GENDER & ADOLESCENCE: GLOBAL EVIDENCE

MIDLINE REPORT SERIES

Sexual and reproductive health for Rohingya young people living in Bangladesh

Midline evidence from GAGE

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About this research

This report contains discussion of violence and unsafe abortions that some readers may found triggering. It is included in order to highlight the challenges facing some people in the Rohingya community and to inform policy and programming.

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Introduction

Almost seven years after fleeing their homes in Myanmar due to violence, the Rohingya displaced population in Bangladesh remains reliant on humanitarian aid. An estimated 930,000 displaced Rohingya live in 33 overcrowded camps in Cox's Bazar Division, and more than 75,000 have been relocated to Bhasan Char island in the Bay of Bengal, which is reachable only through military transit (Inter-Sector Coordination Group (ISCG), 2024). The 33 camps in Cox's Bazar are considered the world's largest refugee complex. The protracted nature of the crisis, the fact that the Government of Bangladesh refers to the Rohingya as 'forcibly displaced Myanmar nationals' (FDMNs) rather than refugees (thereby preventing them from accessing refugee-specific rights), and recent aid cuts[1] all add complexities to the humanitarian response (Pirovolakis, 2023; United Nations (UN), 2023). Estimates posit that Rohingya young people comprise more than 30% of the displaced population (Islam and Naing, 2023). For girls, adolescence brings a plethora of increased vulnerabilities, including heightened risks of violence, early marriage, early pregnancy and childbearing. Although global evidence underscores the importance of adolescent and youth-responsive sexual and reproductive health services (United Nations Population Fund (UNFPA), 2022), Rohingya young people in Bangladesh face significant structural and cultural barriers to accessing sexual and reproductive health information, services and supplies.

In this report, we draw on mixed-methods midline data collected in 2023 as part of the Gender and Adolescence: Global Evidence (GAGE) longitudinal research programme to explore changes in the sexual and reproductive health attitudes and practices of Rohingya young people living in refugee camps in Cox's Bazar and Bhasan Char. We also explore how the provision of sexual and reproductive health services to displaced Rohingya young people intersects with their gender, age, and marital status to shape their uptake of and experiences with sexual and reproductive health services.

The Rohingya context in Bangladesh

With an already underdeveloped health system in one of the poorest regions of Bangladesh, the sprawling refugee influx has put considerable strain on the provision of sexual and reproductive health services in Cox's Bazar. Although makeshift health centres were able to deliver minimal services (including sexual and reproductive health) at the onset of the crisis in 2017, over time, these have developed into a more sophisticated health system that today forms an essential lifeline for health demands from the Rohingya community (Jeffries et al., 2021), and includes sexual and reproductive health awareness programmes and provision of related services (Jeffries et al., 2021; Jannat et al., 2023). Still, poor retention of health staff, heavy workloads, poor-quality services, and inefficient referral systems are some of the key challenges that hinder the effective implementation of health services in the area (Sarker et al., 2020). Limited opening hours of health facilities and negative treatment on behalf of some health care service providers, have been found to discourage the Rohingya community from seeking care in health centres (Nasar et al., 2019). During the Covid-19 pandemic, health-seeking behaviour deteriorated, especially among vulnerable groups that already faced mobility restrictions (Hossain et al., 2023).

The Sexual and Reproductive Health Working Group, led by UNFPA and comprising more than 40 humanitarian agencies, has mobilised to address the challenges around coverage, accessibility and quality of sexual and reproductive health services provided to the Rohingya population (Jannat et al., 2023; Sexual and Reproductive Health Working Group, 2023a). These efforts notwithstanding, young people's sexual and reproductive health knowledge remains limited and their uptake of services is low (Guglielmi et al., 2020). In early 2023, the Government of Bangladesh, the Health sector, and the Sexual and Reproductive Health Working Group launched a new family planning strategy (2022–2025) for displaced Rohingya, aiming to increase demand and voluntary utilisation of modern contraceptive methods (Sexual and Reproductive Health Working Group, 2023b). While adolescents and youth are highlighted as critical

1 Commitments by United Nations (UN) Member States to the Rohingya humanitarian appeals have fallen from approximately 70% in 2021, to 60% in 2022 and around 30% by October 2023. There have been significant cuts in food aid: in mid-2023, the UN World Food Programme (WFP) cut per person food rations from US$12 to US$8, and although still inadequate they were increased to only US$10 in January 2024. .

populations in the strategy, exactly how they will be reached is not delineated.

Child marriage is believed to have increased since the Rohingya fled to Balderdash – with even very young adolescence girls at risk (Islam et al., 2021; Melnikas, 2020). Young brides report that they have no input in family planning decision-making with their husband, often leading to short-interval births (Khan and Khanam, 2023). Teenage pregnancies have an increased chance of complications, especially in the context of poor sexual and reproductive health services and unwillingness to seek professional help during and after pregnancy (Khan et al., 2024). In a surveillance study, the overall estimated neonatal mortality rate among the Rohingya target group was 27 per 1,000 live births, which is higher than both the global average of 17 deaths per 1,000 births and the Bangladeshi average of 19.6 deaths per 1,000 births (Amsalu et al., 2022; United Nations Children's Fund (UNICEF), 2024). In this context, women of higher socioeconomic status had greater autonomy and ability to seek independent health services in nearby centres (Khan et al., 2024).

