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Removing Barriers and Closing Gaps:

Improving Sexual and Reproductive Health and Rights for Rohingya Refugees and Host Communities

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EXECUTIVE SUMMARY

In August 2017, widespread violence carried out with "genocidal intent" in Myanmar forced 745,000 Rohingya to flee to Bangladesh and settle in camps in Cox's Bazar.[1] Fifty-two percent of the refugee population there are women and girls.[2] Those of reproductive age are in dire need of emergency and longer-term sexual and reproductive health and rights (SRHR)[3] services. Many have additional needs related to sexual trauma experienced in Myanmar and/or in Bangladesh.[4,5] For many, these needs are not being fully met due to implementation and access barriers.[6]

In a July 2018 blog,[7] we detailed our recommendations for meeting SRHR needs for Rohingya refugees and host communities in Cox's Bazar. In March 2019, one of us (Schnabel) traveled to the Kutupalong refugee camp with the International Rescue Committee (IRC) to visit IRC-supported healthcare facil-

1 "Myanmar: Tatmadaw leaders must be investigated for genocide, crimes against humanity, war crimes – UN report," OHCHR, Web. 2 Jun. 2019, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23475&LangID=E.

2 "Rohingya refugee response gender analysis," Joint Agency Research Report, August 2018, https://reliefweb.int/sites/reliefweb.int/files/resources/rr-rohingya-refugee-response-gender-analysis-010818-en.pdf.

3 Defined by UNFPA as "a state of complete physical, mental and social well-being in all matters relating to the reproductive system." https://www.unfpa.org/sexual-reproductive-health.

4 "Myanmar's Hollow Denial of Rape of Rohingya," Human Rights Watch, 7 Feb. 2019. Web. 2 Jun. 2019. https://www.hrw.org/news/2019/02/07/myanmars-hollow-denial-rape-rohingya.

5 Joint Agency Research Report, gender.

6 Francisca Vigaud-Walsh, "Still at Risk: Restrictions Endanger Rohingya Women and Girls in Bangladesh," Refugees International, July 2018, https://static1.squarespace.com/static/506c8ea1e4b01d9450dd53f5/t/5b58d950562fa7945e42b7a0/1532549459128/Bangladesh+GBV+Report+-+July+2018+-+final.pdf.

7 Huang, Cindy and Liesl Schnabel, "Making Sexual and Reproductive Health Services a Priority for Rohingya Refugees and Host Communities," Center for Global Development, July 2018, https://www.cgdev.org/blog/making-sexual-and-reproductive-health-services-priority-rohingya-refugees-and-host-communities.

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ities and gather qualitative information on SRHR programming, including challenges in implementation and access facing Rohingya refugees and host communities. Based on this field visit, meetings with other organizations, and a review of relevant reports, this note provides an overview of key gaps in SRHR care in terms of access, capacity, data, and services.

Building on our findings, we make two recommendations to donors that would help drive progress in meeting the SRHR needs of refugees and host communities:

1. *Donors should encourage the government of Bangladesh to address key policy barriers to effective SRHR implementation and adopt a more coordinated approach to reduce them*. Specifically, donors should encourage: (1) access to long-acting reversible contraception (LARCs); (2) access to comprehensive post-rape care; (3) access to safe abortion and post-abortion care; (4) the ability to test for and treat HIV/AIDS in camps; (5) the ability for women to access family planning services without couple's registration; and (6) the ability to build effective and secure health facilities. Many barriers to effective and comprehensive SRHR care affect refugees and host communities and addressing them would support progress toward Bangladesh's existing health and family planning goals.

2. *Donors should increase financing to strengthen local health systems to meet the needs of both refugees and host communities*. There are currently health facilities that serve both refugees and hosts, but a strategy for further development of host community facilities is needed in the medium-term. Donors, including the World Bank and other development actors, should use development financing to help meet SRHR needs, including training health workers, strengthening infrastructure, and improving access to emergency care and hospitals.

In order to meet medium-term SRHR and other needs of refugees and hosts, all actors must facilitate and drive progress, including UN agencies, non-governmental organizations, and donors. In this note, we focus on recommendations for the donor community, as their support and engagement can be catalytic in encouraging policy change.

INTRODUCTION

August 2019 will mark two years since the beginning of the Rohingya refugee crisis in Cox's Bazar, Bangladesh. Currently, over one million Rohingya live in two mega camps, Kutupalong and Nayapara, with limited access to basic rights, including freedom of movement, livelihoods, and education. Conditions for safe, dignified, and voluntary return of the Rohingya to Myanmar do not exist. Even if repatriation started tomorrow, analysis suggests that many refugees would likely remain in Cox's Bazar for the next 10 years.[8] While continuing to push for repatriation conditions, it is critical for donors and other stakeholders to plan for the medium-term. In this note, we focus specifically on the sexual and reproductive health and rights (SRHR) of Rohingya refugees and host communities. Within the Rohingya population, there are currently over 304,000 women and girls of reproductive age, and approximately 30,000 pregnant women, all in need of comprehensive and effective SRHR care.[9] Given the significant amount of humanitarian funding for health, and funding committed by the World Bank and other development actors, donors can help to build and sustain a coordinated SRHR response.

