Research Article

EXPERIENCES OF INTIMATE PARTNER VIOLENCE AMONG CURRENTLY MARRIED ROHINGYA WOMEN IN BANGLADESH: PERCEIVED CAUSES, MENTAL HEALTH CONSEQUENCES AND HELP SEEKING BEHAVIOR

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Our study seeks to gain insights into Rohingya women's experiences with intimate partner violence (IPV), its causes, and their help-seeking behaviour. This article provides empirical evidence on the pattern of IPV in Rohingya camps in Bangladesh, drawing from qualitative interviews with currently married Rohingya women aged 16-45 years (n=20). We adopted the thematic analysis technique for the data analysis, in which themes and subthemes were categorized to explore the Rohingya women's experiences of IPV and their help seeking behaviors to cope with IPV. The findings of our study suggest that IPV is highly prevalent in the Rohingya camps, and the respondents experienced psychological, controlling behavior and physical violence by their intimate partners. This study revealed multiple reasons behind the IPV in the Rohingya community, including early marriage, use of drugs/alcohol by the husband, dowry, extramarital affairs, gambling habits of husband, preferences for sons, and polygamy. It has been seen that survivor women's coping mechanisms are their willpower, acceptance, self-time, hopeful mentality, and emotional and family attachment. The respondents preferred to seek help from family members and NGOs. Despite widespread IPV in the Rohingya community, most of the women want to live with their current intimate partner. Therefore, interventions should respect women's priorities to end violence. Awareness-raising programs regarding the rights of women should be promoted at the community level to sensitize men and women of all ages.

***Keywords**: Qualitative study, Intimate partner violence, Coping, Help-seeking, Rohingya*

1. Introduction

Intimate Partner Violence (IPV) is a serious public health concern (Davis & Padilla-Medina, 2021; Parvin et al., 2016) in both developing and developed countries. The risk of IPV can increase in the case of displaced people, especially refugees and forced migrants (Akhter & Kusakabe, 2014; Welton-Mitchell et al., 2019). However, the experiences of IPV are mostly underreported in the refugee context (Guglielmi et al., 2021; Islam et al., 2021). This is true for the Rohingya community, a group of people who are marginalized and stateless.

Rohingya people who fled from Myanmar to Bangladesh in 2017 due to "clearance operations" by the Myanmar security forces (Green et al., 2022) are living in the world's largest and most densely populated refugee camp in Cox's Bazar. In Bangladesh, they are identified as

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"Forcibly Displaced Myanmar Nationals" (Islam et al., 2022). They are not permitted to go outside of the camp.

The impact of IPV on mental health outcomes is understudied in developing countries (De Prabal & Murshid, 2018). A study revealed that intimate partner violence may increase the risk of mental health symptoms (Breet et al., 2019). When it comes to the Rohingya community, mental health difficulties are associated with safety concerns, loss of livelihood opportunities, and difficulties accessing food (Akhter & Kusakabe, 2014; Riley et al., 2017; Welton-Mitchell et al., 2019). IPV was deeply rooted in the Rohingya's culture before their arrival in Bangladesh and the situation seems to have further deteriorated in a foreign country where they do not have formal legal rights, access to education, societal norms, religious beliefs, and economic security (Guglielmi et al., 2021; Islam et al., 2021). These vulnerabilities may further fuel the IPV in Rohingya camps.

Existing literature suggests that victims tend to seek help from their family members, friends, and relatives (Akhter & Kusakabe, 2014; Jayasuriya et al., 2011; Tenkorang et al., 2018; Welton-Mitchell et al., 2019). Family members of traditional societies often support existing social norms and practices that justify violence against women (Odero et al., 2014). In most cases, family members pressurize victims through counselling to accept and compromise with an abusive intimate partner (Horn et al., 2016). Although familial support is not enough to address IPV effectively, it is unusual that IPV survivors seek assistance from police or a legal aid agency, particularly in a South Asian context (Akhter & Kusakabe, 2014).

Evidence suggests that the Rohingya community permits a husband to behave abusively towards his wife, and the society expects that wives should not disclose those intimate family issues (Guglielmi et al., 2021; Welton-Mitchell et al., 2019). There are numerous barriers to seeking help for IPV for Rohingya women, including blame and shame associated with existing social norms, ambiguous legal protection in the host country, and lack of access to basic services (James et al., 2021; Ripoll, 2017; Welton-Mitchell et al., 2019). In addition, the stateless nature of the Rohingyas makes it more difficult for them to seek help for IPV than others. As the social system normalizes violence and exclusion, it further increases inequalities, marginalization, and oppression against women (Dutta et al., 2016).

