Article

Intimate partner abuse among Rohingya in Malaysia: assessing stressors, mental health, social norms and help-seeking to inform interventions

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Abstract

Intimate partner abuse (IPA) is one of the most common forms of gender-based violence worldwide. Risk for IPA can increase during periods of displacement, especially for refugees and other forced migrants. The current study explores patterns of IPA, its correlates and help-seeking behaviours among Rohingya refugees in Malaysia – a group that is particularly marginalised and vulnerable, being stateless and often unable to legally work or access various services. As part of a larger study, a multinational team collected information about IPA among displaced Rohingya in Malaysia through structured household interviews and focus groups, including women, men, community leaders and service providers (n = 75). Results indicated high rates of IPA. Respondents also reported numerous chronic stressors and suggested links between stressors, mental health and IPA. Social norms emphasising the acceptability of IPA and discouraging help-seeking were also common. These data have broad implications, including for development of a 'healthy relationships' intervention integrating social norms and mental health approaches to address IPA in Rohingya communities, with potential for scale-up within Malaysia and elsewhere.

Key implications for practice

- Practitioners will better understand intimate partner abuse among Rohingya communities, including links with historical and chronic stressors, social norms and mental health.
- Practitioners will better understand preferred sources of help-seeking and barriers to help-seeking for intimate partner abuse among Rohingya communities.
- Practitioners will better understand how to develop interventions for intimate partner abuse, including healthy relationship workshops and public health messaging campaigns based on social norms.

Keywords: domestic violence, help-seeking, intimate partner abuse, Rohingya, social norms

Introduction

Intimate partner abuse (IPA), defined as physical, sexual or psychological harm by a partner (CDC, 2019), is one of the most common forms of gender-based violence (GBV) worldwide. In a multi-country study (WHO, 2013), lifetime prevalence among women with a partner was approximately 30%. Risk for IPA can increase during periods of civil conflict and displacement (Delkhosh, Ardalan, Rahimiforoushani, Keshtkar, Amiri Farahani, & Merghati Khoei, 2017). Yet IPA has received limited attention from humanitarian agencies working with refugees and other forced migrants (Gupta, Falb, Carliner, Hossain, Kpebo, & Jeannie, 2014).

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IPA among Rohingya in Malaysia, Bangladesh and Myanmar

Rohingya are one of the most persecuted minorities in the world (Kiragu, Rosi, & Morris, 2011). While many have fled to camps in Bangladesh, thousands reside in neighbouring countries, including Malaysia, India, Thailand, Pakistan, Saudi Arabia and elsewhere (Asrar, 2017; UNHCR, 2019). IPA is common in many of the countries where Rohingya are residing. IPA among local Malaysians is at least 8% (Shuib et al., 2013). Estimates of IPA among Bangladeshis are substantially higher, ranging from 53% to 62% (WHO, 2005). IPA also appears to be common among Rohingya in camps in Bangladesh (Akhter & Kusakabe, 2014). A study of married women in Myanmar (where many Rohingya have resided for generations) found that 69% of respondents had experienced IPA in the last twelve months (Kyu & Kanai, 2005).

IPA, chronic stressors and mental health

While IPA exists across varied contexts and cultures (Garcia-Moreno, Henriette, Watts, Ellsberg, & Heise, 2005; WHO, 2013), contextual factors potentially exacerbate risk. An inability to cope with stressors typically associated with displacement, such as loss of livelihood opportunities, may play a role in men becoming abusive with their partners (Abramsky et al., 2011; El-Masri, Harvey, & Garwood, 2013; Umberson, Anderson, Williams, Chen, & Campbell, 2003; Akhter & Kusakabe, 2014). As indicated by research with Rohingya in Bangladesh, mental health difficulties appear to be exacerbated by common stressors encountered in the refugee camps, including lack of livelihood opportunities, difficulties obtaining food, discrimination from local communities and safety concerns (Akhter & Kusakabe, 2014; Riley, Varner, Ventevogel, Taimur Hassan, & Welton-Mitchell, 2017). Evidence suggests that mental health symptoms, such as depression and post-traumatic stress disorder (PTSD), may exacerbate risk of IPA perpetration (Breet, Seedat, & Kagee, 2016).

