, tend to report higher IPV prevalence during pregnancy than East or West Asian counterparts.

Table 2.1: Prevalence of IPV during Pregnancy in Selected Asian Countries

	Country	Author/Study Year	Methods	Prevalence
1.	Sri Lanka	(Muzrif et al., 2018)	Clinic-based cross-sectional; 1,375 rural/urban & 800 tea-estate women (6–40 weeks)	15.9%
2.	Sri Lanka	(Moonesinghe et al., 2004b)	Clinic-based cross-sectional; 1,200 women (15–49 yrs)	04.7%
3.	India	(Garg et al., 2020)	Community prospective observational; 1,500 women (<20 weeks)	29.7%
4.	India	(Jungari & Chinchore, 2022)	Community cross-sectional; 550 women who gave birth in last 2 yrs	15.6%
5.	India	(Nath et al., 2021)	Hospital cross-sectional; 350 women >18 yrs (<24 weeks)	03.7%
6.	India	(Jain et al., 2017)	Hospital prospective observational; 400 women (20–28 weeks)	12.3%
7.	India	(Devineni et al., 2018)	Hospital prospective; 200 randomly selected admitted pregnant women	28.9%
8.	India	(Samal & Poornesh, 2022)	OPD cross-sectional; 200 women at 1st antenatal visit	06.5%
9.	India	(Das et al., 2013)	Community cross-sectional; 2,139 women with identified births	15%
10.	Afghanistan / Iran	(Dadras et al., 2021)	Community cross-sectional; 424 women (18–44 yrs)	15.3%
11.	Bangladesh	(Islam et al., 2021)	Community cross-sectional; 424 women (15–49 yrs), ≤6 months post-partum	35.2%
12.	Nepal	(Sharma & Kaphle, 2023)	Community cross-sectional; 263 post-partum women	30.0%
13.	Nepal	(Koirala S, 2022)	Hospital cross-sectional; 220 post-natal women (15–45 yrs)	32.7%
15.	Pakistan	(Shahmir et al., 2023)	Hospital prospective descriptive longitudinal; 105 women (15–49 yrs)	41.0%
16.	China	(Wang et al., 2017)	Systematic literature review; 30,665 women during pregnancy≤1 year postpartum	07.7%
17.	Vietnam	(Hoang et al., 2016)	Community prospective cohort; 1,276 women (<24 weeks)	35.4%
18.	Japan	(Maruyama et al., 2023)	Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)	13.4%
19.	Thailand	(Rosinnate et al., 2015)	Hospital cross-sectional; 230 women >18 yrs (32–40 weeks)	11.7%
20.	Myanmar	(Win Thuzar Aye et al., 2025)	Secondary cross-sectional analysis; 1,045 ever-pregnant women (18–49 yrs)	06.4%
21.	South Korea	(Lee et al., 2022)	Community cross-sectional; 5,953 pregnant women / mothers of young children	07.6%
23.	Jordan	(Abujilban et al., 2022)	Hospital cross-sectional; 223 antenatal women	30.0%
24.	Oman	(Al Shidhani et al., 2020)	Hospital prospective observational; 960 women (mean age 30.3 ± 5.4 yrs)	01.6 %
25.	Hong Kong	(Chen et al., 2022)	Clinic-based longitudinal; 340 women at 1st ANC visit (>18 yrs)	13.5%

In Sri Lanka, two key studies have reported the prevalence of IPV during pregnancy. Muzrif et al. (2018) found a lifetime prevalence of 38.6% and a current pregnancy prevalence of 15.9% among women from rural, urban, and tea-estate sectors (Muzrif et al., 2018). An earlier study by Moonesinghe et al. (2002) reported comparatively lower figures, with 18.3% lifetime and 4.7% current pregnancy prevalence among clinic-attending women aged 15–49 years (Moonesinghe et al., 2004b). When positioned within the broader Asian context, Sri Lanka's prevalence estimates are moderate relative to other countries in the region. They are lower than those reported in Bangladesh (35.2%), Pakistan (41.0%), and Vietnam (35.4%), but higher than the rates found in China (7.7%), South Korea (7.6%), Thailand (11.7%), Oman (1.6%), and Myanmar (6.4%). India exhibits a broad range (3.7% – 29.7%) across studies, with some estimates closely comparable to those of Sri Lanka.

For the pooled prevalence synthesis, 23 studies were included, comprising 52,072 pregnancies and 5,448 IPV events (Figure 2.2). Using a random-effects meta-analysis of proportions (logit scale), the overall pooled prevalence of IPV during the current pregnancy was 14.4% (95% CI 10.3–19.9). Between-study heterogeneity was extremely high (I^2 = 99.1%, τ^2 = 0.8856 on the logit scale; Q = 2357.19, df = 22, $p < 0.001$), indicating substantial variability in prevalence estimates across settings and study designs beyond chance. The prediction interval (2%–55%) suggests that the prevalence in a new, comparable Asian study could plausibly fall anywhere within this wide range (Figure 02). In subgroup analyses, the pooled prevalence was 8.8% (95% CI 3.6–19.9) for Sri Lanka and 15.1% (95% CI 10.6–21.2) for other Asian countries; however, the difference between subgroups was not statistically significant (p = 0.2449)

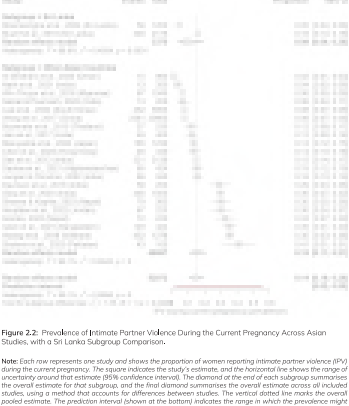


Figure 2.2: Prevalence of Intimate Partner Violence During the Current Pregnancy Across Asian Studies, with a Sri Lanka Subgroup Comparison.

Note: *Each row represents one study and shows the proportion of women reporting intimate partner violence (IPV) during the current pregnancy. The square indicates the study's estimate, and the horizontal line shows the range of uncertainty around that estimate (95% confidence interval). The diamond at the end of each subgroup summarises the overall estimate for that subgroup, and the final diamond summarises the overall estimate across all included studies, using a method that accounts for differences between studies. The vertical dotted line marks the overall pooled estimate. The prediction interval (shown at the bottom) indicates the range in which the prevalence might plausibly fall in a new, similar study conducted in the region. Studies*

2.2. Psychological Violence during Pregnancy

Psychological violence, encompassing verbal abuse, humiliation, intimidation, and controlling behaviours, emerged as a significant yet often under-recognised component of IPV during pregnancy (Senanayake, 2012b). The reported prevalence of psychological violence varies widely from 1.0% in a hospital-based outpatient study in India (Samal & Poornesh, 2022) to 65.0% in a community-based study in Bangladesh (Islam et al., 2021) (Table 2.2).

