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Sexual and Reproductive Health Conditions of Women: Insights from Rohingya Refugee Women in Bangladesh

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Abstract

Introduction The Rohingya refugee influx in 2017 was one of those events that attracted the attention of the international community. With this refugee influx, Rohingya women's sexual and reproductive health (SRH) conditions have been greatly affected. This study aims to find out the condition of Rohingya refugee women's sexual and reproductive health in terms of contraception, sanitation, and hygiene.

Methods A qualitative research approach was applied to conduct the research. For primary data, semi-structured questionnaires were conducted with 50 in-depth interviews, a focus group discussion (FGD) consisting of 10 respondents, and three key informant interviews (KIIs).

Results The results of the study revealed that their sexual and reproductive health is being affected, how non-governmental organizations (NGOs) and the government are strengthening their sexual and reproductive health, and what the current scenario of their SRH is.

Conclusion The results concluded that their SRH conditions are improving from the initial crisis stage, but many factors like gender-based violence and patriarchal society impacts are continuously affecting their SRH continuously.

Policy Implications Sexual and reproductive health is also included in social policy implications. Rohingya women refugees are part of migration and the world's biggest humanitarian crisis. Where social policy implies involvement in meeting societal needs, education, health, migration, poverty, and other crucial global factors, ensuring the safe and better sexual and reproductive health of Rohingya refugees is certainly one of them. Ensuring their better health, easy access to sexual and reproductive health care products, and not being harmed or judged while ensuring and prioritizing their SRH is a major and crucial concern in social policy.

Keywords Sexual and reproductive health · Contraception · Gender-based violence · Rohingya refugee women · Sanitation · Hygiene

Introduction

More than 700,000 Rohingya entered Bangladesh in 2017 during the ethnic cleansing in Myanmar (Faye, 2021). About 52 percent of women entered Bangladesh, where they were subjected to a variety of violations, and they may require special care and attention in terms of their health, as well as their sexual and reproductive health (Karin et al., 2020). Forcibly displaced Rohingya women and girls face a range of sexual and reproductive health (SRH) concerns, including increased risks of maternal morbidity, mortality, and sexual and gender-based violence; higher risks of sexually transmitted diseases; higher risks of unintended pregnancy; and higher risks of unsafe abortion, with its associated complications (Ahmed et al., 2019). Rohingya women were raped in Myanmar, physically tortured, and became pregnant during their arrival. The population is increasing every day, and contraception prevalence is very much needed to reduce this population growth for their own betterment as well. Frequent pregnancy, a high risk of STDs, and physical violence can all have an impact on their SRH (Ahmed et al., 2020; Haar et al., 2019).

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Access to sexual and reproductive health (SRH) care is both a right and a critical need, yet in crisis situations, when vulnerabilities are drastically increased, a lack of sexual and reproductive health care is a leading cause of death, disease, and disability among displaced women and girls of reproductive age (Women's Refugee Commission, 2019). Rohingya refugee women can suffer the same. Poor sexual and reproductive health contributes to maternal mortality and morbidity, reproductive tract, and sexually transmitted diseases such as HIV, casualties, and severe health consequences as a result of unsafe abortion (Jeffries et al., 2021). On the other hand, being raped in Myanmar and also in the refugee camps violates the sexual and reproductive health rights of Rohingya adolescents. The non-use of contraception is increasing their population by a huge number every other day, and also, the rate of HIV and sexual transmitted diseases can increase among them. However, not having a proper sanitation system and a hygienic environment can make them suffer in every stage of violating their SRHR (Joarder et al., 2020).

At the start of this crisis and in the recent phase of their crisis, their situation regarding health and SRH may not be the same, but undoubtedly, their SRH is very crucial to their overall well-being and the violation of their sexual and reproductive health rights (SRHR) is a violation of human rights as well. Refugees' need for and importance of proper SRH is as great as that of women not living in crisis, so a refugee's SRH should be ensured properly in their crisis. This study will also come up with their present scenario and suggestions to solve it.

Background of the Study

The World Health Organization has identified universal public access to sexual and reproductive health (SRH) care as a global health priority (World Health Organization, 2022). Additionally, it plays a crucial role in achieving Sustainable Development Goals 5 (gender equity) and 3, which aim to ensure everyone's health and well-being (Davidson et al., 2022; United Nations, 2015). SRH is a significant public health need in all communities, including those facing emergencies (Tang et al., 2020). Women's health services, particularly preventative SRH care, including contraception, are frequently unavailable or of a quality that does not match the World Health Organization framework for human rights standards in countries that the World Bank classifies as low-income (Cottingham et al., 2010; The World Bank, 2020).

From August 2017 to present, an estimated 918,841 Rohingya refugees have arrived in Bangladesh's Cox's Bazar District from Myanmar (Humanitarian Response, 2022). Due to the increasing number of Rohingya refugees and their congested living conditions in camps, there has been an overwhelming increase in their health risks, especially for women, as the majority of them are women and children. With so many existing problems in the Rohingya camps, lack of hygiene, better sanitation, and less usage and awareness of contraception are harming their sexual and reproductive health both directly and indirectly (Ahmed et al., 2020). Adolescent Rohingya girls and women who are of reproductive age are in desperate need of SRH services, including pregnancy care, childbirth assistance, postnatal care, family planning services, menstrual health, safe abortion, and prevention and management of sexually transmitted infections, including HIV/AIDS (Aktar et al., 2020). About 85 percent of the refugees still do not have access to latrines, which in turn increases the risk of a communicable disease outbreak. A high rate of women reported women facing problems accessing latrines overall, particularly in Kutupalong compared with Teknaf, with the main problems being a lack of gender-segregated latrines and a lack of cleanliness (Islam & Nuzhath, 2018). Without access to electricity, clean water, and latrines, women must resort to walking into jungles in the dark, leaving them susceptible to harassment, violence, and contracting diseases (Karin et al., 2020).

