Unmet Maternal Healthcare Needs in Rohingya Refugee Camps in Bangladesh, 2017- 2023

by Toma Rani

A thesis submitted to the School of Graduate Studies in partial fulfillment of the requirements for the degree of

Master of Gender Studies

Department of Gender Studies, Faculty of Humanities and Social Science

Memorial University of Newfoundland

June 2024

St. John's, Newfoundland and Labrador

Abstract

The plight of Rohingya refugee in Bangladesh necessitates urgent attention to address their maternal health needs. This project aims to develop a comprehensive workbook for aid and development workers serving Rohingya refugee women, focusing on assessing available maternal health services within the camps and identifying areas for improvement. The objectives of this project are twofold: firstly, to provide aid workers with a thorough overview of existing maternal health services available in Rohingya refugee camps in Bangladesh, including antenatal, childbirth assistance, and postnatal care. Secondly, to identify gaps and deficiencies in these services through socio-cultural, economic, and infrastructural barriers that hinder access to quality healthcare for Rohingya refugee women. From the secondary scholarly literature, the project utilizes a qualitative methodology to analyze the existing maternal health services. With a human rights lens, the project paper is the guiding framework for assessing the accessibility, availability, acceptability, and quality of maternal healthcare services within Rohingya refugee camps. Through distributing this project workbook, I aspire to contribute to the broader discourse of health and rights, advocating for policies and interventions prioritizing the dignity and well-being of Rohingya refugee women in Bangladesh.

Acknowledgment

I would like to extend my heartfelt gratitude to my family who have played a vital role in my life to fulfill my dream. Also, I would like to thank you to all the faculty and staffs in Gender Studies Department at the Memorial University of Newfoundland.

I express my sincere thanks to my professor Dr. Jennifer Dyer for guidance, expertise, and unwavering encouragement and her mentorship has been invaluable in shaping the direction and focus of this Project.

Finally, I would like to thank my husband Tonmoy Ghosh, my parents, and my very understanding baby Ira Ghosh for always supporting me, motivating me, and pushing me to achieve my goals and to continuously work hard. I would also like to thank them for always being a positive encouragement and support and for always being there for me.

Toma Rani

June 2024

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

1.0 Introduction

This portfolio-style thesis consists of two sections: a project paper plus a workbook (Addendum 1) that identifies and educates about unmet maternal health needs in the Rohingya refugee community, specifically in refugee camps in Bangladesh. Analyzing data from the most recent research and articles, I examine in the project paper the essential maternal healthcare needs and prospected recommendations to improve services from the perspective of human rights. Then, the workbook acts as a participatory information pamphlet that gives an overview of the present situation of maternal healthcare facilities and helps aid workers by engaging them self-reflectively in their ongoing efforts to address the unmet maternal healthcare needs in Rohingya refugee camps in Cox's Bazar, Bangladesh. In Rohingya refugee camps, one in five expecting women in the camps do not go to the health facilities to give birth. Many reasons include family rules against it and a lack of trust in facility-based services. Also, between September 2017 and August 2018, 52 of the 82 deaths of mothers during pregnancy happened in these camps (Sarker et al., 2020), which indicates an urgent need to ensure proper healthcare facilities. This thesis and the workbook will help to get the concentration of healthcare providers so that the Rohingya women can receive urgent care.

1.1 Forced Migration and Refugee Women

Migration is defined as the movement of a community or people from one place to another place or country. The world has experienced different migration trends, whether internal or

external. This migration has different reasons, such as ethnic cleansing from a country, war, or natural disaster. Sometimes, people migrate voluntarily. However, if the reason is not voluntary, then it is called forced migration. According to the United Nations High Commissioner for Refugees (UNHCR, 2023), the number of forced displacements has grown over the decade. The number was 51.2 million people at the end of 2013; now, this number is 110 million in 2023. Among the 110 million displaced people, refugees comprise 38 percent who are forcibly displaced due to war, conflict, persecution, and human rights violations (UNHCR, 2023). The total population that UNHCR protects, including refugees, asylum-seekers, and others who need international assistance, is 110.8 million.

Refugees are internationally displaced people who have been uprooted, crossed national boundaries, and cannot return home. According to the United Nations Convention in 1951, "a refugee is someone unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion." Refugees' journeys are more profound than migrating across national borders because they cannot find their spaces of belonging and identity. Refugee are forced to seek areas that distinguish their lives from migration because they are displaced. As a result, the story of displacement becomes a part of their life story that influences their later life. The health life of refugee women after the settlement in a new country can be different or affected by individual or community since the women face more struggles during the journey of resettlement (Hawkins et al., 2021). So, there is a need to focus on refugee women's maternal health to explore their real needs and to ensure their health rights.

1.2 Who Are Rohingya Refugee

The Rohingya are an ethnic Muslim community who are originally from Myanmar. According to UNHCR, the Rohingya are a stateless Muslim minority in Myanmar who were forcibly displaced from the Rakhine state of Myanmar to Bangladesh, which began on August 25, 2017 (Riley et al., 2020). They have sought shelter in and around the refugee settlements of Kutupalong and Nayapara in Bangladesh's Cox's Bazar.[1] Nasir Uddin (2020) says the Rohingyas are ethnolinguistic and religious minorities who inhabit the northern part of the Rakhine State in current-day Myanmar. In Rakhine State, they comprised 25 percent of the state's total population until the displacement started.[2] Myanmar's changing political scenario and military regime have persecuted the Rohingya minorities since 1990 under the name of different operations such as 'Operation King Dragon' and 'Operation Clean and Beautiful State' (Sudheer and Banerjee, 2021). It is estimated that about 25,000 Rohingyas were murdered and 19,000 Rohingya women and adolescents were raped during the conflict, and around 392 Rohingya villages were demolished by torching all settlements (Rahman and Sakib, 2021). Due to long-standing persecution, restrictions, violence, and being denied citizenship and basic rights in their country, most of the Rohingya people have fled to the neighboring country Bangladesh in search of safety and shelter. Because

[1] *Rohingya emergency*. (n.d.). UNHCR. Accessed 2023, January 8. www.unhcr.org/rohingya-emergency.html.

[2] In the book *The Rohingya: An Ethnography of "Subhuman" Life* (2020), Nasir Uddin describes a comprehensive portrait of how the state becomes instrumental in producing 'stateless' people, wherein both Myanmar and Bangladesh alienate the Rohingyas as illegal migrants, and they have to face unemployment, mental and sexual abuse, and deprivation of basic human necessities.

of mass displacement and the significant refugee crisis, Rohingya people face human rights violations.

1.3 Background of the Study

I am interested in the Rohingya refugee people because I am a citizen of the host country, Bangladesh. I can remember the situation when the Rohingya crisis started in Bangladesh, as the people of Bangladesh were not happy to provide shelter to a million Rohingya people. Although the government of Bangladesh took this decision to accept them into Bangladesh, it was criticized by many people. For example, Bangladeshi people sometimes use "Rohingya" as a derogatory to debase someone. This situation has urged me to think more extensively about the refugee crisis, especially about the refugee mothers. Given that I recently gave birth to my daughter, I have some understanding of the circumstances that pregnant women may face to get healthcare services, but this is quite a different context. That is why I am particularly interested in the barriers that exist to healthcare information that is already reported widely. This information is important for fully understanding and recognizing human rights, and the framework for this project will be informed by the human rights perspective on maternal health. The audience of the workbook will be development workers, development agencies, and aid NGO workers. Some specific communities that may be included in an eventual target audience include BRAC James P. Grant School of Public Health, International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), Institute of Epidemiology, Disease Control and Research (IEDCR), and Dnet (Digital Networking). All four research centers are in Bangladesh, and they are researching emerging issues, including health issues in Bangladesh. It is noted that I have worked on some projects as a research assistant with

some development organizations (Dnet, BRAC) in Bangladesh between 2019 and 2021, where I worked as a field researcher, and those opportunities provided me with a scenario of how the pregnant women still do not get to reach proper healthcare that is available in Bangladesh.

1.4 Objectives of this Study

This paper and workbook will be an important resource for aid and development workers who may know about these experiences from the front-line workers' perspective. The goal of this project and workbook is to inform front-line aid, NGO, and development workers who are providing maternal healthcare services to Rohingya refugee women about the existing circumstances and essential healthcare needs, as well as to explain what is needed for the betterment of maternal healthcare services in Rohingya refugee camps. The workbook format is intended to be accessible and in a format that does not require an extensive time commitment. The end goal is to provide information to help Rohingya refugee women receive sufficient services from aid and development workers.

1.5 A Brief History of Rohingya Refugee

The Rohingya crisis has become a global issue. Several ethnic communities live in the Rakhine state of Myanmar, where Muslim Rohingya and Buddhist Rakhine are two significant groups. In 1962, the military junta started campaigns against people who had origins in India, China, and Pakistan. This process became a nationwide displacement with residence checks

(Ansar, 2020). The military junta passed a citizenship law in 1982 that declared 135 ethnic groups included as citizens of Myanmar, but they excluded the Rohingya Muslim community (Ty, 2019).

Consequently, the Rohingya community lost their legal citizenship status from Myanmar. As a result, the Buddhist community started to inhabit the land in the Rakhine state, which created conflict between Rohingya Muslims and the Buddhist Rakhine communities. This conflict between the two groups has intensified since 2012. In 2012, the Buddhist monks and Arakanese political party members incited violence and assassinations against Rohingya Muslims, which triggered the displacement of around 120,000 Rohingya (Ty, 2019). The crisis continued into 2017 when the Arakan Rohingya Salvation Army (ARSA) attacked police outposts in Rakhine state. The Rohingya community faced a massive counterattack by the police and security forces of Myanmar. A security force has destroyed approximately fifty-five Rohingya villages to eliminate the evidence of attacks and assassinations on Rohingya Muslims. The armed conflict in Rakhine state displaced around 882000 Rohingya people from Myanmar to Bangladesh in 2017-2018 (Amsalu et al., 2022). Most persecuted Rohingya fled to Cox's Bazar, Bangladesh, as refugees. The mass influx of Rohingya refugees was not wholly unprecedented. Over many years, the Rohingya refugees have been displaced from Myanmar and taken shelter in Bangladesh (Rahman and Sakib, 2021). The first influx of Rohingyas was recorded in 1784 after the fall of Arakan State, and most of the refugees never returned to Arakan. After that, Bangladesh has been witnessed six influxes of Rohingya. The second influx of 22,000 people was recorded in 1942, and the third influx of approximately 200,000 occurred in 1978. The next two influxes happened in 1991 and in 2012, when a significant number of refugees took shelter in Bangladesh. Finally, in 2017, the worst humanitarian crisis and mass series of atrocities occurred towards the Rohingyas, helped by the local Rakhine communities, and about 700,000 people fled to Bangladesh to save their lives

(Rahman and Sakib, 2021). The atrocities included human rights violations, rape, gang rape, and other sexual violence against women and girls, murder, looting, and the burning of homes and villages. There is a certain political will behind this massive migration. Creating a national race identity was their main objective for this mass displacement (Rahman and Sakib, 2021).

The Bangladesh government addresses the Rohingya as FDMN- Forcibly Displaced Myanmar Nationals to avoid international pressure (Bari, 2020). The Rohingya have sought temporary refugees in the settlements of Kutupalong and Nayapara refugee camps in Bangladesh's Cox's Bazar. The Rohingya refugees create, firstly, an economic concern for the host developing country Bangladesh and, secondly, a security concern at internal and international levels (Rahman and Sakib, 2021). With respect to economic concerns, the sudden increase in the number of the total population in the coastal region of Cox's Bazar, which is a great source of income through tourism, is now at risk (Yilmaz and Talukder, 2019). Due to a sudden increase in the demand for food and other supplies, the country faces a supply shortage and price hike, which impacts the whole country. The higher price of the products impacts the daily wages, which affects the local wage earners, and basic rights and needs such as education, health, and security are hindered. Also, Bangladesh, as a least developing country and as an overpopulated country, cannot handle this huge burden. On the other hand, the Rohingya crisis created the possibility of communal conflicts between the local Muslims and Rakhine (an ethnic group living in Cox's Bazar in Bangladesh) people. Also, the scarcity of sanitation, education, medicine, or entertainment materials, and the requirement of extra food instigate illegal work among the locals and themselves and threaten social life (Zafar, 2020).

1.6 Reproductive Health Services in Rohingya Refugee Camps

The reproductive health rights of refugee women have become a crucial area of academic research within migration and refugee studies (Connor, Ayallo, and Elliot, 2016). Like many forcibly displaced people, the refugees' health status is poor. This is also the case for gendered health needs, including reproductive health. Inadequate reproductive health services make it difficult for women with maternal, child, and newborn healthcare needs in Rohingya refugee camps in Bangladesh. There is insufficient healthcare and service management of family planning, pregnancy care, adolescent-friendly health services, and services for rape survivors, especially in hard-to-reach areas. There is also a lack of standardization in healthcare in Rohingya refugee camps (Islam and Nuzhath, 2018). The rapid influx of refugees and overcrowded settlements makes providing proper healthcare challenging. The size of temporary houses, density, and unplanned nature of the make-shift settlements hosting refugees all remain significant obstacles to coordinating services (Islam and Nuzhath, 2018).

Because of widespread violence in Northan Rakhine State in Myanmar, violence against women and girls has become devastating (Uddin, 2020). The rapid influx of Rohingya refugee women and girls in Bangladesh creates an urgent need to strengthen sexual and reproductive health. Resources need to include clinical and psychological support for sexual violence survivors and unconstrained access to fundamental sexual and reproductive care, such as a complete range of contraception methods, menstrual guidelines, safe delivery, newborn care, and emergency obstetrics. Previous research suggests many Rohingya women and girls want to stay home and not interact with male strangers (Ahmed et al., 2015). Rohingya women prefer female health providers and are reluctant to seek healthcare in mixed-gender facilities. Therefore, they have limited decision-making power and generally do not seek healthcare without being attended by a male

relative or husband because the Rohingya women follow the religious rules and regulations where it is prohibited to go outside without male family members. Around 60 babies are born daily in Rohingya refugee camps where the mother who is giving birth has already been through displacement, living away from home, and surviving terror and rape.[3]

Migrant and refugee women's experiences of pregnancy, birth, and post-partum period show barriers to accessing maternal healthcare services in a new country (Niner and Kokanovic, 2013; Grotti, Cynthia, and Nina, 2018). The issue of women's reproductive health, including pregnancy and maternal experiences, needs to be analyzed because women have different experiences of being uprooted and the struggles stemming from that reproductive context. When refugee women enter a new country, they negotiate diverse discourses and cultural constraints, which may include pregnancy and childbirth (Dopfer et al., 2018).

In the host country, Bangladesh, there is a crisis in maternal healthcare services, especially for rural women. According to the Bangladesh Demographic and Health Survey, 78% of mothers who gave birth within the previous three years received antenatal care at least once from a medically qualified clinician (Shahjahan et al., 2017). Approximately 16.2% of pregnant women received two antenatal visits, 13.2% received three, and 31.2% received four or more. In Bangladesh, 36% of mothers received a postnatal checkup by a professional healthcare practitioner, with 34% receiving it within two days of giving birth. Also, in rural areas, there is a practice of home birth with the help of traditional birth attendants. There are two different causes,

[3] *More than 60 Rohingya Babies are Born in Bangladesh Refugee Camps Every Day.* (2018, May 17). UNICEF. Accessed 2023, January 3. DOI: https://www.unicef.org/press-releases/more-60-rohingya-babies-born-bangladesh-refugee-camps-every-day-unicef

and some pregnant women are not willing to go to hospitals as most of the doctors are male, so they follow religious values and give birth to female birth attendants. Secondly, some cannot bear the cost of hospitals as healthcare facilities are not free in Bangladesh, so they rely on birth attendants.

