Addressing SRHR Issues Within the Humanitarian-Development-Peace Nexus in Cox's Bazar

A summary of Pathfinder's work with Rohingya refugees and host communities

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THIS BRIEF DISCUSSES A PROGRAM MODEL FOR DELIVERING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS SERVICES IN THE NEXUS SETTING OF COX'S BAZAR, BANGLADESH

Background

More so than ever before, humanitarian and development actors are being called upon to address larger-scale and more enduring crises. Today's complex emergencies require a multitude of actors to work together to deliver coherent, well-aligned programs in order to effectively meet the needs of affected populations[1].

Cox's Bazar, a district in south eastern Bangladesh, is currently coping with the impact of state-orchestrated violence in neighboring Myanmar that drove hundreds of thousands of members of the ethnic Rohingya group to flee to Bangladesh in 2017. Without citizenship in either Bangladesh or Myanmar, and having lost most of their assets when they fled, nearly 1 million Rohingya now live in sprawling camps in Cox's Bazar's southernmost sub-districts.

While a large and relatively successful aid apparatus was set up to serve Rohingya, there is no clear pathway either for their return to Myanmar or their integration into Bangladesh. Thus, they remain stateless and without access to sustainable livelihoods or freedom of movement[2].

Further, their presence places tremendous pressure on the existing social services in the district. As a result, animosity toward them has developed among the already underserved host communities living in the district[3].

The Humanitarian-Development-Peace Nexus

The humanitarian-development-peace nexus (or "Nexus") describes settings in which protracted, cyclical and/or otherwise complex crises require different types of actors to work together to provide basic services and resolve conflicts. To enhance the effectiveness of Nexus work, an agenda for action was proposed at the United Nations' 2016 World Humanitarian

[1] New Way of Working. 2017. Office for the Coordination of Humanitarian Affairs (OCHA).
[2] 2019 Joint Response Plan for Rohingya Humanitarian Crisis. Strategic Executive Group.
[3] Bulletin. Rohingya and Host Communities, Social Cohesion. Ground Truth Solutions. June 2019.

Summit. Called the New Way of Working, this agenda articulates a strategy for implementing coordinated programs across the humanitarian-development spectrum that are oriented around a collective outcomes framework. This means that humanitarian, development and peace-oriented programs are to operate under a single set of measurable results that requires the combined efforts of a multitude of actors to achieve[1]. Within this framework, explicit efforts should be made to strengthen local institutions and organizations[4]. At the global level, the alignment of the funding structures needed to scale up Nexus oriented work is steadily moving forward.

SRHR Nexus Programming

There are many organizations already working within Nexus settings on the ground, including on SRHR[2]. SRHR work in fragile settings is backed by evidence. Indeed, research has shown that when a vulnerable population has improved access to family planning, their overall resilience also increases[5].

Various types of SRHR interventions have been found to be effective in systematic program reviews. These include interventions incorporating home visits, peer-led and interpersonal education, mass media campaigns, service promotion by community health workers (CHWs), and men's groups focused on reducing intimate partner violence[6].

While adolescents are often a neglected group in SRHR programming, particularly in humanitarian settings, there is evidence demonstrating that certain strategies are effective in increasing adolescent service utilization and improving health outcomes, such as adolescent-friendly services, peer workers and the involvement of young people in program planning and implementation[7].

In the SRHR sphere, a range of local organizations from multiple countries recently articulated that work in Nexus settings is already part of many country programs[8].

[4] The Humanitarian-Development-Peace Nexus, What does it mean for multi-mandated organizations? Oxfam Discussion Paper. June 2019.
[5] Hardee, K. 2018. Family planning and resilience: associations found in a Population, Health and Environment (PHE) project in Western Tanzania.
[6] Singh, N., Smith, J., Aryasinghe, S. et al. (2018). Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review. PLoS ONE 13(7).
[7] Jennings, L., George, A., Jacobs, T., Blanchet, K., Singh, N. (2019). A forgotten group during humanitarian crises: a systematic review of sexual and reproductive health interventions for young people including adolescents in humanitarian settings. Conflict and Health 13:57.
[8] Implementing SRHR Programs Across the Humanitarian Development Nexus. Implementing Best Practices, Inter-Agency Working Group on Reproductive Health in Crisis. May 2019.

