

# BRIDGING COMMUNITY AND HUMANITARIAN APPROACHES TO SEXUAL AND REPRODUCTIVE HEALTH

## Lack of training and awareness limit access to reliable information about SRH for Rohingya in Bangladesh

### Summary: what you absolutely need to know

**1. Rohingya refugees<sup>1</sup> are interested in and mostly accept information about sexual and reproductive health (SRH) shared by humanitarians, but it can be difficult to apply guidance.** Most Rohingya living in camps in Cox's Bazar, Bangladesh have more access to SRH information and services than they had in Myanmar, and people generally trust humanitarians to share factual information. Many people's values and practices in relation to family planning, childbirth, and other aspects of SRH have changed since they came to Bangladesh. This is due partly to having more information and resources from humanitarians, which most respondents found applicable in their lives. But it is sometimes also a response to the difficulties of raising children in the crowded camps while facing an uncertain future. More services are needed and wanted, but there are barriers to accessing existing ones, mainly due to restrictions on movement.

**2. New approaches to SRH coexist with traditional values and practices.** New practices coexist with long-standing ones. Some people think that contraception, abortion, and other SRH practices are immoral. Rohingya often look to older relatives and unlicensed community practitioners like informally trained pharmacists, midwives, astrologers, and traditional healers for advice and treatment. These practitioners are influential, and relied on because of existing trust and relationships. But many Rohingya, especially the younger generation, have had negative experiences and doubt the accuracy of information and quality of services they provide. These community practitioners want training and support, and respondents recommended that humanitarians engage with them to expand their reach and reduce the risk of harm.

**3. Stigma, shame, and embarrassment are factors, but no topic is too sensitive.** According to Rohingya cultural and religious values, it is very important to avoid shame and preserve modesty. The risk of shame sometimes affects people's willingness to seek information and services and practice healthy behaviors. For example, due to concerns that women's modesty will not be protected when giving birth in camp hospitals, many families prefer to have babies at home despite knowing that it is riskier. People are willing to go to humanitarians for services like abortion care, contraception, treatment for sexually transmitted infections (STIs), and support with fertility, but worry that strict confidentiality will not be upheld.

<sup>1</sup> The Government of Bangladesh refers to the Rohingya in Bangladesh as "Forcibly Displaced Myanmar Nationals (FDMN)." The United Nations refers to this population as Rohingya refugees, in line with the applicable international framework; this is also how they refer to themselves. In this document, both terms are used, as appropriate, to refer to the same population.

**4. The language, communication styles, and channels used by humanitarians determine people's level of satisfaction with interactions about SRH.** Refugees are clear about their communication preferences when engaging on SRH with humanitarians. They want Rohingya to be spoken exclusively, without mixing in any Chittagonian, Bangla, or English words and phrases. SRH communication requires careful wording and participants often do not understand what is shared. Respondents emphasized the importance of humanitarians' tone of voice, which should be soft and polite to avoid causing embarrassment and discomfort. In general, they want to interact with humanitarians who show professionalism, compassion, and cultural sensitivity. Outreach workers who provide information and counseling are usually seen as better communicators than staff at clinics.

### Recommendations for humanitarians

- Provide all **information and services to address SRH in Rohingya**, either directly through a Rohingya volunteer or through a Bangladeshi staff member working with a Rohingya interpreter.
- Ensure that staff who interact with camp residents consistently **use field-tested terminology in Rohingya or Chittagonian**, using TWB's glossary as a starting point.
- Recognize that some SRH topics are sensitive or can be embarrassing to discuss, but do not avoid them. **Ensure patient confidentiality and find discreet and indirect channels for sharing information**, such as videos, audio messaging, and placards.
- Engage with and train community practitioners who provide treatment, information, and medication, to **reduce harmful practices and promote the spread of accurate information**.
- Train all staff and volunteers in clinics and hospitals to **practice culturally sensitive communication, maintain professionalism, and use formal language**. They should also speak in a soft tone of voice, which is an important indicator of politeness in Rohingya culture. The volunteers and staff who should be trained and expected to communicate in this manner include outreach workers, counselors, doctors, nurses, and guards.
- Respond to refugees' requests for **training on SRH and access to more family planning resources and support**, and raise more awareness on how to get services.
- Apply **specific engagement strategies to reach groups with their own SRH needs**, including adolescents, couples, families, elders, and community leaders.
- Offer **counseling services** for people with SRH concerns and ensure total anonymity, confidentiality, and privacy.

