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Untold Stories of Displaced Rohingya Pregnant Women Exposed to Intimate Partner Violence in Camp Settings

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Abstract

Intimate partner violence (IPV) strongly impacts the physical, sexual, social, and reproductive health of women, causing an array of psychological and behavioural problems. During pregnancy, the detrimental effects of violence extend to both the mother and the child. Rates of IPV are frequently higher among those in conflict-affected and displaced communities, most of whom live in low and middle-income countries. IPV against Rohingya women is common due to relocation, family breakups, patriarchal norms, and deep-seated gender roles. Despite the high prevalence of IPV in Rohingya refugees in Bangladesh, the matter is often under-examined. This qualitative study aims to explore and understand pregnant IPV victims' unique experiences and hardships among the displaced population in a camp setting. A sample of six pregnant homemakers with no formal education was recruited from a healthcare service provider in Leda Camp 24, a remote camp in Cox's Bazar, Bangladesh. Semi-structured, in-depth, face-to-face interviews were conducted. Participants reported diverse manifestations of IPV victimisation. Physical abuse, emotional abuse, economic abuse, sexual abuse, pregnancy-related consequences, and impact on mental health were commonly experienced by participants of this study. The current research investigates the recurrent abuse experienced by this demography, providing detailed narrative information beyond quantitative descriptions of IPV experiences. This article contributes to the existing knowledge on the intersection of IPV, pregnancy,

and mental health among displaced populations. Governmental and non-governmental stakeholders must contextualise these findings in policies and practices by integrating IPV and violence screening, prevention, and treatment protocols into refugee camps and healthcare service providers.

Keywords
displaced population; domestic abuse; domestic violence; intimate partner violence; pregnant women; refugees

1. Introduction

This article contains details that some readers may find distressing.

Violence against women and girls has been increasingly recognised as a significant international human rights and public health problem and global concern (Ellsberg & Emmelin, 2014; Garcia-Moreno et al., 2006). From overt abusive behaviours such as punching, kicking, or pushing (Campbell, 2002; Devries et al., 2014) to mental health consequences—depression, anxiety, post-traumatic stress disorder, drug addiction, and low self-esteem (Devries et al., 2014; Ellsberg & Emmelin, 2014)— intimate partner violence (IPV) can affect women irrespective of their socioeconomic status, race, ethnicity, or religion. In high-income countries, the likelihood of substance abuse and alcoholism among female survivors of IPV is higher (Fowler, 2007). Antoniou (2020) underlines that substance abuse and low socioeconomic status during pregnancy are the primary risk factors for violence against women.

During pregnancy, the detrimental effects of violence extend to both the mother and the foetus (Antoniou, 2020). Perinatal IPV refers to violence by an intimate partner that happens within the first twelve months after conception, throughout pregnancy, or within the initial year after birth (Hahn et al., 2018; Sharps et al., 2007). Inadequate prenatal care, induced or spontaneous miscarriage, and intrauterine restriction were the most typical unfavourable maternal health-related outcomes after IPV during pregnancy (Martin et al., 2006; Rodrigues et al., 2008; Tiwari et al., 2008). Barez et al. (2022) discovered that the majority of abused women did not reveal instances of violence, even though they were regularly screened for perinatal IPV throughout prenatal care.

In the context of displaced populations in low- and middle-income countries, IPV is often under-examined. Studies highlight that the process of displacement may lead to isolation, disruptions in relationships and families, and less communication during vulnerable periods (Alghamdi et al., 2021; Dowllah & Melville, 2023; Falb et al., 2014; Mishkin et al., 2022). Past quantitative research conducted with different refugee women (Feseha et al., 2012; Hadush et al., 2023; Islam et al., 2021; Sipsma et al., 2015) reported a higher level of the lifetime prevalence rate of IPV. Studies among Rohingya in Malaysia, Palestinians in Jordan, and Syrians in Lebanon underscore alarmingly high rates of IPV, particularly severe physical violence experienced by a significant portion of women (James et al., 2021). Moreover, research across various camp settings like South Sudan, Kenya, and Iraq identified factors like disrupted social roles, exposure to war-related violence, economic hardships, and limited access to essential services significantly heighten the susceptibility to IPV among displaced populations (Ondeko & Purdin, 2004; Strang et al., 2020; Wachter et al., 2017).