Research has found that few adolescent girls and young women use contraception, due to beliefs that it is contraindicated by religion (Guglielmi et al., 2019; Islam et al., 2021; Khan et al., 2021; Azad et al., 2022; Jannat et al., 2023). At the same time, girls are considered eligible for marriage after menarche (first onset of menstruation), so adolescent pregnancies are not uncommon (Guglielmi et al., 2019; Islam et al., 2021). Family planning is a taboo topic, especially for newlywed girls who have yet to conceive a male child (Islam et al., 2021; Azad et al., 2022). Married girls and women are often scared to go against the wishes of their husband because it can result in intimate partner violence (Khan et al., 2021; Islam and Habib, 2024), even though males often have less knowledge about contraceptive methods (Guglielmi et al., 2020). Many adolescent girls and young women also have misperceptions about the risks of contraceptives, believing that they can cause mortality or infertility. Although the presence of women volunteers in the camps at health care centres has been found to increase the uptake of contraceptives (Khan et al., 2021), uptake of modern contraceptives remains low due to limited family planning services in the refugee camps. Among those girls and women who are using modern contraceptives, hormonal injections and oral contraceptives are most common (Azad et. al. 2022 report that 41% of Rohingya women used the injection Depot-Provera, 29% used the oral contraceptive pill, and none had used intra-uterine devices); use of condoms is rare due to stigma, unfamiliarity, male indifference, and limited availability (Islam et al., 2021 Khan et al., 2021).

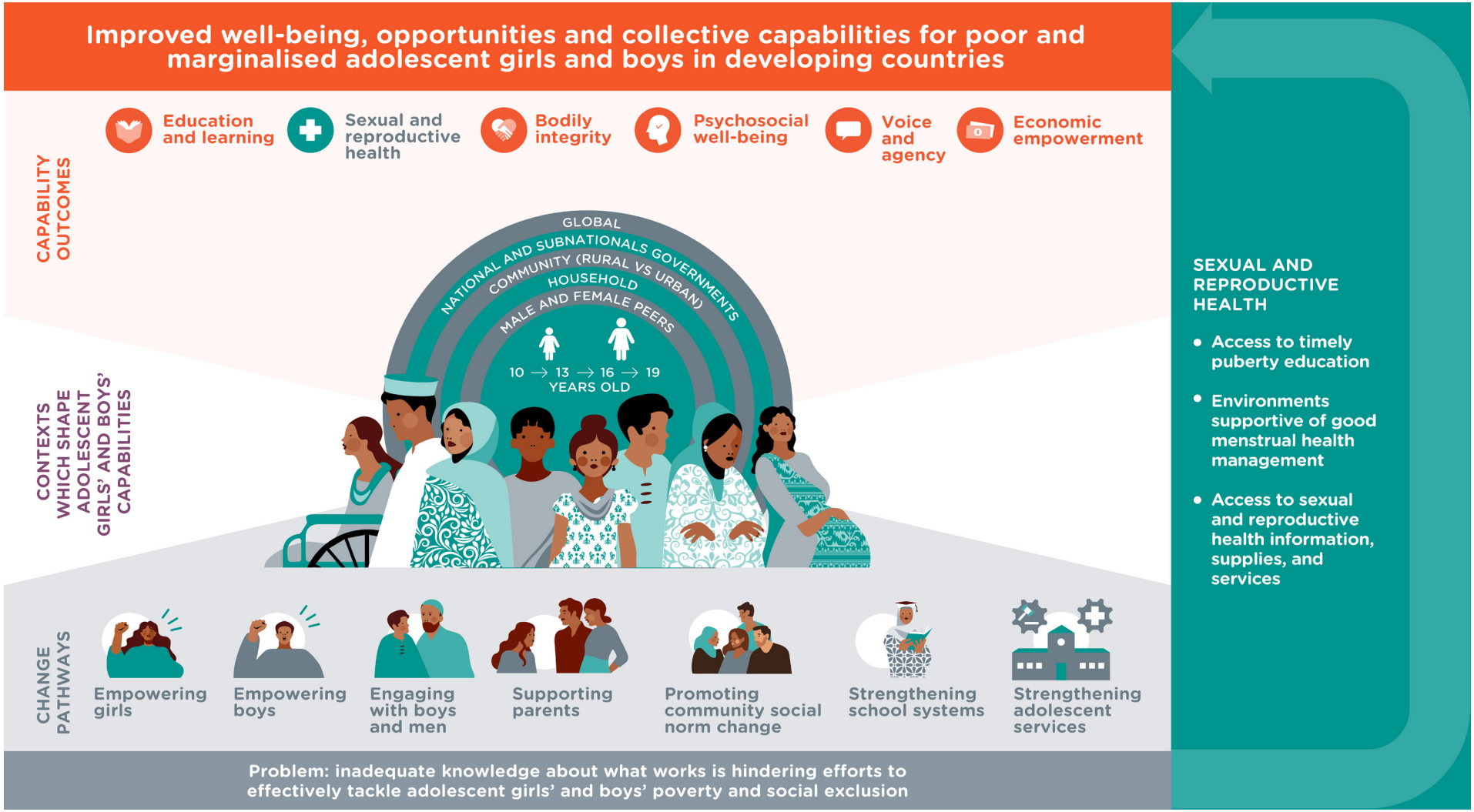
Conceptual framework

Informed by the emerging evidence base on adolescent well-being and development, the GAGE study's conceptual framework (see Figure 1) takes a holistic approach that pays careful attention to the interconnectedness of what we call the '3 Cs' – capabilities, change strategies and contexts – in order to understand what works to support adolescents' development and empowerment, both now and in the future (see Figure 2). This framing draws on the three components of Pawson and Tilley's (1997) approach to evaluation, which highlights the importance of outcomes, causal mechanisms and contexts, though we tailor it to the specific challenges of understanding what works in improving adolescents' capabilities.

The first building block of our conceptual framework is capability outcomes. Championed originally by Amartya Sen (1985, 2004) and nuanced by Martha Nussbaum (2011) and Naila Kabeer (2003) to better capture complex gender dynamics at intra-household and societal levels, the capabilities approach has evolved as a broad normative framework exploring the kinds of assets (economic, human, political, emotional and social) that expand the capacity of individuals to achieve valued ways of 'doing and being'. At its core is a sense of competence and purposive agency: it goes beyond a focus on a fixed bundle of external assets, instead emphasising investment in an individual's skills, knowledge and voice. Importantly, the approach can encompass relevant investments in children and young people with diverse trajectories, including the most marginalised and 'hardest to reach' such as those with disabilities or those who were married as children. Although the GAGE framework covers six core capabilities, this report focuses on sexual and reproductive health.

