# INEQUITIES IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES: A COMPARATIVE STUDY OF REFUGEE WOMEN FROM MYANMAR IN BANGLADESH, THAILAND, AND MALAYSIA

**BY**

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# ABSTRACT

**Background**: Refugee women and girls from Myanmar have been living in Bangladesh, Thailand, and Malaysia for an extended period. Numerous organizations have been delivering a range of sexual and reproductive health (SRH) services to them. However, these women encounter distinct challenges in accessing SRH services in these countries. Ensuring the availability of SRH services is fundamental to meeting their basic needs. Comparing and analyzing these similar situations can provide valuable insights on gaps in service provision and lessons learned.

**Objective**: This study examines sociocultural information about refugees from Myanmar and their host populations and documents the availability of refugee SRH services in Bangladesh, Thailand, and Malaysia. The data was analyzed to identify gaps based on their cultural needs using Minimum Initial Service Package (MISP) objectives as a evaluation tool.

**Method**: This research is a systematic documentary review. Articles, reports, and documents were searched through online databases such as Google Scholar, PubMed, humanitarian organization websites, and personal communications. A total of 69 pertinent articles were included in the study and the data was analyzed through qualitative matrices.

**Findings**: This study documented the sexual and reproductive health and rights (SRHR) needs and availability of SRH services to female refugee population in three countries. Bangladesh provides comprehensive SRH services and partly fulfills all six MISP objectives. However, there were only limited services in one of the refugee camps, Bhasan Char. Thailand partially met five objectives for camp refugees and only one for urban refugees. Malaysia only fulfilled three out of six objectives. Bangladesh sets a positive example with integrated SRH and GBV services, disability inclusivity, and a focus on SRHR, while Malaysia and Thailand have no system of governance for SRH services. Malaysia was found to have the most refugee-unfriendly services with deficiencies in post-natal care and abortion services. Only limited HIV and STD services were offered in Thailand due to the cultural sensitivities of the refugee population.

**Conclusion**: This study demonstrates a diversity of commitments and prominent gaps in SRH services and meeting SRHR needs in the three study countries. It is crucial for both humanitarian organizations and host countries to identify and meet SRHR needs of refugees using a rights-based approach and to routinely evaluate their work against an international standard such as the MISP.

**Keywords:** Myanmar Refugee Women, Sexual and Reproductive Health Services, Bangladesh, Thailand, Malaysia, MISP

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May Thin Khine

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# LIST OF TERMS

| No | Term | Definition |
|---|---|---|
| 1. | Refugee | A person who has fled their own country and is unable or afraid to go back due to a significant threat to their human rights is considered a refugee by the 1951 Convection |
| 2. | Asylum seeker | Asylum-seeker is a legal term used to designate a person who seeks protection in other countries by requesting refugee status after fleeing from the country of origin but has not yet received a final claim from the United Nations. Not all asylum-seekers may obtain refugee status. |
| 3. | Migrant | A Migrant is someone who decides to move for reasons other than a genuine threat to their life or freedom, such as employment, education, reuniting with family, or other personal considerations by United Nations. Migrants, unlike refugees, do not fear persecution or other severe harm in their native nations. |
| 4. | Humanitarian aid | Humanitarian aid refers to support provided to those in need during and after natural disasters and crises caused by human activity, as well as the support provided to those attempting to avert or prepare for such events. |
| 5. | ODA | Official development assistance (ODA) refers to government aid to support and prioritize economic development and welfare in developing nations. |
| 6. | SRH services | SRH services include services for maternal and child health (MCH), HIV and STDs, contraception, safe abortion, GBV, cervical and breast cancer screening and vaccination for human papilloma virus (HPV). |
| 7. | Health Cluster | The Health Cluster is an international coordination mechanism for agencies working in the health sector in humanitarian settings. |