The Rohingya, a Muslim ethnic community, have experienced numerous atrocities in Myanmar and discriminatory laws that endangered close to one million people who are now stateless (Akins, 2018; Zahed, 2021). With no legal status and facing numerous human rights violations, the Rohingya have been left with little choice except to migrate or die (Faulkner & Schiffer, 2019). The Rohingya had been forcibly displaced in Cox's Bazar, one of the poorest areas in Bangladesh, struggling with numerous challenges, including extreme poverty, dense population, frequent natural catastrophes, and climate change (Ahmed, 2010). Pregnancy rates among Rohingya women and girls are high, which may be a sign of a rise in sexual abuse and violence associated with conflicts (Hutchinson, 2017).

IPV against Rohingya women is common due to relocation, family breakups, patriarchal norms, and deep-seated gender roles, which aligns with studies exploring Muslim women's experiences with IPV, highlighting the intersection of cultural and religious factors in shaping these experiences (Ammar et al., 2013; Milani et al., 2018). Statistics from the International Rescue Committee show that 81% of gender-based violence in a camp setting is committed by partners or husbands, with 56% of incidents including physical abuse. Islam et al. (2021) and Gerhardt et al. (2020) found that 72% of partnered women among Rohingya refugees in Bangladesh had suffered IPV. Despite the high rate of IPV in this demography, few studies have examined IPV in Rohingya refugees in Bangladesh.

To the best of our knowledge, no qualitative studies have yet been conducted on this topic among the displaced Rohingya population in Bangladesh. The current study aims to explore through Rohingya women's voices a more in-depth exploration of the unique experiences of pregnant women who are abused. This study will try to answer three research questions:

1. What are the different forms of IPV experienced by displaced Rohingya pregnant women?
2. How does IPV impact pregnant women living in a camp setting?
3. How do various forms of IPV experiences affect their mental health?

2. Materials and Methods

2.1. Design

A qualitative approach was used for this study, as very little is known about this developing area of interest.

2.2. Participants Recruitment

This study was performed in Leda (Camp 24), one of the makeshift refugee settlements in the vicinity of Teknaf, a tiny town in southern Bangladesh that shares a border with Myanmar. The colony is home to an estimated 26,793 individuals (UNHCR, 2021).

The participants were recruited from the IOM Hospital in Leda Camp 24. This facility was chosen to engage with the participants because it offers essential obstetrics healthcare services and provides assistance to women who are victims of domestic violence. Between March and April 2023, participants were recruited during their medical appointments through purposive sampling (Polit & Beck, 2006). Pregnant women over 18, of refugee status, living in a camp setting, and who have been victims of IPV in the last 12 months

were selected. Patients who met the above criteria were contacted, and the research and interview procedures were explained to them. Patients who had indicated interest in participating ($N = 6$) were invited into the research.

2.3. Ethical Considerations

This original qualitative study protocol was approved by the Holy Family Red Crescent Medical College's Institutional Ethical Review Board (Ref. IERC/35/Res/JAN/2023/26/Ex). The Bangladesh Red Crescent granted institutional permission, and verbal informed consent to conduct the research was obtained from the Office of the Refugee Relief and Repatriation Commissioner of Cox's Bazar. All research was conducted in compliance with safety guidelines for researching domestic violence, refugees, and vulnerable populations (Bailey & Williams, 2018; Ellsberg et al., 2001; Jewkes et al., 2000).

Before gaining consent, the research participants were provided with information about their entitlement to refuse participation or withdraw from the study at any point. They were assured that their decision to reject or terminate participation would not affect their ability to receive services in the camp. The authors acknowledge the participants' unease in a situation where they have no prior experience with research or lack of legal standing in the country. Moreover, researchers understand that participants might agree with the expectation that the researcher will be able to support them and their families. This is why the study's participants were thoroughly informed of our objectives and procedures.

Each participant was given a unique identification to guarantee confidentiality and privacy and mitigate any potential risks related to the sensitive content of the interviews. All participants were offered a pre-packaged lunch and travel expenses. This study followed the highest ethical standards and was steadfastly committed to participant safety and well-being, ensuring a secure research environment.