In the case of Rohingya refugees, they face difficulties regarding pregnancy and childbirth, compounded by poor sanitation, lack of security, and insufficient emergency needs and services (Ty, 2019). However, the Rohingya community is more vulnerable because many of the Rohingya refugees are women and girls who have also faced vulnerabilities in Myanmar. The birth and neonatal mortality rate of Rohingya refugees is another concern. Researchers depend on surveys to estimate the mortality rate because of the absence of civil registration of births and deaths and the methodological challenges to collecting data on large numbers of Rohingya refugees. Therefore, it is difficult to estimate the accuracy of the data because most childbirths occur at home during humanitarian crises. The live births were approximately 19477, where the neonatal mortality rate was 27.0 per 1000 live births, and the stillbirth rate was 15.2 per 1000 total births between September 2017 and December 2018 (Amsalu et al., 2022).

In 2018, healthcare centers, labor rooms, sexual and reproductive health units, maternal support units, and neonatal were created with the assistance of the United Nations and the government of Bangladesh (Amsalu et al., 2022). The labor room and reproductive health units are designed to care for pregnant women with uncomplicated labor and childbirth, but critical care for neonatal survival and stillbirths may not be addressed adequately.

The study aims to provide comprehensive information on maternal healthcare services in Rohingya refugee camps in Bangladesh and what needs to be done to upgrade the services so that

Rohingya women can access their maternal healthcare services. In this sense, the workbook will be both descriptive and mediative as it provides a scope for readers to think, generate, and provide thoughts that can be counted as solutions. Also, this project paper will accumulate detailed information about healthcare provider organizations and guide the national and international aid and development workers to ensure proper maternal healthcare services. It is anticipated that the Rohingya refugee women will benefit from this project as the aid workers become informed about the real healthcare needs. Also, it will increase the chances of receiving adequate prenatal, postnatal care, and childbirth care treatment by informing the care workers. This project, in turn, can significantly improve the Rohingya women's maternal health outcomes, reduce maternal mortality rates, and enhance overall well-being by ensuring available healthcare for women in a challenging environment.

1.7 Outline of the Project

In this first chapter, I discuss the background of this study, the objectives of this project, a brief history of the Rohingya refugee community, and a brief description of reproductive healthcare services in Rohingya refugee camps. Chapter Two describes the literature, the context of this project, and how the workbook will impact the Rohingya refugee community. Chapter Three focuses on the methods and methodology used in the research, which includes data collection and analysis of data as well as the themes, concepts, and design of the workbook. Chapter Four presents the theoretical framework used to describe this study broadly. Chapter Five explains the available maternal healthcare services in refugee camps along with service provider organizations, and Chapter Six concludes the project paper with discussions, and offers recommendations.

Chapter 2: Literature Review

2.0 Introduction

This chapter introduces the literature on forced migration and Rohingya refugee women. First, I will discuss the literature on forced migration and refugee women's human rights. Secondly, I will discuss the literature on maternal healthcare needs and services in Rohingya refugee camps. This project includes Rohingya refugee women's reproductive health in Bangladesh. Therefore, it will mainly focus on the literature on the reproductive and sexual health of Rohingya refugee women in Bangladesh. The literature analyzes the human rights and gender perspectives that show how Rohingya refugee women's experiences are recorded in data. It includes articles that address gender issues related to the maternal health of Rohingya refugee women and how they face barriers to getting healthcare services in a new place. Since this project aims to explore the available services in Rohingya refugee camps for women and what services are needed to improve Rohingya refugees' maternal health, their social values and socioeconomic situations need to be considered. Hence, this project has focused on South Asian literature to capture background information. This project chose academic articles and will review online articles to accumulate the most updated sources.

2.1 Literature on Forced Migration and Refugee Women

Political and armed conflict and any organized violence impact directly upon people who live in those areas. Half of the forcibly displaced people are women who experienced severe vulnerabilities during migration. Especially women are at an increased risk, and they experience mental, physical, and sexual violence when they are exposed to forced migration or armed conflict.

In the article titled "Experiences of Armed Conflicts and Forced Migration among Women from Countries in the Middle East, Balkans, and Africa: A Systematic Review of Qualitative Studies," Jolof et al. (2022) mention that women face significant challenges related to their changes in situation, uncertain life, and health-related consequences. However, those refugee women value social support, such as peer support and other assistance. They described that women were forced to migrate because of a need to arrange a safe place to protect their family members and themselves. Similarly, in an article titled "Manzuaat wa Musharadat, Uprooted and Scattered: Refugee Women Escape Journey and the Longing to Return to Syria," Rizkalla et al. (2021) address women whose exposure to violence results in danger and experiencing insecurity, grief, and trauma. Refugee women also faced forced marriage during forced migration. Being exposed to war, women experienced significant challenges; for example, living in a refugee camp makes them stressed regarding safety, food shortage, and temporary shelter. According to Lalla et al. (2020), there is a risk of pregnant women being raped. During forced migration, a strategy patriarchal society follows to protect women and girls is isolating them from the outside world to reduce the risk of being raped, which hinders their freedom, life options, and access to healthcare. Women also have limited opportunities for induced abortion and legal support both when exposed to war and when isolated from it.

Before arriving in the host country, women face considerable health risks related to pregnancy and childbirth within patriarchal structures in society (Jolof et al., 2022). Poor access to healthcare in refugee camps expands women's sufferings. Considering the refugee camp set up, women need protection, maternal health facilities, and support. In an article titled "Mothering During War and Postwar in Bosnia," Robertson and Duckett (2007) mention that women in forced migration encountered considerable challenges during and after childbirth. With the limited

possibilities of accessing quality postpartum care, they did not have the chance to recover after childbirth adequately. Some were forced to discontinue breastfeeding because first, they have to ensure their safest place to survive. The authors identified four common themes of mothering from the data those are "on the move," "living somewhere in between, ""I have to feed them," and "still living in the war inside." They experienced difficulties providing nutrition for their children, which directly impacted migrants' women's reproductive health.

Women are at increased risk of being exposed to, and often they face non-partner sexual violence that reinforces the shame, stigma, and trauma for women in their community (Byrskog et al., 2014). In most cases, this violence is associated with women's sexual and reproductive health, so healthcare providers need to spread awareness so that women can get rid of this shame and trauma. After the migration or displacement, women struggle for survival related to their physical and mental health. War, conflict, and migration reinforce the discrimination of women and girls. Therefore, women's health has been overlooked in the healthcare system after migration. Further, different types of social restrictions, such as women and girls not going outside without the protection of male family members, prevent women from receiving adequate healthcare services during their pregnancy and childbirth. So, to ensure sexual and reproductive healthcare for migrants and refugee women, it is necessary to focus intensively on the migrant and refugee women and their sufferings, experiences, and needs.

In a book chapter titled "The Needs of Refugee Women: A human-rights Perspective," Beyani (1995) argues that the problem of refugee and displaced women is one of the most critical issues relating to the treatment and protection of women. In consideration of refugee women's human rights, there is a theoretical and practical gap that exists (Beyani, 1995). Here, two different questions always appear: firstly, the protection of refugees; secondly, the assertion of human

rights. However, women's rights have tended to ignore the question of the rights of refugee women because the United Nations Convention (1951) omits sexual identity as a ground. The human rights of refugee women should be strengthened by being addressed in the existing framework of human rights. In refugee camps, the human rights of refugee women are crucial but often challenged. Though different aid organizations work to address the issues, it leads to dependency and vulnerability of refugee women.

2.2 Impact of Conservative Culture on Receiving Healthcare

Some authors (Parmar et al., 2019; Raha & Basri, 2018) discuss how social and cultural contexts create barriers to getting healthcare facilities in Rohingya refugee camps in Cox's Bazar, Bangladesh. In an article titled "Mortality in Rohingya Refugee Camps in Bangladesh: Historical, social, and Political Context," Parmar et al. (2019) describe that conservative culture among Rohingya and their Bangladeshi host communities' functions as a barrier for women and girls looking to access reproductive health care in Rohingya refugee camps in Cox's Bazar (Parmar et al., 2019). Rohingya women are generally expected to stay home and do not prefer to interact with male outsiders as they follow the rules of religion. Therefore, the socio-cultural context among Rohingya and Bangladeshi host communities limits the provision of reproductive health services in the refugee camps for care. There are restrictions on their movement, so Rohingya women and girls cannot visit outside the camps for care. Parmar et al. (2019) also mention that over 900,000 Rohingya refugees are women and girls, representing about 52% of the refugee camps in Bangladesh; around 52 maternal deaths among 82 pregnancy-related deaths occurred within these camps between September 2017 and August 2018. Here, different constraints limit women's access

to reproductive health services, such as facility-based births. Another issue is cost, a barrier for all Rohingya refugees seeking healthcare. This article is important for this study because it informs the general situation of Rohingya refugee camps regarding their sexual and reproductive healthcare and maternal mortality rate in Rohingya camps. However, this literature did not present the services available in Rohingya camps for girls and women. The authors did not show if the Rohingya people have conservative religious values and how the healthcare providers and organizations manage the healthcare settings so that Rohingya girls and women can access facilities while keeping their values.

Similarly, in another article titled "Comprehensive Sexual and Reproductive Healthcare in Humanitarian Setting: A Qualitative Approach among Midwives in Cox's Bazar, Bangladesh," Rani Raha and Basri (2018) discuss the way that religious and cultural beliefs, social norms, and values regarding modern contraceptives influence women not to choose and use family planning methods. Here, ideological opposition to family planning, abortion, cultural norms, and other reproductive and sexual health matters often obstruct access to services. This article mainly provides the experiences of midwives in Rohingya refugee camps in Cox's Bazar, which is important for this study as it provides how midwives found the healthcare system of Rohingya refugee camps.

Sexual and reproductive health issues are considered issues of shame and unacceptable culturally. In an article titled "Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Bangladesh," Ahmed et al. (2020) address these issues are not discussed openly in many countries due to socio-cultural and religious norms and attitudes resulting in stigma around the concept of sexual and reproductive health (Ahmed et al., 2020). Due to decades of discrimination and deprivation from access to institutional

sexual and reproductive health education and services in Myanmar, Rohingya women's health-related perceptions, knowledge, and practices are predominated by cultural and religious beliefs. The researchers show that adolescent girls, menstrual hygiene, and related practices are of interest for their better sexual and reproductive health outcomes; however, with insufficient access to safe facilities, Rohingya girls and women suffer a lot. Besides, sexual and reproductive health-related service lacks attention and evidence. In the Rohingya refugee camps, there is a greater need for abortion care because of systematic sexual violence and unwanted pregnancies. However, abortion is extremely opposed by community religious leaders and influential people in the camps, such as community leaders and religious priests. As a result, women do abortions secretly in a traditional way, making it unsafe for them. Some humanitarian organizations are providing the "Minimum Initial Service Package (details are in chapter five)" for sexual and reproductive health, which includes health post and primary health care centers for refugee women, and they provide antenatal and prenatal services. However, access to these essential reproductive and maternal health services remains a major concern because of new settlements and the hardest-to-reach camps areas.

2.3 Low Knowledge of Reproductive Health Limits Initiatives

Rohingya refugee women are a marginalized community in family planning, and their communication ability is low because of their language, as the service providers are from the host country and they speak Bengali (Azad et al., 2022). The Rohingya refugee people use the Rohingya language, which is different from the host community's language. Therefore, service providers do not communicate well with them. Another concern is that Rohingyas are not aware of contraceptives, mainly because of their awareness of family planning and educational

qualifications. Besides, conservative culture and religious beliefs limit family planning initiatives among Rohingya refugees as they follow their religious rules that say it is a sin to use contraceptives, and if they follow family planning, they will break the rules of religion. Therefore, family planning interventions and enhancing the accessibility to health services and education are necessary to improve maternal health among Rohingya refugees.

A study on sexual and reproductive health among Rohingya women evaluates how different myths and perceptions of taboo impose some restrictions on Rohingya women regarding not taking healthcare services (Zakaria et al., 2022). They point out that regarding sexual and reproductive issues, 79.8 percent of Rohingya women ever had a consultation with nongovernment organizations' appointed healthcare providers. The values of the Rohingya community indicate that Rohingya women's communication with a healthcare provider is not permitted.

In a study, Jannat, Sifat, and Khisa (2022) address the condition of Rohingya refugee women's sexual and reproductive health in terms of contraception, sanitation, and hygiene. According to their research result, Rohingya women's conditions are improving from the initial crisis stage. However, some factors, such as the impacts of gender-based violence and patriarchal society impact, continuously affect their sexual and reproductive health.

2.4 Literature on Challenges and Strategies of Rohingya Refugee Women

According to Siddiqi (2021), Rohingya women face challenges that need to be addressed and acknowledged to ensure that they can act and decide spontaneously among available options when they seek healthcare. Siddiqi (2021) uses self-determination theory because it provides valuable insight into supporting these women within their situations. The author concludes with

the self-determination theory, which determines the autonomy of their people's decision-making by focusing on and protecting Rohingya women's autonomous choices. This is necessary because it will maximize their well-being and minimize harm as the refugee community will get chances to determine their own needs and expectations.

Sarker et al. (2020), in their article titled "Effective maternal, newborn and child health programming among Rohingya refugees in Cox's Bazar, Bangladesh: Implementation challenges and potential solutions," describe that there are several associated challenges in providing healthcare in an emergency setting. They mention that some additional security is needed for this humanitarian setting to ensure sexual and reproductive services. The service package for sexual and reproductive health provided by the host government and humanitarian organizations is inadequate regarding the Rohingya community because the camp's size and overpopulation hinder the healthcare process. The majority of Rohingya women give birth at home. Therefore, it is not possible to provide hospital healthcare at home. The authors mentioned that a recent analysis shows that only one in five pregnant mothers searched for delivery care from the healthcare facilities inside the Rohingya camps. Besides, they find an important issue regarding program implementers: a lack of safety associated with service delivery inside the Rohingya refugee camps. A thousand unemployed young men with an uncertain future ahead create a risk of crime as trafficking and drug rings are active in these camps. Therefore, women and young girls are the most vulnerable and often become the victims of violence.

2.5 Conclusion

The Rohingya refugee is a controversial issue in Bangladesh since they have been displaced from Myanmar and take shelter in Bangladesh. There has been different literature and much conversation related to Rohingya refugees that includes significant discussion and autonomous opinion. There are two different perspectives on the autonomous decision-making and agency of Rohingya refugee women; one group says that Rohingya refugee women do not have any decision-making power over their families and male members of their families, and they say this problem must be addressed (Zakaria et al., 2022). Another group says that Rohingya women have their own decision-making power and autonomous choices where they can choose which services they want to utilize and what they are not willing to take, and this is another problem (Siddiqui, 2021). This study focuses on making maternal healthcare available to show what the needs are and how the aid workers make these services available to all Rohingya women in the Rohingya refugee camps rather than analyzing their decision-making processes to get services since the purpose of this project is associated with letting know the development workers and social workers about the necessity of available maternal healthcare services for Rohingya refugee camps.

Chapter 3: Methodology

3.0 Introduction

The chapter discusses the methodology of this project. Here, data collection methods have been processed using secondary data. In this chapter, I have broadly discussed how data has been collected through the secondary data collection process; for example, I have elaborated on the search strategy, search terms, data extraction process, and data analysis. In qualitative research, there are two ways to collect data for analysis; the first one is data gathering from fieldwork, and the second is literature studies. In this project, I have gathered data from literature studies. Most of the information and data are obtained from literature studies through secondary data sources. The benefit of using secondary data is that secondary data already exists. Therefore, they are less costly than obtaining primary data by doing fieldwork because researchers do not have to spend money to conduct research (Kolb, 2012). Also, using secondary research data saves time, and the researcher can concentrate on analysis. Finding information is much easier as there are thousands of databases where researchers can obtain online sources of secondary data.

