



‘We didn’t come here to eat. We came here to save our life’: Health and nutrition challenges facing adolescents in Cox’s Bazar, Bangladesh

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Overview

Maintaining commitments to age-, gender- and disability-responsive healthcare services stipulated in the 2018 Global Compact on Refugees (UNHCR, 2018) is challenging in Bangladesh’s Cox’s Bazar district, which is home for over two million Bangladeshi citizens in one of the poorest regions in the country and some 860,000 Rohingya refugees who fled Myanmar. Local Bangladeshi government structures have limited resources and unclear mandates on health service provision for the Rohingya (Sida, 2019), guided by competing political agendas including the repatriation of the Rohingya to Myanmar, relocation to other areas of Bangladesh and the continuation of parallel humanitarian health-service provision in the camps. The Global Compact seeks to guarantee the expansion of national health systems to refugees and to prioritise sector expertise to enhance quality of care to host communities and refugees alike. The response from the health, food security and nutrition sectors in Bangladesh – guided by the Civil Surgeon, the World Health Organization (WHO), the World Food Programme (WFP), UNICEF and their partners and donors – has provided life-saving clinical and preventive care since the mass refugee influx in 2017 (Sarker et al., 2020). However, limited capacity and political will for the district to absorb the Rohingya into national health systems, have limited the scope for both refugee inclusion and the commitment to age-, gender- and disability-responsive healthcare services for refugees.

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There is strong impetus to understand perceptions around healthcare in Cox’s Bazar, as well as evidence around the health and nutrition status of overlooked populations – including adolescents. In response to the identification of critical gaps in the health sector, including emergency obstetric care and family planning provision, the 2020 Joint Response Plan for the Rohingya Humanitarian Crisis (JRP) (Inter-Sector Coordination Group (ISCG et al., 2020) has declared adolescent health as a key priority.

Drawing on data from the Gender and Adolescence: Global Evidence (GAGE) study nested within the larger Cox’s Bazar Panel Survey (CBPS),¹ this policy brief discusses the age- and gender-based health risks facing adolescents within Rohingya refugee and Bangladeshi host communities. It concludes with recommendations to accelerate progress towards addressing critical gaps for adolescents as the Rohingya crisis becomes more protracted.

Methodology and conceptual framing

This brief is based on mixed-methods data collected between March and October 2019 as part of the GAGE longitudinal research programme, which explores what works to support the development of adolescents’ capabilities (GAGE consortium, 2019) (see Table 1). The

findings reflect realities prior to the covid-19 pandemic; we will be releasing new findings based on phone interviews during the pandemic within the coming months. We have also drawn on previous research to assess the point of intersection between broader Rohingya and host community household studies and our adolescent-specific findings. In Bangladesh, GAGE partnered with researchers from Yale University and the World Bank to implement the CBPS (CBPS, 2019; World Bank, 2019), the GAGE component of which surveyed 2,280 adolescent girls and boys and their caregivers (see Table 2). The quantitative survey was complemented by in-depth qualitative research across three refugee camps² and two host communities in Ukhia and Teknaf upazilas (sub-districts) with a sub-sample of 149 Rohingya and Bangladeshi adolescents, their families, community leaders and service providers, using interactive tools with individuals and groups (see Table 3). Our sample included two cohorts: younger adolescents (10–12 years) and older adolescents (15–19 years). To analyse the quantitative data, we constructed a set of indicators to capture the breadth of experience of Rohingya and host community adolescents. We were then able to explore differences in means, adjusting for sampling weights to make the estimates representative of adolescents living in these locations. To analyse the qualitative data, transcripts

Table 1: Mixed-methods research sample

	Quantitative fieldwork		Qualitative fieldwork	
	Fieldwork sites	No. of respondents	Fieldwork	No. of respondents
Refugee camps	32	1,209	3	112
Host communities in Teknaf and Ukhia	57	1,071	2	37
Total	89	2,280	5	149

Table 2: Quantitative fieldwork

	Quantitative fieldwork				
	Refugee camps		Host communities		Total
	Female	Male	Female	Male	
Adolescent interviews young cohort 10–12	315	332	347	343	1,337
Adolescent interviews old cohort 15–18	257	167	292	227	943
Total	572	499	639	570	2,280

1 The Cox’s Bazar Panel Survey is a partnership between the Yale Macmillan Center Program on Refugees, Forced Displacement, and Humanitarian Responses (Yale Macmillan PRFDHR), the Gender and Adolescence: Global Evidence (GAGE) programme, and the Poverty and Equity Global Practice (GPVDR) of the World Bank.

2 We have anonymised the camp names to protect the privacy of study participants, and refer to them here as Camps A, B and C.