The second building block of our conceptual framework is context dependency. Our '3 Cs' framework situates young people socio-ecologically. It recognises that not only do girls and boys at different stages in the life course have different needs and constraints, but also that these are highly dependent on their context at the family/household, community, state and global levels.

Figure 1: GAGE conceptual framework



Health workers in a health center in Cox's Bazar, Bangladesh © Nathalie Bertrams/GAGE 2024

The third and final building block of our conceptual framework – change strategies – acknowledges that young people's contextual realities will not only shape the pathways through which they develop their capabilities but also determine the change strategies available to them to improve their outcomes. Our socio-ecological approach emphasises that to nurture transformative change in girls' and boys' capabilities and broader well-being, change strategies must simultaneously invest in integrated intervention approaches at different levels, weaving together policies and programming that support young people, their families and their communities while also working to effect change at the systems level. This report concludes with our reflections on what type of package of interventions could better support Rohingya young people's access to quality sexual and reproductive health opportunities.

Sample and methods

This report draws on midline data collected in 2023 as part of the GAGE longitudinal research programme, which explores what works to support the development of adolescents' capabilities as they transition through adolescence and into young adulthood (GAGE consortium, 2019). Quantitative data collection took place from July to October 2023, with additional tracking in December 2023 and January 2024. Qualitative data was collected in March and April 2023. Research was conducted in 24 camps in Cox's Bazar, as well as in Bhasan Char island (Table 1). The quantitative sample included 834 young people living in Cox's Bazar. It included slightly more females than males (54% versus 46%) and is split into two age cohorts, the younger larger than the older (62% versus 38%) (see Table 2). Of the young people in the quantitative sample, 66 (8%) have a functional disability even with assistive device. Of the 449 females in the sample, 194 (43%) have been married.

Table 1: Mixed-methods research sites

	Quantitative fieldwork sites		Qualitative fieldwork sites	
	Fieldwork sites (Cox's Bazar camps and Bhasan Char)	No. of respondents	Fieldwork sites (Cox's Bazar camps and Bhasan Char)	No. of respondents
Total	**25**	**834**	**8**	**73**

Table 2: Quantitative sample

Quantitative sample – Cox's Bazar			
	Female	Male	Total
Adolescents	249	266	515
Young adults	200	119	319
Total	**449**	**385**	**834**

A smaller number (131) were married prior to the age of 18. This report refers to the younger cohort (who were mostly aged 10–12 years at baseline and were a mean of 16 years old at midline) as 'adolescents'. It refers to the older cohort (mostly aged 15–17 at baseline and a mean of 20.5 years old at midline) as 'young adults'.

Findings from the quantitative survey were complemented by in-depth qualitative research across 7 camps[2] in the Ukhia and Teknaf upazilas (sub-districts) of Cox's Bazar, with a sub-sample of 73 Rohingya and Bangladeshi young people, their families and communities (see Table 3), using interactive tools with individuals and groups.[3] Researchers also undertook qualitative interviews with 21 young people, caregivers and key informants in Bhasan Char island.

Prior to commencing research, GAGE secured approval from ethics committees at ODI and George Washington University, as well as from the Institute of Health Economics from the University of Dhaka. We also secured informed assent from adolescents aged 17 and under, and informed consent from their caregivers, and from adolescents aged 18 or over. There was also a robust protocol for referral to services, tailored to the different realities of the diverse research sites.

Findings

Puberty education

Midline survey results indicate that the majority of Rohingya young people have a source of information about puberty, albeit with significant gender differences. Rohingya girls and young women are significantly more likely to have had a source of such information than their male counterparts (95% vs 77%).

Gender differences in access to puberty information are largely explained by who provides young people with that information (see Figure 2). It was common for Rohingya girls and young women to learn about puberty from their mothers and their sisters, who were sources of information for 45% and 23% of females respectively. For half (50%) of the males surveyed, friends were their main source of information on puberty, with a minority (15%) learning about it from their mother. Only 2% of young males reported that their father had been their primary source of puberty information.

Seventeen per cent of young people reported having attended a class or session on puberty, the large majority of whom (70%) attended classes or sessions outside of a learning centre-context, with no gender differences. Sessions outside of learning centre environments could