8 Huang, Cindy and Kate Gough, "Toward Medium-Term Solutions for Rohingya Refugees and Hosts in Bangladesh: Mapping Potential Responsibility-Sharing Commitments," Center for Global Development, Feb. 2019, https://www.cgdev.org/sites/default/files/toward-medium-term-solutions-rohingya-refugees-and-hosts-bangladesh-mapping-potential.pdf.

9 UNFPA Bangladesh Situation Report, March 2019, https://bangladesh.unfpa.org/sites/default/files/pub-pdf/ext%20sitrep%20final%2025%20April%202019.pdf.

Access to effective and comprehensive SRHR care is linked to multiple fundamental human rights, including the right to health and the right to privacy.[10] Women and girls in displacement settings face extraordinary challenges, including life-threatening health risks. For example, in 2015, the United Nations Population Fund (UNFPA) estimated 61 percent of maternal deaths worldwide occur in fragile states, many of them affected by conflict and recurrent natural disasters.[11] The prioritization of SRHR in humanitarian settings is still a recent development; it was not until 1994 (the International Conference on Population and Development, Cairo) and 1995 (UN Women Fourth World Conference on Women, Beijing) that the international community acknowledged equal rights to SRHR for women in displaced settings.[12,13]

Global standards for delivering SRHR in crisis settings have developed over time, resulting in the current implementation standard of the Interagency Field Manual on Sexual and Reproductive Health in Humanitarian Settings,[14,15] and prioritization of SRHR in the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response.[16] SRHR issues are also reflected in development frameworks, including the Sustainable Development Goals (SDGs), primarily SDG 3 (Good Health and Well-Being), SDG 4 (Quality Education), SDG 5 (Gender Equality), and SDG 10 (Reduced Inequalities).[17] Moreover, SDG targets 3.7 and 5.6 specifically point to universal SRHR access.

Despite this important progress in guidance and standards, significant gaps remain in meeting the needs of women and girls in displaced settings. At the global level, these include safe abortion, emergency obstetric and newborn care (emONC), sexually transmitted infections (STI) and HIV services, family planning provision, and more.[18]

While we do not have the data to assess if SRHR gaps are more or less significant in the Rohingya situation compared with other crisis contexts, it is clear that major gaps remain. Addressing them will increase access to life-saving services and begin to build a foundation for meeting medium-term health needs in Cox's Bazar.

GAPS IN SRHR SERVICES AND IMPLEMENTATION

Bangladesh has seen significant progress in its health sector in recent years, including a 50 percent decrease in maternal mortality since 2000.[19] Yet, there are still major SRHR challenges. The govern-

10 "Sexual and Reproductive Health and Rights," OHCHR, Web. 2 Jun. 2019, https://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx.

11 "Maternal Mortality in Humanitarian Crises and in Fragile Settings," UNFPA, https://www.unfpa.org/es/node/13393?page=0%2C0%2C4.

12 UNFPA, Programme of Action of the International Conference on Population and Development, Cairo, 5–13 September 1994, New York: UNFPA, 2004, https://unfpa.org/sites/default/files/event-pdf/PoA_en.pdf.

13 Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, Report of the Fourth World Conference on Women, A/CONF.177/20/Rev.1, New York: United Nations (UN), 1996, http://www.un.org/womenwatch/daw/beijing/official.htm.

14 Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, Inter-Agency Working Group on Reproductive Health in Crises, 2018, http://iawg.net/wp-content/uploads/2019/01/2018-inter-agency-field-manual.pdf.

15 "The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAFM) is the result of a collaborative and consultative process engaging hundreds of representatives from United Nations agencies and non-governmental organizations that make up the Inter-Agency Working Group on Reproductive Health in Crises."

16 Sphere Handbook - Humanitarian Charter and Minimum Standards in Humanitarian Response, 2018, https://handbook.spherestandards.org/en/sphere/#ch001.

17 Fact sheets on sustainable development goals: health targets -- sexual and reproductive health, World Health Organization, 2017, http://www.euro.who.int/__data/assets/pdf_file/0005/348008/Fact-sheet-SDG-SRH-FINAL-04-09-2017.pdf?ua=1.

18 Sara E Casey, et al. "Progress and gaps in reproductive health services in three humanitarian settings: mixed-methods case studies," *Conflict and Health*, 2015 9 (Suppl 1):S3.

19 "Maternal Mortality in 1990-2015, Bangladesh," Maternal Mortality Estimation Inter-Agency Group, https://www.who.int/

ment allocates only 4.1 percent of its budget to health,[20] and spending on SRHR services are only a fraction of this (in 2012, 7.5 percent on maternal health and 7 percent on reproductive health).[21] This lack of funding translates into limited service provision. As of 2015, Bangladesh had the highest rate of adolescent pregnancy in South Asia, and only 38 percent of women gave birth in facilities.[22]

Cox's Bazar, a "lagging district" in Chittagong Division, has seen less health and development progress than other areas of the country.[23] Bangladesh's Family Planning 2020 commitments reference Chittagong as a "developmentally backward division"; the country's goal for the district is for 50 percent of health facilities to meet the criteria needed to deliver postpartum family planning services by 2020.[24] According to data from a 2019 host community needs assessment, Cox's Bazar has high home birth rates, with 53 percent of babies delivered at home in Ukhia and 68 percent in Teknaf.[25] Thus, Cox's Bazar faced significant challenges prior to the Rohingya influx, and the added pressure of hosting over one million refugees has further strained existing systems. In the camps, multiple factors contribute to a lack of comprehensive SRHR care for refugees, including insufficient funds[26] and staff capacity, cultural barriers, poor-quality data, coordination challenges among agencies and implementers, and restrictive policies. As a result, there are gaps in access, capacity, data, and services for the Rohingya. Though we do not have comprehensive data to compare these gaps directly between refugees and hosts, we know that the health system in Cox's Bazar is under significant pressure.