Hossain and Dawson (2021) reported that there are 316,000 Rohingya women of reproductive age, 63,700 pregnant women, and a grave risk and reality of gender-based violence. Women who deliver children born of rape often experience another trauma of being shamed and ostracized, and those who contract HIV and other sexually transmitted infections face social marginalization. Another issue which is affecting or may affect their health in the long run is not using contraception or less usage of contraception. More than 60 Rohingya babies are born in Bangladesh refugee camps every day. Their adolescents have more than five children by the age of 22. Physical relationships without condoms increase the rate of HIV and other sexually transmitted diseases. On the other hand, frequent pregnancy hampers their health with many health issues (Islam et al., 2021a, 2021b). They suffer from a number of significant problems and difficulties, including gender-based violence, being abandoned by their husbands in the camps, early marriage, teenage pregnancies, and a lack of safer pregnancy and childbirth services (Yousuf et al., 2021).

The Rohingya women can get out of the circumstances by having access to basic necessities, educational opportunities, with a focus on sexual and reproductive health, addressing issues like gender equality, relationships, and conflict management. In these circumstances, there is a clear need for provision and access to consistent, reliable, and effective sexual and reproductive health (SRH) services that save lives and promote resilience in humanitarian contexts. There are many factors which can affect and contribute to a woman's SRH, but this study focused on some specific sectors. The objective of this study was to explore the existing sexual and

reproductive health conditions of Rohingya women in the light of sanitation, hygiene, and contraception and to determine if any other factors can affect their SRH. Furthermore, this study investigated the current interventions of NGOs and governments to improve their SRH and reviewed how their conditions can be improved.

Research Questions

The research questions of this study, which the research is willing to find out, are:

1. What are the major problems they are facing with regard to their sexual and reproductive health?
2. Are the existing SRH services efficient enough to provide adequate services?
3. What can be done to improve the SRH conditions for the Rohingya refugee women?

Significance of the Study

This study will help the communities know their sexual and reproductive rights and how to keep their SRH well in terms of a healthy life. This study will reflect the recent scenario of SRH in some Rohingya refugee camps and how everyone is working to achieve better SRH. This study will help policymakers or officials formulate potential policies for improving the condition of Rohingya women. If NGOs or the government want to build up projects for them, this study can help them to understand Rohingya women's conditions and may give them guidelines as well. Better sanitation systems and hygiene practices are critical for women. However, they are the ones who suffer more from these issues, and not maintaining hygiene can create menstrual problems. This study will help other researchers and project makers to know the situation of their sanitation and hygiene and may contribute to these sectors as well.

Theoretical Framework

The condition of Rohingya women's sexual and reproductive health is related to the World Health Organization's health determinates. According to WHO, many factors combine together to affect the health of individuals and communities. Whether people are healthy or not is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health (World Health Organization, 2017).

The determinants of health include:

1. The social and economic environment
2. The physical environment
3. The person's individual characteristics and behaviors

In terms of these three determinants of health by the World Health Organization (WHO), the practices and conditions of Rohingya refugee women's sexual and reproductive health can be measured. Rohingya refugees live in vulnerable social and economic environments because of this great crisis and being displaced from their own country and belongings. Their physical environment is not the same as before and may have a huge impact on their sexual and reproductive health conditions. On the other hand, one's personal characteristics and behavior can contribute a lot to her SRH condition, and as they are in a vulnerable situation right now, their individual characteristics and behavior may change according to the environment. These determinants by WHO can be used for better finding and understanding.

Education, water and sanitation, health care services, and living and working conditions are all aspects of Rohingya women's SRH. On the other hand, water and sanitation have more to provide in anyone's SRH. It can affect one's menstrual hygiene, the hygiene needed in the pregnancy period, and after childbirth (Siddiqi, 2021; Yousuf et al., 2021). Safe water keeps waterborne diseases at bay, and maintaining hygiene can help them live a healthy life in the future as well. These services provide better antenatal care, postnatal care, and delivery facilities than those provided in camps. Because camps may have midwives for these services, health care can provide them with professional doctors and nurses for their better treatment in any situation. Their living conditions also pay into their SRH. Because they are in camps, and the camps may not provide a better environment, including safety and cleanliness, many girls may not feel safe at night because of the fear of being raped, and most of the latrines and houses may not be cleaned properly for the huge population and less space (Health Cluster, 2020; Sarker et al., 2020).

The Hyogo Framework for Action identifies priority actions before an emergency across all sectors; the minimum initial service package (MISP) recommends priority SRH activities during an emergency, and the Granada Consensus builds from the emergency response to identify priorities for action in protracted crises and recovery (UNHCR, 2012). The priorities are:

> Priority 1: Incorporate SRH into multi-sectoral and health emergency risk management policies and plans at national and local levels.

Priority 2: Integrate SRH into health risk assessment and early warning systems for communities and vulnerable groups.
Priority 3: Establish a learning and awareness environment.
Priority 4: Identify and mitigate risks to vulnerable communities and SRH services by addressing underlying risk factors.
Priority 5: Prepare existing SRH services to absorb the impact of emergencies, adapt to them, respond to them, and recover from them.

