Improving Access to Rights-based Reproductive Health Services in Cox's Bazar, Bangladesh

List of Abbreviations

ANC - Antenatal Care

BLAST - Bangladesh Legal Aid Services Trust

CIC - Camp In-Charge

CRR - Center For Reproductive Rights

DGFP - Directorate General of Family Planning

DGHS - Directorate General of Health Services

DGNM - Directorate General of Nursing and Midwifery

FGDs - focus group discussions

GBV - Gender-based Violence

HCF - Healthcare facilities

HP - Health Posts

HPNSP - Health, Population and Nutrition Sector Programme

FDMNs - Forcibly Displaced Myanmar Nationals

IDMC - Internal Displacement Monitoring Center

IDP - Internally Displaced Persons

IOM - International Organization for Migration

KAP - Knowledge, Attitude, and Practice

LARCs - Long-acting Reversible Contraceptives

MDA - Mass Drug Administration

MOHFW - Ministry of Health and Family Welfare

MR - Menstrual Regulation

MRM - Menstrual Regulatory Medicines

NGO - Non-government Organization

NGOAB- The NGO Affairs Bureau

NID - National ID

PHC - Primary Health Centres

PNC - Postnatal Care

UNFPA -United Nations Population Fund

UNHCR - United Nations High Commissioner for Refugees

UNRWA -United Nations Relief and Works Agency

RRRC - Refugee Relief and Repatriation Commissioner, Bangladesh

SRMH - Sexual, Reproductive, and Maternal Health

SRHR - Sexual and Reproductive Health Rights

SRH - Sexual and Reproductive Health

SRHWG - Sexual and Reproductive Health Working Group

WASH - Water, Sanitation and Hygiene

WHO - World Health Organization

1. Background

Refugees and access to Sexual, Reproductive, and Maternal Health services

Ensuring the inalienable human rights of refugees has always been a complex challenge for states and other involved parties. UNHCR, UNRWA, and IDMC statistics show that an estimated 110 million people were forcibly displaced globally due to persecution, conflict, violence, human rights violations or events seriously disturbing public order.[1] Approximately 4.4 million of these people are considered stateless due to historical or political circumstances.[2] As one of these stateless populations, the Rohingyas were displaced to Bangladesh, having suffered decades of violence, discrimination, and persecution in Myanmar.[3] Among them, the majority of Rohingya women and girls residing in Cox's Bazar refugee camps have experienced or witnessed gender-based violence.[4] Alongside the demand for gender-responsive policing in action, in the face of ongoing challenges in Cox's Bazar, women and girls are disproportionately affected by limited access to essential services, including health care.[5]

The UNHCR has adopted its policy for refugee women since 1990 and recognizes the need for specifically addressing women's need in situations of displacement.[6] Refugee women and girls tend to live in camps under a persistent threat of violence, including from intimate partners, family members and neighbors; especially in situations where there is strong stigma making sexual and reproductive health deemed a taboo topic for discussion.[7] These women and girls require the same quality sexual, reproductive, and maternal health (SRMH) services as all women. But an estimated 3.5 million women and girls aged 15-49 who are in need of humanitarian aid also do not have adequate access to SRMH services. Typically, birth rates in refugee camps tend to be high.[8] Additionally, the high birth rate in camps often result in women exclusively being provided with maternal and child health services, at the neglect of other aspects of women's reproductive health. Adolescents and young women in crisis settings are particularly vulnerable to sexual abuse.[9] Young refugees in camps also often lack proper access to menstrual hygiene products, safe community spaces, and proper education regarding their reproductive health.[10]

There are many organizations that are dedicated to addressing the SRMH needs of refugee women and women in refugee-like situations. However, addressing the needs of women in these difficult situations means listening to them and holding stakeholders properly accountable. A successful human-rights accountability work piloted at a refugee settlement in Uganda by the Center for Reproductive Rights in a joint initiative with CARE International applied a human rights framework to build accessible and responsive accountability mechanisms at the settlements and succeeded in bringing the refugee women and girls closer to decisions that impact their lives. The Center recognizes a need for projects of this caliber as intrinsically necessary to make quantifiable changes in the life of displaced women and girls. Thus, in collaboration with Naripokkho, CARE Bangladesh, and Bangladesh Legal Aid and Services Trust (BLAST), this project was launched in Camp 15 in Ukyiha, Cox's Bazar to provide a participatory and rights-based accountability system to Rohingya women and girls to ensure quality SRMH services.

The Persecution of the Rohingya in Myanmar

Myanmar is an ethnically diverse country with 135 different recognized ethnicities.[11] The Rohingya, however, are not one of them. Factors related to historical conflicts and the state's conflation of citizenship with race and religion, also contributed to the Rohingya largely not being considered as Burmeses by the general population.[12] From 1947 onwards, the government of Myanmar did not recognize the Rohingyas as indigenous to the Arakan state and denied them full citizenship, rendering them essentially stateless.[13]

In 2012, communal violence broke out in the region, displacing 1,40,000 Rohingyas into Internally Displaced Persons (IDP) camps.[14] These camps were densely packed, with high rates of malnutrition and water-borne illnesses and aid groups were reportedly evicted, leading to numerous preventable deaths.[15] In 2017, the persecution of the Rohingya reached a crescendo as a cleansing operation carried out by the Myanmar Armed forces, following the attacks of an insurgent group known as the Arakan Rohingya Salvation Army (ARSA), leading to close to 700,000 people fleeing to neighboring Bangladesh.[16] Many of the Forcibly Displaced Myanmar Nationals (FDMNs) arrived severely injured, wounded from bullets, burns and in the case of

women, after experiencing brutal rapes, gang rapes and other forms of sexual assults.[17] As of June 2023, Bangladesh is sheltering 961,700 Rohingya FDMNs.[18]

Situation of Healthcare Facilities in the Rohingya Camps in Cox's Bazar, Bangladesh

Rohingyas were forced to flee to Bangladesh as early as in the 1970s to escape army brutality, rape and murder; most of whom were later repatriated due to pressure from the UNHCR.[19] Further campaigns in 1991–92 led to nearly a quarter million Rohingyas seeking shelter once again[20]. Bangladesh once again attempted to repatriate the Rohingya in 1997.[21] Despite this, by the end of 2015 and before the 2017 influx, Bangladesh was already hosting 231,958 FDMNs.[22] As of 2024, the nearly one million Rohingya, hosted by Bangladesh, are staying in 33 camps across the Cox's Bazar district and the Bhasan Char island of Noakhali district.[23] The living situation in most FDMN camps remains dire, with most living in substandard shelters made with bamboo and tarpaulin sheets, insufficient rations, limited access to healthcare and extremely restricted movement.[24] Widespread sanitation and hygiene (WASH) issues in these camps disproportionately affect women and girls; their need for family planning and feminine hygiene products often go unmet.[25]

With varying levels of services and quality of care, numerous healthcare facilities are operating in Cox's Bazar District camps providing health care to FDMNs and nearby host communities.[26] The WHO identified the high background rates of endemic infectious diseases, such as: measles, dengue, malaria, cholera, tuberculosis, etc, low background immunization coverage, high rates of childhood malnutrition, etc. among the primary risk factors in addressing the healthcare requirements in the camps.[27] The major primary level health care facilities within the camps are primary health care centers (PHCs), health posts, labor rooms or sexual and reproductive health only facilities, community clinics and in the private sector, there are private practicing doctors and pharmacies.[28] Humanitarian organizations, in partnership with the Ministry of Health and Family Welfare (MOHFW), have played a significant role in providing healthcare services, including Sexual and Reproductive Health and Rights (SRHR) as well as family planning support.[29]A revised package was built on the earlier Essential Service Package developed in 2017 and revised in December 2018 by Health Sector under the leadership of MOHFW and RRRC.[30] However, a gap in the funding persists.[31]

In 2020, the COVID-19 pandemic broke out and the underfunded health facilities for the Rohingya who were already living in congested camps were at high-risk of infection.[32] 3,084 Rohingya patients tested positive for COVID-19 following the first reported case on May 14, 2020.[33] Bangladesh began vaccination campaigns from January of 2021 in Rohingya camps as well as the rest of the nation. As of 2022, 86.9% of the population had taken the first dose of the vaccine and 73.5% of the population took the full dose. One study addressing knowledge, attitude, and practice (KAP) among refugees finds that knowledge and attitude regarding Covid-19 among the Rohingya is encouraging, but further research is necessary on the barriers to practice.[35]

A notable barrier to providing healthcare to Rohingyas, despite many international and domestic stakeholders' efforts, is the trauma carried by the people living in these camps. Due to the persecution faced by the Rohingya in Myanmar, many deeply distrust authority figures, including healthcare providers.[36] This paired with some language barriers between FDMNs and service-providers makes it difficult to provide the Rohingya with quality preventative healthcare services, instead of only addressing emergency situations.