Access

In camps, SRHR services are delivered in fixed health facilities, women-friendly spaces, and through community outreach. There are approximately 200 health facilities operating in camps, but only 17 percent have 24/7 access and only three have surgical capacity. Moreover, safety and gender-based violence risks limit women's ability to access 24/7 facilities at night. In 2018, only 43 percent of babies in refugee camps were delivered in healthcare facilities, which the Joint Response Plan (JRP)[27] notes as an indicator of low demand/awareness and access barriers.[28] A recent assessment conducted by Save the Children of 12,000 Rohingya

gho/maternal_health/countries/bgd.pdf.

20 UNFPA, Country Programme Document for Bangladesh, July 2016, https://bangladesh.unfpa.org/sites/default/files/pub-pdf/CPD%20approved%20by%20Executive%20Board%20%281%29.pdf.

21 Najmul Hossain, "Reproductive, Maternal, Newborn, and Child Health (RMNCH) Expenditure Bangladesh," USAID, 2016, https://www.hfgproject.org/reproductive-maternal-newborn-child-health-rmnch-expenditure-bangladesh/.

22 UNFPA, Country Programme Document.

23 "Catastrophes for a host country," 24 May 2018, Web. Jun. 2 2019, https://www.dhakatribune.com/magazine/2018/05/24/catastrophes-for-a-host-country

24 Family Planning 2020 Commitment, Government of Bangladesh, 11 July 2017, http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2018/04/Govt_Bangladesh_FP2020_Commitment_2017.pdf.

25 "Rohingya Crisis in Cox's Bazar District, Bangladesh: Health Sector Bulletin," Health Sector Cox's Bazar, 20 May 2019, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/health_sector_bulletin_no.9.pdf.

26 SRHR has historically been underfunded in humanitarian settings, but studies show that funding has consistently increased over the past 15 years. In 2014, the Inter-Agency Working Group on Reproductive Health in Crises noted that 43 percent of reproductive health-related proposals received funding between 2002 and 2013, which was lower than the 68 percent average for the humanitarian sector. We cannot evaluate the level of funding for SRHR in the Rohingya response compared to other sectors given the data at hand.

27 "This document provides the Strategic Executive Group's shared understanding of the crisis, including the most pressing humanitarian needs and the estimated number of people who need assistance. It represents a consolidated evidence base and helps inform joint strategic response planning."

28 2019 Joint Response Plan for the Rohingya Refugee Crisis, Strategic Executive Group, http://reporting.unhcr.org/sites/

refugees and 8,000 host community members found that only 25 percent of women are delivering in facilities. Moreover, 2019 data from UNFPA and the Center for Disease Control (CDC) shows that for every 100,000 births, 179 women died due to preventable causes and half of these maternal deaths happened in home shelters. [29]

For refugees within camps, referral pathways are consistently weak, meaning refugees do not always obtain the level of healthcare they need. Refugees have limited awareness of referral pathways, and transportation to facilities remains challenging.[30] Though the first option for referrals is to larger health facilities within camps, patients are referred to higher-level facilities outside of camps for emergency care (1,209 obstetric emergencies were referred between August 2017 and November 2019). For many, this means referral to government health facilities, most of which are relatively far from the camps.

This is problematic as referral pathways for SRHR connect refugees not only with essential medical care, but also with legal, law enforcement, economic, and psychosocial resources.[31] To mitigate challenges with referral pathways, some NGOs, like IRC, provide integrated medical services, meaning that health facilities provide a comprehensive set of health and protection services. Additionally, IRC, with funding from UNFPA, is implementing a 24/7 community-based referral project to meet the critical emergency obstetric and neonatal care referral needs. IRC reports a high demand for referrals; for the month of April 2019, a total of 1,081 referrals were conducted, of which 16 percent were emergency obstetric cases.

Capacity

The low percentage of babies born in health facilities is also likely an indicator of low capacity. Capacity restraints[32] in Cox's Bazar, such as poor quality and insufficient quantity of human resources in hospitals, affect both the refugee population and the host community.[33] Furthermore, most facilities have limited bed capacity for essential services (such as labor and delivery). According to the health sector standard, each primary healthcare center (PHCC) is intended to reach 25,000 people within the catchment population. In practice, however, each PHCC covers over double that, leading to access gaps in basic emergency obstetric and newborn care services. In addition, midwives often enter the camps directly from training programs, and therefore do not have sufficient skills to deliver services independently. New midwives would benefit from experienced mentors, but the capacity for ongoing mentorship is limited. A lack of competent midwives has limited the implementation of a full range of services for the Rohingya. For example, one organization reported that it does not provide syndromic STI treatment because it is a difficult skill set for midwives to learn, although syndromic STI diagnosis and treatment is performed by midwives elsewhere around the world.

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default/files/2019%20JRP%20for%20Rohingya%20Humanitarian%20Crisis%20%28February%202019%29.comp_.pdf#_ga=2.251895306.221316619.1550267367-1154611560.1545415555.