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|---|---|---|
| 8. | SRHR | Everyone has the right to sexual and reproductive health, even those who live in humanitarian situations, regardless of sexual orientation, age, marital status, or ableism. Sexual and reproductive healthcare must adhere to human rights principles while also respecting the community's cultural and religious values |

# LIST OF ABBREVIATIONS

| Symbols/Abbreviations | Terms |
|---|---|
| ANC | Antenatal Care |
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| BRAC | Bangladesh Rural Advancement Committee |
| CCSDPT | Committee for Coordination of Services to Displaced Persons in Thailand |
| CEDAW | Convention on the Elimination of All Forms of Discrimination Against Women |
| CEmONC | Comprehensive Emergency Obstetric and Newborn Care |
| CESCR | Committee on Economic, Social and Cultural Rights |
| CHWG | Community Health Working Group |
| DAC | Development Assistance Committee |
| DoTW | Doctors of the World |
| DRC | Democratic Republic of the Congo |
| ECP | Emergency contraceptive pill |
| EMAP | Engaging Men Through Accountable Practice |
| FP | Family Planning |
| FRHAM | Federation of Reproductive Health Associations, Malaysia |
| GBV | Gender-based violence |
| GBVIMS | Gender-Based Violence Information Management System |
| GBVSS | Gender-based Violence Subsector |
| HIV | Human immunodeficiency virus |
| IAFM | Inter-Agency Field Manual |
| IAWG | Inter-Agency Working Group |
| ICMC | International Catholic Migration Commission |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| IOM | International Organization for Migration |

| | |
|---|---|
| IRC | International Rescue Committee |
| iRHIS | Integrated Refugee Health Information System |
| ISCG | Inter-Sector Coordination Group |
| LGBTQI | Lesbian, gay, bisexual, transgender, queer and intersex |
| MISP | Minimum Initial Service Package |
| MOH | Ministry of Health |
| MSF | Médecins Sans Frontières |
| MSRI | Malaysian Social Research Institute |
| MTC | Mae Tao Clinic |
| NGO | Non-governmental organization |
| OCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| ODA | Official Development Assistance |
| OHCHR | Office of the High Commissioner for Human Rights |
| PAC | Post Abortion Care |
| PEP | Post-exposure prophylaxis |
| PHC | Primary Health Center |
| PLHIV | People Living with HIV |
| PNC | Postnatal Care |
| REMN | Reaching Every Pregnant Mother and Newborn |
| SDG | Sustainable Development Goal |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| STD | Sexually transmitted diseases |
| TBA | Traditional Birth Attendant |
| UHC | Universal Health Coverage |
| UNFPA | United Nations Population Fund |
| UNHCR | United Nations High Commissioner for Refugees |
| WAGAR | Women and Girls Protection Project |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |

# CHAPTER 1
# INTRODUCTION AND BACKGROUND

## 1.1 Introduction

In 2019, there were 35 million women and girls of reproductive-aged (15-49 years) who need humanitarian assistance (OHCH R 2020). In addition to the consequences of violence and migration, many women impacted by conflict also experience sexual abuse, human trafficking, and unplanned pregnancy. These women face limitations in access to sexual and reproductive health (SRH) care. SRH services are vital to delivering even in the early phase of humanitarian settings (Onyango and Heidari 2017).

This research paper documents and analyzes the SRH services available to refugee women from Myanmar in Bangladesh, Thailand, and Malaysia and documents the similarities, differences, and gaps as measured against the accepted international standard.

## 1.2 Background

### 1.2.1 Global Humanitarian Situation

According to UNHCR, one in every 23 people will require humanitarian assistance in 2023. The major causes of forcible displacement around the world are violence, conflict, poverty, and climate change (UNOCHA 2022).

In 2019, the number of reproductive-aged women and girls who needed humanitarian assistance was 35 million (OHCHR 2020). During humanitarian crises, women and girls are disproportionately affected especially in protracted setting (UNHCR 2020).