In terms of these five priorities identified by the Hyogo Framework, the SRH conditions of Rohingya can be measured and improved. Incorporating SRH into health emergency risk management policies and plans can improve a woman's SRH along with her other health emergencies and needs. Rohingya refugees came from a dangerous conflict and ended up vulnerable as refugees in Bangladesh, so in this emergency crisis there, SRH may need special attention. These vulnerable women refugees may need learning, help, awareness, and environmental facilities so that they can be assured that their SRH is in a good state. By reducing the underlying risk factors, the vulnerabilities of SRH for vulnerable communities must be ensured. Rohingya women refugees may need better SRH services so that they can recover well from emergencies.

Methodology

Research Method

This research has followed a qualitative research method. However, regarding this issue, there are few studies that have taken place. With the aim of exploring more of the research questions, a qualitative method was chosen so that women could share their experiences and problems elaborately. To emphasize the situation and understand their experiences, qualitative data has been used and, in doing so, Rohingya women and adolescents (both married and unmarried) came up with their bitter stories and very few positive scenarios regarding their sexual and reproductive health.

Sample Size and Sampling Procedure

In this study, semi-structured interviews were conducted with 50 Muslim women from three camps who had migrated from Myanmar to refugee camps in Bangladesh. Participants were primarily recruited by marital status as well as through purposive sampling. All participants were aged between 16 and 42 years. The study was conducted in three Rohingya refugee camps to collect data. A total of 50 interviews (22 unmarried respondents and 28 married respondents) and one FGD consisting of 10 participants were conducted for this study. In camp 15, the researchers took 22 interviews and held one focus group discussion with 10 women. In camp 16, the researchers took 10 interviews, and finally, in camp 1 east, the researchers took 8 interviews of both married and unmarried adults and adolescents in every camp. This research followed a purposive sampling method. The researchers chose members of the population to participate in their study; they were married with children, married with no children, and unmarried adolescents and women.

Study Area

This study was conducted in Rohingya camp 1 east, camp 15, and camp 16—three settlements of Rohingya refugees. The study area was located at Kutupalong (Ukhiya district of Cox's Bazar), Jamtoli (Ukhiya), and Potibunia (Ukhiya). Camp 1 consists of a huge number of refugees' and half of them are women and children. So, contacting women in this camp was feasible enough to collect better data. On the other hand, camps 15 and 16 were not huge like camp 1 but living in a comparatively smaller camp made the women share their experiences even better. As the researchers got easy access to Rohingya women and adolescents in these three camps, so these camps were chosen. Primary data was taken for a better understanding of the issue. And the study area was chosen based on its poor living conditions and the presence of challenging services.

Tools of Data Collection

For this study, the data was gathered from both primary and secondary sources. The tools which were followed for collecting the secondary and primary data are as follows:

The researchers used both IDIs and FGD. The reasons behind conducting both IDIs and FGD were intentional by the researchers to some extent. In IDIs, refugees got to share their personal trauma and experiences, but when they got the opportunity to speak in FGD, they realized some others are in the same pain, and on the brighter side, some are satisfied with their SRH. Sharing their experiences with everyone made their voices bold and powerful, and it made them realize they needed to take care of their SRH for their own betterment.

IDIs

An in-depth interview effectively gathers detailed information on a specific topic beyond the initial and surface-level answers (Sifat et al., 2022a). The researchers conducted 50 in-depth interviews (IDIs) using non-probability purposive sampling. Non-probability purposive sampling was used for

in-depth interviews (IDIs), which were performed among the 50 respondents who participated in this study. The researchers conducted two field interviews in order to improve the questionnaire's design. The interview questionnaire was selected and designed by the researcher to adjust to the situation. It is common in qualitative research to alter interview criteria after the initial interview (Hecht et al., 2019; Sifat et al., 2022a). During the interview, the researcher ensured high levels of privacy and the respondent's confidentiality. Semi-structured questionnaires were followed by in-depth interviews that lasted anywhere from 33 to 60 min per interviewee. As mentioned before, the interviewees were fully assured of their privacy concerns. In order to protect that, interviewees' names will not be mentioned in the survey findings. Those who were skeptical about their experiences being recorded were assured that their data was not being recorded; rather, it was written down. The facial expressions, frightening eyes, vocal intonation, and bursting into tears made observing their situations even better.

Focus Group Discussion

Focus group discussion (FGD) is a good way to meet people from similar backgrounds to discuss the topic of interest (Sifat & Shafi, 2021; Sifat et al., 2022b). Participants were selected through non-probability purposive sampling based on their availability during the data collection period. The respondents were guided by a facilitator who introduced topics for discussion. At the same time, the facilitator distributed a semi-structured questionnaire to all participants. The study was conducted with one FGD, including 10 participants.

KIIs

Key informants interviewed were one camp in charge officer (CiC), one NGO activist from a renowned international NGO, and a government clinical psychologist. The CiC officer was questioned about the SRH situation in his camp, according to his perspective. Also, he brought up some unknown stories and horrible experiences regarding SRH and gender-based violence taking place regularly in his camp. Also, he suggested some way outs and ensured that he and his team were working religiously to improve the situation for women. Another long conversation with the NGO activist shed light on the current SRH situation of Rohingya women and how his organization is dealing with gender-based violence. Also, his organization is working really hard to change the SRH situation, and they are putting emphasis on educating Rohingya men to get educated on their female family members' SRH conditions. Not only that, but the conversation also brought up how crucial sanitary napkins are for maintaining hygiene and providing contraception for SRH, and how they are trying to cover every woman in the camp. On the other hand, the clinical psychologist shared her heartbreaking experiences dealing with harassed women and girls. The perspectives and suggestions of the CiC officer, NGO activist, and clinical psychologist were taken into account since they had their own real-life experiences and expertise regarding this issue. All the interviews were carried out with informed written consent, and the respondents were informed.