Chronic stressors in Malaysia

Rohingya encounter many chronic stressors in Malaysia, largely related to being displaced and associated with their precarious legal status. Approximately 84,000 Rohingya in Malaysia (UNHCR, 2019) face numerous hardships, including lack of employment opportunities and limited access to education and healthcare, with many indicating that life in Malaysia is far more difficult than they had expected (Tazreiter, Pickering, & Powell, 2017). Fragile legal status, discrimination from multiple sectors, and arbitrary arrest and detention by the authorities can make life in Malaysia particularly challenging (FIDH & SUARAM, 2008; Smith, 2012). Local service providers have suggested that IPA among Rohingya in Malaysia is linked to challenges associated with being forced to live as illegal migrants, in addition to tensions involving changes in traditional gender roles and social norms (Tenaganita, personal communication, May 2016).

IPA, social norms and gender roles

Social norms refer to common group standards for acceptable behaviour in a given situation. In recent years, there has been increasing emphasis on the role of social norms in fuelling IPA, especially norms associated with a belief that men should *'discipline'* their wives and that women should tolerate abuse from their partners (Paluck & Ball, 2010). Globally, attitudes condoning IPA are positively associated with abusive behaviours towards one's partner (Capaldi, Knoble, Shortt, & Kim, 2012). Recent multi-country research indicates that norms condoning the control of women by men and justifying wife beating are especially predictive of the geographical distribution of IPA (Heise & Kotsadam, 2015). Interventions utilising social norms approaches have shown increasing promise in addressing GBV, including in low-resource settings (Haylock, Cornelius, Malunga, & Mbandazayo, 2016; Jewkes, Flood & Lang, 2015; Mulawa et al., 2018).

Social norms condoning violence appear to be common in Myanmar, where many Rohingya have lived for generations. There is a proverb in Myanmar – *'If you beat your wife until her bones are broken, she will love you more'* (GEN Myanmar, 2015). In one study, medical staff in Myanmar indicated that women should be *'patient'* with abusive spouses and stated that *'it's natural for this to happen between husbands and wives'* (Greifinger, Richards, Oo, Khaing, & Thet, 2015). Such examples underscore the extent to which social norms in Myanmar sanction IPA and attempt to minimise its negative effects.

Beliefs about gender roles, a form of social norms, stem from cultural views about what is appropriate for women and men. Beliefs, such as that women should be submissive and men aggressive, have been associated with IPA (WHO, 2009). Moreover, gender roles may change in the context of displacement. Research with Rohingya in Bangladesh indicates that men experience frustration stemming from a change in traditional gender roles and associated shame linked to their loss of status as breadwinners (Akhter & Kusakabe, 2014). This may result in increasingly rigid gender role expectations, exacerbating risk for IPA if expectations are violated (WHO, 2009).

In Myanmar, Rohingya women have traditionally been discouraged from working (Ripoll, 2017). Many Rohingya living in Malaysia also prefer that women not work outside home (Al Desoukie, 2018). However, lack of sufficient income-earning opportunities for men may result in women needing to contribute to the household income. Rohingya families often live alongside local Malaysians and may also be influenced by Malaysian women's relative freedom of movement beyond the household (55% of Malaysian women work outside home; Department of Statistics Malaysia, 2017). Changes in traditional gender roles can put women at increased risk of IPA during periods of transition, especially if beliefs about gender roles do not evolve to fit the new context.

IPA and help-seeking

IPA is notoriously difficult to address, in part, because it is underreported. Research suggests there are substantial barriers to women reporting and seeking help for IPA (Gover, Welton-Mitchell, Belknap, & DePrince, 2013). In a study of married women in Myanmar, 93% of survivors of IPA did not seek help (Kyu & Kanai, 2005). This may be due to various social norms discouraging help-seeking, including victim-blame and shame associated with having been victimised (GEN Myanmar, 2014). Furthermore, Rohingya may view IPA as a matter to be dealt with by the family (Ripoll, 2017). Research with other displaced groups suggests that speaking about intra-family violence may be seen to disgrace the family (UN Women, 2013). Finally, Rohingya and other forced migrants often reside in host countries with few legal protections and limited access to services. As a result, such groups may experience greater barriers to help-seeking for IPA than others (Reina, Lohman, & Maldonado, 2014).