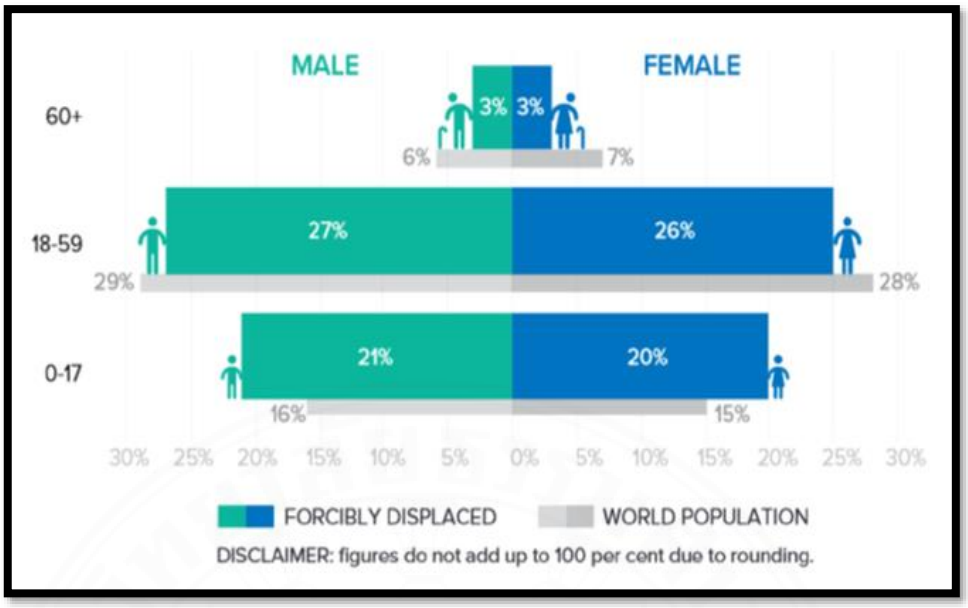


Figure 1.1 Demographics of forcibly displaced people and world population
Source : https://www.unhcr.org/media/40152

Figure 1.1 above shows the distribution of the world population by aged, and sex compared with the distribution of forcibly displaced populations. Globally, the proportion of forcibly displaced people aged between 18 and 59 years is 2 percent less than their share of the global population while the proportion forcibly displaced people aged under 17 years makes up 5 percent more than their proportion of the global population. Early marriage and teenage pregnancy are common issues for people in humanitarian settings. These major age groups have different SRH needs and it is important that services are planned so as to meet age-specific and gender specific needs (UNHCR 2021).

### 1.2.2 Humanitarian Aid

A considerable increase in humanitarian aid requirements is driven in part by the expansion of global needs, growing operational costs and commodity prices, and high inflation in 2023 (OCHA 2022).

Typically, the humanitarian health sector response is initiated and coordinated by the Ministry of Health (MOH), which may also ask for assistance from other health actors. When a ministry is unable or unwilling to act, leadership can be provided through the Humanitarian Cluster system (Sphere 2018).The focus areas in the public health sector for refugees by UNHCR are mental health and social assistance, SRH, nutrition,

water, sanitation and hygiene (WASH), access to healthcare, and strategic health information (UNHCR n.d.).

UNHCR is working together with MOH, other national and international non-governmental organizations (NGO) such as World Health Organization, World Food Bank, Médecins Sans Frontières (MSF), International Federation of Red Cross and Red Crescent Societies (IFRC), International Organization for Migration (IOM) in providing humanitarian assistances (Yousuf, Salam et al. 2020). However, medical and other assistance provided cannot always meet immediate needs, due to sudden increases in numbers of refugees, underfunding, or logistic problems (Srikanok, Parker et al. 2017).

Humanitarian aid has paid great attention to meeting (SRH) needs, with a focus on gender-based violence (GBV) and HIV prevention and treatment (UNHCR n.d.). The provision of SRH care is vital like food, shelter, water and sanitation, security, and basic health services even in the early phases of a humanitarian event (Onyango and Heidari 2017). SRH services should not be limited to women. However, gender inequality is rooted in sociocultural norms, which impact exposure to SRH threats and also accessing SRH services to women and girls (UNHCR 2021).