2.4. Data Collection

Semi-structured, in-depth, face-to-face interviews were conducted (see also the Supplementary File). Open-ended questions in a semi-structured interview approach enable participants to react, and the interviewer may follow up on their comments (McIntosh & Morse, 2015). Questions were developed based on previous research on IPV (Balogun & John-Akinola, 2015; Feder et al., 2006; Kyegombe et al., 2022; Showalter & McCloskey, 2021; Thomas et al., 2008). Furthermore, the authors (IMD and AKB) drew upon extensive expertise and knowledge gained from working with Rohingya refugees for more than five years. They designed questions that were culturally appropriate to the research population. The questions focused on the type and frequency of IPV experienced, coping mechanisms, access to resources and support, and mental health outcomes.

A trained female research assistant, with a graduate degree, administered the questions in person. The interviewer received training on qualitative methods, interviewing techniques, safeguarding participants, risk mitigation, and handling unanticipated emotions from two authors (AKB and MKF). Pre-testing was done to ensure the interviewer's credibility (McIntosh & Morse, 2015).

Before the interview commenced, the interviewer introduced herself, explained the research purpose and procedure, assured participants of confidentiality, informed participants of their option to take breaks if they experienced discomfort, and reaffirmed their right to withdraw at any moment. This facilitated the interviewer in fostering a connection and establishing comfortable interactions. The face-to-face interviews lasted an average of 30 minutes. All participants indicated that family and childcare commitments limited their ability to participate for a longer period of time. The interviews were conducted in a private setting to ensure confidentiality.

2.5. Data Analysis

Reflexive thematic analysis guidelines and methodical procedures were used to analyse the data and provide answers to our three research questions (Braun & Clarke, 2006, 2019). Recorded audio interviews were transcribed semi-verbatim by two authors (IMD and AKB) and reviewed by one of the authors (MKF) for accuracy (Saunders et al., 2018). There was some variation in the quantity of material provided in responses by participants; some of the respondents decided to provide detailed descriptions of their experiences, while others chose to give relatively brief answers.

The researchers (IMD and AKB) meticulously analysed the qualitative data on a per-item basis to establish the credibility of the collected data. This analysis began by comprehensively examining all participants' responses to a particular question. After repeatedly reading the transcripts to familiarise themselves with the content, both the authors adhered to standard coding procedures by underlining keywords or phrases and creating marginal notes to emphasise significant elements in each response, as per McIntosh and Morse's (2015) methodology. Disagreements were discussed until a consensus was achieved. The coding process was executed using the qualitative data analysis software NVivo 12. Afterwards, one author (MFK) reviewed the codes to ensure the reliability of the data.

After completing the coding process, codes were allocated to potential themes, encapsulating the statements' fundamental attributes. The text describes extracting and categorising coded passages related to "the different forms of IPV experienced by participants," "how this experience impacts their lives in a camp setting," and "how it affects their mental health." The themes were established through an iterative categorisation, discussion, and categorisation process for the codes and passages. The themes were rigorously reviewed to ascertain their relevance to the data and their ability to represent it accurately. Ultimately, a selection of extracts was made to serve as representative examples of the themes identified in the research for reporting.

3. Results

This study included six pregnant refugee women aged 18–30, with an average age of 26. All participants are housewives with no formal education and have direct experience with IPV. Significantly, of the six participants, only two are now living with their spouses, while three are separated due to abandonment, and one is divorced. Regarding family demographics, the participants reported having between one to three children. The severity of the IPV experienced is highlighted by the health complications reported, including miscarriage, attempted forced abortion, burns, and hospitalisation.

We explored the lives of pregnant Rohingya women marked by a harrowing confluence of displacement, vulnerability, and violence. While the world has borne witness to the plight of this marginalized population, the specific experiences of those enduring the brutality of their husbands remain largely obscured. This section delves into the heart of this darkness, offering a raw and unfiltered account of the abuse suffered by pregnant Rohingya women in a refugee camp. The data analysis for this article was broadly separated into five main themes. Each theme will be discussed alongside the sub-themes chosen and supported with reference to participant quotes. In the following section, we will discuss various kinds of assault, including sexual misconduct, that some readers may find distressing.