3.1 Design of Workbook

In the development of the project, secondary sources, including online articles, played a vital role in informing the content, structure, and approach of the workbook. From the data extraction process to data analysis and the discussion on the Rohingya refugee women's maternal health, some steps are followed, including secondary data sources that are integrated into the design process. Secondary sources are included in the overall structure and format of the project. Information on each section of the workbook is collected from secondary online articles and

scholarly literature. Some exercises and visual aids are designed to support key concepts and promote active engagement with the material. The findings from the literature review are used to inform the development of content for the workbook. Key topics, such as antenatal care, postnatal care, knowledge, and barriers, are accumulated based on articles and scholarly sources.

3.2 Secondary Data Sources

The project is conducted using secondary data from scholarly literature. Secondary data is cost-effective as I do not need to generate new data. Besides, secondary data provides data transparency, analytic transparency, and production transparency, making the data visible to researchers, although it comes with the risk of bias (Beck, 2019, p. 13). Therefore, the data is collected from scholarly literature and reports from international organizations such as the United Nations High Commissioner for Refugees and the World Health Organization. Within different databases, I have selected particularly PubMed, Google Scholar, and PLOS ONE to search secondary scholarly literature and gather data on Rohingya refugee women's maternal healthcare services.

3.3 Data Collection Methods

The project aims to analyze articles and journals that contain information on maternal health needs and services in Rohingya refugee camps in Cox's Bazar, Bangladesh. As this study is entirely dependent on secondary data, I have used secondary data, and I always focus on how these data are collected. For example, when I have selected to extract data from an article, I carefully

notice the research methodology of the research article as I always prioritize the data collection methods using qualitative research methods such as interviews or focus group discussions because qualitative data can explain the detail information rather than quantitative data. According to Patton (2005), one of the patterns of qualitative data is analyzing data from written documents. I mostly focus on those articles that used the qualitative methodology rather than quantitative. Qualitative research addresses questions concerned with understanding the meaning and experience dimensions of human lives and social works (Fossey et al., 2002). Therefore, the data collection using secondary data collection has been done carefully. Most articles and journals have been accessed through electronic searchable sites using standard search strategies for literature related to Rohingya refugees. Besides, publicly available reports from international and national aid and development organizations were also accessed to gather data.

3.4 Search Strategy and Search Terms

The Rohingya refugee issue has become a complex matter that requires different classes of methods for exploration. This project emphasizes bibliometric methods where the published work will be ascertained, focusing only on the publications from the database from 2017 to 2023. To extract data from published work, I use certain search parameters to address keywords to get the literature from online journals. Here, I have identified ten keywords: maternal health, refugee woman, childbirth, pregnancy, family planning, birth attendant, childcare, contraception, reproductive health, and obstetric care. The main concern is accumulating secondary data and exploring what maternal services exist in Rohingya refugee camps and what is needed to improve the reproductive health services in Refugee camps. The secondary literature I have selected is

supplemented with qualitative data that was collected using qualitative data collection tools, for example, focus group discussions (FGD) and interviews with Rohingya refugee mothers, midwives, and service providers who have work experiences in Rohingya refugee camps.

3.5 Data Extraction

With coding variables such as maternal healthcare institutions, prenatal and postnatal care access, and skilled birth attendance, I have created a data extraction sheet or spreadsheet to record the relevant data from each article systematically. The columns in the sheet will correspond to the variables that will also include bibliographic details such as author, publication year, and journal name. After reading through each journal article and extracting relevant data for each variable, I will put the extracted data into the appropriate columns of my data extraction sheet, ensuring accuracy and consistency in recording the data from each article. Once I extract data from multiple journal articles, I organize the data by themes, identifying patterns and trends.

3.6 Data Analysis

A step-by-step approach was followed to organize data, where I coded and analyzed data manually. The first step started with reading and rereading the selected articles, which discuss the maternal health situations in Rohingya refugee camps. Secondly, points that provide specific themes have been identified and coded. In the third step, the emergent themes were organized as concise phrases capturing the experimental quality of what was represented in the article. This step-by-step approach has been followed to analyze secondary data extracted from articles. I have

used the thematic analysis because it focuses on the data search and generation of themes from the dataset which is appropriate for my thesis as I pointed out themes to show the result of this study.

3.7 Rationale for Workbook Use

The workbook found in Addendum 1, includes information about maternal healthcare in Cox's Bazar Rohingya refugee camps. The workbook serves as an essential tool for development and aid workers in addressing the unmet maternal health needs of Rohingya refugee women because of its structure and approach. For example, there are multiple organizations working in Rohingya refugee camps, and each of the organizations has its own set of programs and initiatives. As such, the workbook acts as participatory information pamphlet that helps aid workers by engaging them self-reflectively in their ongoing efforts to address the unmet maternal healthcare needs in Rohingya refugee camps. The workbook includes some of the context provided in parts of chapter 5 with directed questions to guide the critical responses of aid workers in making change.

3.8 Addressing Gaps

Through the comprehensive sections, the project paper systematically identifies and addresses gaps in maternal health services. For instance, in chapter five, a section is dedicated to assessing the availability, accessibility, acceptability, and quality of maternal healthcare services in Rohingya refugee camps. By collecting data from secondary literature on factors such as the number of healthcare facilities, birth attendants, and referral systems, the workbook helps pinpoint areas where resources are lacking and what interventions are needed.

3.9 Tracking and Incorporating Changes

One of the key strengths of the project paper will be its adaptability to changing circumstances and needs. For instance, in chapter six, there are some activities that allow the reader to incorporate their thinking ideas into the workbook. Therefore, if a new healthcare facility is established within refugee camps in the future or the service-providing system is changed to address the growing demand for maternal health services, this workbook can be updated to reflect the change, incorporating information about the facility's services, staffing, and capacity. Similarly, suppose a new policy is implemented to improve access to maternal healthcare for Rohingya women. In that case, there is a possibility that the workbook can track its impact over time and allow the aid workers to assess its effectiveness and make necessary adjustments.

3.10 Feminist Research

This study will be based on feminist research. According to Charmaz (2012), gender is more than a variable in feminist research because gender is a way of experiencing the world. Hence, a gender lens visualizes the diversified standpoint in research. Feminist research mentions a range of issues, including external examinations of specific topics that affect women and their identities. Similarly, Schiebinger (1999) mentions that feminist research embodies a number of feminist values, such as researchers' honesty about their hypotheses or becoming responsible in their language. Feminist methodological tools must be flexible and revised when the circumstances change. Feminist research aims to liberate marginalized groups from oppression by questioning and challenging the structure (Hesse-Biber et al., 2007). In my project, the brutal violence against Rohingya refugee women and the struggle of their forced displacement and childbirth stories question the existing boundary between borderland and human rights. Letherby (2003), for the

feminist researcher, taking a methodological standpoint is a part of their political practice. The objectives of feminist researchers are to use feminist methods to collect data and use a flexible process in the research to allow women's experiences and voices to be heard. DeVault and Gross (2012), the purpose of feminist researchers is to listen to the voices and perspectives of women that have been silenced or ignored in history, to listen to the gaps or silences in women's discourse, and to find out their meanings of what has been unheard. The purpose of this project is not to evaluate women's perceived experiences regarding crossing the border and becoming a refugee mother but to question the existing situation to know if the Rohingya women are getting enough attention regarding their maternal health.

3.11 Conclusion

This project paper gathers some key factors related to maternal healthcare services, identifying relevant variables from the journal article that have already been reported and analyzed in the articles. This project aims to create an information pamphlet that will help the aid and development workers and guide them on the real situation of maternal services in the Rohingya refugee camp and how they can contribute to upgrading maternal health services so that refugee women can receive the proper healthcare.

Chapter 4: Theoretical Approach and Significance

4.0 Introduction

Theoretically, this project concentrates on the human rights perspective. The human rights approach mainly focuses on the recognition and safety or protection of individuals' rights to health, which includes maternal health. By adopting the human rights and equity approach, this project can assess which maternal services in Rohingya camps fulfill international human rights standards, like accessibility, availability, quality of care, and acceptability. As this theoretical approach emphasizes the recognition and protection of every individual's right to the highest attainable standard of health, including maternal health, it draws upon international human rights instruments, such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and among others. In this approach, maternal health is seen not just as a matter of healthcare provision but as a fundamental human right. First, I have pointed out the theories on the identity crisis of refugee women in refugee camps. Then, theories on human rights and gender rights of refugee women have been addressed accordingly.

4.1 Homelessness and Needs of Refugee Women

Conflict and conflict-induced displacement produce radical and protected uncertainty in people's lives (Horst & Grabska, 2015). In this transition of life, some of the forced migrants received an official status, but others remained as refugees. Homelessness among women is considered particularly damning for women because the proper place for a woman is thought to be in the home. Therefore, refugee women and girls may be a particularly neglected group because

of their identity as homeless and their presence in refugee camps, which are considered dangerous places for women (Giles, 2009). In a refugee camp, the basic needs of refugee women are not entirely met, though the host countries and aid organizations work to fulfill all the needs, which are among fundamental necessities. In refugee camps, good quality healthcare, education, housing, employment, and civil rights must be developed because this requires a regime change in refugee camps. At present, and in most of the refugee camps around the world, these refugee rights are severely ignored and severely limited. Another thing that needs to be considered is the sustainable forms of development aid and the existence of long-term refugee camps (Giles, 2009).

4.2 Human Rights of Refugee Women

Human rights theory provides a robust framework to advocate for the maternal health of refugee women. It offers a lens to analyze disparities and demand equitable access to healthcare. By taking into account this theory, the project highlights how various factors, such as discrimination and access to resources and services, impact access to adequate healthcare. Also, this theory considers how multiple factors, such as gender, refugee status, ethnicity, and socioeconomic status, intersect to impact maternal health. Human rights theory highlights how those intersections create unique challenges and vulnerabilities for refugee women in accessing adequate healthcare. Therefore, human rights theory is appropriate for this project as this theory can describe the real challenges of Rohingya refugee women from the perspective of their ethnicity, gender, and statelessness.

One of the neglected areas of women's concern was in relation to the human rights of refugee women (Edwards, 2010). They argue that the realization of the rights of refugee women

and girls under international law has progressed since the 1990s. Before this period, the refugee women and girls and their interests and needs were ignored or marginalized from the mainstream policies and laws. After that, things have been changed regarding the rights of refugee women and girls. Now, they are relatively high on the international agenda, though there remain many obstacles to achieving their rights and safety. They also mention that, primarily, UNHCR decided to design specific responses to the needs of refugee women. In 1990, UNHCR announced its first Policy on Refugee women, and it remains the organization's official position (Edwards, 2010). It emphasized that men and women are impacted by displacement in different ways and that protection responses and strategies must take this into account. In 1991, UNHCR issued its first set of Guidelines on the Protection of Refugee Women, which stated that special efforts may be needed to resolve problems faced by refugee women. This guideline was updated later in 2008.

According to Rebecca Cook (2013), the emergence of human rights approaches to maternal health might be seen as a mixture of the development of the content and meaning of human rights, the identification of norms and standards that enable their application to preventable maternal deaths, the passage of human rights resolutions, commitments, and declarations, the documentation of violations leading to important fact-finding reports, and most recently to human rights and constitutional litigation. Cook (2013) says the United Nations Human Rights Council has adopted resolutions at the international level. Preventable maternal morbidity and mortality are human rights violations, she acknowledged. The United Nations High Commissioner for Human Rights has accumulated useful performances of human rights-based approaches to eradicate preventable maternal mortality and morbidity. Also, they provide technical guidance on implementing policies and programs to lessen maternal mortality and morbidity in line with human rights standards. For this study, the human rights approach will be focused on identifying how the

Rohingya mothers receive reproductive services, what services they receive, what they do not, why they are willing to take certain services, and which services they are unable to reach.

Yamin (2013) discusses human rights-based approaches for describing the underlying power relations that put women at risk of sexual and reproductive health, rights violations, and maternal morbidity and mortality. She particularly focuses on applying human rights frameworks and human rights-based approaches to maternal health to identify the real causes of maternal morbidity and mortality beyond and within the health system. She points out that at the United Nations level, the Human Rights Council issued two historic resolutions concerning maternal mortality that first established the connections between maternal mortality, sexual reproductive health, and human rights. Moreover, she noted that advancing sexual and reproductive health mainly requires changing decisions at multiple levels. Therefore, only providing redress in the event of violations cannot make a solution for them.

Paul Hunt and Gunilla Beckman (2008) also address the right-based approach. They say that the right to the highest achievable standard of health is determined by the interventions and insights of public health. They consider health systems from a new perspective, where the operational perspective is the right to the highest attainable standard of health. According to them, the health system gives rise to numerous technical issues. However, experts have an indispensable role in addressing these technical issues. They identify a risk that health systems become impersonal, which follows "top-down" and is regulated by experts. They addressed four fundamental key points: transparency, equity, equality, and non-discrimination. Transparency is an effective feature of the health system because it includes access to health information. Transparency applies to all health-related sectors, such as states, public-private partnerships, business enterprises, international organizations, and civil society organizations. For equity, they

pointed out that there is no one definition of equity, but it requires equal access to healthcare. Hunt and Beckman (2008) also describe that the healthcare system must be responsive to the health needs of women, children, adolescents, and the elderly, and this process should be equal, not discriminatory.

Similarly, according to Leslie London (2008), the notion of equality is important in the human rights-based approach. The most common idea of a rights approach would be one where the human rights agenda is used to hold the government accountable. In many situations, a human rights approach deals with a framework for the proactive development of programs and policies so that healthcare purposes can be provided in ways that are consistent with human rights. Afterward, this approach starts to move away from where the individualist framing of rights opens opportunities for popular input to shape health policies. London (2008) also describes that policymakers frame health policy decisions as service delivery issues that require technical inputs to reach the best, which creates a broad misunderstanding. Therefore, sometimes, it appears that health is a service rather than recognizing health as a right. Moreover, London (2008) argues that civil society mobilization should recognize all the different modalities so that a human rights approach operates work for health. Also, she notes that a human rights framework that recognizes the joint interests of the state and its parties is needed. So, on the one hand, policymakers need to recognize the interest of users, communities, and civil society members, and on the other, in realizing the right to health.

The human rights approach emphasizes the motto that every person has the right to the highest standard of physical and mental health. Therefore, this perspective describes that maternal health care services should be accessible, acceptable, available, and of standard quality for all women, including refugee women. Also, this approach describes the importance of non-

discrimination and equal treatment. So, applying this approach, this study can focus on identifying and addressing discriminatory practices or barriers that hinder Rohingya women from accessing health care services. Discrimination can be faced based on gender, refugee status, and ethnicity, and barriers may include language and cultural insensitivity.

4.3 Gender Rights in Refugee Camps

The refugee literature is still biased toward undifferentiated 'people' without gender, age, or other characteristics, but it focuses on ethnicity (Colson, 2008). In refugee studies, little research on forced migration focused on gender issues (Martin, 2010). However, nowadays, researchers and policymakers are paying more attention to gender issues in refugee studies. Martin (2010) discusses that, at first, refugee studies focused on specific nationalities and events. After the Second World War and the Cold War, the refugee regime became universal, and the refugee laws concentrated on protecting refugees worldwide. Mainly, the refugee regime also expanded to provide protection to individuals who are victimized based on their gender. Now, the concept of refugee even includes when individuals inflicted persecution, a group of people or political parties, including members of their own family, if their own government is unable to provide safety for that citizen.

Some writers have focused on women and children and describe how they are affected and the way basic gender and age identities of women and children are affected by life in refugee camps or elsewhere in exile. Therefore, the lives of women in refugee camps remain underprivileged. Gender relations in refugee households are influenced by traditional ideologies that involve an attachment of refugee women to memories of their home, which also shape

household relations (Giles, 2009). Refugee women seem so vulnerable in most cases, and their bodies and minds can wound simultaneously; for instance, abusive words can wound. From the perspective of refugee women, if they come from conflict or war zones, they can experience abusive language, which is also the cause of mental suffering. Therefore, to study refugee women's health, it is necessary to focus on their households' ideologies and gender relations.