29 "3 in 4 Rohingya Refugee Babies are Born in Unsanitary Bamboo Shelters," Save the Children, 3 June 2019, https://www.savethechildren.org/us/about-us/media-and-news/2019-press-releases/rohingya-refugee-babies-born-unsanitary-shelters.

30 Vigaud-Walsh, "Still at Risk."

31 Vigaud-Walsh, "Still at Risk."

32 ISCG Situation Report, Inter Sector Coordination Group, 5 July 2018, https://www.humanitarianresponse.info/en/operations/bangladesh/document/situation-report-rohingya-crisis-coxs-bazar-05-july-2018.

33 "Additional workforce added to Cox's Bazar hospital to strengthen Rohingya refugee response," World Health Organization, Bangladesh, 21 June 2018, Web. 2 Jun. 2019, http://www.searo.who.int/bangladesh/hwcxb/en/.

Data

We have not seen a coordinated mechanism for collecting, analyzing, and using data about whether women and girls are receiving services, and if they are, the quality of those services. The SRHR sub-sector is currently engaging partners to create such a coordination mechanism, but the level of progress is unclear. The SRHR sub-sector has attempted to coordinate data through a common database wherein SRHR survey and assessment findings could be easily accessed by service providers; however, it has been difficult for implementers to access and navigate. UNFPA is the centralized holder of SRHR service provision data, which is mandatorily reported to the government once per week. However, some NGOs reported that the database is not accessible to partners.

Services

Because of restrictive national policies, the Rohingya cannot receive HIV/AIDS testing and treatment in camps; birth control implants delivered by midwives; and comprehensive abortion care. Antenatal care is limited because it is not provided in women's safe spaces. These gaps are explored further in the below recommendations.

RECOMMENDATIONS

In order to understand and respond to these challenges, the UN, donors, and the government of Bangladesh should ensure that refugee and host needs are accurately assessed and met with evidence-based responses. Donors could collaborate with national and local officials to shape new financing and policy approaches that help to improve SRHR services for Rohingya refugees and host communities. We recommend that donors begin by focusing more on overcoming policy barriers and investing in local health systems for refugees and hosts where appropriate.

In 2015, an evaluation of SRHR programming across humanitarian contexts recommended that more programs utilize evaluation and implementation science to assess the best ways to meet SRHR needs.[34] Throughout our recommendations, we recognize that more investment is needed from UNFPA and donors in standardizing data, ensuring quality data collection, and coordinating among partners to use the data to inform priorities. Health indicators should be collected and reported in a centralized manner across organizations, including for demand and supply-side factors. For example, for facility birth rates, supply-side factors would include the physical and safety accessibility of facilities; capacity of those facilities; and capability, attitude, and quality of care. Demand-side factors would include cultural beliefs or preferences around childbirth at home or perceptions about facility birth that prevent women from seeking care. If done effectively, health service statistics could be used to inform both supply and demand indicators for 2019 and 2020, and ultimately improve the impact of services. Additionally, quality data collection and utilization will allow for a better understanding of cost-effectiveness of different funding streams. Overall, any data that is gathered systematically across organizations should be easily accessible to implementing partners and funders in order to optimize decision making around funding and service provision.

34 Sara E Casey, "Evaluations of reproductive health programs in humanitarian settings: a systematic review," Conflict and Health, 2015 Feb 2;9(1): S1.

DONORS SHOULD ENCOURAGE THE GOVERNMENT OF BANGLADESH TO ADDRESS KEY POLICY BARRIERS TO EFFECTIVE SRHR IMPLEMENTATION AND ADOPT A MORE COORDINATED APPROACH TO REDUCE THEM.

The Rohingya situation highlights areas where policies can be improved for both refugees and hosts. The international community, primarily NGOs, has advocated for shifts in certain national policies that restrict SRHR access, but progress has been limited. The success we have seen thus far has been an exception to Bangladesh's family planning policy to allow refugees without a permanent address to access long-acting reversible contraception (LARCs) and midwives to deliver IUDs (further discussed below). In other areas, certain restrictive policies render the Rohingya particularly vulnerable. A key example is the absence of HIV/AIDS testing and treatment for the Rohingya; services are only allowed in government health facilities and refugees do not have freedom of movement and face other barriers to reaching them, such as cost.

More attention in key policy areas is needed, with the understanding that progress will likely be incremental. For example, as with the change in LARC policy, dialogue could begin around exceptions for refugees and host community members in order to move quickly to meet pressing needs. This engagement would hopefully create momentum for a broader policy dialogue, highlighting key SRHR programming and policy issues that have implications for both displaced populations and host communities.

Advancing the policy dialogue and increasing financing and attention in these key areas can also be viewed as an opportunity and model toward meeting Bangladesh's own SRHR goals. For example, Bangladesh's 2016–2030 National Strategy for Adolescent Health lays out multiple key strategies (e.g., "Build capacity for the delivery of age and gender sensitive sexual and reproductive health services which includes HIV/STI prevention, treatment and care")[35] that would be strengthened through policy change at the national level. These policy issues include but are not limited to:

- Access to long-acting reversible contraception (LARCs);
- Access to comprehensive post-rape care;
- Access to safe abortion and post-abortion care;
- The ability to test for and treat HIV/AIDS in camps;
- The ability for women to access family planning services without couple's registration; and
- The ability to build effective and secure health facilities.

