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Original Article

Factors Associated with Poor Mental Health Due to Intimate Partner Violence among Fishermen's Wives in Bangladesh

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Abstract

Background: Intimate partner violence (IPV) is a public health concern in the world, especially in the developing world. Bangladesh, a developing country, has the highest rate of IPV among the South Asian countries. We designed this study to examine survey data from a fishing community in Cox's Bazar district in Bangladesh, aiming to investigate the factors associated with the poor mental health conditions of women who experienced IPV.
Methods: This study used a cross-sectional design. The target population included fishermen's wives within the reproductive age group (15-49 years) who experienced IPV. A convenient sampling procedure selected 120 fishermen's wives from three fishers' villages of Cox's Bazar district in 2022. We assessed the respondents' mental health conditions using the Self-Reporting Questionnaire (SRQ-20). We analyzed the data using Fisher's exact test, independent t-test, and binary logistic regression in SPSS version 26.
Results: The respondents reported the prevalence of physical and psychological abuse by their current intimate partners in the last year. The findings indicated that their intimate partners physically abused 69.2% of respondents and psychologically abused 86.7% of them in the past year. The majority of the respondents (80%, n=96) had poor mental health (SRQ≥7). The results from binary logistic regression models demonstrated that the poor mental health of respondents was associated with several factors, including respondents' age (P=0.045), education (P=0.001), personal income (P=0.002), consumption of betel leaf/smokeless tobacco (P=0.032), not being a member of a non-governmental organization (NGO) (P=0.023), a husband's gambling habit (P=0.05), a history of psychological abuse (P=0.001), and those who seek assistance during crisis times (P=0.027).
Conclusions: The study findings can assist policymakers and fisheries practitioners in formulating policies and programs to reduce IPV in fisheries communities, thereby ensuring that no one is left behind.

Keywords*:* Violence, Mental health, Women, Psychological abuse, Physical abuse

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1. Introduction

Intimate partner violence (IPV) is a public health issue in both developed and developing countries (1, 2). The adverse impacts of IPV on abused women's mental health are extensive (3). There are wide variations in the prevalence of IPV, which includes sexual, physical, and psychological abuse (4).

IPV is often known as "gender-based violence," and researchers around the world have attempted to identify factors associated with poor mental health of IPV survivors. There is growing evidence that IPV is associated with negative health consequences (1, 5, 6). The mental health consequences of IPV include depression, anxiety, eating or sleeping disorders, use of substances, or even suicidal behavior (7-9). Multiple factors, including the age of respondents (10, 11), low academic achievement (12), physical abuse (8), psychological abuse (5, 8), dowry demand (13), poverty (11), support networks during times of crisis (1, 6), shape the variables linked to IPV against women. Suicide ideation is also common among IPV survivors (5). There is a widely held belief that empowered women experience less IPV because they are more financially independent and can make significant decisions for their families and communities (14). On the other hand, uneducated women are more prone to having poor mental health (8). Furthermore, evidence suggested that IPV has an adverse impact on the mental health of pregnant women and lactating mothers (8). Additionally, research revealed that women who belonged to a non-governmental organization (NGO) experienced a higher rate of victimization from their intimate partners (11). Moreover, a partner's

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gambling habit also heightens the risk of IPV (15). Given the connection between IPV and stress, research indicated that women are more likely to use smokeless tobacco when they are under stress (16). When the abuse reached its peak, survivors of IPV sought both formal and informal forms of support to manage the violence (1, 6).

Although several studies from developed countries have explored the impact of IPV on mental health (17, 18), there is a dearth of studies in developing nations on this topic (19). Most research studies conducted on this topic in developing countries primarily focus on the general populace in urban (3) and rural areas (20).

Bangladesh, a developing country, has a high rate of IPV (15), with regional differences ranging from 42% to 76% (11). Existing studies suggest that IPV has detrimental effects on women's physical, reproductive, and mental health (20). The World Health Organization (WHO) conducted a multi-country study that estimated the mental health conditions of abused women to have a mean score of 7.9, indicating poor mental health (21). Many married Bangladeshi women who refuse to comply with all their husbands' demands frequently suffer physical violence, verbal abuse, acid assaults, and mistreatment (1).

