**UNDERSTANDING INTIMATE PARTNER ABUSE AMONG ROHINGYA IN MALAYSIA: ASSESSING STRESSORS, SOCIAL NORMS, AND HELP-SEEKING TO INFORM INTERVENTION**

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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. Rohingya in Malaysia are particularly marginalized and vulnerable, being stateless and often unable to legally work or access various services. Related stressors, along with social norms condoning IPA, may put Rohingya communities at risk, while also contributing to under-reporting and limited help-seeking. As part of a larger study, a multi-national team collected information about IPA among displaced Rohingya in Malaysia through household interviews and focus group 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 and IPA. Social norms emphasizing the acceptability of intimate partner abuse and discouraging help-seeking were also common. These data were subsequently used to develop a 3-day curriculum-based healthy relationships workshop, integrating participant-led development of IPA-focused messaging campaigns. The workshop was created in collaboration with and facilitated by Rohingya community members. This data-driven and collaborative intervention development process empowers communities to generate their own solutions to challenges such as intimate partner abuse. This model has the potential for scale up within Malaysia and elsewhere.

Keywords: intimate partner abuse, domestic violence, Rohingya

**INTRODUCTION**

Intimate partner abuse (IPA), is one of the most common forms of gender-based violence worldwide. In a multi-country study conducted by the World Health Organization, prevalence of IPA ranged from 15% to 71% (Garcia-Moreno et al., 2005). Latest global estimates suggest that lifetime prevalence among ever-partnered women is approximately 30% (WHO, 2013). IPA can have profound psychological and social consequences for survivors, families, and communities (GEN Myanmar, 2014; WHO, 2012). Risk for IPA can increase during periods of civil conflict and associated displacement (Delksoh et al., 2017). Yet compared to other less common forms of GBV, IPA has received limited attention from humanitarian agencies and other service providers working with forced migrants (Gupta et al., 2014).

**IPA among Rohingya**

Among displaced groups, and even compared with other refugees from Myanmar, Rohingya are particularly marginalized and vulnerable. Rohingya are one of the most persecuted minorities in the world, and one of the largest groups of stateless persons (Kiragu, Rosi and Morris, 2011). While many Rohingya have fled to camps in Bangladesh, thousands more reside in neighboring countries including Malaysia, India, Thailand, Pakistan, Saudi Arabia and elsewhere (Asrar 2017). Research with Rohingya in camps in Bangladesh indicates that IPA is common and may be exacerbated by stressors encountered in their host country, including movement restrictions, and lack of employment opportunities (Akhter and Kusakabe, 2014).

**IPA in Myanmar**

In light of limited existing research focused specifically on IPA within the Rohingya community, it is relevant to look to the broader context of Myanmar, where many Rohingya existed for generations prior to being persecuted and forced to flee (UNHCR and IOM, 2018). In Myanmar, intimate partner abuse appears to be common. A study of married women in Mandalay, Myanmar, found that 69% of respondents had experienced domestic violence by intimate partners in the last 12 months (Kyu and Kanai, 2005). Research with intimate partner abuse survivors in seven other locations in Myanmar indicates that IPA is most commonly perpetrated by husbands, and typically entails multiple incidents and multiple types of abuse (e.g. emotional, economic, beatings, forced sex; GEN Myanmar, 2015).

**IPA and chronic stressors**

IPA exists across contexts and cultures (Garcia-Moreno et al., 2005; WHO, 2013). However, some factors may exacerbate risk. For example, research suggests there is a complex relationship between economic stress and intimate partner abuse (see Renzetti and Larkin, 2009 for a review). An inability to cope with various stressors typically associated with displacement may similarly play a role in maladaptive behaviors, including men becoming abusive with their partners (Abramsky et al., 2011; El-Masri, Harvey and Garwood, 2013; Umberson et al., 2003; Akhter and Kusakabe, 2014). Research with Rohingya in camps in Bangladesh indicate that in addition to lack of livelihood opportunities, difficulties obtaining sufficient food, discrimination from local communities, and safety concerns are common, and have been associated with mental health difficulties (Akhter and Kusakabe, 2014; Riley et al., 2017).