To prioritize refugee women, it is necessary to work with human rights activists and refugee advocates together to call states to account for the treatment of women and other vulnerable social groups (Hajdukowski, 2009). By mainstreaming women's rights as human rights, the gender guidelines have developed the mutual strengthening between refugee law and international human rights law. It is important to build on the progress that has already been made. It is certainly possible to strengthen international human rights law for refugee women.

4.4 Intersectionality and Refugee Women

Understanding the experiences and challenges faced by refugee women, particularly for maternal health, intersectionality theory is a valuable framework. The theory of intersectionality by Crenshaw (1991) addresses the need to explain multiple grounds of identity and focuses on the intersections of race, ethnicity, and gender. It intends that the experiences of women are different and highlights the marginalized experiences by recognizing structural, political, and representational intersectionality. In the case of maternal health, a range of issues, including access to prenatal care, childbirth, postnatal care, family planning, and reproductive rights, arise. Refugee women's experiences of maternal health are shaped by their migration status. They may face barriers in accessing healthcare services due to legal restrictions and language barriers (Sunata and

Özsoy., 2023). Additionally, women who are undocumented or living in refugee camps may have limited access to quality healthcare facilities and skilled birth attendants, increasing their risk of maternal complications and mortality. Refugee women and girls are more vulnerable and inclined to both external and internal dominations, particularly from their intimate partners. According to Parmer et al. (2019) there are three delays create major impediments to timely access to effective maternity care in refugee camps. Those are delays in seeking, reaching, and obtaining quality obstetric services that need to be addressed in order further to increase the facility-based delivery rate among the Rohingya refugees. The Three Delays Model is a framework used to understand the determinants of maternal mortality (Parmar et al., 2019). According to this model, the first delay is in the decision to seek care. The second delay is in reaching a health facility, and finally, the third delay is in receiving appropriate care.

4.5 Conclusion

By incorporating these human rights approach theories to research maternal healthcare services in the Rohingya camps, this project brings attention to the ethical and legal dimensions of this forced displacement issue from the perspective of women's maternal healthcare in refugee camps, where it emphasizes the importance of ensuring the rights and well-being of Rohingya women. Also, it is possible to identify gaps, challenges, and potential strategies for improving the fulfillment of human rights in this context. This perspective helps guide development workers and social workers, as well as policy recommendations and interventions that aim to address the unique challenges.

Chapter 5: Available Maternal Healthcare Services in Rohingya Refugee Camp

5.0 Introduction

This chapter presents the available maternal services existing in Rohingya refugee camps in Cox's Bazar, Bangladesh. Using the search terms for examples, Rohingya refugee, maternal health, refugee woman, childbirth, pregnancy, family planning, birth attendant, childcare, contraception, reproductive health, and obstetric care, I have got 7280 results in Google Scholar, 16 in BioMed Central, 8 in PubMed, 486 in PLOS ONE. After screening the articles, I selected 18 articles based on the research objective of those articles. I have found six themes from existing literature: maternal health service providers, types of maternal health services in Rohingya refugee camps, pregnancy and postpartum services, quality of services, acceptability, and participation in decision-making. First, I described the scenario of Rohingya refugee camps, then identified the six important themes and explained them in detail.

5.1 Camp Descriptions

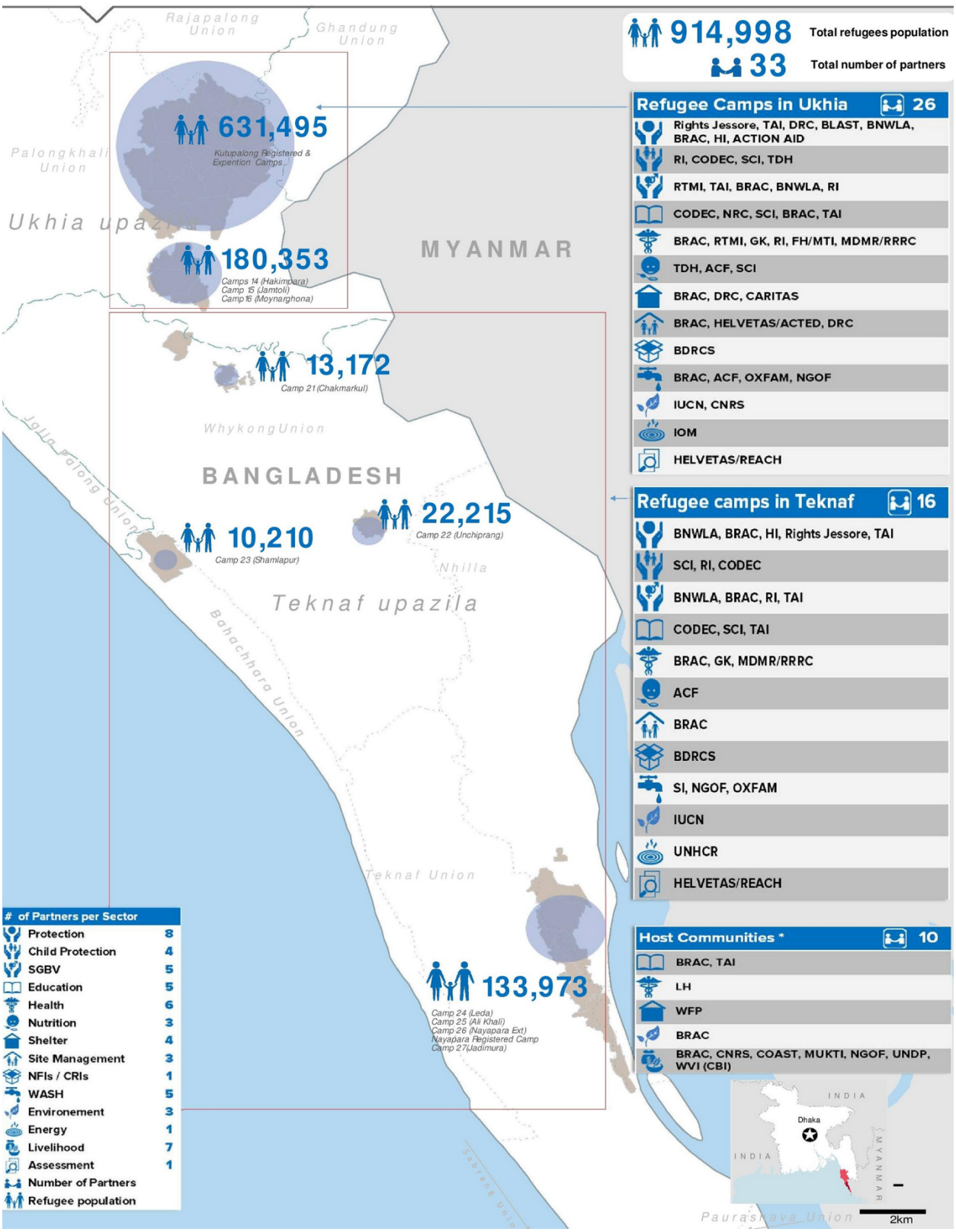
In 2017, the most significant and quickest influx of Rohingya refugees fled from Myanmar to Bangladesh's district of Cox's Bazar. In October 2019, within 34 refugee camps, an estimated 911,566 Rohingya refugees resettled in Cox's Bazar district, of which 905,754 were in Kutupalong camp, which is the largest single refugee camp in the world based on population size (Jeffries et al., 2021). In this camp, the population density is 50,299 persons per square kilometer. Within the Rohingya refugee camps, there are 90 health posts, 41 primary healthcare centers, 23 specialized facilities, and three field hospitals providing healthcare services (Logan, 2021). Most are directed by local or international non-governmental organizations that partner with specialized United

Nations agencies. Refugee camps are made with homemade buildings made of bamboo and tarpaulin. Aid organizations like the United Nations, the International Committee for the Red Cross (ICRC), and the International Organization for Migration (IOM) buy the bamboo that refugees need to build their homes. The makeshift buildings do not ensure much to protect against heavy rain, floods, and landslides. Many families live close together and share bathrooms and water services. The United Nations (UN) calls the Rohingya in Bangladesh "the most persecuted minority in the world." They have to deal with the harsh effects of nature and life in camps to stay alive.

Figure 1: Rohingya Refugee Camp in Bangladesh (below)

Source: Extracted from UN Women, 25th March 2024. https://www.unwomen.org/en/news-stories/feature-story/2021/12/in-coxs-bazar-gender-responsive-policing-efforts-build-trust-with-rohingya-women-and-girls 2024

Figure 2: Map of the Rohingya refugee camps in Cox's Bazar, Bangladesh with populations and partner Organizations (below)



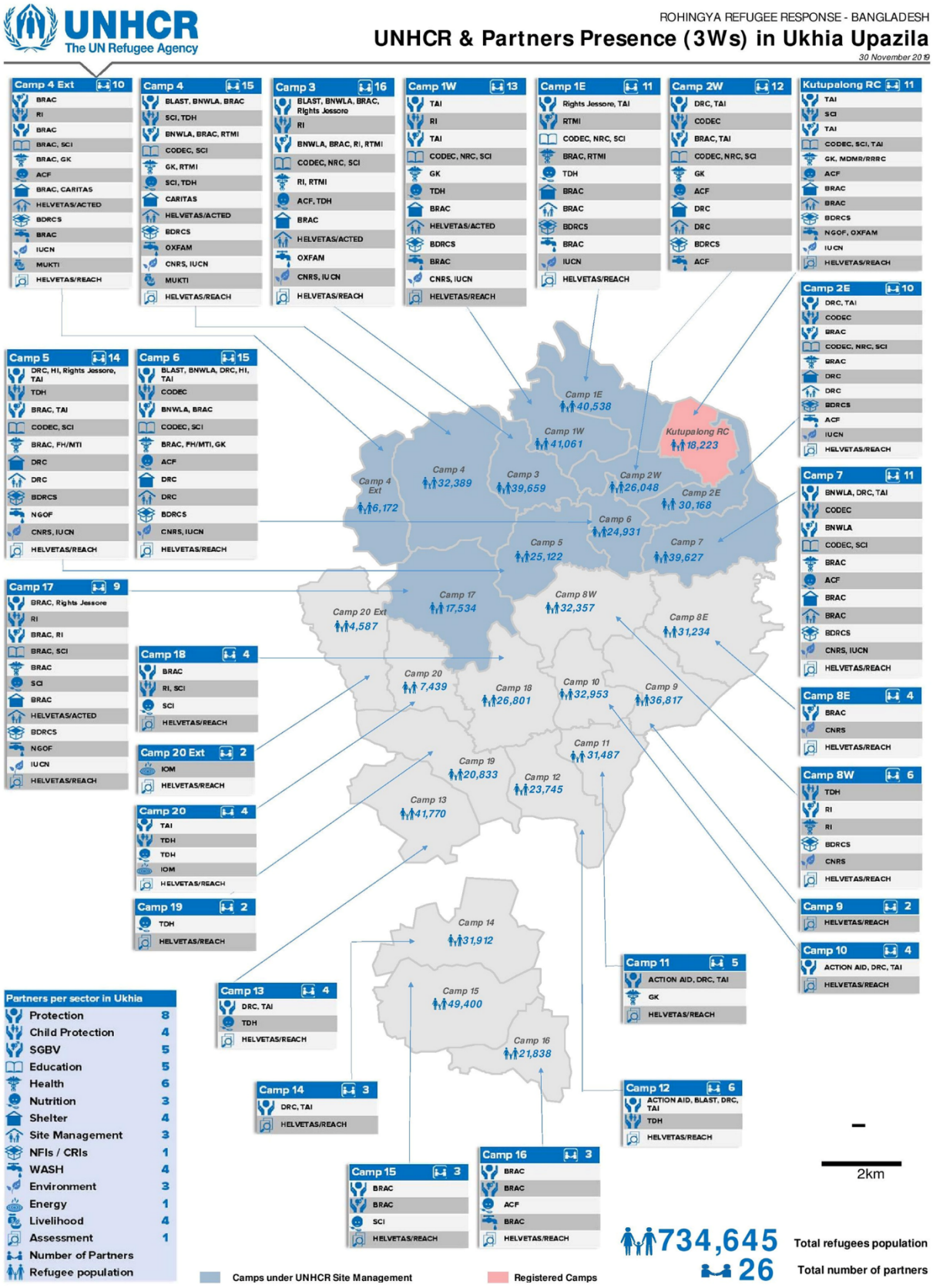
Source: Extracted from https://doi.org/10.1371/journal.pone.0230732.

5.2 Maternal Health Service Providers

There are four groups in charge of health in the Rohingya refugee camp. They are the World Health Organization, the Civil Surgeon's Office of Cox's Bazar, Bangladesh, the Family Welfare Coordination Centre, and the Ministry of Health (Jeffries et al., 2021). Two types of primary healthcare setups are health posts, which are like government community clinics and are considered basic health units by sphere standards, and primary health centers, which are like government union-level sub-centers and are considered health centers by sphere standards. There are more than 100 partners in the health sector coordination group, and there are about 200 health facilities in the refugee camps, providing basic, secondary, and specialized health care. The safety of the Rohingya refugee camps stayed stable, which meant that there were not many direct threats to service performance. Coordination and collaboration are necessary to set up and maintain an effective and acceptable technical answer to this complex scale. There are only two working groups in the health field. They were for mental health and psychosocial support and for sexual and reproductive health. But by the end of 2018, four working groups had been named as the main areas of healthcare where health partner agencies could be represented and work together to make plans and carry out operations. These were community health, sexual and reproductive health, epidemiology and case management, and mental health and psychosocial support.

Figure 3: Partners or Service Providers Organizations (below)

Source: Extracted from https://doi.org/10.1371/journal.pone.0230732.