Table 2.2: Prevalence of Psychological Violence during Pregnancy among Women in Selected Asian Countries: Evidence from Hospital- and Community-Based Studies

	Country	Study	Methods	P
1.	India	(Jain et al., 2017)	Hospital prospective observational; 400 women (20–28 weeks)	12.3%
2.	India	(Samal & Poornesh, 2022)	OPD cross-sectional; 200 women at 1st antenatal visit	01.0%
3.	India	(Das et al., 2013)	Community cross-sectional; 2,139 women with identified births	08.0%
4.	Banglade sh	(Islam et al., 2021)	Community cross-sectional; 424 women (15-49 yrs), ≤6 months post-partum	65.0%
5.	Nepal	(Koirala S, 2022)	Hospital cross-sectional; 220 post-natal women (15–45 yrs)	30.9%
6.	Thailand	(Boonnate et al., 2015)	Hospital cross-sectional; 230 women >18 yrs (32–40 wks)	04.3%
7.	South Korea	(Lee et al., 2022)	Community cross-sectional; 5,953 pregnant womenMothers of young children	5.6%
8.	Saudi-Arabia	(Al Taifi et al., 2021)	Community cross-sectional; 1,330 pregnant women at any gestational age	25.9%

Note: *P indicates the percentage of women reporting psychological IPV during pregnancy, as defined in each original study. Estimates may not be directly comparable because studies differed in the operational definition of psychological violence, measurement instruments, recall period, timing of assessment (antenatal vs postnatal), and sampling frame (hospital/OPD vs community). OPD = outpatient department; wks = weeks; yrs = years.*

In South Asia, the burden of psychological violence appears particularly noticeable. The Bangladeshi study by Md Jahirul Islam et al. (2016) reported an exceptionally high prevalence (65.0%) among postpartum women, highlighting the pervasive nature of emotional abuse. Nepal's hospital-based study (Koirala S, 2022) also reported a high rate (30.9%) among postnatal women, while studies from India documented comparatively lower levels, ranging from 1.0% to 12.3%, depending on setting and gestational stage. In contrast, studies from East and West Asia reported generally lower prevalence rates. Psychological violence was reported at 4.3% in Thailand, 5.6% in South Korea, and 25.9% in Saudi Arabia. Although these figures are lower than those seen in South Asia, they nonetheless indicate that emotional abuse during pregnancy is a region-wide concern.

2.3. Physical Violence during Pregnancy

Physical violence represents one of the most visible and injurious forms of IPV during pregnancy, often resulting in direct harm to both the woman and her foetus (Senanayake, 2012b). As summarised in Table 2.3, the reported prevalence of physical violence during pregnancy across Asian studies ranges from 2.0% to 39.0%, indicating considerable variation across countries and study settings.

Table 2.3. Prevalence of Physical Violence during Pregnancy among Women in Selected Asian Countries: Evidence from Hospital- and Community-based Studies

	Country	Study	Methods	P
1.	Sri Lanka	Moonesinghe et al., 2004 (Moonesinghe et al., 2004b)	Clinic-based cross-sectional; 1,200 women (18–49 yrs)	04.7%
2.	India	Jain et al., 2017 (Jain et al., 2017)	Hospital prospective observational; 400 women (20–28 wks)	10.0%
3.	India	Samal and Poornesh, 2022 (Samal & Poornesh, 2022)	OPD cross-sectional; 200 women at 1st antenatal visit	2.0%
4.	India	Das et al., 2013 (Das et al., 2013)	Community cross-sectional; 2,139 women with identified births	12.0%
5.	Bangladesh	Ferdos & Rahman, 2017 (Ferdos & Rahman, 2017)	Hospital-based cross-sectional; 400 randomly selected women in postnatal wards	39.0%
6.	Nepal	Koirala, 2022 (Koirala S, 2022)	Hospital cross-sectional; 220 post-natal women (18–45 yrs)	28.6%
7.	Thailand	Boonnate et al., 2015 (Boonnate et al., 2015)	Hospital cross-sectional; 230 women >18 yrs (32–40 wks)	3.5%
8.	Saudi Arabia	Al Taifi et al. 2021 (Al Taifi et al., 2021)	Community-Based Cross-Sectional; 1,330 women at any gestational age	5.4%

Note: *P = Percentage of women reporting physical IPV during pregnancy, as defined in each original study. OPD = outpatient department; wks = weeks; yrs = years.*

The highest prevalence was reported in Bangladesh (39.0%), based on a hospital-based study among postpartum women (37), followed by Nepal (28.6%) (Koirala S, 2022). In contrast, comparatively lower rates were observed in Thailand (3.5%), Saudi Arabia (5.4%), and certain Indian studies (2.0%–12.0%). The Sri Lankan evidence revealed that approximately one in ten pregnant women experienced physical violence (Moonesinghe et al., 2004a), underscoring a substantial burden even within a context where such acts are socially condemned and often underreported. Studies from India demonstrate a wide range of estimates from 2.0% in outpatient antenatal settings (Samal & Poornesh, 2022) to 12.0% in community-based surveys (Das et al., 2013), suggesting that prevalence may be higher when data are collected outside clinical environments, where women might feel safer disclosing abuse. Despite these variations, physical violence remains a persistent and serious public health concern, contributing to maternal injuries, pregnancy complications, and adverse neonatal outcomes.

2.4. Sexual Violence during Pregnancy

Sexual violence, though often less frequently disclosed than other forms of IPV, represents one of the most severe violations of women's bodily autonomy during pregnancy (Senanayake, 2012b). As summarised in Table 2.4, the prevalence of sexual violence during pregnancy among Asian countries varies considerably, ranging from 0.5% to 26.3%.

Table 2.4: Prevalence of Sexual Violence during pregnancy in selected Asian settings

	Country	Study	Methods	P
1.	Sri Lanka	(Moonesinghe et al., 2004b)	Clinic-based cross-sectional; 1,200 women (15–49 yrs)	2.7%
2.	India	(Jain et al., 2017)	Hospital prospective observational; 400 women (20–28 weeks)	1.8%
3.	India	(Gomal & Poornesh, 2022)	OPD cross-sectional; 200 women at 1st antenatal visit	0.5%
4.	India	(Das et al., 2013)	Community cross-sectional; 2,139 women with identified births	2.2%
5.	Bangladesh	(Islam et al., 2021)	Community cross-sectional; 424 women (15–49 yrs), ≤6 months post-partum	18.5%
6.	Bangladesh	(Ferdos & Rahman, 2017)	Hospital-based cross-sectional; 400 randomly selected women in postnatal wards	26.3%
7.	Nepal	(Koirala S, 2022)	Hospital cross-sectional; 220 post-natal women (15–45 yrs)	22.7%
8.	Thailand	(Boonnate et al., 2015)	Hospital cross-sectional; 230 women >18 yrs (32–40 wks)	3.9%
9.	Saudi Arabia	(Al Taifi et al., 2021)	Community-Based Cross-Sectional; 1,330 women at any gestational age	13.5%

Note: *P indicates the percentage of women reporting sexual IPV during pregnancy, as defined in each original study (e.g., forced sex or sexual acts through coercion). OPD = outpatient department; wks = weeks; yrs = years.*

The highest levels were observed in Bangladesh, where community- and hospital-based studies reported prevalence rates of 18.5% (Islam et al., 2021) and 26.3% (Ferdos & Rahman, 2017). Similarly, a Nepalese study (Koirala S, 2022) documented a high prevalence of 22.7%, indicating that sexual violence during pregnancy is significant in the pockets of South Asia. In contrast, studies from India and Sri Lanka reported markedly lower prevalence rates, typically below 3%. In Sri Lanka, the only available study by Moonesinghe et al. (2021) recorded a 2.7% prevalence among clinic-attending women aged 15–49 years, while Indian estimates ranged between 0.5% and 2.0% across different study settings (Das et al., 2013; Jain et al., 2017; Samal & Poornesh, 2022). Thailand, representing Southeast Asia, reported a prevalence of 3.9%, which is somewhat higher than most Indian estimates but still considerably lower than the rates in Bangladesh and Nepal. In Sri Lanka, while available data suggest lower prevalence, cultural taboos and social silence around marital sexual coercion likely contribute to underestimation (Department of Census and Statistics, Sri Lanka, 2019).

2.5. Factors Associated with IPV

The factors associated with IPV during pregnancy identified across Asian studies demonstrate a multifaceted interplay between socio-demographic, economic, marital, behavioural, and psychosocial factors (Table 2.5). Although the strength and direction of these associations vary by setting, several common patterns emerge, with younger age, low education, and low socioeconomic status appearing as the most consistently reported correlates of IPV during pregnancy (Ma & zhang, 2025).