Key stakeholders, including donors, should encourage host government support and buy-in for the implementation of these priorities. Dialogue between field-level NGOs, donors, and advocates happens through working groups and sector engagement, but significant progress towards comprehensive and effective SRHR care can only be made by engaging the government of Bangladesh on policy constraints. A group of donors committed to SRHR should seek consistent and coordinated policy dialogue with the government in the following areas.

35 National Strategy for Adolescent Health 2017 - 2030, Ministry of Health and Family Welfare the People's Republic of Bangladesh, https://www.familyplanning2020.org/sites/default/files/National-Strategy-for-Adolescent-Health-2017-2030-1.pdf.

Access to long-acting reversible contraception (LARCs)

In February 2018, the Inter-Agency Working Group on Reproductive Health in Crisis released a statement providing detailed recommendations for the Bangladesh government, implementing organizations, UN agencies, and donors.[36] Among the recommended priorities, UNFPA proposed the government "ensure availability of the full range of short and long acting reversible contraceptive methods, including emergency contraception, and lift restrictions on access to long-acting reversible contraceptive methods." This will require policy adjustments. Access to family planning services, including LARCs,[37] is widely acknowledged as a human right for women in crisis-affected settings.[38] In our consultations with SRHR doctors in Kutupalong, it was noted that women are increasingly expressing interest in LARCs, and providers are counseling patients on family planning methods and options.[39]

However, political and social settings vary and greatly influence refugees' access to family planning services. When the Rohingya first began arriving in Bangladesh, they could only access short-term contraceptive methods. They were unable to access the more critically needed family planning services because of a Bangladesh policy requiring a permanent address to receive LARCs.40 Marking one success, in April 2018, UNFPA and the Bangladesh Family Planning Directorate signed an agreement allowing UNFPA to procure and provide LARCs, including intrauterine devices (IUDs) and birth control implants, 41 to Rohingya refugees.42 However, this policy only extends to married couples after being registered, as per the government of Bangladesh's family planning policy. Although there has been progress in the efforts to provide LARCs to Rohingya women, specifically allowing trained midwives to provide IUDs, more needs to be done. Currently, only medical doctors can provide implants in Bangladesh. Given the extremely limited number of doctors in Cox's Bazar and other rural areas of Bangladesh,[43] this creates capacity barriers that could be alleviated if midwives or other medical personnel were allowed to do so. Shifting Bangladesh's family planning policies to eliminate the requirement of a permanent address and couple's registration, and allowing midwives to provide implants, offers a potential window for widespread benefits in Cox's Bazar and the entire country.[44]

36 "Women and Girls Critically Underserved in the Rohingya Humanitarian Response," Inter-Agency Working Group on Reproductive Health in Crisis, 22 February 2018, http://iawg.net/wp-content/uploads/2018/02/IAWG-Statement-on-Rohingya-Humanitarian-Response.pdf.

37 Long-Acting Reversible Contraceptives (LARCs), Planned Parenthood Columbia Willamette, https://www.plannedparenthood.org/planned-parenthood-columbia-willamette/long-acting-reversible-contraceptives-larcs.

38 Ward Curry, Dara, Rattan, Jesse, Jose Nzau, Jean, and Kamlesh Giri. "Delivering High-Quality Family Planning Services in Crisis-Affected Settings 1: Program Implementation," *Global Health: Science and Practice,* 4 February 2015, doi: 10.9745/GHSP-D-14-0016.

39 When considering LARCs, women often inform providers that they want to discuss the option with their male partners.

40 Skye Wheeler, "Failing Rohingya Rape Victims in Bangladesh," Human Rights Watch, 23 February 2018, https://www.hrw.org/news/2018/02/23/failing-rohingya-rape-victims-bangladesh.

41 "What is the birth control implant and how is it different from an IUD?," National Women's Health Network, 29 March 2018, Web. 2 June 2019, https://nwhn.org/birth-control-implant-different-iud/.

42 Muktadir Rashid, "Dhaka, UN to Coordinate Contraception Campaign in Rohingya Camps," The Irrawaddy, 25 May 2018, https://www.irrawaddy.com/news/dhaka-un-coordinate-contraception-campaign-rohingya-camps.html.

43 Bangladesh, Global Health Workforce Alliance, https://www.who.int/workforcealliance/countries/bgd/en/.

44 This is particularly relevant in the Rohingya case, and many refugee cases, given the prevalence of informal/community healthcare providers such as midwives.

Access to comprehensive post-rape care

The 2019 JRP estimates that 6,555 women and girls are at risk of sexual violence over the next year, and according to UNFPA, 20,165 incidents of gender-based violence were reported between August 2017 and November 2017 (with 14,261 referred to medical care). Though the number of reported cases in 2017 is likely high due to incidents that took place in Myanmar, we heard during our field visit that rising tensions in the camps has led to increased gender-based violence in recent months. In order to fully address the consequences of sexual violence, providers must be able to execute comprehensive post-rape care, which includes access to emergency contraception, safe abortion, services for the clinical management of rape, and psychosocial support.

Some of our consultations with implementing organizations indicated that menstrual regulation—"a procedure that uses manual vacuum aspiration or a combination of mifepristone and misoprostol to 'regulate the menstrual cycle when menstruation is absent for a short duration'"[45]—is provided widely throughout the camps in health facilities and women-friendly centers. However, we heard that adolescent girls are not seeking services until they are multiple months into their pregnancies, at which time it is not possible to provide comprehensive post-rape or abortion care because of restrictive policies.