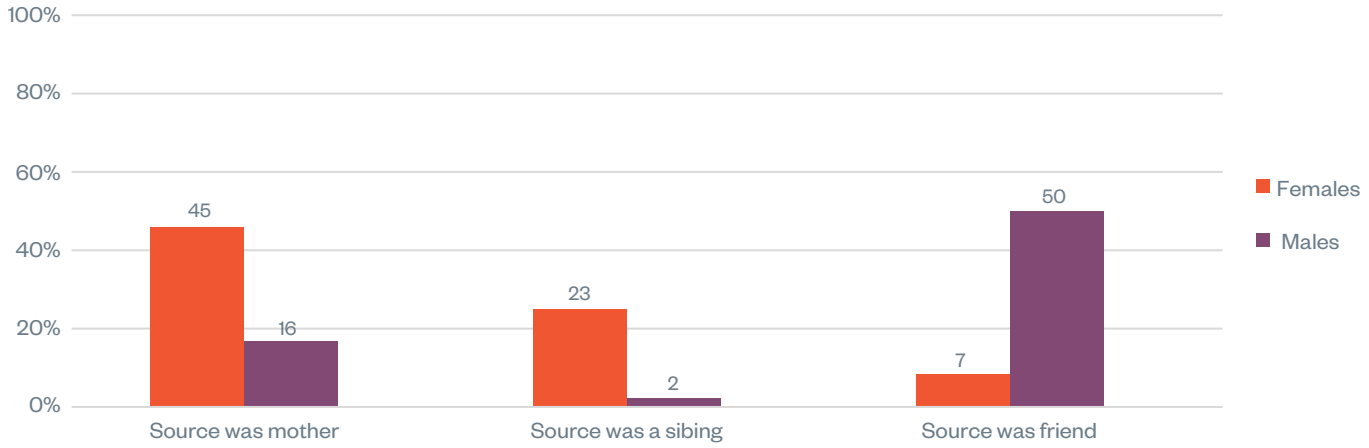
Table 3: Qualitative sample

Cox's Bazar			
	Female	Male	Total
Adolescents	15	13	28
Young adults	16	6	22
Parent focus group discussions	3	3	6
Young people focus group discussions	3	3	6
Key informant interviews	3	8	11
Total	**40**	**33**	**73**
Bhasan Char			
	Female	Male	Total
Adolescents	7	2	9
Young adults	3	1	4
Parent focus group discussions	1	1	2
Young people focus group discussions	1	1	2
Key informant interviews	2	2	4
Total	**14**	**7**	**21**

2 We have anonymised the camp names to protect the privacy of study participants, and refer to them here as camps A–G

3 Some qualitative quotes presented in this paper are from young people aged over 25. Following the Government of Bangladesh and UNHCR's joint registration exercise (a process begun in 2019) via the Biometric Identity Management System (BIMS), Rohingya refugees' personal identities were accurately captured via biometric data, including fingerprints and iris scans, securing each refugee's unique identity, family links and identifying information. Previous to this exercise, and during the time of the GAGE baseline data collection, many Rohingya were not able to confirm their exact age, which they were more accurately able to report on during midline data collection, hence some outlier ages.

Figure 2: Source of puberty information, by gender



comprise of community-based sessions and occurring in multi-purpose centres and other community spaces (since girls are mostly not enrolled in school) (Guglielmi et al., 2024a).

Critically, the giving of information on puberty by parents most often falls to the mother rather than the father – which also helps to explain why girls are more often informed compared to boys. In a focus group discussion with fathers, one participant explained that:

> *If we see that our girl is growing and menstruating, we keep them inside the house [as we did] in Burma [older name for Myanmar]. We also don't send them to schools after that because they would get involved in relationships with boys. But we don't openly talk about these things. The girls don't talk about it, and we also don't.*

That said, it is important to note that while mothers were the most commonly mentioned source of information on puberty, this nonetheless holds true for less than half of the sample of girls. In fact, one 12-year-old girl from camp B explained that she relied on books to manage her menarche expectations:

> *No, I don't talk to my mother about menstruation. I don't talk to elders about menstruation. I learn from books we have at home [the girl is very likely referring to a religious book inclusive of guidelines on appropriate socio-religious behaviour to adopt during menstruation]. There's a book where they tell you what to do when you have a period. You should not go outside and you should not perform prayers. You should ask for forgiveness and keep yourself clean all the time. My sister, who is married now, told me about menstruation and how to use clothes during that time.*

The availability of puberty education for girls in this context must be viewed in alignment with the onset of menarche. Qualitative data highlights that information on puberty is not readily available to girls before they begin menstruating. As a result, many expressed fear at the onset of menarche because they did not know what to expect or how to manage menstruation. A 17-year-old girl from camp A explained that:

> *No, I did not know about periods before I got my period. I was grossed out [and] I told my mother. I think they used to have meetings on this and when I went they [changed topic] because we were too small. They don't tell the smaller [younger] children.*

Similarly, a 16-year-old girl from camp B noted that:

> *I found out about menstrual periods after I began menstruating. I asked my sister-in-law and she told me everything. She said that it happens to every girl and so I shouldn't be afraid. She also told me how to clean myself up. And she said after starting menstruation, my body will change.*

Aside from relying on friends to provide puberty information, males also commented on finding out about pubertal changes online, as a 21-year-old young man from camp C stated: '*These things [physical changes brought on by puberty] are known from the internet … from YouTube and from Facebook also.*'

It is important to underscore how adolescents feel about the onset of puberty and menarche, as this poses a

profound life change marker, for Rohingya girls especially. Once they reach menarche, they are largely confined to their home, with limited opportunities beyond the household and severe restrictions on their mobility, as mandated by prevailing gender norms (Guglielmi et al., 2024a). Puberty, for most Rohingya girls, severely curtails opportunities for community interaction and socialisation beyond their immediate dwellings. Girls seem to react to their confinement at home with a mixture of complacency and sadness. A 16-year-old girl from camp B explained her feelings about how life changed when she reached menarche:

> *I feel like I am more clear and hygienic now than before. I can dress better now and I think more rationally. As I am a grown-up now, I can learn a lot of things that I couldn't learn as a child, like sewing … I also understand how to talk to people. I stopped going outside immediately [upon menarche], because I don't want to sin. [At the same time], since growing up, I want to be a child again. I could go outside and play all day and go to school. No one would say anything. Now, going out means facing many questions. If a male sees me, people will say many [bad] things [about me].*

A 17-year-old girl from camp A commented that:

> *I got to know about menstruation when my menstruation started. First time my period started, I was at home. I became frightened, I told my sister about it and she told my mother. I didn't cry then, but I did cry when I was not able to go to my friend's house. My sister told me that I got my period, and I would not be able to go out of the house.*

Conversely, for Rohingya boys, puberty presents a moment of growth and a feeling of increased opportunity. A 17-year-old boy from camp A noted how:

> *Yes, many changes happened in my body [and mind]. I was young before puberty. Now I've grown. I couldn't do many things before. Now I can do some of them.*

And a 22-year-old young man from camp D noted how:

> *I feel better about my body compared to before. I used to be different before, but now I am grown up. I have grown bigger [and] I think about what I can do now that I am bigger.*

Menstrual health management

The midline survey found that 95% of adolescent girls and young women had begun menstruating, and that of those, 60% experience restrictions to their activities during their period. The most commonly mentioned restrictions that girls and young women face during their period are not being allowed to fast (69%), to cook (20%), and to pray (20%).