Evidence from Sri Lanka indicates that IPV is rooted in both structural and relationship-level vulnerabilities. Muzrif et al. (2018) observed that younger age, low educational attainment, low household income, and belonging to Muslim ethnic groups were associated with higher IPV risk. Moonesinghe et al. (2002) further emphasised that early marriage (below 19 years), limited education, low socioeconomic status, and patriarchal household dynamics such as husbands being the primary decision-makers significantly increased women's exposure to IPV. Additional risk factors included alcohol use by partners, poor sexual relationships, and nuclear family settings, highlighting the combined effects of economic strain and intimate relationship stressors.

Table 2.5: Factors Associated with IPV during Pregnancy in Selected Countries

Factor	Evidence (country, study, design)
Early marriage	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Maternal age – younger	Sri Lanka — Muzrif et al., 2018 [13]; Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Tafi et al., 2021 [35]; Community cross-sectional; 1,330 pregnant women (any gestational age)
Maternal age – older (Age >20)	India — Nath et al., 2021 [19]; Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Previous miscarriage/stillbirth	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Partner-related and behavioural factors	
Partner occupation	India — Nath et al., 2021 [19 (reported as: Husband semi-/skilled occupation (Empl); Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Partner education	Afghanistan/Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years)
Partner alcohol use	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years India — Samal and Poornesh, 2022 [22]; OPD cross-sectional; 200 women at the first antenatal visit Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Thailand — Boonnate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Partner substance use / addiction (alcohol/tobacco/smoking)	India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years)
Marital and psychosocial factors	
Nuclear family setting	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Unmarried status	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Low family support	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Husband decision-maker (patriarchal dynamics)	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Husband's prior marriage	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Poor sexual relationship	Sri Lanka — Maoneseinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Low autonomy in marriage decision	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Traditional male-gender role attitudes	India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years
Stress	Thailand — Boonnate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Lower marital satisfaction	Thailand — Boonnate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)

Factor	Evidence (country, study, design)
Early marriage	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years)
Maternal age – younger	Sri Lanka — Muzrif et al., 2018 [13]: Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) Japan — Maruyama et al., 2023 [29]: Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Talli et al., 2021 [35]: Community cross-sectional; 1,330 pregnant women (any gestational age)
Maternal age – older (Age >20)	India — Nath et al., 2021 [19]; Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Previous miscarriage/stillbirth	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Partner-related and behavioural factors	
Partner occupation	India — Nath et al., 2021 [19] (reported as: Husband semi-/skilled occupation (Emp)); Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Partner education	Afghanistan:Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years)
Partner alcohol use	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years) India — Jangari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years India — Samal and Poornesh, 2022 [22]; OPD cross-sectional; 200 women at the first antenatal visit Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Thailand — Boonnate et al., 2015 [30]: Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Partner substance use / addiction (alcohol/tobacco/smoking)	India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years)
Marital and psychosocial factors	
Nuclear family setting	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years)
Unmarried status	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Low family support	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Husband decision-maker (patriarchal dynamics)	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years)
Husband's prior marriage	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years)
Poor sexual relationship	Sri Lanka — Moonesinghe et al., 2004 [36]: Clinic-based cross-sectional; 1,200 women (15–49 years)
Low autonomy in marriage decision	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Traditional male gender role attitudes	India — Jangari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years
Stress	Thailand — Boonnate et al., 2015 [30]: Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Lower marital satisfaction	Thailand — Boonnate et al., 2015 [30]: Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)

Across the broader Asian region, the most consistently identified risk factors can be grouped into the following themes.

2.5.1. Socio-demographic and Economic Factors

Multiple studies identified low educational attainment, low income, and poor socioeconomic status as primary drivers of IPV during pregnancy (Dadras et al., 2021; Jain et al., 2017; Jungari & Chinchore, 2022; Samal & Poornesh, 2022). In several contexts, women's illiteracy or unemployment, coupled with husbands' low educational level, reinforced dependency and power imbalances that increased IPV vulnerability (Mooneesinghe et al., 2004a; Sharma & Kaphle, 2023). Several studies pointed to broader social and cultural determinants shaping IPV during pregnancy. Examples include religious or ethnic background (Muzrif et al., 2018), caste and gender hierarchy (Jungari & Chinchore, 2022), and son preference (Shahmir et al., 2023). The birth of female children was reported as a trigger for violence in Pakistan, highlighting persistent gender bias in some societies (Shahmir et al., 2023). Unwanted pregnancy, as noted in India, also emerged as a contextual vulnerability influencing IPV dynamics during pregnancy (Nath et al., 2021).

2.5.2. Reproductive and Biological Factors

Several studies noted that IPV risk varied with parity and age at pregnancy. In India and Sri Lanka, higher parity (multigravida or ≥2 pregnancies) and lower maternal age were associated with greater exposure to IPV (Mooneesinghe et al., 2004b; Nath et al., 2021). These patterns suggest that repeated pregnancies may heighten relational stress, especially in settings of financial hardship and limited social support. Early marriage and adolescent pregnancies were also linked with IPV in Sri Lanka (Mooneesinghe et al., 2004b), reflecting the vulnerability of younger women with reduced bargaining power within the household.

2.5.3. Partner-Related and Behavioural Factors

Partner behaviours, particularly alcohol and substance use, were among the most powerful and consistent predictors of IPV during pregnancy. Studies across India, Nepal, Pakistan, and Sri Lanka demonstrated that alcohol consumption, smoking, or substance abuse by partners significantly increased the likelihood of physical and psychological violence (Jain et al., 2017; Samal & Poornesh, 2022;

Shahmir et al., 2023; Sharma & Kaphle, 2023). Substance use often coexisted with controlling behaviour, jealousy, and financial stress, amplifying emotional and physical abuse within intimate relationships (Department of Census and Statistics, Sri Lanka, 2019).

2.5.4. Marital and Psychosocial Factors

Poor relationship quality, marital dissatisfaction, and lack of family support were repeatedly reported as risk factors (Boonnate et al., 2015; Sharma & Kaphle, 2023). Studies from South Asia underscored the role of patriarchal gender norms, including male dominance in decision-making and acceptance of violence as underlying psychosocial determinants (Asefa et al., 2024; Jungari & Chinchore, 2022). Controlling behaviour, stress, and limited communication between partners were also frequently associated with IPV, underscoring the importance of relational dynamics beyond structural deprivation.

2.6. Pregnancy Outcomes among Women Experiencing IPV

IPV during pregnancy is consistently linked with a wide spectrum of adverse outcomes for both the mother and child (Table 2.6). The reviewed studies reveal that IPV compromises foetal growth, pregnancy continuity, and maternal well-being through multiple biological and psychosocial mechanisms, including chronic stress, reduced antenatal care utilisation, and direct physical trauma.

2.6.1. Loss of Pregnancy

Pregnancy loss represents one of the most devastating consequences of IPV during pregnancy. Studies from India, Nepal, Vietnam, and Afghanistan/Iran consistently reported miscarriage, abortion, and stillbirth as major outcomes linked with physical violence and chronic stress exposure (Dadras et al., 2021; Hoang et al., 2016; Koirala S, 2022; Samal & Poornesh, 2022). In Nepal and Afghanistan/Iran, stillbirths were particularly notable, recorded at 2.8% and 7.5%, respectively (Dadras et al., 2021; Koirala S, 2022). Miscarriage and spontaneous abortion were reported in 13.2% of Vietnamese women (Hoang et al., 2016) and 35% of Nepali participants (Koirala S, 2022), while Indian studies (Samal & Poornesh, 2022) highlighted increased rates of pregnancy loss among those abused during the index pregnancy.