3.1. Physical Abuse—A Brutal Reality

The lives of these women were marred by a pervasive and insidious darkness: physical abuse. It was a constant, cruel companion; its presence felt acutely during and after their relationships. Their experiences progressed from a gentle warmth of early fondness to a brutal intensity of violence, unfolding as a terrifying journey into a world of agony and terror. The following accounts illuminate the diverse and devastating forms this abuse took, offering a chilling portrait of lives shattered by brutality.

The physical abuse endured by these women often escalated into acts of extreme and ruthless violence that shattered their sense of safety and security. These brutal assaults left indelible marks, not just on their bodies but on their souls. Five out of six participants reported severe forms of physical assault. One participant described a deeply distressing and abusive relationship with her partner:

> He used to hit me with sticks in front of my children. He used to keep beating me till I fell on the floor senseless. He never stops. I wouldn't remember anything, just my children crying in the background, and he continued beating me. (P1)

Two of the participants talked of being hospitalised because of serious physical assault. These instances also explain the magnitude of the violence. One participant whose relationship was initially positive but deteriorated significantly over time recounted:

> My neighbours rescued me and took me to the hospital. I was there in the hospital and he spent his time in the brothel. My parents took care of me. And he was enjoying himself with his friends and other girls. (P6)

Another participant explained:

> One time, he crossed every line and slapped me. That time I felt like I lost all respect for him. I went to my father's home and decided I would never return to him. (P4)

While the initial acts of physical abuse often manifested as less severe forms, such as slapping, the experiences shared by some of the women reveal a terrifying escalation of violence.

The following testimony reveals the depths of cruelty perpetrated upon the victim, with profound and lasting impacts on their mental health: While carrying a third child, this participant fights for the survival and

well-being of her two girls on her own. She described a particularly horrific form of violence when her partner assaulted her by throwing boiling water. This act of extreme aggression and scalding terror underscores the terrifying reality these women faced:

> I was bruised so badly I tried to hide my blackspot with a cotton cloth in the bruised area. He saw that and took the boiling water and threw it in my hand. I was in so much pain. I always tried to conceal it in front of everyone. I always kept it to myself. I used to curse my fate and complain to Allah for giving me this life. That was so painful. I thought I would die. I can't explain to you the pain I had that day. Even now, you can see the scar mark. Now I have to bear this through the rest of my life. (P5)

The physical abuse endured by these women extended beyond their suffering, casting a long shadow of fear and pain over their children, feeding into a cycle of violence. Participants reported witnessing, and in some cases experiencing first-hand, their partners' violent behaviour towards their children:

> He used to beat our children as well. He once kicked my son just to show his anger. I cried a lot and begged him to show mercy. But he didn't listen to me. (P3)

3.2. Emotional Abuse—A Prison of the Mind

Beyond the physical brutality, these women were trapped in a psychological prison constructed by their partners. Their experiences were characterised by anxiety, uncertainty, and emotional torment. The next section discusses the tactics used to lower their self-esteem and manage their life. The participants' accounts provide a vivid glimpse into the emotional damage caused by violent relationships.

Verbal abuse, a tool of control and intimidation, was a common experience for these women. The constant barrage of insults, criticisms, and threats eroded their self-esteem and impacted the victim beyond herself, with children often bearing the brunt of the mothers' emotional turmoil. One participant spoke of her experience of public humiliation:

> I got really scared of him. I have never seen this side of his. My daughter was only three months old, and she was breastfeeding. I begged him not to create any scene as my daughter started crying. But he was someone else at that time. (P4)

The constant unpredictability of their partners' behaviour created a climate of fear for these women and their children, who lived under a constant shadow of uncertainty. The weight of this unpredictability, as well as the worry of what the future could contain, compounded their already traumatic experiences:

> [I kept thinking] about when he would come back and start shouting and arguing about god-knows-what. I always thought of that. Always. [And] with that, the uncertainty about my children's future. How to educate them. How to give them a good life. How to feed them. Provide them with clothes. It always makes me worried….I always thought about how he was going to react if he beat me again. What will happen to my kids? A lot of things are going through my mind. These make me helpless and weak. Also, alone. (P1)