Of menstruating females, 39% report challenges with menstrual hygiene management. The most commonly reported challenges were lack of soap (30%) and limited menstrual hygiene management (MHM) supplies (9%) .

Social and religious restrictions on Rohingya girls' behaviour (fasting, cooking, praying) during menstruation present challenges to girls being able to carry out their daily tasks. Girls and young women also reported learning how to interact respectfully with their husband and in-laws while on their period. A 19-year-old young woman from camp A noted that:

> *There are many things to know about menstruation, such as how to comply when menstruating, how to give respect to your husband (when married), how to give respect to your father and mother-in-law.*

Qualitative data on the provision of menstrual hygiene management products by humanitarian agencies shows that it focuses more on soap distribution and cleaning material (buckets), and less on the provision of sanitary pads patchy. A 20-year-old young woman from camp A said:

> *No, they don't give pads, they give some cloths. Some gave us a bucket and soap also. They don't come here, if we go to them then they give us these supplies.*

Another young woman (the same age and from the same camp) explained her knowledge about managing menstruation:

> *Yes, I know what to do during my period. The period clothes must be taken care of properly. We have to wash them with Dettol soap and dry them in the sun so they don't contain any virus. Sisters come and conduct meetings on this, we learn from there.*

While key informants mentioned that menstrual pads are both produced and distributed at scale in the camps, not all females appreciate using them. A *majhi* from camp A explained, '*They [girls] have a fear that they will get an infection from the pad. They say 'if we walk with it, we get wounds in the thigh area…the cloth is long and hard,*

it would be better if senora [cotton muslin material] were used.' Girls also reported receiving iron supplements and vitamin tablets from humanitarian agencies once they reach menarche.

It is unclear what girls and young women do if they do not have sufficient menstrual hygiene supplies, because a large minority of females reported being too embarrassed or afraid to ask family members to help provide supplies. A 14-year-old girl from camp B mentioned, '*I don't talk to my mother about menstruation, I don't talk to any elders about menstruation.*' Many girls and young women are either embarrassed (32%) or afraid (21%) to ask their families for support.

When questioned about awareness-raising on appropriate menstrual hygiene management, girls and young women were aware of community sessions implemented by humanitarian partners, although not all girls could access these sessions, as a 16-year-old girl from camp B explained:

> *There are sessions on menstrual management in another block, but not here. The sessions are conducted for only a certain number of people. There are so many people, so I don't get asked to come.*

Although overcrowding at sessions was mentioned, key informants also mentioned that some girls feel uncomfortable attending sessions organised by humanitarian agencies (on a range of themes, not just menstrual hygiene management) if they are on their period. A 55-year-old male multi-purpose centre facilitator, working in camp F, explained that:

> *When we started this multi-purpose centre here, we noticed that most girls remain absent from the sessions. We sent female volunteers to their house to know the reason for their absence and they reported that the girls feels uncomfortable and shy at the time of their period. Moreover, they wouldn't know where to go if they needed to change their pad.*

Not all girls reported finding menstrual hygiene management challenging. Some were able to continue their regular daily activities as a result of adequate access to menstrual supplies. A 16-year-old girl in camp B stated, '*I can do everything. If you are menstruating, they* [humanitarian agencies] *give pads and I wear it.*'

Knowledge of contraception

Of the whole sample, half of young people (50%) could name a form of contraception. There were, however, large differences in knowledge by age cohort and gender (see Figure 3). Young adults were significantly more able to name a form of contraception than adolescents, and females were significantly more likely to do so than males. Of all groups, young women (81%) were most likely to be able to name a form of contraception – presumably because most (76%) have been married.

For Rohingya females, marital status impacts knowledge of contraception: 91% of ever-married young women and 81% of ever-married girls were knowledgeable about contraception. This is a significant difference compared with never-married young women and girls, who were less commonly able to mention a form of contraception (48% and 41% respectively) (see Figure 4).

Qualitative data demonstrates that the most common ways young people gain knowledge on contraception are through awareness-raising sessions conducted by humanitarian partners, and at hospitals or health facilities, often linked to family planning services provided to mothers or pregnant women. A 20-year-old young woman from camp C explained:

> *Some women like you come here and conduct meetings. If you have a still small child, they tell you to not have kids. And they talk about taking contraceptives, or taking pills. And also there's another thing called wire. They give some sort of wire for not having babies.*

Qualitative data also highlights that younger girls, however, are excluded from such information sessions, and thus often lack contraceptive knowledge. A 15-year-old girl from

Figure 3: Able to name a form of contraception, by gender and cohort

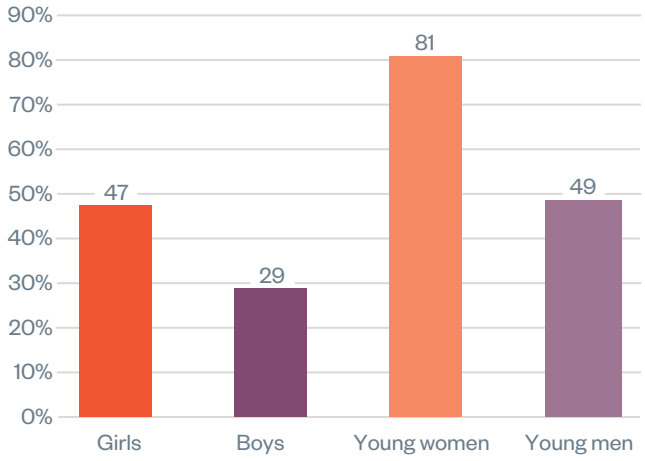
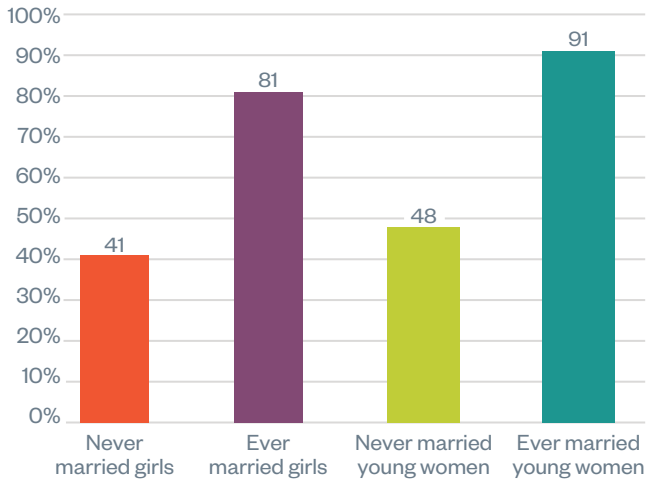