Given this, it may be expected that stressors Rohingya encounter in Malaysia may also exacerbate risk for IPA. UNHCR’s September 2017 figures indicate there are currently more than 62,000 registered Rohingya in Malaysia, along with tens of thousands more unregistered (Carvalho, 2017). Rohingya face numerous hardships in Malaysia 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 and Powell, 2017). Fragile legal status, discrimination from multiple sectors, including local community members and other groups from Myanmar, and arbitrary arrest and detention by the authorities may make life in Malaysia particularly challenging for Rohingya (FIDH and SUARAM, 2008; Smith, 2012). Local service providers have attributed intimate partner abuse among Rohingya in Malaysia to these types of factors associated with the pressures of living as illegal migrants, along with changes in social norms associated with traditional gender roles (Tenaganita, personal communication, May 2016).

**IPA and social norms**

In recent years there has been increasing evidence regarding the role of social norms in perpetuating domestic violence, especially norms associated with a belief that men should ‘discipline’ their wives and women should tolerate abuse from their partners (Paluck and Ball, 2010). Globally, attitudes condoning IPA are positively associated with abusive behaviors towards one’s partner (Capaldi et al., 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 domestic violence (Heise and Kotsadam, 2015). Others have emphasized that in many countries where women agree that a husband has a right to beat his wife, rates of intimate partner abuse tend to be high (Kishor and Johnson, 2004).

Evidence suggests that such social norms condoning violence are common in Myanmar (and by association, likely common among Rohingya). For example, there is a proverb in Myanmar - “If you beat your wife until her bones are broken, she will love you more” (GEN Myanmar, 2015). Even health providers in Myanmar may hold beliefs that relationship violence is to be expected. In one study, medical staff indicated that women should be “patient” with abusive spouses and stated that “it’s natural for this to happen between husbands and wives” (Greifinger et al., 2015). Such examples underscore the extent to which social norms in Myanmar sanction intimate partner abuse and attempt to minimize its negative effects.

Gender roles are essentially social norms that stem from cultural beliefs about what is appropriate for a specific gender. Certain gender roles can perpetuate IPA, such as beliefs that women should be submissive and men aggressive. Moreover, gender roles may change in the context of displacement, which may exacerbate risk for IPA. 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 and Kusakabe, 2014). In Myanmar, Rohingya women have traditionally been discouraged from working (Ripoll, 2017). Many Rohingya living in Malaysia also prefer that women not work outside the home (IRC, n.d.). However, lack of sufficient income earning opportunities for families in exile may mean women also need to contribute to the household income. In addition, Rohingya families often live alongside local Malaysians and may be influenced by Malaysian women’s relative freedom of movement beyond the household (an estimated 54% of Malaysian women work outside the home) (Labor Force Survey Report, 2016). These influences may drive associated changes in traditional gender roles, with increased risk of IPA during periods of transition, especially if social norms about what is acceptable for men and women do not evolve to fit the new context.

Given this, there has been a growing consensus about the need to understand relevant social norms in high-GBV contexts, and the role that interventions targeting social norms might play in reducing gender-based violence (Paluck and Ball, 2010; Private Violence, Public Concern, 2015). Interventions that challenge or provide alternative social norms can be a cost-effective tool for behavioral change, possibly mitigating violence by altering perceptions about which attitudes and behaviors are typical or preferable. However, there is a dearth of research on use of social norm approaches to address intimate partner abuse, including among refugees and other forced migrants (WHO, 2009).

**IPA and help-seeking**

IPA is notoriously difficult to address in large part because it is underreported. Research suggests there are substantial barriers to women reporting and otherwise seeking help for domestic violence (Gover et al., 2013). Barriers to help-seeking for intimate partner abuse may be even greater for recent immigrants (Reina, Lohman and Maldonado, 2014). Research with Syrian refugees underscores this challenge, emphasizing that there is a reluctance to speak about intra-family violence, in part due to concerns over disgracing the family (UN Women, 2013). In a study of married women in Myanmar, 93% of survivors of IPA did not seek help (Kyu and Kanai, 2005). Research suggests that women in Myanmar typically don’t seek help due to various social norms discouraging help-seeking, including victim-blame and an associated sense of shame for having been victimized (GEN Myanmar, 2014). Among Rohingya intimate partner abuse is often seen as a matter to be dealt with by the family alone (Ripoll, 2017). Prohibitions against disclosure of intra-familial violence to those outside the family may explain in part why service providers have been slow to acknowledge the extent of IPA and to develop appropriate interventions to address it, especially among forced migrants.