Current Study

Rationale

There has been a growing consensus about the need to understand prevalence, risk factors and other correlates of IPA in specific cultural and displacement contexts. This is particularly important for developing interventions for IPA, including those targeting social norms (Paluck & Ball, 2010; International Rescue Committee, 2015). However, there is limited research on social norms and IPA, especially among refugees and other forced migrants (WHO, 2009). In particular, little work has focused on displaced Rohingya in Malaysia. As demonstrated through the literature review, current knowledge that may be relevant for Rohingya in Malaysia is largely extrapolated from Myanmar or Bangladesh, and, therefore, does not speak of unique contextual factors in Malaysia.

In the current article, we detail results of exploratory research with Rohingya in Malaysia. This initial phase of a larger study aimed to clarify perspectives from women, men, community leaders and service providers regarding IPA, chronic stressors, mental health, social norms, gender roles and help-seeking.

Methodology

Ethical approvals

This study conforms to ethical guidelines for research on GBV, including IPA (Ellsberg & Heise, 2005; Sikweyiya & Jewkes, 2012; Watts, Heise, Ellsberg, & Garcia-Moreno, 2001; WHO, 2007). The team received approval for the research from the Institutional Review Board at the University of Colorado, Boulder, and the Medical Research and Ethics Committee in Malaysia (MREC).

Sampling and procedures

Data were collected from seventy-five Rohingya community members residing in Malaysia, consisting of thirty structured interview participants [see Table 1] and forty-five focus group participants. Participants were primarily sampled from two of fourteen identified communities in Gombak district, with some service providers and community leaders residing in other areas within Klang Valley. Gombak was chosen as the study site because Rohingya in the area have received relatively fewer services than those living in neighbouring districts. All participants were compensated with a gift of a bag of rice, drinks and snacks, in line with standard practices.

Structured household interview participants (women, $n = 15$; men, $n = 15$) were recruited by local Rohingya researchers using a script. Researchers approached randomly selected households in one community that was determined to be representative based on a district-wide sampling survey. If participants met inclusion criteria (Rohingya community members residing in Malaysia, aged 18–60), the verbal informed consent process was conducted in a private area (as part of the safety protocols, no names were collected, including no written record of consent). At each household, a man or woman was randomly selected to participate. For safety reasons, couples

Table 1: Participant demographics, household interviews ($n = 30$)

Variable	Men ($n = 15$)	Women ($n = 15$)
Age	Mean = 36, range 23–50	Mean = 27, range 18–38
Marital status	67% married and currently living with partner; 33% married and not currently living with partner; mean age when married = 22, range 18–35; one wife only = 71%	100% married and currently living with partner; mean age when married = 20, range 15–26; husband has only one wife = 87%
Children	93% have at least one child, mean number of children = 4, range 0–8	93% have at least one child, mean number of children = 2, range 0–6
Education	47% less than primary education	53% less than primary education
Employment	50% of men are engaged in some type of work	0%; no woman reported working outside home
Income (per month)	7% RM 0–499, 27% RM 500–999, 53% RM 1000–1499, 13% RM 1500–1999	0% RM 0–499, 33% RM 500–999, 67% RM 1000–1499, 0% RM 1500–1999
Time in Malaysia	Mean = 5 years, 5 months, range 2–9 years	Mean = 4 years, 5 months, range 2–10 years
Place of origin	Originally from Buthidaung (40%), Maungdaw (33%) and Sittwe (27%) in Myanmar	Originally from Buthidaung (33%), Maungdaw (27%) and Sittwe (40%) in Myanmar
Religiosity: How important are religious beliefs to the way you live your life?	100% very important	93% very important

All but one respondent indicated the man is the sole contributor to the income of the household.

were not interviewed in the same household, and all participants were interviewed in a private area. The research team, comprised of mental health specialists and trained para-professionals, provided supportive services and referrals to any participants with immediate safety concerns. Structured interviews were administered on tablets using Qualtrics offline survey software. Interviews were conducted in Rohingya language by Rohingya interviewers matched to the gender of the participant.

For focus groups, community participants (women, $n = 15$; men, $n = 12$) were recruited using methods similar to those already described. Focus groups were held separately for women and men at the office of a local Rohingya community organisation. Community leaders ($n = 10$) and service providers ($n = 8$) were recruited separately for two additional focus groups, through the local Malaysian organisations' professional networks. Because only four service providers were able to attend the focus group, additional individual interviews were conducted at the office of each service provider. Community member focus groups were conducted in Rohingya language, while groups with service providers were in Bahasa Malaysia and English. All focus groups were audio-recorded, with permission, and later translated and transcribed in English.