## Rohingya have access to information and services in the camps that were inaccessible in Myanmar

Humanitarian organizations are tasked with providing sexual and reproductive health (SRH) services and communicating effectively about SRH with more than 900,000 refugees/FDMN living in the camps of Cox's Bazar, Bangladesh. But little research has been done to understand whether camp residents are satisfied with current programming. This study by Translators without Borders (TWB) aims to fill this gap by exploring refugees' perceptions of existing SRH services and their recommendations for humanitarians.

Residents have access to information, training, services, and treatment for SRH in the camps, most frequently for matters related to family planning, pregnancy, and birth, but also for issues like STIs, fertility, and menstruation. They rely on humanitarians for support while maintaining certain traditional practices and views. For example, according to a previous [TWB study](#), most women visit NGO clinics during pregnancy but prefer to give birth at home with the assistance of a midwife.<sup>2</sup>

<sup>2</sup> Translators without Borders (2021) Rohingya Women's Pregnancy Experiences and Perspectives, <https://translatorswithoutborders.org/wp-content/uploads/2021/10/Rohingya-womens-experiences-and-perspectives-of-pregnancy-research.pdf>

This reliance on both humanitarian and community services shows how Rohingya think of SRH care through both a medical and traditional lens. Humanitarian responders need to understand these dynamics and communicate about SRH carefully in order to provide the most effective services.

Topics explored during the study included:

- Anecdotes about discussing SRH with humanitarians.
- Level of satisfaction with past interactions and services.
- Feedback on SRH communication by humanitarians.
- Experiences getting SRH care from midwives and other non-humanitarians.
- Requests and recommendations that humanitarians should consider when developing and providing services.

## **Many humanitarian responders work on SRH in the Rohingya camps**

Many camp residents have talked about SRH with Bangladeshi staff and Rohingya volunteers who work for UN agencies and NGOs. The UN agencies they mentioned were UNHCR, IOM, UN Women, and UNFPA. The Bangladeshi NGOs mentioned included BRAC, Bitu, Green Hill, Gono Unnayan Kendra, Gonoshasthaya Kendra, Lighthouse, Mukti, RTM International, Samaj Kalyan O Unnayan Shangstha (SKUS), and Technical Assistance Inc.

The International NGOs were CARE, Community Partners International, Food for the Hungry, Helvetas, International Rescue Committee, Japan Platform, Médecins Sans Frontières, and Partners in Health and Development.

The names of these organizations have been redacted in this report. Respondents seemed to use the term “NGO” interchangeably when describing UN agencies and local, national, and international NGOs.

## **People mostly find information from humanitarians useful and important, and want to learn more**

Respondents said that the options they have for learning about SRH in the camps are helpful. They mentioned the following examples of new and useful information learned from humanitarians:

- Finding SRH services.
- How STIs spread and can be prevented.
- Reasons for having a hospital birth.
- Family planning.
- Male and female contraception.
- Abortion care.
- Protecting the health of pregnant women and nursing mothers.
- Vaccines for mothers and babies.
- Antenatal and postnatal care.
- Personal hygiene during menstruation.
- Puberty and the menopause.
- Descriptions of physiology and the sexual organs.

Respondents wanted more information about all of these topics, some of which they had learned about only vaguely. They pointed out that fewer informational programs are now offered than earlier in the humanitarian response. Respondents felt that humanitarian organizations did not prioritize SRH education enough.

