Family Planning Menstrual Regulation and Post-Abortion Care among Forcibly Displaced Myanmar Nationals (FDMN) in Bangladesh

Findings from Two Studies

পরিবার পরিকল্পনা অধিদপ্তর

UNFPA

Ipas Partners for Reproductive Justice

Name of the studies

Study on Knowledge, Attitude, Practices and Sources of Information about Family Planning, Menstrual Regulation and Post Abortion Care Services Among Forcibly Displaced Myanmar Nationals' (FDMN)

Summary

This study assesses knowledge, attitudes, practices, information sources, and accessibility of Family Planning (FP) and Menstrual Regulation (MR) services among the FDMN community in Teknaf and Ukhiya upazila of Cox's Bazar in Bangladesh. The study followed a cross-sectional survey among women, men, and adolescent girls in Rohingya camps, indicates high awareness of contraceptive methods, with pills and injectables most commonly used and several misconceptions about FP methods, with varying beliefs among girls, women, and men. In the surveyed population, 53% of couples reported using family planning methods. Decision-making in FP and MR often involves joint decisions or male dominance. Knowledge about Menstrual Regulation MR is substantial, but access is hindered by societal factors, such as unmarried status and lack of male consent. The study underscores the need for targeted educational interventions, especially for girls, to correct misconceptions. It also highlights the importance of enhancing access to healthcare professionals and male involvement in FP and MR education. Facility interventions have proven effective in improving positive perceptions of FP. The recommendations emphasize community sensitization to reduce stigma, address specific barriers for women and girls, provide financial assistance for accessing safe MR, and encourage joint decision-making in FP and MR to ensure womens' reproductive autonomy.

Introduction

Women in Rohingya community residing in Bangladesh as FDMN are disproportionately affected by sexual and reproductive health (SRH) hazards, including sexual and gender-based violence (SGBV), unexpected pregnancies, and limited access to quality SRH services[1] . This situation is exacerbated in overcrowded camps where SGBV is rampant, and healthcare access is restricted[2] . Despite efforts by humanitarian actors and local health ministries, the unmet needs for family planning (FP), menstrual regulation (MR), and post abortion care (PAC) services remain substantial.

The influx of the Rohingya population from Myanmar into Bangladesh presents unique challenges in providing reproductive health services. Although there has been progress in offering FP, MR, and PAC services, significant barriers remain due to cultural and linguistic differences, traditional beliefs, and limited access to comprehensive SRH services. A study in 2019 revealed that only slightly more than half of the Rohingya women in the camps used contraceptives[3]. Understanding the sources of information and decision-making processes used by the FDMN community to access these services is crucial for developing strategies to improve access and quality of care. This study aimed to fill the knowledge gap regarding the reproductive health needs and experiences of the FDMN community and assess the impact of ongoing SRH programs in the camps.

Study Objectives

To assess current knowledge, attitude, practices, sources of information and ability to access family planning, menstrual regulation, post abortion care services among FDMN community

Assess the level of knowledge, attitude and practice on FP, MR, PAC services	Identify sources of information for FP, MR and PAC services in humanitarian context	Explore decision-making processes for FP, MR, PAC services	Reveal suggestions for improving utilization of FP, MR, PAC services in terms of quality

Methodology

This study employs a cross-sectional quantitative survey methodology focusing on women of reproductive age (20-49 years), girls (15-19 years), and men (18-50 years), the research was conducted in all 33 camps across Ukhiya, Teknaf upazila of Cox's Bazar. Employing stratified random sampling, the study conducted interviews with 1,088 participants, distributed almost evenly among the three groups. The

sampling process involves listing households in each camp, ensuring no over- or under-enumeration, and then selecting individuals for interviews through a systematic random sampling method. Data was collected using semi-structured questionnaires in Bangla (asked in rohingya dialect) and analysis was performed using STATA 15.0. This study was implemented from February to December'23 with financial support from UNFPA and Ipas Global.

Scaling and Analysis Techniques

Statistical analysis involved the use of descriptive analysis to understand the overall knowledge, attitudes, and practices associated with family planning (FP) and menstrual regulation (MR). The impact of certain potential factors on FP perceptions, FP use, and MR attitudes was examined through binary logistic regression, with adjustments made for various socio-demographic factors.

In this study, a four-point Likert scale for evaluating FP methods and a five-point scale for MR attitudes were used, having 24 and 22 statements respectively. For FP, scores for positive responses ranged from 1 (Strongly Disagree) to 4 (Strongly Agree), and for MR, from 1 (Strongly Disagree) to 5 (Strongly Agree), including an 'Unsure' option. Negative statements were scored oppositely. The total FP score was the sum of 24 statements, up to 96 points, and the MR score was from 22 statements, up to 110 points. Both scores were divided into two categories - Negative or Positive - based on the average score as the dividing criterion.

Findings

The study provides a comprehensive demographic and social overview of girls, women, and men. Notably, 21% of girls, 81% of women, and 99% of men were ever married, with a clear majority of girls never married. Majority of women and men were 25 years or older. In terms of education, a significant portion of women (60%) and men (38%) had no education, with fewer achieving secondary or higher levels. Regarding children, a substantial majority of women and men had three or more children, while most girls had none. Employment patterns showed that 88% of men worked only for cash in the past 12 months, compared to 9% of women and 6% of girls. Income levels varied, with a large portion of families earning less than 5000 BDT in income.

Knowledge, Attitudes and Practice on Family Planning

Contraceptive Awareness: Nearly all participants were familiar with various contraceptive methods. It shows a high awareness of pills, injectables, and implants across all groups, with over 94% of girls and women and 79% of men familiar with implants(Figure:1).

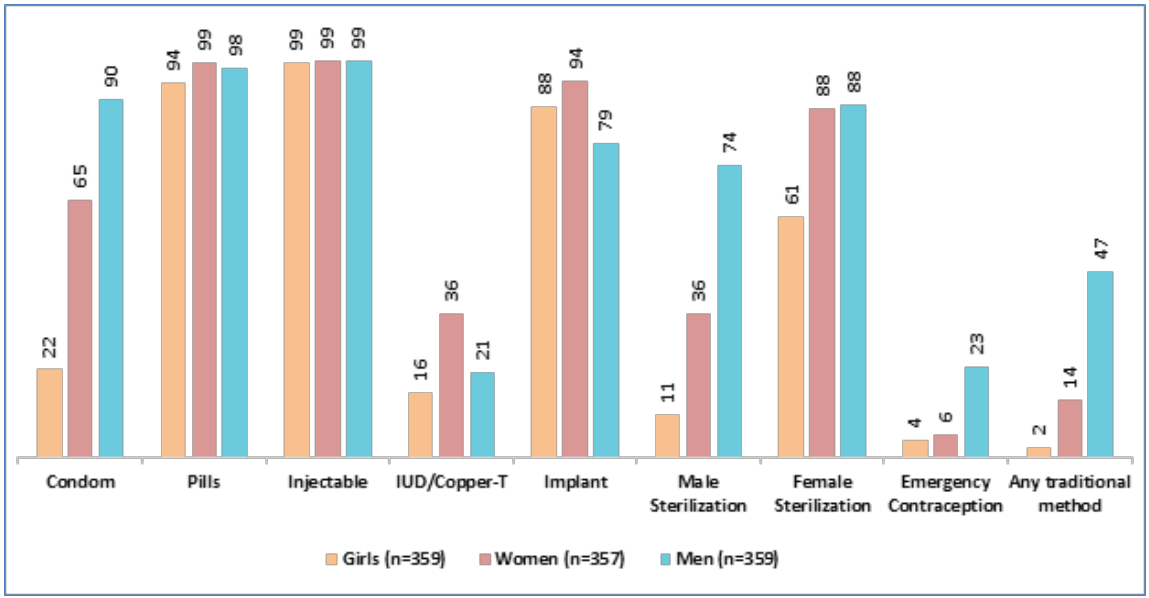

Figure 1: Percentage Distribution of Girls (15-19 years), Women (20-49 years), and Men (18-50 years) Who Ever Heard about Different Methods of FP

Condoms are well-known among men (90%) and women (65%), but less so among girls (22%). Knowledge of IUD/Copper-T and emergency contraception is relatively low in all groups, particularly among girls. While male and female sterilization are quite familiar to women and men, girls are less aware of these methods. Traditional methods are the least known, especially among girls.

Information Sources: Girls predominantly receive their information from neighbors (85%), a similar trend also seen in women (80%), but less so in men (60%). Girls also turn to family members (30%) significantly more than women (13%) and men (23%). Hospitals/clinics are key for adults, with 46% of women and 53% of men using them, compared to only 15% of girls. Friends are a significant source for men (48%), but rarely for women (2%) and girls (3%).

Misconceptions about Family Planning: The survey reveals several misconceptions about family planning methods, with varying beliefs among girls, women, and men. A notable belief that pills can burn the uterus is held by 43% of girls, compared to 35% of women and 34% of men. The misconception that combined pills can cause cancer is highest among girls (44%), while it's 38% for both women and men. Regarding condoms, 36% of men believe condom can cause weakness and impotence, a belief more prevalent among women and girls. Additionally, the idea that injectables can cause cancer is more common among girls (37%) than women (29%) and men (31%). The survey also reveals that 45% of girls think obese women should refrain from using implants, a belief less common in other groups. Furthermore, 35% of women are under the misconception that IUDs can't be used immediately post-abortion and 69% think that tubectomy reduces the ability to work hard.

Table 1: Factors Associate with Perception on FP: Results of Binary Logistic Regression

Possible Determinants	Adjusted Odds Ratio	SE	P Value	95% CI	
Type of the Respondents (Ref: Women)					
Girls	0.29	0.04	<0.001	0.21	0.40
Men	0.51	0.12	0.01	0.32	0.83
Facility type (Ref: Camps without facility intervention)					
Camps with facility intervention	1.66	0.24	<0.001	1.25	2.19
Ever Attended School or Madrasa(Ref :No)					
Yes	1.01	0.13	0.96	0.77	1.30
Did Any Work in the Last 12 Months(Ref: No, Not Working)					
Yes, only cash	1.32	0.30	0.22	0.84	2.07

*Dependent: Perception level- good & poor (ref.)

Girls (OR=0.29, P<0.001) and men (OR=0.51, P=0.01) are substantially less likely to have a positive perception of FP methods compared to women, facility interventions greatly increase positive perceptions (OR=1.6, P<0.001), while education and employment show less definitive impacts (Table 1).

Current use of Contraceptives: In the surveyed population, 53% of couples reported using family planning methods, while 47% did not use any such methods.

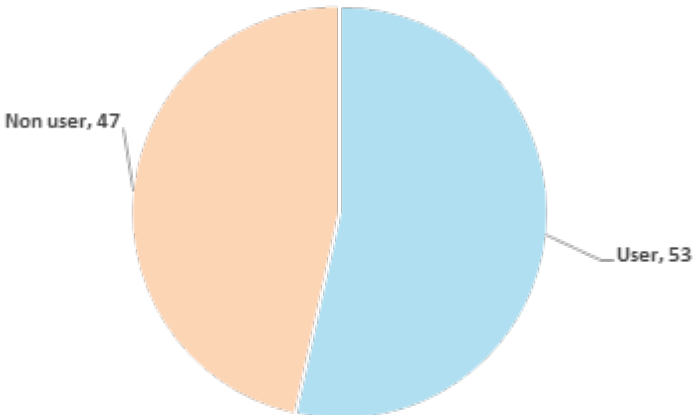

Figure 2: Percentage of couples using FP Methods

Among those who used contraceptives, the most Among those who used contraceptives, the most preferred options were injectables and pills, with 48% and 43% usage rates respectively. Other methods like implants and IUDs were less frequently chosen, accounting for 4% and 3% of users. Interestingly, methods such as condoms, male and female sterilization, and emergency contraception pills were minimally utilized, each representing less than 1% of the total contraceptive use. This distribution highlights a significant preference for certain types of contraceptives over others among the surveyed couples.

However, Positive family planning perceptions and having more children significantly increase contraceptive use, with women holding good perceptions 1.59 times more likely to use contraceptives and each additional child raising the likelihood by 11%, while facility interventions in camps and education (school or madrasa attendance) have lesser impacts on contraceptive use.

Decision-Making in Family Planning: More than half of the couples made joint decisions regarding family planning, but husbands/male partners were often the final decision-makers in case of disagreement.

Knowledge, Attitudes an Practice on Menstrual Regulation (MR)

Menstrual Regulation (MR) Awareness and Access:

Over 70% of girls, 80% of women, and 90% of men knew about menstrual regulation MR (Figure 3), with nearly all identifying medication MRM as the method

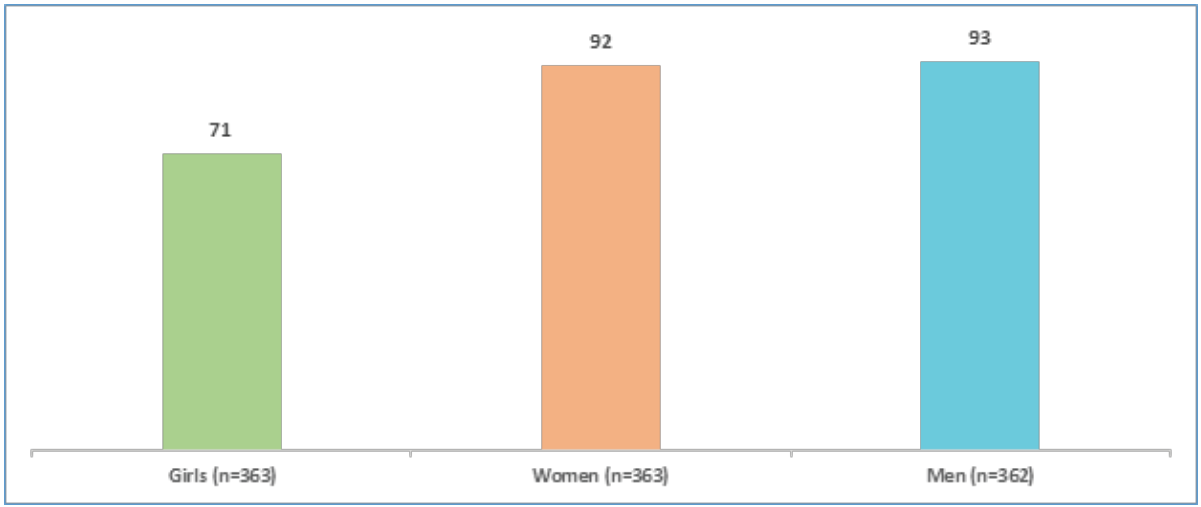

Figure 3: Proportion of Respondents who Heard about MR

Source of knowledge on MR: Neighbors are the most common information source for girls (84%) and women (77%), while men rely more on hospitals/clinics (45%) and doctors (39%). Friends are a notable source for men (57%) but much less so for women and girls.

Attitudes Towards MR: A significant portion of each group believes a woman who has had MR should be restricted from religious services (51% of girls, 47% of women, 33% of men) and is committing a sin (73% of girls, 71% of women, 79% of men).

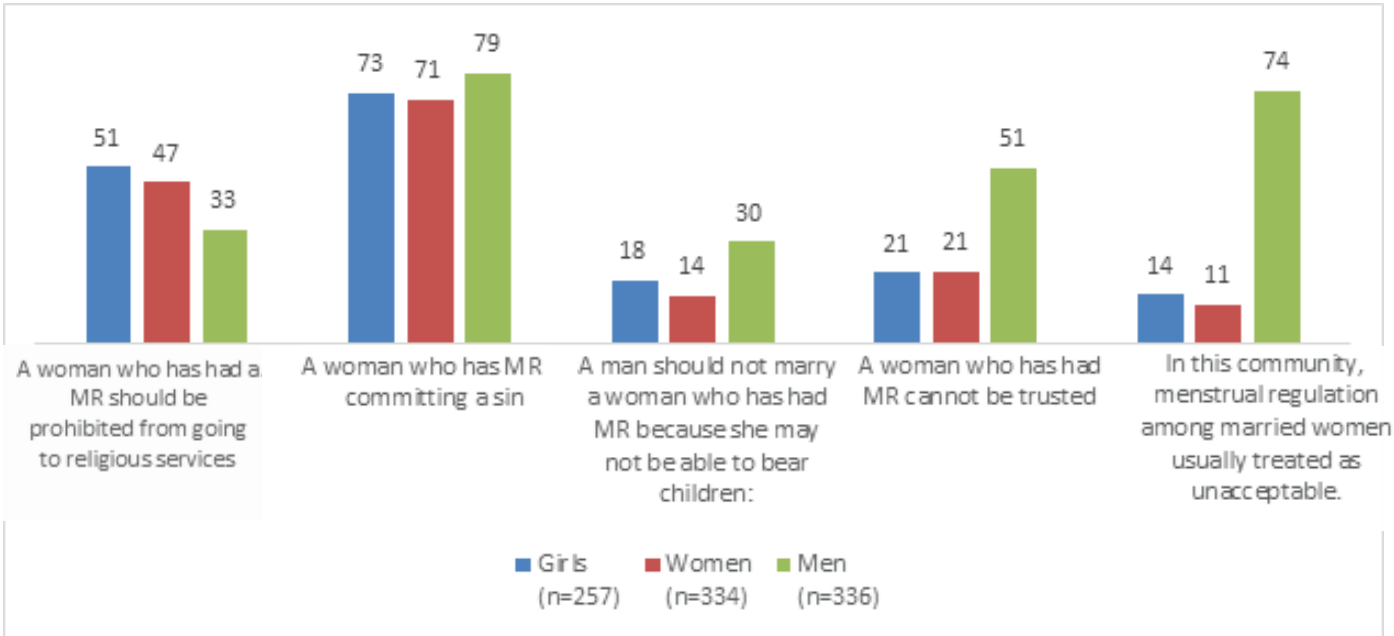

Figure 4: Percentage of Respondents who Expressed Agreement with Various Attitudinal Measurement Statements

Regarding marriage and sexual health, 18% of girls, 14% of women, and 30% of men believe a man shouldn't marry a woman who's had MR due to potential fertility issues. A notable 51% of men, compared to 21% of girls and 21% of women, believe a woman who has had MR cannot be trusted. Finally, societal attitudes toward MR differ based on marital status, with a notably higher percentage of men (74%) finding it unacceptable among married women compared to girls (14%) and women (11%).

Table 2: Factors Associate with Attitude on MR: Results of Binary Logistic Regression

Possible determinants	Adjusted Odds ratio	SE	P value	95% CI	
				Lower	Upper
Type of the Respondents (Ref: Men)					
Girls	2.30	0.58	<0.001	1.41	3.76
Women	4.35	1.07	<0.001	2.68	7.05
Facility Type (Ref: Camps without Facility Intervention)					
Camps with Facility Intervention	1.82	0.26	<0.001	1.38	2.41
Ever Attended School or Madrasa (Ref :No)					
Yes	1.12	0.15	0.38	0.87	1.46
Did any Work in the Last 12 Months (Ref: No, not working)					
Yes, only cash	1.31	0.31	0.26	0.82	2.07

Overall, girls and women were significantly more likely to have positive attitudes than men, with girls 2.3 times and women 4.35 times more likely. Participation in an intervention notably increased positive attitudes by 1.82 times. Educational background and employment status showed a slight, but not significant, increase in positive attitudes.

Experienced with Menstrual Regulation (MR): A small percentage of girls (7%) and women (11%) took steps to terminate unwanted pregnancies, often with the assistance of their male partners (3%). The preferred approach was consulting medical service providers and using MRM.

Decision-Making in MR Services: Nearly all girls and women believed that the husband's consent is essential for MR, and the majority of men and women agreed that the husband should make the final decision regarding MR.

Key Barriers to Accessing Safe MR: The most significant barrier for girls and women is their status as unmarried (29% and 33%, respectively), while for men, it's the attitude of friends and relatives (36%). Parental consent is a major issue for both girls and women (29% and 33%), but much less for men (3%). Insults and ridicule

by community members affect a substantial portion of girls and men compared to men. Additionally, a significant number of men cited financial issues as a barrier.

Conclusion

The findings from the Rohingya community highlight critical issues in the domains of menstrual health management and family planning. Nearly all participants are aware of any contraceptive methods, with injectables and pills being the most common. However, there are widespread misconceptions about the health risks associated with family planning, such as cancer and infertility. Information on FP is primarily obtained from informal sources like neighbors and friends, particularly among men. Girls and men are substantially less likely to have a positive perception of FP methods compared to women. Facility interventions have been found to significantly improve positive perceptions towards FP. A clear preference was shown for injectables and pills as contraceptives among couples, influenced strongly by positive family planning perceptions and family size, while educational have a lesser positive impact.

In terms of MR, most respondents were familiar with MR, though less so in girls compared to adults. Access is often hindered by factors like unmarried status, lack of parental or husband's consent, and financial constraints. Over half of the girls and women, and a third of the men, are aware of the legality of MR in Bangladesh, and nearly all girls and women believe that the husband's consent is crucial for MR. Decision-making in family planning and MR services often involves joint decisions or is dominated by male partners, with a majority believing that men should have the final say. This dynamic reflects the cultural and patriarchal influences on reproductive health decisions within the community. Girls and women are significantly more likely than men to have a positive attitude toward menstrual regulation, and this likelihood increases further with participation in the intervention. Since men often make key decisions but tend to have more negative attitudes towards MR, this can majorly hinder safe MR access for women and girls. However, the use of contraceptives and attitudes toward MR and FP are influenced by these societal norms, highlighting the need for more targeted, gender-sensitive educational and healthcare interventions.

Recommendations

1. Targeted Educational Interventions: Implement educational programs tailored to each group's specific needs and misconceptions, with a special emphasis on informing girls about MR, and dispelling prevalent misconceptions regarding both FP and MR as they show a significant lack of awareness and understanding in these areas.

2. Increase Access to Healthcare Professionals: Encourage individuals, especially girls to seek information from healthcare providers rather than relying predominantly on neighbors and family members, as misinformation is common in informal networks

3. Enhance Male Involvement and Education: Since men are key decision-makers in FP and MR and tend to have negative attitudes towards MR than others, initiatives should focus on educating them about the benefits of FP and addressing their misconceptions, especially regarding MR.

4. Facility Interventions: Scale up facility interventions in camps as they have been shown to greatly improve positive perceptions towards FP and MR. This could include counseling services, information sessions, and accessible medical care.

5. Community Sensitization: Conduct community awareness programs to reduce the stigma associated with FP and MR, particularly targeting men and influential community members.

6. Joint Decision-Making Encouragement: Promote joint decision-making in FP and MR between partners to ensure women's autonomy and involvement in decisions affecting their health

7. Focus on Unmarried Women and Girls: Address the specific barriers faced by unmarried women and girls in accessing FP and MR services, including societal stigma and the need for parental consent.

8. Financial Assistance Programs: Implement financial assistance or subsidy programs to alleviate the financial barriers to accessing safe MR.

References

1. Van Den Akker T, van Roosmalen J. Maternal mortality and severe morbidity in a migration perspective. Best Practice & Research Clinical Obstetrics & Gynaecology. 2016 Apr 1;32:26-38.