UNHCR
The UN Refugee Agency
ROHINGYA REFUGEE RESPONSE - BANGLADESH
UNHCR & Partners Presence (3Ws) in Ukhia Upazila
30 November 2019
Camp 4 Ext 10
BRAC
RI
BRAC
BRAC, SCI
BRAC, GK
ACF
BRAC, CARITAS
HELVETAS/ACTED
BDRCS
BRAC
IUCN
MUKTI
HELVETAS/REACH
Camp 4 15
BLAST, BNWLA, BRAC
SCI, TDH
BNWLA, BRAC, RTMI
CODEC, SCI
GK, RTMI
SCI, TDH
CARITAS
HELVETAS/ACTED
BDRCS
OXFAM
CNRS, IUCN
MUKTI
HELVETAS/REACH
Camp 3 16
BLAST, BNWLA, BRAC, Rights Jessore
RI
BNWLA, BRAC, RI, RTMI
CODEC, NRC, SCI
RI, RTMI
ACF, TDH
BRAC
HELVETAS/ACTED
OXFAM
CNRS, IUCN
HELVETAS/REACH
Camp 1W 13
TAI
RI
TAI
CODEC, NRC, SCI
GK
TDH
BRAC
HELVETAS/ACTED
BDRCS
BRAC
CNRS, IUCN
HELVETAS/REACH
Camp 1E 11
Rights Jessore, TAI
RTMI
CODEC, NRC, SCI
BRAC, RTMI
TDH
BRAC
BRAC
BDRCS
BRAC
IUCN
HELVETAS/REACH
Camp 2W 12
DRC, TAI
CODEC
BRAC, TAI
CODEC, NRC, SCI
GK
ACF
DRC
DRC
BDRCS
ACF
Kutupalong RC 11
TAI
SCI
TAI
CODEC, SCI, TAI
GK, MDMR/RRRC
ACF
BRAC
BRAC
BDRCS
NGOF, OXFAM
IUCN
HELVETAS/REACH
Camp 2E 10
DRC, TAI
CODEC
BRAC
CODEC, NRC, SCI
BRAC
DRC
DRC
BDRCS
ACF
IUCN
HELVETAS/REACH
Camp 5 14
DRC, HI, Rights Jessore, TAI
TDH
BRAC, TAI
CODEC, SCI
BRAC, FH/MTI
DRC
DRC
BDRCS
NGOF
CNRS, IUCN
HELVETAS/REACH
Camp 6 15
BLAST, BNWLA, DRC, HI, TAI
CODEC
BNWLA, BRAC
CODEC, SCI
BRAC, FH/MTI, GK
ACF
DRC
DRC
BDRCS
CNRS, IUCN
HELVETAS/REACH
Camp 7 11
BNWLA, DRC, TAI
CODEC
BNWLA
CODEC, SCI
BRAC
ACF
BRAC
BRAC
BDRCS
CNRS, IUCN
HELVETAS/REACH
Camp 17 9
BRAC, Rights Jessore
RI
BRAC, RI
BRAC, SCI
BRAC
SCI
BRAC
HELVETAS/ACTED
BDRCS
NGOF
IUCN
HELVETAS/REACH
Camp 18 4
BRAC
RI, SCI
SCI
HELVETAS/REACH
Camp 20 Ext 2
IOM
HELVETAS/REACH
Camp 20 4
TAI
TDH
TDH
IOM
HELVETAS/REACH
Camp 19 2
TDH
HELVETAS/REACH
Camp 8E 4
BRAC
CNRS
HELVETAS/REACH
Camp 8W 6
TDH
RI
RI
BDRCS
CNRS
HELVETAS/REACH
Camp 9 2
HELVETAS/REACH
Camp 10 4
ACTION AID, DRC, TAI
HELVETAS/REACH
Camp 11 5
ACTION AID, DRC, TAI
GK
HELVETAS/REACH
Camp 13 4
DRC, TAI
TDH
HELVETAS/REACH
Camp 14 3
DRC, TAI
HELVETAS/REACH
Camp 15 3
BRAC
BRAC
SCI
HELVETAS/REACH
Camp 16 3
BRAC
BRAC
ACF
BRAC
HELVETAS/REACH
Camp 12 6
ACTION AID, BLAST, DRC, TAI
TDH
HELVETAS/REACH
Camp 1E 40,538
Camp 1W 41,061
Kutupalong RC 18,223
Camp 4 Ext 6,172
Camp 4 32,389
Camp 3 39,659
Camp 2W 26,048
Camp 2E 30,168
Camp 6 24,931
Camp 5 25,122
Camp 7 39,627
Camp 17 17,534
Camp 20 Ext 4,587
Camp 8W 32,357
Camp 8E 31,234
Camp 20 7,439
Camp 18 26,801
Camp 10 32,953
Camp 9 36,817
Camp 11 31,487
Camp 19 20,833
Camp 12 23,745
Camp 13 41,770
Camp 14 31,912
Camp 15 49,400
Camp 16 21,838
Partners per sector in Ukhia
Protection 8
Child Protection 4
SGBV 5
Education 5
Health 6
Nutrition 3
Shelter 4
Site Management 3
NFIs / CRIs 1
WASH 4
Environment 3
Energy 1
Livelihood 4
Assessment 1
Number of Partners
Refugee population
Camps under UNHCR Site Management
Registered Camps
2km
734,645 Total refugees population
26 Total number of partners

The Rohingya refugees get medical care at the basic health centers and health posts that are set up in the camps. The health centers and health posts have about 200 doctors and nurses working there right now (Sarker et al., 2020). These health centers and health posts provide a range of services for mothers, babies, and children's health, such as antenatal care (ANC), postnatal care (PNC), referrals, normal births, and counseling. There are more than 1200 community health workers who offer counseling and other services in people's own homes and help people get to other facilities (Sarker et al., 2020).

As the crisis of the influx of refugees to the camps began, many health partner agencies were trying to open health facilities. It was hard to make sure that all health services were the same and that they were given to everyone. Minimum standards have been set for health facilities in the refugee camps so that the health sector can keep an eye on them and make sure that everyone gets the same level of care (Jeffries et al., 2021). With the collaboration between national and international aid organizations, a service package named Essential Health Service Package (MHSP) was approved for Rohingya refugees. Besides this, another service package named Minimum Initial Service Package (MISP) was approved for the reproductive health of Rohingya refugee women (Jeffries et al., 2021).

Table 1: Minimum Package of Essential Health Services for Primary Healthcare Facilities in the Refugee Camps, Cox's Bazar, February 2020 (below)

Health Post (1/10000)	Primary Health Center (1/25000-30000)
Maternal and Newborn Health	
Antenatal Care	Antenatal Care
Postnatal Care	Postnatal Care
Stabilization and Referral of Newborn and Obstetric Emergencies	Normal Deliveries
Iron and Folic Acid (IFA) Supplementation	Basic Emergency Obstetric and Neonatal Care (excluding assisted deliveries)
Tetanus-Diphtheria Vaccination	Essential newborn care
Obstetric Fistula Screening through Clinical History and Referral	Preterm and Newborn and Sepsis Management
Voluntary counseling and testing for Prevention of Mother to Child Transmission (PMTCT)	Post Abortion Care
	Menstrual Regulation
	Tetanus-Diphtheria (Td) Vaccination
	IFA Supplementation
	Obstetric Fistula Screening and Referral
	Voluntary counseling and testing for PMTCT

Source: **https://rohingyaresponse.org/wp-content/uploads/2023/04/Minimum-Package-of-Essential-Health-Services-for-Primary-Healthcare-Facilities-in-FDMNRefugee-Camps.pdf**

5.3 Types of Maternal Health Services in Refugee Camps

According to Ahmed et al. (2019), there are five categories of health facilities in Rohingya refugee camps in Cox's Bazar, Bangladesh. Those include primary health centers, health posts, labor rooms or Sexual and reproductive health (SRH) only facilities, secondary health facilities, and community clinics. The first three categories of facilities are camp-specific and situated inside the camp. The last two types of facilities, like secondary hospitals and community clinics, are situated outside the camps.

In the Bangladeshi Rohingya refugee camps, as of January 2019, there were an estimated 646,000 Rohingya women and girls, including 22,000 pregnant women. The United Nations Population Fund (UNFPA) is the principal organization implementing the Minimum Initial Service Package (MISP), which aims to address reproductive health needs. The MISP has five main goals: ensuring that the program is fully implemented, preventing and managing the effects of sexual violence, reducing HIV transmission, preventing maternal and neonatal mortality, and organizing the integration of reproductive health care into primary care settings. Preventing maternal death involves making a basic emergency care center (Parmer et al., 2019).

Table 2: Basic and comprehensive emergency obstetric and newborn care services (below)

Basic and comprehensive emergency obstetric and newborn care services	
Basic Services	Comprehensive Services
1. Administer parenteral antibiotics	8. Perform surgery
2. Administer uterotonic drugs (i.e. parenteral oxytocin)	9. Perform blood transfusion
3. Administer parenteral anticonvulsants for eclampsia and pre-eclampsia) (i.e., magnesium sulfate)	
4. Manually remove the placenta.	
5. Remove retained products (e.g., manual vacuum extraction, dilation, and curettage)	
6. Perform assisted vaginal delivery (e.g., vacuum extraction, forceps delivery.	
7. Perform basic neonatal resuscitation (e.g., using a bag-valve mask)	

Source: Sex Reproductive Health Matters. 2019; 27(2): 39–49. Published online 2019 May 31. Doi: 10.1080/26410397.2019.1610275

According to Table 2, there is one facility providing Comprehensive Emergency Obstetric and Newborn Care for every 500,000 people. These standards and indicators are meant to be used in humanitarian situations (Parmer et al., 2019). There are some hospitals, such as the Friendship

Hospital, the Malaysian Field Hospital, and the Turkish Field Hospital, that are all close to the camps and offer services like cesarian sections and blood transfusions. These are in the center area of refugee camps so that people can access them easily. The Ukhia Health Complex, which is a government facility 10 minutes from the Kutapalong mega camp, also does cesarian births. So does the Hope Ramu Hospital in Cox's Bazar and the Cox's Bazar District Hospital. It takes about 2.5 hours to drive to the hospitals in Cox's Bazar. Therefore, the result shows that five hospitals provide cesarian deliveries for Rohingya women, which indicates that there are only a limited number of hospitals that provide cesarian deliveries. However, those hospital provides deliveries, but sometimes, pregnant women are sent to get comprehensive services if the condition becomes critical.

Delays in getting maternity care from doctors and nurses need to be fixed right away for the Rohingya people, as many avoidable pregnancy-related deaths happen in the camps when care is not sought (Barua et al., 2022). The United Nations Population Fund and its partners set up a community-based referral transportation project called 'Referral Hub' to help with the problems that come up when people need urgent or regular sexual and reproductive health and rights care. The floors of Referral Hubs (RHs) are cemented together, and the tops are made of bamboo and tin (Barua et al., 2022). They were built in places that are hard to get to and do not have many medical services in Rohingya refugee camps. A lot of Rohingya women give birth at home. In 2019, eight hubs were set up to remove the problems that came up with getting people to emergency obstetric and baby care or getting them to the right place to get it. Those hubs offer ambulance service for all kinds of situations, but they focus on emergency care for pregnant women and babies. However, there are different challenges and barriers to accomplishing this project. Four barriers are initially identified: poor network, shortage of ambulances, poor roads

and transportation ways, and security checkups in camps (Barua et al., 2022). Because of a problem with the network, beneficiaries can not always get in touch with referral hubs through the hotline lines in time. It is also hard for the staff to talk to the hospital authority on the phone before taking the patient to the hospital. There are also delays getting to the building because there are not enough ambulances. Two hubs are usually supported by one ambulance. Because of this, when there are a lot of emergency patients, it is hard for them to provide fast service, which is upsetting for patients who need to be transferred to the facility right away. Bad roads inside the camps make it harder to get to the patient quickly and safely. The camps are in hilly places that do not have any paved roads inside them. Because of this, the ambulance drivers need to go slowly and carefully up and down the hills. Even worse, when it rains, the streets get muddy, which makes it even harder for the staff to move the patient, which adds to the wait time. One big problem is that the camps aren't safe, which slows down how quickly the staff can get the emergency patient to the facility. When patients need to get on the ambulance, the drivers often have to go through security checks that are required by law. As a result, there is more delay in reaching the patient.

5.4 Pregnancy, Home Birth and Postpartum Services

The common health problems among Rohingya women are pregnancy and childbirth-related complications. Though two-thirds of women receive ANC visits, most of them give birth at home, assisted by traditional birth attendants (Rawal et al., 2021). In Bangladesh, the traditional birth attendant is someone, often a woman, who assists women during childbirth in non-medical settings. They do not have any institutional education regarding childbirth. However, they have the experience and cultural knowledge to aid in delivery. In Bangladesh, traditional birth attendants

are very popular, especially in rural areas where people cannot reach hospitals in poverty or for other reasons (Sarker et al., 2016). Because of traditional practices of giving birth at home, the women are not willing to take hospital services during their delivery because women are often pressured by family and friends to wear veils and by social and religious norms, so with the help of traditional birth helpers, they give birth at home (Barua et al., 2022). Another reason behind choosing home birth is hesitation to visit a health facility because they are afraid of mixed-gender areas (Logan., 2021). Even going to facilities is off-limits for them because they avoid mixed-gender areas, cars, or facilities. The Rohingya women can not talk to the male community health workers either because of strict gender rules. It makes harder for the healthcare providers to do their job, which is to get pregnant women information and take them to facilities. In the camps, trained midwives are unavailable at most health centers. Therefore, it creates a risk for them when they give birth at home with the help of traditional birth attendants. After giving birth at home, women are kept on the floor, usually on a mat, until the birth attendant cuts the umbilical cord and delivers the placenta. The woman is washed by the birth attendant or close family members like the mother-in-law or sister-in-law because they think it is their responsibility to protect their family privacy. In most cases, the birth attendant helps the woman on the day of the birth by taking care of her or teaching basic instructions such as how to breastfeed and how to do newborn care, and then family or friends help the mother to recover. Women who give birth at home do not go to the hospital for the following care. They do not go to the doctor because they think it is not a big health problem (Barua et al., 2022).

Different aid organizations set up safe delivery rooms at each camp to encourage women to give birth in hospitals, and they take care of pregnant women during delivery. At these centers, skilled medical staff, such as doctors and nurses, provide care. The delivery room encourages safe

motherhood, breastfeeding, and planning a family after giving birth. It adds more services to help people with reproductive health problems. Therefore, women who give birth in health centers or with the help of institutional delivery do routine checkups in the postpartum period, and their newborns get routine immunizations.

The discussion starts here with why birthing, as a phenomenon that is usually natural, requires medical interventions to be healthy. There is a clear difference between "natural" and "medical," and different values are attached to each. This is a constant result of medicalization, especially when it comes to childbirth (Brubaker and Dillaway., 2009). Here, the primary issue of control over the birth procedure and experience also informs the critique of medicalized birth, the birth setting, and the use of medical interventions. Among Rohingya refugee women who refused to take institutional medical service, it seems that they have traditional cultural and religious values, or they lack knowledge. However, birth is still mostly seen as a medical event that should happen in a hospital, which is the most common cultural view. Many feminists still fight for a more natural approach, but their criticisms are mostly heard in philosophical discussions and among people who support natural childbirth. Also, and this may be even more important, both professionals and women themselves are still arguing about what "natural" birthing really means. Feminists and people who support natural childbirth continue to talk about and represent the experiences of women who are privileged. It is required more interventions on how those factors affect women's experiences in different social settings and how women perceive the medicalization of childbirth.

5.5 Accessibility of Services

The Rohingya women cannot make decisions by themselves whether they will take the hospital facilities for delivery, or they will stay at home and take the traditional childbirth approach. Basically, they need someone as they are not allowed to make decisions, or in some cases, they require companionship from family. For example, the decision maker can be the husband or Imam (religious priest) or sometimes the mother-in-law; they are the ones who make the final decision to send a pregnant woman to a facility or not because they give priority to Imam as Imam are socially and religiously important for the community. Usually, pregnant women only visit or seek healthcare at the facilities when a traditional birth attendant cannot manage the case. Therefore, sometimes, they take longer to make a decision, which leads to a large number of cases ending up in basic emergency obstetric and newborn care facilities with complications such as prolonged labor, retained placenta, and postpartum hemorrhages. About 70 percent of facility-based maternal deaths are caused as consequences of home trials followed by prolonged labor landing up in facilities (Sarker et al., 2020). Therefore, families who chose home birth before are concerned about the potential problems of home birth and making the decision to take facility-based childbirth. The researchers have recommended getting religious and other community leaders on board to influence families that pregnant women and new mothers need to visit health facilities and also recommended deploying female health workers to accompany women from referral hubs to health facilities and providing incentives, such as training or sometimes payment, to traditional birth attendants to refer clients to health facilities. Service providers appoint volunteer community health workers to meet with local leaders to try to convince them that births should not happen at home. They also try to improve privacy and confidentiality within health facilities. The focus is on providing separate delivery beds with curtains, barring unauthorized

persons from delivery rooms, and allowing traditional birth attendants who accompany women to the facility to be present during delivery so that pregnant women can come to the hospital without the fear of neglecting cultural and religious beliefs. It is important to notice how the service providers talk to pregnant women or attendants and how the midwife has to deal with them, for example, if she has strong contractions, if she needs her collaboration, which kind of language style they have to use, and which kind of practice do they have to avoid so the woman feels comfortable delivering in the facility.

Figure 4: Clinic for Maternal Healthcare (below)

Source: Extracted from Healthy Newborn Network, 25th March 2024. https://www.healthynewbornnetwork.org/blog/integrating-reproductive-health-and-newborn-health-services/

5.6 Quality of Services

In the host country, Bangladesh, Health Information Systems (HIS) and other tools are used to keep an eye on people's health and the health services they receive and use. These tools

and systems change from one organization or agency to the next. The government of Bangladesh uses the District Health Information System to keep an eye on things and make decisions such as what policies are needed to take based on the ongoing situation; also, the regional health policymakers determine what projects and programs need to run for better health facility (Aktar et al., 2022). Besides it is the World Health Organization (WHO) and its national, regional, and global partners worked together to see if a core set of sexual, reproductive, maternal, newborn, child, and adolescent health indicators could be used in humanitarian settings in the Rohingya crisis in Bangladesh. After the implementation of any program or project, a team evaluates the effectiveness of the project by collecting data from the community and making a report based on primary data. The organizations publish annual reports and show different aspects of the project and its effectiveness.