Table 3: Qualitative fieldwork

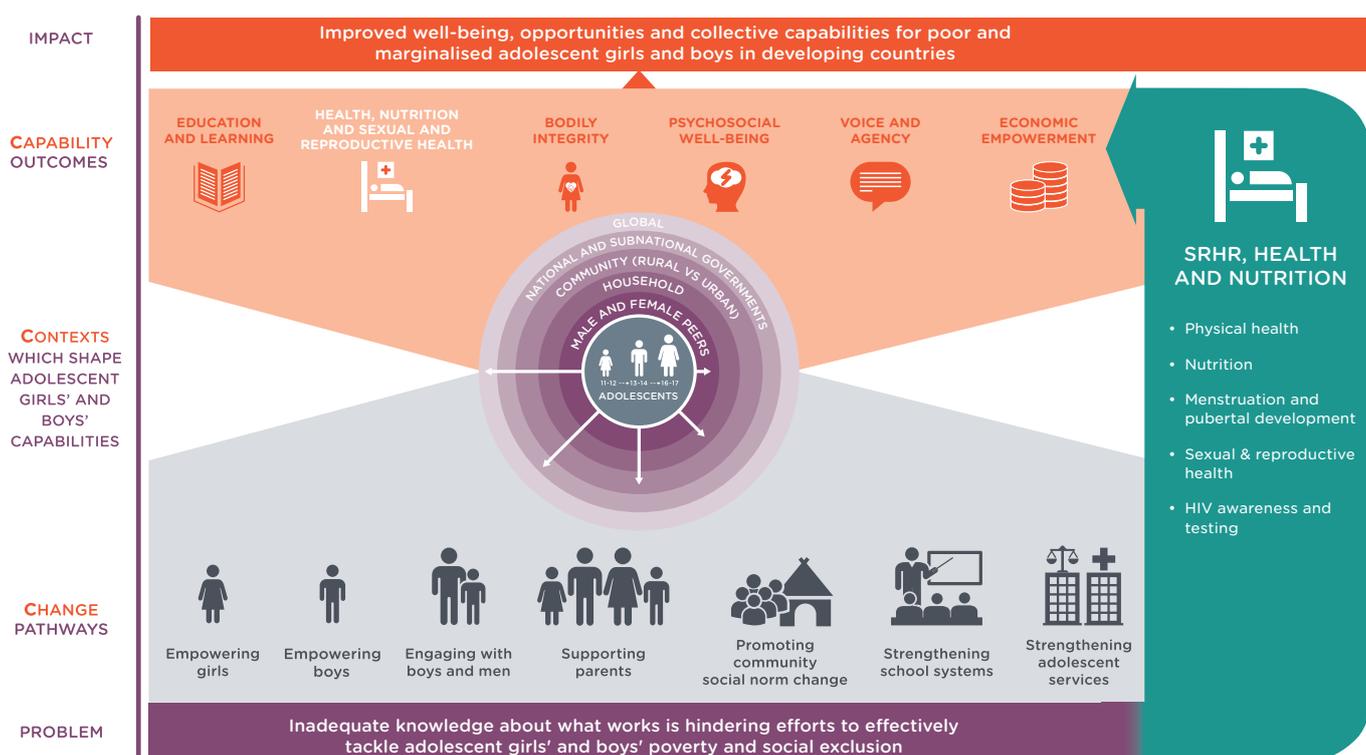
Qualitative fieldwork					
	Refugee camps		Host communities		Total
	Female	Male	Female	Male	
Adolescent interviews young cohort 10–12	16	18	7	5	46
Adolescent interviews old cohort 15–18	26	13	7	4	50
Parent interviews	6	6	0	0	12
Focus group discussions	9	9	3	3	24
Key informant interviews	5	4	3	5	17
Total	62	50	20	17	149

were coded following a thematic codebook shaped around the GAGE conceptual framework and the research tools. In line with the 2030 Agenda’s commitment to leave no one behind, we also included in the sample adolescents facing additional disadvantage: adolescents with disabilities, and adolescent girls and boys who married as children.

Our analysis followed the GAGE conceptual framework (see Figure 1) (GAGE consortium, 2019), which focuses on adolescents’ multidimensional capabilities. This brief focuses on the health capability domain, including

physical health, nutrition, menstruation and pubertal development, and sexual and reproductive health (SRH). The GAGE framework recognises that adolescents’ capability outcomes are highly dependent on contextual realities at household, community and state levels, which also determine the change strategies (such as promoting community norm change, empowering girls, or engaging with boys and men) that can be employed to improve adolescents’ outcomes.

Figure 1: GAGE ‘3 Cs’ conceptual framework



Source: GAGE consortium, 2019

Scope and scale of the challenge: key findings

General health

Self-reported health

On average, 77% of Rohingya and Bangladeshi adolescents in our sample perceived themselves to be healthy (85% and 72% respectively) with limited gender differences. Across both camp and host communities, older adolescents are significantly less likely to report good or very good health than younger adolescents. While 89% of younger Rohingya adolescents report good or very good health, only 78% of older adolescents do. Even more starkly, only 57% of older Bangladeshi adolescents living in host communities report good or very good health compared to 83% of younger adolescents.

Notwithstanding the perception of generally good health, 87% of our sample had experienced health-related symptoms in the four weeks prior to the survey, with persistent headache (65%), runny nose (60%), fever (56%) and persistent cough (56%) being the most commonly reported problems, with no significant differences based on location, gender or age. Our qualitative data demonstrates that sicknesses related to poor water and sanitation practices remain common, and communal latrines, distant water points and overcrowded facilities all hamper regular adherence to water, sanitation and hygiene (WASH) guidelines. In the quantitative sample, 33% of respondents reported stomach pain, nausea or vomiting,

and 13% reported diarrhea at least three times in one day in the past four weeks.

In the camps, although both younger and older adolescents mentioned the fear of catching jaundice and tuberculosis (TB), in line with the quantitative data, the most commonly reported sources of ill health in qualitative interviews were diarrhea, fevers, stomach aches and headaches, and menstrual pain (girls). To avoid sickness, Rohingya adolescents in our sample had adopted certain strategies on personal hygiene and food-related sanitation practices, as a 17-year-old girl from Camp A explained: *'If someone stays messy, flies come and they sit on food and people become sick. We have to be neat and clean so that flies don't come [and] we have to use latrines to go to the bathroom.'* Many other adolescents mentioned the importance of wearing sandals when using toilets, and using soap to wash their hands, bodies and clothes. Awareness-raising on sanitation and personal hygiene has resonated strongly with adolescents, be it via adolescent-tailored outreach, or information from parents (see Box 1). This notwithstanding, our qualitative data underscores that some hygienic products are being received as part of humanitarian assistance packages, yet sold for money in local markets, with one study noting that 'soap' is the fourth most common aid item being re-sold (Hetzer and Hopkins, 2019), though the precise extent of this problem is unknown.

In host communities, adolescents mentioned schools as hubs for WASH and general health information, as one 14-year-old boy in Ukhia upazila explained: *'Teachers tell us to eat healthy food. Madam gives us so many guidelines... Exercise is good for the body.'* Schools were also

Box 1: Adolescents' access to information on water, sanitation and hygiene (WASH) practices

A recent WASH survey (REACH, 2019a) found that 39% of Rohingya households had participated in at least one hygiene training or demonstration in the two weeks prior to the survey, with handwashing practices and food hygiene being the most common training attended. However, while community requests for training are high and engagement is ongoing, uptake of some practices remains low; for example, only 19% of respondents reported washing their hands with soap before feeding children (ibid.). Other practices associated with hand washing are less alarming and a separate UNHCR WASH survey (UNHCR, 2019b) found 92% of respondents washing hands before eating and 75% before cooking.