Despite increased global interest in IPV, research on the link between IPV and help-seeking behavior in refugee contexts is scarce. Some researchers (Guglielmi et al., 2021; Islam et al., 2021, 2022) studied the Rohingya women's attitudes towards IPV. Humanitarian organizations are working to eliminate gender-based violence and protect women from harm in the Rohingya camps. Nordby (2018) examined the role of humanitarian organizations to prevent gender-based violence in the Rohingya camp. A recent study examined the relationships between IPV and the help-seeking behaviour of Rohingya people in Malaysia (Welton-Mitchell et al., 2019) and found that the social norms of Rohingya people discouraged them from seeking help.

Evidence suggests that Rohingya women face numerous barriers to seeking assistance for IPV (Gover et al., 2013; Kyu & Kanai, 2005; Ripoll, 2017; Welton-Mitchell et al., 2019). Although the rate of IPV is higher in the world's largest camp (Islam et al., 2021), very few studies have investigated the help-seeking tendencies of abused women. In particular, limited studies have focused on Rohingya women's help-seeking behaviours after the influx of Rohingya to Bangladesh. This is particularly important for developing interventions for IPV among refugees.

Therefore, the objective of this study is to examine patterns of IPV among Rohingya women living in Bangladesh, the way they cope with the violent behavior of their intimate partners, focusing on the help-seeking behavior.

1.1. Conceptual framework

The theoretical framework of this study is based on Social Learning Theory (Bandura, 1978). Social Learning Theory describes how aggression and violence are learned from society and how individuals who are exposed to violence are more prone to accept violence. Bandura explains that exposure to violence may originate from multiple sources, including family members, communities where they live, and mass media. These agents may lead to the silencing and normalization of IPV (Guglielmi et al., 2021) and negatively impact a person psychologically, socially and physically (Chaudhry, 2016).

Moreover, De Prabal & Murshid (2018) summarized three justifications offered by women for IPV. These include (i) patriarchal norms that make it possible to accept violence; (ii) IPV as a coping mechanism for women that keeps them in unhealthy relationships; and (iii) women are being socialized so that they accept violence in their own lives. IPV survivors adopt numerous coping strategies to normalize violence. In this study, we conceptualize coping mechanisms as the social learning processes that modify the mental health outcomes of IPV survivors. However, if the capacity to cope exceeds their tolerable limit, IPV survivors seek assistance from their existing social network (Sere et al., 2021). To analyze the attitudes towards help-seeking by the IPV victims, we asked the respondents about whether they sought assistance from family members, relatives, neighbors, friends, community representatives, Nongovernmental organization (NGO) employers, camp-in-charge, or others in the last year.

The World Health Organization (WHO) defined IPV as “any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship” (World Health Organization, 2012). For this study, we defined IPV as the experience of a Rohingya woman of physical abuse, psychological/emotional abuse, controlling behaviors, sexual violence, and reproductive coercion by a current intimate partner in the last year. Emotional abuse includes name-calling, verbal assault, false allegation of witchcraft, misbehaving, dominance, deprived food, isolation, ridicule, threat to hurt, or degradation (Sedziafa et al., 2018).

2. Methods and materials

In our study, we employed a qualitative, phenomenological research design (James & Isaacs, 2023). For the purpose of this study, we conducted in-depth interviews with Rohingya women using a semi-structured interview between June 3 to 26 July, 2021. The inclusion criteria of respondents in this study included (i) being identified as a Rohingya woman; (ii) being currently married (not separated/divorced); (iii) having experienced domestic violence by an intimate partner in the last year; and (iv) currently living with the abusive intimate partner. The interviews were conducted until we reached ‘data saturation’ (no new themes emerged) (Hancock et al., 2016), and the final sample size for our study was twenty.

2.1. Data collection and analysis

Given the particular aim of the study, we employed purposive sampling technique to recruit respondents. The recruitment of respondents was done through door-to-door visits and we requested prospective respondents to participate in our study. The interested women who met the selection criteria were invited to participate in our main survey. We included respondents from various age groups to maximize variability in the data.

The data were collected from twenty Rohingya women through face-to-face interviews. The key topics included in the interview guide were the types of IPV experienced by the respondents in the last year; the reasons behind the IPV and their help-seeking behaviors; their mental health status; and the way they cope with stress. We also included a section on the socio-demographic background of the respondents. The questionnaire was prepared in English and then translated into Bengali.