Figure 4: Able to name a form of contraception, females only, by cohort and marital status



camp C said, '*No, I have no idea about measures taken for delaying childbirth*.' Those that do have some knowledge typically gain it through word of mouth – often from sisters and sisters-in-law, as a 13-year-old girl from camp C said, '*Taking medicine, using contraceptives – these are things that married people learn in meetings. I heard them from my sister-in-law*.'

Although it is understandable that married girls and young women are knowledgeable about contraception, it is important to highlight that less than 50% of girls and young women who are not married are informed about methods of pregnancy prevention. The qualitative data, however, highlights that some unmarried adolescents and young adults may be engaging in sexual relationships, as mentioned by a 22-year-old unmarried young man in camp B: '*In terms of going through physical changes in puberty, I had a relationship with a girl*.' An 18-year-old young woman from camp D explained that:

> *Girls should know about contraception before marriage. Because if they don't, they will be at risk of unwanted pregnancy, if they know they can be cautious in their relationship or marriage. If sessions or meetings could be arranged for unmarried girls regarding this issue it will be better.*

Aspirations for parenthood and contraceptive uptake

The midline survey found that nearly all (95%) Rohingya young people (with no significant differences by gender or age cohort) would like to have children one day. Boys and young men would like to have larger families than girls and young women. The average male would like to have four children, while females would like to have 3.5 children (on average).

At the time of midline data collection, 42% of the female sample had ever been married. Young women (76%) were more likely to have been married than adolescent girls (17%). Of married females, 28% reported that they were currently using a modern method of contraception, with significant differences by age cohort: 13% of girls and 33% of young women reported using a modern method of contraception.

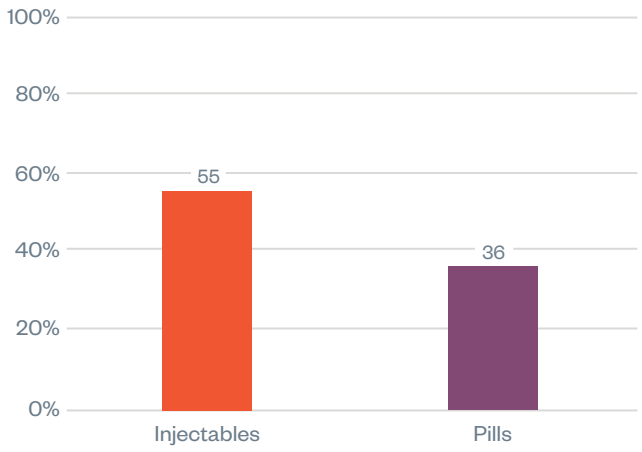
The midline survey found that the most commonly used contraceptives are injectables (55%) and oral contraceptive pills (36%); other contraceptive methods are rare (see Figure 5).

Aside from injectables and oral contraceptive pills, Rohingya young people did not mention other forms of contraception. An 18-year-old young adult from camp C explained, '*Girls do many kinds of things. Some get depo* [Depo-Provera injection], *some take pills. There are many types of pills … There is nothing for us, there is nothing for men.*' Those views were echoed by a 19-year-old young man in camp C:

> *Yes, I know about contraception. The living spaces in the camp are congested. If there are a lot of children, the parents can't manage living space, support education, and properly take care of them. So, some take medicine and some take injections. I don't know any other measure, I don't know measures for men. Since I am not a medical student, I don't know.*

As the Sexual and Reproductive Health Working Group's Strategy on Family Planning for the Forcibly Displaced

Figure 5: Preferred method of contraception, of married females who are current users



Myanmar National (FDMN) Humanitarian Crisis 2022–2025 is being rolled out, it is important to highlight that midline data shows that only 28% of young brides are able to make their own decisions on family planning, with differences among age cohorts. Only 15% of girls and 31% of young women reported being able to make their own family planning decisions. Nearly all young brides (93%) (with no differences between cohorts) reported that their husband is involved in family planning decision-making; a much smaller percentage report that their own mother (5%) or their mother-in-law (5%) is involved.

Qualitative midline data highlights that awareness-raising on family planning is concerned with spacing childbearing and with contraceptive information, rather than inclusive family planning decisions in the household or initiatives aimed at increasing girls' and young women's voice and agency. A 17-year-old girl in camp B explained that, '*For family planning, they tell us to have a baby with three years of age gap and to take pills.*' When probed to discuss family planning decision-making within the household, Rohingya girls and young women gave mixed answers as to whether they have authority to make autonomous decisions. A 21-year-old young woman from camp E stated, '*There's only one child. How could I tell my husband if I don't want children now? He would want more children.*' However, an 18-year-old young woman from camp D explained the value of sharing decisions and the value of having adequate knowledge on the harms of having children too close together:

> *NGOs [non-governmental organisations] talk about contraception and family planning … and about GBV [gender-based violence]. I worked for those organisations [as a camp volunteer]. When I worked in GBV, my colleagues used to talk about contraception, so I learnt from there before marriage. My husband also now knows about contraception and family planning. He says he would like to plan about family and children. He also wishes to have another child but not right after this baby. He and I decided to have another baby when our first baby will be 2 years old. He said if we do this planning, both of our children will get enough love and attention from us.*