2.6.2. Foetal and Neonatal Outcomes

Low birth weight (LBW) and preterm birth (PTB) emerged as the most commonly reported outcomes among women exposed to IPV during pregnancy. Studies from India, Nepal, Bangladesh, and Saudi Arabia demonstrated strong associations between IPV and LBW infants, ranging from 2.4% in Vietnam (Hoang et al., 2016) to 69.5% in Bangladesh (Ferdos & Rahman, 2017). Similarly, preterm birth was reported in several studies, with rates between 2.7% in Vietnam (Hoang et al., 2016) and 63.8% in Pakistan (Shahmir et al., 2023). The combination of physical trauma, maternal stress, and inadequate antenatal nutrition or rest likely contributes to these outcomes.

2.6.3. Maternal Health and Clinical Complications

Several studies identified direct maternal morbidities linked with IPV exposure. Frequently reported maternal complications included hypertensive disorders of pregnancy, such as gestational hypertension (15.1%) and pregnancy-induced hypertension (Saud et al., 2024), and gestational diabetes (13.2%) (Dadras et al., 2021). The chronic physiological stress of abuse, coupled with poor antenatal attendance and nutritional deprivation, may explain these metabolic and haematological imbalances. IPV was also linked to maternal illness during the index pregnancy, as noted in the Indian study

by Samal et al. (2016). Anaemia was reported to affect 71.4% of women in Pakistan (Shahmir et al., 2023).

Exposure to IPV was associated with an array of obstetric complications. Antepartum haemorrhage (APH) and placental abruption were documented in Pakistan and India (Devineni et al., 2018; Shahmir et al., 2023), while pre-labour rupture of membranes (PROM) and intrapartum haemorrhage were reported in Afghanistan/Iran (Dadras et al., 2021). The same study also found gynaecological infections among nearly 40% of abused women, suggesting a link between sexual coercion, poor hygiene, and genital trauma. Obstetric complications in general were observed in over 44% of Bangladeshi participants, with 79% experiencing pregnancy-related complications (Ferdos & Rahman, 2017).

2.6.4. Psychological and Behavioural Outcomes

In addition to physiological effects, IPV has pronounced psychological consequences during pregnancy. The Indian study by Jain et al. (2017) reported clinical depression in 46.3% of pregnant women experiencing IPV (Jain et al., 2017), confirming the strong mental health impact of sustained abuse. Emotional distress, anxiety, and antenatal depression were also noted in many South Asian studies (Senanayake, 2012b), where cumulative psychological stress likely mediates many of the adverse pregnancy outcomes observed.

Factor	Evidence (country, study, design)
Socio-demographic and economic factors	
Lower education	Sri Lanka — Muzrif et al, 2018 [13]; Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 560 women who gave birth in the last 2 years India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) India — Samal and Poornesh, 2022 [22]; OPD cross-sectional; 200 women at the first antenatal visit Afghanistan/Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years) Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years) Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Taifi et al., 2021 [35]; Community cross-sectional; 1,330 pregnant women (any gestational age)
Lower income	Sri Lanka — Muzrif et al., 2018 [13]; Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 560 women who gave birth in the last 2 years India — Samal and Poornesh, 2022 [22]; OPD cross-sectional; 200 women at the first antenatal visit Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Taifi et al., 2021 [35]; Community cross-sectional; 1,330 pregnant women (any gestational age)
Lower socioeconomic status	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 560 women who gave birth in the last 2 years India — Nath et al., 2021 [19]; Hospital cross-sectional; 350 women (>18 years; <24 weeks) India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years)
Women's employment status / unemployment	Afghanistan/Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years) Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years) Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Ethnicity / caste	Sri Lanka — Muzrif et al., 2018 [13] (reported as: Muslim ethnicity (Cls)); Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 560 women who gave birth in the last 2 years.
Birth of a girl child	Pakistan — Shahmir et al., 2023 [16] (reported as: Gave birth to girls (Cls)); Hospital prospective descriptive longitudinal; 105 women (15–49 years)
Reproductive and biological factors	
Higher parity / multigravida	India — Nath et al., 2021 [19]; Hospital cross-sectional; 350 women (>18 years; <24 weeks) India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) Afghanistan/Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years) Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Taifi et al., 2021 [35]; Community cross-sectional; 1,330 pregnant women (any gestational age)

Factor	Evidence (country, study, design)
Early marriage	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Maternal age – younger	Sri Lanka — Muzrif et al., 2018 [13]; Clinic-based cross-sectional; 1,375 rural/urban and 800 tea-estate women (6–40 weeks) Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks) Saudi Arabia — Al Taifi et al., 2021 [25]; Community cross-sectional; 1,330 pregnant women (any gestational age)
Maternal age – older (Age >20)	India — Nath et al., 2021 [19]; Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Previous miscarriage/stillbirth	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Partner-related and behavioural factors	
Partner occupation	India — Nath et al., 2021 [19] (reported as: Husband semi-/skilled occupation (Empl); Hospital cross-sectional; 350 women (>18 years; <24 weeks)
Partner education	Afghanistan/Iran — Dadras et al., 2021 [24]; Community cross-sectional; 424 women (18–44 years)
Partner alcohol use	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years) India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years India — Samal and Poornesh, 2022 [22]; OPD cross-sectional; 200 women at the first antenatal visit Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Thailand — Boonrate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Partner substance use / addiction (alcohol/tobacco/smoking)	India — Jain et al., 2017 [20]; Hospital prospective observational; 400 women (20–28 weeks) Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women Pakistan — Shahmir et al., 2023 [16]; Hospital prospective descriptive longitudinal; 105 women (15–49 years)
Marital and psychosocial factors	
Nuclear family setting	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Unmarried status	Japan — Maruyama et al., 2023 [29]; Secondary analysis of cross-sectional data; 1,230 women (>34 weeks)
Low family support	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Husband decision-maker (patriarchal dynamics)	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Husband's prior marriage	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Poor sexual relationship	Sri Lanka — Moonesinghe et al., 2004 [36]; Clinic-based cross-sectional; 1,200 women (15–49 years)
Low autonomy in marriage decision	Nepal — Sharma and Kaphle, 2023 [25]; Community cross-sectional; 263 postpartum women
Traditional male gender role attitudes	India — Jungari and Chinchore, 2022 [18]; Community cross-sectional; 550 women who gave birth in the last 2 years
Stress	Thailand — Boonrate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)
Lower marital satisfaction	Thailand — Boonrate et al., 2015 [30]; Hospital cross-sectional; 230 women (>18 years; 32–40 weeks)

3. MATERIAL AND METHODS

This report compiles findings from the qualitative component of an ongoing exploratory, sequential, mixed-methods study conducted in the Nuwara Eliya District, Sri Lanka. The qualitative inquiry was designed to generate an in-depth, case-based understanding of how IPV is experienced during pregnancy and the postpartum period, and how these experiences shape maternal health pathways, particularly engagement with ANC. An interpretivist epistemological position guided the study (Crotty, 1998), recognising women's accounts as situated, meaning-making narratives shaped by social relationships, structural constraints, and interactions with the health system. Data were analysed using inductive thematic analysis with free/open coding, enabling pattern identification across cases while retaining contextual detail.

3.1. 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(FHB, 2023). Formal referral and support services for gender-based violence include Mithuru Piyasa/Natpu Nilayam service points and a 24/7 hotline and referral network(FHB, 2020). The district context is also characterised by estate/non-estate settlement patterns, constrained household resources, language diversity, and structural barriers (UNDP, 2023) that may influence both IPV dynamics and access to care (DCS, 2020).

3.2. Participants and sampling

Fifteen case-study interviews were conducted with pregnant and postpartum women who disclosed IPV during their most recent pregnancy. Participants were purposively selected to capture diversity in lived experience, including estate and non-estate settings, different perinatal stages, varying forms/severity of IPV, and different living arrangements. Recruitment was conducted among pregnant women who received services from The Family Planning Association of Sri Lanka and its partners. Recruitment and consent procedures were implemented with safety considerations, including private approaches and careful scheduling to reduce the risk of partner or family surveillance. The sample size was determined based on the study's aim of producing rich, information-dense case narratives rather than statistical representation. The team prioritised depth of experience and breadth of pathways (home, community, ANC/PNC, hospital, and legal responses), and continued sampling until adequate meaning saturation and analytic coherence across the dataset were achieved.