Despite the high prevalence of IPV in Bangladesh, relatively few research studies have addressed this issue (3, 7, 8, 12, 20). There is even less information available regarding IPV in the fishing community. Bangladesh's economy heavily depends on the fishing sector (22). Typically, fishermen are poor (23), and their community views women as inferior. Given the limited knowledge about intimate partner violence (IPV) against fishermen's wives and their mental health conditions, developing appropriate policies and interventions to support these women is challenging. The factors that contribute to poor mental health conditions of women who have survived IPV are crucial for policy and programmatic purposes. By examining the extent of IPV against currently married women in the fishing community and their mental health conditions, this study fills the gap in the literature. Therefore, our study aimed to assess the factors associated with poor mental health conditions of fishermen's wives who experienced IPV by examining the survey data from a fishing community in Cox's Bazar district in Bangladesh.

2. Methods

2.1. Design and Procedure

In this study, we adopted a cross-sectional study design. We conducted the study in traditional artisanal fishing villages in the Cox's Bazar district, Bangladesh. We purposively selected three villages in Cox's Bazar district: Mohd. Shafrir Bil, Nazirar Tek, and Tajiakata. In June 2022, we collected data from fishermen's wives residing in these three fisheries villages using a convenient sampling technique. The household served as the sampling unit; each household only had one interviewee. With a confidence level of 95%, a margin of error of 8%, and an estimated currently married woman within the reproductive age range of 25%, the calculated sample size of this study was 113 (Equation 1). We determined the sample size of this study to be 120 respondents, accounting for a 5% chance of participation loss.

where n represents sample size for a given population, n_o denotes sample size for infinite population, N represents population size, Z is the 95% confidence level, p denotes percentage

$$n_0 = \frac{Z^2 pq}{e^2} \qquad \text{(Equation 1)}$$

picking a choice expressed as a decimal, and e is the confidence interval.

The following requirements were met for the study participants to be included in the sample; the study participants had to: (i) identify themselves as a fisherman's wife; (ii) be currently married, aged between 15 and 49 years, not separated or divorced, and living with their husband; and (iii) have experienced IPV by their current intimate partner in the past year. Researchers collected the data through face-to-face interviews.

2.2. Study Area

These villages are located along the Bay of Bengal. Here, fishermen make up the majority of the population, and the fishing industry drives their economies. Patriarchy is pervasive in the fisheries communities. The villagers rely on sea fishing as a seasonal activity, which is considered their main occupation. The fishermen leave their houses for several months for sea fishing and have very little

work during the lean fishing season. When their husbands are absent, the fishermen's wives assume responsibility for the family, naturally shifting the patriarchal focus to matriarchy (24). When on land, the fishermen occasionally fight or even physically harm their wives to obtain money for purchasing tea or alcohol (24). The majority of the residents in these villages are from a lower socioeconomic class. Cyclones are the most common disaster in the study area.

2.3. Instruments

We used a semi-structured interview questionnaire to assess factors associated with poor mental health conditions of fishermen's wives. The questionnaire included questions about the respondent's age, education status, religion, pregnancy status, income, savings, membership in an organization, tobacco use, help-seeking behavior during crisis times, husband's age, education, income, gambling habit, alcohol use, and demand for dowry. We also asked respondents about their history of IPV and their mental health conditions.

In this study, we developed a conceptual framework based on a review of the literature to guide our analyses, considering how personal characteristics, household characteristics, and history of IPV may affect women's mental health (7). All variables presented in Table 1 were considered as the explanatory variables for the logistic regression model. We performed variable selection for logistic regression by backward selection, removing a variable that had the least significant effect and did not meet the requirements to remain in the model (25). At the conclusion of the process, we eliminated variables that did not significantly worsen the model fit. Finally, we considered the following explanatory variables for this study: (i) personal characteristics: age, education, income, use of betel leaf/smokeless tobacco, membership in an NGO, pregnancy status, and help-seeking behavior during crisis time; (ii) household characteristics: the demand for dowry and the gambling habits of their partner; and (iii) history of IPV: physical abuse and psychological abuse.

WHO defined IPV as "the behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm (26)." For this study, we defined IPV as the experience of a fisherman's wife of physical abuse and psychological abuse by a current intimate partner in the last 12 months. We assessed the presence of IPV using the modified version of the Conflict Tactics Scale: physical abuse and psychological abuse. Physical abuse included physically abusive acts like throwing an object, pushing, kicking, biting, slapping, strangling, beating, burning with something, hitting with an object, and threatening with a weapon. We measured psychological abuse through violent emotional acts such as harassment, stalking, deprivation of food or money, misbehaving, threatening to hurt, and humiliation. We classified a woman as abused in the past year if she answered "yes" to any pertinent questions under the categories of physical abuse and psychological abuse. We then scored these binary responses (yes/no) to each item as "1" for "yes" and "0" for the "no" option. The Cronbach's alphas for physical and psychological abuse are 0.855 and 0.854, respectively.