Because there is no standardised written Rohingya language, materials were translated from English to Rohingya using audio recordings and then back translated to English. Rohingya translations were discussed at length to ensure equivalent constructs were being used. Four team members, local Rohingya researchers (two men, two women), ensured fidelity to materials across interviewers.

Interview measures

Personal and partner exposure to IPA. The Revised Conflict Tactics Scale-2 (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) has been found to be a reliable and valid instrument for assessing IPA in a wide variety of cultural contexts (Chapman & Gillespie, 2018; see Kyu & Kanai, 2005 for adaptation and use in Myanmar). This study used the short form (CTS-2S), a twenty-item scale measuring both perpetration and victimisation of the respondent, including items associated with negotiation, psychological aggression, physical assault, injury and sexual coercion (Straus & Douglas, 2004). The CTS-2S measures IPA in the last year (allowing for responses ranging from once to more than twenty times) and includes response options *'not in the past year, but it did happen before'* and *'this has never happened'*. Concurrent and construct validity of CTS-2S are similar to that of the full length CTS-2 (Straus & Douglas, 2004).

Mental health. Mental health symptoms were assessed using the WASSS-6 (WHO-UNHCR, 2012). This tool includes five items related to mental health symptoms (fear, anger, lack of interest, hopelessness, distress and associated avoidance) and one item associated with functioning. Respondents were asked to rate how frequently they experienced each item during the prior two weeks using the following scale: *(1) none of the time; (2) a little of the time; (3) some of the time; (4) most of the time; and (5) all of the time.*

Chronic stressors associated with the current situation in Malaysia. Participants were asked to indicate *'the top five problems causing you stress during the past month'*. They were given twenty-two items to choose from, informed by the Humanitarian Emergency Settings Perceived Needs Scale (HESPER) (Semrau et al., 2012), with additional investigator-developed items tailored to the context (e.g., *concern about events in country of origin, fear of arrest by local authorities, tension with host community*), including an *'other, specify'* category.

Triggers of IPA. A fourteen-item scale measuring perceived triggers of IPA was taken from the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women, Women's Questionnaire, section 9 (Garcia-Moreno et al., 2005). Participants were asked: *'Are there any particular situations that tend to lead to/trigger your husband/partner's behaviour?'* This question was followed by a list of potential situations (e.g. *money problems, difficulties at work, when there is no food at home, other, specify*). Participants could indicate multiple responses.

Acceptability of IPA. A ten-item scale measuring attitudes about acceptability of wife beating was taken from the WHO Multi-country Study on Women's Health and Domestic Violence Against Women, Women's Questionnaire, section 6 (Garcia-Moreno et al., 2005). For each item, participants were asked: *'Does a man have a good reason to hit his wife if . . . ?'* followed by a brief scenario (e.g. *she does not complete housework to satisfaction; she leaves the home without his permission*). Participants were asked to indicate *'disagree'* or *'agree'* in response to each item.

Beliefs about gender relations. Participants' beliefs about gender roles were measured using an adapted version of the *Community Ideas about Gender Relations* section of the *Attitude and Relationship Control Scales for Women's Experiences of Intimate Partner Violence* (Dunkle, Jewkes, Brown, Gray, McIntryre, & Harlow, 2004). The adapted measure used in this study consisted of twenty-eight items measuring respondents' individual beliefs and perceptions of community beliefs. For brevity's sake, in this study we focus on fourteen items measuring individual beliefs, including twelve taken from the original scale and two investigator-added items: *I think that if a woman is abused by her partner, this is her fate*; *I think people experiencing abuse by their partners should keep it to themselves, there is no benefit in telling someone about the abuse*. Participant agreement with scale items is measured with a five-point scale with responses ranging from strongly disagree to strongly agree.

Attitudes towards help-seeking. Help-seeking intention for IPA victimisation and perpetration was assessed using an investigator-developed question: *'If you were being abused by your partner, would you tell someone/seek help?'* Subsequently, participants were asked: *'If you found that you were using abusive behaviours with your partner,*

would you tell someone/seek help to try to change this behaviour?' Those who indicated *'no'* to either question were asked to explain *'why not'*, and those indicating *'yes'* were asked to indicate where they would seek help, referencing a nine-item list (e.g. family, religious leaders, various types of service providers).