In 1969, the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) adopted Official Development Assistance (ODA) as a gold standard for foreign aid, The DAC provides aid to countries in the DAC list of ODA Recipients (OECD n.d.). But the government of Bangladesh prioritizes ODA funds to citizens and refrains from allocating to refugee programs. Additionally, donor countries segregate ODA and humanitarian funds, strictly limiting their usage to their designated purposes and preventing them from being utilized for other purposes. (LightCastle Analytics Wing 2021).

### 1.2.3 Sexual and Reproductive Health Needs

According to Hossain and Dawson, one in five forcibly displaced girls is married by the age of 18 and experiences constraints in accessing SRH services. Also, one in three refugee women and girls experience physical abuse and sexual and gender-based violence (SGBV) throughout their lifetime. Approximately 60% of maternal deaths are from conflicted nations, and they are mostly preventable (Hossain and Dawson 2021).

A humanitarian crisis, in addition to worsening perinatal outcomes, increases the risk of congenital disorders, miscarriages, preterm birth, low birth weight, and the prevalence of HIV and STIs. Each year, the number of women who have unsafe abortions is estimated to be around 3.2 million, and 12 million adolescent girls give birth in humanitarian circumstances, with obstetric problems accounting for 15% of births (Hossain and Dawson 2021).

Refugee women have a higher risk of unintended pregnancy, induced abortion and complication during pregnancy than host population in WHO report (WHO regional Office for Europe 2001). These SRH problems affected on health and social lives of them and their families (Ussher, Rhyder-Obid et al. 2012).

The adolescent population defined by WHO as those aged between 10 and 19 years old (WHO n.d.). Adolescent SRH needs are more complicated especially in the refugee situation. Experience of forced migration may impact young people's power and agency, putting them at risk of SRH threats. Insecure living conditions and new cultural, social, and legal contexts in the host countries may exacerbate their risk and limit access to SRH services (Tirado, Chu et al. 2020).

Moreover, some cultural practices and religious norms/values impact their SRHR. Shyness and unfamiliarity with SRH issues and marital status are additional factors in constraining access to SRH services by adolescent refugees. So, child marriage and teenage pregnancy were prevalent in this context (Ainul, Ehsan et al. 2018).

Poor economic condition in camps increase the risk of exploitation of women and young girls such as forced marriages, forced labor, and commercial sex trafficking. Transactional sex is one of the negative coping strategies for poverty (Lee-Koo, Jay et al. 2018). There is also increased risk of rape and sexual harassment due to lack of legal status, insecure living conditions and unsafe sanitation arrangements (Parmar, Jin et al. 2019). Gender inequality and patriarchal norms lead to SRH problems and impact ability to utilize SRH services. Decision-making is in the hands of their husbands in some cultural contexts.

### 1.2.4 Sexual and Reproductive Health Services

Approximately 4.3 billion reproductive-aged people are unable to access appropriate SRH services worldwide. Specific populations such as adolescents, unmarried women, migrants, refugees, HIV positive people, disabled people, and LGBTQI

people have limited access to SRH services because of political and sociocultural barriers (Lim, Yap et al. 2020).

The main challenges for refugees are a lack of awareness of their right to access SRH services, lack of knowledge to navigate the health care system in host countries, linguistic barriers, financial problems, acceptability, availability, and quality of care in SRH services(WHO Regional Office for Europe 2017).

Cultural and religious values are related to the acceptability of SRH services. However, community power dynamics, patriarchal values, and harmful traditional practices also violate SRH rights. There is tension in balancing human rights and sociocultural norms and values. Rights based approaches should be used whenever possible because sustainable SRH outcomes cannot be achieved without addressing rights. Refugee women should be at the center of SRH strategies in humanitarian settings but refugee men and LGBTQ+ also need to be included in any SRH strategy for refugees (UNHCR n.d.).