3.2.1. The Illusion of Dominance

Controlling behaviour is more than just a series of actions; it's a covert form of psychological warfare perpetrators utilise to erode their partners' sense of self and independence. Societal norms and expectations can contribute to the insidious exercise of power by one partner over another. Half of our participants described enduring domination within their marriages:

> I didn't get a chance to talk about my problem. He didn't allow me to share [anything] with my parents and brother. He threatened me many times, so many times, about not talking about it. He also threatened to harm my children, which made me so concerned I kept my mouth shut for the whole time. (P2)

3.2.2. The Pain of Neglect

Neglect manifested in various ways, including emotional withdrawal and a disregard for their needs and those of their children. As one participant described, infidelity can be a catalyst for this neglect, as the partner retreats into a shell of indifference:

> We passed through the worst relationship when [another] girl came between us. We were arguing day and night, all the time. He never listened to me. He never asked for any opinion. I felt very valueless in any family issues and decisions. (P3)

3.2.3. Betrayal and Toxic Influences

Infidelity was a recurring theme among most of the participants ($N = 5$), often perceived as a form of psychological abuse. One participant's experience highlights how the revelation of her husband's infidelity marked a turning point in their relationship, ushering in a new era of fear and control:

> He started a relationship with a woman, and that was the moment that changed my whole marriage. After the relationship, he starts ignoring me. He wanted to marry that woman. (P2)

A single mother of two facing financial hardship described how external relationships, particularly those of her partner, had a detrimental effect on their lives:

> He then starts going to brothels. His friends were a really bad influence. He even starts seeing other girls. I didn't have any clue at the time. But soon I realised something was wrong. I found out about his [other] relationships. (P6)

3.3. Economic Abuse—A Crushing Dependency

The female participants in this research encountered a widespread and consistent pattern of financial authority imposed by their partners. The societal norm dictating that women should rely on males for financial support has resulted in an unequal distribution of power, enabling the potential for exploitation and manipulation.

Food deprivation and withholding of basic means was reported by the majority of participants in this study; however, the potential for this form of abuse underscores the degree to which fundamental necessities can be weaponised within these detrimental dynamics. For example:

> He restrained me from having food while I was pregnant. He didn't let me eat. He stopped supplying us with food. Even if I borrowed it from someone else, he deliberately threw it away so that I couldn't have it, since he didn't want me to have it. (P6)

"Financial shackles" are a prevalent phenomenon among undereducated women residing in refugee camps who depend on their spouse's economic assistance. The interdependence between partners is frequently manipulated in cases of IPV:

> He doesn't want to send my kids to school. The relief we regularly get from the NGOs, he sells it to the local market and takes away all the money and spends it on that girl. (P3)

In the absence of financial assistance, victims are compelled to endure a highly challenging circumstance wherein they are incapable of maintaining their family and must rely on others' assistance:

> I had to beg others for food, but not many helped us because no one wants to help the one whose husband is not with them. (P5)

The trauma of abandonment, especially during pregnancy, heightened the hardships faced by these already displaced women, leaving them to navigate life's challenges with increased vulnerability:

> One day when I was pregnant with the third one, I heard he married another girl somewhere. He left us and the camp, went to Chittagong, and started his new family. He wasn't with us for over a month. He didn't come back. Then I decided to chase him, and I went to Chittagong with my daughters, where he was living with another woman. I tried to convince him but he harassed me in front of everyone. He told us he would not come back. Then I asked him to divorce me and give me alimony, and also take responsibility for my children. He refused and kicked us out. Now I am back in the camp with my children and have no guarantee of their future. (P5)

3.4. Sexual Abuse—Pregnancy-Related Consequences

For victims of IPV, pregnancy can be a traumatic ordeal, despite its status as a time of optimism and anticipation. The vulnerabilities of pregnancy are cruelly exploited by abusers, resulting in a range of health-related consequences.