## People value SRH guidelines shared by humanitarians, but they can be difficult to follow

*"I never had a chance to participate in an awareness session about SRH in Myanmar, so I lacked information about it after arriving in Bangladesh. If I had known about SRH earlier I could have protected myself from an unwanted pregnancy shortly after I was married as a young girl [at age 14]. But now I'm alert. I can practice self-care, protect myself, and advise others."*

– Male NGO volunteer, 26 years old

A 25-year-old male NGO volunteer reflected on how his relationship was positively affected when he learned how to support his pregnant wife. *"The staff taught me not to give my pregnant wife heavy tasks like working for a long time and lifting heavy objects, and to give her enough time to sleep and avoid upsetting her."* A 27-year-old man who is unemployed received similar guidance from an NGO, and, *"When I followed their instructions, the love between me and my wife increased a lot."*

Some respondents changed their mindsets and behavior as a result of acquiring new information. The 25-year-old man said that he and his wife faced pressure from relatives to have their baby at home, but he trusted the humanitarian organization that had explained to him the benefits of hospital birth. The couple resisted the pressure and had the baby at a hospital.

The young father was struck by his baby's excellent health after he and his wife followed the antenatal care guidelines they got from humanitarians, had medical care during delivery, and followed a vaccination schedule: *"My baby was born in the hospital, where there was adequate treatment for both my wife and son. My son got vaccinated without any delay. He has better health than other babies because of the safe hospital delivery."*

However, some people who joined information sessions felt that the topics shared were quite basic and vague, or that the sessions were too long and boring.

## Logistical and social factors can make it hard to get SRH services

Residents are not supposed to leave the camp for any reason. But some hospitals run by humanitarian organizations are located outside the camp, and patients seeking care at those facilities find it difficult to get travel permission from the authorities. A 28-year-old female NGO volunteer described her efforts to find medicine needed by a neighbor suffering from HIV after attending an awareness session. Her experience also shows that getting services can be difficult even when people have information about them:

*"She was getting very weak and I advised her to go to [an NGO hospital] for treatment, which we learned about in the session. She told me she received medicine and treatment three times, but nothing more because the NGO staff told her to get travel permission from the CiC and go to Ukhiya for treatment. Unfortunately, she could not get the authorities' permission to exit the camp, and had no one to help her. She felt helpless. I dialed the number the awareness session facilitators gave us, but no one replied."*

Getting transportation inside the camp, which covers a vast area, can also be challenging. Many families live far from clinics and roads accessible by ambulances. This makes it difficult for women to get help from humanitarian organizations when they go into labor, especially at night, when few services are available.

Social factors also create barriers to implementing humanitarian guidance. People are aware that giving birth in clinics has benefits for both the baby's and mother's health. But for many families, that is not enough to overcome fears that a woman's body will be seen by others in the clinic, especially male medical staff.

Clinics and hospitals usually have separate cabins for delivery where women can maintain their privacy and modesty, but many families do not know this. A male member of a community-based organization (CBO) said that humanitarians should be sure to raise awareness about this option. *“Otherwise, both the baby and mother could lose their lives during delivery in the shelter just because of shame,”* he said.

A Rohingya saying, *shoromottun bare moron bala*, translates as *“death is better than shame.”* The concept of shame, which is related to Islamic values around modesty, is so important to people that they may not seek services even in life-threatening situations, such as complications during labor. A 25-year-old mother explained why she gave birth at home: *“I heard that the baby could be delivered at a hospital, but I did not go because I thought there would be a lot of people and I would feel ashamed.”*

## People want information and services for family planning, abortion care, and contraception, but humanitarians should address sensitivities

*“In my opinion, humanitarian workers shouldn’t avoid any SRH topics. Rather than avoiding anything, I suggest they be attentive and speak carefully.”*

– 24-year-old male NGO volunteer

Respondents felt that humanitarians should help the community learn more about different SRH concerns, which would help people protect their health and reduce negative impacts. A male NGO volunteer who works on sharing SRH information with other refugees urged humanitarians to take more action:

*“Family planning and STIs are compelling issues among Rohingya communities – 90 percent of couples don’t know about or practice family planning or STI prevention for their families. Because of our lack of SRH knowledge, the Rohingya community is becoming more vulnerable, and the situation is deteriorating.”*

Most respondents said that no SRH topic was too sensitive to discuss. But some topics are more sensitive than others and require careful communication when providing information and services. The most sensitive topics include abortion, STIs, puberty, and menopause. One person suggested that humanitarians could avoid causing embarrassment by framing SRH as a component of basic health education.