2. Parmar PK, Jin RO, Walsh M, Scott J. Mortality in Rohingya refugee camps in Bangladesh: historical, social, and political context. Sexual and Reproductive Health Matters. 2019 May 31;27(2):39-49.

3. Khan MN, Islam MM, Rahman MM, Rahman MM. Access to female contraceptives by Rohingya refugees, Bangladesh. Bulletin of the World Health Organization. 2021 Mar 1;99(3):201.

4. Abul Kalam Azad M, Zakaria M, Nachrin T, Chandra Das M, Cheng F, Xu J. Family planning knowledge, attitude and practice among Rohingya women living in refugee camps in Bangladesh: a cross-sectional study. Reproductive Health. 2022 May 2;19(1):105.

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Background

Overview of Rohingya Crisis

Rohingya women in Bangladesh, particularly FDMN, face disproportionate challenges in sexual and reproductive health (SRH), including SGBV, unexpected pregnancies, and limited access to quality services

Reproductive Health Challenges

Overcrowded camps worsen the situation, with rampant SGBV and restricted healthcare access, leading to substantial unmet needs for family planning, menstrual regulation, and post-abortion care

Research Need

Understanding of knowledge, attitude, practices and sources of information within the FDMN community is crucial for developing strategies to improve access and quality of care

Aim of the Study

This study can help to identify strategies for improving their access to FP, MR, PAC services and contribute to filling the gap in knowledge regarding their reproductive health needs and experiences

Objectives

To assess current knowledge, attitude, practices, sources of information and ability to access family planning, menstrual regulation, post abortion care services among FDMN community

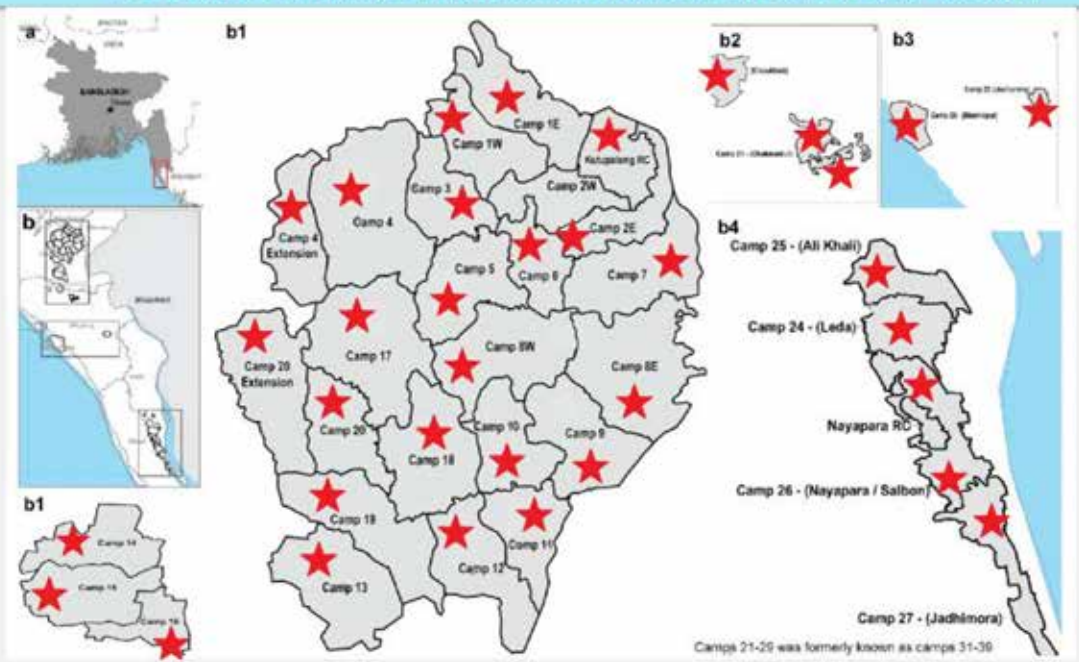
- Assess the level of knowledge, attitude and practice on FP, MR, PAC services
- Identify sources of information for FP, MR and PAC services in humanitarian context
- Explore decision-making processes for FP, MR, PAC services
- Reveal suggestions for improving utilization of FP, MR, PAC services in terms of quality

Methodology

Study Approach	• Cross-sectional quantitative survey
Study Population	• Rohingya women (20-49 years), adolescents (15-19 years), and men(18-50 years)
Sampling Method	• Stratified random sampling
Sample Size Calculation	• 363 per group, totaling 1089 • Applied Cochran's (1977) formula with a prior prevalence of 38.5% for contraceptive use, considering 5% level of significance and 5% margin of error. The calculated sample size of 353 per group, increased to 363 to compensate for potential non-responses
Sampling Procedure	• In each camp, list 150 households; select 11 for each group (women, adolescents, men) using systematic random sampling without replacement
Listing Techniques	• Interview household heads, use sketch maps, focus on systematic and thorough listing without duplication

Study Site

33 Camps in Ukhiya and Teknaf Upazilas of Cox's Bazar district




Findings

Background Characteristic

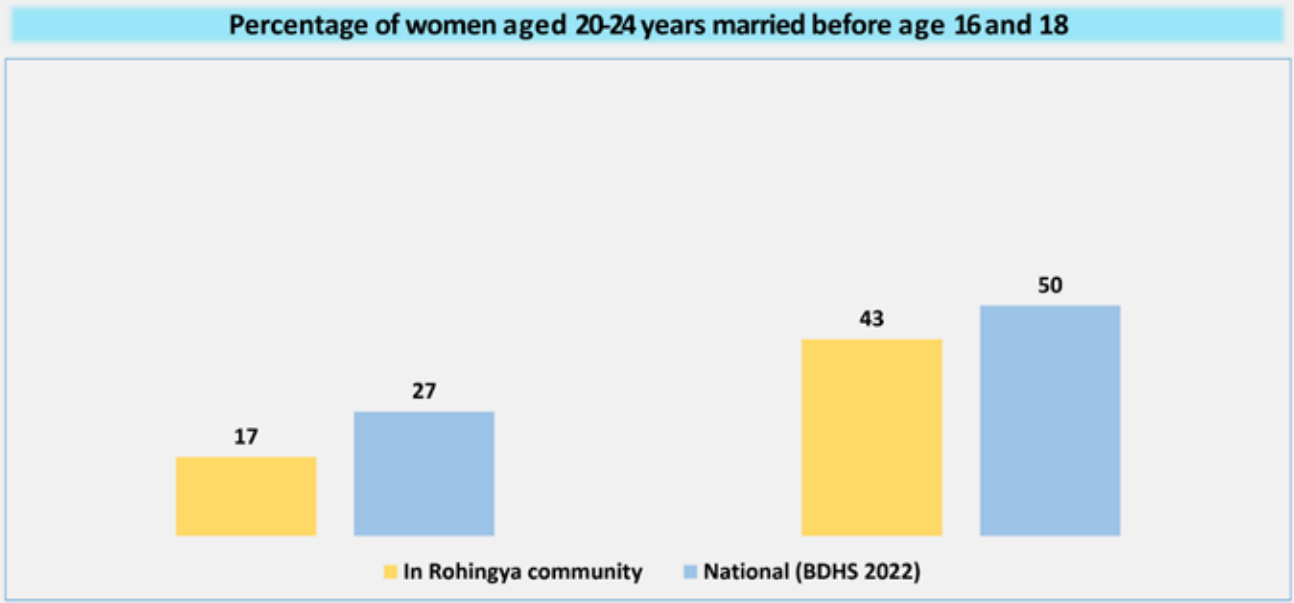
Variables	Girls (n=363)		Women (n=363)		Men (n=362)	
	n	%	n	%	n	%
Marital Status						
Currently Married	77	21.2	295	81.2	360	99.5
Deserted/Divorce/Widow	11	3.0	53	14.6	2	0.5
Never Married	275	75.8	15	4.2	0	0.0
Age						
<20 years	363	100.0	0	0.0	1	0.3
20-24 years	0	0.0	98	26.9	70	19.3
25+ years	0	0.0	266	73.1	291	80.4
Educational Status						
None	110	30.3	218	60.1	138	38.1
Less than Primary	212	58.4	109	30.0	107	29.5
Primary	23	6.3	17	4.7	29	8.0
Secondary or Higher	18	5.0	19	5.2	88	24.3

Background Characteristic

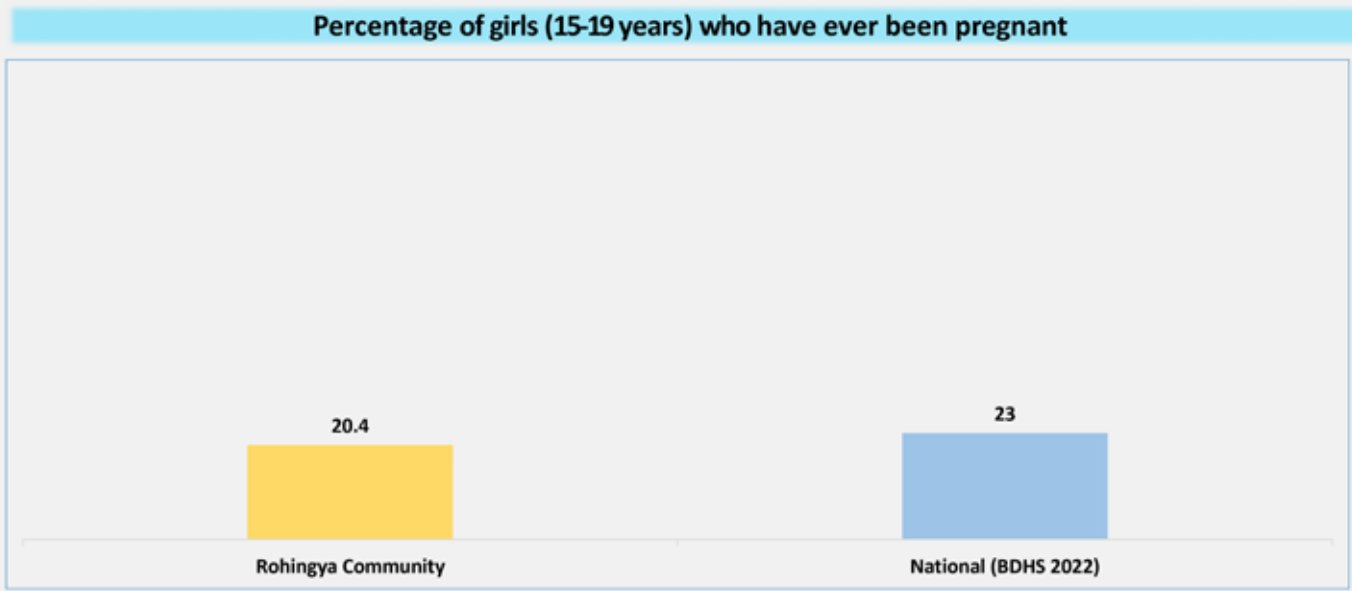
Variables	Girls (n=363)		Women (n=363)		Men (n=362)	
	n	%	n	%	n	%
Number of Living Children						
None	22	29.7	4	1.2	12	3.5
1	43	58.1	45	13.4	48	13.8
2	7	9.5	71	21.2	70	20.1
3+	2	2.7	215	64.2	217	62.5
Mean Child	0.9		3.6		3.4	
Did any Paid Job in Last 12 Months (All Respondents)						
Yes, only cash	21	5.8	33	9.1	320	88.4
No, not working	341	93.9	331	90.9	42	11.6
Intervention Status						
Camps with facility intervention	264	72.7	263	72.5	263	72.6
Camps without facility intervention	99	27.3	100	27.5	99	27.4


15-19
Marriage and Childbearing
45-49

Early Marriage



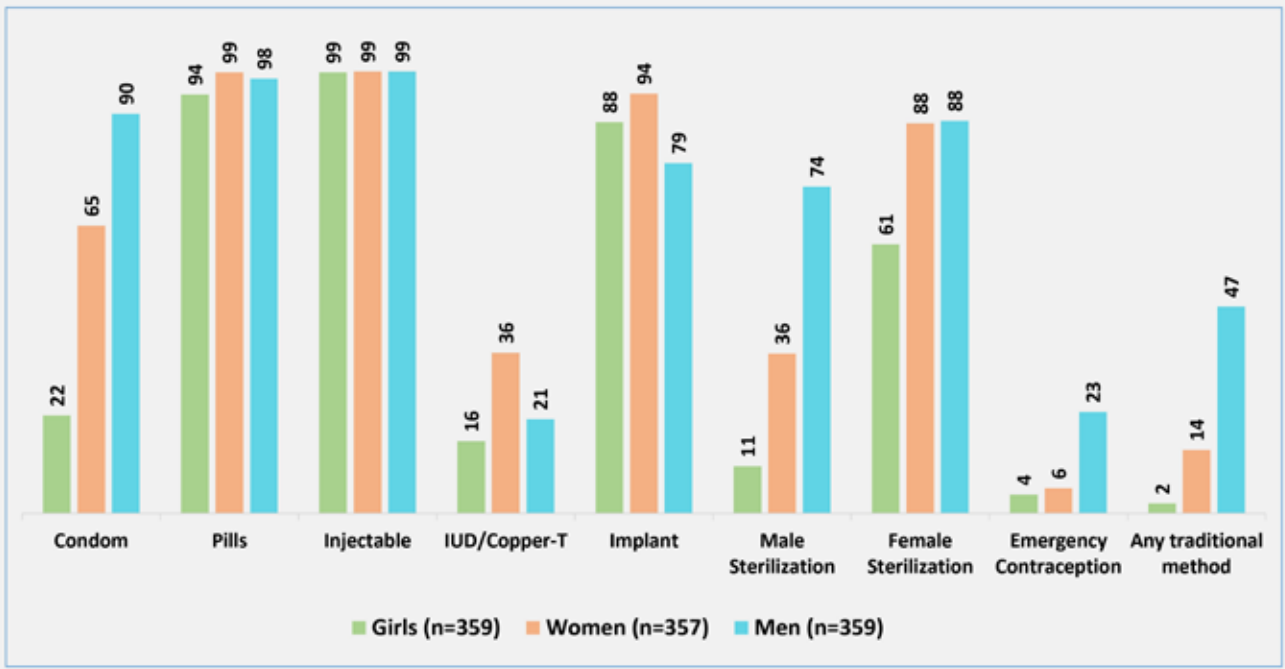
Teenage childbearing




Knowledge and Practice of
Family Planning

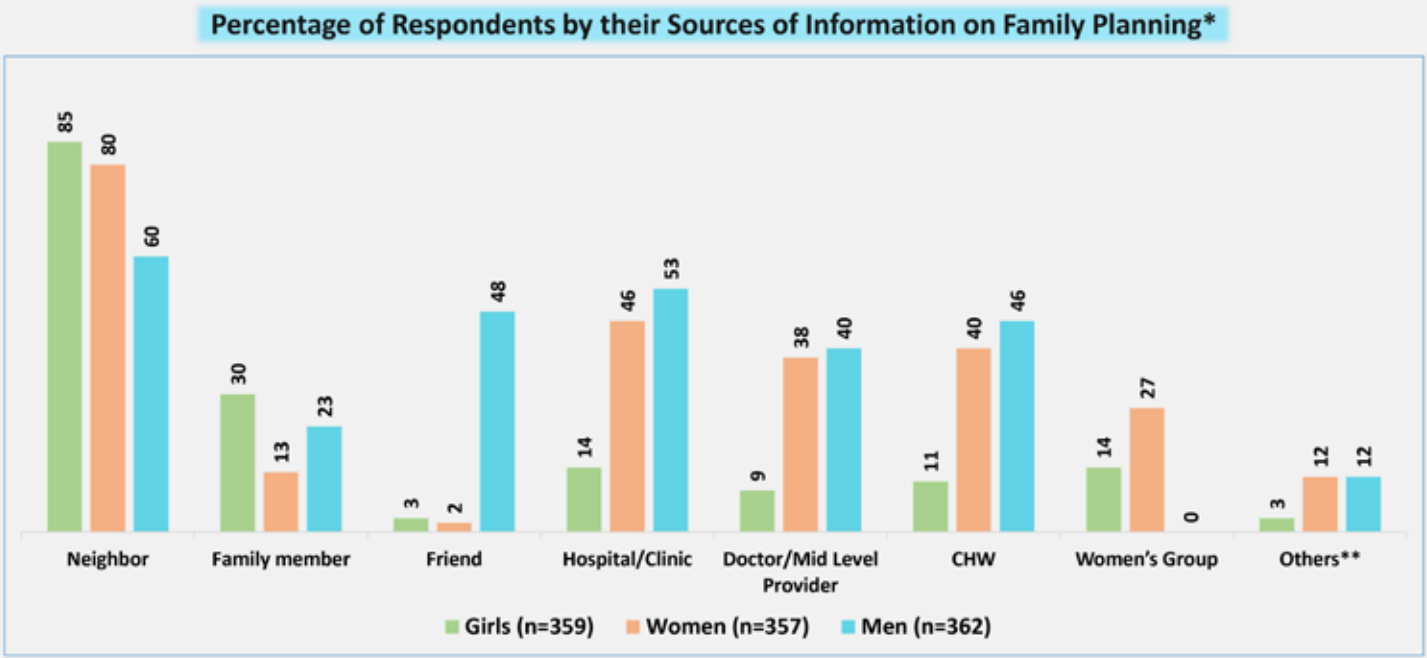
Knowledge on FP Methods

Almost all Respondents (98.9% Girls, 98.4% Women and 99.2% men) ever Heard about any FP Method



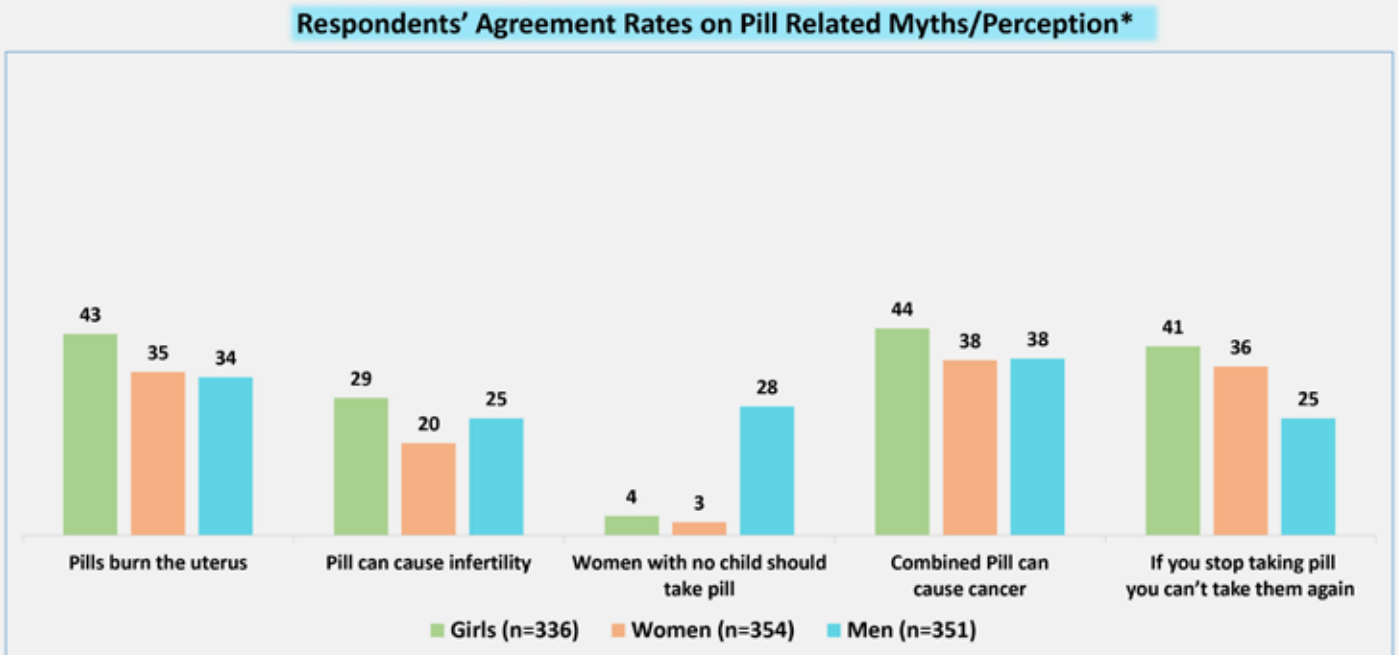
*Multiple Response

Source of Knowledge on FP Methods



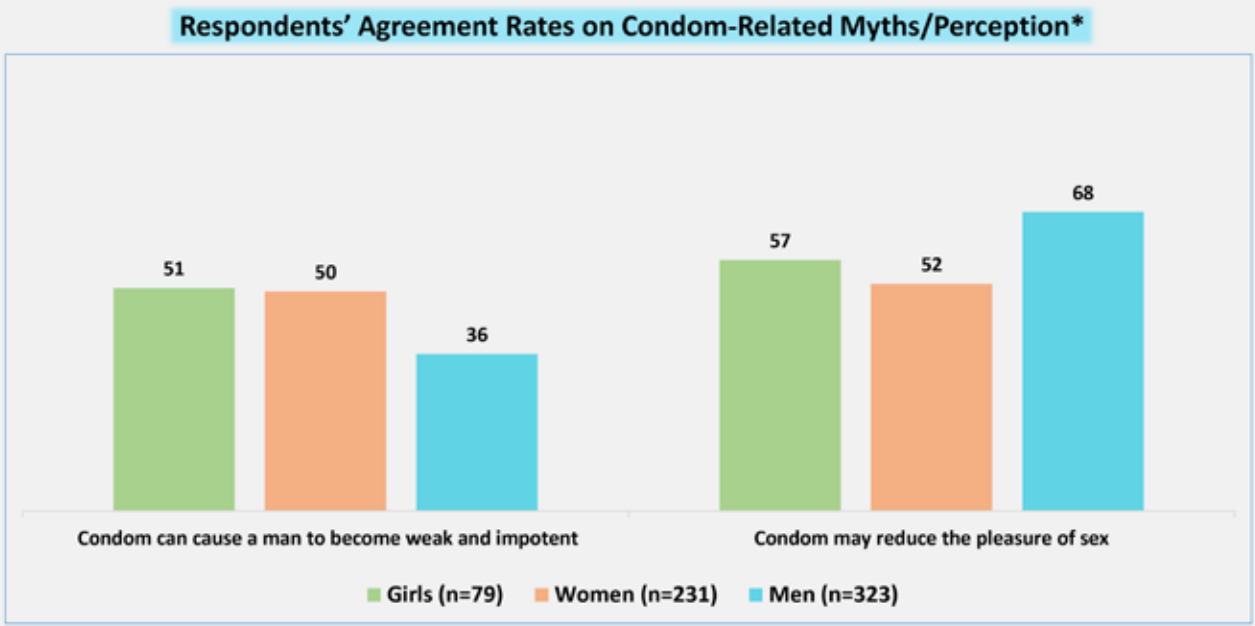
*Multiple response **Others include TBA trained, ISC materials, Pharmacists