Overview of Rights-based Reproductive Health Services in the Rohingya Camps

The unique context of Cox's Bazar, home to a large population of displaced individuals, demands a comprehensive examination of the existing healthcare infrastructure, social determinants, and policy frameworks. As the international community increasingly recognizes the centrality of reproductive health in ensuring the well-being and agency of individuals, especially in crisis settings, research contributions are required in the broader discourse on humanitarian efforts and the realization of reproductive rights.

In 2019, a total of 77.4% of women in Bangladesh, who were between the ages of 15 and 49, had their need for family planning satisfied.[37] But the Government of Bangladesh prohibits abortion unless it is performed to save the life of a woman.[38] However, Menstrual Regulation (MR) is widely used as an alternate method of family planning in Bangladesh since 1979.[39] MR is a procedure that uses manual vacuum aspiration or medicines to "regulate the menstrual cycle when menstruation is absent for a short duration." [40] MR performed using medication is referred

to as MRM. In 2014, an estimated 1,194,000 women induced abortions using both MR and other unregulated and often unsafe methods of abortions and 257,000 women experienced complications.[41] In 2021, Ministry of Health and Family Welfare (MOHFW), Directorate General of Family Planning (DGFP), Directorate General of Health Services (DGHS) and Directorate General of Nursing and Midwifery (DGNM) jointly released official guidelines for Menstrual regulation and post-abortion care.[42]

Contraceptives and MR services are widely available in Rohingya FDMN Camps as a result of the the reproductive health sub-working group (SRHWG), made up of UNFPA and NGOs implementing SRH service, although long-acting reversible contraceptives (LARCs) are not as easily accessible.[43] Despite the availability of contraceptives and MR services, even as of 2022, KAP regarding using contraceptives among Rohingya women was found to be lacking, owing to inadequacy of education and various cultural differences regarding family planning.[44] Adolescents, despite being in danger of sexual violence, do not have equal access to these services, face more barriers to access these services because of cultural stigma and perceived biases from service providers.[45]

During the recent field visits to Camp 15 in Ukhiya, Cox's Bazar, significant challenges affecting women and their sexual and reproductive health rights (SRHR) were observed. The decrease in international funding, escalated by the COVID-19 pandemic and global crises such as those in Afghanistan and Ukraine, has shifted the attention and resources of international donors. Consequently, several organizations have ceased operations in the camps, leading to a noticeable decline in awareness programs. Women in the camp reported resorting to selling hygiene products, previously received through donations, in the local marketplace to obtain monetary benefits. The healthcare situation has also deteriorated, with hospitals shutting down and healthcare staff being only temporarily employed, leading to a lack of consistent medical care. The diminishing support and resources have intensified the vulnerability of women in the camps, highlighting an urgent need for renewed international attention and funding to address these critical issues.

Despite the initiations taken on by various humanitarian organizations, the existing system of accountability needs to be mapped and improved to address those barriers. Meaningful

community participation along with continuous monitoring and transparency is necessary to properly identify the areas where improvement is possible to ensure comprehensive and quality services for FDMNs. The training of over 2000 Rohingya refugee women and girls were facilitated by CRR and implemented by Naripokkho about their health-related rights and held a number training sessions with health service providers and humanitarian policymakers on rights-based approaches and comprehensive SRHR. This includes representatives across the Rohingya community, including adolescents and persons with disabilities, to ensure their distinct SRMR issues are recognized and addressed, and to build a shared understanding of human rights and agency. They are trained to increase awareness about rights-based accountability and build human rights capacity to ground complaints and feedback. This approach ensures that FDMNs have agency over the services provided to them and they can meaningfully engage with the system of SRMH services in place and ultimately access quality, comprehensive and essential SRMH services which they have the right to receive.

2. Objectives and Methodology

2.1 Objectives

As part of an effort to strengthen SRMH service delivery accessed by Rohingya women and girls living in Cox's Bazar, Bangladesh, CRR[46] has designed this rights-based participation and accountability project in partnership with CARE Bangladesh and national level partners Naripokkho and Bangladesh Legal Aid Services Trust (BLAST).[47] Building on the success achieved in Uganda, the center recognized the necessity to apply the same approach in another humanitarian setting where CRR and its partners observe a persistent lack of accountability regarding access to SRMH services and information.

A critical aim of this project is to see that women and girls forcibly displaced from Myanmar, particularly Rakhine State, can enjoy equal access to comprehensive, quality, and lifesaving SRMH services, without discrimination of any kind in Bangladesh.

2.2 Methodology

2.2.1 Coverage of the Study

2.2.2 Geographical Coverage

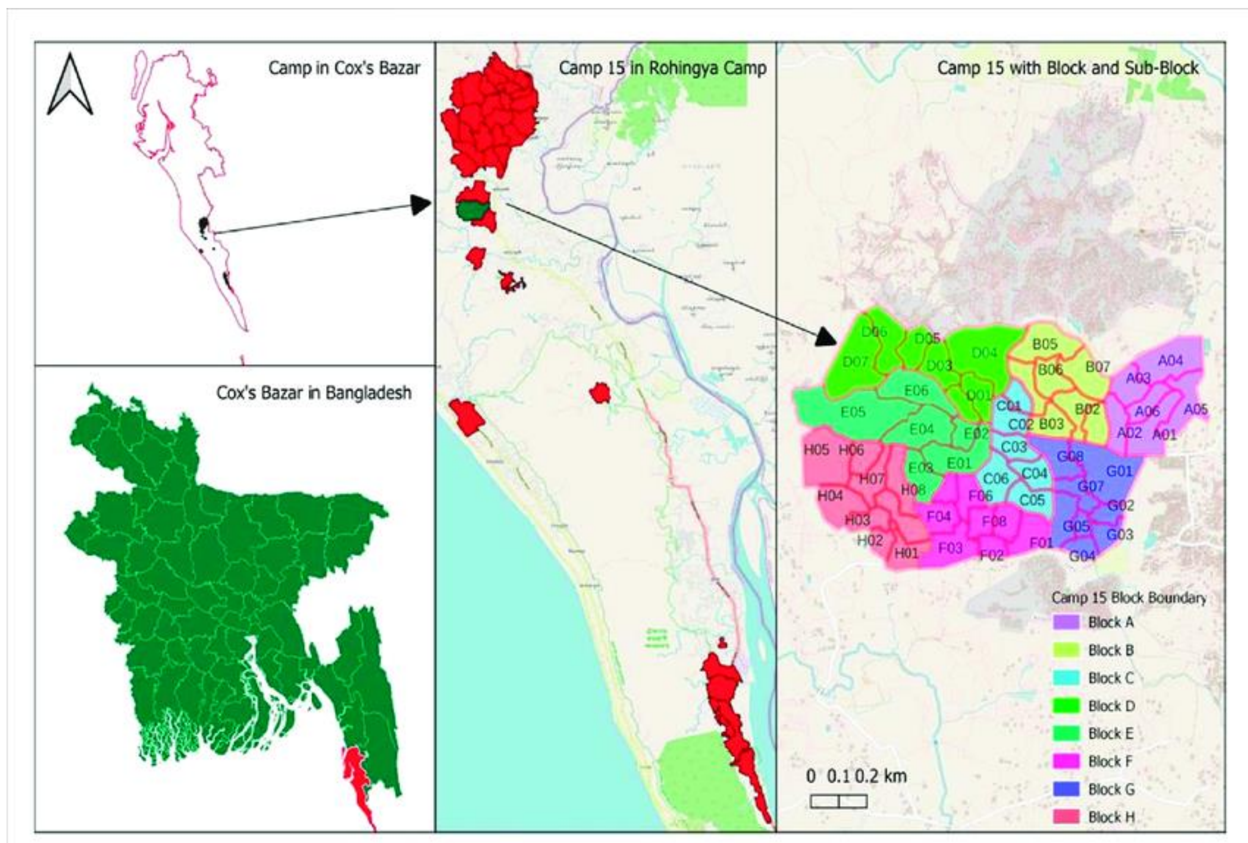

Photo: Map of Camp 15

The project's geographical coverage spans Camp 15 of Kutupalong Camp in Ukhiya, Cox's Bazar. At the project's onset, there were eight healthcare facilities, which have now been reduced to six. Of these, four are Primary Health Centres (PHCs), and two are Health Posts (HPs). Notably, one of the PHCs (Mercy Malaysia) was observed to be almost non-functional, having exhausted its funding in June 2023, and is currently sustained by funds from its trust. Additionally, another PHC operated by the Red Cross ceased its services and was replaced by Save The Children in the beginning of 2024.