Privacy is also essential. A 35-year-old man shared, *“In my opinion, no SRH topics are too sensitive, and most Rohingya refugees are in need of all SRH services and information. But patients’ personal information and the details they discuss with humanitarians should always be kept confidential.”* Another respondent, a 52-year-old housewife, suggested that older Rohingya women should be present during awareness-raising sessions so that younger girls have someone to confide in privately about health concerns.

Although family planning can be a delicate topic in conservative societies, most respondents thought that the lack of family planning in their community was mainly because people lacked information, not because they opposed it in principle. Refugees live in crowded, tiny shelters and feel unable to provide opportunities to their children, which leads them to want contraception. But they also worry that family planning is counter to Rohingya cultural and religious norms. A 48-year-old midwife voiced the tension between these two viewpoints:

*“We need information about SRH and family planning because we are surviving here in a small area with too many people...But it is sensitive in our religion and family planning is considered unacceptable by some. But we are guests in Bangladesh. This is not our country. The local community may hate us if our population increases too much every year.”*

People in the community with stricter religious views might object to humanitarians who discuss certain SRH topics, like abortion. One respondent commented, “Family planning is only okay if the woman’s health is seriously at risk. Otherwise it is not allowed in our religion. Be careful about this!” Facilitators and participants in information sessions that are approved and encouraged by camp authorities are less at risk of offending these people. A few respondents said that some oversight would be helpful. “It would be better to include the volunteers who work in the CiC’s office because that would make it safer for staff to avoid any problems.”

#### Case study: A family affected by mental illness struggles to prevent unwanted pregnancies

Zafor is a 36-year-old father living in the camp with his wife Setara (not their real names) and nine young children. He shared his family’s experiences and their search to get help managing their family planning needs. His story demonstrates the impacts of insufficient awareness-raising programs and services in the camps, and the challenges of accessing contraception even when a couple badly want and need it.

When Zafor and Setara were married in 2004, they dreamed of having a small family. But neither of them had any formal education, and they had little information about family planning and SRH. They were unfamiliar with concepts like birth spacing and safe pregnancy. Before fleeing to Bangladesh, they had seven children, all born at home without support from government-run health facilities, private clinics, or NGOs. Hospital births were not possible because of the movement restrictions imposed on Rohingya in Myanmar.

Setara was four months pregnant with their eighth child when the family fled to Bangladesh in August 2017. Eventually, the baby was born in their new shelter in the camp. Three months later, Setara began to experience severe mental illness. Zafor brought her to an NGO-run hospital, which admitted her for three days. There was no Rohingya interpreter, so Zafor was unable to get advice about how to deal with the care needs of his infant and prevent another pregnancy. Setara received no medical treatment or mental health counseling.

The hospital discharged Setara after three days even though her condition had not improved and the family had received no advice. Neighbors referred Zafor to traditional astrologers, all fellow refugees, who tried to help her but had little success. After three months, Zafor took Setara to a different NGO-run hospital, where there was a Rohingya interpreter. This time, Zafor could understand the doctor, but he was merely informed that no mental health treatments were available, and he took Setara home unimproved.

By then, Setara was fully psychotic and became violent at times. Zafor was overwhelmed by having so many small children and a sick wife to care for. He says he even became suicidal with worry, and was desperate to prevent another pregnancy, but still didn’t know how. Despite the family’s situation, he still hadn’t received any information from humanitarians about family planning, birth spacing, or contraception. He worried that Setara’s condition could become even worse if she became pregnant again.

This fear came true. Setara became pregnant with a ninth child. Her condition and behavior became so severe while pregnant that she was a danger to others. Zafor had nowhere to take her, and even tied her up in their shelter for a few days. Another astrologer tried to help, but could not.

Setara gave birth unassisted in the family's shelter while out of touch with reality. In the months that followed, Zafor tried several more times to get help from humanitarians. He encountered language difficulties because he was unable to fully explain the situation to the staff of a counseling center he visited, who only spoke Chittagonian. Zafor said, "Only Allah knows how my poor family and I are suffering without getting any help. Where should we go and how can our sorrows be relieved?"