The interconnection between women's SRH and multiple human rights, such as the right to life, health, privacy, education, and freedom from torture and discrimination, has been acknowledged by both the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination against Women (CEDAW) of the United Nations. These committees have clearly stated that women's right to health encompasses their SRH. Consequently, states must uphold, safeguard, and fulfill women's sexual and reproductive health and rights (SRHR). Moreover, these services should be available in sufficient numbers, physically and economically accessible, free from discrimination, and of high-quality standards (OHCHR n.d.).

The General Comment 22 of the CESCR advises states to revoke or eradicate laws, policies, and practices that criminalize, impede, or undermine the availability of SRH services, facilities, goods, and information to individuals or specific groups (OHCHR n.d.).

The 1995 Beijing Declaration and Platform for Action represents an unprecedented and highly progressive framework for promoting and safeguarding women's rights. (UN Women n.d.). Furthermore, Articles 19 and 34 of the Convention on the Rights of the Child also highlighted the protection of children under 18 years old

from sexual abuse and exploitation (UN General Assembly Resolution 1989). Sustainable Development Goal (SDG) target 5.6 aims to achieve universal coverage of SRHR. SDG Indicator 5.6.2 focuses on the number of countries that have enacted laws and regulations guaranteeing comprehensive and equitable access to SRH care, information, and education for women and men aged 15 years and older. (UNFPA 2020).

In 2019, 75 out of 107 countries submitted complete data, but 33 submitted only partial data. Restrictions on MCH services among countries in 2019 were noted: around 9% based on marital status, 10% based on age, and 11% related to permission of parents. Around 12 percent of reporting countries restricted to contraceptive services in the policy. Moreover, approximately 28 percent of countries restricted contraception similar to factors of MCH. There are still gaps in SRHR even in ratifying countries and it also reflects the countries' political commitments protecting women (UNFPA 2020).

Additionally, SRH is an important part in SDGs 3, 5, and 10 to establish gender parity, ensure everyone's health and well-being and reduce inequities in accessing SRH services. These goals can only be achieved with partnerships to lead and implement (SDG 17). However, preventive SRH care is of limited or poor quality in accordance with the WHO framework for human rights standards in low-income countries. Lack of patient-centered care , non-respectful, ineffective, and inefficient communication, and limited human and financial resources are all factors in poor quality services (Davidson, Hammarberg et al. 2022).

Effective SRH services are important for achieving universal health coverage (UHC). However, SRH has not been a major topic of discussion in healthcare financing or an established development focus area at the international and national levels (Ravindran and Govender 2020).