Our qualitative data found that Rohingya adolescents receive information on WASH from a variety of sources, including teachers. As explained by a 15-year-old boy in Camp B: *'Teachers tell us that we should wash our hands before and after eating anything. They also tell us that we should wash our hands after coming from the toilet and always keep the toilet neat and clean. If I don't wash my hands before and after eating, I could get fever, cough, cold and TB.'* A 16-year-old girl in Camp A recounted: *'[Girls like you] ask us to stay clean and fit at the time of period, dresses have to be dried in extreme heat, so it will prevent germs.'* Other adolescents reported receiving information from parents and siblings.

During a key informant interview, a teacher in Camp B described improvements in WASH practices among her pupils in the learning centre: *'When I first came here, I found they didn't use shoes to go to the toilets, they didn't wash their hands with soap... They didn't cut their nails, they didn't use oil in their hair, but now they learned it throughout the year. Previously, they didn't wash their hands before eating. A boy would bathe less than once a month. I was planning to resign. Then gradually everything has changed. Now, everyone is neat and clean. They don't take food now before washing their hands. They don't go to the toilet now without sandals. Not only school-going children, other children are also aware now because of many projects run by other organisations.'*

▶ They treat us like dogs. This happens in any hospital. They tease us by calling “Rohingya” ... They let villagers go first ...

(A participant in a focus group discussion (FGD) for older girls in Camp A)

mentioned as sites where mass vaccination campaigns take place. Some host community respondents mentioned concerns about poor sanitation, with one (a 40-year-old key informant in Teknaf) explaining that *‘the whole area is now like an open latrine’* and has deteriorated markedly since the refugee influx.

Health-seeking behaviour

Across locations, seeking treatment for illness or injury is common. In the month prior to data collection, 73% of the Rohingya and Bangladeshi sample mentioned seeking treatment for the health-related symptoms discussed above, 92% for injury and 93% for serious illness. (though suffering injury or serious illness is rare). We found no gender differences in health-seeking behaviour across locations, but our findings indicated that among the camp sample, young adolescents were significantly more likely to seek treatment for health-related symptoms compared to older adolescents (75% and 69% respectively). The qualitative data also underlines that younger adolescents fall ill more often. Depending on location, adolescents seek treatment from a variety of places: in camps, 33% turn to community clinics, with boys significantly more likely to do so compared to girls (40% and 25% respectively); 31% turn to pharmacy stores; and 15% go to satellite clinics.ⁱⁱ In host communities, the majority of our sample reported turning to pharmacy stores (70%); 23% turn to private doctors and 9% go to district hospitals, with only 2% of our host sample turning to community clinics.

Treatment by health professionals

Irrespective of type of health centre, our qualitative data provides a mixed picture as to whether quality care is readily available. Some adolescents mentioned that medical staff were welcoming, kind and knowledgeable, as expressed by a 17-year-old adolescent with a disability in Camp B, *‘The hospital doctor prescribes medicines according to what we describe about sickness. She shows us prescription and carefully explains how and when to take the medicines.’* Other adolescents, however, complained about being harassed by staff. A participant in a focus group discussion (FGD) for older girls in Camp A explained: *‘They treat us like dogs. This happens in any hospital. They tease us by calling “Rohingya”. They don’t treat us well. They let villagers*

go first and after knowing that we are Rohingya, they say, “If you want to get treatment from the doctor then wait here.” They don’t let us go inside.’

Across locations, respondents complained of overcrowded health facilities and high costs for medicines. Rohingya adolescents mentioned waiting in long queues, even when in pain, before being examined, only to be hastily diagnosed and sent away with generic medicine – typically paracetamol or saline water – regardless of their symptoms. A 17-year-old boy in Camp A, for example, noted: *‘We go to hospital. But they just give us paracetamol tablets and discharge us. They only diagnose us when it is an emergency.’*

Although our qualitative data suggest that male and female healthcare staff are available in the various health centres and hospitals, owing to the severe restrictions on Rohingya girls’ mobility once they reach puberty (which dictate that other than immediate family members, no males should see an older girl on her own) (Guglielmi et al., 2020), older adolescent girls must always be accompanied by a parent or older brother. Married girls are not allowed to see doctors alone, and must be escorted by *‘father-in-law or mother-in-law or my husband’*, explained a married 18-year-old girl in Camp B. Coupled with cultural restrictions on girls’ mobility, the additional care and housekeeping duties bestowed on some adolescent girls, means their access to health information is equally limited.

Dedicated services for disabled adolescents

The 2020 JRP indicates that health sector services for persons with disabilities are not adequate to meet their needs, and 2019 WASH surveys have shown that only one-third of Rohingya refugees with disabilities were reported to have accessed support services (ISCG et al., 2020). A case study assessment among people with disabilities, conducted by Humanity & Inclusion (2019) in Teknaf Camp 27, found that 100% of those surveyed faced barriers in accessing health services, primarily due to lack of accessible facilities, long distances to providers, and lengthy wait times. Hostile environmental terrain was also found to limit access to water points, food distribution sites, livelihood training and community spaces. The same assessment found that 10 out of 11 service providers reported a lack of knowledge on how to identify persons

▶ We go to hospital. But they just give us paracetamol tablets and discharge us. They only diagnose us when it is an emergency.

(A 17-year-old boy in Camp A)



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with disabilities, and could not pinpoint their locations (ibid.).

In host communities and camps, disabled adolescents in our qualitative sample reported relying primarily on parents, siblings and neighbours for daily assistance. Regarding hospital care, the qualitative data depicts a mixed picture, with some disabled adolescents largely satisfied with care, both for sporadic sickness (e.g. stomach aches, headaches, toothaches) and related to their chronic condition. In host communities especially, some adolescents mentioned receiving regular care from doctors conducting home visits or specialist doctors treating patients in larger complexes, as described by a 13-year old girl with a visual impairment in Ukhia, *'I have gone to Hospital A, and they gave me an ointment and some tablets. I have also gone to Hospital B for the treatment of my eyes. The behaviour [of doctors and*

▶ I have gone to Hospital A, and they gave me an ointment and some tablets ... The behaviour [of doctors and staff] is very nice.

