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A Clear Case for Need and Demand: Accessing Contraceptive Services for Rohingya Women and Girls in Cox's Bazar

Case Study

June 2019

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth 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.

Acknowledgments

This study was commissioned and funded by the Danish Foreign Ministry.

This report was written by Sara Casey, Cassondra Puls, and Lily Jacobi of the Women's Refugee Commission (WRC), and reviewed by Sandra Krause, Diana Quick, and Sarah Rich of the WRC.

The case study team would like to thank Hassan Abdi (UNFPA Reproductive Health Coordinator) and all the staff at UNFPA-Bangladesh for their support and facilitation of the case study; the nongovernmental organization staff who took time to meet with us; the interpreter and research assistant, Rumana Akter of Community Partners International (CPI), for her valuable support and contributions; and the moderator Habib Ullah of CPI for his support. The researchers would like to thank the members of the refugee community for their willingness to meet with us and share their experiences.

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Contact

For more information or to share comments about this case study, please contact Cassondra Puls, Research Advisor, WRC, at cassondrap@wrcommission.org.

Cover: View of Kutupalong camp, Cox's Bazar, January 2019
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EXECUTIVE 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. Over half of the refugees in the Rohingya camps are women and girls of reproductive age, underscoring the critical need for sexual and reproductive health (SRH) services, including contraception, in the camps.

Globally, studies have shown that forcibly displaced women and girls face heightened SRH concerns, including increased risks of maternal morbidity, mortality, and sexual and gender-based violence (SGBV); higher risks of sexually transmitted infections (STIs); 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, abortion or menstrual regulation (MR) services, and post-abortion care (PAC) are included in internationally accepted minimum standards for humanitarian health response.

In the refugee camp settlements of Cox's Bazar, humanitarian actors, in collaboration with the Ministry of Health and Family Welfare (MOHFWFW) of Bangladesh, have been largely responsible for delivering contraception, along with other health services. Despite this, by the second year of the response to the most recent Rohingya refugee influx, humanitarian actors in the camps reported encountering policy and other barriers that hindered timely provision of the full range of contraceptive and MR services to all refugees in the camps.

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, the government of Bangladesh, 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 (KIIs) 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 (FGDs) with refugee community members; and a review of service delivery data from the United Nations Populations Fund (UNFPA) and partner implementing agencies.

This study is one of three case studies that will document contraceptive service delivery in humanitarian settings.

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 who were working in the camps, however, were 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 and across NGOs facilitated access to contraceptive and MR services**.
  - The Reproductive health sub-working group (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.

Our Top Recommendations:

- **All partners should provide all short- and long-acting contraceptive methods in all health posts (HPs) and primary health centers (PHCs)** 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 hard-to-reach populations.

I. INTRODUCTION

This case study is the first of three such case studies that will document contraceptive service delivery in humanitarian settings. These studies are a follow-up to the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) 2012-2014 Global Evaluation, which found a persistently weak evidence base for sexual and reproductive health (SRH) service provision in humanitarian settings, across areas ranging from adolescent SRH services, to access to safe abortion care in conflict- and crisis-affected contexts. Consequently, the Global Evaluation pointed to a cross-cutting need for more systematic research and robust program evaluation. These case studies aim to build on and advance these efforts.

II. BACKGROUND

The Rohingya are a minority ethnic group that have, for decades, faced systematic discrimination, statelessness, and targeted violence in Rakhine State, Myanmar.[1],[2] Many times in recent years, campaigns of violence resulting in widespread human rights violations have forced members of the Rohingya community in Rakhine State to seek refuge in neighboring Bangladesh. The latest, and most severe, wave of violence against the Rohingya community occurred in August 2017.[3] Myanmar military authorities brutally attacked Rohingya communities in Rakhine State, driving hundreds of thousands of women, men, girls, and boys out of their homes and communities. Within just three months, an estimated 700,000 people escaped by foot over the border into the Cox's Bazar district of Bangladesh, a coastal area in the southeast of the country.[4]

As refugees from Rakhine State continued arriving through 2017 and 2018, new arrivals first settled in makeshift housing inside of existing refugee camps and then, when those camps filled up, settled on the outskirts of camps. As of January 2019, there were an estimated 909,207 Rohingya individuals in two sub-districts, Teknaf and Ukhiya, of Cox's Bazar district of Bangladesh,[5] making up what is currently considered the largest and most densely-populated refugee settlement in the world.[6] Although United Nations (UN) agencies and nongovernmental organizations (NGOs), in partnership with the government of Bangladesh, are providing basic services to refugees, the camps remain highly congested and at severe risk of weather and environmental shocks that could impede service delivery.

The government of Bangladesh does not officially recognize the Rohingya who have arrived in the influxes of recent years as refugees, and instead refers to them as Forcibly Displaced Myanmar Nationals (FDMN).[7] Rohingya refugees are prohibited from working in Bangladesh and thus rely on aid from humanitarian actors, along with any livelihood strategies they may be able to use—such as

volunteer-based work with NGOs, small businesses, market selling, and remittances obtained from relatives—to meet basic needs.

Globally, studies have shown that forcibly displaced women and girls face heightened sexual and reproductive health (SRH) concerns, including increased risks of maternal morbidity, mortality, and sexual and gender-based violence (SGBV); higher risks of unintended pregnancy and unsafe abortion with its associated complications; and unmet need for contraceptives.[8] Consequently, SRH services are an essential component of basic health response in humanitarian emergencies and, as such, SRH services are included in internationally accepted minimum standards for humanitarian health response as articulated in the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health.*[9]

View of Kutupalong camp, Cox's Bazar, January 2019. *© Cassondra Puls/WRC*

A global evaluation in 2012-2014 of SRH services in humanitarian settings found that abortion and contraceptive services have lagged behind other SRH services.[10] Long-acting and permanent methods of contraception, as well as emergency contraception (EC), have been especially neglected.[11] This is despite evidence that a wide choice of methods raises overall contraceptive use[12] and consensus that the provision of contraception is a life-saving health intervention with far-reaching implications for recovery and resilience for individuals and communities[13] that accelerates progress toward global goals.[14]

The government of Bangladesh has made significant commitments to SRH,[15] and the country has achieved progress in improving awareness of, access to, and, on some measures, uptake of contraceptive services.[16] For example, the government of Bangladesh has taken rapid strides since 2010 to create and roll out a UNFPA-supported national midwifery program to increase the number of health workers who can provide effective SRH services, including contraceptive services.[17] In addition, Bangladesh has a relatively less restrictive policy framework for abortion: while abortion is permitted in Bangladesh only to save the life of a pregnant woman, menstrual regulation (MR)[18] can be performed within 12 weeks of a woman's last menstruation without confirmation of pregnancy.[19,20]

Over half of the refugees in the Cox's Bazar camps are women and girls, underscoring the need for SRH services, including contraception, in the camps.[21] In the camp settlements, humanitarian actors, in collaboration with the Ministry of Health and Family Welfare (MOHFW), have been largely responsible for delivering health services, including contraception.[22] Notably, contraceptive and MR service delivery began remarkably early in the response to the most recent influx of Rohingya refugees, with UNFPA taking the lead.[23] Despite this, actors reported encountering policy and other barriers which have hindered timely provision of the full range of contraceptive and MR services to all Rohingya refugees.

Recent reports on the Rohingya refugees in Cox's Bazar refugee camps have highlighted sexual and reproductive health and rights (SRHR) as a whole,[24] or for specific populations[25]; however, this is the first report to focus specifically on contraceptive services and MR for all populations in the Cox's Bazar refugee camps. In doing so, this case study aims 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.

III. OVERVIEW OF METHODS

Methods and Sampling

The case study employed mixed methods, including KIIs with UN and NGO health and SRH program managers; health facility assessments, including SRH knowledge and attitudes surveys of service providers; FGDs with refugee community members; and a review of service delivery data from UNFPA and partner implementing agencies.

Table 1: Case Study Data Collection Methods

Data Collection Type	Number
Interviews with UN agencies	1*
Interviews with NGO pro-gram managers	8
Facility assessments	6
Provider knowledge & attitudes questionnaire	17
FGDs with community members	76 community members in 8 FGDs
** Multiple UNFPA staff were interviewed separately and their responses were consolidated.*	

Case study tools: The WRC used data collection tools adapted from validated instruments used in the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) Global Evaluation,[26] MISP evaluations,[27] and a multi-country baseline study on contraceptive services in humanitarian settings conducted by the WRC, United Nations High Commissioner for Refugees (UNHCR), and the Centers for Disease Control and Prevention (CDC) in 2011 and 2012.[28]

KIIs: The WRC conducted individual interviews with key informants to understand contraceptive and MR service delivery in the refugee camps, including challenges and successes they faced in implementing contraceptive services. With guidance from UNFPA, key informants were purposively selected based on the following criteria:

1. working at UNFPA, a local NGO, or an international NGO that has been directly implementing or supporting contraceptive and/or MR services in the camps for at least one year; and

2. individuals serving within those organizations as health or SRH program managers or coordinators and available in person in Cox's Bazar during the case study field work.

Based on these criteria, key informants from 12 humanitarian organizations were invited to participate in in-person interviews at a convenient time and place in the town of Cox's Bazar. Eight organizations, which included the main providers of contraceptive and MR services in the refugee camps at the time, responded and agreed to participate in an interview (see Appendix A, Table 8). Interviews were conducted one-on-one in English, in a quiet and semi-private location. Responses and information provided by the informants were written down by the moderator. The WRC then collated all answers to questions and carried out thematic analysis to identify recurring and unique themes across the interviews.

Facility assessments: The WRC carried out health facility assessments to evaluate the readiness of facilities to effectively provide contraceptive and MR services. NGO participants in the case study purposively selected the facilities to be assessed. The assessments included interviews with facility staff and a room-by-room walk-through and inventory of essential drugs, supplies, and equipment. Six facilities in Ukhiya and Teknaf camps were assessed: one hospital, two primary health centers (PHCs), one Women-Friendly Space (WFS), and two health posts (HPs).

Provider questionnaires: In each health facility, the WRC administered a questionnaire to health workers providing SRH services to determine their knowledge and attitudes concerning contraception, post-abortion care (PAC), and abortion. Provider questionnaires were administered on paper forms in English. To aid understanding, an interpreter verbally translated the questionnaire into Bengali. During facility assessments, WRC collected 17 questionnaires from doctors, paramedics,[29] and midwives. The results were entered into a spreadsheet for descriptive analysis.

FGDs: The WRC researchers organized FGDs with refugee community members in order to elicit attitudes, experiences, beliefs, and preferences of community members toward contraception. FGDs were conducted with younger married and unmarried women (18-24 years old), older married or widowed women (25-45 years old), and men who were married. The groups included between eight and 11 participants, with at least one person with a disability included in each group. The FGD participants were recruited by NGO partners from within the catchment area of a health facility which offered contraceptive services, with the expectation that the participants recruited would have some prior knowledge of and exposure to contraception services in the camps.

FGDs were held in private rooms within health facilities in Kutupalong camp. The discussions with married men were moderated by a male Rohingya facilitator, who was a refugee community member who could also speak Burmese. The discussions with women were moderated by a female Rohingya-speaking facilitator. With consent of the participants, the moderators audio-recorded the discussions. Subsequently, one of the Rohingya-speaking moderators listened to the audio recordings and transcribed and translated the discussions from Rohingya into English. The WRC team then developed, piloted, and iterated a codebook. Each transcript was double-coded by WRC staff in NVivo10 software package, and discordances between coding were resolved through consensus of coders and/or adaptation of the codebook.

Service delivery statistics: The WRC solicited contraceptive and MR service delivery data from UNFPA and NGO staff who participated in KIIs. The data were cleaned, aggregated, and submitted to descriptive analysis (see Figure 1, Figure 2).