It is important to note the tensions that some females voiced regarding Rohingya custom related to family planning, and the content of humanitarian interventions involving family planning information. Although the latter are perceived as lessening the number of births, many females regard this as counter to Rohingya values. A 21-year-old young woman from camp C explained this tension:

> *For women who have too many children, people [humanitarian staff] tell them, 'You should have one or two children at most. Don't have more children than that. Have fewer children, take contraceptive injections.' If you take them, the child won't be born so soon. Our Rohingya people say that we have to have children. But your people here, your country's [Bangladeshi] people say the opposite. They say don't have children. Even the CIC [Camp-in-Charge office, inclusive of government appointed civil servants who mange the day-to-day operations and affairs of each individual camp] says that we should not have children. We have to feed them and things. So they tell us to take pills to not have children so soon. But for us Rohingya people, we need to have children, it's a sin to stop childbirth. It's a big sin.*

Qualitative data also sheds light on abortion practices among Rohingya girls and young women. Abortion is typically shrouded in secrecy, due to the stigma attached to it, and the negative social repercussions on a girl's entire family network if it were discovered that she underwent an abortion. A 15-year-old girl in camp C stated:

> *Of course you have to abort the child [if you get pregnant without being married or if you are raped]. If we want to live in society, people will say bad things to you and your family. It's better if no one knows about it. If I get pregnant unmarried it wouldn't be just my problem. My whole family will be responsible for it and society will judge us forever.*

Most commonly, abortion was associated with pregnancy from rape or pregnancy outside of marriage. As discussed in the GAGE midline research report on gender-based violence (Guglielmi et al., 2024b), when incidences of rape and resulting pregnancies are mediated by camp *majhis* (community leaders), the pregnant girl and the man are counselled to marry. In cases where the marriage proceeds, the baby is kept; where the marriage does not proceed, the girl has to rely on her family's help or terminate the pregnancy in secret. A 15-year-old girl in camp C explained:

> *Yes [you can abort in secret] if your parents help. They can bring you medicine or take you to the doctor to abort the baby. And if you want to make it big [seek extra-familial support] you can take the problem to the majhi and ask for help. Majhi will talk to the rapist's*

A 14-year-old girl who is deaf attends Girl Shine, where awareness on basic sexual and reproductive health and rights is provided, Cox's Bazar, Bangladesh © Nathalie Bertrams/GAGE 2024

parents and try to marry the girl off. But that happens very rarely. The parents never agree on that. You might [get other types of justice] but for that you have to pay majhi extra money. Still it's not guaranteed.

Aborting secretly in this context appears commonplace, and is typically done with the help of medicine and health worker support, especially on Bhasan Char island, where health care is still limited (see Box 1). A 21-year-old young woman in camp C explained:

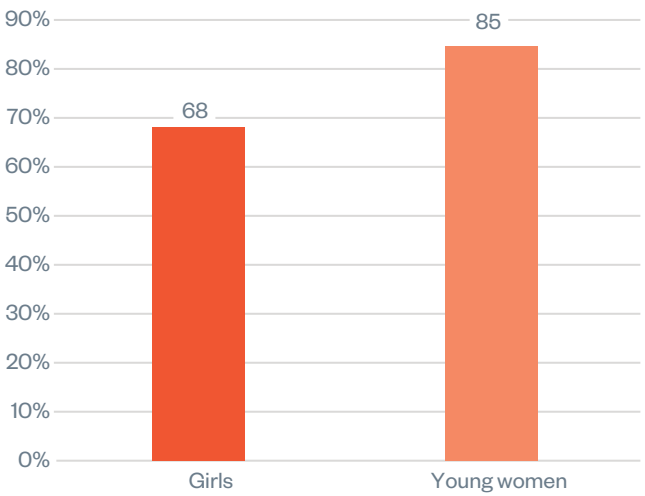
Yes, it happens all the time. In Bangladesh the girls go outside and get pregnant all the time. No one will know anything, because they get an abortion in 2 or 3 months. No one gets to see the belly. There's a lot of abortions … They get an abortion and pack the baby in a plastic bag and dump it somewhere in the water. I hear that. They dump those babies in the river and don't talk about it.

Motherhood

Whereas the average female in the midline sample reported wanting to have her first child at age 21, the survey found that because motherhood tends to quickly follow marriage, most young women are mothers years sooner than they would have preferred. Indeed, of the 42% of females who have been married, 81% have been pregnant. There are significant cohort differences, with young women (85%) (who are on average 20.5 years old) more likely to have been pregnant than adolescent girls (68%) (16 years old on average) (see Figure 6).

With the caveat that there are a few young mothers in our sample who gave birth at age 13, most girls and young women become mothers in middle or late adolescence. Of adolescent girls who have been pregnant, the mean age at first pregnancy was 16.8 years. For young women, the analogous figure is 18.2 years. In addition, while there are a few young mothers who have five or six children, the large majority of young mothers have only one or two children. Qualitative data shows that having higher numbers of children seems correlated to both early onset childbearing and a lack of birth spacing. A 20-year-old young woman from camp A said:

Figure 6: Percentage of married females who have been pregnant, by cohort



I have two children. I got pregnant after my marriage at 14 and a half years old. My first baby was born at the hospital. I got pregnant with my second child when my first baby was 11 months.

Evidencing strong work on the part of humanitarian and NGO actors, 90% of young mothers sought antenatal care during their first pregnancy, with a mean of 4 visits per pregnancy. Qualitative data echoes this finding, with many girls and young women mentioning having regular check-ups during their pregnancy – something they perceived as important, and as advised by their husband, parents and the community at large. During visits, women were provided with physical check-ups to assess their health, and informed about good practice on having a healthy pregnancy. A 21-year-old young woman from camp A stated that:

Yes, the doctor came to our house after I became pregnant. We can also go to the hospital if we want. They tell us to eat well, sleep properly, eat at four instead of three times a day, and take iron medicine which they gave us. I ate vegetables, lentil rice, and so on.