## Humanitarians should always speak in Rohingya or use an interpreter when providing SRH information and services

Most respondents had positive reflections on their past communications with humanitarians about SRH, but also described many misunderstandings and unclarity, especially when a Rohingya interpreter was not present. A man who suffered from an STI admitted that he *"didn't totally get the doctor's points."* But, he said, *"Even when I didn't understand what the doctor was saying, I pretended to understand by responding, 'jee sir, jee sir' [yes sir]."* Some respondents found facilitators poorly trained and blamed managers for failing to ensure that interpretation needs were met.

Most of the problematic interactions were with Bangladeshi staff who did not speak Rohingya or Chittagonian, and did not have a Rohingya interpreter. The resulting language gap caused embarrassment, frustration, and confusion. Many respondents said they had missed a lot of the information shared during sessions they had attended because of language gaps. A male NGO volunteer, formerly a staff member of an NGO that worked on SRH in Myanmar, was critical about the language issues he had observed during information sessions in the camps, even those led by Chittagonian speakers:

*"Most NGO staff use Chittagonian, which is spoken in the Cox's Bazar area and is close to the Rohingya language. But it is not close enough to avoid misunderstandings. Many camp residents, especially older people and children, do not fully understand Chittagonian. That can be particularly damaging when it comes to topics like SRH and GBV."*

The man said that facilitators tended to mix in Bangla and English words when sharing information in Chittagonian, which caused additional comprehension problems. Respondents preferred Rohingya volunteers rather than Bangladeshi staff to facilitate information sessions about SRH, provided they are well prepared by their organizations. However, the presence of a Bangladeshi or foreign staff can also *"give more weight"* to sessions.

There is a certain preference for formality. One focus group participant criticized NGO staff he had observed talking about SRH as if *"storytelling,"* rather than sharing information in a more technical way. Another disapproved of a Bangladeshi facilitator she had observed sitting at a shop after a session, *"talking to other people while sitting inappropriately with his legs out in front of others."* But formality should be balanced with a personable facilitation style – respondents didn't like when facilitators spoke in a scripted way: *"It was like the facilitators came here only to read us some words from a paper written at their office."*

Several people felt that the Rohingya words for the male and female reproductive organs were too vulgar for humanitarians to use openly. Again, they linked this to Rohingya concepts of shame. According to a 26-year-old male driver, *"It was shameful for me to hear the direct words for the sexual organs."* He and others said that these words were shameful to hear even privately and asked humanitarians not to use them.

## Tone and body language affect people's satisfaction with past experiences

For Rohingya, using the right tone of voice in a conversation is very important. Many respondents mentioned the problematic tones of humanitarians when describing negative past experiences. A 28-year-old woman who works as an NGO volunteer advised:

*“Every society has its own style of respectful communication. In our society, a speaker should smile, use a sweet tone of voice, and speak in a heartfelt way. This is how others can be sure that the speaker feels like their equal...Don't show anger. Be respectful toward others and don't speak carelessly.”*

Others echoed her advice; in fact, 12 of the 18 interviewees mentioned “softness” when asked to give advice to humanitarians about communicating with refugees. They felt that speaking gently demonstrated humanitarians' sensitivity to the traumas Rohingya have suffered. As one respondent explained, “They should use polite and sweet words with refugees as we are persecuted.”

An 18-year-old mother added, “We came here after facing many brutalities and violence by the Myanmar military. When someone hurts my feelings, I feel emotional and relive all the violence our community faced in Myanmar. Therefore, I advise NGOs and humanitarians to treat us very softly.”

## Humanitarians should demonstrate cultural sensitivity and show compassion

*“Humanitarians have a duty to study our culture and community, and to see us refugees as human. Sheltering in another country does not mean we are animals. Treat us as human beings. Office managers must give strong instructions to their staff to communicate respectfully and politely with beneficiaries. Just tell us, ‘We are the same as you: human,’ and treat us like that. Nothing else.”*

– 45-year-old community midwife

Demonstrating a humanitarian ethos and dedication to the community is also important. “I want to talk with humanitarian workers who have a humanitarian mindset and really work with refugees from their heart, not those who are just waiting out their time here,” said a 48-year-old midwife.