**STUDY PURPOSE**

Considering the weak evidence-base for prevention of IPA, more research is needed not only to determine what interventions are effective, but to provide information about prevalence, causes and consequences of IPA that can influence intervention development at the outset. Considering the importance of community-specific factors, such as chronic stressors encountered in host country settings, and social norms and help-seeking behavior associated with IPA, interventions should be tailored to the specific communities in which they are implemented. In order to do so, the intervention development and adaptation process should involve collection of initial baseline data to examine relevant phenomena, and ongoing involvement of community members to ensure fit of interventions to specific settings.

In the current paper, we detail the results of mixed-method data collection conducted with Rohingya community members in Gombak District, Malaysia. This exploratory study aimed to clarify perspectives from women, men, community leaders, and service providers regarding: prevalence of IPA; chronic stressors, including those perceived to influence IPA; social norms associated with acceptability of IPA and gender roles; and help-seeking for IPA (including preferred forms and impediments to help-seeking). We go on to explain how this data was used to inform the development of a successful intervention with community members.

**METHODOLOGY**

**Ethical approvals**

Working in collaboration with local research partners and community members, care was taken in designing the research based on ethical guidelines for research on gender-based violence, including intimate partner abuse (see Ellsberg and Heise, 2005; Sikweyiya and Jewkes, 2012; Watts et al., 2001; WHO, 2007). We received approval for this research from the institutional review board at the University of Colorado, Boulder, and the Medical Research and Ethics Committee (MREC) in Malaysia.

**Sampling and procedures**

Data were collected from a total of 75 Rohingya community members residing in Malaysia, consisting of 30 interview participants and 45 focus group participants. Participants were primarily sampled from two of 14 identified communities in Gombak District, with some service providers and community leaders coming from 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 neighboring districts.

Household interview participants (15 women and 15 men) were recruited by local researchers who approached all eligible households in a designated sampling frame, using a recruitment script. If participants met inclusion criteria (age 18-60 and residing in the area), the informed consent process was conducted in a private area of the home and participants were asked to provide verbal consent (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 and approached. For safety reasons, no two people/no couples were interviewed in the same household, and all interviewees were interviewed with no others present. Structured interviews were administered on tablets using Qualtrics survey software. Interviews were conducted in Rohingya language by Rohingya interviewers matched to the gender of the participant.

Community members (women, n = 15 and men, n = 12) were recruited for two focus groups, using methods similar to those described above. Focus groups were held at the office of a local community organization. Community leaders (n =10) and service providers (n = 8) were recruited for two additional focus groups, through the local research partner’s professional networks. These focus groups were held at the office of the research partner, a local non-governmental organization working on behalf of migrant rights. Because only four service providers were able to attend the focus group due to scheduling conflicts, four individual interviews were conducted later at the office of each service provider. The FGDs with community members were conducted in Rohingya, while groups with service providers were in Bahasa Malaysia and English. All focus groups were audio-recorded and then translated and transcribed in English by members of the research team.

Because there is no standardized and well-known written Rohingya language, materials (informed consent, interview questions and focus group scripts) were translated from English to Rohingya using audio-recordings, then back-translated to English. Rohingya translations were discussed at length, and cross-checked with the original English, to ensure equivalent constructs were being used. Four local Rohingya researchers (2 men, 2 women) referenced audio recordings to ensure fidelity to materials across interviewers.

For interviews and focus groups, participants were compensated with a gift of a bag of rice, along with some additional drinks and snacks, in line with the protocol approved by the local research partner.