Inclusion and Exclusion Criteria of Secondary Data

Secondary data was used in terms of theme, pattern, and perspective. The data was compared and contrasted using these themes and patterns, which were linked to relevant literature. The secondary data was collected from articles, newspapers, research studies, and websites. This paper used secondary survey data to triangulate the interpretative approach for verification and reliability for comparable results in a broad setting. Therefore, the researchers searched published studies and literature of Google Scholar, PubMed, Scopus, and Web of Science for population-based original studies. The initial search was executed using a combination of the following terms: "sexual and reproductive health," OR "contraception," OR "gender-based violence," OR "Rohingya," OR "refugee women," OR "sanitation," "hygiene," OR "Bangladesh." The studies included in the quantitative and qualitative analyses, review articles, and reports highlighting various sexual and reproductive health issues. In order to minimize the incidence of missing articles relevant to this scoping review, the researchers did not filter by year during our search. Conference proceedings, non-English publications, and studies were also eliminated, where the entire paper was unable to be accessed.

Data Analysis

QSR International's NVivo 12 was used for the data management and analysis process. Through the interviews, FGDs, the field-level research assistant transcribed and prepared the transcriptions from interviews, FGDs, and quoted the respondents' unaltered speeches as "verbatim." We adopted triangulation approaches to ensure data accuracy, validity, and reliability. While the data was being collected, the researchers visited the study area to investigate without prior discussion to maintain investigator triangulation guidelines. Simultaneously, to achieve high study quality, we collected data through three channels, such as IDIs, FGD, and KIIs as a data source triangulation process. Researchers transcribed the interview recordings in Bengali and then translated them into English. Researchers ensured that the transcriptions were accurate compared to the recordings. Translations were then cross-checked, and the relevant information was

summarized. The data was coded and categorized based on the responses, and thematic analyses were carried out. Along with the analysis of primary data, researchers also conducted content analysis. Researchers avoided any sort of bias or judgments about the respondents' experience while collecting and analyzing data.

Ethical Consideration

All the interviews have been carried out with informed written consent, and the respondents were informed. All procedures performed in studies involving human participants followed the ethical standards with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Results

Impact of Disbelief and Knowledge

Disbelief and lack of knowledge play a major role in determining one's sexual and reproductive health conditions. Throughout the data collection, these two terms appeared in every other woman. Exploring more deeply, it was visible that religious disbelief, not achieving any sex education, and overall illiteracy regarding sexual and reproductive health issues are some strong reasons for falling back.

Lack of Knowledge

As the Rohingya community did not receive any family planning earlier in their country, they are much more unaware of how to plan a family, how to maintain their sexual and reproductive health, and contraception as well. When a person grows up in a community where SRH awareness is lacking, it is likely that the person, like the Rohingya woman, has a lack of knowledge about the subject (Islam et al., 2021a, 2021b; Khan et al., 2021a, 2021b).

Throughout the interviews, only training was received by Rohingya women about what SRH is and its importance to their health. This training is provided by many NGOs, such as BRAC and RTM International. In the case of sexually transmitted diseases (STDs), most women are unaware of how they affect them or how they are transmitted. On the other hand, some Rohingya women are hesitant to seek treatment for SRH or STDs.

According to their perception, if anything happens to them, there are so many medical services and doctors to cure them. Regarding clean latrines and hygiene, the findings are mostly negative. We are less aware of menstrual hygiene and its impact on SRH, and many of them are likely to not clean their latrines as they are not that bothered by it. Sadly, we found few women who miss their menstrual cycle regularly and some who have been missing it for a long time are very reluctant to visit the doctors as they feel it is not a problem at all. On the other hand, some NGOs provide special sanitary napkins for 25 taka (10 pieces), but they sell them out in the market as they lack knowledge of their importance.

Religious Beliefs

Most women assume that God will be angry if they use contraception while in physical relations with their husbands. They believe that a child is a gift from God, and they must not oppose it. In the case of using contraception, they stated that they do not have a voice in this case because, as they are Muslim, it is their duty to please their husband and follow the instructions given by their husband. Some of them also shared their perceptions that, as a Muslim wife, if they do not obey their husband, it will be written as a sin. On the other hand, when the issue of consent took place, the answer was still negative. According to them, their husband holds the ultimate power over their bodies, so how does this consent make sense? Sadly, most of the Rohingya girls are wed off at a very early age or just after their menstruation. The belief under this ritual is that as they are getting out of their puberty stage, we should get married soon so that they can get rid of illegal relationships, societal teasing, and other sins.

While interviewing many women with different perspectives, some shocking behaviors were revealed in the name of so-called religion. One Rohingya woman said:

> The bathrooms are not so near to my house. I have to walk a long way alone to take a bath. When I go to the bathroom, I have to wear my Burkha, and I have to do the same when I come back. I cannot put off my burkha for a minute outside. Along with the burkha, sometimes I have to wear gloves (hand socks) to be more protected and obey my religion. And maintaining this, I sometimes do not take a bath and hold my urine during menstruation. (Unmarried, age 23)

Dr. Bhattyacharya (pseudonym), who is currently working for an NGO in Bangladesh, said that:

> Many women do not want to step outside of their homes because of their conservative perceptions. To maintain this perception, they do not take baths regularly. As a result, they suffer from various kinds of skin diseases, such as ringworm. And also, to maintain religious beliefs, they sometimes do not open up about their menstrual problems and STDs as they think it is not appropriate in their religion.

Gender-Based Violence

The most common reason besides violating one's sexual and reproductive health and rights (SRHR) and effecting one's SRH is gender-based violence. Gender-based violence (GBV) holds a huge portion of women in camps, suffering both mentally and physically. There are numerous cases of GBV in every case. Starting from being beaten up after marriage to having a permanent disability, women are suffering every day. Some basic GBV cases which affect their SRH are forced sex, sex during menstruation, forcible abortion, rape, harassment, etc. (International Organization for Migration, 2019; Tirado et al., 2020).