Overview of SRHR Sector in Cox's Bazar

Over 30 NGOs coordinate to provide SRHR services, including family planning, in 180 health facilities in Rohingya camps in alignment with Government of Bangladesh policies[9]. UNFPA Bangladesh plays a key leadership role within the sector's coordination activities. It also funds a significant portion of SRH service delivery and capacity building activities to support the response[10]. Front line SRHR services, including the Minimum Initial Services Package components, are widely available in the camps[11]. However, social barriers for women and girls limit their utilization[12]. Tertiary services, including Comprehensive Emergency Obstetric and Neonatal Care services, is only available by traveling to one of a handful of host community hospitals[10]. Work is underway within the sector to build capacity among SRHR partners to establish comprehensive SRHR services within camp settings[12]. This is an ongoing process.

National policies were initially restrictive around contraceptive services for Rohingya, with specific permissions being granted in a phased manner, allowing the provision of first only temporary and later long-acting methods. Currently, local health and family planning officials voice strong support for family planning services for Rohingya, in particular for long-acting methods. Government run health facilities are established within camps and local service providers rotate between host communities and camps to ensure service provision for both groups. In addition, a requirement was introduced by the Government of Bangladesh that 25-30% of all program funding directed to the Rohingya response be used for activities targeted toward host communities.

Health and Wellbeing Snapshot

The following data points provide a snapshot of the overall health and wellbeing of the Rohingya population living in camps and the surrounding host communities in Teknaf and Ukhiya.

[9] PowerPoint presentation summarizing SRH Sub-sector Working Group meeting held on November 21, 2019.
[10] Schnabel, L., Huang, C. Removing Barriers and Closing Gaps: Improving Sexual and Reproductive Health and Rights for Rohingya Refugees and Host Communities. Center for Global Development. June 2019.
[11] Ahmed, R., Farnaz, N., Aktar, B. et al. (2019). Situation analysis for delivering integrated comprehensive sexual and reproductive health services in humanitarian crisis condition for Rohingya refugees in Cox's Bazar, Bangladesh: a protocol for a mixed-method study. BMJ Open 2019;9.
[12] Ainul, S., Ehsan, I., Haque, E., et al. (2018). Marriage and Sexual and Reproductive Health of Rohingya Adolescents and Youth in Bangladesh: A Qualitative Study. Population Council.

ROHINGYA		HOST COMMUNITY	
Population	>900,000	**Population**	+/- 560,000
Average household (HH) size	5.6	**Average HH size**	5.1
Highest level of education achieved:	 27% No formal education 41% Some primary 32% Primary and above	**Highest level of education achieved:**	 32% Completed primary or less 49% Some secondary 19% Completed secondary or above
Food Consumption Score (FCS) (% by FCS category)	**5%** Poor, **41%** Borderline, **54%** Acceptable	**Food Consumption Score (FCS)** (% by FCS category)	**4%** Poor, **24%** Borderline, **72%** Acceptable
Pregnant women	9% of HHs	**Pregnant women**	9% of HHs
- **Of these, % in ANC**	73%	- **Of these, % in ANC**	48%
Location of delivery (within past year)	 82% At home 18% At a clinic	**Location of delivery (within past year)**	 56% At home 41% At a clinic 3% Midwife's house

Apart from the above data, sourced from the Joint Multi-Sector Needs Assessment (August - September 2019)[13] other SRHR-focused studies provide further insight into SRHR issues in Cox's Bazar:

- **Contraceptive prevalence:** While 2017/2018 contraceptive prevalence stood at 54% across Chattogram Division (the lowest in the country)[14], in 2018 it was estimated to be 34% among Rohingya[15] (though some SRH partners in Cox's Bazar believe that it surpassed 40% in 2019).

[13] Joint Multi-Sector Needs Assessment, Rohingya and Host Community. October 2019. Accessed here February 26, 2020.

[14] Bangladesh Demographic and Health Survey 2017-2018: Key Indicators. (2018). *National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF*.

[15] Chowdhury, M.A.K., Billah, M., Karim, F., et al. (2018). Demographic Profiling and Needs Assessment of Maternal and Child Health (MCH) Care for the Rohingya Refugee Population in Cox's Bazar, Bangladesh. icddr,b.