(13-year old girl with a visual impairment in Ukhia)

staff] is very nice.' Other adolescents, however, recounted negative treatment by hospital staff, such as a 15-year-old Rohingya girl in Camp A who had become blind two years ago after suffering acute headaches noted: *'When they scolded me, I was just silent without saying a word, like an owl. I just cried.'* Across locations, some adolescents mentioned that high costs related to prescriptions also hindered health-seeking behaviour.

Although qualitative data found that a few disabled adolescents mentioned outreach by community groups and non-government organisations (NGOs) specifically targeting disabled adolescents, services do not appear to have a profound impact on their lives. The neighbour of a 17-year-old girl with a hearing impairment recounted taking the girl, whose family was shot upon fleeing Myanmar, to a dedicated disability centre in Camp B: *'They tested a hearing machine on her. She has been deaf since her birth. They said that this machine wouldn't work for her and that's why they didn't give it to her. The only thing she's received is a packet with flour, sugar, oil and many other things... Just that one packet of food was sent specially for her.'* Similarly, in Camp A, the mother of a 17-year-old girl with a hearing impairment remembered NGO staff providing her daughter with a hearing machine but not the girl's two older siblings who were also deaf: *'They told me that she and my*

If we pay, we will get the treatment, otherwise we won't get it ... Most of the time they give us expired medicine.

(A 12-year-old girl in Ukhia upazila)

other child are grown up now... They never came back, it's been two years.'

Out-of-pocket healthcare costs

Younger and older adolescents, boys and girls, discussed their worries about medical costs in qualitative interviews. An older boy in a focus group discussion in Camp C explained the situation they face: *'The hospital doctors tell [us] to buy [medicine] from outside [of the medical facility]. We go there because of our financial problems – if we have to buy medicines from elsewhere, what is the need of this hospital?'* Similar sentiments were expressed by adolescents in host communities: *'If we pay, we will get the treatment, otherwise we won't get it ... Most of the time they give us expired medicine,'* explained a 12-year-old girl in Ukhia upazila. Previous assessments have found that 81% of Rohingya households with at least one member suffering from an illness used coping mechanisms to manage health issues, with 66% going into debt to pay for health expenditures (ISCG, 2019b). Among host communities, 77% of households reported adopting coping mechanisms, including incurring debt to manage care-related costs for sick family members (ISCG, 2019a). The inadequacy of medicine provided free of charge to Rohingya refugees has been analysed in previous literature (ACAPS, 2020; UNHCR, 2019), yet findings from a WFP (2019) refugee assessment highlighted that the Rohingya inherently distrust camp health facilities, often preferring to self-medicate, at high cost, and even when antibiotics are available free of charge at camp health facilities (ACAPS, 2020).

Our qualitative data also finds that there are transportation costs involved in travel to hospital, sometimes requiring travel to Cox's Bazar, Chittagong or even Dhaka for more serious, malign diseases, which many people cannot afford. A mother in a host community focus group discussion in Teknaf upazila recounted feeling desperate when her son broke his hand: *'It took 1,000 taka as transport cost. It is expensive. Also [I paid] the doctor's fees, the cost of the X-ray, it takes 5,000 to 6,000 taka for treatment. From where will a person like me collect the money? Now, the inner bone is still curved [but] I can't make it okay because of the shortage of money.'* Host community

adolescents mentioned relying on loans in order to receive proper care. Our quantitative data echoes these findings, with 50% of older adolescents reporting that getting money for treatment is a big problem and 32% reporting that distance to the facility is a big problem.

Food security and nutrition

Nearly three years into the Rohingya crisis, the Food and Agriculture Organization of the United Nations (FAO) (2020) reports that levels of food insecurity remain alarming throughout Cox's Bazar, and that Rohingya and Bangladeshi populations need ongoing aid to support their dietary diversity and livelihoods. Many households resort to negative coping mechanisms to meet food needs. Notwithstanding the 100% of Rohingya refugees receiving blanket WFP assistance to sustain minimum required kilocalories through in-kind aid (complemented by sector partners' provision of food vouchers to improve dietary diversity) and, increasingly, e-vouchers, recent Joint Multi-Sector Needs Assessments (ISCG, 2019a; 2019b) found both Rohingya and Bangladeshi households reporting 'access to food' as their greatest need, ranked significantly higher than other needs.

Both our quantitative and qualitative research found that Rohingya and Bangladeshi households face difficulties accessing a varied diet (WFP, 2020b). In our camp sample, 40% of adolescents reported having felt hungry in the past four weeks due to not having enough food, with girls more likely to report hunger than boys (47% and 34% respectively) and the older cohort more likely than the younger cohort (46% and 37% respectively).

Both Bangladeshi and Rohingya adolescents in our sample have height-for-age and BMI-for-age z-scores that are below average. Twenty-four percent of the sample have height-for-age z-scores more than two standard deviations below the mean (WHO definition of stunted) and 16% have BMI-for-age z-scores more than two standard deviations below the mean, indicating thinness. There are no differences in stunting between camp and host, but Bangladeshis living in host communities are 7.2 percentage points more likely to exhibit thinness. Among Rohingya adolescents, males are 8.4 percentage points more likely to exhibit thinness than females. Older adolescents are 22 percentage points (over twice as likely) to be stunted in height, but 8 percentage point less likely to exhibit thinness, in comparison with younger adolescents. These patterns are similar among host adolescents, where males are 8.7 percentage points more likely to exhibit thinness than females, and older adolescents are 9.2 percentage points more likely to be stunted and 11 percentage points less likely to exhibit thinness in comparison with younger adolescents.

► Suppose I went out to find work and my kids are waiting for my return with foods. But I failed to get the work. Then it feels really worst, when I see my kids' faces.

(A participant in a male focus group discussion in Camp A)

Our qualitative data highlights that Rohingya adolescents report not receiving enough meat and fish due to inadequate family incomes, and this is especially the case for adolescents in female-headed households. Adolescents also mentioned suffering from cut-backs on rice distribution, both as a commodity and as a form of revenue, as a 15-year-old girl in Camp C explained: *'Previously we could sell the extra rice [received as food aid] and could buy other things like chicken, fish. Now we can't because we get only 14 kg rice a month for one person.'* While standard in-kind rations provide 2,100 calories thus meeting the required daily intake, further research investigating the relationship between the realities of in-kind food distribution quantity, amount of food received via e-voucher modalities and the respective perceptions by adolescent refugees, will feature in future rounds of our research.