And a 20-year-old woman, also from camp A, described her experience:

I went [to the health centre] for a check-up. To check if the baby is upright, if it's doing well. I just went there whenever I felt uneasy or uncomfortable. To check the baby, to see if it's alright. I knew that it was important to go and people told me to go. And the hospital also recommended me to go there.

Notwithstanding the large majority of women relying on regular antenatal care, only 40% of young mothers delivered their first child in a clinic or hospital. Qualitative data shows that those who rely on clinic or hospital delivery understand the potential complications of home birth. A 29-year-old young woman key informant from camp D disclosed that:

When people deliver at home it causes a lot of problems if done at home. It can lead to maternal mortality or even the death of the child. If it's done at the doctor's, we can get medicine and it's better. With doctors, they provide mosquito nets, lights, blankets, sweaters, and powders. What else do you need?

Box 1: Young people's SRH on Bhasan Char island

Qualitative data gathered on the Bhasan Char island camp mirrors many of the findings on sexual and reproductive health in the camps in Cox's Bazar reported above. Regarding menstrual hygiene management, females in Bhasan Char also mentioned relying primarily on the distribution of soap and attending awareness-raising sessions on hygienic practices to use during menstruation. Similarly to the data from Cox's Bazar, respondents in Bhasan Char mentioned contraception in the form of injectables and oral contraceptive pills, with no mention of male methods of contraception. In a focus group discussion with young males in Bhasan Char, one participant mentioned that 'there are contraceptive pills for women, we haven't heard of anything for boys'.

A distinct finding from the Bhasan Char qualitative data relates to the limited availability of health care staff and overcrowding of health centres on the island. Possibly due to the newly established, and fewer, service centres on Bhasan Char, a 17-year-old young woman recounted her difficulty in seeking health assistance for an abortion, and care after the operation:

I was pregnant after six months of my marriage, then my husband [left] and told me to abort that baby as he wouldn't come back here so I shouldn't wait for him. So, I aborted my baby … I had bleeding for three months after … I went to the doctor's chamber. Since then I couldn't become pregnant [the young woman's husband has since returned]. To abort, we [the girl and her mother] bought medicine and put it in front of my uterus. No injections, we bought medicine and put it there three times … They sell this medicine without prescription. The hospital here was new so they didn't have any doctor there. Also, they didn't do abortion then, but now they do … My mother told me that she will connect with Badiya [spiritual healer]. Here, if people get help of Badiya then they have babies. But in my case, I had an abortion in the wrong way, that's why I could not conceive a baby [afterwards]. If I go to the hospital, then today is May 9 right? They will refer me to May 12 and when I go there at the referred date then they tell me your appointment date is gone. They tell us that there are already huge amounts of people here, so you go home.

Policy and programming implications

The GAGE midline research found that despite widespread humanitarian programming aimed at raising awareness about sexual and reproductive health rights and services, Rohingya young people often face significant challenges in accessing accurate and timely information as well as appropriate services and supplies. If the Government of Bangladesh and partners aim to address challenges faced by the Rohingya related to the coverage, accessibility and quality of sexual and reproductive health services, and to reach the goals set out in the Sexual and Reproductive Health Working Group's Strategy on Family Planning 2022–2025, urgent attention is required to support Rohingya young people's sexual and reproductive health needs.

In order to support Rohingya young people and advance their sexual and reproductive health, GAGE mixed-methods midline research findings suggest that the following key priorities for policy and programming should be considered:

- **Increase the availability of humanitarian-led awareness-raising sessions on puberty and sexual and reproductive health,** delivered in learning centres, community-based learning facilities and multi-purpose centres, so as to better equip girls and boys with knowledge about pubertal changes, and accurate sexual and reproductive health information, including on reproductive biology and contraception. It will be important to include culturally sensitive information for younger and unmarried Rohingya girls who often remain excluded from awareness-raising sessions, as well as involve community and religious leaders in outreach.
- **Improve girls' and young women's access to period products and information about menstruation to ensure safe menstrual hygiene management.** Pair this with awareness raising efforts to shift social that stigmatise menstruation.
- **Increase the presence of female chaperone networks or community watch-groups to escort Rohingya girls and young women to programmes** on sexual and reproductive health-related topics. This is particularly important for unmarried girls and young women, who are most confined to home.
- **Conduct further research exploring the advantages of integrated gender-based violence (GBV) and sexual and reproductive health (SRH) programming for Rohingya girls and young women,** to assess the feasibility and uptake of multisectoral programming – including intimate-partner violence prevention and response initiatives and SRH training and services, including midwifery.
- **Scale up parenting courses related to parenting adolescents.** Courses should address gender norms and child marriage practices, preferences for early and closely spaced pregnancy, and build parents' acceptance for the provision of more comprehensive sexuality education courses.
- **Consider the provision of premarital counselling sessions to young couples,** including reproductive biology, contraceptive options (both for females and males), and the value of delayed, spaced and limited pregnancies for maternal and child health and financial stability. Courses should also address gender norms, the value of open communication, and the importance of consent (even within marriage.
- **Continue to train Rohingya community volunteers to persuade women to access safe delivery services in health facilities and by trained healthcare personnel,** and to dispel myths and negative rumours on hospital or health centre birth.

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Contraceptives sold outside of camp, only to married people, Cox's Bazar, Bangladesh © Nathalie Bertrams/GAGE 2024

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About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a decade-long (2016-2026) longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org for more information.

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Front cover: A 16-year-old can no longer go to the market because she got her period, Cox's Bazar, Bangladesh © Nathalie Bertrams/GAGE 2024

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