- **Method preference:** Nationally in Bangladesh, the oral contraceptive pill is the most commonly used family planning method, followed by injectables; the reverse is the case in Rohingya communities[15,16].
- **Attitudes:** Religious and social attitudes against contraception are prevalent among Rohingya, though providers in camps state that these norms are gradually changing as a result of a growing understanding of the benefits of SRHR services[16].
- **Women's freedom:** Among both Rohingya and host communities, women's freedom of movement is restricted, with unmarried women having less freedom of movement than married women[14].
- **Early marriage:** Early marriage was restricted for Rohingya in Myanmar but increased after settling in Bangladesh due to lack of laws within camps regulating marriage practices[15].
- **Vulnerability:** Host communities report transactional sex occurring between Bangladeshi men and Rohingya women in and around camps; some (often married) Bangladeshi men are also engaging in polygamy by marrying Rohingya women due in part to the low expense doing so incurs[15].

Pathfinder's Cox's Bazar Program

Pathfinder's program works closely with local leaders and health officials in host community areas with the aim of bolstering their ability to maintain existing services for host communities while also ensuring SRHR services in for Rohingya refugees.

Pathfinder's program is structured around the following program objectives:

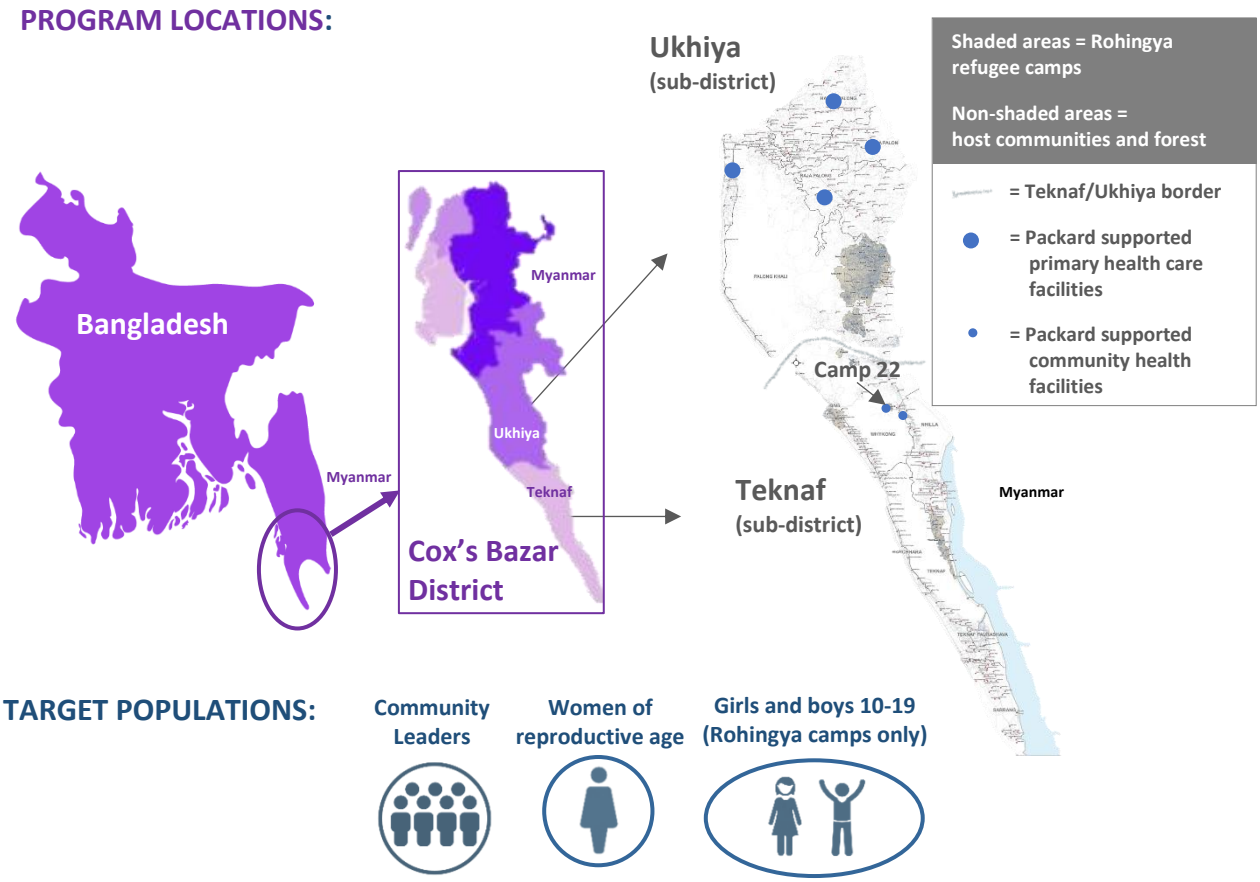
- Providing comprehensive SRHR services
- Increasing demand for SRHR services
- Building capacity among local stakeholders to advocate for SRHR services

From the health perspective, one of the greatest challenges of this setting is that host community health services were overburdened prior to the crisis. The Rohingya influx nearly tripled the population, adding a historically persecuted and highly vulnerable group. This exacerbated the gaps between service availability and needs as host community providers have had to organize coverage for both groups.