Access to comprehensive post-rape and abortion services are further limited by social stigma and cultural barriers in the camps; namely, adolescent girls are only allowed to move when accompanied by parent or other close family members, which is a result of cultural norms and insecurity (harassment, intimidation, and so on). Furthermore, health facilities are very visible in the camps, which, coupled with stigmatization related to rape, prevents women from seeking and receiving confidential or private consultations for abortion.

Access to safe abortion and post-abortion care

Many Rohingya women who were raped in Myanmar viewed abortion as their first option given the stigma associated with giving birth to a child that is the result of rape.[46] Despite recent praise of Bangladesh's menstrual regulation policies,[47] abortion care is insufficient in the camps. CARE, the Center for Reproductive Rights, IPAS, and the Women's Refugee Commission have called on the international community to encourage the government of Bangladesh to lift restrictive legal provisions that create barriers to accessing abortion, specifically penal code 1860, which makes abortion illegal unless it is to save a woman's life.[48,49] We support these efforts, as changing this policy would hold lifesaving benefits for both refugees and host communities; donors should join NGOs in holding this issue as a top priority in policy discussions.

45 Menstrual Regulation and Unsafe Abortion in Bangladesh, Guttmacher Institute, https://www.guttmacher.org/fact-sheet/menstrual-regulation-unsafe-abortion-bangladesh.

46 Vigaud-Walsh, "Still at Risk."

47 Patrick Adams, "How Bangladesh Made Abortion Safer," The New York Times, 28 December 2018, Web. June 2, 2019, https://www.nytimes.com/2018/12/28/opinion/rohingya-bangladesh-abortion.html.

48 Penal Code No. 45 of 1860, secs. 312-316 (1860) (Bangl.).

49 NGO Statement Concerning Sexual and Reproductive Rights of Rohingya Women and Girls Displaced Due to Conflict in advance of the UN Security Council's Mission to Myanmar, Bangladesh, Women's Refugee Commission, 26 April 2018, https://www.womensrefugeecommission.org/images/zdocs/NGO-Statement-on-SRHR-of-Rohingya-Women.pdf.

Ability to test for and treat HIV/AIDS in camps

HIV/AIDS prevalence is a low 0.1 percent in Bangladesh, but numbers of new infections and deaths are increasing.[50] Specifically, rates of HIV for women in Bangladesh are rising, notably for housewives, pregnant mothers, migrant workers, and vulnerable groups such as sex workers and intravenous drugs users. According to UNICEF, these trends are "an early sign of an epidemic."[51] Donors that are invested in HIV prevention and health systems strengthening in Bangladesh should view HIV care as a key priority when supporting the integration of host community and refugee health systems.

The 2019 JRP indicates that "the Health Sector will also work closely with the district health authorities to extend regular national health programmes (including TB and HIV) to cover Rohingya population." Evidence from the response highlights the value of this priority. We consistently heard from health providers that the spread of HIV, along with other STIs, is a persistent public health concern within the Rohingya population. In July 2018, 83 cases of HIV had been confirmed, but this number is likely much higher.[52]

However, according to Bangladesh's national HIV program, testing for HIV is only allowed in selected government facilities, with confirmatory tests limited to a designated district level hospital. Humanitarian actors continue to advocate for the national HIV program to scale up HIV testing and treatment for the Rohingya community. Discussions and assessments are ongoing with the HIV control program for the organizations and health facilities that wish to provide HIV testing. Once facilities are approved for HIV testing, organizations will formally initiate and conduct testing, but confirmatory testing will be still be done by the designated government hospital.

If policies restricting HIV testing and treatment among Rohingya shift to allow implementation of this JRP priority, integration of services must be done with the utmost awareness of cultural and political sensitives. This policy change must also consider current humanitarian politics; the SRHR sub-sector is currently considering the possibility that HIV rates could be higher in the Rohingya population than in the host communities. This may create tensions and stigmatization of the Rohingya during the integration of services with host communities. Stigma around testing and treatment is very present in Bangladesh,[53] putting those who test positive at risk. Even if humanitarian organizations are granted the ability to test for HIV, refugees would have to seek confirmatory testing and HIV treatment at a designated government health facility outside of the camps. Designing systems that ensure confidentiality for patients receiving treatment and the protection of data will be vital. Since refugees do not have freedom of movement, leaving the camps for treatment could potentially reveal their status to community members. In the medium-term, policies and funding should strengthen and allow access to local facilities for all. Short of this, if more organizations begin to test for HIV, policies should also allow for treatment within the camps in order to mitigate the risk of stigma and cultural ostracization.[54]

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50 Bangladesh, Evidence to Action, https://www.aidsdatahub.org/Country-Profiles/Bangladesh.

51 Towards Ending AIDS, UNICEF Bangladesh, https://www.unicef.org/bangladesh/en/towards-ending-aids

52 Hossain, Md Mahbub, Sultana, Abida, Mazumder, Hoimonty, and Munzur-E-Murshid, "Sexually transmitted infections among Rohingya refugees in Bangladesh," The Lancet, Volume 5, Issue 7, PE342, 1 July 2019.