A Rohingya woman named Sajeda (pseudonym) expressed her grief by saying that:

> I was on my period when I got married. My husband forced me to have physical relations, knowing my severe condition. I refused to cooperate with him, but consent does not matter in our case. The next morning, I got taunted by my in-laws and my husband's friend for not having a proper physical relationship on my wedding night. That day I got bullied and harassed by my in-laws, and that night I could not survive my husband's desire. (Married, age 28)

This is not the only case of GBV violating their SRH and SRHR every other day. Taking no consent before physical relations, forcible abortion, and rape are making their lives more vulnerable.

Nur Nahar (pseudonym) expressed her grief over the loss of her child. She mentioned:

> I and Kalam (pseudonym) fell in love while volunteering for an organization. After a few days of talking over the phone, we started our relationship. I was being provoked by him to have a physical relationship, unfortunately without protection. Because of not using any kind of protection, he got myself pregnant with his child. I wanted to get married because of our child and this conservative society, but I was betrayed. I was forcefully miscarriage my own child, even without my knowledge and consent. After a few years, I regained my trust in him and we started our relationship again. At this time, there was nothing different than before. This time I got beaten up for forcing an abortion. To create a respectful image in society, he made a false 'Nikahnama' (Islamic Marriage Contract), and my life got a new chapter full of domination and abuse for being his wife. (26 years old)

Khaleda (pseudonym), a 18-year-old teenage girl, was betrayed and almost got into the trap of human traffickers. She expressed with a terrified voice that:

> I got married to Shahid (pseudonym) in Kutupalong camp. He lured me that we had a better future outside the camp, and we left the camp. He marched to India with me with the help of a broker. I found myself pregnant after reaching India. My miseries started right after I announced myself pregnant. My husband pressured me to get our child aborted. Not only that, but he also threatened me with getting murdered or being sold to some brothel in India. His attitude and behavior shook my soul badly. I got frightened and unwillingly aborted my child. Even sacrificing everything could not make my husband accept me like he did before. Like a coward, he left me in India and returned to camp alone. I spent the most traumatized days there, living alone with fear and helplessness. Fortunately, I had some of my relatives' contact numbers memorized. Later, they rescued me with the help of an organization and took me back to camp. (Married, age 18)

Some women claimed that they took "Depo" (Depo-Provera, a contraception method for women) without informing their husbands or in-laws. They feel frightened of their husbands because if the husbands get to know about this, they will face heinous violence.

Cases are worse if a woman has a drug-addicted husband. Every day, drug addict husbands abuse their wives, and forced sex takes place during menstruation. The scenario for unmarried adolescent girls is not satisfactory either. Unmarried girls face physical abuse, rape by strangers and known people, and forcible abortions every now and then. Unfortunately, the cases of abortion and rape do not get reported because of family honor violations. Unmarried girls get into illegal relationships and end up pregnant. As after getting pregnant, the boy does not want to meet his responsibilities, so she has to abort his child forcibly. On the other hand, the girls do not get post-abortion care or treatment.

The camp in charge officer of Kutupalong said that:

> Rohingya men hardly consider women as a human but a product for their physical desire. They do not feel sufficient with one woman in their life, so they started polygamy. Rohingya men do not care about their wife's health or consent; they only believe their wives are for their enjoyment.

Scenario of Maternal Mortality

The maternal mortality rate in Rohingya refugee camps in Bangladesh is significantly lower than in other refugee camps. In a study by Parmar et al. (2019), fifty-two maternal deaths occurred between September 2017 and August 2018 in the Rohingya refugee camps in Ukhia and Teknaf Upazilas, Cox's Bazar District, Bangladesh. Back in Myanmar, the

Rohingya people suffered a lot with their health care facilities as they were expensive and way far from their locality. But here in refugee camps, the health care facilities are much more available and developed. UNFPA was determined to improve SRH services and prevent maternal mortality cases by making emergency obstetric care available, establishing a 24/7 referral system, providing clean delivery kits to skilled birth attendants and visibly pregnant women, and ensuring community awareness of services (Parmar et al., 2019).

An NGO activist, Rahman (pseudonym), stated that:

> Rohingya women and adolescents are really fit and strong physically, so they can cope with the labor pain and stay strong during their pregnancy. Along with better medical services from different hospitals and NGOs, it is one of the major reasons for the lower maternal mortality rate in Rohingya refugee camps.

Impact of Societal Influences

Every human being belongs to a society. Whether we like it or not, society influences our upbringing, behavioral patterns, perspectives, and so on. In terms of Rohingya refugees' sexual and reproductive health development and overall condition, these norms, values, and patterns paid a lot, or it can be said these terms shaped their sexual and reproductive health to some extent.

Cultural Norms

In terms of menstruation and its problems, girls are not free to talk freely about their condition. Most of the girls said that they do not discuss menstruation with their mother or any family members freely. In the case of extreme menstrual problems, they only share it with their mother, and sometimes, they are not allowed to take medications for it because to take medication they have to discuss it with the doctors, which they consider a cultural shame.