Limitations

This case study was intended to document the state of contraceptive and MR service delivery at a specific point in time in the Cox's Bazar refugee camps. While the researchers spoke to the primary providers of these services, their responses may not be representative of all service delivery for the whole refugee population in Cox's Bazar, or across all time. The organizations delivering contraceptive services may continually be changing practices, so it is possible that the situation of contraceptive service delivery in Cox's Bazar may have changed significantly since the time of the case study data collection.

Although the government of Bangladesh leads the humanitarian response, the case study did not involve interviews with government actors. Due to the scheduling demands placed on the MOHFWFW by the response, WRC researchers were unable to arrange an interview with a representative of the MOHFW. This did not prove to be a significant limitation as the implementation of contraceptive services in the refugee camps is mainly being carried out by humanitarian actors in NGO- or MOHFW-run health facilities.

FGDs for the case study aimed to reach community members who theoretically had access to contraceptive services within the camp (by living near a health facility that provided these services). Therefore, participants in these FGDs may be more aware of contraceptive services and/or more active users of contraceptive methods than the average camp inhabitant. Because of the large number of refugee community members who now work with the UN and NGOs as volunteers, some groups included participants who were also engaged as community health volunteers, and therefore also had higher-than-average knowledge of health information; these participants, however, were asked to respond to questions based on their knowledge of the general community. Because of the location where some FGDs were held, some FGDs included participants who were long-term refugees who had been living in the Kutupalong registered camp[30] since earlier influxes, and whose views might therefore diverge from those arriving during and after the August 2017 influx. Finally, although the FGDs with young women were intended to comprise unmarried adolescents 14-17 years old, none of the participants that NGO partners recruited were under 18 years old, and some of the participants were married, meaning adolescent voices were not fully included in the consultations.[31] However, the majority of the participants in the young women FGDs were 18 or 19 years old and spoke from experience of recently having been adolescents and of knowing unmarried adolescents in the camp, as borne out by the differences in their responses compared to the other FGD participants.

The WRC carried out analysis of the datasets at its offices in New York, United States. Due to the short reporting time frame, the WRC study team was not able to involve study participants in analysis and was not able to share preliminary results with participants or other refugee community members for community validation. Therefore, interpretation of some of the data may have been affected by researcher bias. However, preliminary results were shared with, and feedback elicited from, the reproductive health sub-working group (SRHWG) of the Health Cluster in January 2019 and from select SRH partners in Cox's Bazar in April 2019. The FGD analyses were also reviewed by the local research assistant, who had knowledge of the refugee community and context.

Ethics

The WRC adapted the case study methodology from prior case studies carried out by the WRC and in conformity with its established *Ethical Guidelines for Working with Displaced Populations*.[32]

Before starting the study, the study purpose and methods were discussed with host partner UNFPA, which subsequently contributed to finalization of the case study methodology.

Key informants and FGD participants were informed of the study's purposes, risks, and benefits and given the opportunity to verbally consent to participate in the interview. Names or other identifying information were not collected from FGD participants. The WRC provided an information sheet with the WRC's contact information and directions for anonymous reporting channels to each informant. FGDs were audio-recorded with the consent of the participants; audio recordings were then transcribed into text and the recordings were subsequently deleted.

All data collected for this report were stored securely on password-protected devices and data were not shared outside of the WRC case study team. All individuals or entities named in this report were named with their explicit consent.

IV. FINDINGS FROM KEY INFORMANTS

Service delivery

Contraception

The Cox's Bazar Health Sector's *Minimum Package of Essential Health Services for Primary Healthcare Facilities (Minimum Package) in the FDMN camps*[33] calls for the provision of contraceptive services counseling and short-acting and long-acting reversible contraceptive (LARC) methods in all HPs and PHCs. Contraceptive methods were widely available in the camps, including oral contraceptive pills (OCPs), injectables, implants, intra-uterine devices (IUDs), condoms, and emergency contraceptive (EC) pills. Every partner who was interviewed for the study was providing OCPs, injectables, condoms, and EC; fewer were providing LARCs. Depot medroxyprogesterone acetate, sub-cutaneous (DMPA-CU/Sayana Press) was not available at the time of the study, although UNFPA reported that they expected to obtain stocks "soon" and indicated that, when it became available, DMPA-CU would be provided by midwives. At the time of the study, the government of Bangladesh did not allow the provision of permanent methods in the camps. Ipas is the main provider of LARC methods, and supports paramedics based in Research, Training and Management International (RTMI)-supported facilities, HOPE-supported facilities, and select other health facilities to provide LARCs and MR. In addition to health facilities, the International Rescue Committee (IRC) has placed a midwife at each of 21 WFSs throughout the camps who provide short-acting and LARCs, MR, clinical management of rape, and treatment of sexually transmitted infections (STIs).

Several NGOs that were not providing LARCs stated that they planned to provide them as soon as their health workers received the necessary training. A few said that Rohingya individuals in the camps "didn't want long-acting methods," and that this was the reason their organizations were not providing LARCs. Some organizations expressed that they could not provide LARCs in HPs. However, as most HPs have medical doctors and privacy for antenatal exams, these facilities should be able to provide implants and IUDs as stipulated by the *Minimum Package*. Postpartum IUDs have recently become available at health facilities that also provide delivery care.

Due to a shortage of doctors trained to provide implants, several NGOs organize implant "camps" where the midwives invite interested clients to return on a specific day when a trained doctor comes to the facility to provide implants. In some cases, the NGO may transport a client to a nearby facility

where a trained doctor is present on the same day she requests an implant. Removals must be scheduled for when a trained doctor is present.

Although short-acting methods are the most commonly used in the refugee camps, no organization had a functioning system in place to monitor whether women and girls returned for their next dose. Many organizations reported using the register to track returns, but the registers at the assessed facilities were not set up in such a way to facilitate this tracking.

Save the Children health worker at a HP in Kutupalong camp, Cox's Bazar, January 2019. *(c) Cassondra Puls/WRC*

Menstrual regulation

Menstrual regulation (MR) is widely available in the camps, primarily using the mifepristone-misoprostol combination pill. The Health Sector's *Minimum Package* in the FDMN camps includes MR as a minimum standard in PHCs. According to UNFPA, 29 facilities they support offer MR directly or refer for it. Four of six health facilities the assessment team visited provided MR (although one was stocked out of the combination pill at the time). From early in the emergency, UNFPA funded Ipas to provide MR services in the camps. In the early phases of the emergency response, MR and contraception services for survivors of sexual violence were prioritized, although these services were provided to all Rohingya women and girls who needed them. They quickly realized this was a significant need due to dynamics in camp population, such as high birth rates and the imbalance in the ratio of men to women.[34] Although UNFPA mentioned that some providers were unwilling to provide MR due to religious reasons, none of the respondent organizations mentioned this as a common challenge. Restrictions due to the US "Protecting Life in Global Health Assistance" policy, also known as the Global Gag Rule, have prevented some organizations from providing MR.[35] No serious resistance from the community to MR has been seen, but the issue has not been studied in depth. Analysis of FGDs revealed stigma in the refugee community toward abortion and MR (see Section VI of this report). Despite the widespread availability of MR, PAC numbers are high in some areas of the camps, suggesting that unsafe abortion is occurring—perhaps due in part to this stigma.

Post-abortion care

Most organizations were providing, or at least referring clients for, PAC, which is treatment provided to women who present with complications from an induced or spontaneous abortion. PAC is included in the *Minimum Standards* for PHCs. HPs mainly stabilize PAC clients and then refer them to the nearest PHC or hospital. PAC is an emergency service, so access to facilities and providers 24/7 is important for PAC. Most health facilities had not been operating 24/7 due to staff and funding shortages. However, partners were working to increase the number of facilities providing 24/7 care. Additionally, in all health facilities providing PAC visited by the study team, providers reported offering post-abortion contraception to women.

Skilled staff

Contraception is provided primarily by midwives, as well as by paramedics and family welfare assistants (a lower-level cadre who provide short-acting methods only). Midwife is a relatively new cadre in Bangladesh: the first cohort of midwives graduated in late 2015 and were licensed in early 2016. To address the acute shortage of health workers in the refugee camps, UNFPA negotiated with the government for recently graduated midwives to complete their internship in the camps, instead of a government facility, while waiting for deployment to government posts. Before their internship, where they acquire hands-on training, most recently-graduated midwives are relatively inexperienced and lacking in practical skills; they leave school requiring additional training and support. This is a challenge for NGOs, as they must provide on-the-job and at times more formal training to midwives. Few NGOs hire more experienced paramedics, making the need for training even more acute. Most midwives arrive straight after graduating and work in the camps for about a year until the government determines their permanent placement. This means that most midwives leave at the same time, and the cycle begins again with NGOs recruiting and training new graduate midwives (the most recent batch started work in November 2018); UNFPA assists the NGOs as much as possible with this process.

UNFPA has a team of three expatriate midwives who provide additional support and mentorship to midwives working at UNFPA's partner organizations. One respondent suggested that the need for training, which pulls midwives away from the health facilities, competed with their equal need for practice. As they prepare for the new cohort of midwives, the UNFPA team is developing a basic five-day orientation (training) for the midwives to complete before they start work. This will allow them to spend some initial time practicing before being pulled away for additional trainings. Several NGOs also provide on-the-job training to strengthen midwives' practical skills. Ipas paramedics are posted in a number of UNFPA-supported health facilities—primarily those supported by HOPE and RTMI—where they provide IUDs, MR, and PAC services, leaving the midwives in these facilities to focus more on short-acting contraception.

It is important to note that most health workers in the camps do not speak Rohingya. While Bangladeshi staff from Chittagong province speak a language similar to the Rohingya language, communication between most health workers—especially those hailing from outside the district—and clients is a challenge.[36]

Training

UNFPA contracted with Ipas to provide training to partners on LARCs, MR, and PAC. The national training curriculum required 28 days, which was not feasible in an emergency setting. Ipas reduced the training time to three days each for implants and IUDs and conducted most training in the camps in the early stages because the limited numbers of health workers made it difficult for them

to leave for training. Ipas was able to provide training from the early stages of the crisis due to pre-existing government approvals due to their previous work in the area. UNFPA currently has two master trainers who train doctors in the camps on implant insertion and removal, as it is particularly difficult for the doctors to leave for training. Currently, most Ipas training is conducted at the district hospital in Cox's Bazar. Ipas arranges for trainers from Dhaka to conduct the training; then, these trainers travel to the camps two to three months after the training to follow up with trainees. NGOs provide training to their staff on short-acting contraception.

While Ipas has established a quarterly training schedule, the demand is higher than the available slots, making it challenging to train sufficient staff across the camps. Additionally, NGOs do not appear to have systems in place to ensure providers maintain competency once they are trained. Given the low numbers of LARC users and limited training slots, this is an important gap. Only one NGO described using a system to regularly observe and track provider competence.

In some cases, providers had been trained but the health facilities in which they worked still had not procured the necessary supplies (such as a speculum) or the methods to provide LARCs. Without the supplies needed to practice and to provide the method, providers risk losing their competence. This gap did not appear to be related to stockouts. One NGO in this situation had not made the effort to procure LARC supplies, citing a lack of interest in the community for LARC and the presence of Ipas staff providing them. For another, it appeared that procurement was not linked to the timing of training, resulting in the observed gap. This is particularly unfortunate as other NGOs had the necessary supplies, but were still waiting for training.

In addition to these training needs, some NGO respondents discussed the midwives' weak counseling and interpersonal communication skills. Several organizations provide on-the-job training on basic client care, interpersonal skills, and infection prevention as well.

Supervision

While all organizations mentioned supervision systems, few have checklists or other tools to assist with supervision. Only one organization described a system for regularly checking and tracking provider competence. UNFPA suggested that the Ipas paramedics posted in the health facilities should mentor the midwives and other staff providing contraception and MR. However, in the facilities visited, the paramedics did not generally see mentorship as a part of their responsibilities. Since the Ipas paramedics are the only ones routinely providing IUDs, this is a missed opportunity to improve midwives' skills.