An 18-year-old mother said humanitarians should strive to understand Rohingya culture better: “We are Rohingya Muslims following religion as our guide. So, whoever comes to meet us must first respect our religion and communicate with us in an appropriate way.” We heard that SRH staff and volunteers are not only insufficiently trained, but sometimes seem poorly supervised as well. A 16-year-old girl said she was ridiculed when she approached Bangladeshi NGO volunteers for help with an STI:

*“I really want to hear NGOs' messages...but sometimes I don't want to go because the Bangladeshi volunteers make fun of us and we don't feel comfortable talking with them. For example, a few weeks ago I was facing so many issues due to an STI, but they made fun of me and laughed. They told me that it would go away if I took a shower. I cried so much.”*

Such poor behavior is uncommon, and most offenses described by respondents were less serious, but any negative interaction makes refugees lose trust in humanitarians. Other communication tips for humanitarians were: ensuring that Rohingya interpreters are there to ensure clarity in all interactions, practicing active listening when speaking with community members, making eye contact, ensuring confidentiality, taking time to chat informally, not sounding judgmental, and not acting arrogantly.



## Location, channels, and facilitation styles shape learning experiences

Humanitarian organizations share SRH information in various places, using several channels. Some have produced animated videos on topics like STIs and played them along roadsides, which enables many people to learn about SRH passively. This format reaches more people than sharing information in smaller groups, and avoids the embarrassment that might happen in more intimate settings. Miking is a similar approach that respondents found useful.

People appreciate written materials in Myanmar (Burmese). A male CBO member reported that, while most people in the camp can't read, they assume that written information is factual and important. He had observed that when a non-literate person receives a leaflet from a humanitarian organization, they *"take it to an educated person to read it to them so they can understand what it says."*

Respondents thought that door-to-door visits would be the best way for SRH information and service providers to reach women, many of whom rarely venture outside their shelters. They also said that women-friendly spaces run by humanitarian organizations would be good places to share information and deal with people's concerns. One focus group of female NGO volunteers recommended providing a safehouse where women could get confidential access to services. Table 1 summarizes the locations and channels that respondents recommended for communicating on SRH.

Table 1: Respondents' recommended locations and channels for SRH communication

Locations	Channels
<ul style="list-style-type: none"> <li>• Door-to-door (preferred for women)</li> <li>• Women-friendly spaces</li> <li>• Shelters of respected people in each block</li> <li>• Learning centers</li> <li>• Public open spaces</li> <li>• CiC's office</li> <li>• <b>Majhi's</b> shelter</li> </ul>	<ul style="list-style-type: none"> <li>• In person (preferred)</li> <li>• Phone hotline</li> <li>• Infographics</li> <li>• Video animation</li> <li>• Placards</li> <li>• Posters</li> <li>• Cartoons</li> <li>• Social media and leaflet campaigns</li> <li>• Miking</li> <li>• Audio messaging on WhatsApp</li> </ul>

Overall, people were more satisfied with their past communication with humanitarians who facilitated information sessions than with the medical staff at clinics and hospitals, whose communication style is perceived as less polite. A 45-year-old female teacher said, *"Most NGO workers speak very softly and politely. I like most of their communication styles. But the doctors, nurses, and volunteers in the hospitals speak very disrespectfully when we go there for treatment."*

Another point of dissatisfaction with communication at medical facilities was that many conversations between staff and patients happen without the support of a Rohingya interpreter. Also, patients are not always provided information about their own condition or given instructions on protecting their health. According to a 26-year-old male NGO volunteer who had an STI, *"The [medical staff] were busy with their respective patients. After running tests, the doctor did not tell me what disease I had."*

Outreach workers play an important role in filling certain knowledge gaps. Though the medical staff at clinics have the most technical understanding of SRH issues, they often do not take the time to explain details to patients about their medical conditions. This gap is likely due to heavy workloads and because patient education is not considered their responsibility. However, practitioners are in a unique position to help an individual understand their condition, and every patient deserves at least a brief explanation.