A 15-year-old girl in the Jamtoli camp named Fatema (pseudonym) expressed her grief by saying that:

> I did not want to get married so soon. I had some dreams. I wanted to learn to sew in the coming days, but society was upset that I was not getting married at 15. My community started to pressurize my parents, and they fixed my wedding with a man from this same camp. I once refused to marry because of societal pressure, but I ignored it because of my parents' indifference. Without my consent, I got married, and after marriage, I came to understand that society also structured what a wife should do to her husband in terms of physical relations, having children, and everything else. (Married, age 15)

After coming to Bangladesh, our norms, such as no early marriage, fewer children in the family, and using contraception, seemed new and unusual to them. It took time to get accustomed to our societal norms and the training of SRH, WASH, and others for their betterment. Rohingya refugees faced less linguistic challenges as the language of them and our dialect of Cox's Bazar is quite similar. On the other hand, our culture was not so familiar to them. Similarly, our Rohingya adolescents also feel that discussing about these issues are socially and culturally taboo.

Effects of Patriarchy Society

The influence of patriarchal society is so high in the Rohingya community that they do not have any decisions in their hands. In terms of contraception usage, most of the women stated that it is always their husband's decision. If the woman wants to apply for "Depo," she has to get the permission of her husband, and in most cases, the answer is a big no. Some women claimed that if they applied Depo without their husband's consent, they faced both mental and physical tortures. On the other hand, some women said that IOM provides condoms to women, but it is very shameful for them to collect condoms from IOM because it is a patriarchal society, and it is a matter of their family's honor as well.

Samina (25) (pseudonym) stated her grief by saying that:

> I got married to Yusuf (32) (pseudonym) a few years ago. As we are refugees now, we do not have our own income and are completely dependent on government and NGO-provided commodities. After coming to Bangladesh, I got to know about family planning through various NGOs, and for my family's betterment, I started to take birth control pills. I believed that my husband would be supportive enough to respect my decision, but I was very wrong. My husband reacted negatively when he got to know about my contraception and abused me for a long time. The violence was so severe that I had to get admitted to the hospital. Later, he divorced me and refused to get together with me again. (Married, age 25)

This is how their patriarchy society works that, every decision is in the hand of the male member, and a husband can divorce his wife for any issue as their society made them superior to do so. In the case of menstruation and the disposal of napkins, they are also concerned about patriarchal society. According to their patriarchal societal beliefs, a woman cannot dry out her menstruation clothes openly or in sunlight. If there is a man in the house, they have to hide all their menstrual clothes and sanitary napkins because it is a great shame if the male members get to see them. And this results in a bacterial attack on that cloth.

A Rohingya adolescent named Farmina (pseudonym) said that:

> I have to dry out my menstrual clothes secretly. When my father and brothers are outside, I dry them out in the sunlight, although that process has to be very careful. Once, my father saw my menstruation clothes and beat me, as our community is patriarchal, so our fathers should not see those. (Unmarried, 20)

Some women mentioned that if they have more male members in their family, it is difficult to dry out their menstrual clothes in the sun or openly inside their house. When the male members are outside of the house, they dry out their menstrual clothes. When faced with an emergency or any kind of disease or pregnancy complications, many women cannot visit doctors because their male family members do not allow them to do so. Most of the deliveries take place in their home with the help of midwives, but they are much more unwilling to visit doctors in their pregnancy period and for postnatal care. The patriarchal society pressure is another major reason of wearing Burkha while going to latrines. A woman's honor is in her husband or father's hand, so the male members are always being very protective and end up harming their SRH sometimes.

The Role of Mothers' in SRH

Mothers are considered a girl's best friend or best partner to share her personal hardships or happiness. A girl feels comfortable sharing her health-related matters and mental conditions with her mother. Unfortunately, when I asked adolescent girls whether they share their menstrual irregularities, mental breakdowns, and trauma with their mothers or not, and get solutions from them, most of the girls answered in the negative.

Mothers are not that concerned about their daughters' sexual and reproductive health. They cannot even talk about anything sexual before marriage, and after marriage, every responsibility she has is on her husband's shoulder, not her family anymore.

One of the respondents, Shakirun (pseudonym), said that:

> I have irregular menstruation and during menstruation I feel excessive cramps and an overflow of blood. I wanted to visit a doctor about this. My mother is really strict and not friendly with me, so I hesitated to share it with her, but when I did, she did not pay any heed, saying that, born as a girl, I had to face those pains. (Unmarried, age 17)

Barua (pseudonym), a government clinical psychologist, also shared that:

> In terms of gender-based violence or rape, a girl first runs out to her mother first and shares everything. But instead of complaining about the GBV cases or the rape cases to the authorities, she remains silent as she believes it is a shame for her family. So, the victim does not get any counseling that she might need at that moment. On the other hand, if a mother gets to know about rape, she suggests she take emergency pills and forget about the incident.

Scenario of Sexually Transmitted Diseases

Due to time limitations, we were able to only come up with limited information regarding sexually transmitted diseases. Many women just do not visit the doctor if they feel any STDs, and some others do not visit doctors just for shame.

According to Dr. Bhattyacharya (pseudonym), an NGO activist mentioned:

> The majority of the women of Camp 16 are affected by gonorrhea and leukorrhea. And the reason behind this is unprotected sex, as he stated. Other fungal infections such as vaginal candidiasis are also detected among Rohingya women. According to him, because of not maintaining personal hygiene and contraception, they suffer from these diseases. In the case of HIV, he said that in that camp there were fewer HIV cases detected, but patients with hepatitis B and C are being detected nowadays.

The scenarios of the other camps we visited were quite similar. They suffer from itchiness and gonorrhea quite often but are very unwilling to consult a doctor as they have less knowledge about these and how they can affect their SRH as well.

Scenario of Using Contraception

The reasons above contribute to using contraception in some ways. But the use of contraception increased among them. The hard work and efforts of NGO workers and volunteers made them realize the importance of using contraception and how it keeps their SRH well.