Perception/Myth on Pill



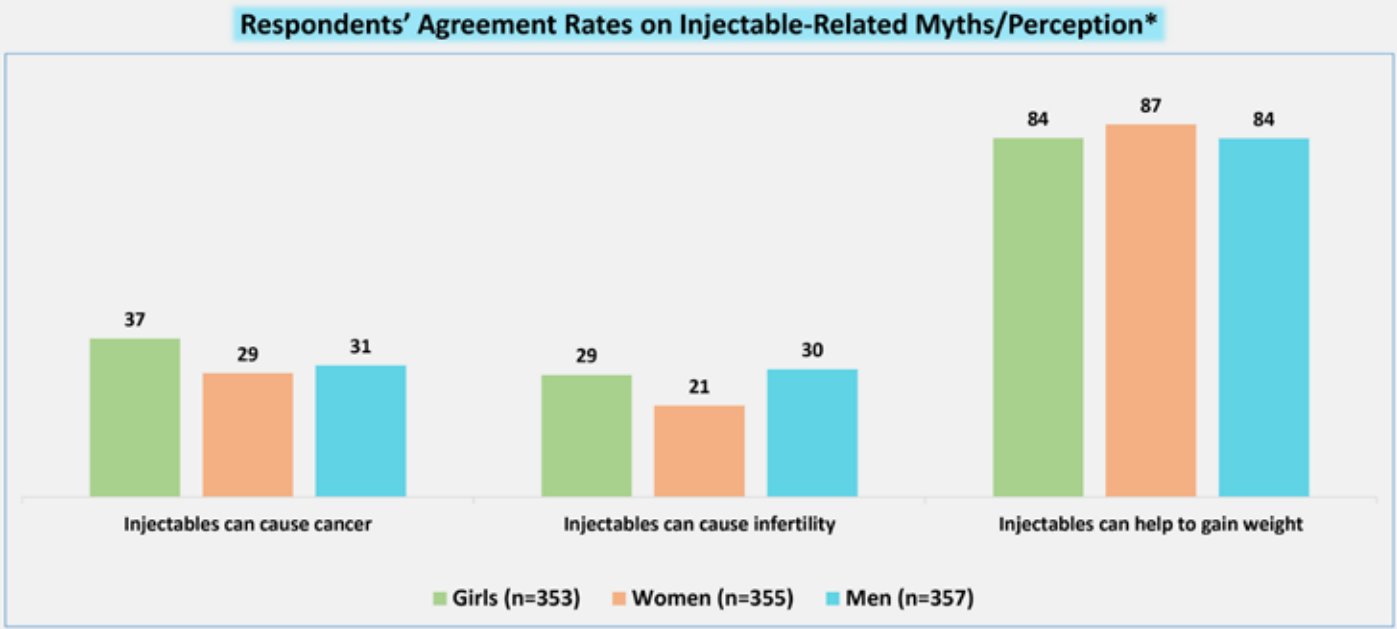
*Among those who ever heard about the pill

Perception/Myth on Condoms



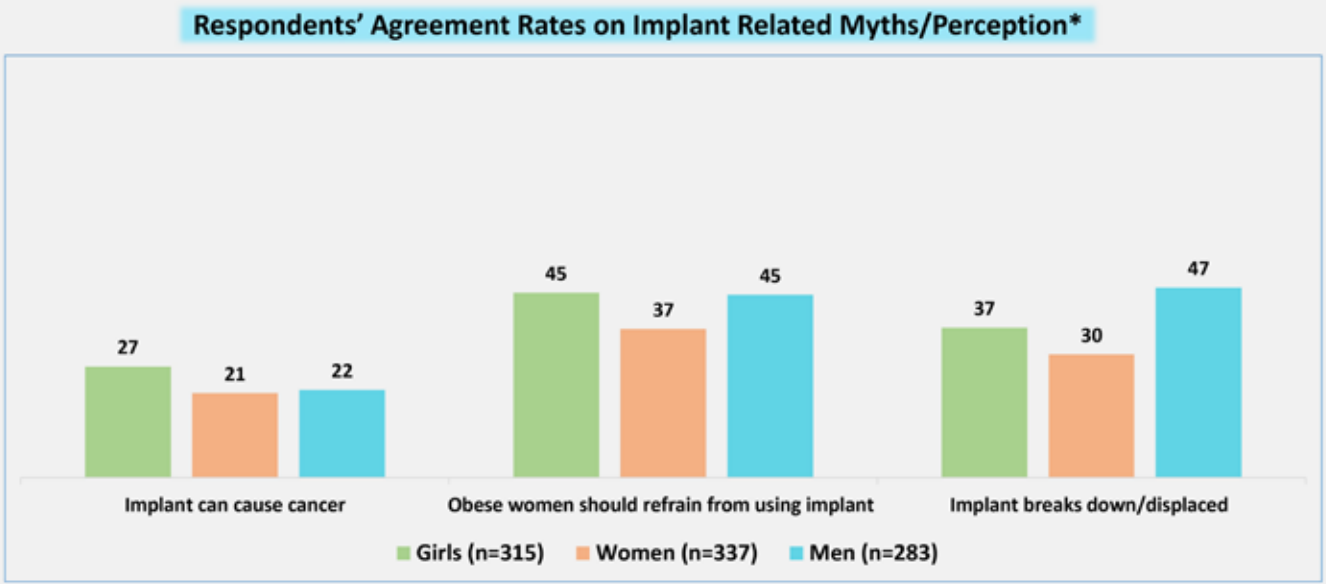
*Among those who ever heard about the condoms

Perception/Myth on Injectable



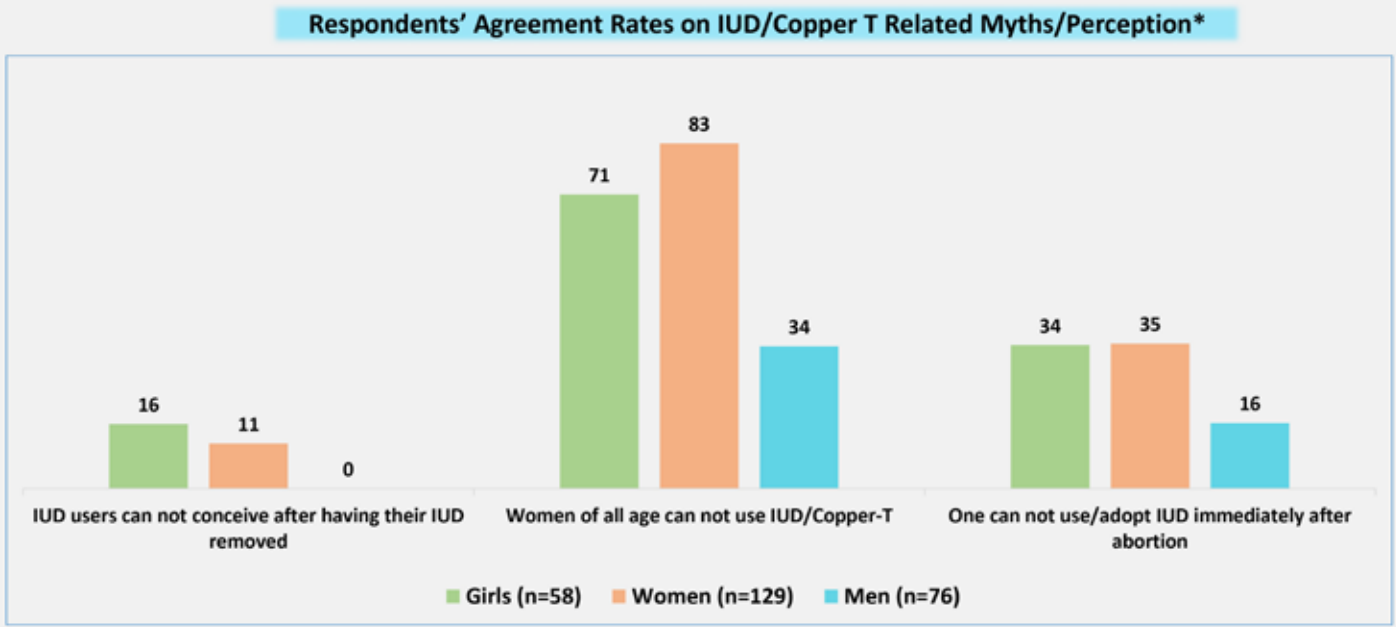
*Among those who ever heard about the Injectable

Perception/Myth on Implant



*Among those who ever heard about the implant

Perception/Myth on IUD/Copper-T



*Among those who ever heard about the IUD/Copper T

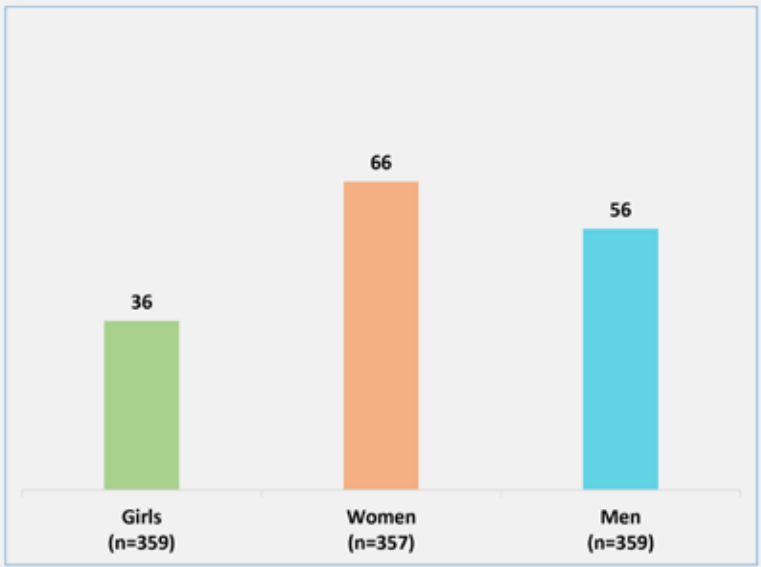
FP Perception Level by Respondents' Type*

Descriptive Statistics of Perception Score on FP Methods(Total Score=96)

Respondent Type	Mean	SD	P value
Girls (n=359)	47.9	14.0	<0.001
Women (n=357)	58.4	12.7	
Men (n=359)	53.2	12.2	

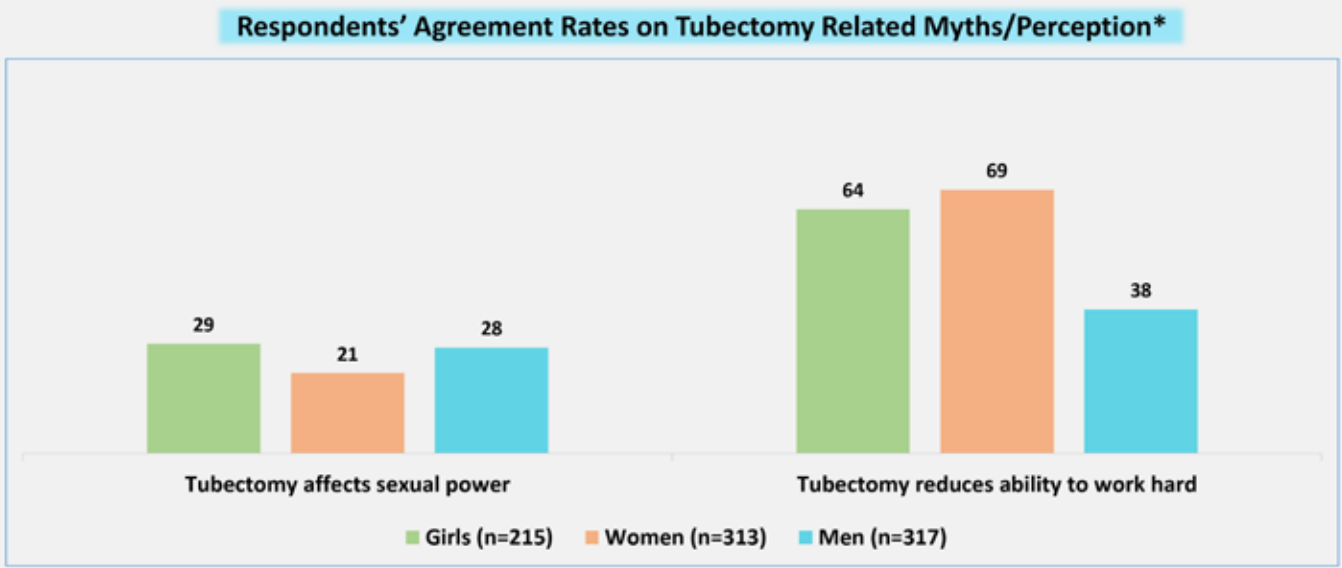
*Among those who have ever heard about FP

Respondent With Good Understanding on FP Methods**



**Classified scores into two categories (Poor vs Good) based on the overall mean (53) as the cutoff value
**Significant at 5% level of significance

Perception/Myth on Tubectomy



*Among those who ever heard about the Tubectomy

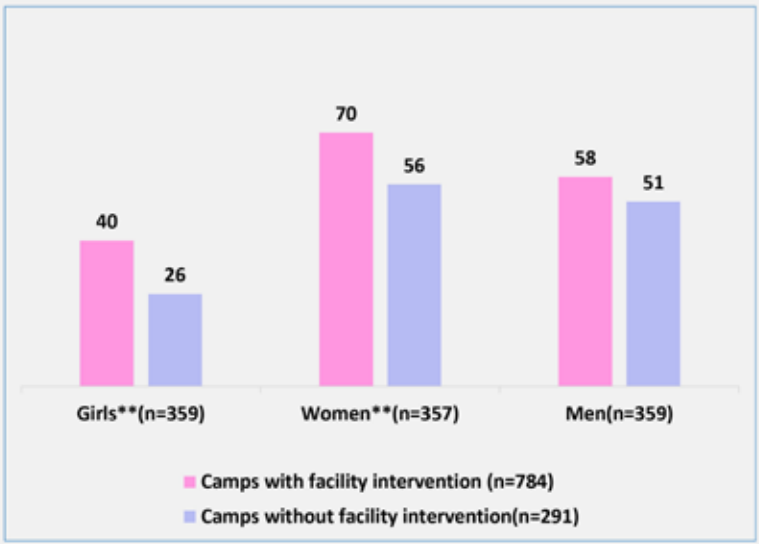
FP Perception Level by Respondents' Type* & Intervention

Descriptive Statistics of Perception Score on FP Methods (Total Score=96)

Respondent Type	Intervention	Without Intervention	P Value
	Mean(SD)	Mean(SD)	
Girls (n=359)	49.2 (13.6)	44.6 (14.6)	0.01
Women (n=357)	59.3 (12.5)	56.0 (12.8)	0.03
Men (n=359)	53.8 (11.7)	51.3 (13.1)	0.09

*Among those who have ever heard about FP

Respondent With Good Understanding on FP Methods By Intervention***



**Significant at 5% level of significance
***Classified scores into two categories (Poor vs Good) based on the overall mean (53) as the cutoff value

Factors Associated with Perception of FP Methods*

Girls & Men's Perception	Girls are 71% less likely, and men are 49% less likely to have a positive perception of FP methods compared to women
Impact of Facility Intervention	Camps with facility interventions have a 66% higher likelihood of a positive perception of FP methods
Education's Influence	No significant difference in FP perception for those who attended school or madrasa
Role of Employment	Being employed shows a potential 32% increase in positive FP perception, though this is not statistically significant

*Among those who ever heard about the condoms

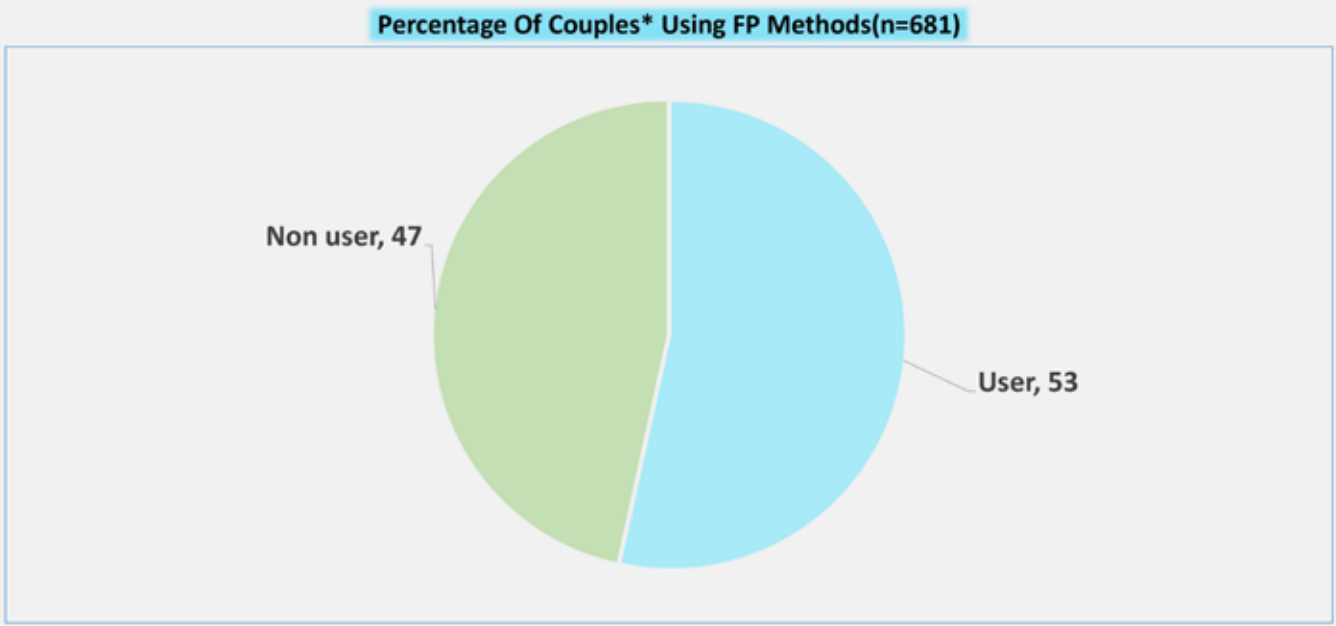
Results of Logistic Regression*					
Possible determinants	Adjusted Odds ratio	SE	P value	95% CI	
				Lower	Upper
Type of the Respondents (Ref: Women)					
Girls	0.29	0.04	<0.001	0.21	0.40
Men	0.51	0.12	0.01	0.32	0.83
Facility Type (Ref: Camps without facility intervention)					
Camps with facility intervention	1.66	0.24	<0.001	1.25	2.19
Ever attended school or madrasa (Ref :No)					
Yes	1.01	0.13	0.96	0.77	1.30
Did any work in the last 12 months (Ref: No, not working)					
Yes, only cash	1.32	0.30	0.22	0.84	2.07

*Dependent: Perception level level- good & poor (ref.)

Summary Findings: Knowledge of FP

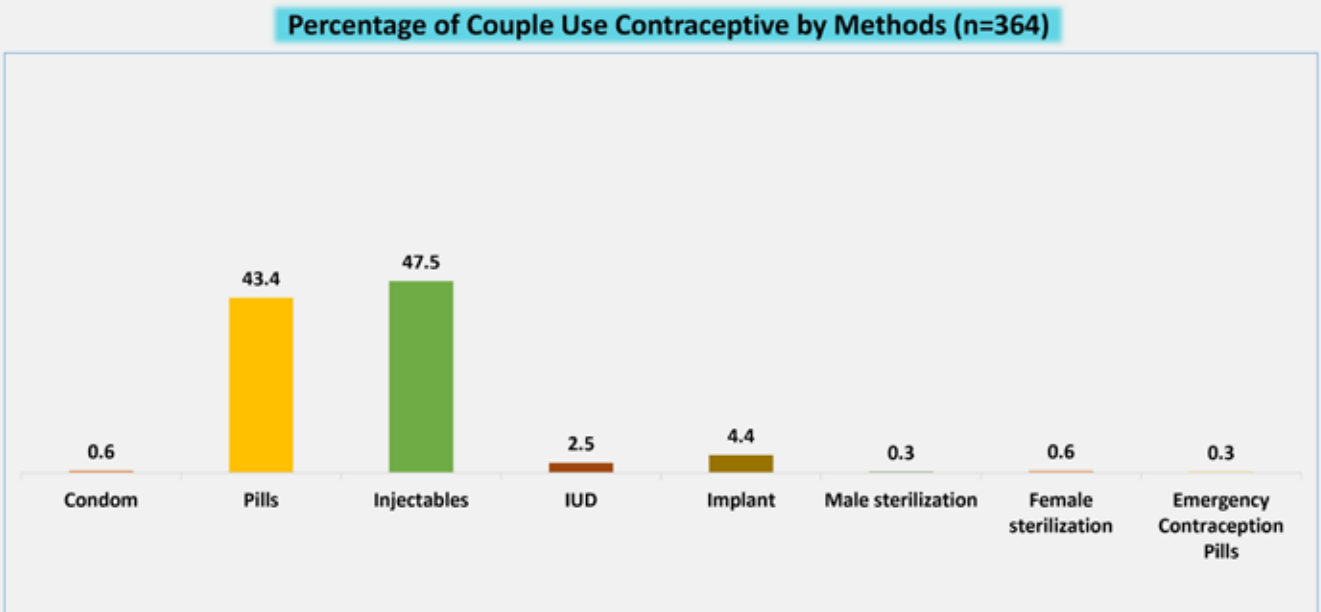
- Nearly all participants were aware of contraceptive methods, with injectables, pills, implants, and female sterilization being the most known
- Neighbors were the main source of family planning information for most respondents, followed by hospitals and clinics. A significant number of men relied on friends for such information, unlike women and girls
- A substantial number of Rohingya people have misconceptions about family planning, believing it leads to issues like cancer, infertility, or impotence.
- Girls and men are substantially less likely to have a positive perception of FP methods compared to women, facility interventions greatly increase positive perceptions, while education and employment show less definitive impacts