Commodities

Partners reported no stockouts of any contraceptive methods in the previous year. When asked about sources of contraceptive method supplies, all partners reported receiving most of their methods from UNFPA. UNFPA reported having supplies from early in the emergency, in part because Inter-agency Emergency Reproductive Health (IARH) kits[37] were pre-positioned in Bangladesh in preparation for their annual cyclone season. UNFPA has primarily stored IARH kits in two warehouses managed by RTMI and HOPE. NGOs reported being able to obtain supplies from UNFPA in a timely manner most of the time, but a few mentioned delays they resolved by moving supplies among their supported facilities (although as seen later in the facility assessment results, individual facilities may have occasional temporary stockouts; see Section V). Some expressed frustration at the continued use of the IARH kits, which sometimes leaves them with too many of some supplies and a scarcity of others. UNFPA is procuring Depo-Provera separately due to higher demand than could be met by the IARH Kits alone, and implants, which were not currently available in the IARH Kits.[38] As mentioned earlier, they expect to roll out DMPA-CU in the camps soon. UNFPA also

expects to launch an electronic stock register with partners soon, which would help them make projections to begin procuring commodities individually and reduce use of the RH Kits. UNFPA also procures misoprostol, as they are training community health workers and volunteers (CHW/Vs) for community-based distribution of misoprostol for postpartum hemorrhage. Most NGOs purchase mifepristone-misoprostol combination pills (MM kits) locally; UNFPA also procures these kits for their partners. The study team also found these MM kits available at private dispensaries (drug sellers) in the markets in the camps, although their quality or source was not assessed. When asked, several sellers said that while they did not have the kits in stock, they could obtain them quickly if needed.

Assortment of contraceptive commodities at HOPE Field Hospital for Women. *© Cassondra Puls/WRC*

Community mobilization

Community outreach and mobilization is a critical component of a health response, particularly as several respondents suggested that contraceptive services, including specific methods, were unfamiliar to many Rohingya before arrival in Bangladesh. In Rakhine State, Rohingya individuals were subject to discriminatory treatment in health facilities, leading to potential distrust of health services among the affected population even after displacement to Bangladesh.[39] Community mobilization and outreach are necessary to raise awareness of available services, address concerns, and ultimately influence health-seeking behavior.

All NGO respondents interviewed reported engaging outreach workers: community health workers (CHWs) when recruited from the Bangladeshi host community, or community health volunteers (CHVs) when recruited from the refugee population. Most NGOs' rosters of CHW/Vs are primarily female—only two organizations reported working with male CHW/Vs. NGOs engage a mix of host community (Bangladeshi) CHWs and Rohingya CHVs, but slightly more reported working primarily with Rohingya CHVs. Most CHW/Vs conduct group education with community members and carry

out meetings with community leaders (including *majis*,[40] imams, and teachers), traditional birth attendants (TBAs), and parents of adolescents. While some NGOs are advocating for community-based distribution of contraception, CHW/Vs are not yet providing methods in the camp. Reasons mentioned for this varied, including resistance from both the government and some NGOs, and a need for additional training to strengthen skills of the Rohingya CHVs.

Some CHW/Vs specifically focus on adolescent girls. In a conversation with one such CHW, she mentioned that she met with both married and unmarried girls. She discussed contraception with married girls but mentioned that many girls face pressure from their family to have a first child, so these conversations are more fruitful after the first birth. She said that girls ask her for help in talking to their husbands about contraception or expressed concern that using contraception shows they have "no trust in Allah." When asked if she helps the girls practice or role play how to discuss contraception with their husbands, she said no, as she herself is unmarried and unfamiliar with how to do this. With unmarried girls, she discusses menstrual hygiene management and helps them understand their bodies, but she does not discuss contraception. When asked if she thought it would be helpful to start talking about contraception with girls before marriage, she seemed embarrassed. It appeared that she herself was uncomfortable with talking about SRH and could use additional support to better support girls, both married and unmarried. While this was only one CHW, it indicates that there may be other CHW/Vs who might also avoid discussing contraception with unmarried girls.

Respondents described the challenges CHW/Vs encounter when conducting community outreach. Several respondents noted that some Rohingya women have been exposed to some contraceptive methods in Rakhine State and are open to contraceptive use. However, some women need to hide their contraceptive use from their husbands. Husbands were described as the primary decision-makers about contraceptive use, and therefore sometimes as a barrier to uptake. Respondents said that male CHW/Vs were necessary to successfully engage men in conversations about contraception. However, as noted above, few organizations currently engaged male CHW/Vs. One NGO, which engages both female and male CHW/Vs, noted that having both male and female CHW/Vs allowed their male workers to focus on mobilizing *majis*, community leaders, imams, teachers, and men. Although most NGOs have their CHW/Vs hold meetings with community leaders, respondents reported varying levels of success in engaging community leaders and gatekeepers, which seems to be connected with religious issues and cultural pressures to have many children.

At the time of the study, UNFPA engaged 410 CHVs to help fill gaps. UNFPA CHVs are mostly Rohingya individuals; however, the Rohingya community has low knowledge of some SRH topics, especially LARCs. UNFPA was therefore developing training plans and materials for CHVs. UNFPA reported that they experience turnover as they build the CHVs' capacity and the CHVs subsequently depart for other opportunities. UNFPA has also made efforts to improve community mobilization by integrating TBAs into the health system, mainly by serving as birth companions and medical escorts for women.

Policy

UNFPA reported a good working relationship with the government, which has enabled it to play a significant role in liaising with the government to ease national policies that affect humanitarian actors' operations and facilitate their compliance with national policies while meeting the needs of the refugee community. This was especially important in the early phases of the emergency. NGO respondents reported that when they were starting operations in Bangladesh, the government required organizations to apply first for registration to carry out operations in the country, and then again for each specific service they provide. For example, providing short-acting contraceptives

reportedly requires a different registration and separate registration process than does providing LARCs. According to UNFPA respondents, organizations must reapply for and renew these registrations every 3-12 months. In Bangladesh, two departments in the MOHFW oversee different aspects of SRH services—the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP)—potentially duplicating the registration processes NGOs are required to go through.

Delays in NGO registrations had major effects on both service delivery and quality early in the emergency. For instance, although the influx of arrivals began in August 2017, provision of LARC was only possible from May 2018 when UNFPA signed a collaborative agreement with the DGFP. In response, UNFPA has been advocating through meetings with the government of Bangladesh, the Office of the Refugee Relief and Repatriation Commission (RRRC), and other government agencies—while respecting the government policies—that delays in registration affect service delivery and decrease service quality.

Providing health services 24/7 required registration with the government. UNFPA respondents reported that it played a major role in obtaining permission for NGOs to run 24/7 health services in the camps, and uses its good working relationship with the government to try to expedite registration processes for SRH partners by providing recommendations and letters of support.

Additional national policies affect the delivery of contraceptive services in the camps. Respondents reported that, according to national policy, displaced individuals in the camps were required to present an identification card with a fixed address in order to receive a LARC. Initially, this policy's application to Rohingya refugees rendered it impossible for refugees to obtain LARCs legally. UNFPA worked to establish a cooperative agreement with the government of Bangladesh to allow refugees to obtain LARCs in the camps without an ID card; by May 2018, they had gotten the agreement from the government to do so. In addition, the national law of Bangladesh reportedly restricts access to contraceptive services to registered married couples. This has remained a point of discussion between UNFPA and the government of Bangladesh, as the government still maintains its request that NGOs register married couples in the camps before providing them with contraceptive methods. UNFPA in the meantime has been allowed a practice of not needing to collect or disaggregate data by marital status and, in health facilities, attempting to establish a practice of not asking a patient's marital status. Therefore, contraceptive services should be provided to any woman, married or unmarried, who requests them at NGO facilities. While several respondents explicitly stated that they do not ask about marital status, a few NGOs continue to the follow the government policy of providing methods only to married women.

Respondents pointed out that the Bangladesh MOHFW permits only medical doctors to provide implants; mid-level providers are not authorized to provide implants. Initially, the MOHFW wanted doctors to go to Dhaka for a three-week training on implants. Because it is difficult to remove doctors from the response for so long, UNFPA instead posted two master trainers in the camps so doctors don't have to leave the response to receive training. UNFPA provides a three-day training with a three-day follow-up, and had trained 30 doctors as of the assessment. Due to the positive relationship between UNFPA and the MOHFW, if UNFPA confirms that a doctor is competent, the MOHFW will certify the doctor.

Coordination among partners

In addition to liaising with the government, UNFPA has served a coordination role among partners operating in the refugee camps. Due to the limited space in the camps, partners have had to work side by side in the facilities, including UNHCR and UNFPA, which initially coordinated in one facility. As a result, SRH partners developed memorandum of understanding (MOUs) and now coordinate service delivery in health facilities across the camps according to their areas of expertise. For example, an IRC gender-based violence (GBV) counselor, RTMI midwives, and an Ipas paramedic may operate in the same facility. This arrangement allows national NGOs to get support through partnership with other actors and permits each organization to work to its strengths.

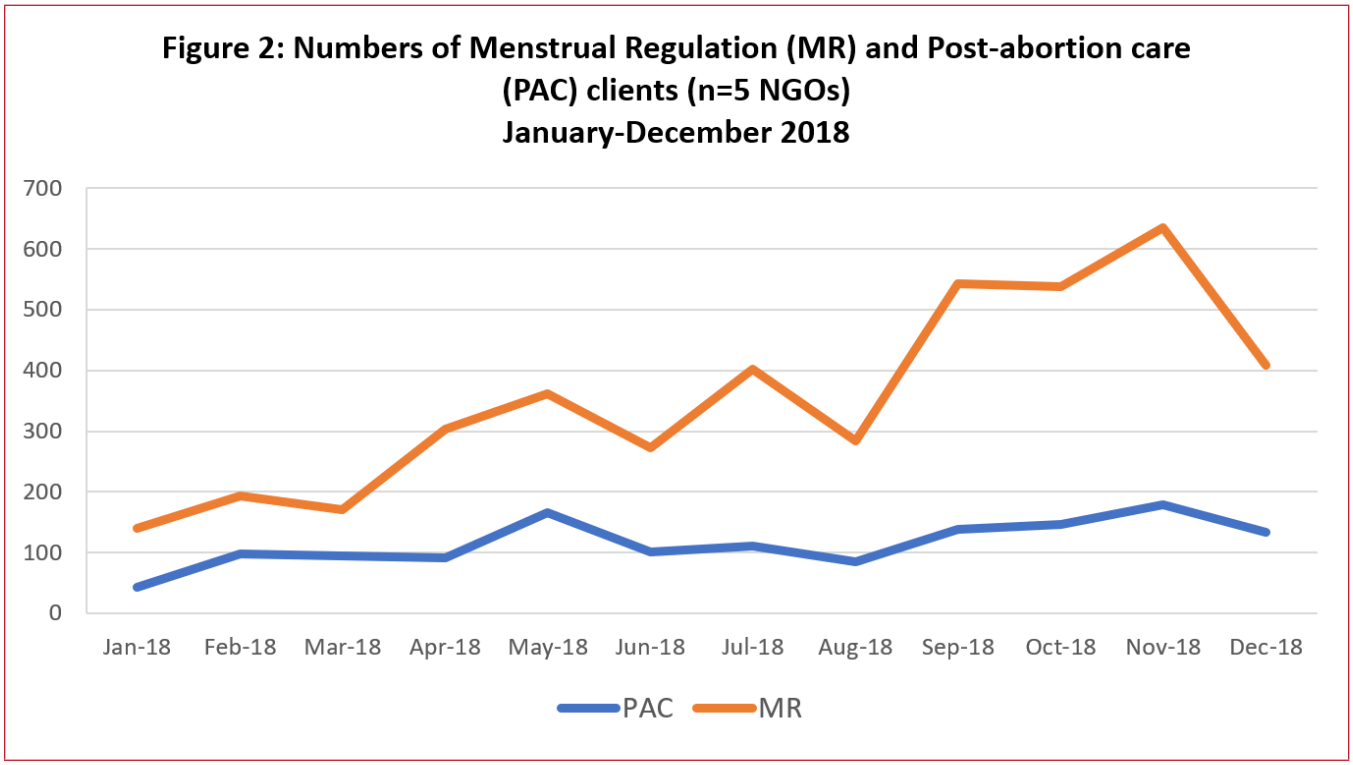
As of January 2019, UNFPA counted 53 partners delivering SRH services in the camps. UNFPA leads the SRHWG, which coordinates among the SRH partners. UNFPA had a consistent SRH coordinator for three years—meaning less interruption in leadership—as well as a dedicated coordination staff, including a coordinator, information manager, and a logistician, who lead the SRHWG and also support coordination among SRH partners. This coordination has had positive externalities, as the SRH coordination team reportedly created mapping tools that were adopted by the wider health sector. The UNFPA coordination team holds SRHWG meetings, which are open to all SRH actors, including midwives and other field staff. In addition, UNFPA has monthly roundtables with its implementing partners to discuss challenges.