2.2.3 Study Groups Sampled

Naripokkho staff undertook field-based human rights documentation interviews in two distinct phases, with a particular focus on Rohingya women and girls in camp number 15. During the first phase, conducted from August 2022 to June 2023, one-on-one interviews were conducted with a total of 468 Rohingya women and girls. Notably, the participants were selected to ensure representation across age groups, with females aged 18-45 and adolescent girls aged 09 to 17.

Photo: Beneficiary being interviewed by Naripokkho staff.

The second phase took place in March 2024. Focus group discussions (FGDs) were conducted with three groups: Group 1 consisted of women aged 46 and above, Group 2 comprised women aged 18-45, and Group 3 included adolescents aged 9 to 17.

Photo: Focus Group Discussion (FGD)

2.3 Data Collection

For data collection, the interviewers were equipped with the necessary training and experience to conduct interviews, including proficiency in working with refugees, addressing SRHR violations, and dealing with conflict-related trauma. The interview methodology as a part of data collection adhered to internationally recognized guidelines for human rights fact-finding missions and reports, such as the Lund-London Guidelines on International Human Rights Fact-Finding Visits and Reports by Non-Governmental Organizations.

The questionnaires contained predetermined questions specifically tailored for interviewees, ensuring the validity, sensitivity, and objectivity of the information gathered. Interviewers implemented comprehensive measures before, during, and after the interviews to prioritize the safety of both interviewees and individuals in communities. This included careful considerations of interview locations, dates, times, and durations, all while maintaining sensitivity to the interviewees' situations.

2.3.1 Tools Used For Data Collection

Data was collected using the following tools:

1. Physical observation of facilities - coordinator, consultant, program manager, field staff directly observed facilities to check the services available.

2. Key Informant Interviews (KIIs) were conducted by Naripokkho field staff. A structured questionnaire (annexe 1) was administered to the respondents. Translation and Interpretation services were provided accordingly.

3. Focus Group Discussions (FGDs) were conducted using guidelines (annexes 2-4). The project consultant and two field staff were engaged with each FGD. Translation and Interpretation services were provided accordingly. Notes were taken and discussions were recorded.

4. In-depth interviews (IDIs) were conducted with different health care service providers.

5. Key Informant Interviews (KIIs) were conducted with the Camp In-Charge (CIC) and representatives from CARE and BLAST.

6. Case studies were documented from two FDMN women who experienced complications related to SRMH services.

2.4 Data Analysis

Data were analyzed using a thematic analysis approach, separately for observation, key informant interviews, and focus group discussions. Using the thematic analysis approach, we were able to analyze, identify and interpret patterns and themes throughout the dataset.

To carry out the analysis, the transcribed data from the KIIs were entered into a dataset. Once all the observations were arranged, we moved forward to data cleaning and codes were prepared which would help us in further analysis of the data. We used a combination of excel and statistical software, STATA, to go through this step. The integrated approach allowed us to identify patterns and relationships that are essential to answer the question.

2.5 Ethical Implications

Interviewers took meticulous steps to ensure that informed and voluntary consent was obtained before, during, and after the interviews. Reliable interpretation, transcription, and translation services in local language were provided, and continuous assurances were given throughout the interviews, emphasizing the interviewees' right to refrain from responding to any question and the option to end the interview at any time.

2.6 Study Personnel

In the initial phase, a temporary office was established by Naripokkho in 2022 within the camp in the block designated by the Camp In-Charge (CIC). The objectives included establishing a participatory and rights-based social accountability mechanism in Cox's Bazar to collect, review, remedy, and monitor health-related complaints among Rohingya women and girls. An effective network with other humanitarian response actors in the Camp was developed. Activities like designing, implementing, and monitoring social accountability programming outcomes alongside compiling and disseminating lessons learned in meaningful consultation and participation with Rohingya women and girls began in this phase.

Monthly meetings were organized for 20 groups to foster connections and build rapport with Rohingya women and adolescent girls. The process involved careful coordination and approval from key stakeholders, including CIC and RRRC, for volunteer recruitment and training. Following this, staff development and capacity-building training sessions were conducted, laying the foundation for the subsequent task of collecting household data from the homes of project beneficiaries to establish a comprehensive database. Monitoring was conducted by the Project

director and staff from Naripokkho. The staff demonstrated a meticulous and comprehensive approach in the identification and selection of interviewees, aiming to prevent any potential traumatization, victimization, or exploitation. Furthermore, when needed interviewers addressed the collected sexual and reproductive, as well as general health-related complaints from women and adolescent girls by sharing this information with relevant support service providers and experts including health service providing organizations, healthcare providers, and the Camp In-Charge (CIC). This effort not only facilitated swift assistance to those in need but also accelerated the process of establishing a robust network and impactful collaboration with the service providers, policy-making entities, and interviewees.

3. Data analysis & Discussion

Characteristics of Participants

During the first phase of the project, one-on-one interviews were conducted with 468 Rohingya women and girls to get a comprehensive idea about the existing healthcare services available. Women across different age groups were selected for the interview. Majority of the respondents were between the ages of 18-45 years and 9.18% of the surveyed population were children aged between 9-17 years old. Less than 2% of the respondents belonged to women-headed households.

Total respondents	**468**
Age group: 9-17 years old	43
Age group:18-45 years old	402
Age group: >46 years old	23

Table 1: Age distribution of survey respondents

The second phase took place in March 2024. Focus group discussions (FGDs) were conducted with three groups: Group 1 consisted of women aged 46 and above, Group 2 comprised women aged 18-45, and Group 3 included adolescents aged 9 to 17.

Access to Healthcare

The healthcare facilities in Camp 15 were not inconveniently located for the respondents. Most HCFs were located within walking distance from the majority of the respondent's houses. Few respondents (n=27) noted that their homes were far from the HCF and they had to cross over hilly areas/mountainous roads which is quite difficult during pregnancy.

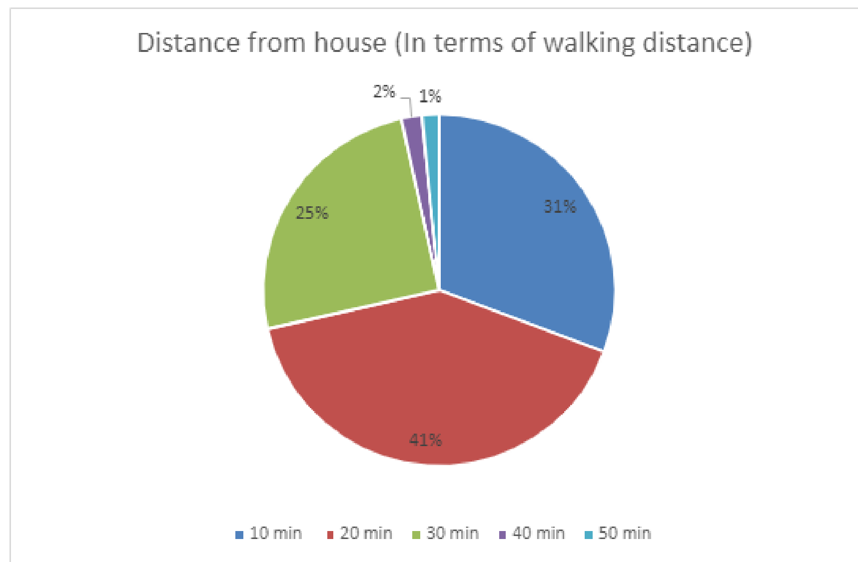

Figure 1: Distribution of respondents' walking distance

Utilization of health services

Medecins Sans Frontieres Bangladesh (MSF) (45%) and Bangladesh Red Crescent Society (BDRCS) (15%) were the most visited HCFs for treatment of illnesses and other healthcare-related services. There were also a considerable number of HCF operated by other NGOs such as BRAC, Mercy Corps - Bangladesh, and International Organization for Migration (IOM). The HCFs provided and offered different types of health services, which is presented in Table 2 along with the utilization rate of each service by the respondents.