Vegetables, pulses and oil were found to be more sufficient in quantity, though the lack of dietary diversity was a challenge for adolescents who expressed the desire not to eat the same meal everyday. Our qualitative findings largely mirror the recent Refugee influx emergency vulnerability assessment (REVA) (WFP, 2020a) which found that 94% of all Rohingya refugeesⁱⁱⁱ are either highly or moderately vulnerable, a measure encompassing food consumption score, the adoption of high-risk coping strategies, and the economic capacity to meet essential needs. Although the food security sector continues efforts to allow the Rohingya to access fresh food items via WFP-contracted retail outlets resembling supermarkets, fresh food corners within the retail outlets and the more recent introduction of farmers markets – the latter reflecting a market experience in line with many rural populations' open-air market experience in the region, while boosting market linkages between host communities who provide the fresh commodities – economic vulnerability remains the major driver of food insecurity for refugees. The 2020 REVA in fact illustrates that ongoing work to bridge the humanitarian – development nexus will be an ongoing priority, focusing on refugee's economic and livelihood opportunities (ibid).

In our qualitative data, parents expressed shame and sorrow at not being able to provide for their families, as a participant in a male FGD in Camp A highlighted: *'Suppose I went out to find work and my kids are waiting for my return*



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with foods. But I failed to get the work. Then it feels really worst, when I see my kids' faces.' Prior to displacement, the Rohingya mentioned earning wages, relying on subsistence farming and fishing, and depending on family and friends for loans. All this has changed, as one participant in a focus group discussion for women expressed: *'We have to eat very little instead of having much, as we used to eat in Burma. We don't get enough food to eat now. But we are thankful. We didn't come here to eat. We came here to save our life.'*

In our host community sample, 20% of adolescents reported having felt hungry in the past four weeks due to not having enough food, with no significant differences by gender and age. Notwithstanding some outliers, difficulty accessing nutritious food was a dominant theme during qualitative interviews with our host community sample. Many parents mentioned not being able to provide meals for their adolescent children due to poverty, as stated in a focus group discussion in Teknaf: *'I can give [my sons and daughters] two times rice and one time water per day. People of this area don't see meat ever in a month.'* Adolescents, parents and key informants all expressed concerns around increasing poverty levels, hikes in commodity prices, and declining nutritious intake since the Rohingya influx. Respondents recalled previously *'relying on food produced from their own gardening land but now there's no scope for it because Rohingya refugees are staying everywhere in every corner'* (key informant in Teknaf). Food insecurity challenges are compounded by ballooning prices of fruits, fish and meat, due to the population spike caused by an influx of both refugees and aid workers. Adolescents learn about the importance of eating nutritious food to remain healthy, but their reality is such that *'we cannot get this proper food'* (12-year-old girl, Ukhia) – a sentiment echoed by many others.

The data indicates that 41% of Rohingya adolescents and 25% of Bangladeshi adolescents had seen their household cutting back on food provided to them in the past month, though there were no significant gender differences across locations: *'Every child is the same to the parents. So they will give them the same food. There won't be any differences. Why should they?'* explained a 15-year-old girl in Camp C. Age differences were reported among host communities only, with the younger cohort more likely to receive less food (31% compared to 16% of the older cohort). The qualitative data indicates more marked differences in food availability between adolescents and young children: *'We can't get nutritious food, that is why we can't eat. ACF [Action Contre la Faim] gives nutritious food, but only to the young children,'* according to a young girl in a focus group discussion in Camp A.^{iv}

Puberty and menstruation

The provision of information and uptake of menstrual hygiene management (MHM) in the camps has improved compared to previous years; in 2019, 90% of women and girls received MHM materials from humanitarian actors, including reusable and disposable pads, and multi-purpose cloths (ISCG WASH Cluster, 2020). The distribution of materials is not always timely or consistent, however, and the 2020 JRP (ISCG et al., 2020) reported that 24% of Rohingya women and girls did not receive MHM materials in the previous three months, which makes it very difficult for them to manage menstruation. Girls also face cultural taboos surrounding the visibility of MHM materials, which could result in unhygienic disposal of supplies, and washing in overcrowded and unsanitary facilities to avoid being seen by men (REACH, 2019b).

Reaching puberty is an important threshold for Rohingya and Bangladeshi adolescents. Among the camp sample, 93% of older Rohingya adolescents reported having a source of information about puberty, with no significant differences by gender. Rohingya girls typically get information about menstruation from their mothers, sisters or sisters-in-law at menarche (the first occurrence of menstruation), and seldom before. As a 12-year-old girl in Camp A explained: *'I don't know what menstruation is.'* Through their families, girls learn about cultural norms related to puberty, including restrictions on girls' mobility when they are 'grown up' and that any interaction with males beyond their immediate family risks harming family honour (see Box 2). Girls are meant to stay indoors. A few girls expressed anxiety about these mobility restrictions, with one commenting during a focus group discussion in Camp B: *'I am concerned about puberty. I don't like it. Girls can't study at that time. We take the veil after puberty and we can't visit anywhere as before, our parents forbid us to go out. We have to stay in home. We have to cook rice and vegetables.'* However, most appeared resigned to these changes. A girl living with a disability in Camp A noted, *'[When I had my period, my parents] said "don't go out, don't do this" [and] if I don't stay clean then I can be possessed. Won't we go to hell if we don't listen to my parents?'* Parents

 **I am concerned about puberty. I don't like it. Girls can't study at that time. We take the veil after puberty and we can't visit anywhere as before, our parents forbid us to go out.**

(A participant in an FGD in Camp B)

We make them confident about their period.

(A teacher from Teknaf)

also disclosed discussing puberty with their daughters, including their suitability for marriage once they *‘become adolescents’*.