One participant stated that her relationship evolved over time. The maltreatment escalated following the birth of their first child, a daughter. Her spouse has neglected to support their family, has engaged in sexual misconduct, and has subjected her to physical and emotional abuse. In one particularly distressing narrative, she recounted how her spouse attempted to terminate her pregnancy forcibly. This chilling account sheds light on the extreme measures of control and violence that can manifest within intimate relationships:

> During this turmoil, I was pregnant with my second child. One night we had a big argument that I can't forget. He kicked my belly and tried to abort my child. He got so mad, and he was furious at that time. (P2)

Another participant shared a similar story of facing adversity after giving birth to a girl. The harrowing event of suffering a miscarriage was a direct consequence of the brutal abuse inflicted upon her. This tragic outcome underscores the extreme violence experienced by many victims and the devastating, long-lasting consequences that extend far beyond physical injuries. The physical toll of IPV is often devastating, but its impact can be even more profound when it results in the loss of life:

> But it all suddenly changes after the birth of my first child. It was a girl. He was so unhappy that I didn't give birth to a boy….Once, my husband beat me so bad I had a miscarriage. I was three months pregnant. I can't describe it. It was [such] a horrific experience…I actually can't remember it properly. (P1)

3.4.1. A Battleground of Intimacy

During the discussion, participants revealed disturbing patterns of sexual exploitation and coercion. From being blamed for their partner's sexual dissatisfaction to enduring forced sexual encounters, these women's bodies became battlegrounds for power and control. Their experiences highlight the complex and insidious nature of sexual abuse within the context of IPV. One participant's existence was once filled with optimism; however, it had since transformed into a desolate landscape characterised by dread and despair. The man she had once cherished was transformed into a tormentor, his physical arousal casting a lengthy shadow over her life:

> When I was pregnant with his child, that time he started mistreating me. It is because he was not enjoying the physical relationship with me. (P3)

3.5. The Psychological Aftermath

IPV devastates not just the body but the soul, leaving deep emotional and psychological scars. Victims often endure severe mental health struggles, such as depression, anxiety, and post-traumatic stress disorder, long after the abuse ends. The constant wearing down of one's self-esteem and overwhelming fear can trap survivors in a relentless cycle of trauma, profoundly impacting their well-being and ability to lead fulfilling lives.

Half of the women we interviewed explicitly described feelings of unease and uncertainty. This constant state of heightened arousal is a hallmark of life under the shadow of abuse. Fear of the unknown, dread of the next violent outburst, and the overwhelming sense of being trapped can create a debilitating level of anxiety that profoundly impacts daily life:

> So much uncertainty came in front of me. I didn't have any food to feed my child. Then I started working as a domestic household worker. That way, I start providing food. But I had no peace of my mind. I was so worried all the time. (P2)

Their stories reveal a collective experience of emotional upheaval, marked by feelings of hopelessness, worthlessness, and a profound sense of isolation:

> I was sad. I didn't like it at all. He used to beat me whenever I tried to tell him using that drugs was not good for him. It broke my soul. I was devastated. I had to go through a lot of pain. And I was so distressed. (P6)

IPV creates a suffocating sense of isolation. Over half of the participants in our study described profound feelings of loneliness during their abusive relationships:

> I was so helpless and alone. I cried a lot. I cried alone. And I lost every hope, but my children were the reason I was still going on. I can only trust Allah. No one else. I just blame my luck. (P5)

Their stories reveal how the absence of meaningful connection can amplify the pain of their experiences:

> I wasn't in good health. My mental health wasn't good at all. How can I be in a good mood when so much turmoil is happening in my domestic life? (P1)

4. Discussion

The present investigation describes the abuse encountered by participants as a recurrent sequence of abusive conduct, as opposed to singular occurrences. The study highlighted the significant impact of IPV exposure during pregnancy and how individuals found solace and strength by redirecting their attention and efforts towards securing a bright future for their children. This research contributes to the expanding body of literature that explores the experiences of pregnant women who face significant and ongoing abuse, including psychological, physical, and economic hostility.

During in-depth interviews, all the participants disclosed experiencing moderate to severe physical abuse perpetrated by their respective spouses, thus signifying a prevalent occurrence within this community. Participants even stated episodes of hospitalisation due to the high severity level. This is consistent with the findings from past quantitative research conducted on different refugee women (Feseha et al., 2012; Hadush et al., 2023; Islam et al., 2021; Khawaja & Barazi, 2005; Sipsma et al., 2015). Protective mechanisms and adaptive techniques, which are believed to enhance resilience, are still being implemented by these women in the aftermath of these incidents.