Use of any FP Method



*Ever married/unmarried non-pregnant

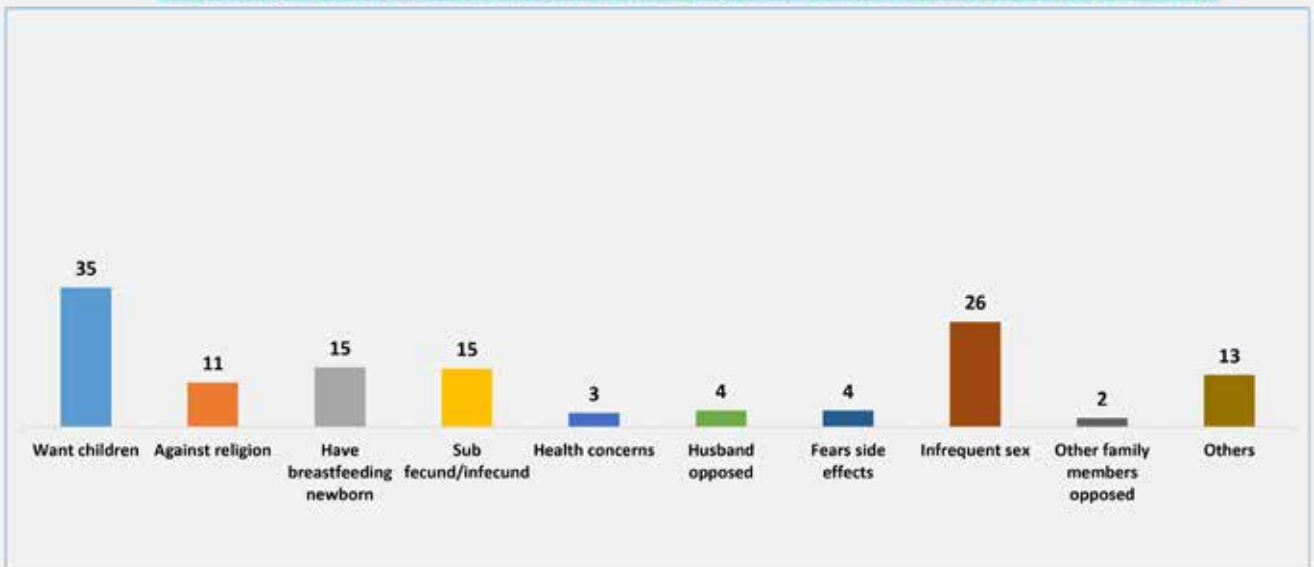
Contraceptive use by Methods



*among current user

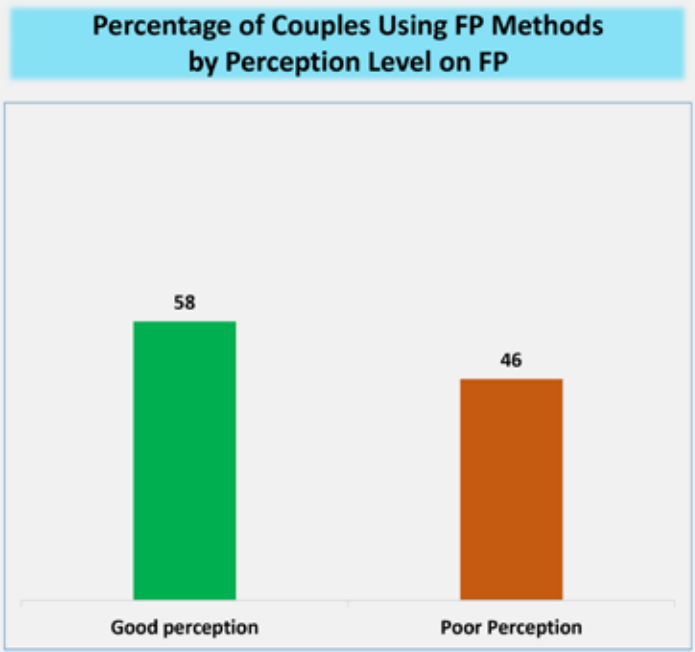
Reason for Not Using FP methods

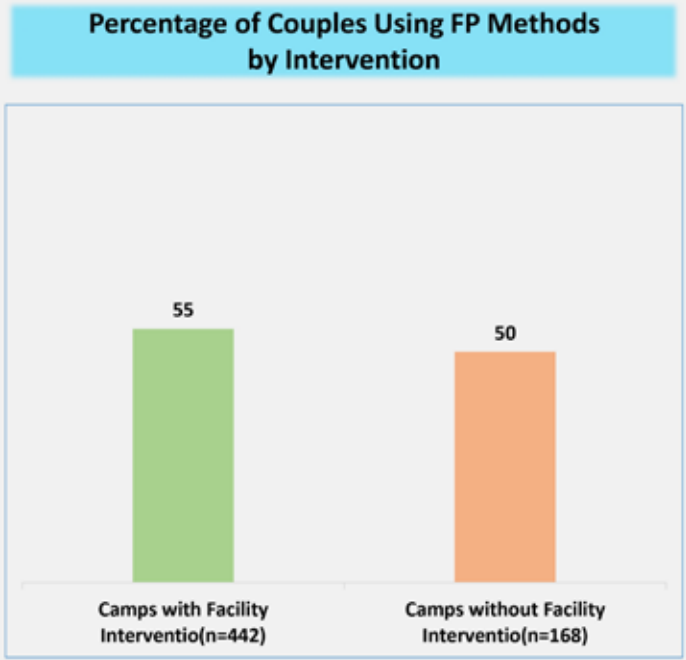
Percentage Distribution of Reasons for Not Using Contraceptives among Non User (N=317)



*multiple response

Contraceptive use by Perception and Intervention status*





*Ever married/unmarried non-pregnant

Factors Associated with Use of FP*

Women with a good perception of family planning are 1.61 times more likely to use it, a statistically significant finding

Those who attended school or madrasa are 38% more likely to use family planning

For each additional child, the likelihood of using family planning increases by 11%

*Ever married/unmarried non-pregnant

Results of Logistic Regression**					
Possible determinants	Adjusted Odds ratio	SE	P value	95% CI	
				Lower	Upper
FP Perception level (Ref: Poor)					
Good	1.59	0.26	0.01	1.14	2.21
Facility Type (Ref: Camps without facility intervention)					
Camps with facility intervention	1.04	0.19	0.79	0.73	1.50
Ever attended school or madrasa (Ref :No)					
Yes	1.38	0.22	0.05	0.99	1.90
No. of children	1.11	0.04	0.01	1.03	1.20

**Dependent: FP usage- User & Non-user (ref.)

Decision-Making on Family Planning

Decision-Making Patterns in FP Usage among the current user of FP methods	Girls (n=18)	Women (n=141)	Men (n=205)
	%	%	%
Who usually decides about the use of FP			
Woman	16.7	9.9	11.2
Husband/Partner	16.7	34.8	19.5
Both	66.6	55.3	68.7
Other	0.0	0.0	0.5
Who usually makes the final decision in case of disagreement			
Woman/Self	16.7	16.3	14.6
Husband/Partner	83.3	83.7	84.4
Other	0.0	0.0	1.0
Who should take the final decision about the use of FP			
Woman/Self	16.7	19.2	18.5
Husband/Partner	77.8	80.1	80.5
Other	5.6	0.7	1.0

Summary Findings: Practice of FP

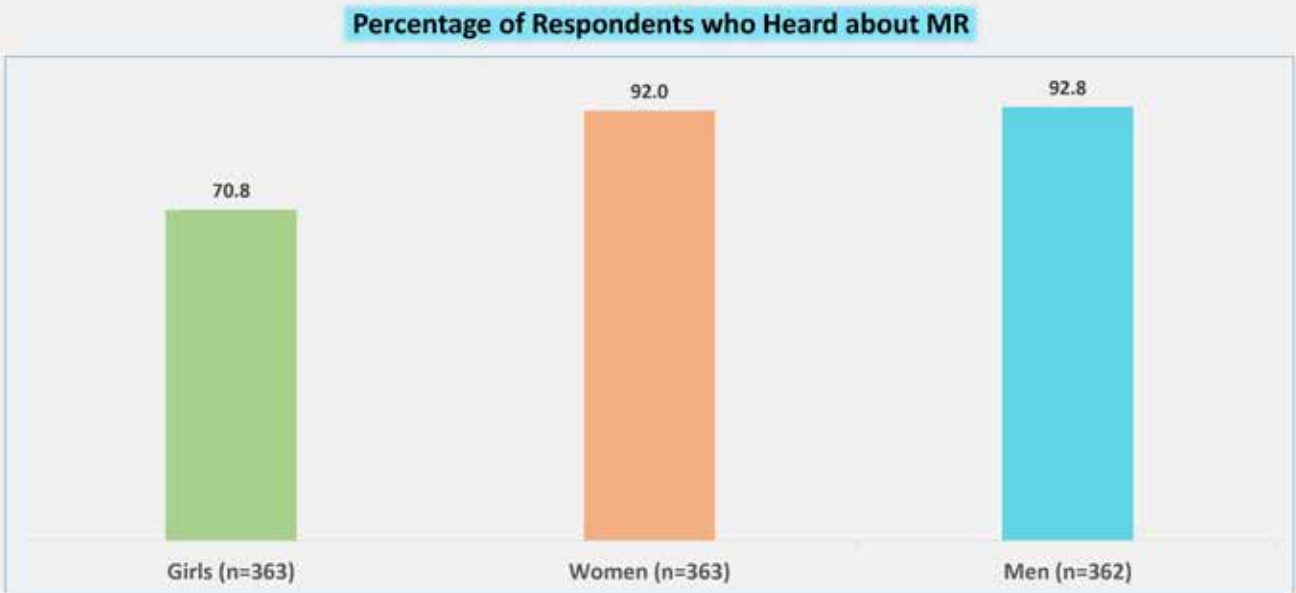
53% couples used contraceptives during the interview period, mainly pills and injectables

Over half made joint family planning decisions, but in disagreements, husbands/male partners often had the final say, with around 80% believing they should

Women with a good perception of family planning are 1.61 times more likely to use it, while education (school and madrasha) has less positive impact.

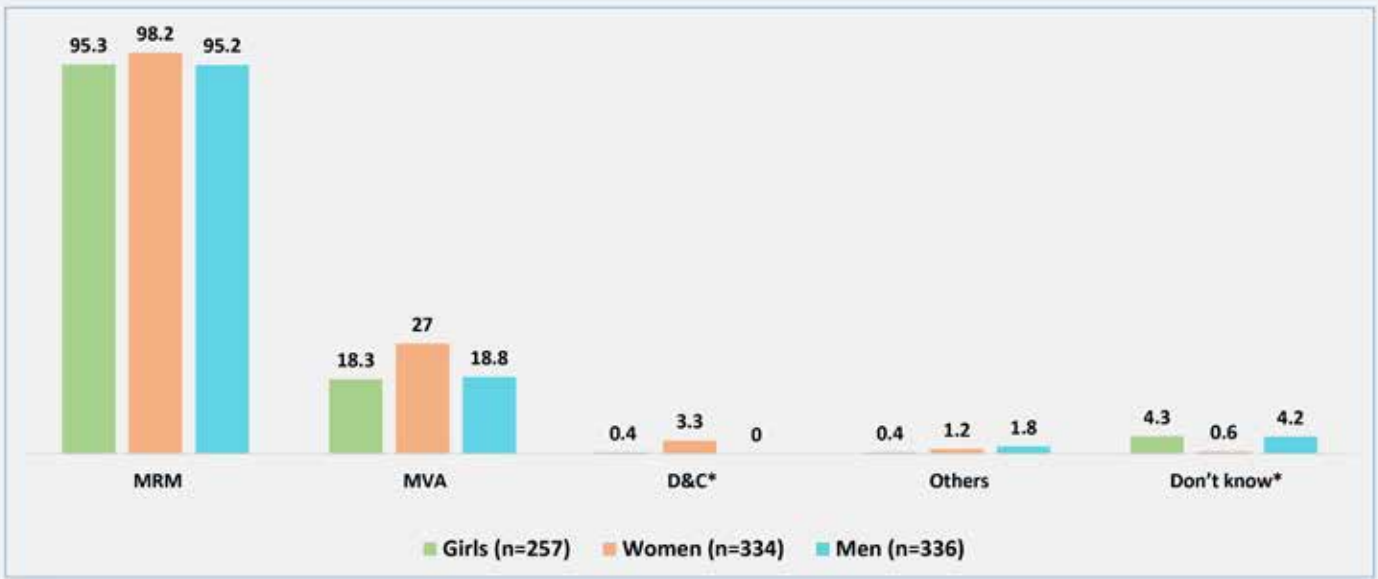

Knowledge, Attitudes and
Practice of Menstrual Regulation
(MR)

Knowledge on MR



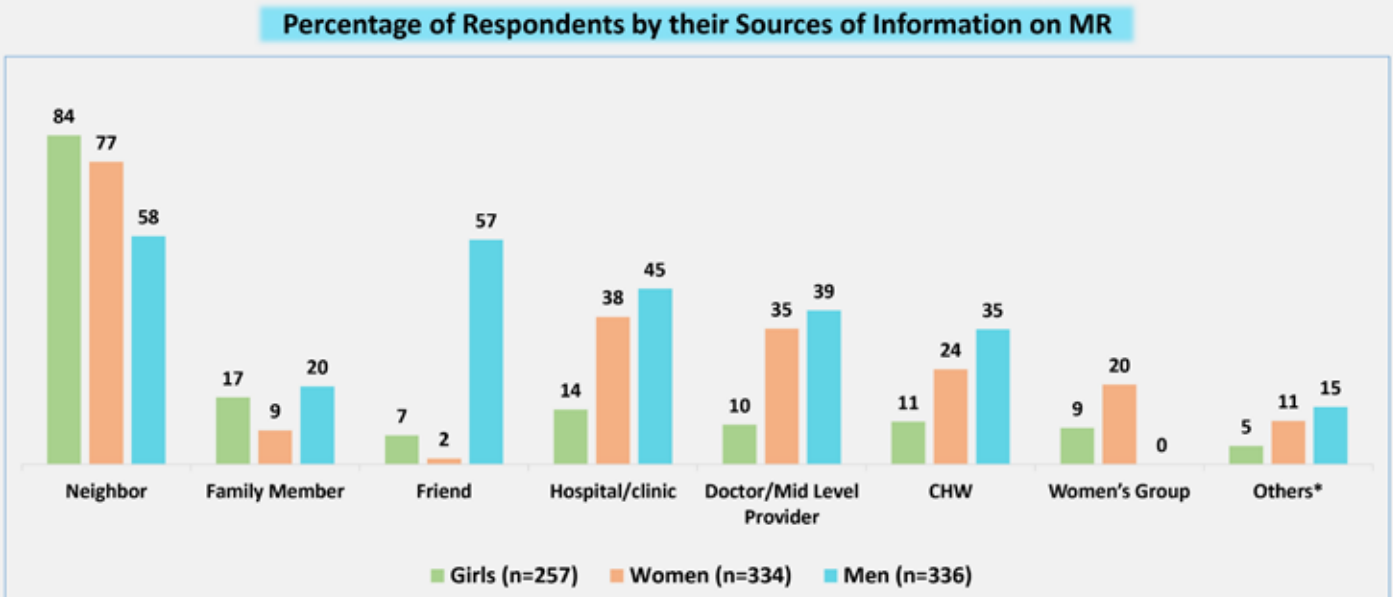
Knowledge on MR

Percentage Distribution of Respondents Who Heard of Various MR Method*



*Multiple response

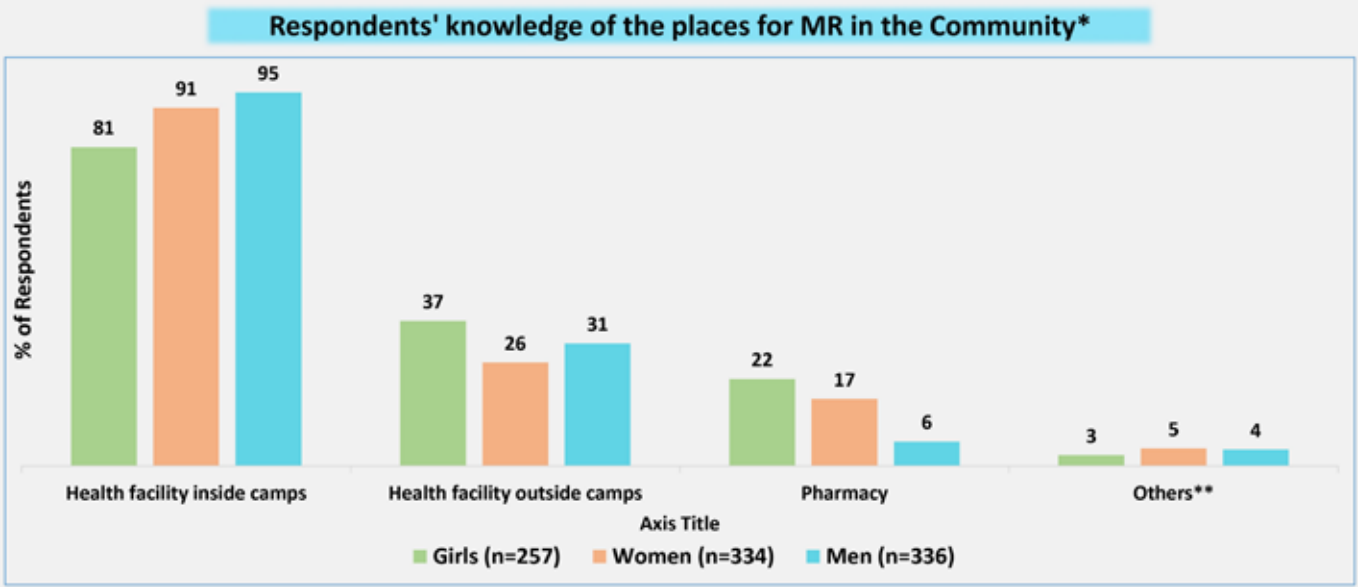
Source of Knowledge on MR



*Multiple response

**Others include TBA(trained), pharmacists, CIC office meeting etc.

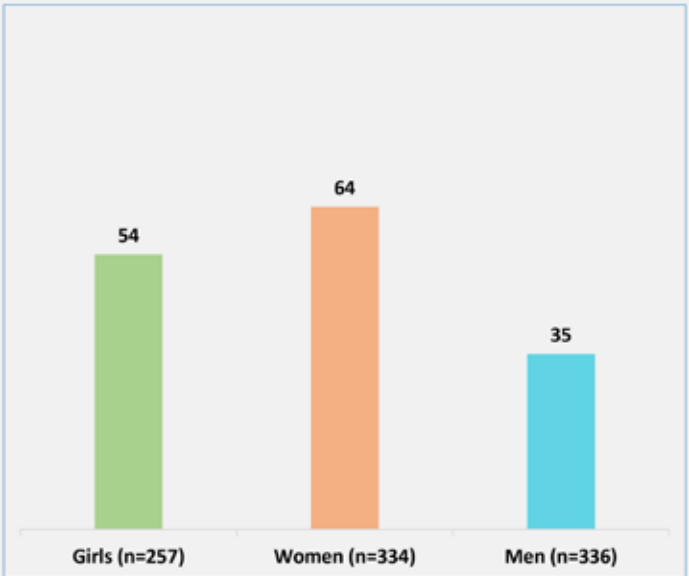
Access Points for MR Services in the Community



* Multiple response ; among those who heard about MR **Others include TBA,TBA(trained), pharmacists, Self-made traditional remedies etc.

Perceptions of the Legality of MR

Percentage of respondents who thought MR is legal in Bangladesh



*among those who heard about MR

Knowledge on Legitimate Timeframe for Menstrual Regulation in Bangladesh	Girls (n=139)	Women (n=212)	Men (n=110)
	%	%	%
<12 weeks	62.6	54.3	71.8
12 weeks	27.3	37.3	24.6
13-24 weeks	6.5	7.1	3.6
Don't Know	3.6	1.4	0.0

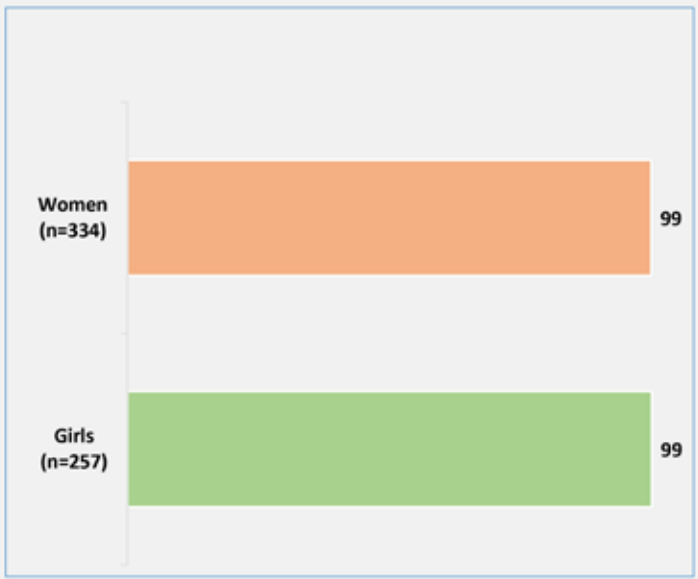
Barrier to Accessing Safe MR

Barrier to Accessing Safe MR*	Girls (n=257)	Women (n=334)	Men (n=336)
	%	%	%
Status as unmarried girls	29.2	32.6	8
Parental consent	29.2	32.6	3.3
Insults and ridicule by community members	30.4	23.9	8.3
Attitude of friends and relatives	26.5	17.6	36
Fear of pregnancy being exposed	20.6	16.5	2.4
Distance to facilities	1.2	12.3	9.8
Lack of knowledge of where to go	3.1	7.5	1.8
Financial difficulties	1.2	5.1	13.7
Attitude of health care providers	1.6	1.5	0.9
Inconvenient hours at facilities	0.4	1.8	17
Don't know	22.2	22.5	18.8

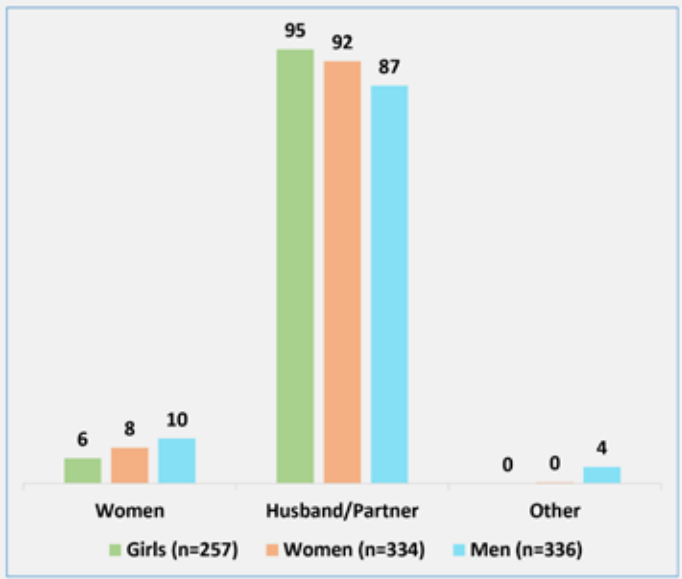
*Multiple response and among those who heard about MR