The interview was conducted in Rohingya language. The first author conducted all the interview sessions with the help of two female interpreters who have expertise in both Bengali and Rohingya language. The first author is a development professional who has over 4 years of job experience with the Rohingya response project and is familiar with the Rohingya culture. This study was conducted in Camp 9 and Camp 10 at Balukhali, Ukhiya Rohingya camp in Bangladesh.

Each interview session took approximately 40 to 60 minutes. Before the survey began, the interpreters received an orientation about the research objectives, interview guidelines, and ethical aspects of conducting interviews. Interviews in the Rohingya language were transcribed and then translated into Bengali by the first author with the help of the interpreters. Subsequently, the interviews were translated into English carefully so that we could maintain the accuracy and originality of the emotions of the respondents.

We de-identified the names of all interview transcripts before the data analysis. We used a data-driven thematic approach for data analysis (Clarke & Braun, 2013), through which we generated several themes and subthemes under the broad categories. This technique has been widely used by researchers to explore qualitative interviews (Dhillon et al., 2022; Mondal, 2021; Vitali et al., 2022). The analysis followed the stages proposed by Clarke & Braun (Clarke & Braun, 2013): familiarization with the data, coding, searching for themes, reviewing themes, defining and naming themes, and finalizing the analysis. The second author randomly checked the transcription and translation to check the quality and accuracy of the data. In the beginning, both authors read the transcripts of each interview and coded the data. Next, the similar codes were merged into categories. Finally, several themes and subthemes were generated, aligning with the key research questions of this study. In the findings section, we presented relevant quotes from the respondents pulled from the transcripts that captured aspects of each theme/subtheme. We calculated the frequencies with which the categories were repeated in the interviews and their occurrence (Vitali et al., 2022).

2.2. Ethical considerations

This study was conducted following the guidelines for researching domestic violence against women by the WHO (World Health Organization, 2001). We obtained informed consent (verbal

consent) from every respondent for participating in this study. The participation of respondents in this study was voluntary. Respondents were assured of the confidentiality of the information gathered. The study protocol was approved by the Department of Social Relations, East West University in Dhaka. There is no institutional ethics committee, however, the researchers are aware of research ethics. The researchers strictly maintained ethical standard and confidentiality of the personal issues, including the participants' safety and anonymity. To maintain the trustworthiness of this study, we relied on the principles of credibility, conformability, and dependability as proposed by Holloway & Galvin (Holloway & Galvin, 2016).

3. Findings

3.1. Socio-demographic background

Table 1 provides the socio-economic background of the twenty respondents. The mean age of the respondents was 26.2 years (range 16-45 years). None of the respondents had any formal educational qualifications. They can only sign their own names, which is required to receive basic support and services from the camps. Interestingly, all of them can read Arabic, which they learned at home to read the Holy Quran.

Table 1. Demographic profile of the respondents

Participant ID	Age (years)	Age at first marriage	Relationship lengths (years)
P1*	18	14	4
P2	24	15	9
P3	30	13	17
P4	25	16	9
P5	23	15	8
P6	37	14	24
P7	29	16	14
P8	24	17	8
P9	18	17	1
P10	16	15	2
P11*	42	13	27
P12	32	14	15
P13	45	15	30
P14	28	16	12
P15*	20	15	5
P16	25	16	9
P17	23	15	8
P18	17	14	3
P19*	30	14	14
P20	18	15	3

*Note. *=Polygamous household*

Around 45% of respondents reported that their husbands received secondary school education while they were in Myanmar. All of them were housewives and did not have an income. The average age at first marriage was 14.95 years. The average length of the relationship with the current intimate partner was 11.1 years, and 20% of households were polygamous. Around 30% (n=6) of the respondents were pregnant during the interview.

The key themes and subthemes generated from twenty interviews are described below sections.

3.2. Type of violence faced by the respondents

The respondents faced a multitude of IPVs (Figure 1). The respondents were asked whether they had faced violent behavior from their intimate partner in the last year. Around 80% (n=16) of respondents were physically abused by their husbands in the last year, and 10% (n=2) of them were reportedly severely injured. The majority of the respondents (95%, n=19) were psychologically or emotionally abused by their intimate partners. The respondents were also more likely to report experiencing violent, controlling behaviour by their husbands (85%, n=17). They also informed us that their husband does not allow them to go out of their houses and is not providing household finances.