Focus group discussion topics. Key topics addressed in all four focus groups included beliefs about factors contributing to IPA in the community and barriers to help-seeking.

Analysis

For the quantitative data, files were initially cleaned, processed and analysed using IBM SPSS Statistics 24. For the qualitative data, five coders, all trained in qualitative coding using Nvivo, independently coded all focus group transcripts, based on categories associated with questions (e.g. factors perceived as contributing to IPA, barriers to help-seeking). Coders were from differing backgrounds (two Malaysians, one Indonesian and two Euro-Americans). Coders were also able to create new categories as needed, utilising a deductive organising framework for code types, but allowing for inductive components as well. Finally, a consensus approach was used, resulting in a merging of coding across coders and responses across focus groups.

Results and Discussion

Women reported high levels of victimisation, with nearly all indicating that their partner had pushed, shoved or slapped her in the last year and over half reporting that their partner had punched, kicked or beat her up in the last year (20% and 0% of men reported the same, respectively) [Table 2]. In addition, 40% of men admitted having pushed, shoved or slapped and 33% of men indicated they had punched, kicked or beat up their partner within the last year [Table 3]. Of note, although all women were married and living with their partners at the time of data collection, only 67% of married men in the sample were currently living with their partner at the time of data collection

Table 2: Personal exposure to IPA over the past twelve months, household interviews

	Men (n = 15)	Women (n = 15)
	In the past year (%)	In the past year (%)
My partner insulted, swore, shouted, or yelled at me	7	87
I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner	0	33
My partner pushed, shoved, or slapped me	20	94
My partner punched, kicked, or beat up me	0	54
My partner destroyed something belonging to me or threatened to hit me	0	13

WHO defines *current IPA* as within the last year (WHO, 2013). Frequency of times from one to more than twenty are collapsed. Select items are presented here as examples. Full-scale responses are available upon request.

Table 3: Use of IPA against partner over the past twelve months, household interviews

	Men (n = 15)	Women (n = 15)
	In the past year (%)	In the past year (%)
I insulted, swore, shouted, or yelled at my partner	40	7
My partner had a sprain, bruise or small cut or felt pain the next day because of a fight with me	20	7
I pushed, shoved or slapped my partner	40	0
I punched, kicked or beat up my partner	33	0
I destroyed something belonging to my partner or threatened to hit my partner	7	27

Select items presented, with frequency of times from one to more than twenty collapsed.

Table 4: Mental health symptoms last two weeks (WASS-6)

How often during the last two weeks did you feel . . .	Men (n = 15)	Women (n = 15)
	Mean (SD), range	Mean (SD), range
So afraid that nothing could calm you down?	2.3 (1.63), 1–5	1.5 (0.92), 1–4
So angry that you felt out of control?	1.5 (0.64), 1–3	1.4 (0.51), 1–2
Uninterested in things that you used to enjoy?	1.6 (0.74), 1–3	1.7 (0.72), 1–3
So hopeless that you did not want to carry on living?	1.2 (0.77), 1–4	1.2 (0.41), 1–2
So severely upset about an event in your life that you tried to avoid places, people, conversation or activities that reminded you of such event?	1.6 (0.91), 1–4	1.5 (0.92), 1–4
Unable to carry out essential activities for daily living because of fear, anger, fatigue, disinterest, hopelessness or upset?	2.0 (1.2), 1–5	1.6 (0.83), 1–4

(1) None of the time; (2) a little of the time; (3) some of the time; (4) most of the time; and (5) all of the time.

[Table 1]. Rates of perpetration reported by men could be expected to be even higher if all were living with their partner at the time of data collection. Moreover, rates of both perpetration and victimisation are notoriously under-reported across contexts, suggesting that actual levels may be significantly higher (Felson & Par, 2005; Gover et al., 2013).

Perhaps surprisingly, both men and women endorsed low rates of mental health symptoms [Table 4]. It is not clear if the low rates of self-reported mental health symptoms are an accurate reflection or are artificially low due to stigma or misunderstanding of the Rohingya version of the questionnaire. However, during focus group discussions, participants emphasised mental health concerns that they linked to historical and current stressors and risk of IPA [Table 7].