Figure 5: Delivery Room (below)

Source: Extracted from Unicef, 25th March, https://www.unicef.org/rosa/stories/ante-and-post-natal-care-ensure-health-rohingya-mothers-and-children

There are two types of maternity care services in Rohingya refugee camps; those are primary maternity care facilities that refer to basic healthcare services provided to pregnant

women, including prenatal checkups, basic obstetric care, and postnatal care. These services are often provided through clinics or health centers. Secondary maternity care facilities usually involve more specialized services, such as treatment for complications during childbirth and care for newborns requiring medical attention. Ensuring the quality of both primary and secondary maternity care is another ongoing problem in sexual and reproductive health (Jeffries et al., 2021). There is a possible gap in processes and resources, such as internal capacity, funding, and materials. The capacity to provide maternity care is limited, so the health facilities cannot provide sufficient services at a time in response to a number of patients. Secondly, funding for healthcare services is another concern because most of the service providers are appointed contractually and for possible renewal. Also, medical materials are not sufficient compared to the total number of attendants, so there is always a resource gap in the system. No matter how easy it is to get resources, problems with infrastructure on the ground level make it harder to distribute as the locations of the camps and material transportation process are difficult. At the basic health level, the quality of care led by midwives needs to be improved across all the camps. This can be done by giving mentorship support to the midwives, many of whom are new graduates with little work experience, so they are not that experienced to handle the situations. At the same time, making sure that people can get emergency obstetric care has always been a worry. However, there are a lot of operational problems. For example, most field hospitals need more trained surgeons and anesthesiologists to keep them open 24 hours a day, seven days a week. This makes their services less reliable. To help with this, a hospital rotation plan was put in place to make sure that at least one facility was open every day of the week that camp staff could use for emergency transfers (Jeffries et al., 2021). Even though this cycle plan has worked in some cases, it still needs to be improved by how reliable services are, how much blood is available, how many hospital staff

members are needed, and how quickly staff members leave their jobs. Because of this, a lot of emergency maternity cases end up being sent to government hospitals, where they are often treated much more slowly because of the pressure of the number of patients compared to the capacity of service.

5.7 Acceptability of Services

Rohingya women would rather see a doctor who is a woman and are hesitant to go to a facility where men and women work together because they avoid mixed-gender areas as they believe mixed-gender areas are against the rules of their social and religious beliefs (Parmer et al., 2019). In the Rohingya community, sexual and reproductive health is considered taboo because of religious teachings, orthodox views, and social norms (Zakaria et al., 2022; Parmer et al., 2019). This indicates that Rohingya women believe talking too much about their sexual and reproductive health would be a religious offense. As a result, the Rohingya people do not talk about sexual and reproductive problems openly and do not seek information about them (Zakaria et al., 2022). The Rohingya women think it is too early to learn, as they have their senior family and community members who know well, and they get advice when they need it.

Rohingya culture does not encourage knowledge about reproductive and maternal health, nor does it encourage sexual and reproductive health, family planning, or the use of birth control (Zakaria et al., 2022). A number of local and foreign nongovernment organizations (NGOs) are working to improve the status of sexual and reproductive health through communication interventions. It is often used to teach people about health facts that are good for women, help them adopt healthy mindsets, and get them to do suggested healthcare strategies, and it can help

with almost every aspect of preventing disease and promoting health. Because of this, the government, local and foreign NGOs, and health services are all working to help the Rohingya people with their sexual and reproductive health problems.

Rohingya women do not want to take part in nongovernment organizations (NGO) run health information programs about sexual and reproductive health because of the overwhelming response by Rohingya people, and they think that it is inappropriate, a religious taboo, or does not follow the rules set by their families and society (Zakaria et al., 2022; Parmer et al., 2019). There are posters and billboards in the camp about sexual and reproductive health, but the Rohingya women ignore them because they think those posters are about women's private issues, which are not allowed to be shown. In refugee camps, women from all families are not allowed to leave the house or talk to health workers because it is against the Rohingya religion, and their husbands do not allow it. Even though there are medical services in the camps, these are not used very often for sexual and reproductive health and pregnancy because girls and women are not allowed to leave the house (Parmer et al., 2019).

5.8 Limited participation of Rohingya refugee women in decision-making

Rohingya refugee women do not take part in making decisions about family planning very often. Because fewer people are participating, there are more accidental and short-interval births (Khan & Khanam, 2023). A lot of the time, Rohingya refugee women depend on their partners to make choices about their reproductive health, like how to plan their families and whether to take part in birth control programs. The number of short-interval births went up as women's involvement in making decisions about pregnancy with their partners went down (Khan &

Khanam, 2023). Ironically, the Rohingya community holds that fertility and family planning are the full responsibility of women, so men do not take part in the decision-making process. Even though they were forced to leave Myanmar and move to Bangladesh, they have not changed the way they do things. Also, new problems have come up in refugee camps. Problems with family planning and birth control make it harder for women to be involved in making decisions about childbearing. The Ministry of Health and Family Welfare of Bangladesh, along with about 150 national and international development partners, including UN agencies, launched a range of programs in 2017 to help Rohingya refugees get family planning and birth control (Khan & Khanam, 2023) in response to a large number of refugees. The current family planning programs in the Rohingya refugee camps need to be completely rearranged right away. There should be a special focus on getting more guys involved in family planning and getting them to use birth control. Also, counseling programs should start teaching women about how having too many babies close together can be bad for them. Another important area is getting women to take an active role in making decisions about childbearing. One way to do this is to argue against the idea that men are the only ones who can decide about fertility and promote the idea that it is the duty of both partners.

5.9 Human Rights and Refugee Women's Maternal Health

From the above discussion, it has been clear that Rohingya refugee women in Bangladesh have health problems because the country's health infrastructure is not well organized for the mass people of Rohingya refugee camps. Also, the cultural and religious beliefs of the Rohingya people create a barrier to accessing health facilities for Rohingya women. Therefore, the Rohingya refugee

women face many problems in their everyday lives regarding their reproductive and maternal health. This project mainly points out the condition of the maternal health system in refugee camps. Here, I want to apply human rights frameworks to maternal health, so it is possible to identify the key causes of maternal morbidity and mortality within the refugee camps. One important rule of general human rights law is that if one right is affected by something that affects another right, then both rights will be affected. Because of this, human rights give us a way to talk about how government projects and other projects by national and international aid organizations might affect people's health and how projects might affect the health of refugee people.

Rohingya women are more insecure with respect to safety because of their experiences of displacement, and many women and girls have been sexually abused or faced harassment. Besides, movement restriction outside of the refugee camps is a cause for child marriage in Rohingya camps. To protect the girls, parents fix their marriage early so that they can protect them from sexual violence. Also, there is a knowledge gap within Rohingya women regarding reproductive health. Therefore, they are being deprived of their health rights, which impacts their overall life in refugee camps.

5.10 Conclusion

This chapter mainly describes the situation of maternal health of Rohingya refugee women. It is seen that the Rohingya women still do not get adequate health facilities regarding their reproductive and maternal health. However, it is possible to teach the Rohingya women about significant sexual and reproductive health problems and dispel their dogmatic beliefs, myths, and misunderstandings. Religious leaders should be encouraged to take part in planning and carrying

out the program because it will assist the service providers in reaching the women who need it. The Rohingya women's overall health situation is poor, and they have limited access to and use of health care services. They lacked adequate knowledge of reproductive health, especially maternal health. Their poor health status, as well as their limited access to health services, make them more vulnerable. There is a need for proper hospital care on a larger scale, with a particular emphasis on improving easy access to maternal and child health services that promote antenatal, postnatal, and safe delivery. Besides, male participation should be promoted in order to improve the participation of healthcare services.

Chapter 6: Discussions and Recommendations

6.0 Introduction

This chapter presents those issues that need to be resolved to help the reader think about solutions or recommendations. The overall goal of this chapter is to make the reader think about the possible solution that might be helpful to the aid and development worker to accumulate their thoughts and ideas so that they can recommend those suggestions to the aid agency and implement them accordingly.

6.1 Barriers Need to be Removed

Women and girls experience barriers to freedom of movement in Rohingya camps when they reach their puberty stage (Yousuf et al., 2020). They are restricted to the home and controlled from going to public places. They also have restricted access to and control over resources as well. They faced double restrictions in their homeland in Myanmar. They faced barriers by their government and military in Myanmar and by the male guardians. In the refugee camps, they are facing the same situation, such as being controlled by the male guardians on the one hand and by the security of the Rohingya camp on the other hand. Thus, whenever they try to go outside the camp, they need permission from both guardians and camp security.

Women's access to reproductive health care, including facility-based deliveries, is restricted by a number of other factors. Cost is typically a barrier to health care for all Rohingya refugees. In a 2017 Médecins Sans Frontières (MSF) survey, the main obstacle reported by 42% of individuals who could not receive care in the camps was cost. (Parmer et al., 2019). Although

the Basic Emergency Obstetric and Newborn Care facilities serve a population of approximately 900,000 and satisfy the Sphere standard of five such facilities per 500,000 people, many refugees find it difficult to access these facilities due to crowded camps, a lack of roads and difficult terrain.

For refugee women within camps, referral pathways are weak (Schnabel & Huang, 2019). Therefore, women do not always get the level of healthcare they need. They have limited awareness of referral pathways and limited transportation to access healthcare. Though the first option for referrals is to larger health facilities within camps, patients are referred to higher-level facilities outside of camps for emergency care, such as obstructive care or other emergency health issues. There is also a problematic referral pathway that requires legal, law enforcement, and economic resources. Some nongovernment organizations try to lessen challenges with referral pathways. For this reason, a community-based referral project has been created that provides services 24/7 to meet critical emergency obstetric and neonatal care referral needs.

6.2 Gap Needs to be Removed

There is still a knowledge gap regarding these practices of reproductive health for Rohingya refugee women in the camp settings (Shahabuddin et al., 2020). Among Rohingya women and girls, a knowledge gap exists in their sexual and reproductive health. Most of the women feel shy and do not feel comfortable to share their reproductive health conditions. The main challenges are the cultural values and traditional misconceptions (Azad et al., 2022).

Also, there is a gap in resources and systems, including internal capacity, funding, and materials (Aktar et al., 2022). Even if there are resources, problems with infrastructure on the ground make it hard to share and analyze data properly. In places where resources are scarce and

there aren't national organizations in camp settings, people have to input and analyze data manually. This makes it tough for frontline staff to report their information accurately and on time, hurting the overall quality of the data.

6.3 Delays in Decision Making

Due to misconceptions and anxieties about medical facilities, the sociocultural expectation and desire among Rohingya refugees are to give birth at home with the help of traditional birth attendants (Barua et al., 2022). Most deliveries still take place at home, and there are reports of complicated cases being referred late. This raises the risk of maternal death.

Parmer et al. (2019) state that three delays create major impediments to timely access to effective maternity care. The first delay involves some core points, which are…

- Women's ability to make decisions
- The availability of care
- Their social status
- The cost of care
- How bad do they think their illness is
- How far do they live from the facilities
- their past experiences with the healthcare system
- how good do they think their care is

The second delay is because it is difficult to get to a health center. This could happen because it is…

- Hard to get from home to a facility
- Physical obstacles
- Limited or expensive transportation or bad road conditions

The third delay happens because of a wait to get the right care at a center. This could happen because of problems with …

- The facility's staff or materials
- Lack of the skills of the people

It is important to note that these delays affect each other. For example, women may not decide to get care if they know a lot of people have experienced the third delay, which means they waited too long to get it. These delays can be addressed by supply-side and demand-side interventions. Addressing societal perceptions and anxieties regarding facility-based deliveries is necessary for this, as it involves males and other family members in health education.

6.4 Care for Pregnant Women in Camp

The conditions in Rohingya refugee camps, particularly for women, present numerous challenges to self-care during pregnancy, pregnancy and delivery care, care of newborns, access to resources for care, and child development and psychosocial stimulation. Rohingya women often have limited access to quality prenatal care. The overcrowded conditions and insufficient healthcare facilities in the camps make it difficult for pregnant women to receive regular check-ups. The risk of malnutrition is high due to food insecurity in the camps. Pregnant women struggle to obtain a balanced diet rich in essential nutrients, which is crucial for their health and the development of the fetus (Jubayer et al., 2023). Access to clean water and sanitation in Rohingya

camps can be challenging, posing risks of infections that could affect both the mother and the unborn child. The camps lack adequate medical facilities for safe deliveries. Emergency obstetric care is not readily available, which increases the risks during childbirth. In the absence of proper medical facilities, some women resort to traditional birth attendants, which is risky in complicated cases. Security concerns in the camps hinder the timely and safe transportation of pregnant women to healthcare facilities during labor. The challenging living conditions make it difficult for women to access postnatal care for themselves and their newborns. Due to limited educational resources, some mothers lack essential knowledge about proper newborn care practices, including breastfeeding and hygiene. The scarcity of resources leads to challenges in providing adequate nutrition for newborns, impacting their growth and development. The camps struggle to provide comprehensive healthcare services, including maternal and child health, due to overcrowding and resource constraints. Among Rohingya refugee women, around 47 percent do not receive antenatal care, and 68 percent do not take preconception care (Khan et al., 2023). Nearly one-third of the pregnancies in Rohingya refugee camps are unintended, as most of them do not take family planning services. The lack of preconception care and lack of healthcare counseling during the pregnancy period leads to adverse outcomes such as unwanted pregnancies. Besides, Rohingya women often rely heavily on humanitarian aid for essential resources, including healthcare and other basic needs, which makes them vulnerable to fluctuations in aid availability.

6.5 Challenges to Conduct Reproductive Health Issues

In the Rohingya community, asking questions during interviews, especially issues on pregnancy, maternal health, menstrual health, family planning, sexually transmitted infections, and abortion, is a big challenge (Ahmed et al., 2020). Women and girls are reluctant to talk about their

experiences. The shame and embarrassment of sharing their reproductive and sexual health condition with outsiders, women cannot know the basic health care and service availability. For them, it is a sensitive topic that women feel uncomfortable discussing due to sociocultural and religious beliefs, stigma, and fear of being socially ashamed.

However, because of the cultural hesitations on discussing reproductive and sexual health issues, husbands are more protective and reluctant to allow their wives to talk about these issues with the interviewers (Ahmed et al., 2020). Sometimes, male family members were present at home during data collection due to restricted access. Their presence makes female respondents uncomfortable speaking freely about their reproductive health-related experiences.

6.6 Conclusion

The Rohingya women and girls in Rohingya camp and their access to healthcare facilities to access maternal health services is not improving. Women should be included in conversations about their needs and priorities for care so that they can get the proper care that they need. Coordination efforts of different aid workers and aid agencies need to improve to address gaps in completion and accelerate expansion to more comprehensive services. International development agencies should work to support health policies and programs that impact entirely the Rohingya and better meet the needs of Rohingya refugee women.

This project provides some insight into what services are provided to Rohingya refugee women upon resettlement in Cox's Bazar Rohingya camps in Bangladesh. The project finds that there is a need to educate and connect the Rohingya women to medical services is prominent, with an emphasis on working with community associations or staff to promote communication so that

the Rohingya women can understand the need of taking health services. It is also important to address the barriers so that nongovernment organizations and national and international aid organizations can continue to provide culturally and religiously appropriate maternal healthcare to Rohingya refugee women. Despite the various barriers, restrictions and difficulties challenged by Rohingya women, such as the poverty of refugee camps, hunger, lack of facilities and safety and violence problems, maternal mortality and stillbirth, knowledge about health and maternal and childcare is needed to prevent those challenges. Besides, though, there are many challenges to service delivery, including the interest of searching service stations or healthcare institution, proper planning and distributions methods are needed, which requires resources, funding, community, and volunteer support.

