Annals of Case Reports and Clinical Studies
Case Report (ISSN: 2834-5673)

Journey from Domestic Violence to Safe Birth: A Case Study

Mumtaz Fathima, Maimoona Ahmed*

Fernandez Hospital, 4-1-1230, Off Abid Road, Bogulkunta, Hyderabad 500001,India

Citation: Mumtaz Fathima, Maimoona Ahmed. Journey from Domestic Violence to Safe Birth: A Case Study. Ann Case Rep Clin Stud. 2025;4(12):1-5.

Received Date: 14 December 2025; **Accepted Date:** 16 December 2025; **Published Date:** 18 December 2025

***Corresponding author:** Maimoona Ahmed, Consultant Obstetrics, Fernandez Hospital, 4-1-1230, Off Abid Road, Bogulkunta, Hyderabad 500001, India

ABSTRACT

Introduction: Domestic violence and abuse (DVA) during pregnancy poses significant risks to both maternal and fetal health, including physical injuries, miscarriage, preterm birth, low birth weight, and stillbirth. Exposure to physical, emotional, sexual or economic abuse during pregnancy not only endangers the mother's health but also compromises the well-being and development of the unborn child. Every woman deserves a pregnancy journey marked by dignity, security, and care, where both she and her child can thrive without the threat of violence. Incidence of DVA increases in pregnancy in 30% cases. Timely intervention is critical to identify the women at risk and ensure safe pregnancies.

We present a case report of one such survivor of DVA who received care at our crisis centre and had a successful outcome.

Case Details: This study presents the case of Priya (name changed), 28-year-old woman who experienced emotional, financial, and physical abuse during her pregnancy. This was picked up in her antenatal period and she was referred to the Raahat crisis centre (catering to survivors of DVA). Priya received counselling, medical care, and family interventions that facilitated accountability and behavioural change among her abusers. She was provided with continuity of care by obstetrician and midwife during her pregnancy and childbirth. Through this comprehensive support, she was able to navigate her pregnancy safely and give birth to her child in a secure and supportive environment. This case highlights the importance of targeted interventions in enabling survivors of DVA to achieve safe births and positive maternal and child outcomes.

Conclusion: Her journey is a testament that with timely identification, individualised intervention and collaborative care in pregnancy, survivors of DVA can reclaim their strength and have a positive birthing experience.

Keywords: Domestic violence and abuse; Pregnancy; Counselling; Outcomes, Birth experience

INTRODUCTION

Domestic violence and abuse (DVA) is a major public health issue affecting women globally, particularly during their reproductive years. Globally, 1 in 6 women are victims of domestic violence and abuse [1]. In India, the National Family Health Survey (NFHS-4) estimates 1 in 3 married women to be subjected to DVA with physical violence being the most common (30%), followed by emotional violence (14%) and sexual violence (7%) [2].

Pregnancy does not protect women from violence. Instead, it may trigger the onset or escalation of abuse in some relationships [3].

DVA during pregnancy includes physical, emotional, sexual, and financial abuse and is associated with adverse maternal and neonatal outcomes. Studies have demonstrated links between violence during pregnancy and increased risk of miscarriage, preterm birth, low birth weight, fetal growth restriction, and maternal mental health disorders such as anxiety, depression, and post-traumatic stress disorder [4-6]. Psychological stress and trauma related to abuse may also result in poor antenatal care attendance and reduced health-seeking behaviour [7].

Healthcare interactions during pregnancy provide a crucial opportunity for identifying women experiencing DVA and initiating early intervention. Professional guidelines recommend routine inquiry about DVA during antenatal care and emphasize the role of healthcare providers in ensuring safe disclosure, documentation, and referral [8]. This case study presents the journey of a pregnant woman experiencing domestic violence and highlights how timely identification, multidisciplinary intervention, and continuity of obstetric care led to a safe pregnancy and favourable birth outcome.

METHODOLOGY

This manuscript adopts a qualitative descriptive case study approach based on clinical records and service documentation from a hospital-based crisis centre for survivors of domestic violence. The case was anonymized using a pseudonym, and identifying details were altered to maintain confidentiality and ethical integrity.

Data included patient history, psychosocial assessment, interventions provided, and maternal and neonatal outcomes. The case was contextualized using relevant peer-reviewed literature and clinical guidelines to support interpretation and discussion. This approach enables detailed examination of individual experience while linking findings to broader clinical and public health evidence.

Our hospital-based crisis centre (Raahat) caters to survivors of DVA. We get referrals from the clinics as well as walk-ins who have seen our centre details on social media and hospital website. The centre provides compassionate, confidential, and coordinated support, including clinical care, counselling, legal and police referrals, skill-building opportunities, and livelihood assistance. In addition to direct survivor services, the centre prioritises training and sensitisation of healthcare providers and other hospital staff. It also conducts community awareness campaigns to promote understanding and prevention of domestic violence and abuse.

CASE REPORT

Patient Information

Mrs Priya* (name changed to protect identity) was a 28-year-old woman, gravida 1, referred from the Obstetrics Outpatient Department to the Raahat Crisis Centre during her first pregnancy. She was a graduate in engineering, employed as a software professional, and was married to Mr Santosh* (name changed to protect identity) since the past 2 years. Theirs was a love marriage against the wishes of the family members.