Respondents mainly received services related to common health issues like fever, cough, itching, and diarrhea. FGD findings also reflect that respondents usually visit HCFs to address problems like colds, fevers and muscle pain. This implies that these conditions are prevalent among the population and require frequent medical attention. Certain specialized services, such as those related to mental health and gastrointestinal problems show lower utilization rates compared to

more general health services. This could be due to potential barriers to accessing specialized care, including stigma, lack of awareness, or limited availability of services in certain areas. There are variations between the number of services offered and those actually used. For instance, in the case of services related to infectious diseases, compared to the amount offered (n = 338), the usage is low (n = 95). Data on chronic disease demonstrates similar observations. This might suggest over-provision or redundancy in service offerings, or it could indicate factors such as self-medication or seeking care elsewhere.

Service for some health conditions, such as tuberculosis (TB), show relatively low utilization despite being serious conditions. This might indicate challenges in diagnosis, access to treatment, or public awareness about the importance of seeking medical care for these conditions. Majority of the respondents have mentioned SRMH (Sexual, Reproductive and Maternal Health) services are available in the HCFs. The statistics show noticeably low utilization rates, particularly when it comes to pregnancy-related care including delivery, antenatal care (ANC), and postnatal care (PNC), even when these treatments are reportedly available. Although HCFs offer delivery services, respondents prefer having normal deliveries at their homes unless there are complications. 41 respondents reported giving birth in their homes. Delays in receiving health cards and the time consuming process to acquire services related to ANC/PNC could discourage patients from seeking these services. The number of hospitals offering services related to menstrual regulation and menstruation is also very low, which contradicts with the data provided in the later part of the section. This could reflect a lack of understanding of such services.

Type of Related Services	**Provided**	**Offered**	**Used**
Infection diseases			
Cholera	1	1	0
Cold	47	19	7

Diarrhea	261	107	35
Jaundice	154	40	5
TB (Tuberculosis)	25	10	2
cough	393	161	46
Total	**881**	**338**	**95**
General Health condition			
Allergy	3	0	3
Fever	396	265	191
Gastrointestinal	10	1	4
Itching	318	226	140
Mental health	16	7	0
Primary Checkup	57	111	30
Total	**743**	**499**	**338**

Chronic disease			
Asthma	95	45	1
Diabetes	208	98	13
TB (Tuberculosis)	25	10	2
Total	**328**	**153**	**16**
Pain related Condition			
Body ache	18	12	2
Chest pain	21	10	2
Headache	18	12	3
Knee pain	7	2	0
Stomachache	5	3	1
Throat ache	4	6	3
Total	**73**	**45**	**8**

SRMH Services			
Menstruation	3	0	2
Family Planning	48	60	13
Delivery	344	281	7
Pregnancy care	0	1	2
PNC (Postnatal care)	351	261	7
ANC	345	264	10
MR	4	1	1
Total	**1095**	**868**	**42**

Table 2: Distribution of Related Healthcare Services Provided, Offered, and Used by Respondents

Knowledge about general SRMH services

80% of the respondents had knowledge about one to two types of SRMH services. Notably, knowledge related to community outreach and education programs were mentioned multiple times. For example, respondents knew about pregnancy checkups, requiring nutritious diets, and the signs of danger in pregnancies and a few mentioned child marriages as well (n=30) (Table 3). This indicates that these respondents were effectively exposed to community outreach programs.

17% of the respondents had no knowledge of any of the services (n=80). Although contraception services and family planning services are frequently used by the respondents, it was rarely mentioned. None of the respondents mentioned menstrual regularization (abortion) services. This could indicate either there is asymmetry of information or respondents did not understand the question, which raises concerns over how well people are able to obtain and apply important reproductive health care efficiently. Women and girls may encounter difficulties getting timely and appropriate treatment if they don't have a sufficient grasp of these services and their potential advantages, which might have a negative impact on their health.

FGD findings suggest that mother-in-laws usually share knowledge of SRMH to their daughter-in-laws and hospitals do not offer awareness sessions. Adolescent members participate in sessions from various organizations where they learn about menstrual hygiene and the problems of early marriage.

General SRMH Services	**% of times each service was mentioned by the respondents**
Community outreach and education	75%
Reproductive Health Services	31%
Maternal Health Services	5%
Family-Planning Services/ Contraception	0.74%
Sexual Health Services	20%
Did not hear about it	16%

Table 3: Knowledge of general SRMH services

Opening hours of the HCF

The HCFs have specific opening hours. Majority of the respondents (n=358) report that the facilities are open all 24 hours of the day for delivery and emergency patients, other responses disclose they have fixed timings either from 9 am to 5 pm or from 8 am to 5 pm. Since the HCFs are operated by different organizations, it is expected that they will have different opening hours. The HCFs are closed during weekends.

Access to medicines and necessary equipment

Through one-on-one interviews, respondents reported that there is sufficient supply of medicines and necessary equipment in the health centers. Around 32% of the respondents (n=150) did not know about equipment available and 16 of them shared that most HCFs do not have X-ray services.

Although 70% of the respondents mentioned that there are sufficient medicines available, they did not clarify the kind of medicines they were referring to. Respondents raised concerns that the same medicine, eg.Napa (an Analgesic), is prescribed for all types of health issues. FGDs allowed to provide a more detailed description of the access to medicines and the respondents share the following concerns:

> *"Sometimes, the hospitals provide fewer medications than indicated on the prescription. Consequently, the medications run out before the expected date. Upon returning for more medication, we are denied as the records show that we already have sufficient medication."*
>
> *"When multiple members of the same family visit the doctor with similar problems, the doctor examines only one member and provides medication for that individual."*

To sum up, disparities between recorded resources and real distribution methods inside medical institutions have been found, exposing the need for better accountability and supervision procedures.

Access to SRMH services

Period care and MR

70% of the respondents had access to period care and menstruation regulation (abortion) services.

> *"I typically seek medical attention for menstrual pain and vaginal discharge"*- a girl shared during the FGD.

Table 4 shows the types of services that the respondents received from the HCF. These services are not only restricted to older women but aim to provide sufficient access to adolescent menstrual care. Out of 43 adolescent females, 30 of them reported to have access to the services.

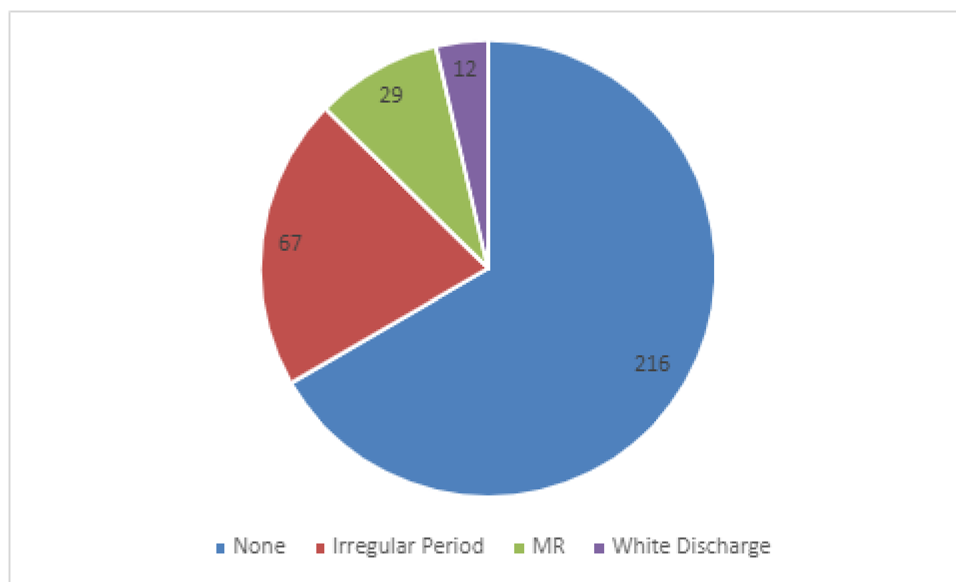

Figure 2: Distribution of respondent using period care and MR services

Even though health care facilities offer such services, they are highly under-utilized, ie. respondents rarely visited health centers for these services.