3.3. Data collection

Data were collected through individual in-depth interviews guided by an open-ended interview framework. Interviews were conducted in a case-narrative style, enabling participants to describe the progression of pregnancy, relationship dynamics, violence patterns, care-seeking decisions, and disclosure/help-seeking experiences across time. Interviews took place in confidential locations suggested by participants to support privacy and comfort. To promote safety and minimise social risk, interview procedures avoided the use of identifying markings in maternal records and emphasised voluntary participation and the right to withdraw at any stage. A trained, MBBS-qualified female interviewer conducted all interviews. She had prior training in GBV-related services and had no prior relationship with the participants. The interviewer adopted a non-judgmental approach, used sensitive inquiry techniques, and reinforced confidentiality throughout the interview process. Given the sensitive nature of IPV disclosure, ethical safeguards included monitoring distress and providing information on available referral pathways when participants expressed a need for support. These safeguards were aligned with first-line response principles and the district's GBV service linkages (FHB, 2020).

3.4. Data Analysis

With consent, interviews were audio-recorded and transcribed verbatim. Transcripts were de-identified by removing names, locations, and other potentially identifying details. Digital files were stored securely with access restricted to the research team. Data analysis followed an inductive thematic analysis process (Braun & Clarke, 2006) supported by NVivo (version 15.3). First, transcripts were read repeatedly for familiarisation and case-level understanding. Second, free/open coding was conducted to capture participants' descriptions of violence, coercive control, drivers and sustaining conditions, economic restriction, ANC/PNC barriers, concealment/disclosure strategies, and physical/psychological impacts. Third, the initial code list was reviewed and consolidated into a structured codebook, with code definitions refined using constant comparison across cases. Fourth, candidate themes were developed by grouping conceptually related codes and examining how they worked together to explain the relationship between perinatal IPV and maternal health pathways. NVivo outputs such as word trees, cluster analysis (e.g., Jaccard similarity), and project maps were generated as supporting analytic visuals to help explore patterning, co-occurrence, and conceptual relationships. These outputs were used to stimulate

analytic reflection and to validate the internal structure, but the themes were ultimately grounded in transcript data and interpretive coding rather than in automated output alone.

3.5. Ethical Considerations

Given the sensitive nature of intimate partner violence during pregnancy, careful attention was given to the ethical conduct of the study in order to protect the rights, safety, privacy, and dignity of all participants. Ethical safeguards were integrated throughout the research process, from recruitment and informed consent to data collection, referral, storage, and reporting. The study recognised that discussing experiences of violence could evoke emotional distress and, in some situations, could increase the risk of harm if participation or disclosure became known to a perpetrator. Accordingly, the study was designed to minimise social and emotional risk while ensuring that participants had access to appropriate information, support, and referral options.

To reduce the possibility of drawing attention to gender-based violence, the survey was conducted under the safe title 'Well-being during Pregnancy and Pregnancy Outcomes'. Interviews were arranged on a one-to-one basis in private settings, and where family members, partners, or other persons were present, the interview was postponed or relocated to ensure privacy and safety. No identifying remarks were made on antenatal records, and all interview materials were managed in ways that protected participants from being linked to IPV disclosure. Participants were informed that their involvement was entirely voluntary and that they could decline to answer any question or withdraw from the study at any stage without any penalty or effect on the services available to them.

Informed consent procedures were implemented in participants' preferred language, namely Sinhala, Tamil, or English. Participants were provided with an information sheet explaining the purpose of the study, procedures, potential benefits and risks, confidentiality protections, and their rights as research participants. Adequate time was given for questions and clarification before written consent was obtained. For participants who were unable to read or write, the information was explained verbally in their spoken language, and consent was documented using a thumbprint. To further protect confidentiality, consent forms were maintained separately from study data and were not cross-referenced with interview records.

Confidentiality and data security were maintained throughout the study. Personal names and direct identifiers were not recorded in the research dataset. Interviews were conducted in confidence, and research personnel were trained on ethical conduct, privacy protection, and the management of sensitive disclosures. Hard-copy materials were kept under lock and key, while digital files were password-protected and encrypted, with access restricted to the research team. Audio recordings and transcripts were de-identified prior to analysis,

and raw data were retained only for the period necessary for analysis and report preparation, after which they were scheduled for secure disposal. Because participants might experience distress or require assistance during or after the interview, referral and support mechanisms were built into the study. Field personnel received training on risk assessment, emotional first-line support, and the WHO LIVES approach. Participants were provided with contact details for relevant support services, including Mithuru Piyasa/Natpu Nilayam services, the national hotline, and FPA Suwasewa.

4. RESULTS

This section presents the findings of the qualitative inquiry conducted among pregnant and postpartum women in the Nuwara Eliya District, Sri Lanka, who disclosed experiences of intimate partner violence during their most recent pregnancy. The findings are organised around the major themes that emerged from the inductive thematic analysis and illustrate how violence was experienced, sustained, and navigated during the perinatal period, as well as its implications for maternal health, disclosure, and help-seeking pathways.

4.1. 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 4.1).

Table 4.1: Socio-demographic Profile of the 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; OL= GCE Ordinary Level, A/L= GCE Advance Level

[1] 1. Never married, 2. Currently Married – First Marriage, 3.Currently Married – Remarried (second or later marriage), 4. Divorced or Separated, 5. Widowed
[2] Number of pregnancies before this pregnancy

Figure 4.1 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 included sexual violence in addition to physical and psychological abuse. Economic abuse was reported less frequently 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 the analytic framing of IPV as a spectrum of coercive control rather than a single-event exposure.

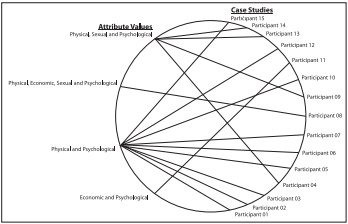


Figure 4.1: Distribution and Co-Occurrence of Violence Types Across Participants (NVivo group query).

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.*

4.2. Thematic structure of perinatal IPV experiences and responses

Inductive thematic analysis resulted in four themes. Figure 4.2 presents a conceptual map summarising how the four themes relate to each other across the perinatal period. The model positions women's experience of perinatal IPV as a spectrum of coercive control (Theme 01), which includes physical, sexual, emotional, and economic abuse, alongside restrictions that undermine safety, autonomy, and access to antenatal care. These experiences are shown as being triggered and sustained by a household ecosystem (Theme 02), characterised by alcohol use, in-law influence, jealousy, and conflict linked to pregnancy-related role expectations. Women's responses are represented through selective disclosure and help-seeking navigation (Theme 03), in which silence, concealment, reliance on trusted PHMs, religious coping, temporary separation, and engagement with hospitals or legal systems serve as strategic safety actions rather than linear pathways. The map also illustrates how ongoing exposure to IPV contributes to maternal well-being and functional impacts (Theme 04), including psychological distress, disrupted sleep and appetite, and health crises requiring clinical attention. This conceptual overview provides the interpretive structure for the four themes presented below.

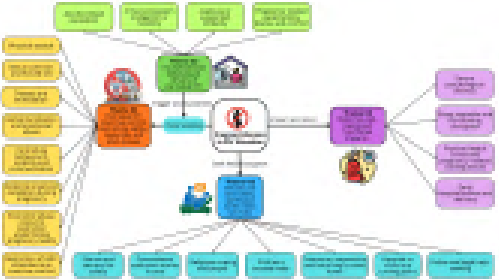


Figure 4.2: Conceptual overview of thematic findings linking perinatal IPV, sustaining household drivers, help-seeking pathways, and maternal well-being impacts

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*

Theme 1: Perinatal IPV as a spectrum of abuse and coercive control restricting 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 requiring care, rest, and consistent maternal health follow-up.