WHO (27) developed a self-reporting questionnaire (SRQ-20) to assess the mental health conditions of the respondents. Several studies (9, 28) have used SRQ-20 to measure the mental health conditions of abused women. SRQ consists of 20 yes/no questions about symptoms experienced in the last 30 days, such as headaches, loss of appetite, difficulty sleeping, being easily frightened, handshaking, feeling nervous, tense, or worried, poor digestion, trouble thinking clearly, feeling unhappy, crying more than usual, finding it difficult to enjoy daily activities, finding it difficult to make decisions, suffering from daily work, feeling like a worthless person, having the thought of ending one's life, feeling tired all the time, experiencing uncomfortable sensations in the stomach, and being easily tired. The system assigns a score of 0 for "no" responses and 1 for "yes" responses to each item. The maximum score that SRQ-20 can achieve is 20. If the sum of the SRQ is ≥7, it is an indication of poor mental health conditions (15). A woman whose score on the SRQ is ≥7 was coded as "1" for poor mental health and "0" for normal health (SRQ is<7). The Cronbach's alpha for SRQ-20 is 0.628. Researchers have proven SRQ-20 to be valid for use in low- and middle-income countries, such as India, Vietnam, and Brazil (9).

2.4. Statistical Analysis

The analysis focused on identifying the factors associated with poor mental health conditions

Table 1: Characteristics of women who experienced poor mental health			
Variables	**Total (%)**	**Poor mental conditions (%)**	**P value**
Age (year), Mean±SD	29.55±6.31	29.90±6.26	0.231
15-24 years	29 (24.2)	21 (72.4)	0.438
25-34 years	63 (52.5)	51 (81.0)	
35-49 years	28 (23.3)	24 (85.7)	
Educational status of respondents			
No formal education	32 (26.7)	21 (65.6)	0.036
Primary and secondary	88 (33.3)	75 (85.2)	
Age at first marriage (year), Mean±SD	16.49±1.12	16.43±1.19	0.313
16 years or before	59 (49.2)	52 (85.2)	0.174
17 years or after	61 (50.8)	44 (74.6)	
Having personal income			<.001
Yes	59 (49.2)	55 (73.2)	
No	61 (50.8)	41 (67.2)	
Currently pregnant			0.530
Yes	32 (26.7)	26 (81.3)	
No	88 (73.3)	70 (79.5)	
Consume betel leaf/ tobacco			0.042
Yes	97 (80.8)	74 (76.3)	
No	23 (19.2)	22 (95.7)	
Having membership in an NGO			0.179
Yes	55 (45.8)	41 (74.5)	
No	65 (54.2)	55 (84.6)	
Religion			
Islam	100 (83.3)	81 (81)	0.547
Hinduism and others	20 (16.7)	15 (75)	
Average monthly income of the family (USD), Mean±SD	120.74±22.16	121.82±22.14	0.282
Age of husband	35.54±6.28	36.05±6.51	0.084
15-24 years	2 (1.7)	1 (50.0)	0.816
25-34 years	57 (47.5)	45 (78.9)	
35 years and more	61 (50.8)	50 (82.0)	
Husband's educational status			
No formal education	8 (6.7)	7 (87.5)	0.816
Primary and secondary	95 (79.2)	89 (79.6)	
Gamble habit			0.155
Yes	24 (20.0)	22 (91.7)	
No	96 (80.0)	74 (77.1)	
Demand for dowry			0.560
Yes	22 (18.3)	19 (86.4)	
No	98 (81.7)	77 (78.6)	
Physical violence			0.807
Yes	83 (69.2)	67 (80.7)	
No	37 (30.8)	29 (78.4)	
Psychological violence			0.004
Yes	104 (86.7)	88 (84.6)	
No	16 (13.3)	8 (50.0)	
Respondents seek assistance			0.795
Yes	89 (74.2)	72 (80.9)	
No	31 (25.8)	24 (77.4)	

*Age and monthly income: Independent T-test, and the rest: Fisher's exact test; NGO: Non-governmental organization; SD: Standard Deviation

of fishermen's wives. The dependent variable is the mental health conditions of the respondents, whether they are poor or normal. The explanatory variables that have been considered were the age of the respondent (continuous), education of the respondent (no formal education, have attended school), having personal income (yes/no), consuming betel leaf/tobacco (yes/no), being a

member of any NGO (yes/no), currently pregnant (yes/no), seeking assistance during crisis time (yes/no), demanding a dowry (yes/no), having a gambling habit of a partner (yes/no), having experienced physical abuse in the past year (yes/no), and having experienced psychological abuse in the past year (yes/no). This study used SPSS version 26 for data analysis. We performed data analysis using Fisher's exact test, independent t-test, and binary logistic regression. A significance level of less than 0.05 was considered for statistical tests.