Rohingya in Malaysia often experience stressors that are exacerbated by displacement and statelessness. Both women and men fear arrest by authorities and worry about a lack of livelihood opportunities in Malaysia [Table 5]. Many also experience stress associated with

Table 5: Top stressors associated with current conditions in Malaysia, household interviews

Stressors	Men (n = 15), %	Women (n = 15), %
Fear of arrest by authorities (police, immigration)	93	87
Livelihood difficulties (limited work opportunities)	87	93
Concerns about extortion of money	60	33
Difficulties accessing healthcare	53	40
Lack of access to education for children	47	67
Safety concerns	47	60
Separation from family members	33	20

Top seven stressors identified out of twenty-two options.

Table 6: Situations perceived by women as triggering IPA, household interviews

Situations	(n = 15, women), %
Money problems	80
Work difficulties/lack of employment	46
Family problems	40
Husband thinks wife is disobedient	40
Not enough food	27
No specific trigger (*he acts this way for no reason*)	20

Table 7: Factors perceived by women, men, community leaders and service providers as contributing to IPA, focus groups

Environmental stressor-related (representative quotes in italics)

Financial problems, employment problems: *not enough money; can't find good jobs*

UNHCR process: *everyone is stressed out about the UNHCR process*; registration issues

Security issues: including arrest and detention

Husband's problem of drug abuse, drinking, gambling: *there is not enough money to run the household when the man spends it all on drinking, drugs, gambling*

Social norms-related

Normalisation of violence within the culture: *violence is a normal experience*; *many in the community think it is normal for a man to release his tension by abusing his wife, they don't know that it is wrong*

Men believe they can do anything they want to their partner: *some men think they can do anything to a woman without consequences*

Lack of adherence to religious values and practices: *couple needs to pray more often; couple needs to know about religious teachings emphasising respect*

Forced marriage/child marriage: in such situations *the woman doesn't have any power*

Jealousy/distrust: concerns from men or women about the other having affairs

Housework distribution: between partner and spouse

Perceived disobedience of wife: *husband comes home tired and expect things from his wife that she may not be able to provide*

Mental health-related

History of trauma increases risk of IPA: *from the time in Myanmar, during the journey the trauma has never really been dealt with, never worked through; the person is not able to form any kind of relationship because of their traumatic past; the main factor is trauma, trauma of what happened to them in Arakan causing their brains to be rewired, they can't think rationally anymore; people are carrying the stress of what is happening in Myanmar and have never released it properly*

Mental health symptoms increase risk of IPA: *it is indeed depression and other symptoms of mental health issues that are the cause of IPA.*

Table 8: Acceptability of IPA, household interviews (select items)

Does a man have a good reason to hit his wife if . . . ?	Men (n = 15) Agree (%)	Women (n = 15) Agree (%)
He finds out she has been unfaithful/cheating	100	100
She disobeys him	100	93
She does not take care of the children	93	53
She talks about private familial issues outside of the home	93	53

Table 9: Beliefs about gender roles, household interviews (select items)

	Men (n = 15) Agree (%)	Women (n = 15) Agree (%)
A man owns his wife	100	100
A woman should obey her husband	100	100
A woman needs a man's permission to work	100	100
There is no point in telling others about abuse within a couple	93	93
Children belong to the man and his family	93	93
A man has the right to punish a woman	80	87
If man beats his wife, it shows he loves her	73	67
If a woman is abused, it is her fate	67	93

Strongly agree and agree responses have been collapsed for the purposes of this table.

limited access to healthcare and education and have ongoing concerns about safety. Stress related to events occurring in Myanmar and separation from family members is also common. Women perceived many of these environmental stressors as primary triggers for their partners' abusive behaviour, with an emphasis on money problems and work difficulties/unemployment [Table 6]. Responses were similar in focus groups, although focus group participants also emphasised links between IPA and use of alcohol and drugs, beliefs about the acceptability of IPA and mental health difficulties [Table 7].

For both men and women in this sample, social norms and gender roles condoning IPA were common [Tables 8 and 9]. For example, in individual interviews, all men and nearly all women agreed that a man has a good reason to hit his wife if she disobeys him; all men and women agreed that a woman needs a man's permission to work; over 80% of men and women agreed that a man has a right to punish a woman; 73% of men and 67% of women agreed that if a man beats his wife, it shows that he loves her. Participants also noted that normalisation of violence within the culture meant that both men and women did not always recognise that IPA was *'wrong'*. Interestingly, women were just as likely as men (and in some cases more likely) to endorse gender roles condoning male control and acceptability of IPA, signalling the need for interventions to address IPA-related attitudes among both genders.