Table 1. Participant demographics, household interviews.

|  |  |  |
| --- | --- | --- |
| **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 wife only = 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 of the 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 |
| 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 |

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

**Interview Measures**

**Personal and partner exposure to IPA.** The Revised Conflict Tactics Scale-2 (CTS-2; Straus et al., 1996) is widely used in assessing domestic violence (see Kyu and Kanai, 2005 for use in Myanmar). This study used the CTS2 Short Form (CTS-2S), a twenty-item scale measuring both perpetration and victimization of the respondent including items associated with negotiation, psychological aggression, physical assault, injury and sexual coercion (Straus and 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 CTS2S are similar to that of the full length CTS2.

**Chronic stressors associated with the current situation in Malaysia.** Participants were asked to indicate the *top 5 problems causing you stress during the past month*. They were given 22 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 14-itemscale 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 behavior?* 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 10-item scale measuring attitudes about acceptability of wife beating was used, 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 et al., 2004). The adapted measure used in this study consisted of 28 items measuring respondents’ individual beliefs and perceptions of community beliefs. For brevity’s sake, in this study, we focus on 14 items measuring individual beliefs, including 12 taken from the original scale, and 2 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 5-point scale with responses ranging from strongly disagree to strongly agree.

**Attitudes towards help-seeking.** Help-seeking intention for IPA victimization and perpetration was assessed using an investigator developed question: *If you were being abused by your partner, would you tell someone/seek help?* Those who indicated “no” were asked to explain “why not”, and those indicating “yes”, were asked to indicate where they would seek help from a 9-item list (e.g., your family, religious leaders). Subsequently, participants were asked: *If you found that you were using abusive behaviors with your partner, would you tell someone/seek help to try to change this behavior?,* again with follow-up questions about reasons why not and where they would seek help.

**Focus Group Discussion Topics.** Key topics addressed in all four focus groups included factors contributing to IPA in this community (sources of conflict, including stressors, social/gender norms), and beliefs about help-seeking (encouraging and discouraging factors, including social/gender norms).

**RESULTS**

For the quantitative data, files were initially cleaned, processed, and analyzed using IBM SPSS Statistics 24. For the qualitative data, five coders from differing backgrounds independently coded all focus group transcripts, based on categories established according to the questions asked of each group (e.g. factors perceived as contributing to IPA, barriers to help-seeking). Coders were also able to create new categories as needed, representing an integrated approach to coding, utilizing a deductive organizing framework for code types, but allowing for inductive components as well. Subsequently, a consensus approach was used, resulting in a merging of common responses across coders and across focus groups.

Table 2. Personal exposure to IPA over the past 12 months, based on household interviews.

|  |  |  |
| --- | --- | --- |
|  | **Men (n = 15)** | **Women (n = 15)** |
|  | In the past year | In the past year |
| 4. My partner insulted, swore, shouted, or yelled at me | 7% | 87% |
| 5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner | 0 | 33% |
| 10. My partner pushed, shoved, or slapped me | 20% | 94% |
| 12. My partner punched, kicked, or beat up me | 0 | 54% |
| 14. My partner destroyed something belonging to me or threatened to hit me | 0 | 13% |
| 15. I went to see a doctor (MD) or needed to see a doctor because of a fight with my partner | 0 | 20% |
| 18. My partner used force (like hitting, holding down, or using a weapon) to make me have sex | 0 | 7% |

Note: WHO defines *current IPA* as within the last year (WHO, 2013).) Numbering based on item order in CTS short-form, with frequency of times from one to more than 20 collapsed. Key items presented here, full scale available upon request.

Table 3. Use of IPA against partner over the past 12 months, based on household interviews.

|  |  |  |
| --- | --- | --- |
|  | **Men (n = 15)** | **Women (n = 15)** |
|  | In the past year | In the past year |
| 3. I insulted, swore, shouted, or yelled at my partner | 40% | 7% |
| 6. My partner had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my me | 20% | 7% |
| 9. I pushed, shoved, or slapped my partner | 40% | 0 |
| 11. I punched, kicked, or beat up my partner | 33% | 0 |
| 13. I destroyed something belonging to my partner or threatened to hit my partner | 7% | 27% |
| 16. My partner went to see a doctor (MD) or needed to see a doctor because of a fight with me | 0 | 0 |
| 17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex | 0 | 0 |

Note: Numbering based on item order in CTS short-form, with frequency of times from one to more than 20 collapsed. Key items presented here, full scale available upon request.