The maternal healthcare services in Rohingya refugee camps reveal a gap in services, such as overcrowded conditions, limited access to skilled professionals, and insufficient prenatal and postnatal care. The consequences of these inadequacies on the health of mothers and newborns are a matter of concern. Causes such as overcrowding, funding issues, and cultural barriers underline the complexity of the challenge. To address this crisis, the development and aid workers' action is needed because they can collaborate both with Rohingya community and service providers. Therefore, they can play a vital role to recommend how to overcome those barriers and how to ensure maternal services to all Rohingya refugee mothers. There is also a need for local healthcare workers to be trained and collaborate with international organizations. Stakeholder involvement and policy changes are crucial for the success of these initiatives.

Conclude by stating hope for positive changes and improvements in maternal services within Rohingya refugee camps. With collaborative efforts and collective action, it is possible to bridge the gaps in maternal healthcare and ensure the well-being of the vulnerable population.

Bibliography

Ahmed, R., Aktar, B., Farnaz, N. et al. (2020). Challenges and strategies in conducting sexual and reproductive health research among Rohingya refugees in Cox's Bazar, Bangladesh. Confl Health 14, 83. https://doi.org/10.1186/s13031-020-00329-2

Ahmed, R., Farnaz, N., Aktar, B., Hassan, R., Shafique, S. B., Ray, P., ... & Rashid, S. F. 2019. Situation analysis for delivering integrated, comprehensive sexual and reproductive health services in humanitarian crisis condition for Rohingya refugees in Cox's Bazar, Bangladesh: protocol for a mixed-method study. *BMJ open*, *9*(7), e028340.

Ahmed, Salim., Shommu, Nusrat S., Rumana, N., Barron, Gary. R. S., Wicklum, Sonja., and Turin, Tanvir. C. (2015). Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review. *Journal of Immigrant and Minority Health*, *18*(6), 1522–1540. DOI: https://doi.org/10.1007/s10903-015-0276-z.

Aktar, B., Rajendra, K.L., Clark, E. *et al.* (2022). Feasibility of establishing a core set of sexual, reproductive, maternal, newborn, child, and adolescent health indicators in humanitarian settings: results from a multi-methods assessment in Bangladesh. *Reprod Health* **19**, 121. https://doi-org.qe2a-proxy.mun.ca/10.1186/s12978-022-01424-8

Amsalu, R., Costello, J., Hasna, Z., and Handzel, E. (2022). Estimating stillbirth and neonatal mortality rate among Rohingya refugees in Bangladesh, September 2017 to December 2018: a prospective surveillance. *BMJ Global Health*, *7*(4), e008110–. https://doi.org/10.1136/bmjgh-2021-008110

Azad, M. A. K., Zakaria, M., Nachrin, T., Das, M. C., Cheng, F., & Xu, J. (2022). Family planning knowledge, attitudes, and practices among Rohingya women living in refugee camps in

Bangladesh: a cross-sectional study. Reproductive Health 19, 105. https://doi.org/10.1186/s12978-022-01410-0

Bari, S. (2020). The Rohingya Refugee Crisis: A Time Bomb Waiting to Explode. *Social Change (New Delhi)*, *50*(2), 285–299. DOI: https://doi.org/10.1177/0049085719901038

Barua, M., Chowdhury, S., Saha, A. et al. (2022). Community-based referral transportation system for accessing emergency obstetric services in the Rohingya refugee camp during the COVID-19 pandemic in Bangladesh: facilitators and barriers through beneficiaries' and providers' lens using a mixed-method design. Confl Health 16, 51. https://doi.org/10.1186/s13031-022-00485-7

Beck, C. T. (2019). *Secondary qualitative data analysis in the health and social sciences*. Routledge.

Beyani, C. (1995). The needs of refugee women: A human-rights perspective. *Gender and Development*, *3*(2), 29–35. https://doi.org/10.1080/741921812

Brubaker, S. J., & Dillaway, H. E. (2009). Medicalization, Natural Childbirth and Birthing Experiences. Sociology Compass, 3(1), 31–48. https://doi.org/10.1111/j.1751-9020.2008.00183.x

Byrskog, U., Olsson, P., Essén, B., & Allvin, M. K. (2014). Violence and reproductive health preceding flight from war: accounts from Somali born women in Sweden. *BMC Public Health*, *14*(1), 892–892. https://doi.org/10.1186/1471-2458-14-892

Charmaz, K. (2012). "Writing Feminist Research." Handbook of Feminist Research: Theory and Praxis. Ed. Sharlene Nagy Hesse-Biber. USA: SAGE.

Colson, E. (2008). Gendering those Uprooted by Development. In Indra, D. (Eds.), *Engendering forced migration: theory and practice* (pp. 23–39). Berghahn Books. https://hdl-handle-net.qe2a-proxy.mun.ca/2027/heb08671.0001.001

Connor, Helene., Ayallo, Irene., and Sue Elliot. (2016). *From Mama Afrika to Papatūānuku : African mothers living in Auckland [The health and well-being of a group of African immigrant and refugee background mothers living in Auckland, Aotearoa/New Zealand]*. Unitec Institute of Technology.

Cook, R. (2013). Human Rights and Maternal Health: Exploring the Effectiveness of the Alyne Decision. Journal of Law, Medicine & Ethics, 41(1), 103–123. DOI: https://10.1111/jlme.12008

Crenshaw, K. (1991) Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review, 43(6), 1241–1299.

DeVault, Marjorie L. and Glenda Gross. (2012). "Feminist Qualitative Interviewing: Experience, Talk, and Knowledge." *Handbook of Feminist Research: Theory and Praxis (*2nd ed.). Thousand Oaks: SAGE Publications, Pp. 206-236. https://dx.doi.org/10.4135/9781483384740.

Dopfer, Christina., Vakilzadeh, Annabelle., Happle, Christine., Kleinert, Evelyn., Muller, Frank., Ernst, Diana., Schmidt, Reinhold E., Behrens, Georg M N., Merkesdal, Sonja., Wetzke, Martin. And Jablonka Alexandra. (2018). "Pregnancy-Related Health Care Needs in Refugees-A Current Three Center Experience in Europe." *International Journal of Environmental Research and Public Health*, *15*(9), 1934–. DOI: https://doi.org/10.3390/ijerph15091934.

Edwards, A. (2010). Transitioning Gender: Feminist Engagement with International Refugee Law and Policy 1950-2010. *Refugee Survey Quarterly,* 29(2), 21–45. https://doi.org/10.1093/rsq/hdq021

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. The Australian and New Zealand journal of psychiatry, 36(6), 717–732. https://doi.org/10.1046/j.1440-1614.2002.01100.x

Giles, W. (2009). The Gender Relations of Home, Security, and Transversal Feminism. In Hajdukowski-Ahmed, M., Khanlou, N., & Moussa, H. (Eds.), *Not Born a Refugee Woman: Contesting Identities, Rethinking Practices* (pp. 55–66). Berghahn Books.

Global Trends:Forced Displacement in 2022. (2023). UNHCR. Copenhagen. Accessed 2023, December 15.

Grotti, Vanessa., Malakasis, Cynthia., Quagliariello, Chiara. and Nina Sahraoui. (2018). "Shifting Vulnerabilities: Gender and Reproductive Care on the Migrant Trail to Europe." *Comparative Migration Studies*, 6(1), Springer International Publishing. Pp. 1–18, DOI: https://doi.org/10.1186/s40878-018-0089-z.

Hajdukowski-Ahmed, M., Khanlou, N., & Moussa, H. (2009). Not born a refugee woman: contesting identities, rethinking practices. Retrieved from https://hdl-handle-net.qe2a-proxy.mun.ca/2027/heb08663.0001.001.

Hawkins, M.M., Schmitt, M.E., Adebayo, C.T. et al. (2021). Promoting the Health of Refugee Women: a Scoping Literature Review Incorporating the Social Ecological Model. *Int J Equity Health* 20, 45. https://doi.org/10.1186/s12939-021-01387-5

Hesse-Biber, Sharlene, Nagy., and Patricia Lina Leavy. (2007). "*Feminist Research Practice."* Thousand Oaks, CA: SAGE Publications.

Horst, C., & Grabska, K. (2015). Introduction: Flight and Exile—Uncertainty in the Context of Conflict-Induced Displacement. *Social Analysis*, *59*(1), 1–18. https://doi.org/10.3167/sa.2015.590101

Hunt, Paul, and Backman, Gunilla. (2008). Health Systems and the Right to the Highest Attainable Standard of Health. *Health and Human Rights*, *10*(1), 81–92. DOI: https://doi.org/10.2307/20460089

Islam, M. M., and Nuzhath, T. (2018). Health risks of Rohingya refugee population in Bangladesh: a call for global attention. *Journal of Global Health*, *8*(2), 020309. https://doi.org/10.7189/jogh.08.020309

Jannat, S., Sifat, R.I. and Khisa, M. (2023). Sexual and Reproductive Health Conditions of Women: Insights from Rohingya Refugee Women in Bangladesh. Sex Res Soc Policy 20, 855–868. https://doi.org/10.1007/s13178-022-00758-z.

Jeffries R., Abdi, H., Ali, M., Bhuiyan A., et al. 2021. The health response to the Rohingya refugee crisis post August 2017: Reflections from two years of health sector coordination in Cox's Bazar, Bangladesh. PLOS ONE 16(6): e0253013. https://doi.org/10.1371/journal.sarpone.0253013

Jolof, L., Rocca, P., Mazaheri, M. *et al.* (2022). Experiences of armed conflicts and forced migration among women from countries in the Middle East, Balkans, and Africa: a systematic review of qualitative studies. *Confl Health* 16, 46. https://doi.org/10.1186/s13031-022-00481-x

Jubayer, F., Kayshar, S., Arifin, S., Parven, A., Khan, S. I., & Meftaul, I. M. (2023). Nutritional health of the Rohingya refugees in Bangladesh: Conceptualizing a multilevel action framework focusing the COVID-19. Nutrition and Health (Berkhamsted), 2601060231169372–2601060231169372. https://doi.org/10.1177/02601060231169372

Khan, M. N., & Khanam, S. J. 2023. Women's participation in childbearing decision-making and its effects on short-interval births in Rohingya refugee camps of Bangladesh. *The Lancet*

Regional Health. Southeast Asia, *15*, 100250. https://doi-org.qe2a-proxy.mun.ca/10.1016/j.lansea.2023.100250

Khan, M. N., Khanam, S. J., & Alam, M. B. (2023). Exploring the Impact of Preconception Care and Unintended Pregnancy on Access to Antenatal Healthcare Services among Rohingya Women: Insights from a Cross-Sectional Survey. *Journal of Migration and Health*, 100213.

Kolb, B. (2012). Conducting secondary research. In *SAGE Secondary Data Analysis* (Vol. 0, pp. 111–128). SAGE Publications Ltd. https://doi.org/10.4135/9781473963702

Lalla, A. T., Ginsbach, K. F., Penney, N., Shamsudin, A., & Oka, R. (2020). Exploring sources of insecurity for Ethiopian Oromo and Somali women who have given birth in Kakuma Refugee Camp: A Qualitative Study. *PLoS Medicine*, *17*(3), e1003066–e1003066. https://doi.org/10.1371/journal.pmed.1003066

Letherby, G. (2003). "*Feminist Research in Theory and Practice."* Maidenhead, GBR: McGraw-Hill Professional Publishing.

Logan M. (2021). Persecution and a pandemic: delivering maternal healthcare to the Rohingya. *BMJ*. https://doi.org/10.1136/bmj.n2722

London, L. (2008). What is a Human Right-Based Approach to Health and Does it matters? 10 *Health and Humanities*. https://heinonline.org/HOL/LandingPagehandle=hein.journals/harhrj10&div=10id=&page

Martin, S. F. (2010). Gender and the Evolving Refugee Regime. *Refugee Survey Quarterly*, *29*(2), 104–121. https://doi.org/10.1093/rsq/hdq027

More than 60 Rohingya Babies Born in Bangladesh Refugee Camps Every Day. (2018, May 17). UNICEF. Accessed 2023, January 3. DOI: https://www.unicef.org/press-releases/more-60-rohingya-babies-born-bangladesh-refugee-camps-every-day-unicef

Niner, Sara., Kokanovic, Renata. and Denise Cuthbert. (2013). Displaced Mothers: Birth and Resettlement, Gratitude and Complaint. *Medical Anthropology*, vol. 32(6), Taylor and Francis Group, Pp. 535–51, DOI: https://doi.org/10.1080/01459740.2013.769103

Parmar, P. K., Jin, R. O., Walsh, M., and Scott, J. (2019). Mortality in Rohingya Refugee Camps in Bangladesh: historical, social, and political context. *Sexual and reproductive health matters,* 27(2), 1610275. https://doi.org/10.1080/26410397.2019.1610275

Rahman, M. S. and Sakib, N. H. (2021). Statelessnesss, forced migration and the security dilemma along borders: an investigation of the foreign policy stance of Bangladesh on the Rohingya influx. *SN Social Sciences,1* (7), 160. DOI: https://doi.org/10.1007/s43545-021-00173-y

Rani, R. P., Basri, R. (2018). Comprehensive sexual and Reproductive Health Care in Humanitarian Setting: A qualitative approach among midwives in Cox's Bazar, Bangladesh. https://urn.kb.se/resolve?

Rawal, L.B., Kanda, K., Biswas, T. *et al.* (2021). Health problems and utilization of health services among Forcibly Displaced Myanmar Nationals in Bangladesh. *Glob Health res policy* **6**, 39. https://doi-org.qe2a-proxy.mun.ca/10.1186/s41256-021-00223-1

Riley, A., Akther, Y., Noor, M., Ali, R., and Welton-Mitchell, C. (2020). Systematic human rights violations, traumatic events, daily stressors, and mental health of Rohingya refugees in Bangladesh. *Conflict and Health*, *14*(1), 60–60. DOI: https://doi.org/10.1186/s13031-020-00306-9

Rizkalla, N., Adi, S., Mallat, N. K., Soudi, L., Arafa, R., & Segal, S. P. (2021). Manzuaat wa Musharadat , Uprooted and Scattered: Refugee Women Escape Journey and the Longing to

Return to Syria. *Frontiers in Psychology*, *12*, 537131–537131. https://doi.org/10.3389/fpsyg.2021.537131

Robertson, C. L., & Duckett, L. (2007). Mothering During War and Postwar in Bosnia. *Journal of Family Nursing*, *13*(4), 461–483. https://doi.org/10.1177/1074840707309350

Rohingya emergency. (n.d.). UNHCR. Accessed 2023, January 8. DOI: www.unhcr.org/rohingya-emergency.html.

Sarker, B. K., Rahman, M., Rahman, T., Hossain, J., Reichenbach, L., & Mitra, D. K. (2016). Reasons for Preference of Home Delivery with Traditional Birth Attendants (TBAs) in Rural Bangladesh: A Qualitative Exploration. PloS One, 11(1), e0146161–e0146161. https://doi.org/10.1371/journal.pone.0146161

Sarker, M., Saha, A., Matin, M., Mehjabeen, S., Tamim, M. A., Sharkey, A. B., Kim, M., Nyankesha, E. U., Widiati, Y., & Shahabuddin, A. S. M. (2020). Effective maternal, newborn and child health programming among Rohingya refugees in Cox's Bazar, Bangladesh: Implementation challenges and potential solutions. PLoS ONE, 15(3), e0230732. https://doi.org/10.1371/journal.pone.0230732.

Schiebinger, L. (1999). *Has feminism changed science?* Cambridge, MA: Harvard University Press.