Pathfinder's program strategy is designed to:

1) **Support the Government of Bangladesh to strengthen existing SRHR services** that were overburdened before the influx and are now under further stress.
2) **Address immediate humanitarian needs,** by providing SRHR services in new Rohingya refugee camp settlements where there were none.

A depiction of the target population and local implementation area in Cox's Bazar (which is a district in South Eastern Bangladesh) is below.



SRHR Services in the Camp Setting

Beginnings

Pathfinder's Cox's Bazar program began with the establishment of a small clinic days after the onset of the crisis in August 2017. The clinic was initially funded through private individual donations and operated by a Bangladeshi NGO partner under Pathfinder's Smiling Sun program. Less than a year into the crisis, the Packard Foundation began funding the clinic. After population movements stabilized and an organized system for delivering basic services had been established, the clinic was upgraded into a formal site and relocated from its original roadside transit location to the nearest Rohingya settlement, Camp 22 in Teknaf's Whykong Union.

Current Status

From April 2018 to the present, Bangladeshi NGO Research, Training and Management International (RTMI) took over the management of the clinic. Having worked with the Rohingya community since 2007, RTMI is an experienced national NGO that operates 27 health facilities within Rohingya camps providing SRHR services. Its activities—in both camps and host communities—encompass a range of evidence-based components of comprehensive SRHR services including door-to-door visits by community health workers, front-line delivery care, responding to gender-based violence (including clinical management of rape), adolescent-friendly spaces, youth engagement and peer groups. Most of its facilities are equipped to provide normal delivery services. However, they do not provide assisted vaginal delivery and thus meet six out of the seven Basic Emergency Obstetric and Neonatal Care (BEmONC) criteria.

Services Provided Under the Packard-funded Clinic

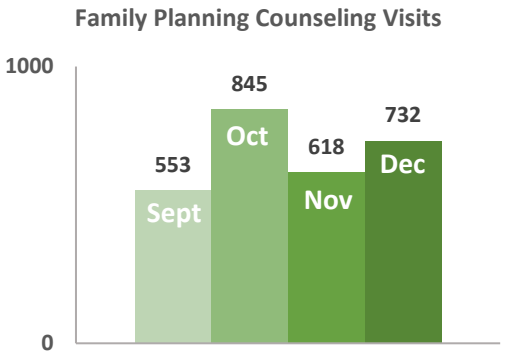
Pathfinder's Packard-funded clinic is a primary care health post in a four-room structure constructed using cost-effective durable materials. It provides maternal and child health counseling, antenatal care (ANC), postnatal care, family planning, child health services, and syndromic management of sexually transmitted infections (see service trends charts[16]). Available contraceptive methods include pills, condoms and injectables, all of which are supplied by the Government of Bangladesh. Pregnant women receiving ANC at the clinic are referred to one of the small handful of more comprehensive primary care health facilities that support normal delivery in Camp 22. For any issues that require advanced secondary-level and tertiary-level care, patients are referred outside the camp to higher level Government- and NGO-run facilities.