Table 4. 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% |

Note: Top 7 stressors identified out of 22 options.

Table 5. 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 6. Factors perceived by women, men, community leaders and service provider 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*) |
| Stress related to events in Myanmar (*people are carrying the stress of what is happening in Myanmar and have never released it properly*) |
| UNHCR process (*everyone is stressed out about the UNHCR process*; registration issues) |
| Security issues, including arrest and detention |
| Husbands 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** (representative quotes in italics) |
| Normalization 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 emphasizing 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*) |

Table 7. Acceptability of IPA, household interviews.

|  |  |  |
| --- | --- | --- |
|  | **Men (n = 15)** | **Women (n = 15)** |
| *Does a man have a good reason to hit his wife if…?* | Agree | 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% |
| She leaves the home without his permission. | 87% | 86% |
| She refuses to have sex with him. | 67% | 53% |
| She does not complete her household work to satisfaction. | 60% | 33% |
| He suspects that she is unfaithful/cheating. | 53% | 20% |
| She wants to continue her education or do paid work outside the home. | 33% | 13% |
| She asks him whether he is having relations with other women. | 33% | 13% |

Table 8. Beliefs about gender relations, household interviews.

| *Please tell me if you strongly agree, agree, disagree or strongly disagree with the following statements:* | **Men (n = 15)** | **Women (n = 15)** |
| --- | --- | --- |
|  | Agree | 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% |
| Men should have the final say in all family matters | 93% | 93% |
| 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 woman cannot refuse to have sex with her husband | 93% | 87% |
| Working women should give their wages to their husband | 80% | 87% |
| 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% |
| Men and women should be treated equally | 67% | 73% |
| Woman can’t do anything about men's relations with other women | 60% | 80% |
| Men should share the work around the house with women | 13% | 20% |

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

Table 9. Willingness to disclose incidences of IPA, and to whom, household interviews.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Would you tell someone…** | | | | | | |
| *If being abused…* | | | | *If perpetrating abuse…* | | |
| **Men (% Yes, n)** | **Women (% Yes, n)** | | | **Men (% Yes, n)** | | **Women (% Yes, n)** |
| 7% (1) | 60% (9) | | | 13% (2) | | 50% (7) |
|  | | | |  | | |
|  | | *If being abused…* | | *If perpetrating abuse…* | | |
| *If you would tell, who would you tell?* | | **Men (n)** | **Women (n)** | **Men (n)** | **Women (n)** | |
| Family | | 1 | 9 | 2 | 5 | |
| Close friends | | 1 | 3 | 2 | 3 | |
| Religious leaders | | 1 | 6 | 2 | 0 | |
| Police | | 0 | 3 | 0 | 0 | |

Note: Numbers above based on small subcategory of those who would help-seek (n’s included to clarify sample size). Participants could select multiple options from a 9-item list. Other options of social organizations, legal organizations, medical services, or mental health counsellors were not selected by any respondents.

Table 10. Barriers to help-seeking for victimization 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? Firstly we just have UN and we could not go there as we do not have cards. Without documentation we cannot go to police station as well. It’s like there was no way to go for help.* |
| 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.* |

**DISCUSSION**

Women reported high levels of victimization, 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 them up in the last year (only 20% and 0% of men reported the same respectively). 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. 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. 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 victimization are notoriously underreported across contexts, suggesting that actual level may be significantly higher (Felson and Par, 2005; Gover et al., 2013). These results underscore the importance of interventions targeted towards Rohingya communities in Malaysia, especially considering the numerous adverse effects of intimate partner abuse, including increased risk for mental health difficulties (WHO, 2013).