Yet, for many women, it marked a tightening of control rather than protection. . Instead of reducing violence, pregnancy often intensified surveillance and conflict, positioning the perinatal period as a time when both bodily vulnerability and dependence on the household increased.

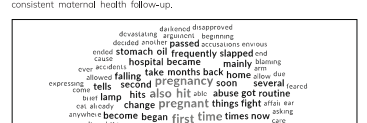


Figure 4.3: Word cloud illustrating perinatal IPV experiences and coercive control during pregnancy.

Note: *The word cloud is generated from NVivo text-query outputs within Theme 01-coded data. Larger words indicate higher frequency of appearance in participant narratives, highlighting how pregnancy-related terms co-occurred with descriptions of physical violence, control, and restrictions affecting safety and maternal care access.*

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 ongoing 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."

> "Just a few days ago, he started hitting me again and even tried to hit my stomach. I protected it because of the baby, but that made him even more aggressive. I slipped and fell down."
>
> **RESPONDENT:**
> **Case 08, Age 36 years, Non-estate**

Sexual coercion during pregnancy was described as forced compliance within a climate of fear and power imbalance. Women articulated that refusal was often 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 through pregnancy needs; food, transport, medicines, and clinic-related costs became sites where control was exercised through 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 relationship power rather than maternal need.

> "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. But even then, they didn't take me to the hospital or allow me to go."
>
> **RESPONDENT:**
> **Case 08, Age 36 years, Non-estate**

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 (Figure 4.4).

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.

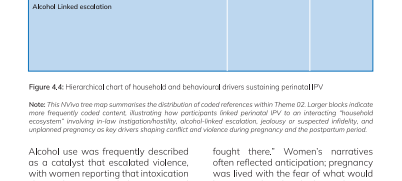


Figure 4.4: Hierarchical chart of household and behavioural drivers sustaining perinatal IPV

Note: This NVivo tree map summarises the distribution of coded references within Theme 02. Larger blocks indicate more frequently coded content, illustrating how participants linked perinatal IPV to an interacting "household ecosystem" involving in-law instigation/hostility, alcohol-linked escalation, jealousy or suspected infidelity, and unplanned pregnancy as key drivers shaping conflict and violence 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

> His sisters have a problem with me. They tell things to my husband about me, and after that the problems started. After three months of marriage, he started to drink more than before. Every time he drinks, he shouts at me, saying that I don't have money
>
> **RESPONDENT:**
> **Case 07, Age 41 years, Estate**

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 her husband always asks, "You didn't answer my phone; were you with another man? Were you pregnant by him? This shows that 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, so I didn't get paid. They told me to come back only after I gave birth. Then, my sister's husband spoke to my husband about it, but he 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 did not signify acceptance, but survival. Pregnancy was managed alongside fear, and speaking openly was perceived as risky in contexts where 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

> "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."

RESPONDENT:
Case 07, Age 41 years, Estate

> If I go to the hospital, there will be a problem. So I go to a private hospital, and if they ask, I tell them that I fell.
>
> **RESPONDENT:**
> **Case 13, Age 33 years, Estate**

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.

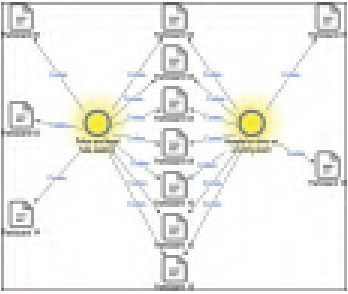


Figure 05. Case-level map showing hospital/clinic encounters and police/legal pathways as key help-seeking nodes within selective disclosure processes

Note: *This NVivo project map visualises how coded references to hospital/clinic as a turning point and police/legal help-seeking were distributed across participant case studies. The links indicate which participants' narratives contributed to each help-seeking pathway, demonstrating that both formal routes were typically described as escalation-driven responses; often activated when violence became severe, visible, or medically urgent rather than routine or early-stage disclosure.*

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

Women's narratives highlighted that IPV during pregnancy was carried in the body and mind, disrupting sleep, appetite, emotional stability, and everyday functioning. Rather than being a period of protection and anticipation, pregnancy and early postpartum were described as periods of survival under 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.

> "Yes, I sometimes don't eat, I don't feel like eating and I find it hard to do daily activities. I just keep thinking about these things.
>
> **RESPONDENT: Case 11, Age 28 years, Estate**"

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 produced by the experience 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 eating, and reduced 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 activity: "I sometimes don't eat... and I find it hard to do daily activities. I just keep thinking about these things." These accounts emphasise 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 linked to 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 health deterioration. One participant linked pregnancy complications to the broader context of distress and instability: "I got pressure during that pregnancy, so I had to get admitted early for the delivery." Such accounts show 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 in late pregnancy.

> "I have even fainted thinking about this, as I couldn't eat properly. I did get admitted after that but no one ever came to see me or take care of me"
>
> **RESPONDENT:**
> **Case 10, Age 20 years, Non-Estate**



Figure 4.6: NVivo word tree illustrating how suicidal thoughts were narrated within experiences of severe psychological distress during pregnancy

Note: *This word tree was generated from an NVivo text search query for "suicide" within Theme 04-coded data. The branching structure shows the surrounding phrases used by participants when describing overwhelming distress, including thoughts of self-harm and the protective role of children and family support in shaping coping and continued survival, highlighting the depth of psychological burden associated with perinatal IPV.*

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 specifically during the perinatal period, with particular attention to maternal health pathways. Rather than presenting violence as isolated incidents, women's narratives showed 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 services.

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, controlling of mobility/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 the 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 (dependence, health needs, mobility constraints) can be used to tighten control and isolate women at the very time they require additional care and support.

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 internal household protection during pregnancy. Jealousy and suspected unfaithfulness also featured as recurring drivers, sometimes intensifying controlling 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 node. 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 produces protection. Even when healthcare providers noticed harm 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 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 forward. 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 was shaped by ambivalence and constraint. Women described weighing the possibility of protection against the risks of escalation, stigma, or community exposure. This indicates that formal services may be perceived as high-stakes interventions rather than routine sources of support, particularly within rural/estate contexts where fears of social repercussions were acute and alternatives for safe housing or financial security were limited.

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 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 mental health support integrated 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.

Despite Sri Lanka's recognised maternal health achievements, research on IPV during pregnancy remains sparse and largely overlooked in the national reproductive health agenda. Available studies, such as Senanayake (2011) and Maoneesinghe & Barradough (2018), highlight the existence and implications of IPV among pregnant women, yet comprehensive prevalence data at national and subnational levels remain limited. Much of the existing literature is concentrated in small-scale, hospital-based, or regional studies (e.g., in the Badulla district or plantation sector settings), which lack representativeness across diverse ethnic, geographical, and socio-economic contexts. Moreover, these studies often focus on physical violence, with less attention to

emotional, sexual, and controlling behaviours, and rarely explore the intersecting vulnerabilities of marginalised populations such as adolescents, disabled women, or estate-sector workers (Senanayake, 2012b). Furthermore, limited research has been conducted on the longitudinal impact of IPV on maternal and neonatal outcomes in Sri Lanka, and the voices of pregnant women themselves regarding their help-seeking behaviours, coping mechanisms, and barriers to care are underrepresented. This evidentiary gap restricts the formulation of context-specific interventions and undermines the integration of IPV screening within maternal health programmes.