Regarding IPA and help-seeking, 40% of women stated that they would *not* seek help if being abused. Help-seeking intention was much lower among men; only one man (7%) indicated that he would seek help if being abused, while only two (13%) would seek help if they were perpetrating abuse. Those inclined to seek help preferred informal help-seeking options, indicating a preference for family members and religious leaders. Options of social organisations, legal organisations, medical services and mental health counsellors were not selected by any respondents.

While this reluctance may be due in part to barriers to access (e.g. transportation, language), social norms appear to play a role. In focus groups, both women and men emphasised the role of shame and social stigma in discouraging help-seeking for IPA and stressed that IPA is a *'private matter'* to be resolved within the family. Some participants even noted that asking for help would lead to being *'laughed at'*, presumably because violence is perceived as normative. Concerns about help-seeking sources violating confidentiality were also a concern, as were issues such as not possessing appropriate documentation to allow for legal residence in Malaysia and worries about being able to communicate in the language used by local service providers [see Table 10].

Using results to inform intervention

'Healthy Relationships' workshops

These data have important implications for the development of tailored interventions targeting social and gender norms, mental health and stress. We used data to inform a three-day, curriculum-based, mental health integrated, *'healthy relationships'* workshop for Rohingya women, men and community leaders in Malaysia (Welton-Mitchell, James, & Tenaganita, 2018). The manualised intervention includes community-specific examples of IPA and discussion about risk factors and consequences of IPA, with emphasis on chronic stressors, mental health and coping, social norms, gender roles and overcoming barriers to help-seeking (manuscript forthcoming).

The three-day workshops concluded with participants developing anti-IPA/pro–help-seeking community

Table 10: Barriers to help-seeking for victimisation and perpetration of IPA, responses from focus groups and household interviews combined (qualitative data)

Themes: Barriers to help-seeking for IPA	Representative quotes
Lack of perceived options	*If you fracture the family unit, then where are they going to go? So that is one of the fears women have*
Belief that talking about the situation won't result in change	*This is like painful things I have experience, after talking what do I get out of it anyway, [is the person] able to help me? People will laugh because they think there is no point in telling*
Perceived as private matter	*They think it is family matter you don't need to tell to others. We can't tell private things to others*
Belief that the couple will solve problem without help from others	*We will solve it with discussion. She is my wife and we will be good to each other again, so there is no benefit in telling; I can change myself; I will settle my own family matters*
Shame; concerns about negative perception of community by outsiders	*It is a shame in the community to talk about. How can I tell others my mistake? It's a shame if I tell and people will laugh at me. They're already in a community with a lot of stigma, talking about this adds on another layer of stigma*
Concerns that consequences of reporting will be too harsh	*Because a lot of times survivors think that reporting means that some action, some harsh action will be taken*
Violence perceived as normal/acceptable	*This is a way to teach/educate my wife but I know my limits so I won't harm her*
Concerns about lack of confidentiality	*They could see someone who comes from the [area] and they can quickly identify someone and they think okay, this person is going to tell my husband now that I was seeing the UN*
Lack of documentation prevents help-seeking	*Where will we go for help? Without documentation, we cannot go to police station*
Language barriers prevent help-seeking	*. . . language barrier cause them [to] feel like they don't have rights under law at all, so they are not entitled to seek help, knowledge*

messaging campaigns. The resulting posters incorporated social norms approaches and were transformed into professional-grade materials by a local artist. Materials were tested for impact on IPA-related attitudes among men and women during the last phase of the research, using a randomised controlled trial design (manuscript forthcoming).

Conclusion

This article highlights results from the exploratory phase of a multi-phase research study on IPA among Rohingya in Malaysia. Despite the clear benefits of this research in promoting better understanding of the needs of Rohingya in Malaysia and elsewhere, results should be interpreted with caution considering the small sample size. This empowering context-specific approach to intervention development and adaptation has the potential for scale-up for broader use in Malaysia and elsewhere. A parallel process has already been used successfully with Syrian refugees in Lebanon (manuscript in preparation).

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Conflicts of interest

There are no conflicts of interest.

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