2.5. Ethical Consideration

We conducted this study based on WHO's (29) guidelines for examining domestic violence against women. Every respondent provided us with their informed consent to participate in this study. Participation in this study was completely voluntary, and participants received a guarantee about the privacy of the data collected. The Department of Social Relations at East West University in Dhaka approved the study protocol. The researchers are conscious of research ethics, even though there is no institutional ethics council in the university setting. We strictly maintained the ethical standard and confidentiality of personal information for participants' safety and anonymity.

3. Results

A total of 120 female respondents participated in this study (Table 1). The average age of the respondents was 29.55±6.31 years. Around 52.5% of respondents were in the age group of 25-34 years (range: 19 to 43 years). The majority of the respondents (26.7%) do not know how to read or write. The average age of the first marriage of respondents was 16.48±1.12 years (range: 13 to 19 years). Around 49.2% of respondents had income from several sources, including homestead vegetable gardening, poultry rearing, and drying fish. None of the respondents owned land. Over one-fourth of the respondents were pregnant at the time of the interview. None of the respondents smoked, but 82.5% chewed betel leaf or smokeless tobacco. No polygamous households were identified. Among the respondents, 45.8% were members of some NGOs.

Around 83.3% of respondents were Muslims. The reported average monthly income of the household was USD 120.74±22.16 (1 USD=93.45 Bangladeshi Taka, as of 30 June 2022). The average age of the respondent's husband was 35.54±6.28 years. Only 6.7% of the respondents' husbands were illiterate. Twenty percent of respondents reported their partner's gambling habits. Demand for dowry was also prevalent in the studied communities.

Table 1 displays the prevalence of violence. The majority of the respondents reported having experienced psychological abuse (86.7%), followed by physical abuse (69.2%). The commonly reported physical violence includes throwing an object (67.5%), pushing (65.8%), kicking (81.7%), biting (68.3%), slapping (68.3%), strangling (67.5%), beating (24.2%), burning with something (40.8%), hitting with an object (38.3%), and threatening with a weapon (9.2%). The three villages studied showed no significant difference in terms of physical (P=0.13) and psychological (P=0.60) abuse. Around three-quarters of the respondents seek help after experiencing abusive behavior.

Among those surveyed, 80% of respondents had experienced poor mental conditions (SRQ≥7). The mean score of mental health conditions for the whole sample was 9.83 (SD=2.24), ranging from 2 to 12. The mean score of mental health conditions was higher in Mohd. Shafrir Bil (M=12.12±1.94) than in Tajiakata (M=9.87±2.33) and Nazirar Tek (M=9.50±2.44) districts. However, the mental health conditions (poor/normal) did not differ significantly among the studied villages (P=0.85). None of the respondents reported suicidal thinking in the last 30 days.

We adopted the logistic regression technique to determine the factors associated with poor mental health conditions of IPV survivors. Table 2 shows the associations between different socio-demographic factors (explanatory variables) and poor mental health conditions (dependent variable). The age of respondents showed a significant positive association (OR: 1.13, 95% CI=1.00-1.27, P=0.045) with mental health outcomes. For instance, as respondents' age increases, the probability of adverse mental health conditions increases. Respondents with no formal education are more likely to have poor mental health conditions (OR: 12.99, 95% CI=2.84-59.39, P=0.001). Personal income demonstrated a significant positive association (OR: 11.67, 95% CI=2.44-55.78, P=0.002) with mental health outcomes, suggesting that financial autonomy heightens the likelihood of poor mental health.