Data collection and use

UNFPA aims to collect data from the estimated 53 partners working in the camps. While the information management specialist reported that data collection was improving, not all partners report each month. All except one assessed facility had a dedicated register for contraceptive services and for MR/PAC. Each SRH partner reports its own data, although they earlier had issues with multiple partners present in one facility double counting some clients. For example, an Ipas paramedic may provide MR and a contraceptive injectable to a woman in an RTMI facility. The woman is therefore counted as a new client, but when she returns for her next injection, she goes to the RTMI midwife who then also counts her as a new client. UNFPA's coordination team compiles, analyses, and presents the data at SRHWG meetings. High-performing partners may also be asked to present on data and best practices.

The UNFPA coordination team has made efforts to standardize indicators and their definitions; however, this process is ongoing and thus consistent definitions are not always used across NGO reports. For example, at the time of the case study, partners used different definitions of a "new" contraceptive service user, which created a further impediment to efforts to compare data. While the UNFPA team uses facility-level data to work with partners and drive program management, it is not always clear how to interpret data given these inconsistencies. Increases in numbers may indicate increased uptake, improved reporting, or additional facilities providing the service. The UNFPA information management specialist recognized the data quality issues and the challenges they are facing, and is working toward improving the data quality with the partners.

Data reported by six NGOs show increasing numbers of contraceptive clients in 2018 (Figure 1). While method mix has not changed drastically over time, LARC clients have increased from fewer than 100 clients per month to around 1,000 per month. The figure used contraceptive methods service provision data (including OCPs, injectables, condoms, implants, IUDs, and ECPs) for the months of January-December 2018, as reported by six of the interviewed organizations. One organization provided data on visits to start a contraceptive method only, not including revisits at the time of the report.



The numbers of clients using MR mostly increased over 2018, with a small decrease in December (Figure 2). The numbers of PAC clients remained relatively stable throughout 2018, suggesting that women may still be resorting to unsafe abortions.

The outside of an RH counseling room, seen at a Save the Children-run HP in Kutupalong camp, Ukhiya, Cox's Bazar, January 2019.
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V. FINDINGS FROM HEALTH FACILITY ASSESSMENTS

Health facility assessments

The WRC study team conducted facility assessments in six health facilities: one hospital, two health centers, and three HPs or WFSs (see Table 2).

Table 2: Health Facilities Assessed (n=6)

Facility Name	Location	NGO(s) supporting	Type of facility
Leda Health Center	Teknaf, Camp 24	IOM, Ipas	Primary Health Center (24/7)
RTMI Kutupalong PHC	Ukhiya, Kutupalong, Camp D5	RTMI, GK, IPAS, IRC	Primary Health Center (24/7)
IRC Women-Friendly Space	Ukhiya, Camp 13	IRC, Mukti	WFS
CARE HP	Ukhiya, Camp 13	CARE	HP
Save the Children PP HP	Ukhiya, Camp 4	Save the Children	HP
HOPE Field Hospital	Ukhiya, Camp 4	HOPE	Hospital (24/7)

Table 3: General Infrastructure

	At least 1 qualified health provider available 24/7	Functioning power supply	Functioning water supply	Minimum infection prevention supplies*
Hospital (n=1)	1	1	1	1
Health center (n=2)	2	2	2	2
HP/WFS (n=3)	N/A	3	3	1

**Minimum infection prevention supplies included presence of a washing station with soap, gloves (sterile or non-sterile), regular trash bin, antiseptics and appropriate disposal method for medical waste; sharps are separated from other waste.*

All facilities had functioning power and water supplies, and waste management systems at the time of the assessment. Four of six facilities had the minimum supplies required for infection prevention; data were missing regarding the availability of soap at one facility, and one facility did not have gloves. It is important to note that in most facilities, the health worker had to leave the contraception room to wash her hands, whereas a hand washing station in or near his/her room would be preferable.

Contraception

Of the six assessed facilities, three qualified as functioning contraceptive service delivery points, defined as having provided contraceptive services in the last three months, skilled staff present, and the equipment and supplies to provide a minimum method mix (IUDs, implants, OCPs, injectables, condoms and EC) (Table 4). In most health facilities, health workers had the supplies they needed to provide contraception in the room where they provided contraception service. This reduces the time spent moving back and forth from the pharmacy. In the larger facilities that also provided delivery services, IUDs were inserted in the delivery room. In this case, it is important to ensure that all the necessary supplies for IUD insertion are available in the delivery room, so the health worker does not need to run back and forth between the delivery and contraception room.

Table 4: Functioning contraceptive service delivery points

	Health facility (n=6)
IUD	3
Implant	3
Oral contraceptive pill	5
Injectable contraceptive	6
Condoms	6
Emergency contraception	6
Functioning contraceptive service delivery point	**3**

In one facility, the midwife had been trained on the provision of IUDs in November 2018, two months prior to the assessment, but the facility lacked the necessary supplies for her to provide IUDs in the facility. The NGO reported they were in the process of procuring the necessary supplies. In those facilities where implants were provided (n=3), provision was restricted to periodic visits by trained doctors (the aforementioned "implant camps"). Implants were reportedly provided in one additional facility; however, the researchers were not able to assess the equipment and supplies used for implant insertion, as the doctor brings these with her and they were not available at the assessment visit. One facility did not have contraceptive counseling materials on site, and one facility was stocked out of progestin-only pills. Detailed tables can be found in Appendix B.

Menstrual regulation

Three facilities qualified as functional MR service delivery points, defined as having provided MR in the past three months, availability of skilled staff to provide the service, and the supplies to provide MR with medication (Table 5).

Table 5: Functioning MR service delivery point

	Health facility (n=6)
Post-abortion contraception is offered to all MR clients	4
MR performed in the last 3 months	4
Skilled staff trained to provide MR	4
Misoprostol-mifepristone combination pill in stock	3
Functioning MR service delivery point	**3**

Two facilities said they did not provide MR at all. One facility providing MR did not qualify as a functional service delivery point as it was stocked out of the misoprostol-mifepristone combination pill at the time of the assessment.

Post-abortion care

Only one facility, a PHC, qualified as a functional PAC service delivery point. A functional PAC service delivery point is defined as having skilled staff providing PAC services, PAC services available 24/7 (PAC is considered emergency care), offering contraception to all post-abortion clients, and the equipment and supplies required to provide PAC with manual vacuum aspiration (MVA) or misoprostol.

Table 6: Provision of PAC to an acceptable standard

	Health facility (n=6)
Post-abortion contraception is offered to all PAC clients	5
Skilled staff trained to provide post-abortion care	4
PAC services available 24/7	1
Equipment and supplies to provide PAC with MVA	2
Supplies to provide PAC with misoprostol	**4**
Functioning PAC service delivery point	**1**

Two facilities that had 24/7 services did not qualify because a provider trained in PAC was not available 24/7. Two HPs had staff able to provide PAC with misoprostol but indicated that they usually stabilized clients presenting with post-abortion complications and referred them for PAC at a higher-level facility; researchers lacked data on the availability of misoprostol at one of those facilities.

Knowledge and attitudes of service providers

Seventeen health workers completed the knowledge and attitudes assessment. Detailed tables with response rates can be found in Appendix C.

Table 7: Professional classification of respondents (n=17)

Professional classification	Number
Medical doctor	2
Midwife	9
Paramedic	5
Family planning assistant	1

All respondents reported providing contraceptive counseling in the past three months, and 16 respondents reported providing post-abortion contraceptive counseling. Just under half (eight) of respondents reported having provided an IUD. Both doctors reported inserting an implant in the past three months.[41]

Three respondents reported providing PAC with MVA and seven respondents reported providing PAC with misoprostol in the past three months. Five respondents reported performing MR using the mifepristone and misoprostol combination pill. Less than one in three respondents reported ever receiving instruction or training on PAC with MVA (4), PAC with misoprostol (6), and MR (5) with medication.

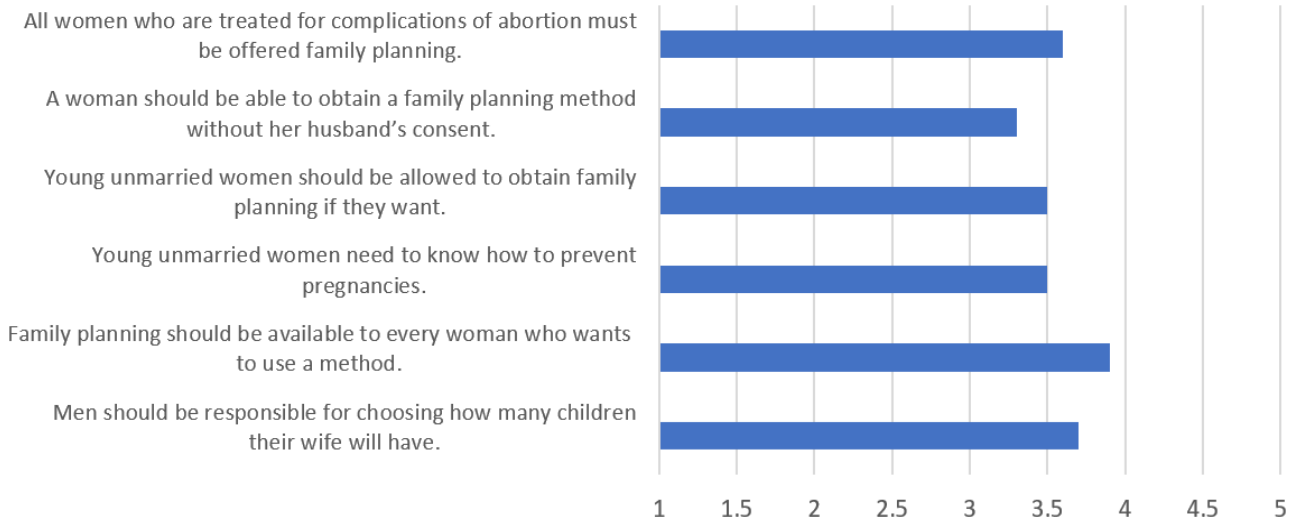
The tool also included nine questions to assess providers' technical knowledge of contraception and post-abortion care. Respondents demonstrated a good knowledge of contraceptive services, with a mean score of 4.4 out of 5. However, only six of 17 respondents were able to correctly identify the common changes in a women's menstrual period following the insertion of an IUD. This has potentially negative implications for counseling women about IUDs and leaving them unprepared for initial heavy bleeding.