Schnabel, L., & Huang, C. (2019). *Removing Barriers and Closing Gaps: Improving Sexual and Reproductive Health and Rights for Rohingya Refugees and Host Communities*. Center for Global Development. http://www.jstor.org/stable/resrep29656

Shahabuddin, A. S. M., B. Sharkey, A., Jackson, D., Rutter, P., Hasman, A., & Sarker, M. (2020). Carrying out embedded implementation research in humanitarian settings: A qualitative study in

Cox's Bazar, Bangladesh. PLoS Medicine, 17(7), e1003148–e1003148. https://doi.org/10.1371/journal.pmed.1003148

Shahjahan, Md., Chowdhury., H.A., Al-Hadhrami. A., et al., (2017). Antenatal and postnatal care practices among mothers in rural Bangladesh: A community based cross-sectional study. Midwifery, 52. https://doi.org/10.1016/j.midw.2017.05.011

Siddiqi, H. (2021). Protecting autonomy of Rohingya women in sexual and reproductive health interventions. Voices in Bioethics, pp. 7, 1–8. https://doi.org/10.52214/vib.v7i.8615

Sudheer, N., & Banerjee, D. (2021). The Rohingya refugees: a conceptual framework of their psychosocial adversities, cultural idioms of distress and social suffering. Global mental health (Cambridge, England), 8, e46. https://doi.org/10.1017/gmh.2021.43

Sunata, U., and Özsoy, S. (2023). Feminization of refugee: Intersectionality, solidarity, resistance. International Migration, 61(1), 273–287. https://doi.org/10.1111/imig.12990

Ty, Rey., (2019). The Rohingya Refugee Crisis: Contexts, problems, and solutions. *Sur : International Journal on Human Rights*, *16*(29), 53–66.

Uddin, Nasir. (2020). *The Rohingya: An ethnography of "subhuman" life* (First edition.). Oxford University Press.

MID-YEAR TRENDS 2023 (n. d.). UNHCR. Accessed 2024, March 15. https://www.unhcr.org/sites/default/files/2023-10/Mid-year-trends-2023.pdf

What is a refugee? (n. d.). UNHCR. Accessed 2022, August 22. https://www.unhcr.org/what-is-a-refugee.html.

Yamin, Alicia E. (2013). From Ideals to Tools: Applying Human Rights to Maternal Health. PLoS Med 10 (11): e 1001546. https://doi.org/10.1371/journal.pmed.1001546

Yilmaz, M. L., and Talukder, M. İ. A. (2019). Economic Impact of Rohingya Exodus on Bangladesh. Liberal Düşünce Dergisi, 24(95), 111-129. https://doi.org/10.36484/liberal.592964

Yousuf, R., Salam, M. M., Akter, S., & Salam, A. (2020). Safety and security of sexual-reproductive health and gender-based violence among Rohingya refugee women in Bangladesh. Int J Hum Health Sci (IJHHS), 5, 163-70.

Zafar, A. (2020). The Rohingya Refugee: A Review of Security Threats for Bangladesh. GSJ, 8(9).

Zakaria, Muhammad, Nachrin, Tania., Azad, Md. Abul Kalam., (2022). Evaluating the Effectiveness of Utilization of Health Communication Intervention on Sexual and Reproductive Health of the Rohingya Women Living in Cox's Bazar Refugee Camp.
DOI: https://dpo.org/10.1016/j.heliyon.2022.e12563.

Addendum 1: Workbook

A Workbook to Help Aid Workers to Improve and Develop Unmet Maternal Healthcare Needs in Rohingya Refugee Camps in Bangladesh

By Toma Rani

The increasing influx of Rohingya refugee women and girls in Bangladesh highlights the urgent need to improve sexual and reproductive health. Clinical and psychological assistance for survivors of sexual violence, as well as unrestricted access to basic sexual and reproductive care, including a full variety of contraception techniques, menstruation guidelines, safe delivery, newborn care, and emergency obstetrics, are required. There are five types of health facilities in Rohingya refugee camps in Cox's Bazar, Bangladesh. Primary health centres, health posts, labour rooms, secondary health facilities, and community clinics are examples of these. The first three types of facilities are camp-specific and located within the camp. The final two categories of facilities, such as secondary hospitals and community clinics, are located outside.

Pregnancy, Home Birth and Postpartum Services

The common health problems among Rohingya women are pregnancy and childbirth-related complications. Though two-thirds of women receive Antenatal (ANC) visits, most of them give birth at home, assisted by traditional birth attendants. In Bangladesh, the traditional birth attendant is someone, often a woman, who assists women during childbirth in non-medical settings. They do not have any institutional education regarding childbirth. However, they have the experience and cultural knowledge to aid in delivery. In Bangladesh, traditional birth attendants are very popular, especially in rural areas where people cannot reach hospitals in poverty or for other reasons. Because of traditional practices of giving birth at home, the women are not willing

to take hospital services during their delivery because women are often pressured by family and friends to wear veils and by social and religious norms, so with the help of traditional birth helpers, they give birth at home. Another reason behind choosing home birth is hesitation to visit a health facility because they are afraid of mixed-gender areas. Even going to facilities is off-limits for them because they avoid mixed-gender areas, cars, or facilities. The Rohingya women can not talk to the male community health workers either because of strict gender rules. It makes harder for the healthcare providers to do their job, which is to get pregnant women information and take them to facilities. In the camps, trained midwives are unavailable at most health centers. Therefore, it creates a risk for them when they give birth at home with the help of traditional birth attendants. After giving birth at home, women are kept on the floor, usually on a mat, until the birth attendant cuts the umbilical cord and delivers the placenta. The woman is washed by the birth attendant or close family members like the mother-in-law or sister-in-law because they think it is their responsibility to protect their family privacy. In most cases, the birth attendant helps the woman on the day of the birth by taking care of her or teaching basic instructions such as how to breastfeed and how to do newborn care, and then family or friends help the mother to recover. Women who give birth at home do not go to the hospital for the following care. They do not go to the doctor because they think it is not a big health problem.

Different aid organizations set up safe delivery rooms at each camp to encourage women to give birth in hospitals, and they take care of pregnant women during delivery. At these centers, skilled medical staff, such as doctors and nurses, provide care. The delivery room encourages safe motherhood, breastfeeding, and planning a family after giving birth. It adds more services to help people with reproductive health problems. One in five expecting women in the camps do not go to the health facilities to give birth. There are many reasons for this, such as family rules against it

and a lack of trust in facility-based services. Also, between September 2017 and August 2018, 52 of the 82 deaths of mothers during pregnancy happened in these camps. Institutional delivery has been getting better over time since it started. Therefore, women who give birth in health centers or with the help of institutional delivery do routine checkups in the postpartum period, and their newborns get routine immunizations.

Accessibility of Services

The Rohingya women cannot make decisions by themselves whether they will take the hospital facilities for delivery, or they will stay at home and take the traditional childbirth approach. Basically, they need someone as they are not allowed to make decisions, or in some cases, they require companionship from family. For example, the decision maker can be the husband or Imam (religious priest) or sometimes the mother-in-law; they are the ones who make the final decision to send a pregnant woman to a facility or not because they give priority to Imam as Imam are socially and religiously important for the community. Usually, pregnant women only visit or seek healthcare at the facilities when a traditional birth attendant cannot manage the case. Therefore, sometimes, they take longer to make a decision, which leads to a large number of cases ending up in basic emergency obstetric and newborn care facilities with complications such as prolonged labor, retained placenta, and postpartum hemorrhages. About 70 percent of facility-based maternal deaths are caused as consequences of home trials followed by prolonged labor landing up in facilities. Therefore, families who chose home birth before are concerned about the potential problems of home birth and making the decision to take facility-based childbirth. The researchers have recommended getting religious and other community leaders on board to influence families that pregnant women and new mothers need to visit health facilities and also recommended deploying female health workers to accompany women from referral hubs to health

facilities and providing incentives, such as training or sometimes payment, to traditional birth attendants to refer clients to health facilities. Service providers appoint volunteer community health workers to meet with local leaders to try to convince them that births should not happen at home. They also try to improve privacy and confidentiality within health facilities. The focus is on providing separate delivery beds with curtains, barring unauthorized persons from delivery rooms, and allowing traditional birth attendants who accompany women to the facility to be present during delivery so that pregnant women can come to the hospital without the fear of neglecting cultural and religious beliefs. It is important to notice how the service providers talk to pregnant women or attendants and how the midwife has to deal with them, for example, if she has strong contractions, if she needs her collaboration, which kind of language style they have to use, and which kind of practice do they have to avoid so the woman feels comfortable delivering in the facility.

Quality of Services

In the host country, Bangladesh, Health Information Systems (HIS) and other tools are used to keep an eye on people's health and the health services they receive and use. These tools and systems change from one organization or agency to the next. The government of Bangladesh uses the District Health Information System to keep an eye on things and make decisions such as what policies are needed to take based on the ongoing situation; also, the regional health policymakers determine what projects and programs need to run for better health facility. Besides it is the World Health Organization (WHO) and its national, regional, and global partners worked together to see if a core set of sexual, reproductive, maternal, newborn, child, and adolescent health indicators could be used in humanitarian settings in the Rohingya crisis in Bangladesh. After the implementation of any program or project, a team evaluates the effectiveness of the project by

collecting data from the community and making a report based on primary data. The organizations publish annual reports and show different aspects of the project and its effectiveness.

Acceptability of Services

Rohingya women would rather see a doctor who is a woman and are hesitant to go to a facility where men and women work together because they avoid mixed-gender areas as they believe mixed-gender areas are against the rules of their social and religious beliefs. In the Rohingya community, sexual and reproductive health is considered taboo because of religious teachings, orthodox views, and social norms. This indicates that Rohingya women believe talking too much about their sexual and reproductive health would be a religious offense. As a result, the Rohingya people do not talk about sexual and reproductive problems openly and do not seek information about them. The Rohingya women think it is too early to learn, as they have their senior family and community members who know well, and they get advice when they need it.

Rohingya culture does not encourage knowledge about reproductive and maternal health, nor does it encourage sexual and reproductive health, family planning, or the use of birth control. A number of local and foreign nongovernment organizations (NGOs) are working to improve the status of sexual and reproductive health through communication interventions. It is often used to teach people about health facts that are good for women, help them adopt healthy mindsets, and get them to do suggested healthcare strategies, and it can help with almost every aspect of preventing disease and promoting health. Because of this, the government, local and foreign NGOs, and health services are all working to help the Rohingya people with their sexual and reproductive health problems.

Rohingya women do not want to take part in nongovernment organizations (NGO) run health information programs about sexual and reproductive health because of the overwhelming response by Rohingya people, and they think that it is inappropriate, a religious taboo, or does not follow the rules set by their families and society. There are posters and billboards in the camp about sexual and reproductive health, but the Rohingya women ignore them because they think those posters are about women's private issues, which are not allowed to be shown. In refugee camps, women from all families are not allowed to leave the house or talk to health workers because it is against the Rohingya religion, and their husbands do not allow it. Even though there are medical services in the camps, these are not used very often for sexual and reproductive health and pregnancy because girls and women are not allowed to leave the house.

Limited participation of Rohingya refugee women in decision-making

Rohingya refugee women do not take part in making decisions about family planning very often. Because fewer people are participating, there are more accidental and short-interval births. A lot of the time, Rohingya refugee women depend on their partners to make choices about their reproductive health, like how to plan their families and whether to take part in birth control programs. The number of short-interval births went up as women's involvement in making decisions about pregnancy with their partners went down. Ironically, the Rohingya community holds that fertility and family planning are the full responsibility of women, so men do not take part in the decision-making process. Even though they were forced to leave Myanmar and move to Bangladesh, they have not changed the way they do things. Also, new problems have come up in refugee camps. Problems with family planning and birth control make it harder for women to be involved in making decisions about childbearing. The Ministry of Health and Family Welfare of Bangladesh, along with about 150 national and international development partners, including

UN agencies, launched a range of programs in 2017 to help Rohingya refugees get family planning and birth control in response to a large number of refugees. The current family planning programs in the Rohingya refugee camps need to be completely rearranged right away. There should be a special focus on getting more guys involved in family planning and getting them to use birth control. Also, counseling programs should start teaching women about how having too many babies close together can be bad for them. Another important area is getting women to take an active role in making decisions about childbearing. One way to do this is to argue against the idea that men are the only ones who can decide about fertility and promote the idea that it is the duty of both partners.

Human Rights and Refugee Women's Maternal Health

From the above discussion, it has been clear that Rohingya refugee women in Bangladesh have health problems because the country's health infrastructure is not well organized for the mass people of Rohingya refugee camps. Also, the cultural and religious beliefs of the Rohingya people create a barrier to accessing health facilities for Rohingya women. Therefore, the Rohingya refugee women face many problems in their everyday lives regarding their reproductive and maternal health. This project mainly points out the condition of the maternal health system in refugee camps. Here, I want to apply human rights frameworks to maternal health, so it is possible to identify the key causes of maternal morbidity and mortality within the refugee camps. One important rule of general human rights law is that if one right is affected by something that affects another right, then both rights will be affected. Because of this, human rights give us a way to talk about how government projects and other projects by national and international aid organizations might affect people's health and how projects might affect the health of refugee people.

Rohingya women are more insecure with respect to safety because of their experiences of displacement, and many women and girls have been sexually abused or faced harassment. Besides, movement restriction outside of the refugee camps is a cause for child marriage in Rohingya camps. To protect the girls, parents fix their marriage early so that they can protect them from sexual violence. When Rohingya women and girls approach puberty, they face restrictions on their freedom of mobility. They are kept to the home and prevented from going to public places.

How would you recommend barriers be removed for Rohingya refugee women? Write your thoughts in the table below…

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

There is still a knowledge gap about reproductive health practices among Rohingya refugee women in camp settings. Among Rohingya women and girls, there is a knowledge gap in sexual and reproductive health. Most women are hesitant and may not feel comfortable discussing their

reproductive health concerns. Therefore, they are being deprived of their health rights, which impacts their overall life in refugee camps.

As a reader, what would you recommend to improve the knowledge gap for Rohingya refugee women? Write your thoughts in the table below…

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Due to misconceptions and worries about medical facilities, Rohingya immigrants have a social expectation and desire to give birth at home with traditional birth attendants. Most deliveries continue to take place at home, and there have been reports of complicated cases being referred late. This increases the risk of maternal mortality. They have a limited understanding of referral pathways and limited mobility to healthcare. Though larger health facilities within camps are the first option for referrals, patients with emergency health conditions, such as obstructive treatment, are directed to higher-level hospitals outside of camps. There is also a challenging referral channel

that necessitates legal, law enforcement, and economic resources. Some nongovernmental organizations attempt to mitigate problems through referral pathways.

How would you recommend to resolve the delays for Rohingya refugee women? Write your thoughts in the table below…

1.
2.
3.
4.
5.
6.
7.
8.
9.
10

The congested environment and lack of healthcare facilities in the camps make it difficult for pregnant women to undergo routine check-ups. Food insecurity in the camps increases the risk of malnutrition. Pregnant women struggle to obtain a well-balanced diet high in key nutrients, which is critical for their health and the development of the fetus. Access to clean water and sanitation in Rohingya camps can be difficult, increasing the risk of diseases for both the mother and the unborn child. The camps lack basic medical facilities to ensure safe deliveries. Emergency obstetric care is not widely available, raising the hazards of delivering.

How would you make improvements to pregnancy care for Rohingya refugee women? Write your thoughts in the table below…

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Because of societal reluctance to discuss reproductive and sexual health issues, men are more protective and unwilling to enable their wives to address these issues with the interviewer. Male family members were occasionally present at home during data collection due to limited access. Their presence makes female respondents uneasy talking openly about their reproductive health experiences.

As a reader, what steps would you recommend to resolve the above mentioned issues for Rohingya refugee women? Write your thoughts in the table below…

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.