The stories shared by the participants reflect recurring patterns often found in individuals who have experienced emotional and psychological mistreatment. The themes are consistent with prior scholarly works on psychological consequences in non-refugee victims (Karakurt et al., 2014; Radell et al., 2021; Tiwari et al., 2008). Mishkin et al. (2022) discovered that IPV victims among displaced pregnant women living in Iraq express concerns about causing harm to their children. The findings of this study are in line with the information discussed in this article regarding physical abuse and threats towards children. Participants in this current research demonstrated a strong determination to provide a better future for their children, despite the challenging conditions of the camp setting. They focused their attention and efforts on securing a promising outcome.

The current study highlighted the impact of infidelity on the development of aggressive reactions. Participants discussed how their once positive relationships took a turn for the worse when their partners became entangled with drugs and other women. In their qualitative study among Somali refugees in Ethiopia, Abudulai et al. (2022) highlight the impact of romantic jealousy on relationship conflict and IPV in a society where polygyny is common.

According to previous studies (Hadush et al., 2023; Sanders, 2015), individuals subjected to economic control by their partners often experience restricted access to financial resources. The present investigation also exhibited these phenomena women who made a lower financial contribution than their husbands were likely to experience violence in their relationships (Hadush et al., 2023).

Previous studies underscore the critical role of social support in mitigating IPV during pregnancy, particularly within the context of displacement and camp settings (Alhusen et al., 2015; Da Thi Tran et al., 2022; Mishkin et al., 2022). Narratives from the participants in this research confirm the intersection of limited resources, inadequate support networks, and the overarching humanitarian crisis resulting in heightened vulnerability.

Participants highlighted how displacement amplifies existing gender inequalities and power imbalances, making women more vulnerable to violence. The participants' expressions of fear of abandonment and uncertainty about the future of their children shed light on the deep psychological distress experienced by women in these circumstances. This concern, along with limited economic prospects and reliance on male partners for support, can contribute to a situation of dominance and manipulation, which in turn raises the chances of experiencing IPV.

5. Limitations

The current study has offered significant new insights into the lives of IPV victims; however, this research has limitations. Firstly, mental health literacy among this population is relatively low, so this format may be unable to capture the full scope of victims' experiences. The study focused on capturing a snapshot of the participant's experiences during a specific time. Longitudinal data would have provided a better understanding of the dynamic nature of IPV and its impact on mental health over time. The study's sample size was restricted to six participants with comparable attributes, and the results may not be generalizable. Lastly, the interviews lasted around 30 minutes, as participants expressed their limited ability to engage in interviews for a prolonged duration due to their responsibilities in providing care and fulfilling family commitments. This constraint was a factor in determining the interview length. So, this format may not be able to capture the full scope of the victims' experiences. Nevertheless, this study was able to capture meaningful and insightful data that shed light on the challenges faced by participants.

6. Conclusion and Policy Implication

This research presents empirical evidence of IPV experienced by women during pregnancy, as well as their remarkable resilience in overcoming this adversarial situation. The finding demonstrates recurrent abuse experienced by pregnant IPV survivors in a displaced camp setting and their distinctive physical, psychological, sexual, and financial victimisation and perpetration.

Stakeholders such as the UNHCR, the IOM, the Government of Bangladesh, and various non-governmental organisations must contextualise these findings within their policies and practices. This includes enhancing security measures and enforcing existing legal penalties. Additionally, there is a critical need for instructional sessions targeting both the displaced community and the general public to raise awareness regarding the detection of abuse and the implementation of effective mitigation strategies. Health and social education should focus on encouraging victims of physical violence to report incidents to legal authorities. Employment opportunities, skill development, and education will assist them in attaining financial independence, which may reduce violence.

Allocating personnel with expertise in mental health or social work to address various manifestations of violence can address the unique circumstances encountered by displaced populations in camp settings. Our recommendations underscore the necessity for refugee camps and healthcare service providers to integrate IPV and violence screening, prevention, and treatment protocols into their operations. Consequently, interventions and support services must be tailored to address these multifaceted dynamics and deliver comprehensive care to individuals navigating such complex circumstances.

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Conflict of Interests

The authors declare no conflict of interests.

Data Availability

The authors are open to correspondence with interested parties and encourage further research utilising the available qualitative data.

Supplementary Material

Supplementary material for this article is available online in the format provided by the author (unedited).

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