Knowledge of PAC was lower, with a mean score of 2.1 out of 4 (Table 13, Appendix C). This corresponds with comparatively fewer respondents reporting ever receiving instruction or training on PAC services. Fewer than half of respondents (7) were able to correctly identify that a woman's fertility returns quickly after abortion, but all respondents were able to correctly identify that they should provide the following information to a PAC client: when she can conceive again; provider or refer her for contraception; and the consequences of an unsafe abortion.

Respondents demonstrated attitudes that were generally supportive of equitable and good quality contraceptive services and abortion care. The results are presented as mean scores ranging from one to four for each statement. All scores are based on Likert scale responses to each statement: strongly agree (4), agree (3), disagree (2), and strongly disagree (1). Some statements were reverse coded so that high means always signal attitudes that promote equitable and good quality contraceptive and abortion care.

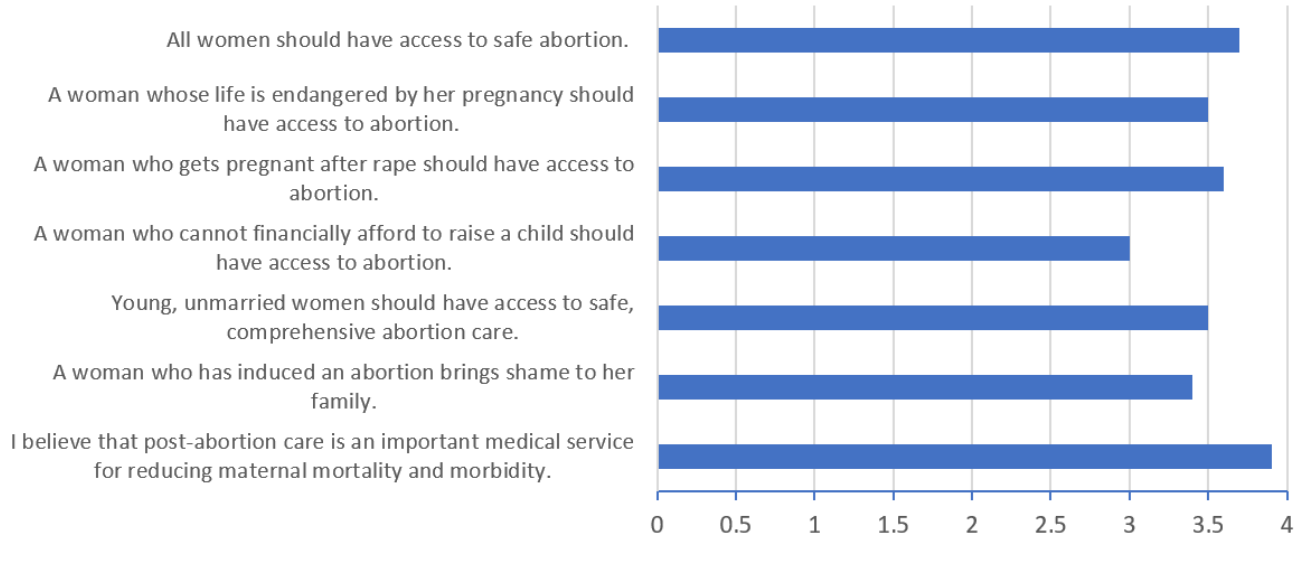
Attitudes were mostly favorable for general questions about contraception (Figure 3). For example, the mean score for the statement "Family planning should be available to every woman who wants to use a method" was 3.9. More specific statements were less favorable. "A woman should be able to obtain a family planning method without her husband's consent" had a mean score of 3.3. Notably, the mean score was not below 3 for any contraceptive services statement.

Figure 3: Provider attitudes toward contraceptive services (n=17)



Attitudes towards abortion and post-abortion care were similarly favorable, with no means less than 3 (Figure 4). The statement, "I believe that post-abortion care is an important medical service for reducing maternal mortality and morbidity" had a mean score of 3.9. Respondents generally agreed that "all women should have access to safe abortion" (mean 3.7), and under some conditions, to save her life (mean 3.5) or in cases of rape (mean 3.6). Respondents were least likely to believe that abortion should be available for economic reasons (mean 3). Similar to the stigma reported later in the FGDs (Section IV), the statement "A woman who has induced an abortion brings shame to her family" had a mean of 3.4.

Figure 4: Provider attitudes toward PAC and abortion care (n=17)



VI. FINDINGS FROM COMMUNITY

Contraceptive services

Knowledge and beliefs of contraception and contraceptive methods

The levels of knowledge and awareness of contraception among Rohingya refugee participants in FGDs varied depending on the type of contraceptive method. Participants were largely aware of and reasonably knowledgeable about short-acting contraceptive methods, especially injectables, which were referred to as "Depo." Most participants also knew of implants, which they called "needle" or "stick." However, when asked, most participants did not know what an IUD or "copper T" was. One participant mistakenly believed that IUDs were not at all available in camp health facilities: "The thing that is inserted into a woman's uterus is not available here" (Man, married). Similarly, nearly all participants across groups were unfamiliar with EC or how to use it. In one group, women seemed receptive to learning about EC so they could learn how to use it. However, one young woman confused EC with abortion: "We don't like it [EC]. One should control it before getting pregnant, not after pregnancy" (Young woman, 18-24). Many participants in all groups were unaware of methods that protect against STIs and did not indicate awareness that condoms protect against STIs.

Participants in all groups recognized that spacing and limiting births has advantages for the health of women and children. Notably, participants across groups also linked these advantages with the challenging conditions of displacement, discussing the financial difficulties of raising children in displacement:

> "Suppose, if you have four to five children, you can give them education. Make them educated. How can someone give education to more children if he is struggling to feed them?" (Man, married)

> "Yes I've done it [had an implant inserted]. If I didn't do it, then I would've faced problems to raise children with proper food and care. We couldn't bring anything from Burma except our children. Here they just give us dal, rice and oil. How can we fill our children's stomachs with this? Will they take dal every day? No." (Young woman, 18-24)

> "When they give birth too much and are suffering from it ... they ask for methods like Depo or needle [implant]. I myself have given birth to four children. Now when it is difficult for me to take care of them, I can't give them education, can't give them food. So, we take our method." (Woman, 24-45)

One young woman stated explicitly that women should use contraceptive methods because of displacement:

> "In our society it is not liked to [use] methods like Depo or needle [implant]. ... It is against Allah. ... But still, what can we do? It is not our land. We've come from one place to another. We can't provide everything our children ask for. Because of that, we are compelled to take methods." (Young Woman, 18-24)

Younger married women expressed perceived physical benefits to contraceptive use, such as making their periods regular and that "it increases the appetite and makes the body feel fit" (Young Woman, 18-24). Participants stated that injectables and implants caused weight gain, which was

perceived as a positive side effect; as one woman said, "[Depo] helps to gain weight and makes them [women] beautiful" (Young woman, 18-24). Men also mentioned that contraception helps to "see the beauty of the body" (Man, married), by preventing physical changes in women's bodies due to multiple childbirths. Older married women also expressed that spacing or limiting births led to less "suffering" and more "enjoyment" for the mother (Women, 25-45) and facilitated her ability to manage domestic responsibilities.

Notably, women perceived that injectables are for younger women, who may still wish to continue childbearing, while they associated implants, a long-acting method, with older women, whose childbearing years were considered to be over: "Older women use these methods [implant]. Young women like Depo. After 35 it is a bit hard to give birth, so they insert it [implant] and keep silent" (Woman, 25-45). Men perceived injectables to be the preferred contraceptive method for women because, it did not require women to visit health facilities on a monthly basis, unlike OCPs for which women have to return to facilities monthly to obtain a new packet of pills.[42]

Participants across groups discussed negative side effects they associated with use of different methods of contraception, many of which were perceived side effects rather than real. When asked about disadvantages of short-acting contraception methods, older women most commonly mentioned "bleeding" when using Depo; while it is not clear what women meant by this, increased menstrual bleeding or spotting can sometimes be associated with starting this method. Other participants mentioned conditions that are not at all associated with contraceptive methods, but which they misconceived as being associated with contraception. With regard to short-acting methods, some younger women mentioned infection, rashes on the abdomen, disease, and "being skinny" (Young woman, 18-24), none of which are associated with use of short-acting contraception. Other misconceptions about contraceptive methods included the beliefs that "if you stop taking [OCPs] you can't take them again" (Young woman, 18-24); with respect to reduced menstrual periods caused by some methods, "if menstrual blood doesn't come out for a long time, then disease will occur" (Young woman, 18-24). Other women noted that contraception affects individual women differently, although the perceived effects were still inaccurate: "Depo sometimes suits women and sometimes it doesn't. When it doesn't suit [a woman], then it causes rashes and infection [on that woman's body]" (Young woman, 18-24). One male participant made a similar remark: "Some [women] have bleeding. To some [women] it [Depo] suits them. For some it becomes the reason of disease" (Man, married).

Women also described negative side-effects associated with the use of long-acting contraceptive methods, including stomachaches, while the younger women also mentioned disease, dizziness, blood deficiencies, and nutritional deficiencies in breast milk. Other participants expressed misconceptions about contraception, especially LARCs, including that long-acting methods "lead to disease" (Young woman, 18-24); implants "harm their [women's] health. They [women] become weak" (Man, married); and a long-term method is not reversible or removable until it expires, which the participant thought was three or five years later: "If you take three-years one, then you've to wait for three years. If you take five-years one, you have to wait five years" (Young woman, 18-24). One woman stated that the IUD has no "expiration date" (Woman, 25-45). This statement could reflect several mistaken beliefs about the IUD, including that it remains effective for perpetuity, or that it cannot be removed.

Participants were generally less aware of LARCs, especially IUDs, than other methods; however, when the moderator described the long-acting methods to participants, the methods raised concerns among participants about removal services: Given their displacement status, and the uncertain timeline for repatriation, both older and younger married women communicated

concerns that they would be unable to access LARC removal services once back in Myanmar. A younger married woman said: "If we go back to Burma we would have to come back [to Bangladesh] to take that needle out" (Young woman, 18-24). One older married woman said she preferred short-acting method for this reason: "We are like guests here in Bangladesh. We don't know in which time we have to go where. We are not sure about our timing, so we take Depo for short term" (Woman, 25-45). More broadly, because of contraception being discouraged in Islam, older and younger women also expressed concerns regarding LARCs potentially remaining in the body after death, which might have religious implications: having a contraceptive method in the body at time of death could make the body impure in the afterlife. One participant said: "We don't know when Allah is going to take us. It is Allah's decision. We don't have time to take it [the IUD or implant] out. So monthly pills are very much taken" (Woman, 25-45).

MM Kits, seen in a private dispensary at a market in Kutupalong camp, Cox's Bazar, January 2019.
© Rumana Akter/WRC

Sources of information on contraception and contraceptive services

Participants in all groups reported receiving information about contraceptive services from CHW/Vs: "Most of the time NGO people tell us about it. They go block to block. NGOs send workers to community people to talk about family planning. They discuss about methods of family planning" (Man, married). Young women also cited youth centers and WFSs (Young woman, 18-24). Young women also mentioned CHW/Vs, but they were more likely than older married women or men to cite their peers as a source of information: "Whenever we three women sit together, we talk about it [contraception]. Some say that Depo is good. Some say that the pill [OCP] is good" (Young woman, 18-24). Older women mentioned additional information sources: the hospital or health facility, doctors, teachers, and community meetings held by volunteers.

Younger and older women reported that *majis* sometimes discuss topics related to contraception,

such as sharing information about which facilities offer contraceptive services; advocating to have smaller families; or working with CHW/Vs to recommend that women use a contraceptive method. Men, however, claimed that community leaders do not talk about contraceptive services: "No, they [*majis*, imams, and sheikhs] don't talk about it [contraception]. Only NGOs talk about it" (Man, married).