Sri Lanka's policy framework increasingly embeds IPV response within maternal health services. The National Guidance for first-contact providers supports IPV enquiry in antenatal and postnatal care settings where privacy and referral mechanisms are in place, including use of the four-item HITS tool, while the accompanying SOPs direct PHMs to conduct sensitive enquiry, provide first-line support (L.N.V.E.S.), and refer survivors to dedicated services such as Mithuru Piyasa/Natpu Nilayam, with follow-up through routine field systems (FHB, 2011, 2019, 2020). However, recent evidence from the World Bank–supported GBV costing study (2025) suggests an implementation gap: IPV during pregnancy may remain under-identified and inconsistently managed due to limited practical capacity, variable uptake of protocols, and missed opportunities to integrate IPV assessment across ANC/PNC contacts, including postnatal and immunisation settings. These gaps are further compounded by low awareness and limited usability of the 24/7 helpline, resulting in delayed identification, fragmented referral pathways, and uneven access to specialised support (FPA Sri Lanka & World Bank Group, 2025).

These findings should be interpreted in light of several limitations. The sample is small and context-specific, and the study captures women's accounts rather than the perspectives of partners, family members, or service providers. In addition, as a qualitative component nested within a broader mixed-methods programme, the analysis prioritises depth and interpretive insight over statistical generalisability. Nevertheless, the patterns documented here offer important transferable lessons for perinatal care systems in similar rural and estate-sector contexts where women may face intersecting vulnerabilities and constrained support options.

5. CONCLUSIONS & RECOMMENDATIONS

5.1. Conclusions

The literature reviewed in this report shows that intimate partner violence during pregnancy is a significant maternal health and public health concern across Asia, including Sri Lanka. The evidence indicates that IPV during pregnancy occurs in multiple forms, including physical, psychological, and sexual violence, and is associated with important socio-economic, behavioural, and relational risk factors such as low education, low income, younger age, early marriage, patriarchal decision-making, poor relationship quality, and partner alcohol use. The review also demonstrates that IPV during pregnancy is linked with serious maternal and pregnancy-related consequences, including psychological distress, miscarriage, preterm birth, low birth weight, and other maternal complications.

Within this broader evidence base, the present qualitative inquiry provides an important context-specific understanding of how perinatal IPV is experienced in the Nuwara Eliya District. The findings show that IPV during pregnancy and the postpartum period is not experienced as a series of isolated incidents, but rather as a spectrum of coercive control. Women described overlapping physical, sexual, emotional, and economic abuse, together with mobility restrictions, surveillance, threats, and denial of essential resources. A particularly important finding is that antenatal care itself became part of this control, with some women being prevented from attending clinics independently or needing permission and supervision to access maternal health services.

The study further demonstrates that women's experiences of IPV were shaped by a wider household and social environment. Alcohol use, in-law hostility, jealousy or suspicion, and pregnancy-related role expectations emerged as important drivers that triggered or intensified violence. These findings are consistent with the literature review, which identified partner alcohol use, poor family support, low autonomy, and patriarchal relationship dynamics as recurrent factors associated with IPV during pregnancy in Sri Lanka and other Asian settings.

Another important conclusion is that disclosure and help-seeking during pregnancy were highly strategic rather than straightforward. Women often chose silence, concealment, or partial disclosure in order to avoid escalation, social stigma, or further surveillance. In this context, the Public Health Midwife emerged as a particularly trusted and potentially protective figure within the maternal care pathway. Hospitals and police or legal services were more often approached only when violence became acute, medically urgent, or otherwise unmanageable. This suggests that service contact alone is insufficient; protection depends on whether women can disclose safely, in

private, and within a system that can respond confidentially and effectively. The findings also confirm that perinatal IPV has substantial consequences for maternal well-being. Women described disrupted sleep, reduced appetite, emotional strain, poor daily functioning, and pregnancy-related health crises occurring within a context of fear and instability. Taken together with the literature review, these findings reinforce that IPV during pregnancy should not be treated as only a social or family issue. It is also a maternal health issue that can disrupt continuity of care, undermine maternal nutrition and rest, intensify emotional distress, and threaten pregnancy safety.

Overall, this report concludes that perinatal IPV in the Nuwara Eliya District is shaped by the intersection of gender inequality, household power relations, economic vulnerability, and service access constraints. Although Sri Lanka has policy provisions and service structures that support IPV enquiry and referral within maternal health services, the report findings suggest that important implementation gaps remain. Strengthening confidential, survivor-centred, and practically usable responses within routine maternal healthcare is therefore essential, particularly in rural and estate-sector settings where women may face layered structural disadvantage.

5.2. Recommendations

1) Strengthen confidential IPV screening within routine ANC and PNC contacts - Antenatal and postnatal care contacts should be used more deliberately as protection-sensitive entry points for identifying and responding to IPV during pregnancy. In practical terms, this means ensuring that women are given safe opportunities to speak alone during selected ANC, PNC, and postpartum follow-up contacts, rather than only in the presence of partners or family members. Privacy should be treated as a core service requirement for IPV-sensitive maternal care, especially because the findings showed that disclosure was often constrained by surveillance and fear of escalation.

2) Strengthen the role of Public Health Midwives in first-line IPV response - Given the repeated importance of PHMs in women's narratives, PHMs should be further supported as frontline responders for perinatal IPV. This support should go beyond general awareness and include practical training on safe enquiry, recognition of coercive control, first-line emotional support, immediate safety assessment, confidential documentation, and referral follow-up. Refresher training and supportive supervision should be prioritised in districts such as Nuwara Eliya, where structural vulnerability and access barriers are greater.

3) Establish clearer district-level referral pathways linking maternal health and GBV services - The report findings suggest that hospitals, police/legal services, and Mithuru Piyasa/Natpu Nilayam services often

function as disconnected or crisis-driven response points rather than as a coordinated pathway. A district-level referral protocol should therefore be developed or strengthened in Nuwara Eliya to clarify who does what when IPV is identified during pregnancy, including referral criteria, emergency contacts, feedback loops, and follow-up responsibilities. This should include stronger coordination between hospital maternity units, field maternal health services, GBV support services, and social protection actors.

4) Tailor service responses to estate-sector and Tamil-speaking communities in Nuwara Eliya - As the study setting includes estate-sector populations facing poverty, service constraints, and linguistic as well as structural barriers, district responses should be adapted to this context. IPV-related information, first-line support, and referral communication should be consistently available in Tamil as well as Sinhala, and outreach strategies should be designed to reach women in estate communities who may face greater isolation and reduced mobility. Strengthening access in plantation and rural areas is especially important given the district's documented structural vulnerabilities and the predominance of estate-sector women in the qualitative sample.

5) Improve safe dissemination of information on support services - The discussion highlights that formal services and helplines may be underused or approached only at points of crisis. Information on available support services, including Mithuru Piyasa/Natpu Nilayam, hospital-based services, and helplines, should therefore be shared more effectively through discreet and safe channels. In practice, this may include low-visibility IEC materials, confidential provider-to-client communication during private consultations, and careful reinforcement during PHM follow-up, rather than approaches that could expose women to further risk within the household.

6) Expand Sri Lankan research on perinatal IPV beyond physical violence and facility-based samples - The literature review and discussion both indicate important evidence gaps in Sri Lanka. Future research should therefore generate broader and more representative evidence on IPV during pregnancy, including emotional abuse, sexual coercion, and controlling behaviour, rather than focusing predominantly on physical violence. There is also a need for more district-level and community-based follow-up studies, including research among estate-sector and otherwise marginalised populations to identify outcome of IPV during pregnancy in the Sri Lankan context.

7) Incorporate IPV during pregnancy more explicitly into district and national maternal health planning - Given the weight of evidence presented in both the literature review and the qualitative findings, IPV during pregnancy should be treated more explicitly within maternal health planning, implementation, and monitoring. District maternal and reproductive health programmes should incorporate practical indicators

related to screening, referral uptake, and service readiness for IPV response. At policy level, greater emphasis should be placed on translating existing national guidance into routine, monitored practice within ANC, PNC, postnatal, and related maternal-child health contacts.