FGDs pointed out the barriers that prevent female from taking the services, such as:

> *"I accompanied my friend to the hospital due to her excessive vaginal discharge. However, we were denied a token by the distributor because of our age. My friend, feeling too*

embarrassed to disclose it to her mother, shared the issue with me. Eventually, she had to disclose it to her mother to seek treatment."

Another respondent shared the following experience during the one-on-one interviews:

"I went with a stomach ache due to heavy bleeding but I was sent back with no treatment."

These experiences shared by respondents underscore the importance of creating a supportive and non-judgmental environment within healthcare facilities, where individuals, especially adolescents, feel empowered to seek help without fear of stigma or discrimination.

HCFs do not offer SRMH knowledge to adolescent girls. Adolescent girls learn about menstrual hygiene and the problems of early marriage from participating in sessions from various organizations. Moreover, hygiene products are not available in the health centers and women usually use cloth pads during their menstruation. Alarmingly, it has been noted that multiple female members within families resort to sharing the same undergarments and menstrual clothes, raising serious concerns about hygiene and health risks.

The few instances when hygiene products are provided, the items are of subpar quality. Numerous instances have been reported where adolescents and women resort to selling undergarments and cotton clothing in exchange for money due to the inadequate quality provided.

"Some organizations used to distribute sanitary napkins in the past, but not anymore. Additionally, we received panties previously, but they were uncomfortable to wear in hot weather. Most of them resorted to selling these panties in the market."

MR and abortion has been used interchangeably during the interviews and FGD. 20 respondents have mentioned that they went through MR procedure and none of them belonged to the adolescent age group. It could be because either there is no incidence of early pregnancy or due to the stigma associated with early pregnancy, the affected were afraid to visit health centers.

Family Planning services

Family planning services refer to methods of contraception such as oral contraceptive pills, contraceptive injection, implants, intrauterine devices (IUD), and condoms. These methods rely on different mechanisms and varying levels of effectiveness in preventing unintended pregnancy.

Around 16% of the respondents did not know anything about family planning services. Table 4 displays the total number of services mentioned by the respondents when asked about the types of family-planning services provided to married couples by the HCF. Majority of the respondents noted that health centers provide or suggest at most five different contraceptive methods for the married couples, which are injectables, contraceptive pills, condom, implant and IUD.

Among the given services, the preferred method of contraception is injectables, such as Depo-Provera as mentioned by 129 respondents, followed by contraceptive pills. Only 16 out of 468 respondents confirmed to have taken condoms from health centers. This shows that condom is the least favored method of contraception. During the FGDs, respondents mentioned Depo-Provera to be the preferred contraceptive hence coinciding with the evidence found in the KIIs.

Table 4: Family planning services provided by HCF

Although the majority of the respondents received family planning services through their preferred method during consultation, around 4% of the respondents reported their choice of contraceptive method was disregarded by the doctors and a different method had to be used. Similar experiences were highlighted by respondents during the interviews and FGD. Instances of over-counseling have been noted, leading to unintended consequences such as the incorrect administration of contraceptive implants. Pressure from campaign targets set by the office further exacerbates the issue, resulting in undue stress on both volunteers and beneficiaries.

Services during and after childbirth

Not all the health centers have facilities for child birth. Moreover, it is not mandatory to have deliveries at health posts or health centers. The majority of the respondents reported to go through normal deliveries at their own homes. There are no adequate follow-up mechanisms in place for

Total services provided	Frequence of respondents	Percentage
0	89	18.54
1	6	1.25
2	28	5.83
3	52	10.83
4	148	30.83
5	157	32.71

patients receiving SRMH services, such as postpartum care or STI treatment. After a minimum period of 10 days, patients need to seek services themselves for follow-ups. Delays in receiving ANC and PNC cards, especially after normal deliveries at home have also been reported during FGDs.

Behavior and quality of service from health service providers

When asked about the quality of service during childbirth, one of the respondents expressed the following concern:

> *"The health service providers are usually very impolite, and speak disrespectfully when we have any concerns or questions but when the condition of the patient is complicated, the quality of service is good".*

Apart from the problems with getting proper services at the health care, there are also dissatisfaction with how patients are treated at the centers. Few respondents have agreed that nurses and doctors act politely with patients, on the other hand, some noted that if patients are scared or have queries about certain issues, nurses react rudely and doctors are unresponsive. The behavior of guards and other staff is similarly unsatisfactory. One of the respondents held the opinion that it is better to die at home than visiting the HCF due to the ruthless behavior of the staff, nurses and doctors. After waiting for long hours in the health centers, the service seekers are not treated respectfully.

Further discussion about this issue during the FGDs lead to the following experience of one of the members:

> *"During postpartum care, I experienced severe pain while being washed. The midwife scolded me for expressing discomfort, which was humiliating. I have decided not to go to that hospital anymore."*

Due to the high volume of patients, there have been cases where healthcare providers fail to provide adequate information to patients on medication usage, leading to misunderstandings and improper administration.

Although it has been reported that there are complaint boxes, none of the respondents were able to share any incidents regarding complaints. One of the respondents pointed out during the KII that if any one wants to complain, they are threatened by the staff or authorities.

Efforts that ensure that patients receive respect, decency, and compassion from healthcare workers must be implemented along with the access to reproductive health treatments. Furthermore, the absence of reported incidents through complaint boxes suggests that there are inadequate protocols in place to handle concerns, which highlights a larger problem with accountability and transparency in healthcare settings. The lack of channels for patients to express their grievances and pursue compensation for maltreatment or inadequate medical attention might weaken public confidence in the healthcare system, therefore deter people from accessing important reproductive health treatments.

Inclusivity in the HCF

Around half of the respondents (n = 237) reported that the HCFs are equipped to provide services to people with disabilities. The rest of the responses responded that they did not know about the disability services or that the health centers are not suitable for patients with disabilities. One of them mentioned that even if the health center is inclusive, the staff personnels do not operate the services properly because of their incapability, lack of training and ethical responsibilities.

These findings highlight the urgent need for better staff training and the implementation of more robust measures to ensure that healthcare services are accessible and effectively managed for individuals with disabilities.

Discussion

The FGDs were conducted at the second phase of the study in March, 2024. The responses recorded from the FGDs were more precise and specified the concerns properly that indicated the impact of the project on the women of the camp. Respondents were aware about the SMRH services and could confidently refer to any concerns related to the questions. They were also specific on the challenges that they face in the accessibility of these services which indicate that they know about their rights and are knowledgeable enough to raise voice over concerns.

Naripokkho has been ensuring and creating awareness of family planning services and SRMH services for women and adolescent females since the beginning of the project. The case studies mentioned below reflects the impact of the project in Camp 15:

Case Study 1: "I can decide, too"

"I am Sabekun Nahar, 35 years old. I live in Camp 15 Main Block G and Sub Block G-10A Room No-08, FCN No-234000. In 2017, I came to Bangladesh from Myanmar with my father, mother, brother and sister, my two sons, two daughters and my husband. My husband works as a daily wage worker. After coming to Bangladesh, I conceived one more time and now, I have five children; my youngest is a three-years-old girl. My husband got married again. Meanwhile, I became pregnant without my knowledge. Now I am worried about what to do. One day volunteer Khaleda Ahmed Abhi came to my house to discuss awareness and practice of family planning. I told her my story. Khaleda Ahmed Abhi then brought up the subject of MR to me, then I decided to do MR. She took me to BDRCS hospital for MR and after 27 days of MR, I got an implant. Now I am physically healthy, no problem."