Clinical Presentation

During antenatal care, Mrs Priya disclosed experiencing emotional, financial, and physical abuse by her husband during pregnancy. Her husband was not working, and she was the sole bread-earner in the family. She reported persistent feelings of anxiety, loneliness, emotional exhaustion, and uncertainty about her future. The abusive environment had significantly affected her mental well-being and sense of safety.

Interventions

Following disclosure, Mrs Priya received comprehensive support through a multidisciplinary model of care. Individual counselling sessions focused on emotional support, validation of experiences, safety planning, and strengthening coping strategies. She was informed about her rights and available support services.

Medical care was continued under the supervision of an obstetrician, with coordinated support from a midwife to ensure continuity of care throughout pregnancy and childbirth. Multiple couple counselling and family counselling sessions were conducted, addressing communication issues and abusive behaviours while prioritizing patient safety.

Outcome

Over the course of pregnancy, positive engagement with interventions was observed. Mrs Priya reported improvement in her partner's behaviour and increased family support. Her husband increased his efforts to find employment and did so successfully by the end of the pregnancy. She was able to continue her pregnancy in a more secure and supportive environment.

She delivered a healthy baby girl at term. The intrapartum and postnatal periods were uneventful, and both maternal and neonatal outcomes were favourable.

DISCUSSION

This case demonstrates the complex relationship between domestic violence and pregnancy outcomes and underscores the importance of early identification and integrated care. DVA during pregnancy has been consistently associated with adverse maternal and neonatal outcomes, including preterm birth and low birth weight. Biological mechanisms such as chronic stress, elevated cortisol levels, and inflammation may contribute to these outcomes [5,6].

Emotional and financial abuse, though often under-recognized, can be equally harmful. Psychological abuse has been linked to antenatal depression and anxiety, which independently increase the risk of obstetric complications [7,9]. Mrs Priya's symptoms of emotional distress and uncertainty are consistent with findings in existing literature.

Pregnancy offers a critical window for screening and intervention due to repeated healthcare contact. Professional bodies such as the American College of Obstetricians and Gynaecologists recommend routine screening for DVA as part of comprehensive antenatal care [8]. Evidence suggests that counselling and advocacy interventions can reduce violence exposure and improve quality of life for pregnant women [10].

Hospital-based crisis centres provide a safe environment for disclosure and enable coordinated access to medical, psychological, legal, and social support services. Continuity of care through obstetricians and midwives further enhances patient trust and engagement. While reconciliation occurred in this case, it is

essential that all interventions remain survivor-centred and safety-focused, recognizing that reconciliation may not be appropriate or safe in many situations.

This case also emphasizes the need for incorporating domestic violence awareness and response training into medical education. Improved provider competence can enhance screening, documentation, and referral, ultimately improving maternal and neonatal outcomes [11].

CONCLUSION

This case highlights that timely identification of domestic violence during pregnancy, combined with individualized counselling and multidisciplinary collaboration, can lead to positive maternal and neonatal outcomes. Pregnancy-related healthcare encounters are critical opportunities for intervention and support.

Integrating routine DVA screening, crisis centre services, and continuity of obstetric care can empower survivors, improve mental health, and promote safe birth experiences. Strengthening training and awareness among healthcare providers remains essential to addressing domestic violence as a component of comprehensive maternity care.

Figure 1: poster for Raahat Crisis centre with helpline number.

ACKNOWLEDGEMENT

We acknowledge with gratitude the support of Ms. Ekta Verma from the Invisible Scars Foundation (ISF) for the Raahat Crisis Centre.

REFERENCES

1. Garcia Moreno C, Jansen H, Watts C, Ellsberg M, Heise L. WHO multi country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization; 2005.
2. International Institute for Population Sciences (IIPS) & ICF. National Family Health Survey (NFHS-4), 2015–16: India (DHS Final Report No. FR339). Mumbai: IIPS. 2017.
3. Devries KM, Kishor S, Johnson H, et al. Intimate partner violence during pregnancy: analysis of prevalence data from 19 countries. Reprod Health Matters. 2010;18(36):158-170.
4. Silverman JG, Decker MR, Reed E, Raj A. Intimate partner violence around the time of pregnancy: association with breastfeeding behavior. J Womens Health. 2006;15(8):934-940.
5. Shah PS, Shah J. Maternal exposure to domestic violence and pregnancy and birth outcomes: a systematic review and meta-analyses. J Womens Health. 2010;19(11):2017-2031.
6. Taillieu TL, Brownridge DA. Violence against pregnant women: prevalence, patterns, risk factors, theories, and directions for future research. Aggress Violent Behav. 2010;15(1):14-35.
7. Bacchus LJ, Ranganathan M, Watts C, Devries K. Recent intimate partner violence against women and health: a systematic review and meta-analysis. BMJ Open. 2018;8:e019995.
8. American College of Obstetricians and Gynecologists. Intimate partner violence. Committee Opinion No. 518. Obstet Gynecol. 2012;119: 412-417.
9. Sharps PW, Laughon K, Giangrande SK. Intimate partner violence and the childbearing year: maternal and infant health consequences. Trauma Violence Abuse. 2007;8(2):105-116.
10. Kiely M, El-Mohandes AAE, El-Khorazaty MN, Gantz MG. An integrated intervention to reduce intimate partner violence in pregnancy. Obstet Gynecol. 2010;115(2):273-283.
11. Garcia-Moreno C, Hegarty K, d'Oliveira AF, et al. The health-systems response to violence against women. Lancet. 2015;385(9977):1567-1579.