Decision-Making in MR Services*

Percentage of Respondent Believing Husband's Consent is Required for MR

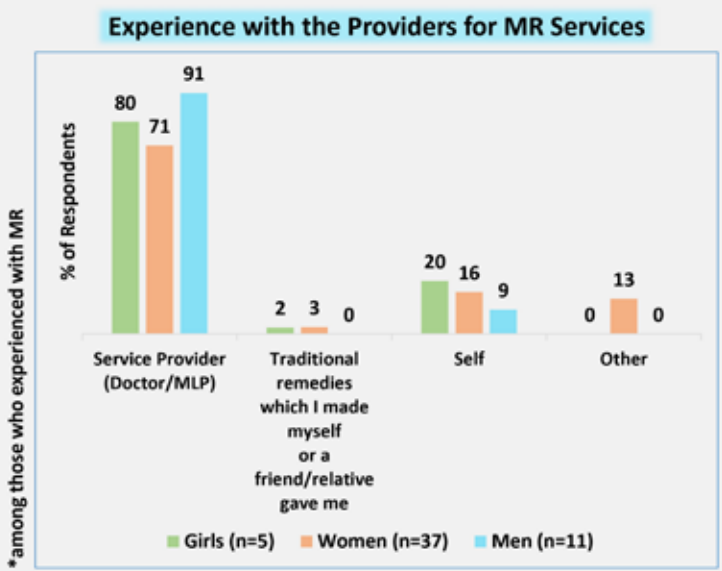


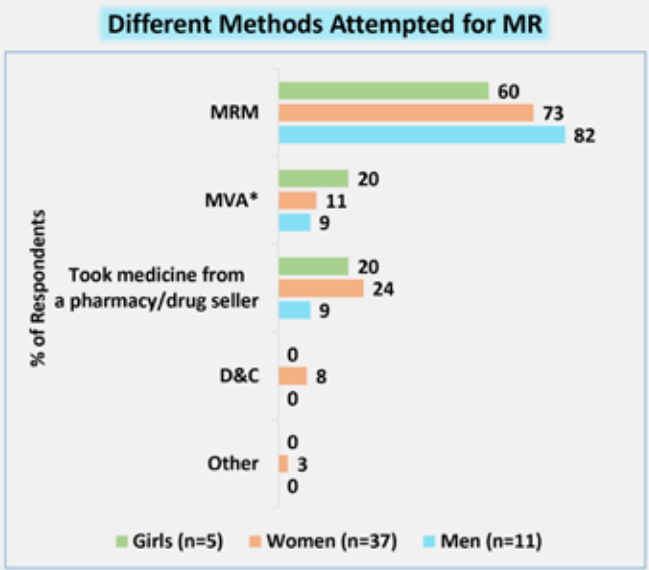
Respondent's View on the Ultimate Decision-maker for MR



*among those who heard about MR

Experienced with MR*





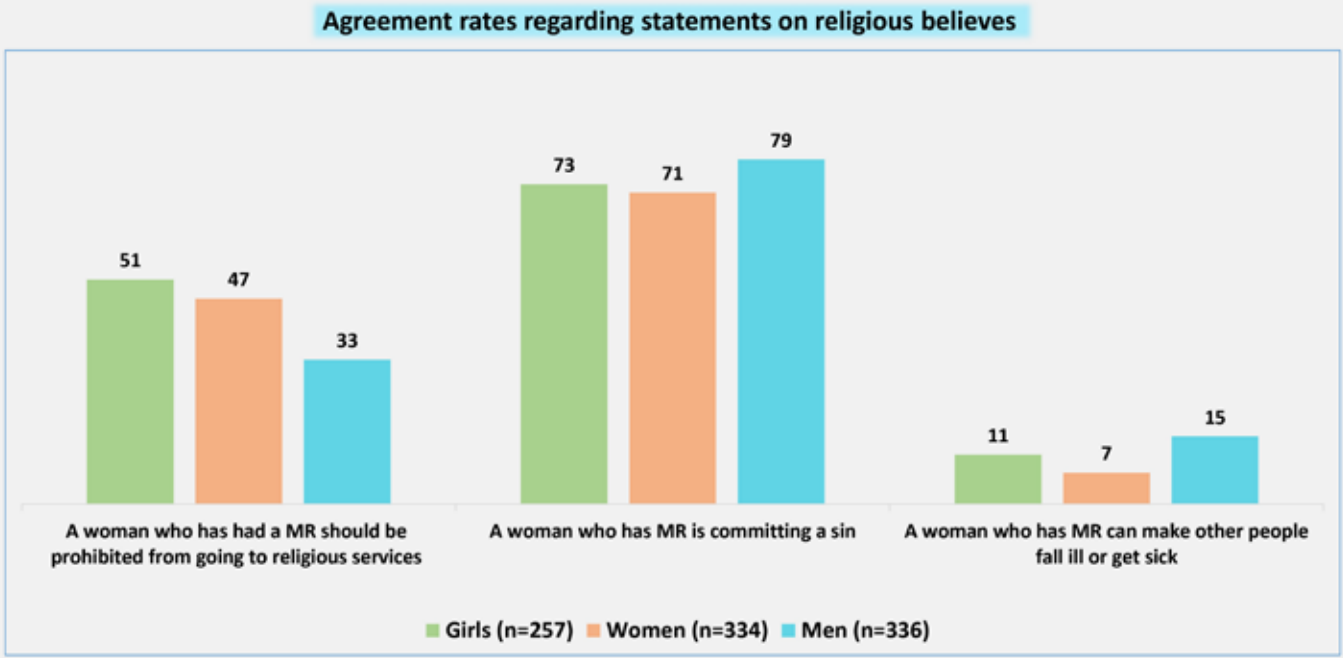
- 5 (6.8%) girls and 37 (11.1%) women took steps to terminate an unwanted pregnancy and 11 (3.2%) men assisted their partners.
- The predominant choice for both groups was to consult service providers/Doctor/MLP and use MRM for the procedure.

Self-efficacy to Seek MR

Respondent's agreement rates on the self efficacy indicators				
Indicators	Girls (n=257)	Women (n=334)	Indicators	Men (n=336)
	%	%		%
If I wanted to have MR I could	75.5	74.0	If my wife wanted to have a MR without my consent she could	2.4
I know where to get MR in my community	78.6	80.8	I know where my wife can get MR in my community	94.1
I am able to pay the cost to travel to get MR	75.1	72.5	I am able to pay the cost to travel for my partner/wife to get an MR	92.3
I could speak with MR provider doctor, nurse, midwife if I wanted have MR	89.1	90.4	I could speak with an MR provider doctor, nurse, midwife if my wife wanted to have MR	98.5
I could tell my family if I wanted to have MR	74.3	64.1	I could tell my family members if wife wanted to have MR	67.6
I know the difference between a safe MR provider and an unsafe MR provider	74.7	73.7	I know the difference between a safe MR provider and an unsafe MR provider	98.8
I could tell my husband if I wanted to have MR	91.4	92.5		

*among those who heard about MR

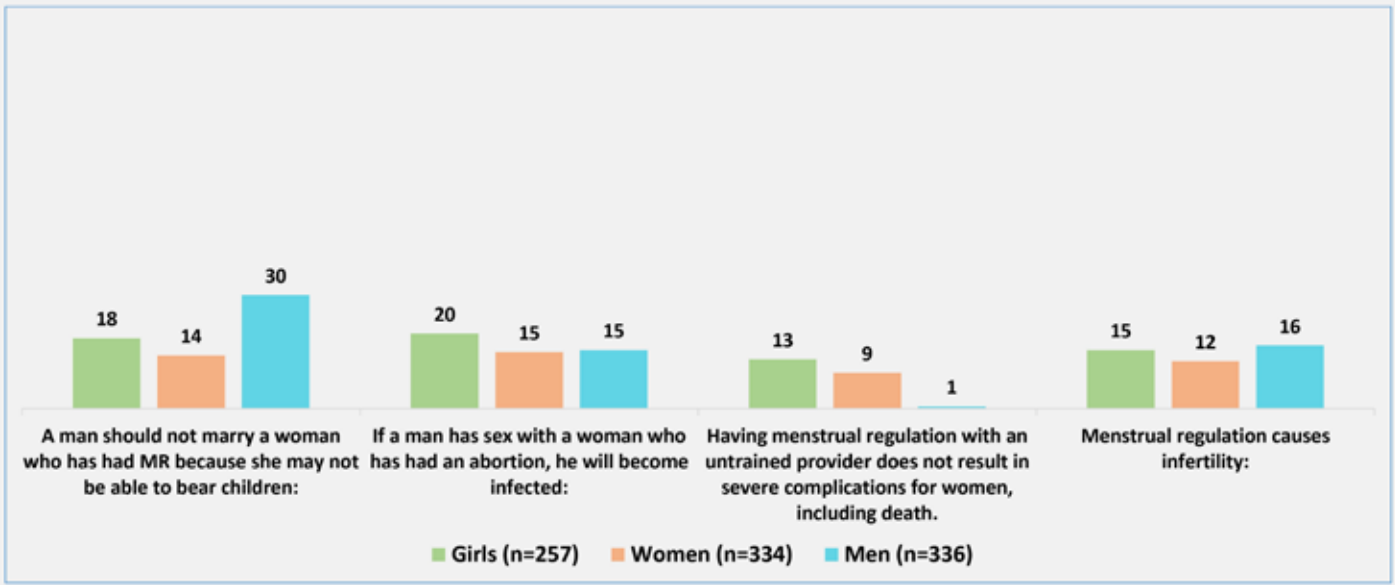
Attitudes Toward MR



*among those who heard about MR

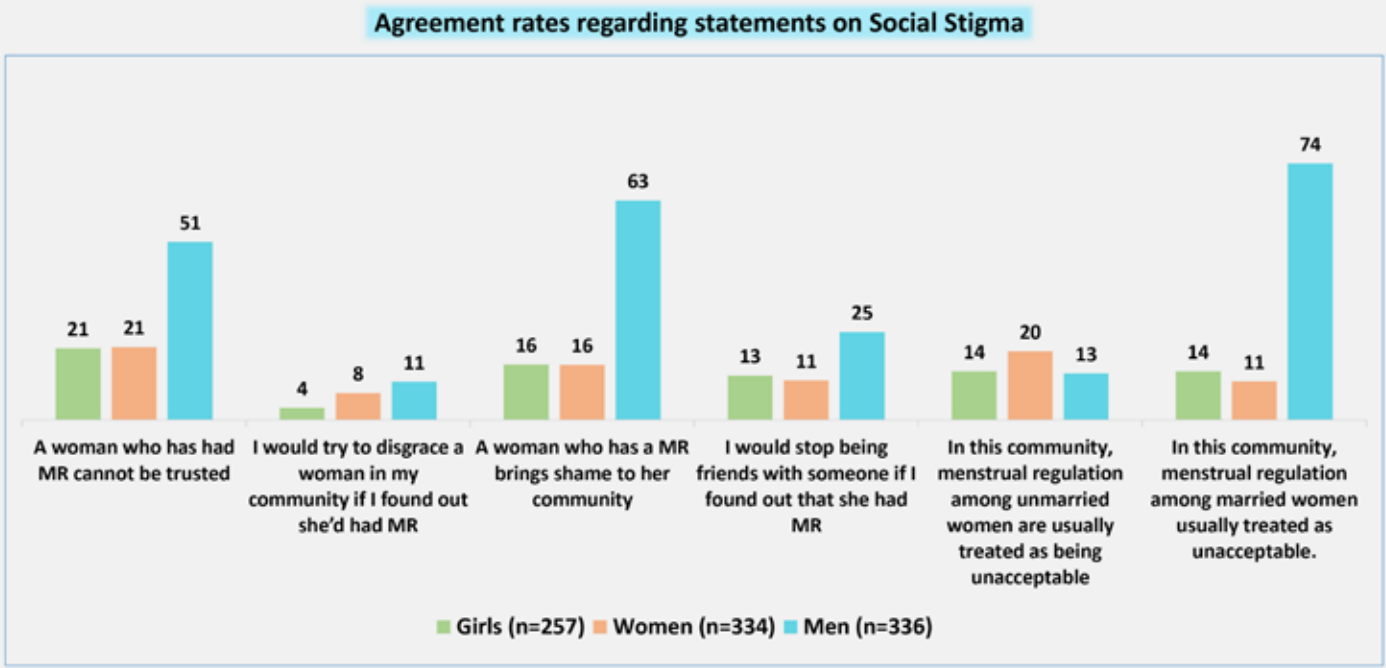
Attitudes Toward MR

Agreement rates regarding statements on some misconceptions



*among those who heard about MR

Attitudes Toward MR



*among those who heard about MR

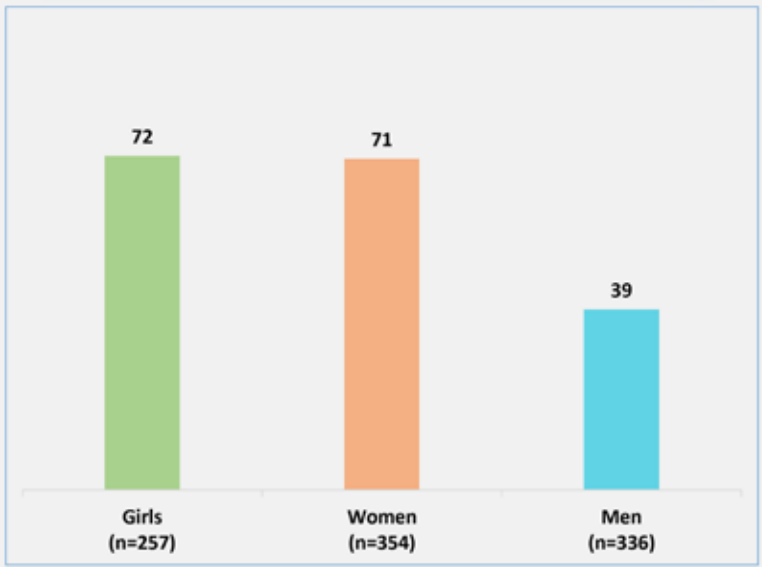
Attitudes Toward MR* by Respondents' Type*

Descriptive Statistics of Attitude Score on MR
Total Score=110

Respondent Type	Mean	SD	P value
Girls (n=257)	88.0	11.7	<0.001
Women (n=354)	87.5	13.2	
Men (n=336)	78.3	16.3	

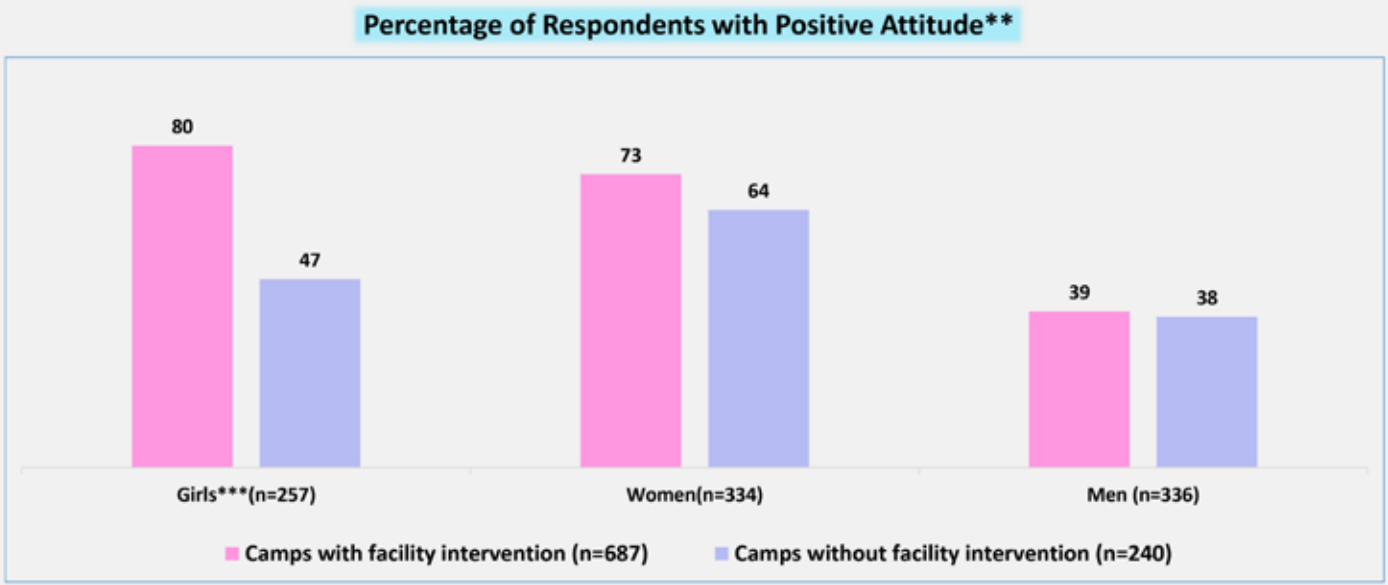
*Among those who have ever heard about MR

Percentage of Respondents with Positive Attitude**



**Classified attitude scores into two categories Negative vs Positive based on the overall mean (84) as the cutoff value
**Significant at 5% level of significance

Attitudes Toward MR by Respondents' Type* & Intervention*



*Among those who have ever heard about MR
**Classified attitude scores into two categories Negative vs Positive based on the overall mean (84) as the cutoff value
***Significant at 5% level of significance

Factors Associate with Perception on MR*

Girls & Women's Perception	Girls are 2.3 times, and women 4.35 times more likely to have a positive attitude toward MR compared to men
Impact of Facility Intervention	Participation in the intervention increases the likelihood of a positive attitude by 1.82 times
Education's Influence	Attending School or Madrasah indicates a slightly higher, yet non-significant, tendency towards a positive attitude (1.12 times more likely)
Role of Employment	Being employed shows a 1.31 times higher chance of a positive attitude, though not statistically significant

*Among those who have ever heard about MR

Results of Logistic Regression					
Possible determinants	**Adjusted Odds ratio**	**SE**	**P value**	**95% CI**	
				Lower	**Upper**
Type of the Respondents (Ref: Men)					
Girls	2.30	0.58	0.00	1.41	3.76
Women	4.35	1.07	0.00	2.68	7.05
Facility Type (Ref: Camps without facility intervention)					
Camps with facility intervention	1.82	0.26	0.00	1.38	2.41
Ever attended school or madrasa (Ref :No)					
Yes	1.12	0.15	0.38	0.87	1.46
Did any work in the last 12 months (Ref: No, not working)					
Yes, only cash	1.31	0.31	0.26	0.82	2.07

*Dependent: Perception level level- good & poor (ref.)

Summary Findings: Knowledge, Attitude and Practice of MR

- Over 70% of Girls, 80% of women, and 90% of men knew about menstrual regulation MR, with nearly all identifying medication MRM as the method
- Over half of the Girls and women and a third of the men were aware that menstrual regulation MR is legal in Bangladesh. Among them, approximately 27% Girls,37% of women and 25% of men knew the legitimate limit is 12 weeks
- Unmarried status and lack of parental consent were the main hurdles for accessing MR, according to women. Additionally, a significant number of men cited financial issues as a barrier
- Nearly all Girls and women believed that husband's consent is essential for MR, and the majority of men and women agreed that the husband should make the final decision regarding MR
- 6.8% (5) of girls and 11.1% (37) of women sought to terminate an unwanted pregnancy, with 3.2% (11) of men helping their partners. The preferred method for both was consulting service providers and using Menstrual Regulation Medication (MRM)
- Girls and women are significantly more likely (2.3 and 4.35 times respectively) to have a positive attitude than men, interventions notably boost positive attitudes(OR=1.82,P<0.001), education and employment show a higher but not significant tendency towards positivity

Recommendation

Targeted Educational Interventions	• Implement educational programs tailored to each group's specific needs and misconceptions, with a special emphasis on informing girls about MR, and dispelling prevalent misconceptions regarding both FP and MR as they show a significant lack of awareness and understanding in these areas.
Increase Access to Healthcare Professionals	• Encourage individuals, especially girls to seek information from healthcare providers rather than relying predominantly on neighbors and family members, as misinformation is common in informal networks
Enhance Male Involvement and Education	• Since men are key decision-makers, initiatives should focus on educating them about the benefits of FP and addressing their misconceptions, especially regarding **MR**
Facility Interventions	• Scale up facility interventions in camps as they have been shown to greatly improve positive perceptions towards FP and MR. This could include counseling services, information sessions, and accessible medical care

Recommendation

Community Sensitization	• Conduct community awareness programs to reduce the stigma associated with FP and MR, particularly targeting men and influential community members
Joint Decision-Making Encouragement	• Promote joint decision-making in FP and MR between couples to ensure women's autonomy and involvement in decisions affecting their health
Focus on Unmarried Women and Girls	• Address the specific barriers faced by unmarried women and girls in accessing FP and MR services, including societal stigma and the need for parental consent
Financial Assistance Programs	• Implement financial assistance or subsidy programs to alleviate the financial barriers to accessing safe MR


Thank
you

Exploring Availability, Acceptability, Misconceptions, Myths and Social Barriers Related to Family Planning, Menstrual Regulation and Post Abortion Care Services Among Forcibly Displaced Myanmar Nationals' (FDMN)

Summary

This study focuses on optimizing Sexual and Reproductive Health (SRH) services, specifically Family Planning (FP), Menstrual Regulation (MR), and Post-Abortion Care (PAC), for Forcibly Displaced Myanmar Nationals (FDMN) in humanitarian settings. The study addresses cultural influences, misconceptions, and social barriers impacting SRH services among FDMN, aiming to improve reproductive health outcomes.

The study employs a participatory qualitative research approach involving Rohingya women, men, religious leaders, local leaders, SRH service providers, and key stakeholders. Findings reveal existing misconceptions/myths, preferences, and barriers related to FP, MR, and PAC services. Cultural and religious factors influence attitudes, with myths affecting service acceptability. Barriers include societal pressures, religious restrictions, and facility-level challenges.

To enhance ongoing SRH services, the study recommends targeted awareness campaigns led by religious leaders, precise information dissemination in local languages, and initiatives to engage men in open discussions. It advocates for accessible facilities, comprehensive referral support, an expanded Community Health Worker network, and incentives for community participation. The report emphasizes policy development, coordination, and research initiatives to ensure a sustainable and inclusive reproductive health service system tailored to the unique needs of the FDMN community.

Introduction

Understanding the cultural beliefs of the Forcibly Displaced Myanmar Nationals (FDMN) is crucial for optimizing the delivery of Sexual and Reproductive Health (SRH) services, particularly Family Planning (FP), Menstrual Regulation (MR), and Post-Abortion Care (PAC) services in humanitarian settings. Cultural influences significantly shape attitudes toward SRH services, and unaddressed misconceptions and barriers can lead to unintended pregnancies and adverse reproductive health outcomes, impacting both individuals and communities in the long term. Despite the patriarchal nature of the FDMN community, there is a notable gap in knowledge regarding perceptions and social barriers related to SRH services, underscoring the need for comprehensive information to address current and future service demands. This research aims to document misconceptions, myths, and social barriers among FDMN women, explore FDMN men's perspectives, and engage key stakeholders, including religious and local leaders, in designing effective and sustainable SRH programs. By raising awareness, dispelling myths, and mitigating social barriers, the research seeks to reduce unintended pregnancies and improve reproductive health outcomes among FDMN in humanitarian settings, contributing to the overall well-being of the population. Understanding and addressing existing misconceptions and barriers are essential steps in designing impactful SRH programs tailored to the unique needs of the FDMN community.dispelling myths, and mitigating social barriers, the research seeks to reduce unintended pregnancies and improve reproductive health outcomes among FDMN in humanitarian settings, contributing to the overall well-being of the population. Understanding and addressing existing misconceptions and barriers are essential steps in designing impactful SRH programs tailored to the unique needs of the FDMN community.