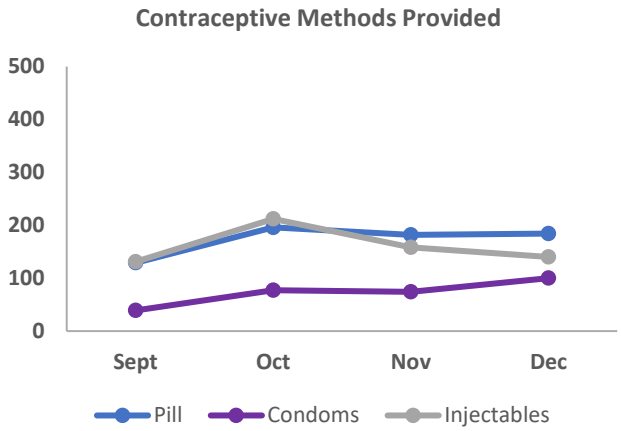
The clinic team—made up of 6 clinical service providers, 1 Youth and Adolescent Officer and 11 CHWs—engage in coordination and outreach activities as well. They have partnered with host community government officials and local Rohingya leadership to help promote the available services. Two government-employed clinical providers supplement the health post's staff, and formal discussions are regularly held with influential Rohingya men who live in the vicinity of the clinic, including Mahjees and Imams, to raise awareness about family planning. This is considered a powerful approach to building demand for and acceptance of family planning service utilization among women. Community SRHR education sessions are led on a weekly basis for men and women separately. In addition to these, adolescent boys' and girls' groups meet weekly in facilitated sessions following a structured 14-session adolescent health and wellbeing curriculum.

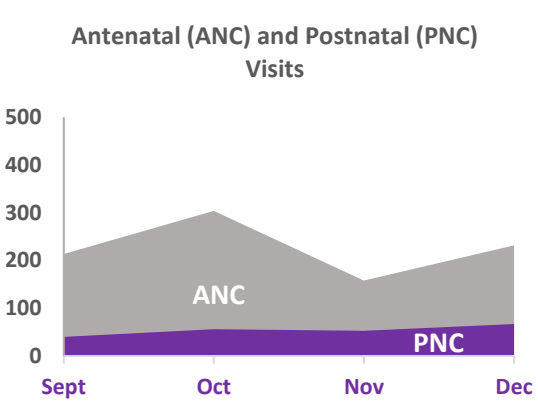
[16] Provided to Pathfinder by RTMI in a program report for September – December 2019.

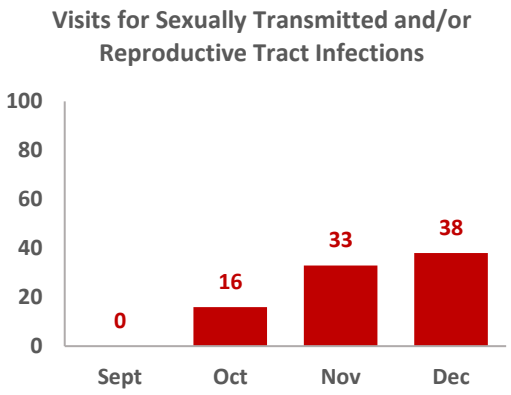
Service Trends from Packard-funded Clinic Serving Rohingya

September – December 2019









System Strengthening Outside the Camps

Pathfinder supports 5 primary care-level health facilities in host community areas. It first invested in supply-side activities such as facility renovations and procurement of supplies and equipment. It also provided a comprehensive training on family planning counselling, with a focus on evidence-based interpersonal communications techniques, to all front-line family planning service providers in Ukhiya and Teknaf. One of the trainings was structured to allow for participants to bring their children accompanied by caregivers. This allowed many female providers to take the training as their personal childcare responsibilities would have otherwise prevented them from doing so.

Program efforts are now directed toward demand generation. This component has three channels: 1) assisting CHWs to enhance the community-based education sessions on family planning and improved health seeking behavior they organize with women, 2) introducing

community-based education sessions on family planning with men, and 3) establishing a stakeholder group of influential leaders (e.g., members of local government, school teachers/headmasters, Imams etc.). In one community, Packard funding supports adolescent boys' and girls' SRHR health and wellness groups following the same 14-session curriculum used with young people in the nearby camp.

Challenges

A number of challenges shape day-to-day implementation. Some of the most critical are described here.

Legal and Policy

The legal and policy restrictions (such as lack of citizenship and limited mobility) faced by Rohingya constrain their access to services. This is reflected in the phased-in permission given for first only short-acting and later long-acting contraceptives within camps.

Gender Norms and Adolescence

Compounding their history of extreme marginalization in Myanmar, social and gender norms place limitations on women's and girls' autonomy to a greater degree than they do within host communities. Focus group discussions held while gathering information for this brief provided a clear demonstration of this: adolescent girls from host communities spoke freely and expressed a desire to become financially independent prior to having children. In contrast, adolescent Rohingya girls appeared to engage in conversation reluctantly, and expressed a desire to consider family planning services only after having their first child.