According to the CIC officer of camp 16:

> Initially, the birth rate of Rohingya infants was more than we could even control. But because of tremendous hard work and programs, we have declined the rate. 5–15% of women have started using contraception, and they are optimistic about family planning, and many are applying the family planning strategies in their real

life. And we are hopeful that the rate will increase in the near future.

IOM and UNHCR provide contraception to women, but the reasons discussed above make them not use it in a regular manner. They are more into applying Depo than other contraception. So, in three of the camps, we found that the contraception they are interested in using is Depo and, in some cases, emergency pills and condoms.

Scenario of Sanitation and Hygiene

The scenario of sanitation is quite satisfactory. Initially, they faced many challenges with sanitation, as it was an emergency crisis then. They had to use totally unclean latrines as many people had to use them and there was a shortage of latrines as well. At the time of menstruation, they faced tremendous problems. They had less space to wash their clothes and dry them out. Some of them said that they had to use damp clothes and had to stay in the same clothes for more than 7 h during their menstruation. Fortunately, their situation has improved a lot, and they can now use sanitary napkins, clean clothes, and have a sufficient number of latrines as well. However, the cleanliness of latrines is questionable as they are less likely to clean latrines and more likely to depend on others to clean them. Some women reported that using unclean latrines and vessels caused itchiness and discomfort during menstruation. Some women said that during their pregnancy they felt sick of the bad odor from latrines, and they faced difficulties using latrines when they were far from their home.

In terms of personal hygiene, most of them use soap after using the washroom, but they have to buy it on their own. Surprisingly, most of them know they have to change their sanitary napkin or cloth every 6 h, and they follow it. Moreover, they are in a better situation in terms of sanitation and hygiene than before.

Some Exceptional Cases

Amidst so many negative cases, tortures, and suffering, there were few cases where a woman was actually being cared for and her SRH was being prioritized.

Rahima Khatun (pseudonym) lives in Jamtoli camp with her husband and two children. She has been married for 7 years and has only had two children, which is unusual in their societal norms. After asking her about this issue, she said:

> I felt severe labor pain during my pregnancy. For a moment, I thought I would pass away from that pain. Labor pain was not the only thing I had to deal with, I had various health complications after my pregnancy, especially severe menstrual problems. Keeping this in mind, I requested my husband to use contraception and stop taking the child further. Initially, he hesitated about my request, but I consider myself fortunate enough that he understood my situation and accepted my request. Now, I am living a healthy and happy life with my husband and children. (Married, 26)

We also visited some houses where the women and the whole family were educated and knew about their SRH and SRHR. They are very much concerned about their health and so are their husbands. In terms of using sanitary napkins and maintaining menstrual hygiene, they are well aware and visit the doctor immediately if they feel any physical complications. Women from this well-educated family stated that they cannot have many children in this small space, and, having knowledge of family planning, they use contraception for their own good.

Improvement of SRH in the Last Two Years and Initiatives

SRH conditions were much more vulnerable with so many pregnant women, raped women suffering from mental trauma, women getting pregnant for rape, no usage of contraception, less awareness, and insufficient sanitation facilities. Fortunately, the present situation in 2019 reflects that their situation in SRH has developed much more than in 2017. They are getting awareness programs and training to ensure their better SRH and the importance of contraception. On the other hand, the number and quality of latrines have improved a lot according to their perception. Even with their SRH conditions, contraception usage still faces many kinds of challenges, but undoubtedly, it has improved a lot.

NGOs like BRAC, RTM International, Plan International, and many others are providing training for women and making them aware of their SRH and its betterment. For women and adolescents, there are "women friendly spaces" and "adolescent friendly spaces" that are constructed where women and adolescents can talk about their well-being, daily life scenarios, and problems, play games, learn sewing and drawing, and participate in other informative sessions for their overall well-being. There are also GBV sections in many NGOs who are committed to reducing GBV, and ensuring GBV does not affect their lives. Some NGOs, along with RRRC's help, conduct programs and trainings on how to keep their latrines clean and spread their importance as well.

Discussion

This study examined how the insufficient basic living conditions in the camp make Rohingya women and girls highly vulnerable to exploitation when it comes to SRH challenges. They reportedly experienced forced prostitution or were physically or sexually abused. Lack of income-generating activities in the camp puts women and adolescent girls at higher risk

of exploitation, including forced marriages, forced labor, and trafficking for commercial sexual purposes. The Rohingya refugees are really concerned about safe pregnancy and childbirth, even though there are maternal health care facilities in the camp. Their opinions on having children, family planning, and contraception are influenced by the social, cultural, and historical context. Due to ignorance or being prevented by their husband or mother-in-law, who are the major decision-makers on their attendance at the healthcare facility, they do not willingly go to the healthcare facilities for childbirth.

Due to a lack of access to education and healthcare services, their ignorance of HIV/AIDS and other sexually transmitted infections makes them more vulnerable to their illness (Ahmed et al., 2019). Even while lifesaving activities are currently given priority when providing SRH care at refugee camps, access to vital comprehensive reproductive, maternal, and newborn health services is still a significant problem because of community norms and traditions. It is crucial to educate them on issues like gender equality, pubertal changes and hygiene, relationships, as well as SRH and well-being (Khan et al., 2021a, 2021b; Pandit et al., 2022).

This study reflected that because of their vulnerability, transitions, and lack of information in traditional beliefs and cultures, providing comprehensive SRH services is subjected to particular problems in a refugee camp. Although quite a few partner organizations in the Rohingya refugee camps of Cox's Bazar are offering the minimum initial service package of SRH, access to inclusive reproductive, maternal, and newborn health services continues to be difficult due to inconsistencies in the implementation of the minimum package of health services that are being operated and approved by various authorities. It seeks to provide integrated, comprehensive services to address the immediate SRH requirements of Rohingya women and adolescent girls, who are extremely vulnerable. In terms of SRH awareness, many female members of the refugee camp thought contraception were prohibited by religion, and many more believed it led to infertility. In this study, the refugee women knew a little about pregnancy but not enough about sexual and reproductive health.