Study Objectives

To understand existing misconceptions, myths and social barriers related to family planning, menstrual regulation and post abortion care services and availability, acceptability status of the services among FDMN community in humanitarian context

Understand the language and local terminology used by FDMN to talk about FP, MR, PAC services in the camp	Explore availability, acceptability, misconceptions, myths and social barriers related to demand and utilization of FP, MR and PAC services	Identify approaches for overcoming existing barriers and improving SRH care seeking behaviors for FP, MR, PAC services	Identify approaches for attaining sustainability of quality SRH services particularly for FP, MR and PAC services

Research Design

DESIGN	Cross sectional study design following participatory qualitative research.
SITE	Camps in Ukhiya and Teknaf Upazilas of Cox's Bazar district
POPULATION	Rohingya women and girls of reproductive age (15-49 years), Rohingya men, Rohingya religious leaders (Imam) and local leaders (Majhi), SRH service providers; community health workers/volunteers; relevant officials from UNFPA and relevant NGOs, Key stakeholders
STUDY PERIOD	February'23 to October'23
ETHICAL APPROVAL	EEthical approval from Bangladesh Medical Research Council
FUNDED BY	UNFPA and Ipas Global

Data Collection Methodology

Desk review: Existing literature, published/unpublished reports, articles and other documents related to FP, MR, PAC related services in humanitarian context

Key Informant Interviews (KIIs): 11 interviews were conducted with FDMN women and men; Religious leader (imam) and local leader (majhi); Officials from DGFP, UNFPA and relevant NGOs working in SRH sector in the humanitarian context.

Focus Group Discussions (FGDs): 11 group discussions were conducted with SRH Service providers in the camps; Community health workers/volunteers; Religious leaders (Imam) and local leaders (Majhi).

Community Dialogue Meetings (CDMs): 12 CDMs were conducted with FDMN women, girls and FDMN men.

Stakeholder Consultation Workshop: One stakeholder consultation workshop was conducted with Representatives from GOB officials, UN agencies and NGOs working for SRH services.

Findings

Availability & Acceptability of FP, MR & PAC Service

In the camp, FP services, locally termed "Azadur," offer various methods, including Pills, Injectable, Implant, IUD for women, and Condom for men. MR and PAC services, known as "Gagosol Bondho," and "Khunjari" provide MRM and MVA procedures, with traditional approaches (holy water, amulet, roots) also used. Attitudes towards FP, MR, and PAC are influenced by misconceptions about Islamic principles, but positive shifts include increased awareness and independent service utilization by Rohingya women. Challenges persist, with some seeking clandestine abortion services from traditional healers. Usually, the responsibility for family planning has fallen on women. Method use is hindered by male reluctance, discomfort and cultural stigma. The community favors short-term FP methods, hesitates on long-term options. Traditional methods initially prevail in MR and PAC services, with a preference for MRM over MVA. Information-seeking primarily involves service providers, community leaders, and religious leaders, with a preference for service centers offering quality care without extended waiting times and costs.

"আসলে এটা হচ্ছে ক্যাম্পের একটা নিয়ম। মানে হচ্ছে ওরা মেয়েদেরকে একটু ইয়া করতে চায় আরকি। ফ্যামিলি প্ল্যানিং যেটা আছে সেটা মেয়েরা বেশি ইউজ করে। ছেলেরা ইউজ করতে চায় না" ***("Actually, there is a rules in the camp. Means, they want women to use it. Women mostly use family planning methods. Men do not want to use the methods mostly.")***

"প্রথম যে অবস্থা ছিল, আগের থেকে অনেক অনেক পরিবর্তন হয়েছে। নিজের থেকেও অনেক সচেতন হয়েছে....তারপরো এটা পুরোপুরি যে ইয়া হইছে তেমন কিন্তু, না" (***"There has been a lot of change from what it was before." A lot more self-aware....But it does not mean that it has changed completely")***

Misconceptions and Myths Related to FP, MR, PAC Services

Misconceptions and Myths Related to FP Services

Pills
-Sinful Act
-Creates wounds in the stomach.
-Burns the womb/uterus.
-Leads to permanent infertility.
-Consumption of pills implies having a disease.
-Killing fetus before Pregnancy
-Enough to take during the day of intercourse only

“খাইতে খাইতে পেড’র আত জ্বলি যাইলি, বাচ্চা ন হ, জান্নামে যাইবো” ***(”Taking the pill regularly will burn the uterus. Can't get pregnant anymore, will go to hell”)***

- রোহিঙ্গা নারী **(FDMN Woman)**

Injectable
-Sinful Act
-Creates wounds in the stomach.
-Burns the womb/uterus.
-Causes heart disease
-Causes cancer
-Leads to permanent infertility
-One dose could work up to one year

Condom
-Considered as child's toy
-Cause pain and infection for men
-Used by non-religious individuals
-Associated with non-Muslims (Bedini)
-Used by Christians.
-Contains pork oil

IUD
-Sinful Act
-Could have adverse body effect
-Could lost or misplaced,
-Could insert into stomach
-Create problems during intercourse
-Exclusive Method for No More Children
-Leads to permanent infertility
-Last funeral prayer cannot be performed
-Prevents the entry into heaven
-To be deprive from the intercede of Prophet on the final day
-To be deprived of the acceptance of prayers

"ইতারা গার ভিতরে, গায় বাইরের তুন চিজ গলাই দিলে ইয়ার বলে এবাদত কবুল ন হ, নামাজ কবুল ন হ। ইয়ান হইতু চায় মায়াপোয়া ইন দি্ইয়ার গার ভেতরে কিন ডেইল্লা গলাই রাখখসে। উজ্ঞা গার ভিতরে গলাই থাকলি, ইয়ান দিলে ইবাদত কবুল ন হয়। ইয়া মাইরয়্য যে, নামাজ ন পড়?" ***(“The people of the society say) if any outside object enters the body, the prayer is not accepted, and the namaz is not accepted. They say, women do it to stay young. They say... Why did you enter them into the body? If they are inside the body, the prayer will not be accepted. You have taken this method, do you not pray?!”)***

-FDMN Woman

Implant
-Sinful Act
-Burns the womb/uterus.
-Could have adverse body effect
-Could lost or misplaced
-Could insert into the muscle.
-Leads to permanent infertility
-Last funeral prayer cannot be performed
-Prevents the entry into heaven
-To be deprive from the intercede of Prophet on the final day
-To be deprived of the acceptance of prayers

Misconceptions and Myths Related to MR and PAC Services

-Unforgiveable sin, alike to taking a life	-Causes difficulties in conceiving later on
-Requires cutting the abdominal	-Leads to permanent infertility
-MVA syringe could suck the entire blood from the body	-Last funeral prayer cannot be performed
-Requires inserting hands into the belly/uterus	-Prevents the entry into heaven
-Causes excessive bleeding	-To be deprive from the intercede of Prophet on the final day
-Burns the womb/uterus	-To be deprived of the acceptance of prayers
-Causes cancer	-Lead to divorce or anything worse due to the sin

"মইরলে জানাযা ন হইবু। জামাইয়ে মইরলে মাফ দিতু ন, ইন গুনাহ। ইন গুনাহ পরিবার ভাঙ্গি" *("Funeral prayer will not be held after death... Husband will not forgive after death. That would be sin. Because of this sin the family will be broken")*

- রোহিঙ্গা নারী **(FDMN Woman)**

"ইবা নিলে জায়েজ না, ইসলামত্ হারাম...এবা জায়েজ না, ইসলামে জায়েজ না। এবা জায়েজ না..." *("These processes are not religiously legal, it is haram in Islam...these are not legal, these are not legal in Islam ")*

- রোহিঙ্গা নারী **(FDMN Woman)**

Barriers Related to FP & MR Services

Barriers Related to Receive FP, MR and PAC Services	*Barriers Related to Providing FP & MR Services*
• Women's barriers to accessing FP and MR services: -Familial restrictions, requirement of husband's	• Resistance from husbands and in-laws • Community-wide opposition and restrictions on

Barriers Related to Receive FP, MR and PAC Services	***Barriers Related to Providing FP & MR Services***
permission and fear of divorce -Societal pressures and negative attitudes from neighbors and community members -Religious leaders' discouragement, associating it with sin -Fear of defamation for unmarried girls -Misconceptions about the services -Practical obstacles such as long wait times and facility distance. • Men's barriers to accessing FP services: -Embarrassment and societal stigma associated with collecting methods -Objections from parents and wife -Difficulties in hiding method -Limited understanding and discomfort with the method -Fear of judgment, particularly for unmarried men	facility access despite counseling efforts • Traditional Birth Attendants discouraging the use of Family Planning (FP) • Client misuse of methods, leading to complications, or resorting to traditional abortion methods • Reluctance towards potential side effects of FP methods • Resistance to follow-up visits and unwillingness to make adjustments • Barriers faced by community health workers/volunteers: -Humiliation -Opposition from family and community leaders -Potential legal threats -Community hostility -Poor service quality -Restrictions on discussing specific topics • Comprehensive efforts needed to address these challenges for effective reproductive health service delivery.

"শরম জাগাত মাইজ্জে গরে এবা (IUD) অইলদ্দে নিজ জামাইর লাই এক্কার শরম জিনিস। আর আরার রোহিঙ্গা মহিলা যে আছে উন ওর লাই এক্কান শরমিন্দা জিনিস..." *("The product (IUD) that is used in the secret (uterus) parts is considered very embarrassing to the husbands. And it is disgraceful to the Rohingya womenfolk as well")*
- রোহিঙ্গা পুরুষ (FDMN Men)

"ইমামরা বুঝায়, সিডাব্লিউ যারা বুঝাতে যায় ওদেরকে দেখে নামাজ পরলে নামাজ হবে না। তাদের সাথে কথা বলা ছেলেদের সাথে কথা বলার মতোই গুনা" *("Imam says that those CHW try to make them understand, namaz (prayer) will not be accepted, if you see their face. It's a sin to talk with these girls like talking to boys...")*
- রোহিঙ্গা নারী (FDMN Woman)

Suggestions from the Respondents for Improving Ongoing FP, MR, PAC Services and Attaining Sustainability of FP, MR, PAC Service

Improving Ongoing FP, MR, PAC Services	Attaining Sustainability of FP, MR, PAC Service
• Increasing the number of dedicated facilities • Establishing separate centers near communities or blocks • Effective communication in local languages • Respectful treatment of clients • Provision of supplementary medicines for client satisfaction • Offering transport services • Providing incentives for long-term methods • Ensuring 24/7 facility availability • Streamlining referral processes • Increasing the number of Community Health	• Regular counseling sessions with religious leaders to overcome stigma • Involving religious leaders in community outreach • Creating awareness through demographic-specific meetings • Emphasizing couple and family counseling • Appointing dedicated Community Health Workers (CHWs) • Generating interest by offering incentives and refreshments • Enhancing services by increasing facilities

Improving on-going FP, MR, PAC Services	Attaining Sustainability of FP, MR, PAC Service
Workers (CHWs) • Providing short-term methods at home to improve community outreach • Simplifying withdrawal services • Ensuring comprehensive support during referrals • Taking essential steps to enhance the accessibility and effectiveness of reproductive health services.	• Ensuring 24/7 availability of services • Setting up facilities in or near camps • Strengthening the entire system through policy development • Establishing institutional linkages with existing government facilities • Coordinating among service providers • Avoiding program duplication in camps • These focused strategies collectively contribute to a sustainable and inclusive reproductive health service system.

Recommendation

• Targeted Awareness Campaigns: Recognizing prevalent religious misconceptions surrounding FP, MR, and PAC services, it is crucial to initiate community-based awareness programs led by religious leaders. This effort aims to dispel misconceptions while emphasizing the compatibility of these services with Islamic principles.

• Local Language Information: Given linguistic differences within the Rohingya community, precise information dissemination in local languages is essential. Implementation of this strategy, facilitated by community and religious leaders, ensures accurate communication and addresses language barriers.

• Men's Engagement Initiatives: Acknowledging that reluctance from men poses a barrier to service uptake, proactive campaigns are needed. Engaging men in open discussions, addressing cultural stigma, and promoting method use through targeted initiatives will help overcome this challenge.

• Accessible Facilities: Recognizing that distance and time constraints deter people from availing services, it is

crucial to expand facilities and establish local/block based centers. This step aims to provide convenient access to FP, MR, and PAC services, minimizing travel and wait times.

• Comprehensive Referral Support: To mitigate complications, optimizing the referral process is essential. Offering thorough support and emphasizing the importance of follow-up visits will contribute to a more effective healthcare system.

• Expand Community Health Worker Network: Acknowledging the accessibility and acceptance of community workers, expanding their involvement is necessary. Increasing Community Health Worker (CHW) outreach will provide better access to information and support within the community.

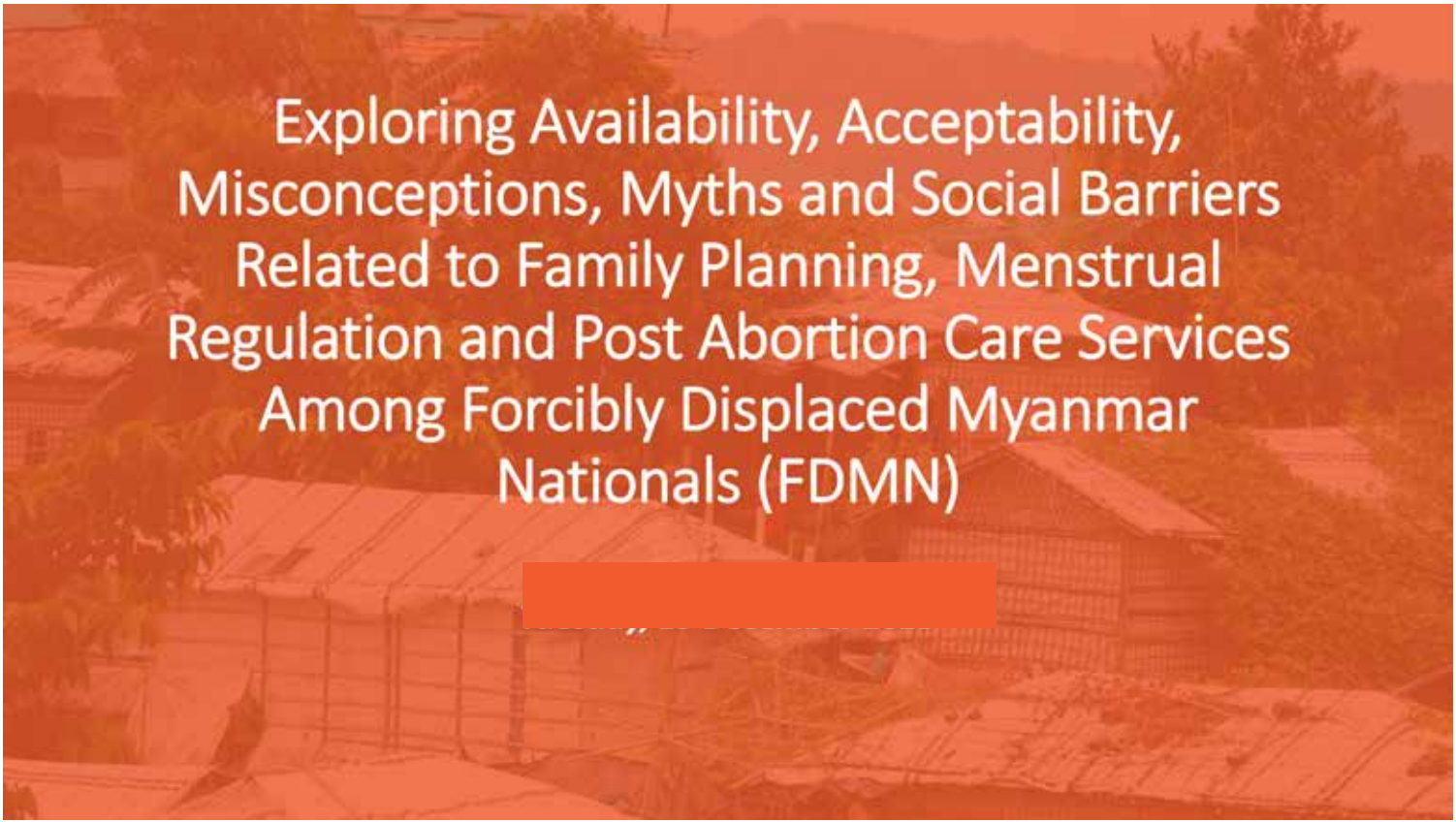
• Incentives for Participation: Recognizing that participation in awareness programs is voluntary and time-consuming, providing incentives and refreshments at community meetings will encourage interest and active involvement.

• Policy Development and Coordination: Addressing the lack of coordination among stakeholders, there is a need for comprehensive policy development. This includes formulating policies for a coordinated approach, establishing government linkages, and preventing program duplication for a sustainable reproductive health system.

• Research Initiatives: Acknowledging the lack of adequate information about men's views on FP, MR, and PAC services, rigorous research initiatives are required. This study aims to explore cultural and religious factors, providing valuable insights to address existing gaps in knowledge and perception.

Conclusion

The study on Rohingya reproductive health highlights progress in awareness and shifting attitudes, yet persistent myths hinder service utilization. Short-term Family Planning methods are preferred, but socio-cultural barriers persist. To improve, focus on dispelling myths, addressing barriers faced by women and men, and enhancing service delivery is crucial. Sustainable changes involve increased facility accessibility, community engagement, targeted education, and inclusive strategies to overcome stigma and strengthen the reproductive health service system.


Exploring Availability, Acceptability, Misconceptions, Myths and Social Barriers Related to Family Planning, Menstrual Regulation and Post Abortion Care Services Among Forcibly Displaced Myanmar Nationals (FDMN)

Background

Overview of Rohingya Crisis

Forcibly Displaced Myanmar Nationals (FDMN) in Bangladesh has introduced an unique challenges in delivering reproductive health services, including family planning (FP), menstrual regulation (MR), and post-abortion care (PAC) services

Reproductive Health Challenges

The often-neglected domain of Sexual and Reproductive Health (SRH) faces an urgent need for effectiveness, hindered by cultural, religious, and linguistic barriers specifically affecting the FDMN community

Research Need

A clear understanding of knowledge, attitude, practices, sources of information and ability to access the SRH services along with existing misconceptions, myths, and social barriers within the FDMN community is vital for effective SRH service delivery and planning.

Significance and Impact

Bridge knowledge gaps to design effective interventions, aiming to reduce unintended pregnancies and enhance reproductive health outcomes among FDMN.

Objectives

To understand existing misconceptions, myths and social barriers related to family planning, menstrual regulation and post abortion care services and availability, acceptability status of the services among FDMN community in humanitarian context

- Understand the language and local terminology used by FDMN to talk about FP, MR, PAC services in the camp
- Explore availability, acceptability, misconceptions, myths and social barriers related to demand and utilization of FP, MR and PAC services
- Identify approaches for overcoming existing barriers and improving SRH care seeking behaviors for FP, MR, PAC services
- Identify approaches for attaining sustainability of quality SRH services particularly for FP, MR and PAC services

Study Design

Ethical approval by BMRC

- Cross-sectional study design following participatory qualitative research

Design

- Rohingya women and girls of reproductive age (15-49 years); Rohingya men; Rohingya religious leaders (Imam) and local leaders (Majhi); SRH service providers; community health workers/volunteers; relevant officials from UNFPA and relevant NGOs; Key stakeholders

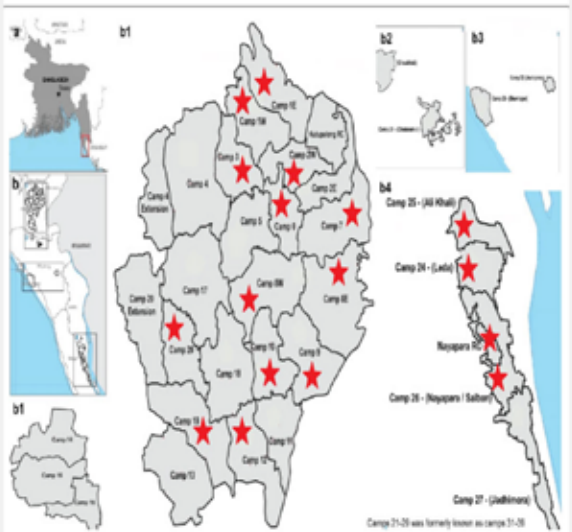
Population

- February'23 to October'23

Study Period

Study Site

Camps in Ukhiya and Teknaf Upazilas of Cox's Bazar district



Methodology

Literature Review

- Existing literatures, published/unpublished reports, articles and other documents related to FP, MR, PAC related service in humanitarian context

Key informant interviews

- Number of KII: 11
- Types of Respondents:
  - FDMN women & men
  - Religious leader (imam) & local leader (majhi)
  - Officials from DGFP, UNFPA and relevant NGOs working in SRH sector in the humanitarian context

Focus Group Discussion

- Number of FGD: 11
- Types of Respondents:
  - SRH Service providers in the camps
  - Community health workers/volunteers
  - Religious leaders (Imam) and local leaders (Majhi)

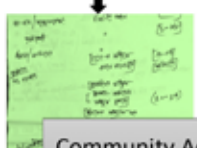
Stakeholder Consultation Workshops

- Number of Workshop: 1
- Types of Respondents:
  - Representatives from GOB officials, UN agencies and NGOs working for SRH services

Community Dialogue Meetings

- Number of CDM: 12
- Types of Respondents:
  - FDMN women and girls
  - FDMN men

Free Listing and Ranking



Community Action Plan


Findings


Availability & Acceptability of FP, MR &
PAC Service

Available FP Services in the Camp

Oral Pills

(Dabai/ Mashik Card /Maya Card / Mayabori/ Shukhi Femicon)

Injectable

(Depo/ Depo Card/Futa)

Condom

(Fadana/ Baskondul)

Implant

(Phuish/ Neddle/ Rubber)

IUD

Tar/ Kabati/ Suta/ 10 Years Method/ Shoromor Jagat Puja Porai

Available MR & PAC Services in the Camp

Attitudes Towards FP, MR, PAC Services

Mixed attitudes persist towards FP, MR, and PAC services

Some still believe these services are prohibited in Islam

Misconceptions contribute to confusion and indecisiveness among people regarding service utilization

Women are usually perceived as solely responsible for family planning

The community's attitude has shifted positively over time, with increased knowledge about FP, MR, and PAC services

More individuals are using FP services compared to previous periods

Women are increasingly accessing FP, MR, and PAC services independently, often without informing others

Service utilization is shifting from drug stores to dedicated service centers

Despite progress, some individuals still seek abortion services secretly from traditional healers or birth attendants

Attitudes Towards FP, MR, PAC Services

"ইসলামত ইতারারো, ইয়ার ব্যাভার গইরল্লে গুনা, আল্লাহ ধরিবো।... হুজুর ওন যারা আছে ইতারা মানা গরে দে ইয়া। ইন ন গবিরবার। হেইনদইল্লাই কিছু ন গরে। আর কিছু হদ্দে" কি আরার পুয়াইন ছাঁইন আত্তু লাইবো, বেশ লাইবো, আই আইলে কেনে? আল্লার এত্তুন দের। আর লইলে কি অয়য়ে? তো হেই ধরণর এবা ভাবিত্তরে হদ্দে ন গরিবো। আর কিছু আছে হদ্দে সমাজত্তত আছি আরে এক্কানা খারাপ হইতো ফারে" ("These are forbidden in Islam. Using these will be a sin and have to be accountable to Allah. Imams forbid using these. Many people don't use these for that. Many others want to have children, many children. They want to have as many children as Allah gives them. What will they do then? Then they won't use these. Some people do not use these because of the fear that they might be considered as bad by society")