Rohingya girls also cited that menstrual hygiene education is sometimes provided by aid workers, who teach appropriate use of single-use or reusable sanitary pads, appropriate disposal methods, and the importance of washing clothes with soap and drying them in the sunlight. Girls learn that their *‘waist has to be washed three times a day. They give us a bottle with which the waist has to be washed and clothes should be dried properly. It has to be dried in such way that men can’t see it. Some red clothes and pads are also given,’* explained an 18-year-old girl in Camp B. The distribution of MHM items, however, is insufficient and patchy across locations, with some girls receiving hygiene kits while others complained that *‘It’s been 8–9 months that they have stopped providing [soap and sanitary pads]’* (older girl in a focus group discussion, Camp C).

Adolescent boys in our sample also reported learning about puberty primarily from family members, as a 15-year-old boy in Camp C noted: *‘Parents and grandparents talk about bodily changes.’* Fewer boys mentioned learning about puberty from teachers.

Similarly, in host communities, knowledge of puberty was varied, with some young girls claiming no specific knowledge on menstrual management, as a 12-year-old girl from Ukhia explained: *‘I only know that during their period girls have to wear “one thing” but I don’t know what “the thing” is.’* Others appeared fully knowledgeable on bodily changes and hygienic practices associated with puberty. Overall, 98% of our older adolescents in host communities reported having a source of information about puberty, with no significant differences by gender. Bangladeshi boys

and girls mentioned a variety of sources through which they receive puberty education, including their family members, teachers and NGO training sessions, although information appears gender-specific, as a 14-year-old boy in Ukhia commented: *‘Why would I know about girls?’* This notwithstanding, some key informants explained that many adolescents do not understand the multitude of health issues associated with puberty and that menstrual hygiene education is superficial.

Across locations, many adolescent girls and boys cited the cultural rather than bodily changes associated with *‘becoming an adolescent’*, particularly as these affect girls – as expressed by a 13-year-old girl from Ukhia: *‘[Puberty] changes are that younger girls can go out, we can’t go out now. We must wear Burqa when we go anywhere [during menstruation]. We can’t play now. We can’t go outside during period for seven days, I [only] go to school wearing Burqa.’* In host communities, adolescents mentioned school teachers and NGO training as influencers in this regard, citing them both as promoting awareness on menstruation and motivating girls to manage their menstruation without shame, and promoting school attendance during menstruation. *‘We make them confident about their period,’* explained a 33-year-old teacher from Teknaf.

Cultural and religious norms around menstruation see 66% of Rohingya older girls and 53% of Bangladeshi older girls facing alterations to their normal activities during menstruation.^v Qualitative and quantitative data illustrate that in camps and host communities alike, the most common reported changes to girls’ routine include not fasting (69% of older girls in camps mentioned this change and 85% of older girls in host communities), not attending a place of worship (63% in camps and 84% in host communities), and not worshipping at all (43% in camps and 63% in host communities).

Sexual and reproductive health (SRH)

To meet the Sustainable Development Goals (SDGs), Bangladesh has made significant commitments to

Box 2: Case study: handling menstrual management with a visual impairment

Sadia is a 13-year-old girl living in Ukhia who became blind five years ago. She has never attended school, citing distance to travel as the main barrier. In terms of menstrual management, she has relied primarily on guidance from her grandmothers, who emphasise how important it is to keep her menstruation hidden.

‘[My grandmothers] have told me to move carefully so that the people outside can’t see me. I have stayed in the house without going outside. I have [only] gone to the washroom and come back quickly. I wear a cloth for bleeding in the morning and change it in the evening. I dry these cloths under my dresses, which are kept outside hanging on a rope after being washed. I keep those clothes hidden under the thin dresses of mine in the sunlight. And in the evening I bring the clothes in the house and hang somewhere so that none can see those. Only the people of our home have seen me, and this is a [community] regulation. Why would the people see the girls during menstruation! I can’t see with my eyes, but my hands are okay, I can do these [things alone] using my own intelligence.’



© European Union 2019 (photographer: Mallika Panorat)

improving SRH, demonstrating progress in awareness, access and uptake of contraceptive services, as well as developing adolescent-specific SRH and family planning initiatives (government of Bangladesh, 2017). Compared to national averages, however, Cox's Bazar is a 'lagging district', which has not met many of the national criteria to advance SRH and family planning (ibid.). The Rohingya influx has brought new and compounding challenges to the already weak local system. Globally, displaced girls have heightened SRH concerns, including greater risks of maternal morbidity and mortality, contracting sexually transmitted infections (STIs), and unintended pregnancy (Women's Refugee Commission (WRC), 2019). Notwithstanding the inclusion of contraceptive services as part of minimum standards of humanitarian response, efforts by the government of Bangladesh and humanitarian actors have encountered various barriers to the timely provision of SRH services to girls in camps and host communities alike. Though improved from previous years, regular data collected by the Community Health Working Group shows that approximately half of camp deliveries in camps occurred in a health facility (52.9%) (UNHCR, 2020). Also noteworthy, ISCG data (2019a, 2019b), highlights that 53% of Rohingya households reported that husbands decide where pregnant girls deliver, compared to 44% of host community households (ibid).

Across locations, less than half of our older cohort was able to mention a birth control method (47%), and only 42% of ever-married adolescents could, demonstrating the profound gap in SRH education – particularly as child marriage among adolescents is widespread (Ainul et al., 2018). Importantly, boys were significantly less likely to be able to name a contraceptive method compared to girls (38% and 55% respectively) – a key finding in communities where male decision-making is commonplace. In terms of contraception, our qualitative data found that some girls use short-acting injectable methods (i.e. Depo-Provera) to prevent pregnancy, as a 17-year-old married girl in Camp A explained: *'I don't want another son, I can't feed this one properly, why would I take another?'* However, this was the exception rather than the norm in our sample. This is echoed in the quantitative data, where injectables were the most well-known contraceptive method, named by 76% of adolescents who could name a method. Previous literature reports that limited contraceptive use among the Rohingya

▶ I don't want another son, I can't feed this one properly, why would I take another?

(A 17-year-old married girl in Camp A)

▶ We give [adolescents] a little idea [about contraception], not in details ... If we get a case [of pregnancy], we directly refer it to a hospital.