Recommendation

Recommendation for the Non-governmental Organizations

First, NGOs are doing a lot for the Rohingya refugees' and Rohingya women's sexual and reproductive health as well. In terms of making them aware of the importance of contraception, they can call for programs with both husband and wife to enlighten them with family planning strategies and contraception's importance. If both the husband and wife are aware of the significance, it may result in more positive effects and a better understanding between them.

Second, gender inequality and gender-based violence are harming women's SRH to a great extent. NGOs can convince women to report immediately after any kind of violence, without being frightened, so that action can be immediately taken against those who exploited her.

Third, the cultural stereotype that a woman has to accept every injustice just because she is a woman should be broken with proper programs and counselling. As Rohingya refugees are getting accustomed to our culture, we can put our positive norms into them so that they can cut off their stereotypes and respect women and their health.

Fourth, to end gender-based violence against women and harm their SRH, one important solution is to respect women. Rohingya men rarely respect their wives, daughters, or sisters and are less concerned about their health. Teaching about respecting someone is really tough, but programs related to this and letting people know about SRH and the pain a woman goes through can hopefully work to reduce gender-based violence cases as well as improve SRH.

Fifth, providing knowledge about SRH to the male members, such as husbands, brothers, and fathers, can contribute to women's SRH improvement. Knowledge about SRH should not only be for adolescent girls and women, but the male members of their lives should also be enlightened. If men get SRH knowledge, hopefully, they will understand its importance and help their female family members at home.

Recommendation for Government

First, Bangladesh has many challenges for its own citizens and welcoming this many refugees could make the situation even worse. Without controlling the population, the consequences may go out of control. In these circumstances, the government may revert to the family planning program strategy of the 1990s, where the family planning workers went door-to-door and made the couples aware of their health, better family planning, and STDs as well. If there is family planning, frequent pregnancy will stop, hopefully, and mothers will achieve better health conditions.

Second, in terms of the researcher's perception, some pregnant women or women facing any kind of disability may find it difficult to use latrines with Asian pans. So, for them, if there could be latrines with English pans, it would be better. So, the government should take this initiative to improve the situations of pregnant women.

Strength and Limitations of the Study

The strength of this study is huge. The positive and brighter sides of this study are that Rohingya refugee women understood and, to some extent, admitted that their SRH is important. Realizing the significance of SRH is crucial to maintaining better health and especially better SRH. Through this study, women got to know the consequences of unsafe abortion, not using condoms or any kind of protection, using unhygienic latrines, not maintaining menstrual hygiene and the consequences of STDs. Another major strength of this study is that, with the help of its findings, people can have knowledge about what the conditions of their SRH are and how much attention this topic needs in terms of their better health. People who are influential or who work for SRH can also come forward to improve their SRH conditions and empower them mentally.

The first and foremost limitation the researchers faced during this study was language barriers. Rohingya women speak in their own language, which is quite similar to the Chittagong dialect, so it was quite difficult to communicate with them as they do not know any other language except Burmese. Most women were shy about talking about these issues, as for them it is a very sensitive issue to share. For this reason, the researchers could not randomly ask women and many women. Opening up on this issue was another limitation of this study. Many women did not know about these terms and issues, so for them, it was a very new concept to talk about and they were not interested in talking about these issues. However, it is important to know whether they feel any problems with their existing sanitation services and whether they even feel the importance of hygiene for their health. Another major limitation the researchers faced was limited time for data collection. The Rohingya refugee camps are not nearby, and it takes so much time to reach them as the roads are not well constructed, so the researchers could not collect more data. It would be better if the researchers could get more time for data collection so that they could have taken interviews from more respondents. These were the major problems the researcher faced during this study.

Conclusion

Rohingya refugee women live in very vulnerable conditions, and their weak sexual and reproductive health can make their situation worse. Ensuring their better sexual and reproductive health is as important as providing them with their needed items like food and clothes. Strengthening their SRH can provide them with a better environment to live in, mental well-being, and better health, which is also a right for them. Although the SRH of Rohingya refugee programs has met with much success, there are still gaps remaining. In terms of sanitation and hygiene, as they can contribute to their SRH, special focus on them is also needed, and undoubtedly, better sanitation facilities help the women live a stress-less life and achieve better health. The researchers want to conclude this study by saying that improving the SRH of Rohingya women and adolescents can reduce their vulnerabilities and give them the opportunity to live a better life with better health conditions. Sexual and reproductive health is also included in social policy implications. Rohingya women refugees are part of migration and world's biggest humanitarian crisis. Where social policy implies involvement in meeting societal needs, education, health, migration, poverty and other crucial global factors, ensuring the safe and better sexual and reproductive health of Rohingya refugees is certainly one of them. Ensuring their better health, easy access to sexual and reproductive health care products, and not being harmed or judged while ensuring and prioritizing their SRH is a major and crucial concern in social policy. Future studies should be encouraged on how their SRH conditions have improved in all the camps. Also, enlightening men and boys regarding SRH can be a great deal, so that they will be aware of their own SRH and put emphasis on their spouse's, daughter's, and sister's SRH as well.

Author Contribution All the authors conceptualized and designed the study. SJ, RIS, and MK conducted the interviews, translated, and analyzed the data. SJ wrote the first draft and all authors have contributed to the final draft.

Declarations

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

Conflict of Interest The authors declare no competing interests.

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