-FDMN Man

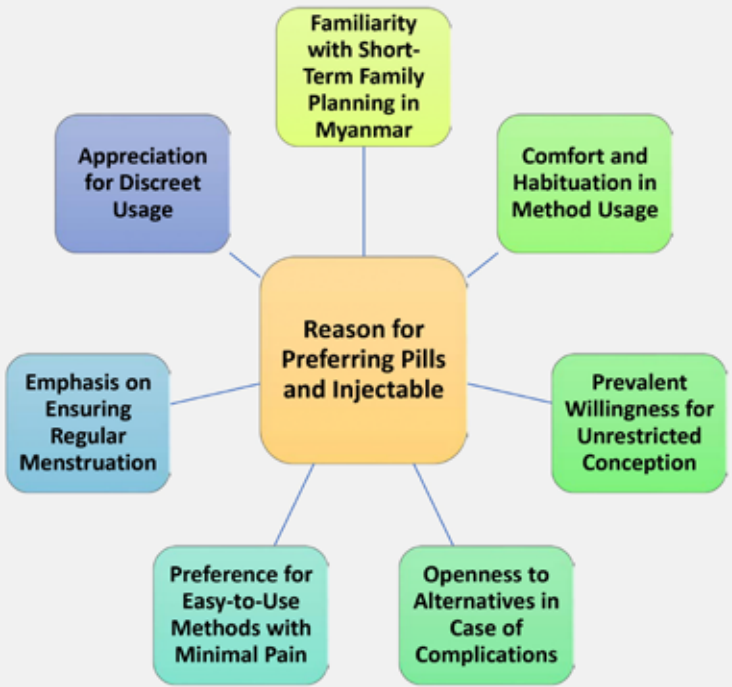
"প্রথম যে অবস্থা ছিল, আগের থেকে অনেক অনেক পরিবর্তন হয়েছে। নিজের থেকেও অনেক সচেতন হয়েছে... তারপরো এটা পুরোপুরি যে ইয়া হইছে তেমন কিন্তু না" ("There has been a lot of change from what it was before. A lot more self-aware....But it does not mean that it has changed completely")

- Service Provider

Preference for FP Methods

- Preference for short-term family planning methods, especially injectable and pills
- Ipas intervention increased awareness of implant and IUD options
- Limited enthusiasm for adopting long-term contraceptive methods in the community
- Gradual interest among women in using implants
- Reluctance persists among women regarding the adoption of IUDs
- General lack of interest among men in utilizing family planning methods

Preference for Pills and Injectables



"মাসে মাসে মাসিক অই যাগই, বাইচ্চা যেতুনত মনে হয়, এতুনত লই ফারে। মাস দুইমাস ওষুধ খেলে ২/৩ মাস বাচ্চা দূরে করে নেওয়ায় যায়, আবার ১ সপ্তাহ না খেলে মাত্র বাচ্চা পেটে চলে আসে" ("Regular menstruation occurs (by taking it). You can get pregnant whenever you want. "By these for 2 to 3 months, can prevent pregnancy for that time and again can conceive a baby by not taking it for week")

-FDMN Woman

ওনারা মনে করেন পিল খায়। ওটা যদি মানে মাথা ব্যথা করে, মাথা ঘুরায়, অশান্তি বোধ করে, ওরা চেঞ্জ করে ইনজেকসন নেয়। যাদের ইনজেকসন (suit) করে না তারা পিল নেয়" (*"Suppose they use pills. If they suffer from headache, nausea or fatigue, then they change the method. Then they take injection. Those who are taking injection and do not suit, they change it with pills")*

-CHW

Preference for Condom

Reason for not Preferring Condom

- Unfamiliarity
- Limited Application Understanding
- Discomfort
- Reduction of Sexual Pleasure
- Shyness in Collection and Usage
- Concerns about Bursting and Potential Pregnancy
- Privacy Challenges for Storage and Disposal
- Misconceptions
- Fear of creating the wrong impression

কনডম ঘরে রাখার কোন জায়গা নেই। ইউজ করার পর ফেলার কোন জায়গা নেই। যার কারণে লজ্জায় পড়তে হয়। এর জন্য ইউজ করতে চায় না। বাচ্চারা দেখলে ওটা একটা লজ্জা।

"Do not have a place in the home to keep and throw out the condom. That is why feel shame. That is why do not want to use it. If children see it that is a very shameful feeling."

-FDMN Man

"বউ জামাই দুইজনেই শান্তি ন ফায়। জামাইরা এক্কবারেই নিতে চায় না। জামাইয়ে সেন্টারত লইতো যাইতো ন চায়" ("Husband and wife do not get real pleasure if they use it. Husband don't want to use it at. Husbands don't want to go to the center to collect it")

-FDMN Woman

Preference for Implant & IUD

Reason for not Preferring Implant & IUD

- Short-Term Contraceptive Preference
- Limited Knowledge about the methods
- Concerns about Pregnancy Intervals and Family Conflicts
- Religious Objections
- Anxiety about the Procedures
- Fear of Misplacement
- Cultural Modesty and Discomfort, Especially with IUD
- Requirement for Experienced Provider Services
- Concerns about Withdrawal Complications
- Concerns about Removal Uncertainty
- Apprehension of Potential Side Effects and Infertility
- Husband's Obstruction

"ইতারা গার ভিতরে, গায় বাইরের তুন চিজ গলাই দিলে ইয়ার বলে এবাদত কবুল ন হ, নামাজ কবুল ন হ। ইয়ান হইতু চায় মায়াপোয়া ইন দি।...ইয়ার গার ভেতরে কিন ডেইল্লা গলাই রাখখসে। উজ্ঞা গার ভিতরে গলাই থাকলি, ইয়ান দিলে ইবাদত কবুল ন হয়। ইয়া মাইরয্য যে, নামাজ ন পড়?" ("The people of the society say) if any outside object enters the body, the prayer is not accepted, and the namaz is not accepted. They say, women do it to stay young. They say... Why did you enter them into the body? If they are inside the body, the prayer will not be accepted. You have taken this method, do you not pray?!")

-FDMN Woman

"এখনো অনেকে আছে যে ভুল ধারনা আছে। বাচ্চা হবে না। এগুলো নিতে চায় না কারণ অনেক বেশি সময় লাগে। সন্দেহ করে থাকে। আমরা বললেও বিশ্বাস করতে চায় না" ("There are still many people who have misconceptions. Think that, may never be able to conceive again. Don't want to take because it takes too much time. They are suspicious. They do not want to believe even if we say")

-CHW

Preference of MR & PAC Services

- Women initially favor traditional methods (amulet, holy water, root).
- Medical treatment is sought only if traditional methods prove ineffective.
- Preference for medical treatment through MRM.
- MVA is considered only when MRM cannot complete the procedure.
- MVA procedure is chosen as a last resort when no other options are available.

Preference of MR & PAC Services

Preferring MRM

- Convenient to take like regular medicine.
- Quick service with minimal time.
- Avoidance of MVA procedure due to fear.
- Allows discreet use without informing others.

Not Preferring MVA

- Painful and troublesome procedure.
- Associated risk of exposure.

"ওরা এমনিতেই মেডিসিন বেশি নিতে পছন্দ করে। এমভিএর সিরিঞ্জটা দেখলে ওরা ভয় পায়। কিছু যন্ত্রপাতি এখানে ব্যবহার করতে হয় যেটা ওরা ভয় পায়। পিপিতেও ওদের অনেক আপত্তি। ওরা অনেক লজ্জা পায়। ওদের গোপন জায়গা কেন আমরা দেখবো? এমন..." ("They prefer to take medicine. They get scared when they see the MVA syringe. Some equipment is used here which they fear. They also have many objections to PP. They are very shy. Why do we see their secret place? Like this...")

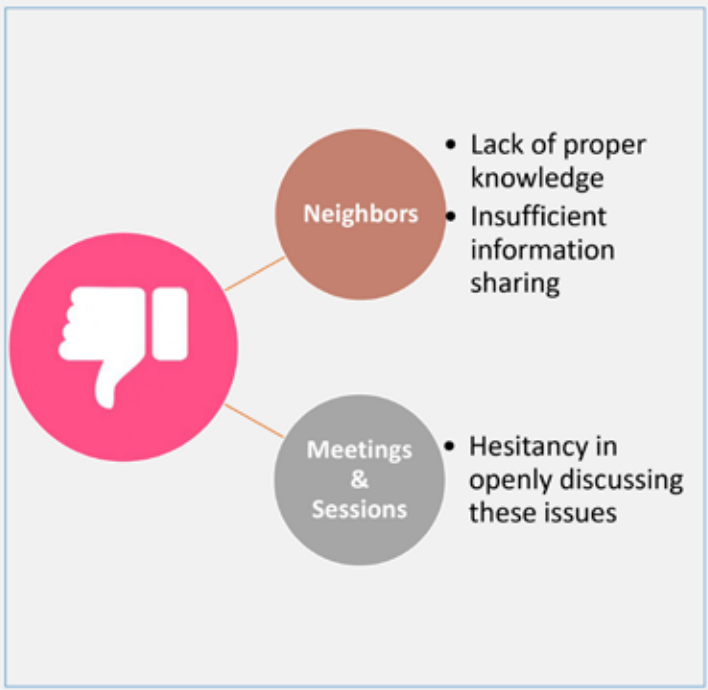
-Service Provider

"ব্যাথ্যা পাওয়ার ভয় থাকে। ওষুদে কাজ না করলে অনেক সময় ওয়াশ করতে বাধ্য হতে হয়। হাত ঢুকায় দেয়, বাতি ঢোকায় দেখে এর জন্য অনেক ভয় লাগে" ("There is fear of pain. If the medicine does not work, then has to do wash. (Service providers) put their hands in, see by putting the torch; because of this, it is very scary")

-FDMN Woman

Sources to Get FP, MR & PAC Related Information

Preference of Sources for FP, MR & PAC Related Information



Place to Get FP, MR & PAC Related Services

Most Preferred Place to get Service

NGO Facilities

Women Friendly Space

- Service providers communicate effectively in the local language
- Some facilities offer transport support
- Women dedicated service (WFS)
- Free of cost

Least Preferred Place to get Service

Certain NGO Facilities

Drug Store

Facilities outside Camp

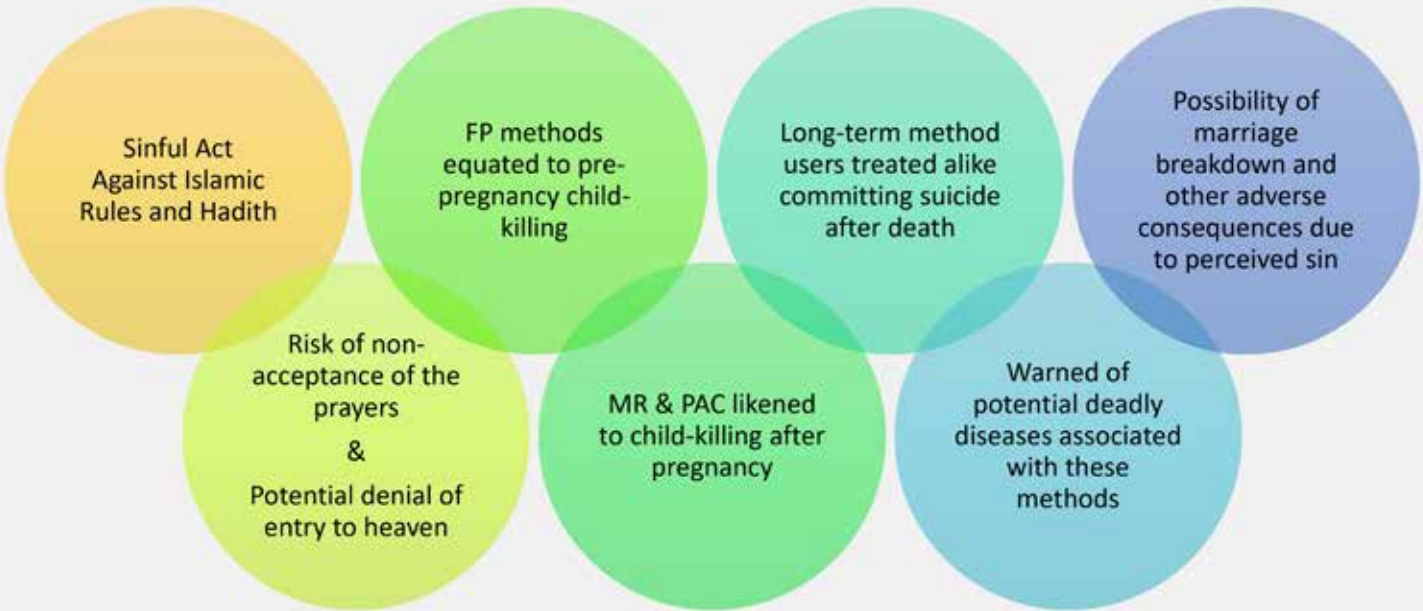
- Lengthy waiting times.
- Lack effective communication of service providers
- Inadequate treatment by service providers.
- Reluctance to obtain medication due to associated costs (drug store)
- Services outside the camp are expensive

Summary Findings (Availability & Acceptability of FP, MR & PAC Services)

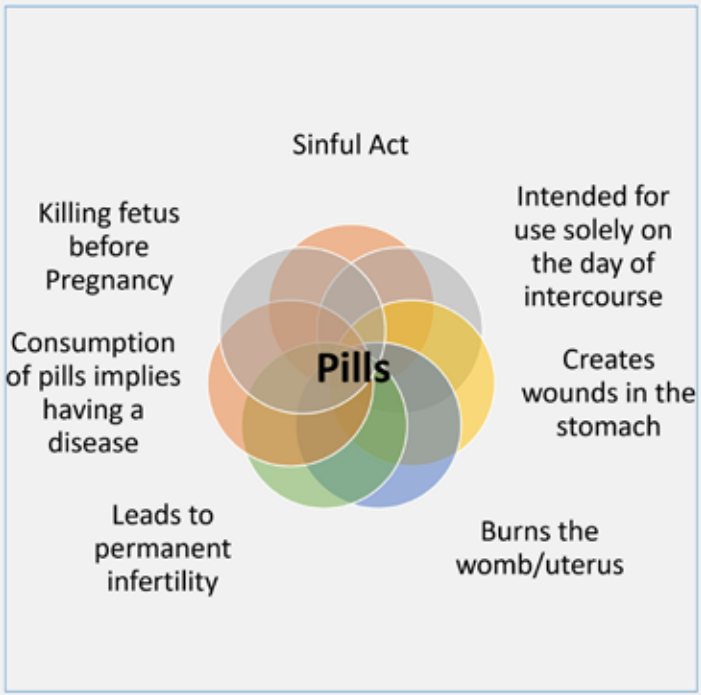
Availability & Accessibility	• Diverse methods of FP, MR, and PAC services are available • Community has access to the services
Attitude	• Positive shifts in attitudes, particularly among women- but challenges persist
Preference	• Short-term FP methods preferred due to familiarity • Traditional methods initially preferred for MR
Reliable Information Sources	• Service providers, Majhis (community leaders), Imams (religious leaders)
Preferred Service Center Attributes	• Quality service provision, friendly service providers, no cost incurred & minimal waiting time


Misconceptions, Myths and Social Barriers Related to FP, MR, PAC Services

Misconceptions and Myths (FP, MR and PAC)



Misconceptions and Myths about Pills



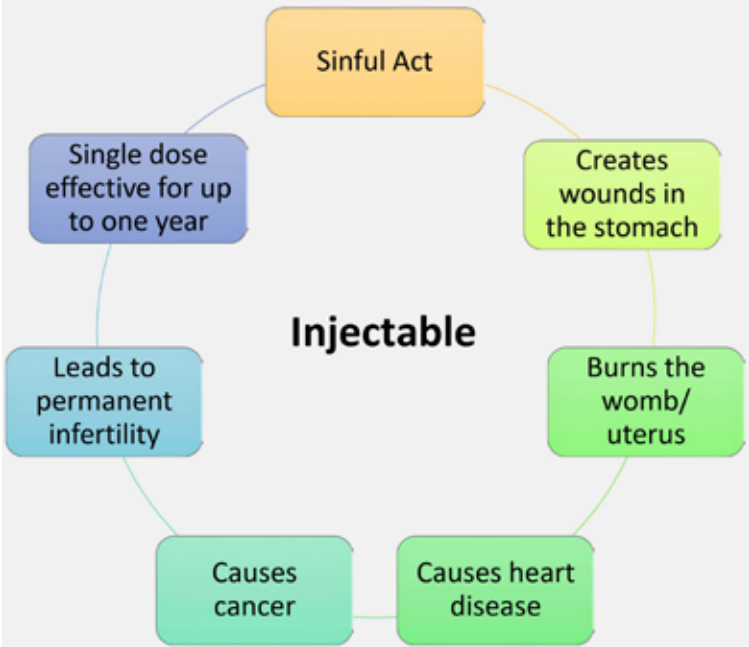
"খাইতে খাইতে পেড়র আত জ্বলি যাইলি, বাচ্চা ন হ, জান্নামে যাইবো" ("Taking the pill regularly will burn the uterus. Can't get pregnant anymore, will go to hell")

- FDMN Woman

"তারা মনে করে যে, পিল খাওয়ার মানে হচ্ছে সন্তান গর্ভে আসার আগেই তাকে হত্যা করা" ("They think that taking the pill means killing the baby before it even comes into the womb")

-CHW

Misconceptions and Myths about Injectables



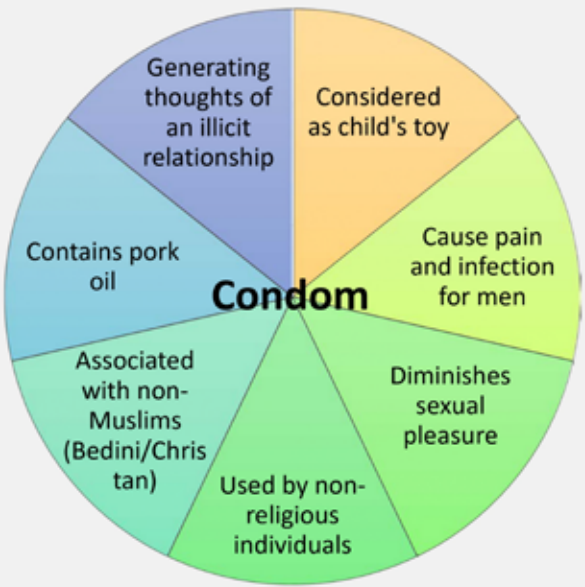
"পেট জ্বলি যাগই বলি হয়, ঘা আই যাগই বলি হয়, তইলে আর বাইচ্চা অই ন ফারিবো" ("The uterus will burn, there will be sores. Then won't have children anymore")

-FDMN Woman

"তারা মনে করে ডিপু নিলে রোজা হবে না। রোজা ভেঙ্গে যাবে। রমজান মাসে তাই তারা ডিপু নেওয়া বন্ধ রাখে" ("They think that fasting will not be accepted if they take Depo. The fast will be broken. So they stop taking Depo during the month of Ramadan")

-Service Provider

Misconceptions and Myths about Condoms



"আমি এগুলা দেখতেও পারি না, ছুঁতেও চাই না। অনেকে বলে কনডমের মধ্যে যে তেল থাকে সেগুলো নাকি শুকুরের তেল দিয়ে তৈরি" ("I do not even like to see the condom. I do not like to touch it. The oil that is used for the oiliness of condoms, many people said that it is made from pork oil")

-FDMN Woman

"বেগ মাইনষে ইবারে হারাপ নজরে চায়। হারাপ মাইনষে ইবারে এক্কা বেশি ব্যবহার গইত্তু চায়। হন উজ্ঞা জুলুম গরা পরে এইল্যা বেশ ব্যবহার গরেদে ফাদানা। এইল্যা ব্যবহার গরদে গোপনে। এইল্যা ব্যবহারে ঘাঁ হয়" ("Everyone looks down on it. Bad people use it. Those who rape must use condoms. It has to be used secretly. It causes sores")

-FDMN Man

Misconceptions and Myths about Implants

- Sinful Act
- Burns the womb/uterus
- Could have adverse body effect
- Could lost or misplaced
- Could insert into the muscle
- Leads to permanent infertility
- Last funeral prayer cannot be performed
- Prevents the entry into heaven
- Deprive from the intercede of Prophet
- Deprived of the acceptance of prayers

"শরীরের ভিতর ইক্কা ওইক্কা দৌড়ে। শরীরের রক্ত চুষে" ("It runs inside the body, It sucks the blood from the body")

-FDMN Man

"ইবা দিলে মরি ফালিগেই খুলিত ন ফারিবো। ইবা লই হবরত গেলে গুনাহ হইবো। নবী সুপারিশ করবে না।" ("If dies while having it in the body, it cannot be removed after death. Burial with it will be a sin. The Prophet will not intercede")

-FDMN Woman

Misconceptions and Myths about IUD

- Sinful Act
- Could have adverse body effect
- Could lost or misplaced,
- Could insert into stomach
- Create problems during intercourse
- Exclusive Method for No More Children
- Leads to permanent infertility
- Last funeral prayer cannot be performed
- Prevents the entry into heaven
- To be deprive from the intercede of Prophet on the final day
- To be deprived of the acceptance of prayers

"শরম জাগাত মাইজ্জে গরে এবা (IUD) অইলদ্দে নিজ জামাইর লাই এক্কার শরম জিনিস। আর আরার রোহিঙ্গা মহিলা যে আছে উন ওর লাই এক্কান শরমিন্দা জিনিস... ইবা এরে এক্কেরে নেই...এগিন ইসলামত্তম মাইজ্জে মানা...তোয়ারা দশ বছর পর্যন্ত বন্ধ গরদ্দে অয়লে, তোয়ারলাই কী আছে?... এবা ব্যভার গইরল্লে মাঝে মাঝে বউ জামাইয়র ছাড়া ছাড়িও অয়যাগুই" *("The product (IUD) that is used in the secret (uterus) parts is considered very embarrassing to the husbands. And it is disgraceful to the Rohingya womenfolk as well...They are not here at all. They are completely forbidden in Islam. If you stop conceiving for 10 years, why do I need you? If this method is used, many times the husband divorces the wife")*

-FDMN Man

Misconceptions and Myths (MR & PAC Services)

Misconceptions and Myths (MR & PAC Services)