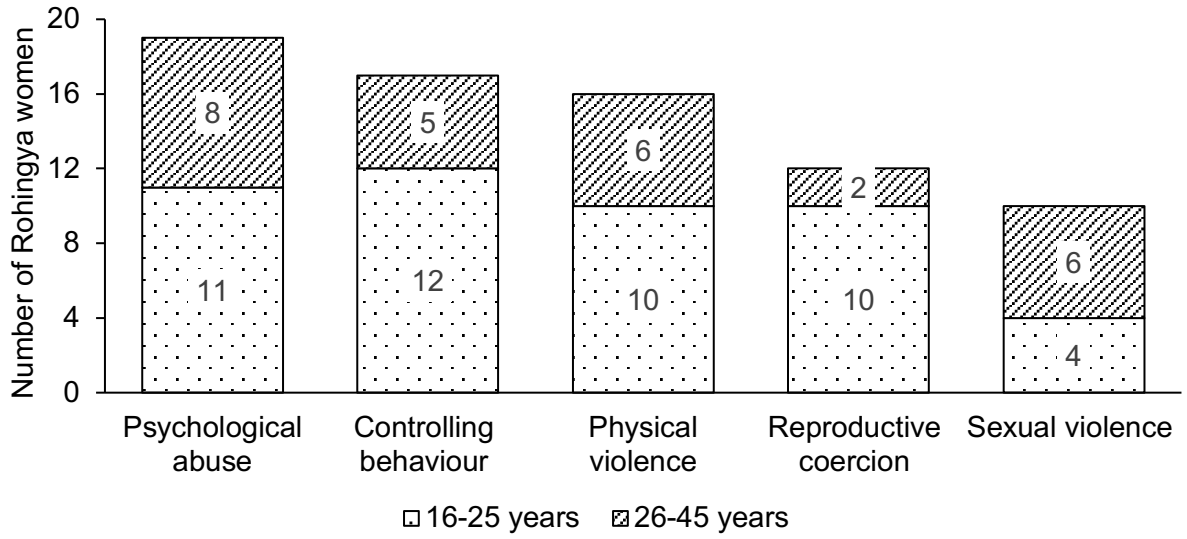

Figure 1. Types of violence experienced by the respondents (segregated by age group)

The respondents also experienced sexual violence (n=10) and reproductive coercion (n=12) by their husbands. The most commonly reported sexual violence includes forced intercourse, hitting sensitive body parts, hitting with sharp weapons, and burning. As one of the respondents explained,

"My husband gets angry with a normal conversation with him. He cannot tolerate me, and when he gets angry, he hits the sensitive and private parts of my body. He always uses abusive language. He once used a cigarette to burn my chest. I cannot breathe properly when he hits me. I always feel scared when he is home." *(Respondent-16, 25 years).*

Marital rape is also common in the Rohingya camps. However, the respondents informed that they were not aware of such abuse. One respondent informed us:

> "Marital rape is unknown to us. We never think of forced intercourse as sexual abuse, but rather we think of it as our duty." *(Respondent-5, 23 years).*

Respondents also informed us that they experienced violent behaviour by their husbands because they adopted family planning. One of the respondents shared her experiences as:

> "I am twenty-nine years old, but I already have five kids. I am three months pregnant now. I am suffering from malnutrition. In our community, we believe that contraceptive users lose their fertility. If this happens, it causes irregular menstruation and prolonged menstrual bleeding. In this case, if we need to visit a doctor, we have to incur extra expenses. For this reason, my husband does not allow me to take contraceptive pills." *(Respondent-7, 29 years).*

Overall, a higher proportion of respondents who were married at 15 years or younger faced psychological abuse, controlling behavior, physical abuse, and reproductive coercion when compared to those who were married at 16 years or later (Figure 1). These findings illustrate how common IPV is in the Rohingya community.

3.3. Perceived causes of IPV

The Rohingya women identified several reasons that lead to IPV (Figure 2). These factors are described below:

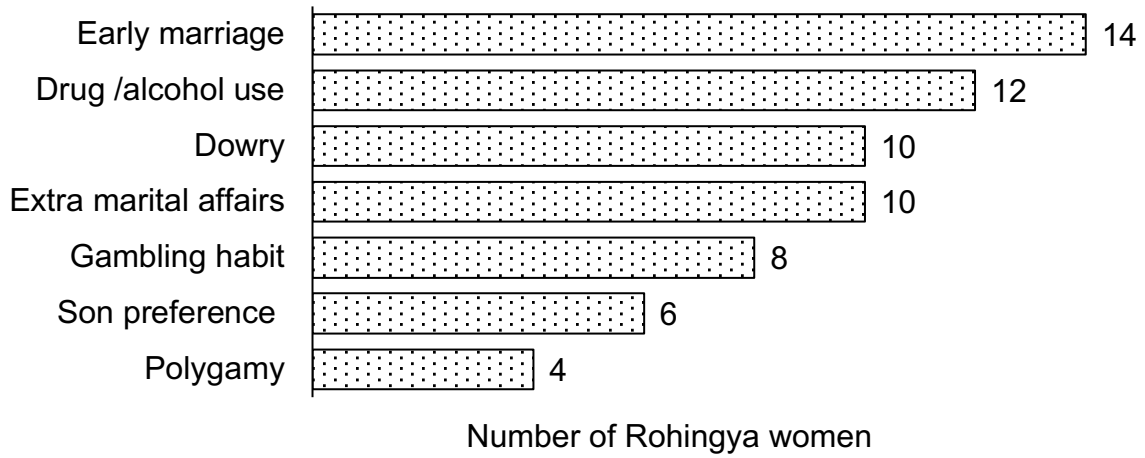

Figure 2. Perceived causes of IPV reported by respondents (multiple responses considered)

3.3.1. Early marriage

About 70% (n=14) of the women interviewed felt that early marriage was the cause of their marital discord. As a result of early marriage, it becomes difficult to raise children and even to perform household work properly. One of the respondents shared her experience as:

> 'My husband is a drug addict. He beats me every day. I got married at the age of 13. Early marriage is prevalent in our culture. If we are unable to marry at our young age, our neighbors will start speaking ill of us by spreading rumors to defame us. Our parents arrange a marriage ceremony soon after our menstrual cycle starts. Because of this, my father had decided to arrange a marriage ceremony. Boys do not have any risk of getting defamed. Parents are not as eager to marry off their sons as they are their daughters." *(Respondent-3, 30 years)*

> Another respondent noted:
> "I have two daughters. For this reason, my husband and in-laws physically and psychologically abused me. Forced marriage is normal in our Rohingya community. If an unmarried girl crosses the age of 15, people say bad things about her. I had not agreed to marry, but I had to obey my parents' commands. Now I am passing through an abusive domestic life." *(Respondent-17, 23 years)*

These two excerpts highlighted how respondents perceived early marriage as a cause of IPV. The respondents also informed that if they cannot fulfill their husband's sexual pleasure properly, their husband tortures them. In addition, if they are unable to perform household work properly due to physical weakness, they are also subjected to physical and mental torture by their husbands.

3.3.2. Drug /Alcohol

More than half of the respondents (n=12) reported that their husbands abused them more when they got drunk. As a result, they (their husbands) either disappeared from the house or slept at home. Sometimes their husbands pressured them to give money for drugs. Sometimes they steal money. As one respondent noted:

> "My husband is drug addicted. He sold all of my gold jewelry for drugs. He beats me for the drug money. A few days ago, he tied me up and physically tortured me a lot for drug money." *(Respondent-7, 29 years)*

Because of their husbands' use of drugs/alcohol, the respondents face psychological and financial stress to meet the needs of their children.

3.3.3. Dowry

Dowry (n=10) is one of the most common practices in Rohingya society's marriage culture. It is commonly in the form of gold or other goods. If the gold ornaments and articles that are supposed to be given to the husband before marriage are not paid after the marriage ceremony, then the husband continues to pressurize the wife for the dowry, even after the birth of children. The respondents were also abused physically and emotionally by their husbands for the dowry. One of the helpless mothers shared her bitter experience:

> "I cannot organize the marriage ceremonies for my three girls. The reason behind this delay is our inability to manage dowry money. My husband verbally abuses me in front of my girls for giving birth to three girls." *(Respondent-13, 45 years)*

Dowry payment sometimes propagates polygamy because polygamous men do not ask for a dowry from the bride's family. Unmarried girls are not safe in Rohingya camps.

3.3.4. Extra marital affair

The respondents (n=10) perceived that the extramarital affairs of their husbands were the reason for violence. This is especially prominent when they become pregnant. Their husbands torture them if they ask about extramarital relations. The respondents shared their experiences as:

> "My husband had an extramarital relationship during my pregnancy. Sometimes he comes home, and sometimes not. I heard that he married her." *(Respondent-18, 17 years)*

Another respondent commented:

> "My husband has an affair with a woman from camp 10. He used to talk with her on the phone. My husband beat me when I asked him about it. He wants to divorce me. If he divorces me, I have nowhere to go. I feel insecure and helpless." *(Respondent-14, 24 years)*

3.3.5. Gambling habit

Respondents (n=8) perceived their husbands' gambling habits as another cause of their husbands' violent behavior. Frustrated and helpless spouses of gamblers commented:

> "He sold the daily necessities of our family, forcibly took the money, and pawned the gold ornaments to manage gambling money. Most of the time, he tortures me if I protest against his gambling behavior." *(Respondent-10, 16 years)*

Another respondent shared her experiences:

"My husband is not good at anything. He cannot do any kind of work. The food and groceries provided by the NGOs come in the name of me and my children. But my husband steals those rations to manage money for gambling. He takes over the family finances. Therefore, we are unable to purchase daily necessities for my kids. If I ask anything to my husband, he physically and mentally tortures me." *(Respondent-3, 33 years)*

Respondents reported a wide range of abuse from their husbands, including physical assaults, psychological abuse, stalking, and threats. The situation becomes worse when their husbands torture them to pay gambling money or debt.

3.3.6. Son preference

Preferences for sons have been considered one of the reasons for Rohingya women's experience with IPV. Examples of the comments for child preferences in the Rohingya community:

"I was unable to give birth to a son despite trying many times. I have been praying to the Almighty and crying for a son. I have nothing to do if Allah does not give it to me. But my husband and in-laws always blame me, saying that I am responsible for not giving birth to a son. My husband has declared that he will divorce me if I give birth to another daughter. I am always under stress." *(Respondent-12, 32 years)*

Another respondent commented:
"My husband does not allow me to use any form of birth control. If I want to use any birth control method, he tortures me. Many diseases develop in my body. I already have two girls. He wants a son, and for this reason, I got pregnant again." *(Respondent-17, 23 years)*

3.3.7. Polygamy

After the influx of Rohingya in Bangladesh in 2017, most marriages were unregistered, which increased polygamy in the camps. Several respondents (n=4) reported that polygamy is one of the reasons for the abusive behavior of their husbands.

3.4. Mental health consequences

The respondents were under severe stress that hurt their mental health and well-being. The majority of the respondents (n=19) were suffering from anxiety, and some of them were not able to perform any of their daily activities, such as eating, drinking, or sleeping properly. They are always afraid of their husbands.

About four-fifth of respondents (n=16) reported that they suffered from depression. The majority of the respondents (n=19) had symptoms of severe chronic stress. The respondents (n=10) informed us that they sometimes feel bored with life. They want to kill themselves. Suicidal thoughts come into their minds. About one-fifth of the respondents had already

attempted suicide. More than half of the respondents (n=12) often choose self-harm because they cannot tolerate torture. These include cutting off one's hair suddenly, hitting oneself with something heavy, beating one's children, going without food for days, burning or throwing away essentials, and cutting one's body with sharp objects.

3.5. Coping strategies

The respondents adopted several coping strategies to prevent, ignore, reduce, or absorb violence. Such strategies include obedience to their husbands, commitment to childcare duties, apologizing for their faults, accepting IPV as a social norm in their community, and engaging in hobbies to forget the violent behaviors of their partners. The notable coping strategies that emerged from the interviews are discussed below:

Most of the respondents (n=19) informed us that they have accepted IPV because they have no other option but to accept the violent behavior of their husbands. They believed that men should be aggressive and women should accept it. The questions posed by several respondents during the interview session were: Where will I go? Who will give me shelter at their home? Who will give shelter to my children? They have no option but to stay in their parents' house for a long time, as the house in the camp is small.

In general, their parents will not support their separation from their husbands. They are helpless in the camp. They, too, are unable to live in a separate place as they do not have permission to go outside the camp. Considering the above realities, the respondents have accepted all sorts of IPV and are living with their abusive partners in toxic relationships. For example, a helpless IPV survivor commented:

> "There will be conflict in the conjugal life. I have accepted the social rules that say my husband has the right to abuse me physically and mentally. Above all, my husband is the only person who will keep me in his house and earn for me and my children." *(Respondent-12, 32 years)*

Another respondent commented:

> "Where will I go? I have no place to go. He (spouse) was a good person when we were in Myanmar. After arriving in Bangladesh, he became violent. He has no work in this country. He is unable to go outside of the camp. He is staying at home all day and fighting with me over a silly issue. In Myanmar, we had assets like land and cattle. We were used to farming, but after coming to Bangladesh, we have no opportunity to work. Everything is our bad luck." (*Respondent-19, 30 years)*

In Myanmar, Rohingya men are expected to be the breadwinners. They were engaged in agriculture or small business. But they are not allowed to work outside the Rohingya camps in Bangladesh. In the camps, men also became responsible for domestic chores as they stayed home. This reversal of traditional gender roles and men's frustration over restricted lives in the camps often led to the increasing violence of men against women.