These data on IPA should be considered in context. Rohingya in Malaysia often experience stressors that are unique to, or are exacerbated by, displacement and statelessness. Data regarding chronic stressors suggest that both women and men fear arrest by authorities and worry about a lack of livelihood opportunities in Malaysia. Many also experience stress associated with limited access to healthcare and education and have ongoing concerns about safety. Stress related to events occurring in Myanmar and separation from family members were also concerns. Interestingly, women perceived many of these environmental stressors as primary triggers for their partners’ abusive behavior, with an emphasis on money problems and work difficulties/unemployment.

For both men and women in this sample, social norms and gender roles condoning IPA were common. For example, 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. 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, signaling the need for intervention to address IPA-related attitudes among both genders.

Data also suggested that social norms and gender roles were associated with perpetration of IPA. For example, focus group participants noted that normalization of violence within the culture meant that both men and women did not always recognize that IPA was “wrong”. Others linked IPA to gender norms dictating specific roles for men and women – for example, that men perceive their wives as disobedient when their wives do not fulfill specific gendered tasks such as household work.

With regard to 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 indicated that he would seek help if being abused, while only two would seek help if they were perpetrating abuse. This includes both formal and informal help-seeking options (i.e. seeking help at a hospital compared to seeking help from friends or extended family members). Qualitative data regarding impediments to help-seeking revealed numerous barriers associated with community norms. Both women and men emphasized the role of shame and social stigma in discouraging help-seeking for IPA and stressed that IPA is a “private matter” to be resolved in the household. Interestingly, some participants noted that asking for help would lead to being “laughed at,” presumably because violence is perceived as normative. Confidentiality was also cited as a concern, as were issues such as possessing appropriate documentation to allow for legal residence in Malaysia and worries about being able to communication in the same language as local service providers (most service providers are not able to communicate in Rohingya or Burmese). Results emphasize the need for messaging campaigns that clearly advertise accessible help-seeking options and utilize positive social norms approaches, for example, by communicating that other community members support help-seeking.

**Intervention Manual**

In collaboration with local partner organizations and community leaders, and incorporating these results, we developed a 3-day curriculum-based workshop for women, men, and community leaders (Welton-Mitchell, James and Tenaganita, forthcoming). The intervention manual included community-specific examples of IPA and discussion about causes and consequences of IPA, with emphasis on the role of chronic stressors, mental health, social norms, gender roles, and strategies for overcoming barriers to help-seeking. Experiential components such as games, role-plays, and coping skill practice (e.g., breathing exercises) were used to convey content. Workshops concluded with community-member development of messaging campaigns incorporating social norms approaches. Separate workshops were conducted for men and women, with one mixed gender group of community leaders, for a total of 5 intervention groups. Men were asked to examine gendered social norms regarding IPA and modes for affecting change in attitudes that may promote IPA. Women were asked to focus particularly on ways that gendered belief systems may impact help-seeking in hopes of shifting beliefs and promoting help-seeking. Community leaders examined both topics. All groups developed associated messaging campaigns (images and slogans) targeting members of their own communities. These campaigns have been transformed into professional grade posters and will be tested for effectiveness during subsequent phases of the project using a randomized controlled trial design.

The intervention appears to have been effective. Participants (n = 72) were interviewed before the workshops began and two weeks later. Although the pre-post design has some methodological limitations, differences indicated a decrease in beliefs that IPA is acceptable and that help-seeking is unacceptable, a decrease in mental health symptoms, improvement in functioning and self and community efficacy related to managing relationship conflicts, and increased use of adaptive coping skills (separate manuscript with detailed results in preparation).

**CONCLUSION**

This paper outlines results of the initial exploratory phase of a multi-year mixed methods study. The purpose of the data collection highlighted in this manuscript was to facilitate understanding of community-specific factors related to intimate partner abuse among Rohingya in Malaysia. Although the sample size is relatively small, these data are informative as a standalone resource and as a tool for cultural-adaption of an IPA intervention to a specific community. This approach to intervention development and adaptation has the potential for scale-up for broader use in Malaysia and elsewhere; a parallel process has been conducted successfully working with Syrian communities in Lebanon (manuscript in preparation). Such a data-driven and collaborative intervention development process begins with understanding the dynamics of a particular phenomenon in specific context. The ultimate goal is to empower communities to generate their own solutions to challenges such as intimate partner abuse.

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