Notably, older women attested that few people in their community speak openly about contraception because "our Rohingya people are shy to talk about it" (Woman, 25-45). However, as noted above, some female participants said they might speak to their husband and relatives about the importance of contraceptive use during displacement: "Community people are also talking about not having children early because you are in an emergency setting, a temporary place; please space the babies" (Woman, 25-45).

Sources of contraception

Participants in all groups reported that contraceptive services could be obtained at health facilities, with some naming the specific organizations HOPE, RTMI, Action Aid, MSF, IOM and Red Crescent. However, young women also mentioned obtaining contraceptive products from shops or "outside" (Young woman, 18-24) because "only married couples will do it [seek contraceptive services] openly [at a facility]" (Young woman, 18-24). For their part, men noted that CHW/Vs "are taking [contraception] with them for every household" (Man, married), although at the time of the study, CHW/Vs were not authorized to distribute methods. Men also mentioned that women could get contraceptive services from the WFSs (Man, married), which was being done. When probed to provide information about additional sources for contraception services, some participants referred to the seeking of treatment from community or traditional doctors to remove long-acting methods.[43] For example, these "private doctors" might charge 300-400 taka (3.50 – 4.75 USD) to remove an implant (Man, married) and one participant mentioned that TBAs could remove IUDs (Young woman, 18-24).

Abortion services

Source for abortion information and services

Participants in all groups were aware of MR services, which participants referred to using the word for "abortion" in Rohingya, and acknowledged that both married and unmarried women in their communities were seeking abortions.[44] Young women said that women might seek an abortion "if they are not ready" (Young woman, 18-24). Older married women discussed abortion, and noted that in these cases—when a woman's period stops for one or two months—the community would not be aware that she had been pregnant: "How is the community supposed to know about it? So, if you abort within one or two months, no one is going to know about it. If the woman is eight or nine months pregnant, then they will know about it. If I abort in one or two months, people will think I have my regular period" (Woman, 25-45).

Participants in every group reported that women procured abortion pills from private dispensaries or pharmacies in the camps. Although men and older married women mentioned that women could seek abortions at health facilities or hospitals, younger married women were less likely to name the health facility or hospital as a place for a young woman to obtain an abortion: "[Abortion in a hospital] is not possible for adolescent girls, only for married ones" (Young woman, 18-24). This comports with increased stigma for unmarried women obtaining abortions, and the aforementioned perception that procuring medication from a dispensary is "secret," or less likely to result in a woman or girl's contraceptive choices being known by the community. One man said that women who had "secret affairs" might go to a "secret doctor" for an abortion (Man, married).

Younger women said that they hear information about abortions or PAC from service providers at a hospital and that, if an unmarried girl they knew got pregnant or had post-abortion complications, they would advise the girl to go to the hospital: "If any unmarried girl gets pregnant we'll ask her to go to the hospital. What else could we do?" (Young woman, 18-24). Participants in all groups reported that PAC could be obtained from health facilities. Men said that women suffering from abortion complications might "make an excuse" to go to the hospital (Man, married), or that women might get medicine from the pharmacy, or a "check up with a private doctor who can come to visit home" (Man, married).

Methods of abortion

Participants in all groups noted that women can terminate a pregnancy by obtaining pills, something they can do in secret or that women can do on their own. Notably, participants in all groups also mentioned unsafe abortion, mostly by using roots or plants they knew in Myanmar. Older married women mentioned the root of a plant named "horojala," saying that "you have to insert it in the entry point of the uterus" (Woman, 25-45). Younger married women also mentioned the use of a "thin root they [women] directly put in the vagina from where we get period. Then they make a knot in the end so that it doesn't go very deep to touch the liver" (Young woman, 18-24). This was regarded as dangerous, and some women had heard of women dying from this method. Most likely due to stigma and fears of legality, women argued that the practice of using plants in this way only happened in Myanmar, and no longer was practiced in the camps in Bangladesh; however, one man remarked that "many women who got pregnant by military did this [used a tree root to induce abortion] because they don't need the child" (Man, married). While female participants were less forthcoming about the frequency of unsafe abortions in the camps, some men expressed that they perceived unsafe abortions to be commonplace in the camps, with one man remarking, "some girls are doing it in the latrine right now" (Man, married).

Attitudes toward abortion

Participants across groups expressed stigma towards women who have abortions, and most suggested that women who obtained abortions did so in secret. Concerns about stigma were particularly acute for unmarried women. Participants made a number of statements to this effect, including "the community won't want a bad character girl" (Young woman, 18-24), "people will throw her out of society" (Young woman, 18-24), the community will "punish [a woman] and talk about her" (Young woman, 18-24), and "If [the] community gets to know about it [abortion], you can't say what's going to happen to her" (Young woman, 18-24). A participant in a male FGD added that women have to hide their abortions "to save herself from shame because she cannot tell about it to anyone else" (Man, married) and another said women should hide it "so that nobody gets to know about it and to protect herself from stigma" (Man, married).

Men were supportive of abortion when a man does not want his partner to have a child. One man stated that a husband might choose abortion for his wife if the husband doesn't want her to have a child: "If a husband doesn't want children then his wife cannot do anything, so the husband will tell her to go to the health facility" (Man, married). Men also expressed that abortion might be a choice for a woman whose husband left her: "Normally, married women don't want to do abortion, but if it is one or two month and [her] husband left her, then she will try just to make herself free from responsibilities" (Man, married). Men also reported that an unmarried woman might seek an abortion if the man she had sex with would not marry her, which was reportedly common.

Notably, rape connected to sexual and gender-based violence targeted at Rohingya women was mentioned by both men and older married women when discussing the incidence and means of abortion in their communities. Participants did not explicitly endorse abortion in these cases, but

mentioned it as a strategy that some women resorted to within the context of the sexual violence many Rohingya girls and women faced in Rakhine State and during the flight to Bangladesh. Women attested that "there are many women who are victims of rape on the [way] to Bangladesh [from] Burma. … There are women who have children from Burma military's rape" (Woman, 25-45). Men stated that a woman might seek an unsafe abortion if "someone had forcefully done it [sex] to her" (Man, married) and that "many women who got pregnant by military did this [unsafe abortion]" (Man, married). One participant recounted the story of a daughter who was a victim of sexual violence in Rakhine State, and subsequently sought an abortion in Kutupalong camp in Bangladesh:

> Participant 1: I know a woman whose daughter got pregnant of one and a half months, so the mother's daughter secretly went to Kutupalong for medicine. She got pills, one to take and two to put in their mouth. She got her period the day after taking pill.
>
> Participant 2: Where's her husband?
>
> Participant 1: She was raped in Burma. (Women, 25-45)

Illustration seen in an IRC midwife room in a Women Friendly Space, Ukhiya camp, Cox's Bazar, January 2019. *Photo © Sara Casey/WRC*

Barriers to contraception and abortion

Barriers related to religious beliefs

Participants generally reported that imams, sheikhs, and other religious community leaders did not talk about contraceptive services, except to advocate for larger families and having children: "Islamic leaders will say that if you've planted a tree then you must water them to grow. To get fruits. They will ask for more kids" (Woman, 25-45).

Participants in every group expressed unsupportive attitudes toward contraception and abortion related to religious beliefs. According to both female and male participants, having many children is "pious work" and not having as many children as possible is a "sin" and "denying Allah's blessing" (Young woman, 18-24). One participant stated, "Spacing birth and family planning are sinful … it is not allowed in Sharia" (Young woman, 18-24), and another said, "According to our Quran and Hadith, if you are about to have a child then don't stop it [don't have an abortion]" (Man, married).

Barriers related to physical and financial access

Participants in every group confirmed that services at health facilities were free. However, several younger married women brought up transportation costs: "It [the health facility] is a little bit far from my house. I have to pay 20 or 30 taka [for transport]. This one is nearest to me, so I have to pay 20 taka [transportation cost]. For some others, it's very costly to reach here" (Woman, 25-45). Women in these groups cited paying between 5 taka and 50 taka (0.06-0.60 USD) for transport to health facilities.[45] According to one participant, traveling long distances, compounded with long wait times at the facility (see below), can be "painful" (Young woman, 18-24).

Distance also impedes the ability of persons with disabilities to access services. According to one participant, "For people with disabilities, it is hard to bring them here [to the facility]. We who can walk can come easily" (Young woman, 18-24).

As mentioned, unmarried women, in particular, rely on drug shops for abortion medication. Costs for abortion medication from private dispensaries were reported to be "much taka" (Young woman, 18-24) and "costly" (Young woman, 18-24). Participants estimated that abortion medication from a dispensary would cost 300 or 600 taka (Man, married); 500 taka (Young woman, 18-24); 400-500 taka (Young woman, 18-24). Notably, these estimates differed somewhat from actual prices quoted by shopkeepers in the camp. An informal survey of four dispensaries in two camps done by one of the WRC data collectors indicated that all the shops did have MM kits available to purchase, at prices ranging from 280-400 taka (3.30-4.70 USD). One shopkeeper reported referring customers who cannot afford the kits to the hospital.

Additionally, both men and women mentioned lack of childcare as a barrier that made visiting health facilities challenging for parents of small or many children.

Barriers for unmarried girls and women

Participants in six of the eight FGDs attested that women or girls cannot get contraceptive services at facilities unless they have a male guardian; are married; or present themselves as married. They mentioned that service providers in the facility will ask for the husband's name (Young woman, 18-24) or "call the husbands to the facility" for permission before providing services (Woman, 25-45); that hospitals will ask your marital status (Man, married); and that "only married [people] can use methods" (Young woman, 18-24). A participant in a married men's group said, "If an unmarried [woman] ask for family planning, they [service providers] won't give it to you" (Man, married).

This also applied to abortion: a participant in a younger married women's group said that obtaining an abortion in a hospital "is not possible for an adolescent girl, only for married" (Young woman, 18-24). Notably, participants in one group also perceived these restrictions to apply to PAC: participants in the older married women's group said that unmarried women wouldn't be given PAC services without her guardian present, and even a married woman experiencing post-abortion complications would not be given service without her husband present (Woman, 25-45).

Participants stated that this was both because they believed service providers would not provide

services to unmarried or unaccompanied women, and also because of cultural attitudes: an unmarried woman seeking contraceptive services at a facility would "not even say she is unmarried out of shame" (Young woman, 18-24) or would "become shy" (Man, married). The younger married women attested that girls and women might get around this barrier by lying to facilities about their marital status: "If they [unmarried women] lie about her marital status … they [service providers] wouldn't know" (Young woman, 18-24).

According to men, unmarried girls who want an abortion would have to go to the health facility on a premise or "excuse," such as another health issue or visiting relatives. One man said that unmarried girls might not be able to go to the hospital because people might see her. In that case, they might go to a different health facility where they would not be recognized and could present themselves as a married woman with children: "There are many health facilities. They can go to another facility saying that 'I've already many kids and I have a husband'" (Young woman, 18-24).

Participants mentioned that adolescent girls are closely monitored by their parents and are not allowed to go outside without permission or alone. This makes it difficult for unmarried women to access contraceptive and abortion services at facilities or at drug stores confidentially and without risking community reprisal. Conversely, if a young woman does not obtain services to prevent or end a pregnancy, she faces the possibility of an arranged or early marriage to the sexual partner (Man, married). This begins to explain why unmarried women might resort to unsafe abortion, and further relates to the phenomenon of early marriage in the camps: parents are marrying girls early to mitigate the risk of pregnancy happening before marriage (Young woman, 18-24).

Barriers posed by male partners

Men and women participants reported that men, especially husbands, are the primary decision-makers about contraceptive use. Per one participant, "Some husbands are very strict. … If [the] husband allows them that, yes you can do this for this reason, then you can do it with husband's permission" (Woman, 25-45). One woman addressed birth spacing and limiting more broadly, stating, "It is men. They are the producer. If they say carry it, you have to. If they say abort it, you have to do it. If they say don't abort it, you can't" (Young woman, 18-24).