Case Study 2: "The Story of Nurbahar"

"I am Nurbahar, 29 years old. I live in Camp-15 Main Block G and Sub Block G-10 House No. 265 and FCN No. 227920. I came to Bangladesh from Myanmar in 2017 with my husband, children and parents. My husband works as a daily wage worker in Bangladesh. One of my children was born in Myanmar. After coming to Bangladesh, I gave birth to two more children, the youngest child is one and a half years old. While my youngest baby was still small, I became pregnant again, hence I was worried about what to do. One day, Formina Apa, a volunteer, came to my house and discussed family planning methods in detail, then I told her about my story, she told me about doing MR. After discussing it with my husband, I decided to do MR. Farmin Apa took me to MSF hospital for MR. I am healthy now and take family planning birth control pills. I am now well, by the grace of Allah."

Case Study 3: "Amena's Untold Story"

"I am Amena, 24 years old. My husband's name is Md Enam Ullah, age: 35. We have 2 sons and 1 daughter. We got married in 2020. My husband's profession is head sailor. Three of our children were born in the first four years of our marriage. One day a volunteer named Nasima came to our house to talk about family planning. When I asked where she came from, Nasima replied that she is a regular volunteer who is working to ensure quality family planning and reproductive health care for women and youth. Considering my physical health and family, she advised me to consider family planning methods which then I share with my husband. However, my husband stopped me for which I got worried. Suddenly, a few days later, my husband went to a meeting at the office of Naripokkho. After the meeting, my husband came home and gave me his opinion on family planning. Then, I seek help from volunteer Nasima Apa. She took me to a women friendly health center where they gave me advice on different family planning methods. Now my little baby is one month old. Now, I am in a good state due to taking family planning methods. Not knowing anything about family planning before, I have been conceiving babies every year frequently. This will no longer occur. I am living a very healthy life. Thank you very much Nasima Apa."

Case Study 4: "Rokeya's Untold Story"

"I am Rokeya Begum, 20 years old. In 2017, I came to Bangladesh from Myanmar with my father, mother, brother and sister. I got married in 2020. My husband works as a daily wage worker. We have two daughters and the youngest child is seven months old. My physical condition is not very good. One day, Nasima apa came to my house from an NGO called Naripokkho to discuss family planning methods, reproductive health care and sexually transmitted diseases. After listening to Nasima apa, I mentioned my white discharge. I have been suffering for almost a month and did not know what to do. Nasima Apa informed me that the disease is well treated at IOM Hospital. She accompanied me to the hospital and I got treatment and got well from taking regular medicine. Nasima Apa, thank you very much if you did not come to my house, then I would not have known anything. Moreover, I am taking the contraceptive pill, Depo-Provera, due to my physical condition. I am much better now."

Case Study 5: "The Story of Kamalida"

"I am Kamalida, 23 years old. My husband's name is Rashid Ahmed, age: 27 years old. I have 6 children and the youngest one is 18 months old. I came to Bangladesh as a refugee with the Rohingya community in 2017 to save my life after being persecuted by the Myanmar army. I got married while living in Myanmar. Romana Apa, a female volunteer, used to visit our block houses once a month. Romana Apa spoke to me and my daughter about the coronavirus, dengue, sexually transmitted diseases and HIV. Regarding cleanliness, Romana Apa also mentioned about what to do and not to do during menstruation and she discussed with me in detail about the methods of family planning. I didn't know these before, if I had known before then I wouldn't have had so many children. Now I have a lot of problems with a small house and a family. Moreover, my husband doesn't work. I don't want to have more children, which I discussed with my husband and I decided that I will take contraceptive pills. Then Romana Apa took me to BDRCS Hospital and the doctor prescribed me with pills. I am now taking pills regularly and have no problems. All my family is fine by the grace of Allah. Romana apa, thank you very much."

Case Study 6: "Taslima's Dilemma"

"I am Taslima, 18 years old. My husband's name is Mo Elias, age: 23 years old. In 2017, I along with my parents migrated from Myanmar to Bangladesh. After that, I got married to Mo Elias in 2021. Within a few days, a daughter came to our life. She is now 9 months old. I never chose family planning methods because my husband did not want to take any such steps. I don't dare speak against my husband's wishes. I am confined at home and can't share anything with anyone. I went to tell my mother-in-law. She told me that she doesn't want advice in the absence of my husband and she wants several grandchildren. I felt that I was in big trouble. Suddenly, Nasima apa from

Naripokkho visited me. I could not tell her anything out of shame but when I listened to her, I realized that she was talking about the same things that I was too ashamed to refer to. She discussed in detail about the family planning methods and awareness. I discussed this matter with my husband. After many requests, he agreed and allowed me to take contraceptive pills. After that, my physical condition became stable. I take pills at regular intervals every night to avoid unwanted pregnancy. Thank you, Nasima Apa and Naripokkho, I would not have known anything about family planning if you had not come to my house. I am now physically fit."

Case Study 7: "Learning about new things"

"I am Rosina (pseudonym) working in BRAC school in sub-block 13 of G block. I am a citizen of Bangladesh. I have a son who is 21 months old. Every day we see women volunteers in our block houses talking to women and girls about health rights, family planning. One day I found one of their volunteers alone and called them. After meeting Khaleda Ahmed Abhi Apa, I wanted to know about their work. Khaleda Apa said that they are working on raising awareness about family planning methods, women's health rights and reproductive health care for women and youth. I know about family planning but never heard about reproductive health rights and women's health rights. So after hearing the words I was interested to know more from her. Khaleda Apa told me in detail and I was delighted to hear it. I was also very worried because my period had stopped for 2 months. On one hand, I was working and on the other hand, my child is very young so I was not mentally ready for another pregnancy at the moment. Moreover, I assumed people in the village would not accept the MR method well, so I asked for Khaleda Apa's advice. Khaleda Apa took me to BDRCS hospital and there I underwent MR and returned home healthy. After resting for a few days at home, I am again focused on office work and am worry free. I am thankful to Naripokkho for helping me in such a difficult time. Now, I know when to make the right decision in our life."

Case Study 8: "Bringing justice to Hamida"

"In September 2023, Amin Sharif's mother Hamida Begum went to the MSF hospital at around 1 am as her labor pains increased. The nurse/midwife stationed there received them and Hamida Begum's baby was delivered around 3 am. In such a situation, the midwife kept telling the people accompanying Hamida Begum very rudely that they don't provide any service to clean the blood of the mother and those accompanying the new mother need to bring in tools to clean the blood themself. Hamida's parents cried and pleaded that it is not possible to go home at such a late night to bring the cleaning products. Hamida Begum felt very bad about their behavior. The next day, a volunteer went to Hamida's house after hearing all the incidents and we went to the MSF hospital. We discussed the matter with them and the hospital replied that there was no provision of sanitizer in the hospital at that time, hence they said that. The hospital sincerely apologized for misbehaving with us and also said that this will not happen again."