53 Towards Ending AIDS, UNICEF.

54 We recognize that this recommendation may apply beyond the camps to other qualified facilities that are not authorized to perform HIV/AIDS testing and treatment; an assessment should be conducted of whether or not there are other areas where

The ability for women to access family planning services without couple's registration

As discussed above, in Bangladesh, family planning services in government-run facilities are restricted to registered married couples. Within the Rohingya community, male partners often limit women's access to SRHR services. Those who are able to access services should be able to utilize comprehensive care, including family planning. According to NGO partners, Bangladesh's family planning policy has already restricted the Rohingya's ability to access LARCs and will create further barriers and discrimination for unmarried refugees and hosts when trying to access services in the medium-term. Adolescent girls are particularly vulnerable under this policy, since they have the highest unmet need for contraceptive services[55] but are often not married until well into reproductive age. Donors should encourage an immediate policy shift on this issue.

The ability to build effective and secure health facilities

Throughout the duration of the Rohingya crisis, an ongoing challenge for SRHR implementers has been increasing accessibility to health clinics and increasing the number of women that are seeking life-saving services (e.g., giving birth in facilities). Health facilities in the refugee camps are built from temporary materials due to government policies prohibiting the development of cement or permanent structures (with the current exception of Camp in Charge (CiC) structures). This policy limits service provision across sectors in the response, but holds specific challenges for SRHR. The regulation is ineffective for clinics that provide SRHR services, including abortion care. Clinics are often one or two connected rooms, with doors that remain open to the camps, with lines of men, women, and children formed outside. Since SRHR services are integrated with other comprehensive health services, there are no clinics or hospitals for women to seek care that are not also accessible to men. This is extremely restrictive for women who need to access services confidentially, especially post-rape and abortion care. As a result, women often feel more comfortable seeking SRHR care, especially for family planning and STI treatment, in women-friendly spaces. However, men cannot receive treatment for STIs in women's spaces, leading to cycles of re-infection for women. Additionally, women-friendly spaces offer a more limited set of services, including a lack of antenatal care.

We recognize that there are limitations to this recommendation, as overcrowding and space constraints affect all sectors. Tradeoffs will be difficult and intermediary steps will likely be necessary. In order to address cultural and capacity barriers, at a minimum more doctors should be placed in women's safe spaces, and facilities should prioritize maintaining clients' privacy and client waiting areas. As an intermediate step, the government of Bangladesh should consider adjusting its policies towards land use and permanent structure building for clinics, especially those that provide delivery rooms.

this policy should be addressed.

55 UNFPA, Country Programme Document.

DONORS SHOULD INCREASE FINANCING TO STRENGTHEN LOCAL HEALTH SYSTEMS TO MEET THE NEEDS OF BOTH REFUGEES AND HOST COMMUNITIES.

On average, refugees are displaced from their country of origin for 10 years.[56] Given the lack of conditions for safe, dignified, and voluntary return of the refugees to Myanmar, it is likely that the Rohingya situation will be protracted, meeting or exceeding the global average. While humanitarian response gaps deserve careful attention, it is also time for funders, the Bangladesh government, and implementing partners to consider medium-term plans for providing quality SRHR services at scale to refugees and hosts.[57] Medium-term plans should include analysis on how best to meet SRHR needs in a way that incorporates development actors, approaches, and financing. For example, a set of INGO recommendations for women and girls in crises, released in April 2019, recommends that donors align investments "along the humanitarian-to-development continuum to ensure reliable and predictable funding for SRHR during acute crisis as well as long-term, protracted crises."[58] Close assessment of the funding needed for SRHR-specific priorities over the medium-term is needed, including efforts to expand to multi-year funding. This analysis can help to meet needs in the longer-term while prioritizing cost-effectiveness and integration now.

The 2019 JRP recognizes that it is important to expand to comprehensive SRHR services. In an effort to support comprehensive services while also striving for medium-term inclusion, funders should support programs and organizations working to address issues facing both the Rohingya and the host community. New JRP commitments for 2019 offer an opportunity for donors to prioritize the Minimum Initial Service Package's (MISP's) sixth objective,59 which includes planning for integration of comprehensive services into primary healthcare.60 While it may be politically difficult to recognize the protracted nature of displacement, it is important to plan for this likelihood. Building up parallel health systems for refugee communities rather than building the capacity of existing health systems to accommodate referrals can be inefficient, unsustainable, and can exacerbate refugee-host community tensions. The 2019 JRP also emphasizes the importance of prioritizing social cohesion for refugees and hosts across sectors.[61] Given the sensitivity and cultural variables related to SRHR implementation (for example, in regard to HIV prevalence), social cohesion between refugees and hosts should be a top priority when developing health systems in Cox's Bazar. To pursue an approach of improved health systems for refugees and hosts, greater freedom of movement is required to allow refugees to access these systems.

There are multiple health facilities that serve both refugees and hosts,[62] but a strategy for

56 Devictor, Xavier and Quy-Toan D0, "How Many Years Do Refugees Stay in Exile?," World Bank Blogs, 15 September 2016, http://blogs.worldbank.org/dev4peace/how-many-years-do-refugees-stay-exile.

57 Some funding allocations already include considerations of the host community.

58 "Women's and girls' rights and agency in humanitarian action: A life-saving priority," A joint statement and recommendations endorsed by more than 40 international agencies and women's rights organizations, CARE, https://care.ca/2019/04/womens-and-girls-rights-and-agency-in-humanitarian-action-a-life-saving-priority/.

59 Minimum Initial Service Package, Inter-Agency Working Group on Reproductive Health in Crisis, http://iawg.net/minimum-initial-service-package/.