Some of the respondents (n=8) often thought to leave their husbands. However, they are scared that if they leave their husbands, they have no option but to go outside of the camp. In a few cases, respondents (n=2) pushed their husbands to protect themselves when the tolerance limit was exceeded. After that, the respondents were subjected to more violent behavior from their husbands.

Half of the respondents said they have emotional attachments to their husbands and would never leave or divorce them. They are optimistic and accept that quarrels and disputes are integrated into conjugal life. Thus, leaving or divorcing their husbands is not a solution for them. They accepted violent behavior and tried to keep quiet when there was a quarrel. They accept that men will get a little angry. They also believe that family is the place where their emotions are best expressed.

Some of the respondents (n=8) believed that today's situation would not last forever. They hope that the tension in their family will be resolved someday and that they will be able to go back to their country and live in peace.

More than two-third of the respondents (n=14) believe that IPV is their own fate, and they blame themselves for the abusive behavior of their husbands. They believed that when their husbands became angry, they should remain silent and not speak loudly to them.

Religious coping (n=18) is the most commonly practiced coping strategy. When they go through severe psychological stress, they appear to find solace in prayer to Allah and seek assistance from Him. They believe that the Almighty is by their side and is watching everything, and He will judge everything. They say Allah gives them [women] patience to bear anything and everything.

About half of the respondents (n=10) used self-time as a coping strategy. They adopted several strategies if they felt too stressed, including spending time with their children, talking with their neighbors, applying oil to their scalps, sewing *Nakshi Katha*, preparing home decoration items, doing a makeover on their faces, putting *Thanaka* (traditional makeup) on their faces, and so on to forget everything.

3.6. IPV and Help-Seeking behavior:

The majority of the respondents informed that they sought assistance from their known network, which is classified in this study as informal (n=14) and formal (n=16) sources of assistance as described below:

3.6.1. Informal Support

More than half of the respondents (n=12) said that they got help from family members (such as parents, brothers, sisters, and children) during violence. The role of family members is vital in providing various forms of emotional support during this difficult time. One of the respondents explained:

"My mother and siblings are always by my side. If there is any danger, they are the first to protect me." *(Respondent-05, 23 years)*

However, families are not always supportive. One of the respondents shared her hostile experience as:

"During pregnancy, he (spouse) beat me severely, kicked in my stomach, and threw me out of the house. When I went to my parent's house, my father told me to accept everything and go back to my husband's house. I gave birth to a girl who was very sick. She died after two days. My in-laws blame me for her death." *(Respondent-18, 17 years)*

About one-third of women (n=6) reported that they received help from neighbors during violence. Sometimes the neighbors came and stopped their husband. They also helped the respondents get assistance from humanitarian organizations. When asked about the neighborhood support, one respondent replied:

"Several days ago, my husband tied me up and tortured me a lot. I had pain in my whole body. My neighboring sister helped me go to the doctor at the health facility." *(Respondent-20, 18 years)*

Only a few women (n=2) reported that they received help from friends and relatives during a violent incident. However, sometimes they provide emotional and safe shelter after the violence.

3.6.2. Formal support

About three-fifth of women (n=12) said that they were victims of violence and received support from various humanitarian organizations working in Rohingya camps. When they could not bear the torture anymore, they complained to the humanitarian aid workers, who assisted in getting various emotional and psychosocial support.

Almost one-third (n=6) of women said that they went to the community leader **(**community representative known as *Majhi***)** after being a victim of violence. Most of the respondents did not seek assistance from the *Majhi*. They claimed that community leaders were somehow biased and did not get any kind of support. As a result, women often have to suffer various types of physical and mental torture after the hearings with *Majhi*.

If Majhi fails to resolve an issue, only then the issue is taken to the Camp in Charge (CIC) office. Some of the respondents (n=6) went to the CIC office for judgement.

4. Discussion

This study documents the prevalence of IPV in the Rohingya community and the way they cope with the violent behavior of their intimate partners, focusing on help-seeking behavior. The

findings of our study suggest that the prevalence of IPV is high in the Rohingya camps in Bangladesh. These findings are in line with the results of another study (Welton-Mitchell et al., 2019) which found high rates of IPV among Rohingya refugees in Malaysia. Our study found that the respondents were more likely to have experienced psychological, controlling behavior, and physical violence by their husbands. The frequency and intensity of IPV seem to have been aggravated in a foreign country not only due to their rigid social and cultural norms but also their inability to enjoy the freedom of movement along with inadequate support (e.g., food) provided by different non-government organizations and multilateral development agencies (Islam et al., 2021).