Author Contribution

MSS conceptualized the literature review, conducted the synthesis and meta-analysis, and drafted the manuscript. PK conducted the literature search, screening, and data charting. LS led the overall study, formulated recommendations, and critically reviewed the manuscript. JD, CB, AD, PS and CR contributed to conceptualize the research design, interpretation and critical review. All authors approved the final manuscript.

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.

Conflict of Interest

The authors declare that there are no conflicts of interest.

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 23rd April 2025. The official approval letter was issued on 25th April 2025.

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Annexure 01: Information Sheets

Well-being during Pregnancy and Pregnancy Outcomes:
A Prospective Cohort Study in the Nuwara Eliya District, Sri Lanka
Information Sheet for Pregnant Women

Dear Participants,

I am ..... [Write your name], the Public Health Midwife (PHM) assigned to your area. In addition to my routine duties, I am working as a Field Research Officer for a research study titled "Well-being during Pregnancy and Pregnancy Outcomes: A Prospective Cohort Study in Nuwara Eliya District, Sri Lanka", conducted by The Family Planning Association of Sri Lanka.

This research is led by a team of experts, including:

- **Dr. Lakshman Senanayake,**
  Consultant Obstetrician & Gynecologist
- **Mr. M. Suchira Suranga,**
  Director, The Family Planning Association of Sri Lanka
- **Dr. Chinthaka Banagala,**
  Senior Lecturer in Obstetrics and Gynecology, Kotelawala Defence University
- **Dr. Achintha Dissanayake,**
  Senior Lecturer in Obstetrics and Gynecology, Kotelawala Defence University
- **Mr. Janaranga Dewasurendra,**
  Assistant Director (M&E), The Family Planning Association of Sri Lanka

It is a pleasure to inform you that you have been selected as a participant in this study. The study aims to explore well-being during pregnancy, including intimate partner violence (IPV), and its association with pregnancy outcomes. If you agree to participate, you will be invited to take part in a series of interviews with me during next few months. There will be three interviews conducted at different stages of your pregnancy and one interview after the delivery. These interviews will be conducted in a private and confidential setting. No personal identifying information will be linked to your responses.

During each interview, which will last about 30 minutes, I will ask questions and record your answers. You may decline to answer any questions that make you uncomfortable. Participation for this study is completely voluntary, and you can withdraw your consent at any time without any loss of benefits or services. If you choose to withdraw, your responses will not be included in the study. The

information you provide will be treated with the highest level of confidentiality and will only be used for research purposes. The information you provide will be handled with the utmost confidentiality and used solely for research purposes. Findings will be reported in aggregate form, ensuring that no individual or identifying details are disclosed.

You are welcome to ask questions about the study at any time. Participating in this study does not involve any major risks or hazards and the care you receive will not be jeopardized for any reason. However, if you experience any inconvenience or discomfort during the interviews, please inform me immediately and we will stop the interview.

This study adheres to strict ethical standards for social and health research, recognized nationally and internationally. It has been reviewed and approved by the Ethical Review Committee of the Faculty of Medicine, Kothalawala Defence University, Sri Lanka.

If you have any further questions or concerns, you may contact:

- **Dr. Lakshman Senanayake, Tel:** 777 730688
  Consultant Obstetrician & Gynecologist
- **Mr. M. Suchira Suranga, Tel:** 0772 600896
  Director, The Family Planning Association of Sri Lanka
- **Dr. Chinthaka Banagala, Tel:** 0772 647413
  Senior Lecturer in Obstetrics and Gynecology, Kotelawala Defence University
- **Dr. Achintha Dissanayake,**
  Senior Lecturer in Obstetrics and Gynecology, Kotelawala Defence University
- **Mr. Janaranga Dewasurendra, Tel:** 0716 813780
  Assistant Director (M&E), The Family Planning Association of Sri Lanka

Thank you for considering participating in this study.

Sincerely,

.....

Dr. Lakshman Senanayake
Principal Investigator

Annexure 02: Consent forms

Well-being during Pregnancy and Pregnancy Outcomes:
A Prospective Cohort Study in Nuwara Eliya District, Sri Lanka
Consent Form

Participant's Statement

I hereby confirm that the Field Research Officer has provided a clear explanation of the study, including its objectives, potential benefits, procedures, voluntary nature of participation, duration, and measures for confidentiality which I understood well.

- I confirm that I have received an information sheet about this study and have read it carefully.
- I had the opportunity to discuss this study with the Field Research Officer and to ask any questions. All my questions were answered to my satisfaction.
- I understand that my personal information will be used solely for this study and that my anonymity will be maintained at all times.
- I confirm that I have had sufficient time to make an informed decision about my participation in this study.
- I understand that my participation is voluntary, and that I am free to withdraw from the study at any time without providing a reason, and without any impact on my future benefits or penalty.

Consent to Participate

I, _____ (Full Name), have understood the information provided and hereby give my voluntary consent to participate in this study.

Participant's Signature..... Date.....

Investigator's Statement

I have explained the study to the above participant and she has indicated willingness to take part.

Signature of investigator ..... Date.....

Full Name .....

Annexure 03: In-depth Interview Guide

Well-being during Pregnancy and Pregnancy Outcomes:
A Prospective Cohort Study in Nuwara Eliya District, Sri Lanka
In-depth Interview Guide for Case Studies among Survivors

Background Information

1. Can you tell me a little about yourself (e.g., age, family background, living situation)?
2. Can you tell me a little about your partner and your relationship with him? How long have you been together?

Context and Dynamics of IPV

3. Can you describe the nature of your relationship with your partner before and during your pregnancy?
4. Have you experienced any of the following types of violence? If yes, could you share your experiences? a) Emotional or verbal abuse, b) Economic violence, c) Physical violence, d) Sexual violence, e) Controlling behavior (e.g., social isolation, avoid taking treatments), Cyber violence (e.g., online harassment)
5. In your opinion, what were the main triggers or reasons for the violence?
6. How often did the violence occur, and were there specific patterns or situations when it escalated?

Impact of IPV

7. How did IPV affect your relationship with family members, friends, or community?
8. How has experiencing IPV affected your emotional and mental well-being? Ex: Sleeping quality
9. Did the IPV have any impact on your physical health during pregnancy? If yes, please explain
10. In what ways did IPV influence your pregnancy and your ability to care for yourself and your baby?

Healthcare-Seeking Behavior and Access to Services

11. Were you able to seek healthcare during your pregnancy (Ex: Routine clinic visits)? If yes, what were your experiences like?
12. Did IPV affect your ability or willingness to seek healthcare or disclose your experiences to healthcare providers?
13. Were there any specific barriers that prevented you from accessing healthcare or support services?

Help-Seeking Behavior and Support Networks

14. Did you disclose your experiences of IPV during pregnancy to anyone (e.g., family, friends, healthcare providers)? If yes, how did they respond?

15. Were there any community or organizational support services you tried to access? If yes, what were your experiences?
16. What challenges or barriers did you face when trying to seek help?

Coping Mechanisms and Resilience

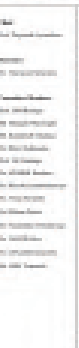
17. How did you cope with the IPV you experienced?
18. Were there any strategies, practices, or people that helped you during this time?

Recommendations and Closing Reflections

19. In your opinion, what could be done to better support women who experience IPV during pregnancy?
20. Are there any services, interventions, or policies you think should be introduced or improved?
21. Is there anything else you would like to share about your experiences? Do you have any questions for us?

Annexure 04: Ethical Clearance Letter





[redacted]

[redacted]

[redacted]

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