60 Integration is currently happening. The health sector denied IRC the ability to construct a standalone/parallel BEmONC center; rather it requested that IRC integrate BEmONC services into an existing 24/7 PHCC or construct a PHCC.

61 2019 JRP.

62 These are often clinics in or near camps that are open to the host community, rather than host community primary health clinics that are expanded to include refugees.

further development of host community facilities is needed, including investment in training health workers and improving access to emergency care. Host community members have reported decreased health coverage due to the refugee influx, contributing to increased tensions.[63] Overall, alongside efforts to facilitate improved refugee and host community access to health facilities outside the camps, more assessment and planning is needed to determine if new facilities are needed in the immediate area and what higher-level government facilities need expansion due to the refugee caseload. This is especially needed as donors fatigue sets in for camp-based facilities.

The World Bank has made major investments in Bangladesh's health systems for many years, including through its $500 million Health Sector Support Project.[64] Announced in July 2017, the project supports strengthening health systems and quality and coverage of service delivery, specifically in Sylhet and Chittagong divisions.[65] Twenty-seven percent of the project funding is designated to reproductive and maternal health.[66] In June 2018, the World Bank committed an additional $50 million in development financing to its Health Sector Support Project to meet the needs of the Rohingya situation.[67] The World Bank's financing will support health systems strengthening and health infrastructure priorities of the government of Bangladesh. Given this incoming development funding and the World Bank's robust support of Bangladesh's health systems, the assessment described above could be led by the government of Bangladesh and the World Bank, in close consultation with humanitarian and development actors and affected populations. Other actors should align funding and leverage it against the assessment and systems plan that is developed.

Guidance for the 2019 JRP requires all implementing organizations to designate 30 percent of their budget and operations to host community activities. Given this requirement, most donors are funding host community response, often through support to district hospitals. Some donors are beginning to fund programs that will intentionally meet the medium-term needs of both the host community and the refugee population. For example, Sweden's funding to UNFPA supports the Ministry of Health and Family Welfare of Bangladesh in integrating midwives across the country's health system, including for the Rohingya in Cox's Bazar.[68] Canada has committed $300 million over three years to the Rohingya crisis, with specific designation to SRHR,[69] and the Asian Development Bank (ADB) has committed $200 million in development financing to improve facilities for displaced Rohingya, with a project that "will refurbish camp roads to link essential food storage and distribution centers, hospitals,

63 Rohingya Gender Analysis, Joint Agency Report.

64 "World Bank Helps Bangladesh Address Urgent Health Needs of Rohingya," The World Bank, 20 September 2018, Web. 2 June 2019, https://www.worldbank.org/en/news/press-release/2018/09/20/world-bank-helps-bangladesh-address-urgent-health-needs-of-rohingya.

65 "World Bank Provides $570 Million to Improve Bangladesh's Health Sector and Public Procurement Performance," The World Bank, 28 July 2017, Web. 2 June 2019, https://www.worldbank.org/en/news/press-release/2017/07/28/world-bank-provides-570-million-to-improve-bangladeshs-health-sector-and-public-procurement-performance.

66 Health Sector Support Project, The World Bank, http://projects.worldbank.org/P160846/?lang=en&tab=details.

67 "World Bank Announces Support for Bangladesh to Help Rohingya," The World Bank, 28 June 2018, https://www.worldbank.org/en/news/press-release/2018/06/28/world-bank-announces-support-for-bangladesh-to-help-rohingya.

68 "Sweden and UNFPA Over $US 7 Million Agreement to Strengthen Midwifery Services for the Most Vulnerable in Bangladesh," UNFPA Bangladesh, 27 October 2017, Web. 2 June 2019, https://bangladesh.unfpa.org/en/news/sweden-and-unfpa-over-us-7-million-agreement-strengthen-midwifery-services-most-vulnerable.

69 The Canadian Press, "Canada Pledges $300 Million in Aid to Help Rohingya, but Stops Short on Resettlement," The Star, 23 May 2018, Web. 2 June 2019, https://www.thestar.com/news/canada/2018/05/23/canada-pledges-300-million-in-aid-to-help-rohingya-but-stops-short-on-resettlement.html.

schools, and improve emergency access."[70] It is likely that the increasing population in the camps every year will put further strain on SRHR service provision. The next tranche of funding for the ADB project should a further support medium-term SRHR objectives, including strengthening infrastructure and improving access to hospitals.

CONCLUSION

Though NGOs are working to encourage the Bangladesh government to adjust key SRHR policies, these efforts could be amplified by the united voices of humanitarian and development donors. For example, the World Bank and other major development donors have the opportunity to use existing and newly allocated funds for health and SRHR to support policy changes that will improve the rights of all women in Bangladesh, including the Rohingya. The ability of Rohingya women and girls in Cox's Bazar to access essential SRHR services is not improving fast enough. As advocacy efforts and strategies are developed, Rohingya and host community women must be included in conversations about their needs and priorities for care. Coordination efforts across stakeholders must improve to address gaps in implementation and accelerate expansion to more comprehensive services. International development actors should work strategically to support SRHR policies and programs that directly impact the Rohingya and also better meet the needs of both the refugees and host communities.

70 "ADB Approved $100m Grants for Rohingyas in Bangladesh Camps," The Daily Star, 6 July 2018, Web. 2 June 2019, https://www.thedailystar.net/rohingya-crisis/adb-approves-100m-grants-rohingyas-bangladesh-camps-1601017.

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