Also, there seem to be gaps in referral systems between humanitarians who share information and those who provide treatment. An 18-year-old girl who was the victim of sexual exploitation by a Bangladeshi NGO volunteer said that she confided in the facilitator of an SRH awareness session about an unwanted pregnancy which she had not mentioned to anyone else. She told the facilitator that she needed psychosocial support to help her emotionally process what had happened.

But the facilitator, a Bangladeshi woman, *“did not give me any advice or further support. I thought she...would say something after hearing my story. I was hoping to get some kind of help or support about that unexpected event because I often think about it and feel depressed.”*

## Community practitioners are relied on but sometimes cause problems

Non-humanitarians also provide SRH information and services in the camps. They include “community doctors” (called “quacks” by Rohingya who speak English), “informal pharmacists,” and midwives. These practitioners provide important and risky procedures including abortions, STI treatment, and contraceptive injections like Depo Provera. Most of them are self-taught or were minimally and informally trained by elders. Some combine conventional Western and traditional approaches to healing.

Rohingya rely on them despite their low level of training, and many people prefer getting treatment from them even though they charge a fee for their services, which NGO clinics do not. Ultimately people just trust them more, even though they often make mistakes. According to a 48-year-old midwife, *“We rely on informal doctors and pharmacists because the NGO clinic staff don’t care about the patients and only give instructions rather than medication...We have little confidence in them and only go in times of emergency.”* Also, it was normal to rely on them in Myanmar because access to formal healthcare was often denied to Rohingya.

Respondents described cases where community practitioners had given incorrect information or treatment that made conditions worse. When this happens, patients usually go to an NGO clinic for help. For example, a young woman bled heavily after an abortion performed by a community midwife and community doctor, and she had to be admitted to a hospital. She and her husband had also received misinformation from the midwife. The husband, a 25-year-old teacher, said they regretted relying on the midwife:

*“I once heard from the midwife that a nursing mother cannot get pregnant as long as her baby is still breastfeeding. But it was wrong, because my wife got pregnant when our baby was still so small...The midwife’s communication was polite and soft...but now I think I was wrong to follow her guidance.”*

Midwives seem to want more technical training and support. One of the two midwives interviewed for this study said she was satisfied with the information she learned from an NGO training that targeted midwives, which was mostly about referring patients to clinics. But she also wanted humanitarian organizations to provide material items, such as instruments used during deliveries, that would help her perform her duties more safely.

None of the respondents mentioned getting SRH information or support from religious leaders. But because they are among the most trusted people in the community, some thought it would be good to engage them. A 30-year-old man said that the mosque would be an ideal place to learn about SRH but that he doubted it would be possible to talk about non-religious matters. Another man said he had heard that religious leaders in other Islamic countries agreed on and promoted family planning. He thought Rohingya Islamic scholars should learn from their counterparts elsewhere and be exposed to a scientific way of thinking about SRH.

A few respondents also recommended engaging CBOs. CBOs are usually led by prominent community members who have earned the community's trust, and several are led by women.

### People also turn to relatives and friends for information

Talking about sexuality and sexual health can be embarrassing for anyone, and the Rohingya community is no exception. Some respondents said they prefer to talk about delicate matters with the people closest to them, especially relatives. A 27-year-old housewife compared the serious and reserved tone used by humanitarians who shared information with her about STIs to the friendly and joking – but still informative – tone used by her husband and sister-in-law when they shared similar information.

Female respondents said that girls could learn about religious practices and SRH at the same time, since reaching puberty entails lifestyle changes for girls who are no longer allowed to leave their shelters and must wear hijab after getting their first period.

Respondents mentioned siblings, parents, in-laws, and older women as people they could talk to about SRH more comfortably than humanitarians. Elders are important sources of information, but some respondents described their advice as superstitious and medically inaccurate. (An earlier report from TWB describes traditional Rohingya beliefs about what women should and shouldn't do during pregnancy.<sup>3</sup>)

A 25-year old schoolteacher said that humanitarian organizations should train parents to communicate with their children about SRH and provide sex education within the family. He suggested parents would need to be carefully prepared for this to avoid sharing inaccurate information.