Meanwhile, women acknowledge that "even after marriage girls are using methods without their husband's knowledge" (Young woman, 18-24). One participant said, "Even if the husband doesn't give permission, they can still use three-months [Depo]" (Woman, 25-45); because Depo-Provera is injected on site at the health facility, it is easier to hide its use. However, not all women agreed with or were supportive of this practice: "Why are you saying the wrong thing? … If husbands don't give permission, women can't even do the three-month method [Depo]" (Woman, 25-45).

Women reported further barriers and risks related to men's control of reproductive choices. A woman who makes different contraceptive services choices than her husband might be forced to leave home (Woman, 25-45) or be beaten by her husband (Young woman, 18-24). Both men and women linked women's use of contraceptive methods with husbands abandoning their wives; one man said that "the woman who doesn't want to stay with her husband, she takes all these methods" (Man, married), while one woman suggested that having multiple children was necessary to keep a husband from straying:

> "It [contraception] is good for women, but sometimes husbands try to look for other women. If you want fish, you need to make a barricade in a channel. If you don't barricade there, fish can slip from your hand." (Woman, 25-45)

Quality of services

Participants in all the group discussions spoke positively about the quality of the services provided at the health facilities. Younger women in one group mentioned that "there is a hospital beside us that is not good," (Young woman, 18-24) but overall, participants seemed satisfied with service quality in at least one health facility.

Participants were satisfied with the treatment they received from the providers at their favored health facilities. Participants specifically mentioned the availability of female providers in a facility as an advantage, and that some providers "speak to [them] in Rohingya" (Young woman, 18-24). One participant said: "They speak to us very nicely here. Wherever we find good behavior, then we go there more" (Woman, 25-45); another said, "they never scold us" (Woman, 25-45). Some facilities hand out cards to patients for follow-up services, which patients are expected to present at the next appointment; one young woman preferred facilities that did not require such a card:

> "We can easily get our medicine here. We don't need a card. In other places you need a card. If we don't take it with us, they scold us. … It's just a piece of paper. If we have to go after 15 days, we don't find it, then they start to scold us. It hurts us. Sometimes we take medicine and sometimes we go back without taking medicine. Because we don't want to be scolded. … But here you can collect your medicine if you even forget to bring your card." (Young woman, 18-24)

Participants in all the groups said that services were free of cost, and they had never been charged for contraceptive services at a health facility. One participant mentioned that some health facilities will "give company to support lame or those who have a disability. … Sometimes they are providing tom-tom [vehicle]" (Woman, 25-45).

While participants were satisfied with the quality of services and the treatment from service providers, participants in all groups remarked on long wait times at facilities. Women were generally tolerant of long waits because the service is free and of good quality, because others are before them in line, or because they accept that there is nothing for them to do about it, and "if you want happiness for your health then you must wait" (Woman, 25-45). Men were more likely to see wait times as an inconvenience. One man said, "It happened where people went at 8:00 a.m. and came back at 4:00 p.m. Even after waiting that long, sometimes we don't get service … there is not a day when we went there and got our service immediately" (Man, married). Men perceived this to occur because they believe that CHW/Vs show favoritism to their relatives in the line, or because they perceive that doctors discuss personal business among themselves instead of seeing patients.

VII. DISCUSSION

Discussion of findings

The case study found that contraceptive and MR services were being provided in the camps. All partners that the study team spoke to reported providing contraception in all their supported health facilities, and many likewise provided MR. These services are widely available, and community members were generally aware of them. This is one of very few humanitarian settings where safe abortion (known as MR in this context) was provided to the displaced population from the early days of the emergency. The UNFPA coordination of the SRHWG was functioning well, which likely contributed to the widespread provision of these services.

The entrance to a delivery room at an RTMI-run PHC in Kutupalong camp, Cox's Bazar, January 2019.
© Cassondra Puls/WRC

UNFPA's early support to organizations that were already present and registered in Bangladesh, as well as a strong NGO sector in Bangladesh, meant they could introduce these services early in the emergency. Pre-positioning of supplies prior to the emergency likely contributed to this rapid introduction of contraceptive services. Coordination among partners, particularly where partners with different expertise provided complementary services in single health facility, likely contributed to widespread introduction of these services across the camps. This ensured that services were implemented early while additional health workers with additional partners were trained. Contraception, including LARC, was mandated in both HPs and PHCs in the *Minimum Package*; MR was included for PHCs.

The successful implementation of contraceptive services in Cox's Bazar also highlights the importance of sufficient and consistent funding. UNFPA has a coordination team of three people who share the responsibility of ensuring a consistent funding stream for SRH services. Further, neither UNFPA nor the partners reported experiencing stockouts of contraceptive methods, likely also related to this funding. Despite reporting no stockouts, the team did find stockouts of specific commodities at two facilities during the health facility assessments. The teams said they were obtaining supplies from their own storehouses. It is important to also highlight that UNFPA is still procuring the IARH Kits at a time when they should be moving away from exclusive reliance on the kits to procuring commodities individually (bulk item procurement) as the situation has stabilized. As one partner pointed out, they have less flexibility with the kits—meaning overstock of some supplies and understock of others.

The weak skills of new midwives appeared to be one of the largest barriers to good quality service provision. While UNFPA and Ipas provide training, it is important for the NGOs to adequately supervise and support their midwives to ensure they have the necessary skills to provide good quality services. This requires regular supervision and support as well as periodic observation of their interactions with clients.

While training on LARC, MR and PAC is ongoing, it is insufficient for the number of organizations and staff needing training. Doctors are present at most HPs, meaning that implants could be provided more regularly if these doctors are trained rather than relying on periodic visits for implant "camps." Some health workers were trained to provide LARC or MR, but lacked the necessary supplies and equipment to do so.

Health workers who were assessed with an attitudes questionnaire overall expressed attitudes mostly favorable to good quality contraceptive and MR services. However, in the completed knowledge questionnaires, few health workers could identify the most common changes in menstrual bleeding after IUD insertion; discussing common side effects is an important component of contraceptive counseling, and the FGDs for this study indicated that both women and men in the camps had many misconceptions about the side effects of contraception. In facilities where midwives and other health workers have little opportunity to insert an IUD after training (due to low client numbers), supervisors may consider bringing a pelvic model on a regular basis to provide the opportunity for the health worker to practice IUD insertion under observation with a checklist, even if she has few clients. This is an imperfect solution to help maintain competency despite low client numbers.

It is important to note that while short-acting methods were nearly universally available, the availability of LARCs service provision was more mixed. Several barriers have slowed the introduction of LARCs by the partners. Per government policy, only medical doctors, and no mid-level providers, were authorized to provide implants. NGOs must register separately to provide LARCs, a process that takes time, and which some NGOs were still working on at the time of the study. Space constraints in the camps allow little privacy, hindering effective counseling and making it more difficult to have sufficient private space to insert IUDs. Ipas paramedics are largely responsible for the provision of LARC in the camps as they are placed in facilities run by partner organizations. Ipas should support its paramedics to mentor the midwives they work with to strengthen the midwives' capacity to provide LARC and MR.

Some NGO informants justified their organizations' not providing LARCs by saying refugee community members don't want them. However, in the FGDs, community members expressed lack of awareness, inaccurate knowledge, or belief in myths about LARCs, indicating that, rather than saying that the community "does not want" LARCs, further community education is needed. This is also consistent with the findings of a household survey conducted in the camps in early 2018, where fewer than 3% of married women cited implant or IUD as contraceptive methods they knew of.[46] Further, women in the community who were aware of long-acting methods expressed concerns about being able to have LARCs removed when they wished—including in the possible case of return or repatriation to Rakhine, where Rohingya have historically been marginalized and discriminated against within the health system and where removal might not be easy to obtain. This concern could be allayed with counseling, community education, or other awareness-raising that included thorough information about removal services in camp health facilities, stressing that removal could be done immediately—that is, as soon as a trained service provider is available to do so—in the case that women must leave the camp at short notice.

Given the dominance of short-acting methods in the method mix, it would be good for NGOs to monitor whether women are returning on time for their next dose. Organizations could consider using a system of filing client cards by month of return visit. At the end of the month, they could easily see who has not returned for her next dose and contact the appropriate community health worker/volunteer to ask the client to come see the midwife. This must be done in a confidential manner so a woman keeping her contraceptive use secret may continue to do so. It could be worth monitoring continuation for a few months without following up with women to see whether women do in fact largely return on time. If many do not, then organizations could explore how best to reach out to them while maintaining confidentiality.

The FGDs, while suggesting various barriers that may still exist for many girls and women in the refugee camps to access contraceptive services, created a picture of an especially constrained and challenging situation for unmarried adolescent girls: adolescent girls appeared to be targets of sexual violence both in Myanmar and potentially still in the camps, yet it could also be extremely difficult and risky for them to access and obtain SRH services at health facilities, given both the perceived bias from service providers and the community stigma. These barriers to accessing services may have stark consequences: The fact that many FGD participants mentioned use of traditional plants to induce abortion, along with relatively stable monthly numbers of PAC clients, indicate that adolescent girls and women may still be resorting to unsafe abortions.

Given the stigma around adolescent girls and sex, it would be good if CHW/Vs were better prepared to discuss topics like sexuality and contraception with the unmarried girls. To account for cultural sensibilities, it could be discussed in the context of preparing for the day they are likely to get married—something that most girls end up doing—given that many marry young. It is important that CHW/Vs are themselves comfortable with the topics.

Effective strategies

This case study identified some effective strategies and contexts that supported success in contraceptive service delivery and uptake in the Cox's Bazar refugee camps:

- 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 before and throughout the duration of the emergency, allowing for more consistency in leadership and more effective maintenance of NGO/government relationship-building efforts.
- 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.
- MOUs 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.
- Community health work included family planning topics from early in the emergency and consistently during the emergency, to educate and spread awareness among community members on the availability of contraceptive methods.

VIII. RECOMMENDATIONS

Based on the case study, some additional recommendations to all partners in SRH provision in Cox's Bazar refugee camps were identified.

- All partners should provide all short- and long-acting contraceptive methods in all HPs and PHCs as called for in the *Minimum Package of Essential Health Services.*
  - Alongside this service provision, NGOs should support their providers to offer thorough counseling and correct information to clients about the expected side-effects of all contraceptive methods; and
  - NGOs should support CHW/Vs to provide correct information about LARCs and dispel misconceptions common in this community about long-acting methods in particular.
- 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 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 as soon as they complete training, rather than lose their new competencies while awaiting provision of supplies.
- Procurement should move away from exclusive use of the IARH kits to bulk item procurement (procuring commodities individually) as the emergency situation has stabilized to permit more efficient procurement of needed supplies.
- SRH partners should maintain competency of providers trained in IUD insertion with, for example, use of pelvic models to observe IUD insertion with a checklist.
- 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 strengthen community mobilization activities, specifically:
  - Ensure CHWs/Vs are fully prepared to discuss with and engage adolescent girls, including unmarried girls, in sexuality and contraception education.
  - Ensure CHWs/Vs are educated about LARCs in particular to raise awareness of long-acting contraception methods and dispel common misunderstandings among community members about contraception and LARCs.
  - Ensure CHWs/Vs are supported to help women and girls talk to their husbands and male guardians/partners about contraception, possibly through role plays in small group.
  - Ensure CHWs/Vs know which facilities do and do not provide MR, so they can educate and refer community members accordingly.
  - Establish links between Bangladeshi imams supportive of contraception and their Rohingya counterparts to help dispel beliefs that contraception is contrary to the practices of Islam.