(Female NGO health service provider, Camp A)
is due to the belief that it is religiously and culturally immoral to engage in family planning (Ainul et al., 2018). Similarly, in host communities, birth control was reported to be available but costly and this, coupled with prevailing social norms,^{vi} means uptake is slow.

Moreover, our data in camps as well as host communities underscores the priority placed on pregnancy response rather than prevention, as key informants indicated:

'We give [adolescents] a little idea [about contraception], not in details. We explain what would happen to them if they get into an intimate relationship, but we don't teach them what actions should be taken. If we get a case [of pregnancy], we directly refer it to a hospital.' (Female NGO health service provider, Camp A)

'We provide nutrition support for pregnant women, nutrition support for children, check-up pregnant women and girls issues [including] those who married early. Health awareness increased now. They were taking treatment with leaves before but now they are going to hospital [to] deliver their babies. Some come with sexual diseases.' (Male NGO community medical officer, Ukhia host community)

Mothers in our camp sample mentioned regularly attending check-ups, being provided with antenatal vitamins and having ultrasound scans. In camps, hospital birth was nonetheless viewed as a measure of last resort for girls who have unforeseen emergencies or have undergone difficult pregnancies. In some camps, extensive distances to get to either nearby hospitals or reach skilled birth attendants have resulted in maternal and infant mortality. A participant in a women's focus group discussion in Camp B recalled one situation: '

A girl was pregnant. All the medical centres are closed on Friday, but she was in a great deal of pain. Then a man from the Camp In Charge [office] came with transport and he took her to the hospital, but all were closed. Eventually they took her to hospital [approximately 30 minutes by car], and she got treatment there. But her child is dead and it's been four days that she is there.'

Drug use

Our qualitative data highlights that drug use and trade is a growing concern among host communities, luring adolescent boys (primarily) away from education and decent work. While there have been reports of increased drug use and trade in the camps as well, our qualitative evidence points to a mixed picture. Some adolescents (though mostly the younger cohort) seemed not to know about illicit activities at all, while older boys commented on 'drug and weed' usage after dusk and an increase in the potentially lucrative drug business. The qualitative data illustrates that girls are significantly less involved in drug use and smuggling than boys, who, in turn, are said to act violently when taking drugs – a finding that

Box 3: Cultural perspectives on gender and their impact on uptake of SRH services

In a 2018 briefing, the Inter-Agency Working Group on Reproductive Health in Crises reported that Rohingya girls are under-served by the health sector response, noting that cultural restrictions on adolescent girls' mobility have prevented them accessing sexual and reproductive health (SRH) services in health facilities or other safe space information settings throughout the camps (IAWG, 2018). A male health worker providing maternal, newborn and child adolescent health services in Camp B gave key insights into the cultural implications of adolescents using SRH services:

'Daily, we serve on average 100–120 people, and mostly pregnant women. About 5% are adolescents. When they first came here, if women see a man then they fear [him], like watching a tiger. The situation was like that. But that was not fear I think, maybe it was their practice of Islam. But now [women] are talking, roaming, taking relief and coming to centres for postnatal care. Previously their husband was coming for it but now they are coming. So, changes will come gradually. [But] adolescent girls are still following previous culture, they are staying at home ... cultural development is very rare [for girls]. NGOs are working on awareness ... on what to do and not do during pregnancy and what foods to eat. But few listen to us, also about what I told them to do with a newborn baby!

They are rewarded when a new baby is born here. They don't have any work, that's why they reproduce more and more. We provide condoms, pills, but only 10% of people take it and they take it [only] for a few days ... The tendency [for adolescents] to get married is very bad. It's getting worse day by day, even for boys under 18. They are getting married but they are breaking up again. And teenage girls are getting married. Then the husband is leaving when they have a baby.'

resonated in host communities and camps. A 15-year-old boy described his worries: *'My brother-in-law [is addicted]. He takes drugs regularly and does do evil work. Every night he abuses my elder sister. He becomes unconscious after taking drugs. He batters my sister and says slang words. I avoid him.'*

Findings illustrate the interaction between the drug trade in host communities and camps when the two are in very close proximity. Teknaf upazila, close to the border with Myanmar, is particularly susceptible to the drug trade. During two separate FGDs in Camp C, for instance, participants mentioned the use of heroin and other drugs stemming from host communities and entering the camps, yet felt powerless to take any measures to counter this trend as *'we are not from this country'*. Qualitative data from host communities equally demonstrates the rise in drug business since the Rohingya refugee influx. One man (a father) in an FGD in Teknaf noted: *'The Rohingya people are not afraid of anything, they can take life risks easily.'*

Regardless of who operates the trade, our data underscores poverty and lack of livelihoods as its root cause, across locations. The drug business is seen to offer an income to adolescent boys who must contribute

► Those who are dealing with drugs are doing it because they don't have any other job ... If the government shows us some mercy and gives us some job opportunities, I think these kinds of bad deeds will reduce for sure.

(A participant in an FGD in Camp C)

to household finances, yet have no prospect of livelihoods. An FGD in Camp C highlighted the issue: *'Those who are dealing with drugs are doing it because they don't have any other job. So this issue can be eradicated by providing them with proper jobs. The government should be strict with this situation so those drugs could not get inside [the camps]. If the government shows us some mercy and gives us some job opportunities, I think these kinds of bad deeds will reduce for sure.'*



Refugees walk on an elevated footpath in Chakmakul camp © European Union 2018

Policy and programming implications

Our findings highlight the need for greater efforts in policy and programming to improve the health status of Rohingya and Bangladeshi adolescent girls and boys in camps and host communities respectively, as well as to address perceptions surrounding health practices. Key priorities for action directed towards multi-stakeholder audiences include the following:

For health sector UN and NGO partners

- **Strengthen health awareness, outreach and communication between health professionals and the public, and emphasise gender-transformative interventions through community dialogue on barriers to accessing health services.** To mitigate the cycle of negative experiences fueling distrust among Rohingya households towards health staff and dissatisfaction with free medicine provision, sensitisation campaigns in refugee camps on the effectiveness of free healthcare and medicine availability could be incorporated, including on the back of outreach and awareness on covid-19 measures.
- **Maintain and further strengthen investment in bottom-up communication** via standing health committees comprising health staff, influential Rohingya leaders including women self-organising leaders and camp officials, as well as the general public. Such efforts need to include a focus on gender barriers to confidentially accessing health services, continued engagement with and by the Rohingya in monitoring and evaluation of health services, and training healthcare providers and workers on culturally sensitivity service provision.
- **Promote access to mainstream and disability-specific health services as well as disability-specific information for adolescents with disabilities.** Mobile outreach teams to identify³ and refer adolescents with disabilities need to be scaled, informed by data collection to better understand specific and intersecting barriers to health uptake for young people with disabilities, with particular attention to gender- and age-specific challenges. There need to be greater efforts to include adolescents with disabilities in accessibility audits

and sector decision-making, as well as enabling their participation in identifying health barriers and enablers.⁴

- **Intensify SRH awareness-raising uptake, particularly around contraception and through increased engagement with boys, parents and community leaders.** While acknowledging the strides that have been made in providing antenatal and postnatal care, cultural issues surrounding home births and male decision-making need to be addressed as these represent barriers to uptake. Ongoing efforts to engage with shifting social norms targeting parents, girls, boys and influential community leaders, including around dissemination of information on contraceptives should be intensified. Mobile outreach teams and community health workers⁵ should make additional commitments to secure the participation of Rohingya and Bangladeshi married and unmarried older adolescent girls who face severe mobility restrictions that prevent them seeking healthcare. Adolescent boys, who are largely overlooked in the SRH response, need access to SRH services and information, which could be disseminated through schools, community spaces and dedicated adolescent-friendly spaces. Across locations, messaging on the negative health consequences of early pregnancy needs to be amplified.
- **Invest in streamlined menstrual hygiene management provision** to ensure comprehensive and regular access to services. More specifically, ensure that budgeting and coordination for the distribution of dignity and hygiene kits inclusive of MHM materials (provided by WASH, gender-based violence and other sectors) are sized to individual needs, rather than average household needs and that distributions take place across camps and host communities at regular intervals.

For nutrition and food security UN and NGO partners

- **Prioritise enhancing food security and dietary diversity in tandem with additional livelihoods and training opportunities for adolescents to catalyse household and self-resilience.** In camps, consistent complementarity of fresh protein food items alongside continued food assistance should be prioritised in the sector response.

3 See Washington Group Questions (www.washingtongroup-disability.com).

4 As per the Inter-Agency Standing Committee (IASC) Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action (IASC, 2019).

5 See Guidance Note for General Community Health Workers/Volunteers (CHW/V) Bangladesh Rohingya Response.

For private-sector actors

- **Scale income-generating and food production activities** (including innovative homestead vegetable gardening techniques) with market linkages in host communities, to mitigate against lost land and livelihoods, which could fuel food insecurity.
- **Invest in skills development programmes for Rohingya adolescents, ensuring coordination with private-sector partners to promote market linkages.** The roll out of the government of Bangladesh's Skills Development Programme is greatly anticipated in this regard and should both facilitate the reintegration of Rohingya adolescents in Myanmar when repatriation becomes possible as well as provide an interim solution for adolescents to utilise skill sets in camp life.

For community leaders

- **Facilitate the continued engagement with and by the Rohingya in monitoring and evaluation of health services.** Community leaders should also be involved in the training of healthcare providers and workers on culturally sensitivity service provision.
- **Amplify messaging on the negative health consequences of early pregnancy** by the regular dissemination of adolescent-relevant SRH information and the availability of awareness sessions.

For the government of Bangladesh

- **The roll out of the government of Bangladesh's Skills Development Programme is greatly anticipated and should both facilitate the reintegration of Rohingya adolescents in Myanmar when repatriation becomes possible as well as provide an interim solution for adolescents to utilise skill sets in camp life.** Alongside the private sector and sector partners, market linkages overlapping with acquired skill sets need to be assessed in the design phase of interventions.
- **Substance abuse prevention and response measures are urgently needed, both within host communities and camps,** and should take a multi-actor approach spearheaded by relevant ministries, including involving adolescents themselves, parents, community leaders, teachers, religious leaders and police – again, drawing on international good practice.⁶ Further research into the contextually specific drivers leading to adolescent drug use and trade should be explored.

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Endnotes

- i Only 4.8% of our sample experienced injury in the four weeks prior to data collection and 7.2% experienced serious illness.
- ii Based on discussions with Rohingya response field managers, our interpretation of the quantitative camp data is such that *community clinics* are intended as *primary health centres* and *satellite clinics* are intended as *health posts*.
- iii This figure includes older wave registered refugees, although they are comparatively better off than new wave refugees and old wave unregistered refugees.
- iv In the camps, nutrition intervention programmes focus on children under five years old (U5) as well as children over five years old; adolescent girls; and pregnant and lactating women. Nutrition programmes for adolescent girls focus on anaemia prevention through iron and folic supplementation targeting girls aged 13–19 (See: Action Against Hunger (AAH) (2019) Emergency Nutrition Assessment Final Report: Nayapara & Kutupalong registered Rohingya Refugee camps and makeshift settlements. Cox's Bazar, Bangladesh 25th September – 23rd October 2019.) It is important to note that the anaemic focus of the humanitarian response with regards to adolescent population programmes means that measures such as stunting and wasting are not covered by sector nutrition surveys.
- v During menstruation, religious guidelines prescribe changes to girls' regular prayer and the extent to which these are perceived by girls as exemptions or as constraints will be further investigated in follow-up rounds of our longitudinal data collection.
- vi Owing to family planning commitments in Bangladesh to control population growth, the country's total fertility rate has been in steady decline over the past four decades. Although the government remains the major provider of contraceptives, private sector provision, typically through the sale of temporary contraceptive methods at subsidised prices, has increased from 36% in 2004 to 47% in 2014 (MOHFW, 2015). In low-resource communities in Cox's Bazar, purchasing birth control from pharmacies is an expense many households cannot afford, as noted in division's low contraceptive prevalence rate compared with other areas of the country (Ibid). Moreover, cultural barriers limiting birth control more generally imply that any price can interfere with birth control uptake especially when males dictate household expenses.