## Rohingya think humanitarians should engage more closely with community members and practitioners

*“Both trained and untrained midwives in our community deliver babies, and some ‘informal doctors’ treat patients. I haven’t seen any collaboration between NGOs and these people. I think NGOs dislike them and want to stop them from working because they are not professionals.”*

– 18-year-old housewife

There is little collaboration between community practitioners and humanitarians, and nearly all respondents said there should be more in order to improve refugees' access to SRH information and services. A 27-year-old man said, “Knowledgeable people from the community like midwives, community healers, teachers and majhi should talk about SRH with the refugees by partnering with the NGOs. They should be trained on SRH to raise awareness and disseminate factual information. Otherwise they may give out false information.”

A female CBO member who shares SRH information in the community thought NGOs could learn from CBOs “how to approach women in general. We have a better understanding and techniques for it since we are from the same community.” A 45-year-old midwife explained that community practitioners wanted access to correct information, but needed to learn it from NGOs:

<sup>3</sup> Translators without Borders (2021) Rohingya Women's Pregnancy Experiences and Perspectives, <https://translatorswithoutborders.org/wp-content/uploads/2021/10/Rohingya-womens-experiences-and-perspectives-of-pregnancy-research.pdf>.

*“People who address SRH in the community are knowledgeable in some ways, yet untrained. They have knowledge but they do not work systematically. I am surprised that NGOs still haven’t provided them training...We don’t have a library in the camp where we could study... If NGOs really want to promote and upgrade the knowledge of the community, first they should engage our people, train them well, and then work together.”*

A 27-year-old housewife said that there are respected older Rohingya women in the camp who are known for their traditional healing abilities. She thought these women could accompany humanitarian staff who work on SRH, because this would encourage people to be receptive when new perspectives are shared. Older women could also be resource persons for younger women and girls to confide in privately about SRH concerns after information sessions.

Collaboration would also help humanitarian organizations expand their reach and convince more people to accept new information. A 25-year-old male NGO volunteer said, *“Humanitarian organizations alone can’t give information to every refugee, so knowledgeable people from the community should collaborate with NGOs. These knowledgeable people can help reduce the shame of others who are too shy to talk about SRH.”* Furthermore, midwives, community doctors, *majhi*, and neighbors are *“first responders”* for all types of issues, especially at night when humanitarians are not in the camp. They will inevitably be approached for help on SRH concerns, and should be as well prepared as possible.

## **We heard from a targeted sample of 44 Rohingya respondents**

The study was led by one international researcher and five Rohingya-speaking researchers in July and August 2022 in Camps 1E, 1W, 3, 4 Ext, 9, and 18 in Cox’s Bazar, Bangladesh. Rohingya-speaking researchers spoke to most respondents in person or by phone and the international researcher talked to some respondents remotely using video conferencing. The study utilized three qualitative research methods:

- **Interviews with individuals**, all Rohingya who have interacted with humanitarians about SRH by attending an awareness-raising session or as a patient.
- **Focus group discussions** with representatives from two groups: 1) Rohingya who have volunteered with humanitarian organizations on SRH-related programs and 2) Rohingya who have worked to address SRH as members of CBOs.
- **A case study** in which the research team examined a camp resident’s experiences of SRH-related communication with humanitarians in detail.

We interviewed 18 people: ten women and eight men. Twenty-five people participated in five focus group discussions: five female and five male NGO volunteers, and ten female and five male CBO members. The case study was conducted by a member of the research team who approached a man familiar to him and who had dealt with a challenging SRH-related issue.

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## About Translators without Borders

TWB is a nonprofit organization offering language and translation support for humanitarian and development agencies and other nonprofit organizations on a global scale. TWB Bangladesh has supported the Rohingya refugee response since 2017, providing language and translation support to response partners and conducting research and training to meet the language and communication needs of the Rohingya and host communities. TWB is a cornerstone of CLEAR Global, an initiative launched in 2021 to expand our ambition to help people get vital information, and be heard, whatever language they speak.

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