Child marriage is considered a normal practice in the Rohingya community. Our study found that the mean age at first marriage of the respondents was 15 years, which was consistent with the findings of Guglielmi et al. (2021). A possible explanation for the increasing number of harmful practices (domestic violence, child marriage) among the Rohingya people in Bangladesh is that they were strictly monitored in Myanmar (Guglielmi et al., 2021). But due to the current ambiguous legal protection, IPV is more likely to occur in a foreign country (Islam et al., 2021).

The findings of our study also suggest that Rohingya women accept IPV as their socialization process, which is in line with Islam et al. (2021). It has been seen that survivor women's coping mechanisms are their willpower, acceptance, self-time, hopeful mentality, and emotional and family attachment. In addition to these, our study also revealed the helplessness of women. They are continuing a toxic relationship by enduring torture due to various family, social, and religious restrictions on women.

Our research has found that women who are victims of IPV suffer more psychologically, which was also found in other studies (Welton-Mitchell et al., 2019). They suffer from various mental disorders, including anxiety, stress, and depression.

In our study, help seeking intention for IPV among the Rohingya women was higher than in previous studies (Welton-Mitchell et al., 2019). When a woman is a victim of violence by her intimate partner, her own family members are the first to help. In that case, it can be understood that strong family bonding or relationships help a survivor woman get psychosocial support and shelter. However, families are not always found next to survivors in Rohingya camps. Many survivors are helpless. In many cases, there is no one in her family who can stand by her, protest, and help her get justice. Many families may also be hostile or unsupportive. In such a helpless time, the people who came first to the survivor's side were their neighbors, relatives or friends. However, it was only in a few cases that Rohingya women approached their friends or relatives for assistance. This is because, in most cases, their friends and relatives are living in separate camps. It is not possible for their friends or relatives to come forward immediately during the violence.

The findings of our study suggest that 60% of respondents seek help from formal sources, such as an NGO. Our findings are different from the previous study conducted in Malaysia (Welton-Mitchell et al., 2019), which reported that Rohingya women in Malaysia did not seek help from social organizations. Our observation is also inconsistent with previous findings (Ripoll, 2017) that reported that the Rohingya community perceived domestic violence as a family issue that should be resolved by their family alone.

Moreover, the findings of the study show that IPV survivors were less likely to seek assistance from community representatives. The findings are consistent with Akhter & Kusakabe (2014) that community representatives are hindering the referral and redress mechanisms for victims of abuse. Although an earlier study (Ripoll, 2017) reported that psychological abuse among married Rohingya women is perceived as normal and to be resolved by the family alone, our findings suggest that most of the respondents sought assistance if they faced psychological abuse. This may be because humanitarian organizations have been providing mental health services in the camps, which increases the help-seeking intention of Rohingya women against IPV.

Study Limitations

We acknowledged several limitations of this study. We only conducted this study in two camps. Since this study was conducted during the COVID-19 pandemic, when government-imposed mobility restrictions were in place, we did not get permission to enter several camps. Moreover, we were unable to reach other camps or blocks due to unstable situations in those blocks or camps. IPV is a sensitive issue, and Rohingya women are reluctant to talk about it publicly. It was also challenging to conduct interview sessions with the Rohingya women at their homes, which are small in size. The respondents were afraid that other family members and neighbours could hear the discussion. However, the researchers handled the situation carefully, since one of them has been working on the Rohingya response project for over four years.

The sample size was small, and thus generalizing the findings of this study to the whole Rohingya community requires caution. Further studies may consider a representative sample size to get a more generalized picture of intimate partner violence and the help-seeking behaviour of both women and men.

5. Conclusion

Although all respondents had been abused by their intimate partner in the past year, only four-fifths sought assistance from formal or informal sources. A higher level of acceptance of IPV was prevalent among the respondents. The respondents are more likely to seek assistance from family members and NGOs. However, in cases of sexual abuse and reproductive coercion, the respondents were less likely to seek assistance.

The findings of our study have several policy priorities. Even though the majority of the respondents are experiencing IPV, most of the women want to live with their current intimate partner. Therefore, interventions should focus on greater gender empowerment, respect women's priorities, and education of men by religious and other authorities to end violence. Rohingya women also need to be aware of their self-care and self-protection. Community level awareness should be promoted to create awareness about the human rights of women and to remove negative and disrespectful attitudes towards women. Interventions should also focus on different types of livelihoods and life skills. An effort should be made to educate the *Majhi* so that they can sensitize the Rohingya people to minimize the harmful consequences of IPV.

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