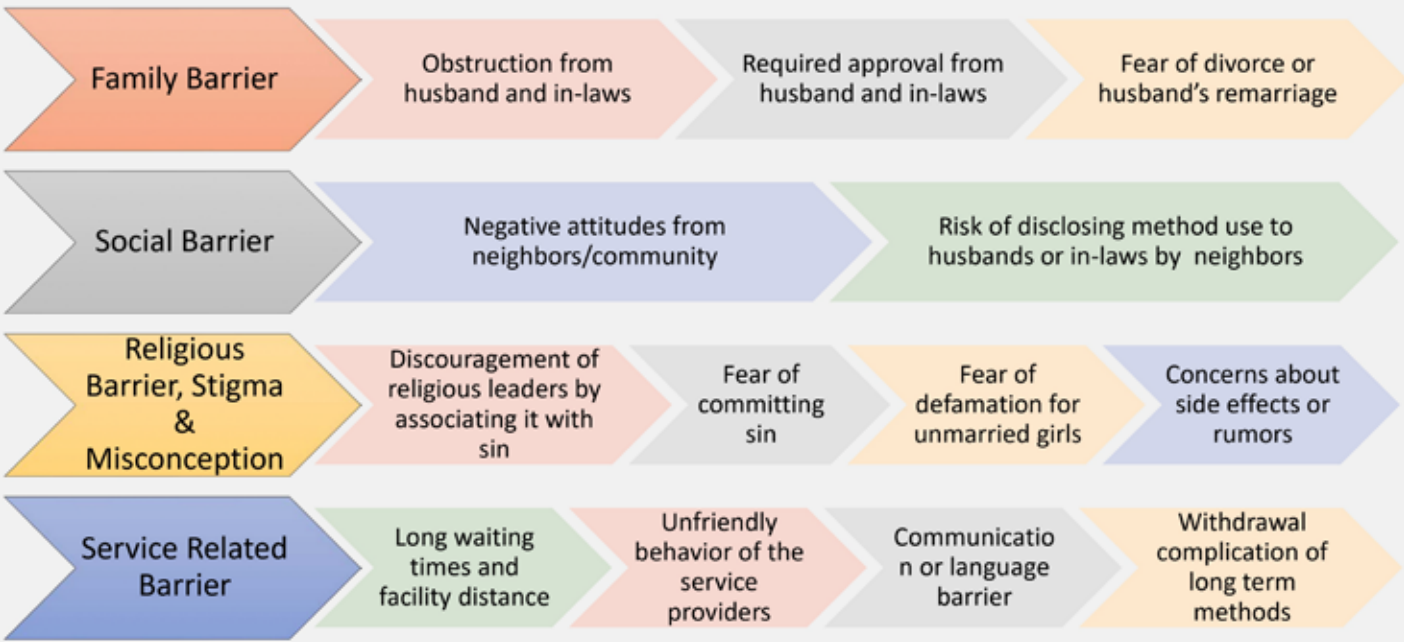
"ও আল্লাহ! যারা আল্লা ওয়ালা আছে, ইতারা কি হনোদিনও এগিন গইত্তু চাইবো নে। ইবা অইলদে গুনাহ, কিয়ামতের মাডত মাঝে আল্লা ধরিবো। আল্লাহয় হইবো দে কি, তর ফেডত মাঝে যে ওগ্গা ফোয়া দিল, ফোয়া ইবা তুই কি হারণে হতি গইজ্জস দে। ফোয়া ইবারে তুই খুনি গইজ্জস। কিয়াল্লায় খুনি গইজ্জস....এদুরত ফোয়াইবা মা-বাপরে জান্নাত দিতো না দিবো।... ইবা খুনি গরি ফালইলে ফোয়া ইবা গেলেগুই ফোয়া ইবা আল্লার আদালতর মাঝে বিচার ইয়ান দিবু" ("Oh Allah! Those who obey Allah will never do this. Doing so would be a sin. You will be accountable to Allah on the Final Day. Allah will say, I gave you a child, why did you damage it? You killed that child. Why did you kill it? That child will not allow his parents to enter Heaven...If the child is killed in this way, the child will raise complain in the court of God that day")

-FDMN Woman

"ওই দাবাই ব্যবহার গইল্লে বাইচ্চা ওগগা বরবাত যায়। বরবাত যাইলে আইলদ্দে ইবা আরলাই গুনা। আতত্তু গুনাহ অয়বু" ("Taking this drug destroy the fetus. It is a sin to spoil the fetus. This will cause sin")

FDMN Man

Barrier Related to Receive FP Services for Women



Barrier Related to Receive FP Services for Women

"ধর্মীয় ভাবে গুনাহ। হাসবেন্ড নিতে দিবে না এটা বলে। আল্লাহ যখন দিছে আমাদেরকে বাচ্চা নিতেই হবে।" ("It is an act of sin. It says that the husband will not be allowed to take it. When Allah gives us, we have to have children")

-CHW

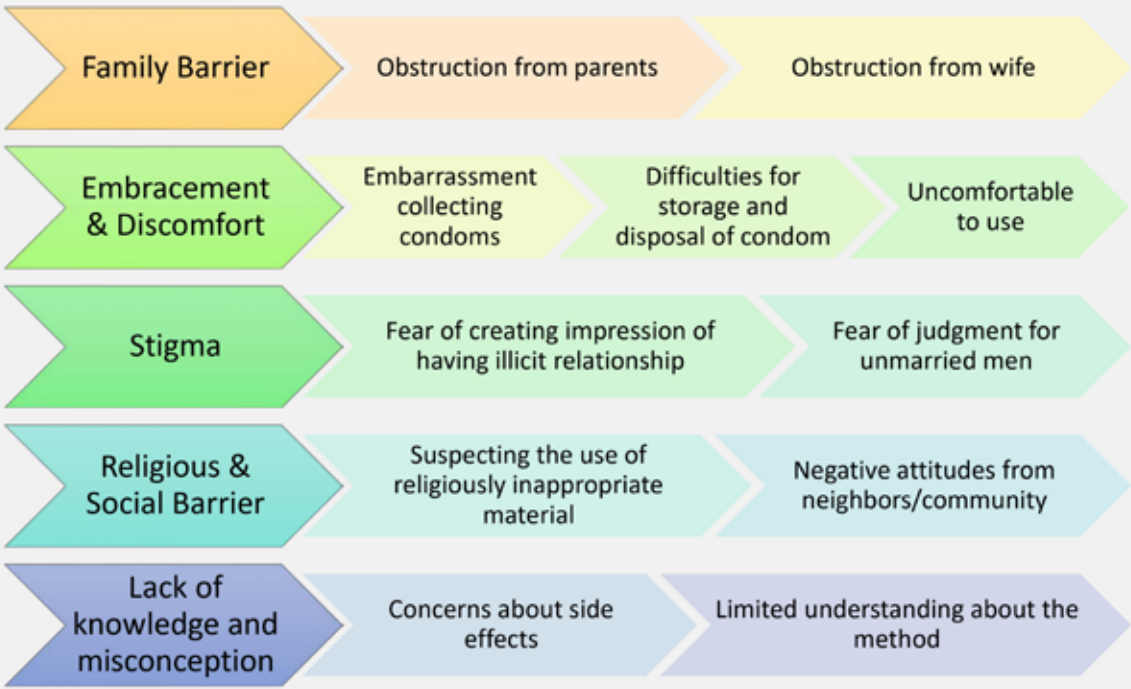
"জামাইর কারণে মাইপুয়াইন্দি ব্যবার গরিত ন পারে। ওগগো মাইপুয়া চাদ্দে কি অই ব্যবহার গইরগুম। জামাইরে হদ্দে কি আই ইন্দিলা ইন্দিলা গইরতো চাইর। হদ্দে ন অইবো।" ("Women cannot use the method because of their husbands. Women want to use the method. But, men do not allowed them to use the method.")

-Maji

আসলে ইয়য়ান নয়। যেন নে কি হয়লাম ধর্মীয় ব্যাপারে ইতারাততু ডরাইওরে ন গরে। আশেপাশের মানুষ হুন ওরে শরমেই ওরে ইয়ার ওরলাই বলি ন গরে।... মাইসে কি হইবো, আর বাচ্চা লইবো হিয়ায় ব্যবহার ন গরে। (Actually that's not the thing. they are not afraid of religious restriction. there afraid of the people of neighbourhood. they made them feel shy. they think people will gossip about that, they also want to take child, that's why they don't want to take the service.)

-FDMN Man

Barrier Related to Receive FP Services for men



Barrier Related to Receive FP Services (Men)

"লোকজন এটা নিয়ে ঠাট্টা মশকরা করে যে, স্ত্রীর সাথে থাকার জন্য ফাদানা লাগবে কেন, তারা এই ধরনের কথা বলে" (*"People make fun of men, why do they need Fadana to sleep with his wife, they talk like this"*)

- FDMN Man

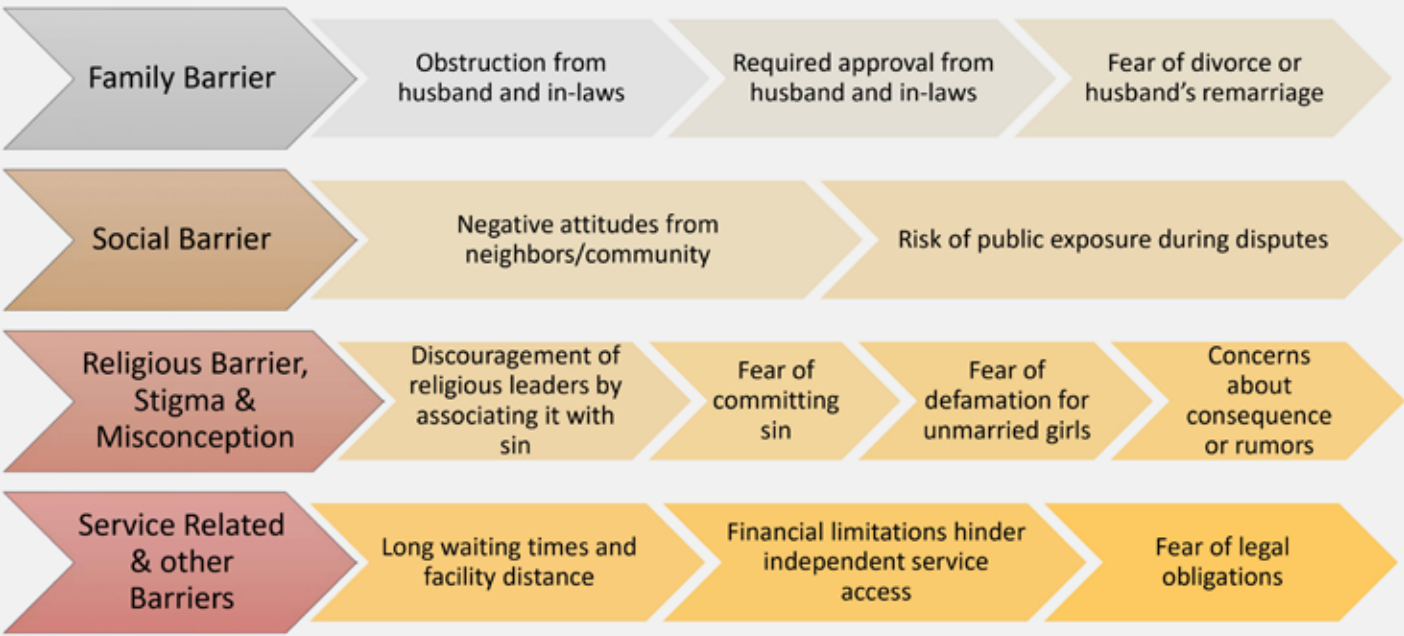
"যদি পদ্ধতি ব্যবহার করার কারণে বউয়ের বাচ্চা না হয়, তখন লোকেরা স্বামীকে জিজ্ঞেস করে, কেন তোমার কোন বাচ্চা হচ্ছে না, আমার স্ত্রীর তো আরো একটা বাচ্চা হয়ে গেছে" (*"If the wife does not have a child for any method, people ask his husband that, why he is not having child while my wife is having another child"*)

-FDMN Man

পুরুষের সবচেয়ে বড় বাধা বউয়ের কারণে। বউ চায় না স্বামী কনডম ব্যবহার করুক কেননা, তারা ফিল পায় না। ("A man's biggest obstacle is his wife. Wife doesn't want husband to use condom because they don't feel pleasure")

- FDMN Man

Barrier Related to Receive MR and PAC Services



Barrier Related to Receive MR and PAC Services

"গুরা মাইফোয়া অক্কলে লইতু চাইলে ফাজেরা মাইফুয়া ডাকিব ইবারে। ফাজেরা মানি ইবার দাম নাই। ইবারে খারাপ ভাবিবু, খারাপ ডাকিবু।...এক্কার হতা হইতে কেয়ার ন গরিবু। মাইনসে বেশি নিরসটি টরাইয়েবে হতা হইবো। ...আবিয়াত্তা মাইফুয়া অক্কল, আবারতুতুন কি গরে, পাড়া পাড়া নি যায়, গলার মাঝে ঝাড়ার চোয়া বাধি দিবো, মাথা এরাই দিবো, উদ্দা মাথায় দেশে দেশ দুরাইবো। ইয়ান সম্পর্কে খারাপ দুনিয়া জানি জাগোই।... জিন্দেগী ইবারগান হতম গরি ফেলায়" ("If any young girl wants to take that service then everyone will call her fazera. Fazira means they do not have any value. Everyone will consider her as a bad girl....Everyone will call her bed girl. They will not care to her... if the girl visit neighbourhood, then her head will be saved, the dust remover will be tied in their neck, this is how they will be taken from door to door. Everyone will know that she is a bad girl. They finish her life")

-FDMN Woman

"ইন গরিলে গুনাহ হইবু, ফেলায় দিলে, জান এক্কারা হইলেও হই গিয়ে গুনাহ। উয়া জানা নষ্ট হই যাইবু গুই। আল্লাহর ডরে ন গরে। জান মারি ফেলন ভালা ন" ("Doing so would be a sin. Doing abortion, spoiling the fetus would be a sin. A life will be wasted. They refrain from doing this out of fear of Allah. Killing life is not a good thing")

-FDMN Woman

Barriers Related to Providing Services at Facility

Husband and in-laws obstruct service access and confront providers for providing service	Leaders forbid and restrict service access	Leaders lack cooperation in promoting awareness despite continuous counseling	Misguidance by Traditional Birth Attendants:	TBA mislead against FP to increase deliveries
Non-compliance with instructions (e.g., taking pills only on the day of intercourse)	Complications resulting from traditional methods	Reluctance to allow adjustment time for side effect	Desire to withdraw the method shortly after initiation	Reluctance to complete the procedure once initiated
Reluctance to attend follow-up visits	Unwillingness to adopt or change methods despite counseling	Reluctance to opt for long-term methods	Insistence on chosen methods, regardless of suitability	Obtaining methods without prescription, leading to complications

Barriers Related to Providing Services at Facility

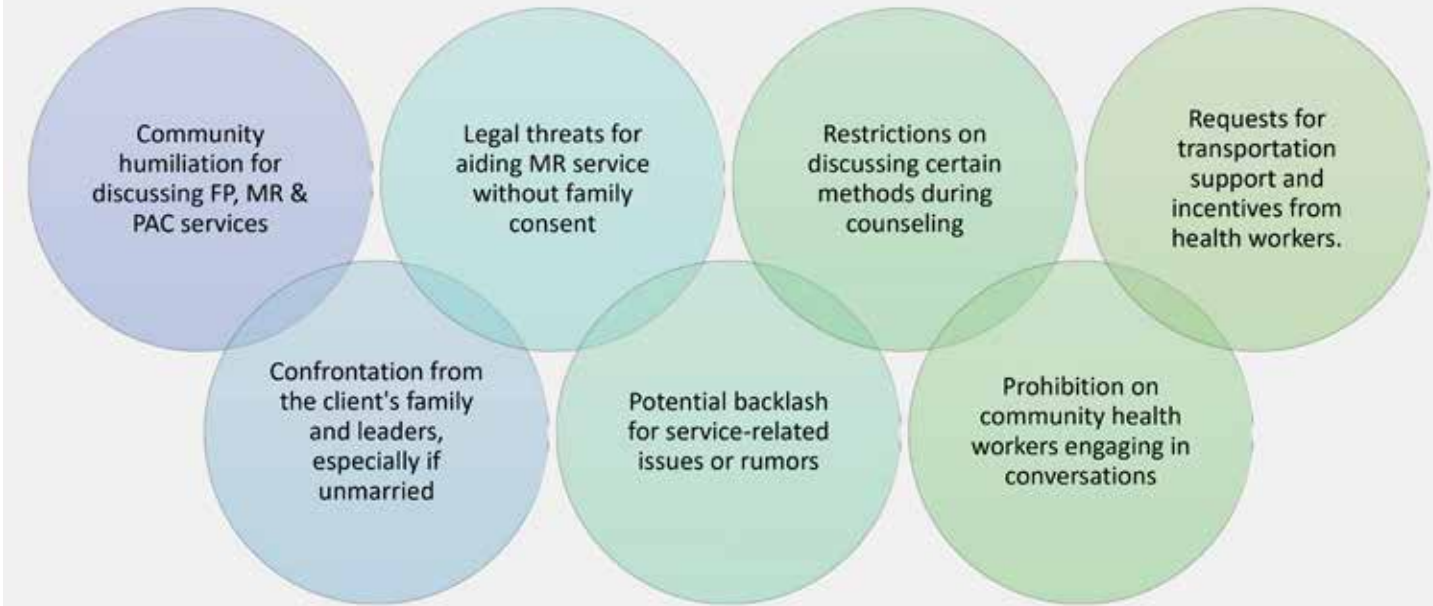
"বেশিরভাগ সময় হচ্ছে ওরা নিতে চায় কিন্তু, হাসবেন্ড আর শ্বাশুড়ি ইচ্ছেমতো নিতে দেয় না...অনেকের মধ্যেই ধারণা আছে একটা ডিপু মারার পর অনেক সময় মাসিক বন্ধ থাকে। পিরিয়ড না হলে আর আসতে চায় না। পিরিয়ড হলে তারপর আসকে। আবার অনেকে আছে, যেদি স্বামী সহবাস করবে সেদিনই শুধু একটা পিল খাবে, বাকী দিন খাবে না") ("Most of the time they want to take it but the husband and mother-in-law don't allow it...Many people have the idea that menstruation stops after taking depo. They do not want to come if not getting the period again. After getting period then comes. There are also many people who take only one pill on the day of intercourse and do not take it for the rest of the day")

-Service Provider

"সার্ভিসের মাঝপথে চলে যায়... ফলো-আপ করতে আসতে বললেও আসে না। তারা মূলত আমাদের কথা শুনতে চায় না" ("They left in the middle of the service...Even if when asked to come for follow-up, they don't come. They basically don't want to listen to us")

-Service Provider

Barriers Related to Providing Services at Community



Barriers Related to Providing Services at Community

"ইমামরা বুঝায়, সিডাব্লিউ যারা বুঝাতে যায় ওদেরকে দেখে নামাজ পরলে নামাজ হবে না। তাদের সাথে কথা বলা ছেলেদের সাথে কথা বলার মতোই গুনা" *("Imam says that those CHW try to make them understand, namaz (prayer) will not be accepted, if you see their face. It's a sin to talk with these girls like talking to boys...")*

- FDMN Woman

"এই বাধাটা সিএসডাব্লিউরা বেশি পায়। ওরা যখন ডোর টু ডোর যায়, হাজবেন্ডরা ওদের সাথে অনেক খারাপ ব্যবহার করে। অকথ্য ভাষায় গালিগালাজও করে। অনেক ব্লক আছে সেখানে মাঝিরা ওদেরকে ঢুকতে দেয় না" ("CSWs face this obstacle more. When they go door to door, the husbands treat them badly. They also abuse them in unspeakable language. There are many blocks where smajis do not allow them to enter")

-Service Provider

"পদ্ধতি খুলতে না পারলে তারা আমাদেরকে আক্রমন করে। এটা ফেইস করতে হয়। অনেক প্রশ্নের সম্মুখীন হতে হয়। কথা অনুযায়ি সেবা না পেলে পরে ব্লকে গেলেই আমাদেরকে এই প্রশ্নগুলোর সম্মুখীন হতে হয়" ("If they can't manage to withdraw the method, they attack us. We have to face it. Many questions have to be faced. We have to face these questions when we go to the block after someone do not get the service as promised")

-CHW

Summary Findings (Misconceptions, Myths and Social Barriers)

Misconceptions	• FP, MR, and PAC services hindered by societal misconceptions and barriers • Beliefs range from viewing services as sinful to fears of divine consequences
Barrier to get service	• Familial restrictions, societal pressures, religious misconceptions and the need for permission obstruct women from seeking services • Societal stigma and embarrassment impede men from seeking services
Barrier to provide service	• Societal resistance, misguidance, discouragement, clients' misuse of methods and reluctance towards side effects complicate service delivery


Attaining Sustainability Related
to FP, MR, PAC Services
pregnancy
Health
sexual
prevention
protect
Reproductive
infection
bacteria
safer
erotic
hygiene
condom
transmitted
awareness
epidemic
illness
medicine
teenagers
physical
disease
satisfying
aids
hiv
sexually
adult
treatment
herpes
healthy

Attaining Sustainability (Suggestions from Stusd Participants)

Enhance and oversee Majis and Imams' involvement in community counseling
Intensify targeted community meetings
Prioritize couple and family counseling at facilities
Appoint CHWs for home-based counseling
Emphasize counseling for male members
Provide refreshments during sessions
Incentivize long-term methods (Implant & IUD)
Introduce incentives for small families
Expand facilities and service providers
Ensure 24/7 service availability
Develop policy for government linkage
Establish coordination with stakeholders
Prevent program duplication in the camp

Improving on-going Services (Suggestions from Study Participants)

Scale up facilities and sincrease ervice providers
Establish local centers (near blocks) for increased accessibility
Ensure 24/7 facility availability
Improve communication in local languages
Ensure respectful client treatment
Provide supplementary medicines
Offer transport services
Provide short-term methods at home for community outreach
Simplify withdrawal services for IUD and implements
Streamline referral processes
Increase the number of Community Health Workers (CHWs)

Study Recommendation

Targeted Awareness Campaigns	Recognizing prevalent religious misconceptions surrounding FP, MR, and PAC services, it is crucial to initiate community-based awareness programs led by religious leaders. This effort aims to dispel misconceptions while emphasizing the compatibility of these services with Islamic principles
Local Language Information	Given linguistic differences within the Rohingya community, precise information dissemination in local languages is essential. Implementation of this strategy, facilitated by community and religious leaders, ensures accurate communication and addresses language barriers
Men's Engagement Initiatives	Acknowledging that reluctance from men poses a barrier to service uptake, proactive campaigns are needed. Engaging men in open discussions, addressing cultural stigma, and promoting method use through targeted initiatives will help overcome this challenge
Accessible Facilities	Recognizing that distance and time constraints deter people from availing services, it is crucial to expand facilities and establish local/block based centers. This step aims to provide convenient access to FP, MR, and PAC services, minimizing travel and wait times
Comprehensive Referral Support	To mitigate complications, optimizing the referral process is essential. Offering thorough support and emphasizing the importance of follow-up visits will contribute to a more effective healthcare system

Study Recommendation

Expand Community Health Worker Network	Acknowledging the accessibility and acceptance of community workers, expanding their involvement is necessary. Increasing Community Health Worker (CHW) outreach will provide better access to information and support within the community
Incentives for Participation	Recognizing that participation in awareness programs is voluntary and time-consuming, providing incentives and refreshments at community meetings will encourage interest and active involvement
Policy Development and Coordination	Addressing the lack of coordination among stakeholders, there is a need for comprehensive policy development. This includes formulating policies for a coordinated approach, establishing government linkages, and preventing program duplication for a sustainable reproductive health system
Research Initiatives	Acknowledging the lack of adequate information about men's views on FP, MR, and PAC services, rigorous research initiatives are required. This study aims to explore cultural and religious factors, providing valuable insights to address existing gaps in knowledge and perception


Thank
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