4. Legal Framework

The Constitution of Bangladesh implicitly ensures the safeguarding and advancement of healthcare as an integral component of human rights, as delineated in articles 15 (ensuring basic necessities), 16 (fostering rural development and agricultural progress), and 18 (upholding public health and moral standards).[48] Addressing healthcare governance in Bangladesh, the 4th Health Sector Programme of the Government of Bangladesh marks a significant step towards universal health coverage and meeting Sustainable Development Goal targets. Core objectives of the Health, Population and Nutrition Sector Programme (HPNSP) encompass enhancing the Ministry of Health and Family Welfare's (MoHFW) governance and oversight functions, bolstering leadership, management, and regulatory capacities to ensure superior service quality. Additionally, the program aims to streamline the MoHFW, optimizing its efficiency, accountability, and performance by eliminating redundancies and inefficiencies.[49]

The healthcare landscape in Bangladesh operates within a pluralistic framework involving four principal stakeholders: the government, private sector, nongovernmental organizations (NGOs), often referred to as the "third sector," and donor agencies. Under the governance of the Ministry of Health and Family Welfare (MoHFW), the system is overseen by two key bodies: the Directorates General of Health Services (DGHS) and Family Planning (DGFP). These entities coordinate the delivery of general health and family planning services across the country. Services are administered through a network of facilities including district hospitals, Upazila Health Complexes at the subdistrict level, Union Health and Family Welfare Centers at the union level, and community clinics at the ward level. Additionally, urban primary care services are managed by the Ministry of Local Government, Rural Development, and Cooperatives.[50]

However, Bangladesh is unable to grant official refugee status to the forcibly displaced Rohingya population and remains committed to facilitating their safe repatriation to Myanmar. As such, FDMNs find themselves unable to access refugee rights or fall under the constitutional provisions for healthcare afforded to Bangladeshi citizens. Instead, healthcare services in the Rohingya camps are predominantly provided by UN agencies and NGOs. The NGO Affairs

Bureau (NGOAB) facilitates NGO activities in the camps, issuing service permits that enable them to extend their services to both FDMNs and host communities.[51]

In 2023, the introduction of the General Health Card for FDMNs marked a significant advancement in healthcare accessibility and efficiency for the Rohingya community in the camps. Spearheaded by the World Health Organization (WHO), this initiative has been made possible through the funding and support of the United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM), United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF) representing a collaborative effort between healthcare providers, refugee communities, and international organizations. Developed to consolidate individual medical information, the General Health Card revolutionized healthcare delivery within the camps by providing comprehensive access to a patient's medical history, including treatments, surgical procedures, and investigation.[52] The delivery of medical assistance is streamlined by requiring FDMNs to present their Health cards and host community members to provide their National ID (NID) for accessing healthcare services in the camps. However, focus group discussions (FGDs) unveiled instances of delays in obtaining Antenatal Care (ANC) and Postnatal Care (PNC) cards, particularly in cases of home deliveries. Shockingly, in certain cases, infants reached eight months of age before receiving a PNC card.

Photo: FDMN women holding General Health Cards as they await services at a healthcare facility

Besides, the WHO-led Health Sector in partnership with UNHCR, IOM, and other stakeholders, collaborated with the government of Bangladesh to establish a Patient Referral Standard Operating Procedures (SOP) in the Rohingya camps. This collaborative effort aimed to address operational challenges and priorities by defining responsibilities, standardizing services, enhancing accountability, and establishing effective monitoring and decision-making mechanisms through medical referral committees.[53] However, a significant number of participants in the focus group discussions (FGDs) expressed concerns about the lengthy nature of the referral system. Particularly during emergencies, patients face challenges accessing higher-level healthcare facilities without the necessary referral documents signed by the appropriate authority.

In Camp 15, the Camp-in-Charge (CIC) holds monthly meetings with healthcare providers to streamline medical services and maintain accountability. However, it is unfortunate that high workloads often lead to the attendance of replacements in meetings rather than the principal healthcare service providers. Naripokkho conducts door-to-door awareness sessions and believes having medical representatives present during the sessions would enhance effectiveness, but this is also not feasible due to the providers' workload. Additionally, the current accountability

mechanism does not include participation of beneficiaries. To improve service delivery and ensure the protection of SRMH rights, a more inclusive accountability mechanism is needed, involving management, service providers, advocates, volunteers, and beneficiaries, fostering a comprehensive and transparent approach to healthcare in the camp.

5. Recommendations

Recommendations for HCFs:

1. Ensure that all facilities providing SRMH services have an adequate number of trained healthcare service providers.

2. Implement an accountability mechanism for service providers to uphold quality standards, supported by an inclusive monitoring plan.

3. Ensure transparency in medicine distribution by monitoring whether the accurate number of medicines is provided according to the prescription.

4. Allocate more time to patients and ensure thorough explanation of the prescription. Additionally, appoint interpreters for patients who may require language assistance.

5. Conduct training sessions to enhance empathy and improve the behavior of staff associated with healthcare facilities (HCFs).

6. Make feedback and complaint boxes functional, addressing language barriers by training beneficiaries and assuring them of anonymity in their feedback.

7. Introduce alternative methods for submitting complaints, such as using images, illustrations, or emojis in feedback forms. A specific individual can be designated to receive feedback.

8. Prioritize the beneficiary's preference regarding the method of contraceptives they wish to avail.

9. Refrain from pressuring staff to meet specific quotas for the distribution of certain contraceptives, as this may create undue pressure among the beneficiaries.

10. Increase the presence of community mobilizers in HCFs, with representatives accompanying NGO volunteers during beneficiary visits to foster trust and positive relationships.

11. Minimize staff turnover to maintain consistency and continuity of care.

12. Ensure timely responses to meeting invitations and capacity-building training requests by improving communication with their head offices.

13. Optimize the process for HCF visits for observation or data collection by reducing lengthy and time-consuming formalities. The objective is to facilitate seamless access for observation, thereby ensuring effective oversight of facility operations.

14. Promote a supportive work environment within HCFs by addressing issues such as workload management, staff morale, and burnout prevention strategies.

Recommendations for NGOs:

1. Ensure a coordinated approach with CIC by sharing each other's activities related to SRMH services though regular communication.
2. Expand outreach efforts to reach more beneficiaries.
3. Offer culturally sensitive and age-appropriate SRMH education and awareness programs tailored to the needs of women and adolescents.
4. Strengthen referral systems under the guidance of CIC by establishing partnerships with healthcare providers and organizations to ensure continuity of care for women and adolescents seeking SRMH services.
5. Advocate for the inclusion of SRMH education in school curricula to promote informed decision-making and empower young people to make healthy choices.
6. Conduct regular community outreach events and campaigns to raise awareness about SRMH issues and reduce stigma surrounding reproductive health.
7. Establish support groups or peer education programs for women and adolescents to facilitate open discussions about SRMH concerns and share experiences.

Recommendations for Government:

1. Enhance collaboration between CIC, Naripokkho, CARE, and health service providers in the camp.

2. Regularly update and review the referral systems to minimize delays in ANC and PNC services. Simplify and streamline the referral process to ensure timely access to specialized SRMH services.

3. Ensure the attendance of concerned health service providers in the monthly meetings.

4. Allow scopes for the beneficiaries to be a part of the monthly meetings alongside the health service providers and relevant NGOs.

5. Establish a robust monitoring and evaluation framework to track the performance of SRMH service providers.

6. Introduce a feedback mechanism for camp residents to report on the quality and accessibility of health services.

7. Ensure transparency in the allocation and utilization of resources dedicated to SRMH services.

Recommendations for Naripokkho:

1. Ensure that the study findings are disseminated widely through various channels, including policy briefs and community outreach events, to maximize their impact and relevance.

2. Foster partnerships with local healthcare providers, NGOs, and government agencies to maximize existing resources and expertise in the field of SRMH research and programming.

3. Encourage healthcare facilities (HCFs) to send one of their representatives during follow-ups, counseling, awareness-raising, and visits to beneficiaries.

4. Facilitate the feedback and complaint submission mechanism and help build trust between FDMNs and HCFs.

5. Establish a robust monitoring and evaluation framework to track the progress and impact of the project, and to identify areas for improvement and future research priorities.

6. Allocate resources for sustainability planning to ensure that study findings are translated into actionable recommendations and long-term solutions that benefit women and adolescents.

7. Collaborate with the CIC and management to streamline the referral system, ensuring prompt access to ANC and PNC services.

Annexe 1: Questionnaire

Naripokkho

"Ensuring quality family planning and reproductive healthcare for women and youths"

Format for gathering complaints regarding sexual and reproductive healthcare

Name of Information collector/Surveyor:

Designation:

Name of Information provider/participant:

Age:

Women/Teenager

Name of head of household:

Relation with head of household:

Number of women's death witnessed in the past one year:

Number of child death witness in the past one year:

FNC number:

Block/sub-block:

Name of care provider organization:

1. Is the distance between your home and the healthcare center appropriate? If not, why?
2. To the best of your knowledge, what kind of services do your nearest health post/healthcare center provide?
3. What services do your healthcare center provide? Which services have you received?
4. What do you know about overall sexual, reproductive and maternal health?
5. Are health posts/ healthcare centers open during specific time periods?
6. To the best of your knowledge, do health posts/healthcare services have adequate medication and necessary machinery supplies?
7. Do health posts/healthcare centers have adequate airflows and light and is social distancing maintained? (Write in detail.)
8. Is there adequate privacy (for example: are there rooms with curtains, are tests conducted one by one)? (Write in detail)
9. Are there hygiene facilities for menstruation and menstrual regulation (abortion) services? What services have you received so far? (Write in detail)
10. What family planning services are available for married people? What services do you receive?
11. Do health posts/ healthcare centers force births and are any consent forms signed?
12. What type of maternal care is available during pregnancy and what is the quality of care?