Trauma resulting from the well-documented history of targeted sexual violence against Rohingya women and girls by the Myanmar military, as well as strict religious observation among Rohingya, likely contribute to the differences observed in normative gender expressions between Rohingya and host community women and girls. Given this, establishing comfort and genuine communication in community education sessions with young Rohingya women, and in particular with adolescent girls' groups, can be difficult.

Numbers of Health Workers too Low

According to local family planning officials, host communities are currently underserved due to high numbers of vacant positions prior to the crisis and human resources being further stretched following the crisis. This results in many households not being reached through normal door-to-door services because CHWs are assigned to spend 2-3 days each week in Rohingya camps so have less time to spend in host communities.

Gaps in SRHR Service Provision

Apart from the services provided by RTMI and select other NGOs, comprehensive SRHR services are not yet widely available to either Rohingya or host communities in Cox's Bazar. The lack of skilled staff is the greatest barrier to scaling-up and broadening the range of available services.

EFFECTIVE INTERVENTION APPROACHES

PARTNER WITH LOCAL GOVERNMENT

Institutional partnerships with local government and health/family planning officials in the form of staff co-location, facility infrastructure development, service provider training, and technical assistance for systems strengthening and service delivery lead to greater impact

VISIBLY SUPPORT HOST COMMUNITIES

Provision of visible support and essential resources to host communities to enhance the government's ability to respond to the crisis demonstrates good will and is well received by host communities

COMPREHENSIVE SRHR SERVICES

Strategic work through program planning cycles, training and coordination within the health sector are important for scaling-up from the Minimum Initial Services Package to comprehensive SRHR services

ENGAGE COMMUNITY LEADERS AND INFLUENCERS

Engagement of appointed community leaders (Mahjees), Imams and other influential individuals in Rohingya communities reduces social barriers and misinformation about family planning

WORK WITH ADOLESCENT BOYS AND GIRLS

Working with adolescent boys and girls builds life skills and promotes positive gender norms and improved health seeking behavior

COMMUNITY EDUCATION WITH MEN AND WOMEN

Targeted engagement through behavior change communication with men and women boosts acceptance of family planning by enabling joint discussion and decision making between partners

Current and Future Priorities

There are immediate and ongoing needs that must be met in order to improve access to and quality of SRHR services for both Rohingya and host communities in Cox's Bazar. First and foremost, it is important to ground program planning around the shared goal of ensuring comprehensive SRHR services for all. This will involve ongoing training and supervision, expansion of the range of services available at different facilities across geographic locations, greater access to long-acting contraceptive methods, better referral pathways and strong relationships with communities.

In addition, being a supportive partner to host communities' health sector leadership will remain critical as economic and human resource challenges brought by the Rohingya crisis show no sign of abatement. It is necessary to balance investments directed to refugee and host communities, but to tailor programs for each area to their unique contexts. Furthermore, with the anticipated spread of COVID-19 within Bangladesh, including in the densely populated camps, adjusting SRHR programs to reduce human contact (e.g., fewer group activities, limiting the number of people within clinics at one time, and physical distancing in waiting areas etc.) but maintain service availability is an urgent priority.

Finally, interventions directed toward adolescents and youth should consistently follow evidence-based approaches and tested curricula. As adolescent and youth program experience within camp settings grows, lessons learned, successful approaches and curricula that have generated desired behavioral results should be shared and adopted more broadly by implementers working with young people.

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Data Collection

To collect the data necessary to inform this brief, a team from Pathfinder Bangladesh carried out a series of facility and community visits to program sites. Interviews were held with service providers, government officials, influential Rohingya leaders, and representatives from national and international NGOs. The team also observed community education (or "Courtyard") sessions on SRHR and held focus group discussions (FGDs) with adolescents and youth.

Locations	Health Facility Visits	Key Informant Interviews	FGDs	Community Education Sessions	Meetings with Local Leaders	Meetings with NGOs
Camp 22 Rohingya settlement, Teknaf	1 health post	1 doctor 1 midwife	1 boys 1 girls	1 (women)	1 with Mahjees, Imams, influential men	
Host Communities, Ukhiya and Teknaf	1 community clinic 1 secondary level facility	1 Upazila Family Planning Officer 4 Family Planning Inspectors 3 Family Welfare Assistants 3 Family Welfare Volunteers 2 Community health workers	1 boys 2 girls 1 young married women	1 (women)	1 Union Parishad	3 natl.NGOs 2 intl. NGOs

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