Table 2: Multiple logistics regression of socio-demographic characteristics with poor mental health condition (0=Normal, 1=Poor)

Variables	Odds Ratio	95% CI	P value
Age of respondent (continuous)	1.13	1.00-1.27	0.045
Education of respondents (0=no formal education; 1=having formal education)	12.99	2.84-59.39	0.001
Having personal income (0=No; 1=Yes)	11.67	2.44-55.78	0.002
Currently pregnant (0=No; 1=Yes)	1.94	0.42-8.95	0.397
Consume betel leaf/ tobacco (0=no; 1=yes)	0.07	0.01-0.80	0.032
Having membership in an NGO (0=no; 1=yes)	0.19	0.04-0.79	0.023
Gamble habit (0=no; 1=yes)	7.21	1.00-52.06	0.050
Demand for dowry (0=no; 1=yes)	3.12	0.47-20.94	0.241
Physical violence (0=no; 1=yes)	2.57	0.58-11.37	0.213
Psychological violence (0=no; 1=yes)	21.77	3.25-145.77	0.001
Respondents seek assistance (0=no; 1=yes)	7.53	1.26-44.90	0.027

Surprisingly, betel leaf/tobacco consumers (as a proxy variable of substance use) reported poor mental health conditions (OR: 0.07, 95% CI=0.01-0.80, P=0.032). Moreover, women who were members of an NGO were less likely to report poor mental health conditions (OR: 0.19, 95% CI=0.04-0.79, P=0.023) as compared with women who were not members of an NGO. The study participants who reported that their husbands had gambling habits reported having poor mental health (OR=7.21, 95% CI=1.00-52.06, P=0.050). Also, women who seek assistance from family members have a higher likelihood of reporting poor mental health conditions (OR: 7.53, 95% CI=1.26-44.90, P=0.027).

We found a positive association between all types of violence (physical and psychological) and poor mental health conditions. However, only psychological abuse is significantly associated, suggesting that respondents who have higher scores on psychological abuse also reported poor mental health conditions (OR: 21.78, 95% CI: 3.25–145.77, P=0.001). However, pregnancy status, demand for dowry, and physical abuse did not produce any significant associations with mental health conditions.

4. Discussion

This study reported the factors associated with poor mental health among the currently married fishermen's wives in Bangladesh. Overall, we found that the majority of the fishermen's wives were physically (69.2%) and psychologically (86.7%) abused by their husbands during the past year. These findings were consistent with the existing literature, which shows that IPV is common in Bangladesh (7, 8, 20).

Though the rate of IPV in the current study is much higher than in the previous studies from Bangladesh, these studies did not focus on the mental health of fishing communities (3, 11). The current study revealed that four-fifths of the respondents had poor mental health. Our findings supported other studies that showed that IPV is associated with poor mental health (1, 5, 6). The higher mean score of mental health conditions (SRQ: 9.83) compared with previous studies (8, 21) could be attributed to our inclusion of only married women living with their intimate partner, potentially explaining the poor mental health condition of the majority of respondents in our study sample. Additionally, we collected data in an intervention area, where participants may have reported more violent behavior from their intimate partner. Furthermore, we asked them to report on their mental health conditions in the last 30 days. However, it is possible that the respondents may have reported mental health conditions that exceed the duration of the survey.

The age of the respondents had a significant influence on mental health conditions, which was consistent with an earlier study (10, 17) but inconsistent with Mendonça and Ludermir (30), in which respondents' age did not differ with mental health conditions. Given the positive coefficient, we can deduce that as respondents age, their mental health conditions tend to decline. This may be explained by the fact that women adopt submissive behavior as they get older in an environment that is not supportive and where gender norms are traditional (31). This interpretation is supported by another study that reported that aged respondents may adopt several coping strategies to normalize IPV (1), which was not explored in the present study.

Our findings indicated that respondents' education is the strongest factor associated with poor mental health. Research indicated that lower-educated women are more prone to experiencing IPV (8, 20) and are often associated with poor mental health (14), which contradicts this finding. The unexpected finding may be due to the fact that educational attainment leads to better recognition of rights (15). Unquestionably, conventional gender norms are strong in fisheries villages. Therefore, the influence of gender norms may override the educational attainment of fishermen's wives. Another explanation could be that women who have experienced abuse and have some level of education may have more bargaining power with their husbands, making it difficult for them to control their emotions. This could lead to ideological conflicts between spouses, ultimately resulting in depression.

Our analysis also indicated that respondents with personal income are more likely to have poor mental health conditions. This finding is different from other studies, as existing literature suggests that low income could give rise to stress or conflict within the family, which may lead to poor mental health (11).