13. Did you face any kind of postpartum complication at the health post or healthcare centers? (write in detail)

14. Is your preferred family planning method given priority when family planning services are provided? If so, what kind of service have you received?

15. Is there a way for healthcare services recipients to make their complaints known?

16. Write about the method of complaining you have seen in detail.

17. Are the healthcare centers adequate for women, youths and people with special needs?

18. Are healthcare providers sensitive in their behavior?

19. Are there services for women who have been victims of violence?

20. The opinion of the information collector/surveyor:

Annexe 2: FGD Guideline for women aged 46 and above

This FGD guideline for women aged 46 and above to assess the quality of SRMH services provided to FDMNs. Verbal consent has been taken from the group as a whole before starting the interview.

My name is ______________, and I have come to you on behalf of Naripokkho to talk to you about the SRMH services provided to you. As human beings, you have the right to receive services to protect your sexual, reproductive and maternal health and there are a number of government, non-government and international organizations that have taken the responsibility of protecting these rights. We are conducting a study to better understand how and where SRMH services are provided to you, what is the quality of these services, what facilities are available, and what problems you may have faced when receiving these services. It is very important for us to understand this so we can focus our efforts on providing you with the better services so that all your needs are met and to ensure that your rights are protected.

This is why we would like to hear from you regarding your knowledge and experience in receiving SRMH services and what, if any, barrieres you and your community may have faced. Please do not hesitate to respond in your own language. We have interpretation services, and our community volunteers are here to assist with translations from Rohingya to Bengali. Your names will not be recorded and your identities will be strictly confidential. I would like to tape this interview for the accuracy of my records but I will not tape anything without your permission. If you agree to participate in this discussion, then I will proceed.

Location of FGD:_____________________________________

FGD group: ____

Number of people in the FGD:___________________________

Position of FGD members:______________________________

Interviewer's name:___________________________________

Signature of the Interviewer:____________________________

Date of FGD: _______________________________________(dd/mm/yyyy)

Starting time of FGD:_________________________________

Ending time of FGD:___________________________________

The FGD will cover the following questions to explore the condition of rights-based SRMH services. These questions are meant to be conversation starters that should be covered and expanded upon as required. They serve only as guides to provide a degree of structure. The discussion is not meant to be restricted on these points only. Please expand and add as necessary.

Q1. Do you visit the HCFs in your camp? For what type of issues do you usually go to the doctors?

Q2. Do you have any other women of reproductive age in your household?

Q3. Do you share your SRHR knowledge with women of reproductive age in your household?

Q4. What contraceptives do you usually suggest to the women of reproductive age in your household?

Q5. Have you seen any cases of maternal death in your household or neighborhood?

Q6. Have you seen any women going to the hospital for abortion? Are you aware of any casualties related to this?

Q7. What type of problems do women face when receiving SRMH services?

Q8. Are there adequate follow-up mechanisms in place for patients receiving SRMH services, such as postpartum care or STI treatment?.

Q9. How effective are referrals to higher-level healthcare facilities for specialized SRMH services that are not available within the camp?

Annexe 3: FGD Guideline for women aged between 18 to 45

This FGD guideline for women aged 18 to 45 to assess the quality of rights-based SRMH services provided to FDMNs. Verbal consent has been taken from the group as a whole before starting the interview.

My name is ______________, and I have come to you on behalf of Naripokkho to talk to you about the SRMH services provided to you. You have the right to receive services to protect your sexual, reproductive and maternal health and there are a number of government, non-government and international organizations that have taken the responsibility of protecting these rights. We are conducting a study to better understand how SRMH services are provided to you, what is the quality of these services, what facilities are available, and what problems you may have faced when receiving these services. It is crucial for us to understand this so we can focus our efforts on providing you with the better services so that all your needs are met and to ensure that your rights are protected.

This is why we would like to hear from you regarding your knowledge and experience in receiving SRMH services and what, if any, barrieres you and your community may have faced. Please do not hesitate to respond in your own language. We have interpretation services, and our community volunteers are here to assist with translations from Rohingya to Bengali. Your names will not be recorded and your identities will be strictly confidential. I would like to tape this interview for the accuracy of my records but I will not tape anything without your permission. If you agree to participate in this discussion, then I will proceed.

Location of FGD:_______________________________________

FGD group: ____

Number of people in the FGD:____________________________

Position of FGD members:________________________________

Interviewer's name:_______________________________________

Signature of the Interviewer:_______________________________

Date of FGD: ____(dd/mm/yyyy)

Starting time of FGD:_____________________________________

Ending time of FGD:______________________________________

The FGD will cover the following questions to explore the condition of rights-based SRMH services. These questions are meant to be conversation starters that should be covered and expanded upon as required.They serve only as guides to provide a degree of structure. The discussion is not meant to be restricted on these points only. Please expand and add as necessary.

Q1. How many children do you have, and what are their ages?

Q2. What contraceptives do you use?

Q3. Do you choose the contraceptive measure by yourself?

Q4. What SRMH services do you receive from the HCFs?

Q5. What problems do you encounter while receiving SRMH services?

Annexe 4: FGD Guideline for adolescent girls aged between 13 to 17

This FGD guideline for adolescents aged between 13 to 17 to assess the quality of rights-based SRMH services provided to FDMNs. Verbal consent has been taken from the group as a whole before starting the interview.

My name is ______________, and I have come to you on behalf of Naripokkho to talk to you about the SRMH services. You have the right to receive healthcare services to protect your sexual, reproductive and maternal health and there are a number of government, non-government and international organizations that have taken the responsibility of protecting these rights. We are conducting a study to better understand how SRMH services reach you, what facilities are provided to you, what quality of these services, and what problems you may have faced when receiving these services. It is very important for us to understand this so we can focus our efforts on providing you with the better services so that all your needs are met and to ensure that your rights are protected.

This is why we would like to hear from you regarding your knowledge and experience in receiving SRMH services and what, if any, problems you may have faced. Please do not hesitate to respond in your own language. We have interpretation services, and our community volunteers are here to assist with translations from Rohingya to Bengali. Your names will not be recorded and your identities will be strictly confidential. I would like to tape this interview for the accuracy of my records but I will not tape anything without your permission. If you agree to participate in this discussion, then I will proceed.

Location of FGD:______________________________________

FGD group: ____

Number of people in the FGD:_____________________________

Position of FGD members:________________________________

Interviewer’s name:______________________________________

Signature of the Interviewer:_______________________________

Date of FGD: ____(dd/mm/yyyy)

Starting time of FGD:____________________________________

Ending time of FGD:_____________________________________

The FGD will cover the following questions to explore the condition of rights-based SRMH services. These questions are meant to be conversation starters that should be covered and expanded upon as required. They serve only as guides to provide a degree of structure. The discussion is not meant to be restricted on these points only. Please expand and add as necessary.

Q1. Do you have any female members in your family who are older than you?

Q2. From whom did you first come to know about menstruation?

Q3. Do you visit hospitals? What issues do you usually go to visit the doctor for?

Q3. Are you provided with any SRMH awareness sessions by hospitals?

Q4. What do you use during menstruation?

Q5. Are you given any hygiene products by hospitals?

Q6. What type of problems do young women face when receiving services from HCFs?

Endnotes

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[47] For this project, the Center partnered with CARE Bangladesh and national level partners Naripokkho and Bangladesh Legal Aid Services Trust (BLAST). The Center's commitment to collaborating with national-level organizations underscores its dedication to achieving goals with ownership, sustainability, and legitimacy.

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