

Case Study Summary

As of January 2019, nearly one million Rohingya individuals who had fled ethnic violence in Rakhine State, Myanmar, were living in refugee camps in the Cox's Bazar district of Bangladesh, which are now the largest and the most densely populated refugee settlements in the world. More than half of the refugees in the camps are women and girls of reproductive age, underscoring the critical need for sexual and reproductive health (SRH) services, including contraception, in the camps.

Forcibly displaced women and girls face a range of SRH concerns, including increased risks of maternal morbidity, mortality, and sexual and gender-based violence; higher risks of sexually transmitted infections; higher risks of unintended pregnancy; and higher risks of unsafe abortion, with its associated complications. Therefore, contraceptive services, including long-acting and short-acting contraceptive methods, menstrual regulation (MR) services,¹ and post-abortion care are included in internationally accepted minimum standards for humanitarian health response.

In January 2019, the Women's Refugee Commission (WRC) conducted a case study of contraceptive service delivery in the refugee camps of Cox's Bazar, which aimed to document the important work that humanitarian actors and other stakeholders are undertaking to provide contraceptive services and MR in the refugee camps; to highlight challenges; and to document how some of these challenges were overcome.

The case study employed mixed methods, including key informant interviews with United Nations (UN) and nongovernmental organization (NGO) health and SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys of service providers; focus group discussions with refugee community members; and a review of service delivery data from the UN Population Fund (UNFPA) and partner implementing agencies.

Our Key Findings

- **Contraceptive and MR services were widely available in the camps, although greater barriers existed to availability and access to long-acting reversible contraceptive (LARC) methods.**
 - » LARC methods were less widely available than short-acting methods.
 - » Women and girls expressed concern about accessing removal services for LARCs if they moved away from the camps.
- **Adolescent girls faced particularly high barriers to accessing contraceptive and MR services.**
 - » Adolescent girls appeared to be targets of sexual violence both in Myanmar and potentially still in the camps, yet it can be extremely difficult and risky for them to access and obtain SRH services, given the perceived bias from service providers and the community stigma.
- **Midwives provided contraceptive services but lacked prior experience, while community health workers spread awareness of services.**
 - » Contraception is provided primarily by midwives. Most midwives, however, are inexperienced and lacking in practical skills.
 - » Community health workers included family planning topics from early in the emergency and consistently throughout, to educate and spread awareness among community members on the availability of contraceptive methods.
- **Consistent funding and continuity of leadership contributed to availability of contraceptive supplies and services.**
 - » UNFPA-Bangladesh had consistent funding before and during the emergency, which contributed to the pre-positioning of contraceptive supplies, the availability of supplies from the onset of the emergency, and the presence of a dedicated SRH coordination team.
 - » There has been a consistent SRH Coordinator since before the emergency, allowing for continuity in leadership and effective maintenance of NGO/government relationship-building efforts.
- **Coordination within the SRH Working Group (SRHWG) and across NGOs facilitated access to contraceptive and MR services.**
 - » The SRHWG, made up of UNFPA and NGOs implementing SRH services, prioritized contraception and MR from the very beginning of the emergency by using weekly meetings, information management, mapping, and updates about commodity availability to support services.
 - » Memorandums of understanding between NGOs operating in the refugee camps allowed different NGOs to operate in the same facilities, which enabled partners to work to their areas of expertise and quickly increase coverage of contraception and MR services.

¹ Menstrual regulation is a procedure to "regulate the menstrual cycle," through manual vacuum aspiration or a combination of mifepristone and misoprostol, when menstruation has been absent for a short duration—a procedure which, outside the Bangladesh context, is included within the term abortion.



Illustration seen in an International Rescue Committee midwife room in a women-friendly space, Ukhiya camp, Cox's Bazar, January 2019. Photo © Sara Casey/WRC

Our Top Recommendations

All partners should provide all short- and long-acting contraceptive methods in all health posts and primary health centers as called for in the *Minimum Package of Essential Health Services*.

- The SRHWG should identify and train trainers locally rather than depending largely on trainers traveling from Dhaka.
- SRH partners should maintain competency of providers trained in intra-uterine device (IUD) insertion with, for example, use of pelvic models to observe IUD insertion with a checklist.
- Agencies should link training to the procurement and availability of supplies to ensure that providers can practice their skills and provide new methods as soon as they complete training, rather than lose their new competencies while awaiting provision of supplies.
- As the emergency situation has stabilized, procurement should move away from exclusive use of the Inter-agency Emergency Reproductive Health Kits to procuring commodities separately, to permit more efficient use of resources for needed supplies.
- The SRHWG should further standardize definitions of indicators to ensure data reporting is consistent, and NGOs should apply these standardized definitions. This is crucial to ensure use of the data to make decisions about programs.
- SRH partners should continue to strengthen community mobilization activities in order to dispel misconceptions about contraceptive methods, influence male decision-makers in the community, and continue to expand services to harder-to-reach populations.

Read the full report – <https://wrc.ms/FPinCoxsBazar>

For further information, contact Cassondra Puls, cassondrap@wrcommission.org

Women's Refugee Commission

The Women's Refugee Commission improves the lives and protects the rights of women, children, and youth who have been displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice. Since our founding in 1989, we have been a leading expert on the needs of refugee women, children, and youth and the policies that can protect and empower them.

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