IX. APPENDICES

APPENDIX A: DATA FROM KEY INFORMANT INTERVIEWS

Table 8: Organizations and Agencies interviewed

Organization	Number
BRAC	1
CARE	1
CPI	1
HOPE Foundation for Women and Children of Bangladesh	1
Ipas	1
IRC	1
RTMI	1
Save the Children	1
UNFPA	3

Table 9: Service delivery as reported in KIIs

	No. of supported facilities in camps	Implant	IUD	Pills	Injectable	Condom	ECP	MR	PAC
BRAC	9	X		X	X	X	X	Refer	X
CARE	4 (+8 outreach teams)	†	X	X	X	X	X		X
HOPE	9 (including 1 hospital)		*	X	X	X	X	*	*
Ipas	37		X	X1	X1	X1	X1	X	X
IRC	27 (including 21 WFS)	X	X	X	X	X	X	X	X
RTMI	20	X	*	X	X	X	X	*	*
Save the Children	10	††	††	X	X	X	X		X

X=Organization reported providing the service
† While CARE was registered to provide LARCs at the time of the study, they needed to complete training of their doctors. CARE has "implant camps" at which they bring trained MOHFW doctors to provide implants to their clients.
†† At the time of the study, Save the Children was awaiting training to be able to provide LARCs
** Ipas paramedics provide IUDs, MR, and PAC in HOPE and RTMI facilities.*
1 Ipas usually provides IUDs, MR, and PAC in other NGO facilities that have midwives providing short-acting methods. However, where Ipas is the only contraceptive provider, they provide both short- and long-acting methods.

APPENDIX B: DATA FROM HEALTH FACILITY ASSESSMENTS

Table 10: Facilities with essential components to provide contraception, MR, and PAC

	Hospital (n=1)	Health center (n=2)	HP/WFS (n=3)
ORAL CONTRACEPTIVE PILLS			
OCPs provided in last 3 months	1	2	3
Staff trained to provide short-acting methods	1	2	3
BP cuff	1	2	3
Stethoscope	1	2	3
Daily combined oral contraceptive pills	1	2	3
Progestin–only contraceptive pills	1	2	2
Facility able to provide OCPs	**1**	**2**	**2**
INJECTABLES			
Injectables provided in last 3 months	1	2	3
Staff trained to provide short-acting methods	1	2	3
BP cuff	1	2	3
Stethoscope	1	2	3
Injectable contraceptive (progestin-only)	1	2	3
Needles and syringes	1	2	3
Facility able to provide injectables	**1**	**2**	**3**
INTRAUTERINE DEVICE (IUD)			
IUD insertion or removal performed in last 3 months	1	2	0
Staff trained to provide IUDs	1	2	1
Sterile gloves	1	2	0
Graves Speculum, medium	1	2	0
Uterine sound	1	2	0
Uterine tenaculum	1	2	0
Sponge forceps, straight	1	2	0
Mayo scissors, curved	1	2	0
Gauze/cotton	1	2	1
Antiseptics	1	2	1
IUD	1	2	1
Facility able to provide IUD	**1**	**2**	**0**
IMPLANT			
Implant insertion or removal performed in last 3 months	1	2	1
Staff trained to provide implants	1	2	1
Sponge forceps	1	2	0

	Hospital (n=1)	Health center (n=2)	HP/WFS (n=3)
Sterile gloves	1	2	0
Needles and syringes	1	2	1
Antiseptics	1	2	1
Lidocaine	1	2	0
Gauze/cotton	1	2	1
Implant	1	2	0
Facility able to provide implant	**1**	**2**	**0**
EMERGENCY CONTRACEPTION			
Emergency contraceptive pills	1	2	3
Facility able to provide emergency contraception	**1**	**2**	**3**
CONDOMS			
Male condoms	1	2	3
Female condoms	0	0	0
Facility able to provide condoms	**1**	**2**	**3**
MR USING MEDICATION			
MR performed in the last 3 months	1	2	1
Number trained to provide MR	1	2	1
Family planning offered to all MR clients before discharge	1	2	1
Misoprostol-mifepristone combination pill	1	2	0
Facility able to provide MR using medication	**1**	**2**	**0**
PAC USING MVA			
PAC performed in last 3 months using MVA	1	2	0
Vaginal speculum, Graves medium	1	2	0
Sponge forceps	1	2	0
Uterine tenaculum	1	2	0
Uterine dilators, sizes 13-37 (French)	1	2	0
Vacuum aspirators/syringes	1	2	0
Flexible cannulae, 4 - 12 mm	1	2	0
Adapters	1	2	0
Kidney dish	1	2	0
Antiseptic solution	1	2	0
Gloves (sterile or non-sterile)	1	2	0
Lidocaine	1	2	0
Paracetamol OR Ibuprofen	1	2	0
Oxytocin	0	2	0
Needles and syringes	1	2	0

	Hospital (n=1)	Health center (n=2)	HP/WFS (n=3)
Facility able to provide PAC using MVA	0	2	0
PAC USING MISOPROSTOL			
PAC performed in the last 3 months using misoprostol	1	2	2
Misoprostol 200 mcg tablets	1	2	1
Facility able to provide PAC using misoprostol	1	2	1

APPENDIX C: PROVIDER KNOWLEDGE AND ATTITUDES DATA

Table 11: Providers' provision of services and training

	Service	Provided the service in the past 3 months (n=17)	Ever received instruction or training on how to provide this service (n=17)
1.	Counsel women and girls about family planning	17	11
2.	Insert an IUD	8	9*
3.	Insert a postpartum IUD (within 24 hours of delivery)	2	3*
4.	Insert an implant	2 (out of 2 doctors)	1
5.	Provide emergency contraception	8*	6***
6.	Perform manual vacuum aspiration (MVA) for post-abortion care	3	4*
7.	Provide post-abortion care using misoprostol	7	6*
8.	Perform menstrual regulation using MVA	3	4*
9.	Perform menstrual regulation using mifepristone and misoprostol combination pill	5**	5**
10.	Provide post-abortion contraceptive counseling	16	7*
** = 1 missing response, ** = two missing responses, etc.*			

Table 12: Providers' knowledge: FP

FP	n=17
The person responsible for making the choice of a family planning method is the: a. health care provider **b. client** c. client's partner d. village elder	17/17
The most important part of counseling is: **a. informing the client about all available methods and answering her concerns and questions about using contraceptives** b. making a good decision for the client c. using up all surplus supplies in the health facility d. making friends with the client	17/17
The most common side effect of Depo-Provera is: a. jaundice and liver damage b. increased facial hair c. reduced sexual desire **d. changes in the menstrual cycle**	17/17

FP	n=17
Most women experience changes in their menstrual periods following the insertion of an IUD. You should explain to new IUD users that they can have: a. less bleeding than usual but more menstrual cramping during the first few periods following insertion b. more bleeding than usual and less menstrual cramping during the first few periods following insertion c. less bleeding than usual and no menstrual cramping during the first few periods following insertion **d. more bleeding than usual and more menstrual cramping and pain during the first few periods following insertion**	6/17
A mother who is less than six months postpartum and amenorrhoeic (her menses have not returned after delivery) is protected from pregnancy as long as she: a. breastfeeds her baby during the day and the baby sleeps at night **b. breastfeeds the baby on demand day and night** c. bottle feeds the baby d. breastfeeds the baby at night and bottle feeds during the day	17/17
Potential users of emergency contraception include: a. Unmarried women b. Young women c. Women who smoke under the age of 35 **d. Any woman who has had an episode of unprotected sex**	17/17
	4.4/5
Correct answers are marked **in bold.**	

Table 13: Providers' knowledge: PAC

PAC	n=17
Both MVA and misoprostol are effective methods for treatment of incomplete abortion if the uterine size is not greater than: a. 10 weeks b. 12 weeks **c. 13 weeks** d. 16 weeks	0/17
Which one of the following is a WHO recommended regimen for misoprostol for treatment of incomplete abortion and miscarriage? a. 400 mcg oral b. 600 mcg oral **c. 600 mcg sublingual** d. 800 mcg sublingual	11/17
After uterine evacuation for incomplete abortion, a woman's fertility may return: a. After 4 weeks b. After her first menstrual period **c. Within 7-11 days** d. After her first ovulation	7/17
What information do you give patients who were treated for an incomplete or unsafe abortion? a. Information about when a woman can conceive again b. Refer for family planning or provide FP methods c. Information about the consequences of an unsafe abortion **d. All of the above**	17/17
Mean Number of Correct Responses	**2.1/4**
Correct answers are marked **in bold.**	

ACRONYMS AND ABBREVIATIONS

CDC	US Centers for Disease Control and Prevention
CHW/V	Community health worker or community health volunteer
CPI	Community Partners International
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DMPA-CU	Depot medroxyprogesterone acetate, sub-cutaneous
EC	Emergency contraception
ECP	Emergency contraception pill
FDMN	Forcibly displaced Myanmar national
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
HP	Health post
IAWG	Inter-agency Working Group for Reproductive Health in Crises
IOM	International Organization for Migration
IRC	International Rescue Committee
IUD	Intra-uterine device
KII	Key informant interview
LARC	Long-acting reversible contraception
MISP	Minimum Initial Service Package
MM kit	Mifepristone-misoprostol combination pills
MOHFWFW	Ministry of Health and Family Welfare
MOU	Memorandum of understanding
MR	Menstrual regulation
MSF	Médecins Sans Frontières
MVA	Manual vacuum aspiration
NGO	Nongovernmental organization
OCP	Oral contraception pill
PAC	Post-abortion care
PHC	Primary health center
UNFPA	United Nations Population Fund
RC	Registered camp
RH	Reproductive health
RH Kit	Reproductive Health Kit
RRRC	Office of the Refugee Relief and Repatriation Commission
RTMI	Research, Training and Management International
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRHWG	Reproductive health sub-working group
STI	Sexually transmitted infection
TBA	Traditional birth attendant
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WFS	Women-friendly space

ENDNOTES

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34 One NGO respondent shared that, given that there were many more women than men in the camp, men could marry, have sex with, and impregnate women, and then later abandon the women, with little consequence to the man. See Section VI of this report, where female community members shared similar testimony.
35 In January 2017, the U.S. government passed the "Protecting Life in Global Assistance" policy, which prohibits U.S. global health assistance from being provided to non-U.S. NGOs that perform abortion in cases other than rape, incest, or threat of life to a woman; that provide counseling or referral for abortion; or lobby to make abortion more available in their own countries. PAI, 2017. "What You Need to Know about Protecting Life in Global Health Assistance Restrictions on U.S. Global Health Assistance: An Unofficial Guide." https://pai.org/wp-content/uploads/2017/10/WYN2K-10.5.pdf.
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38 Implants will become available through the IARH kits as a complementary commodity once the revised kits are rolled out.
39 Fullerton, 2018.
40 *Majis* are individuals from within the refugee community who serve as leaders at the sub-block level within the governance structure of the camps (Strategic Executive Group, 2018).
41 In Bangladesh, only medical doctors are authorized to provide contraceptive implants.
42 This would also be true of implants and IUDs, which also would not require women to visit facilities every month; however, men in the discussions did not mention this as an advantage of implants and IUDs, perhaps because of the lower awareness of long-acting methods.
43 The reasons why people might seek removal services from private doctors, and not from health facilities, was not clear from the FGD data collected.
44 "Menstrual regulation" is a term specific to the Bangladesh context, and not necessarily reflective of the Rohingya language in which the FGDs were conducted; therefore, this section uses the word "abortion" to refer to what otherwise is referred to as menstrual regulation in other parts of the report.
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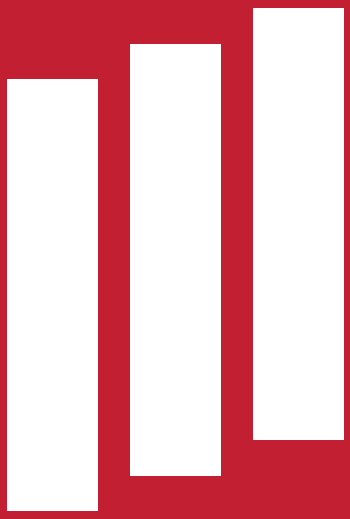

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