Substance use is common for women in developed countries (17). However, the social norms in Bangladesh do not favor women drinking alcohol or smoking. Nevertheless, the use of smokeless tobacco products and chewing betel leaves is common among the lower socioeconomic groups, regardless of their sex (32). In this study, we used respondents' chewing of betel leaves or use of smokeless tobacco as a proxy variable for substance use and alcohol consumption. The findings indicated that respondents who chewed betel leaves or consumed smokeless tobacco reported better mental health than those who did not consume tobacco. This finding is not surprising, as the social system of Bangladesh conditioned women in such a way that they accepted violence in their own lives. IPV survivors use substances or alcohol as a coping mechanism (33) to normalize violence (1).

Our findings of a negative association between membership in an NGO and poor mental health appear to have an important policy implication, as a member of an NGO reported normal mental health conditions. We were unable to locate any literature that discussed the connection between membership in an NGO and mental health conditions. The closest literature to this reported that women who were members of microfinance organizations experienced higher IPV than their counterparts (11). Our findings were thus inconsistent with the existing literature. One possible explanation for this intriguing finding is that the interventions of NGOs may be useful for the fishermen's wives. However, we did not explore what types of interventions could potentially reduce the mental stress of IPV survivors, a topic that could be of interest for future research.

The gambling habits of the partner increased the probability of poor mental health conditions in the fishermen's wives. The lean fishing season leaves fishermen with nothing to do but stay home. Existing literature indicates that the frequency and intensity of IPV increase when spouses request money for gambling (1).

Dowry agreements at marriage pose a significant risk of IPV (13). This practice, though still highly prevalent in the fishing community, did not pose a significant risk of poor mental health conditions in our study. However, the positive coefficient suggests that a demand for dowry could lead to poor mental health conditions. This is because partial or nonpayment of dowry increases the likelihood of experiencing IPV (11, 13), which in turn increases women's stress levels and leads to a decline in their mental health.

Our study revealed that respondents who sought assistance from their family members often reported poor mental health conditions. This may be because abused women are often silent about their experiences of violence, and they only seek assistance when they are unable to cope with the abusive behavior of their husbands (1). The WHO multi-country study showed that one-third of physically abused women sought assistance (21).

The findings of our study suggested that psychological IPV was associated with poor mental health conditions. This finding was consistent with the findings of other studies (3), which reported that psychologically abused women had poor mental health conditions. IPV causes physical and psychological harm to women, leading to long-term health consequences (34).

4.1. Limitations

In this study, we adopted a cross-sectional study design, which has limited ability to draw causal inferences. The analysis included only currently married women to fishermen (15 to 49 years old) who live with their husbands; therefore, women who have ended their relationship with their abusive partners were not included in this analysis. In addition, we only included the current prevalence of violence (in the past year), not the lifetime prevalence. The sample size in this study was also small. This is because the respondents felt shy about sharing their intimate issues. The inclusion criteria for respondents were limited to women living in the fishing communities in three areas of the Cox's Bazar district. Therefore, we cannot generalize the findings of this study to the entire fishing community of Bangladesh. Despite these limitations, our study has provided fresh insights into the association between IPV and poor mental health conditions in fishing communities in Bangladesh.

5. Conclusions

This study highlighted that the majority of respondents in fishing communities face physical and psychological abuse from their husbands, leading to poor mental health. Our observations suggested that mental health conditions are poor for women who are aged, have no formal education, have personal income, consume betel leaf/smokeless tobacco, are not members of an NGO, have husbands with gambling habits, have experienced psychological abuse, and have sought assistance during crisis times. Governments and non-governmental organizations should introduce counseling, support services, advocacy, legal aid, and shelter homes for IPV survivors. It is also important to ensure that IPV survivors have access to adequate mental health services. We believe that the findings of our study will greatly assist practitioners and policymakers in developing policies and programs that guarantee no one falls behind. Future research should focus on the coping strategies of IPV survivors (such as problem-focused coping, avoidance coping, emotion-focused coping) and their effectiveness.

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Authors' Contribution

Md. Sanaul Haque Mondal: Substantial contributions to the conception and design of the work, the analysis, and interpretation of data for the work, drafting the work and reviewing it critically for important intellectual content. Ms. Kamrun Nahar: Substantial contributions to the conception and design of the work; the acquisition of data for the work. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work, such that the questions related to the accuracy or integrity of any part of the work.

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Conflict of interests: None declared.

Ethical Approval

The participants were briefed about the purpose of the study and sought their consent and time for the interview. To maintain confidentiality, participants' pseudonyms have been used. Also, verbal informed consent was obtained from the participants.

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