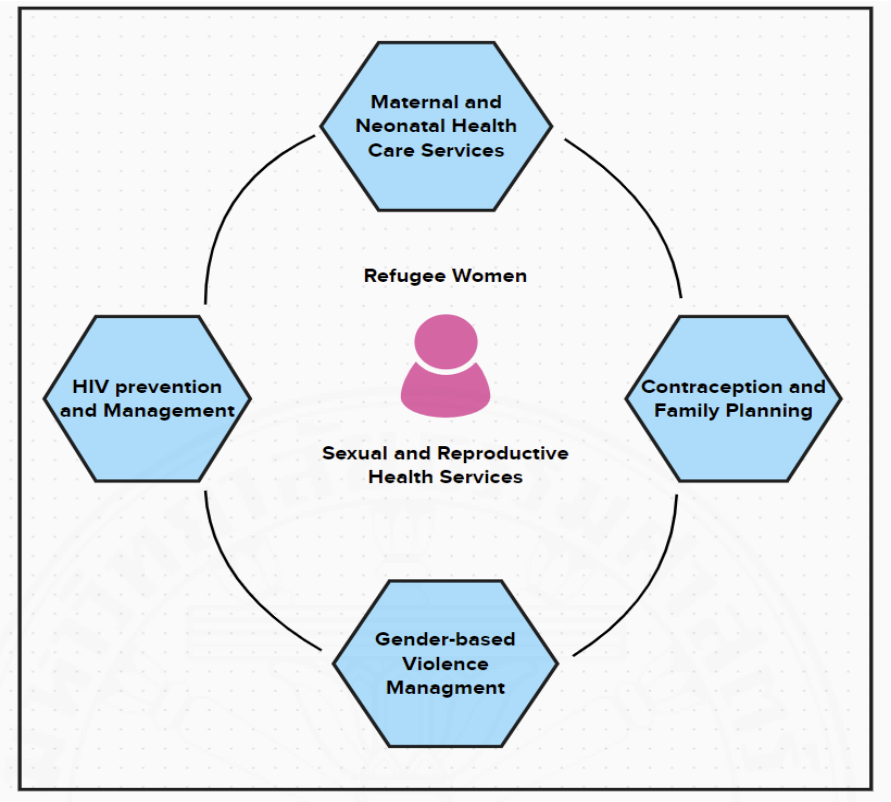


Figure 1.2 Sexual and reproductive health services provided by UNHCR.
Source: https://www.unhcr.org/what-we-do/protect-human-rights/public-health/sexual-and-reproductive-health

Figure 1.2 above shows the provision of SRH services to refugee women by UNHCR. These include maternal and neonatal health care services, HIV prevention and management, GBV management (clinical, mental and social support), contraception and family planning (UNHCR n.d.).

### 1.2.5 Minimal Initial Service Package (MISP)

The Minimum Initial Service Package (MISP) is an international standard defining the minimum level of SRH care that must be provided in humanitarian situations. It was created by the Inter-Agency Working Group (IAWG) and the Inter-Agency Field Manual (IAFM) in 1999 and then twice revised by UNHCR, the latest revision being in 2017 (UNFPA 2018). Early evaluations of the MISP implementation in acute humanitarian settings produced a diverse range of findings, including low awareness of the MISP by humanitarian agencies, insufficient SRH training among

humanitarian staff, logistical challenges and poor coordination (Onyango and Heidari 2017).

The six objectives of the MISP are as follows (UNFPA 2020):

1) to ensure the health sector/ cluster identifies an organization to implement the MISP and to lead SRH organizations.

2) to prevent sexual violence and addressing the needs of survivors

3) to prevent the spread of and reduce deaths and complications from HIV and other STIs

4) to prevent excessive maternal and neonatal deaths and morbidity,

5) to prevent unwanted pregnancies and plan for comprehensive SRH services

6) to plan for comprehensive SRH services and to integrate into primary health care as soon as possible by collaborating with health sector/ cluster partners to address the six-health system building blocks.

Although adherence to the MISP can reduce mortality in pregnant refugee women, its implementation may be impeded by the host country and the sociocultural values of the refugees themselves which not only impacts the acceptability and accessibility of SRH services but also complicate evaluations of these services. Religious practices and host government laws also impede the implementation of services. SRH services apart from MCH are still taboo topics in some countries.

### 1.2.6 Health Cluster

The Humanitarian Health Cluster aims to fulfill these vulnerable populations' health needs in humanitarian situations while adhering to humanitarian principles. The Health Cluster is hosted by WHO. It prepares for and reacts to humanitarian emergencies to deliver timely, suitable, and effective coordinated health intervention to improve the health outcomes of impacted people. In order to strengthen multi-sectoral action and better health outcomes, the Health Cluster works closely with other Humanitarian Clusters as well as the WHO programs and other partners on specific thematic projects.

In times of humanitarian and public health emergencies, the Health Cluster's mission is to save lives and encourage human dignity. The number of refugee women is increasing, and SRH problems are significant in humanitarian situations. Effective coordination and implementation by Health Cluster is crucial to addressing SRH issues in humanitarian situations (Health Cluster n.d.).

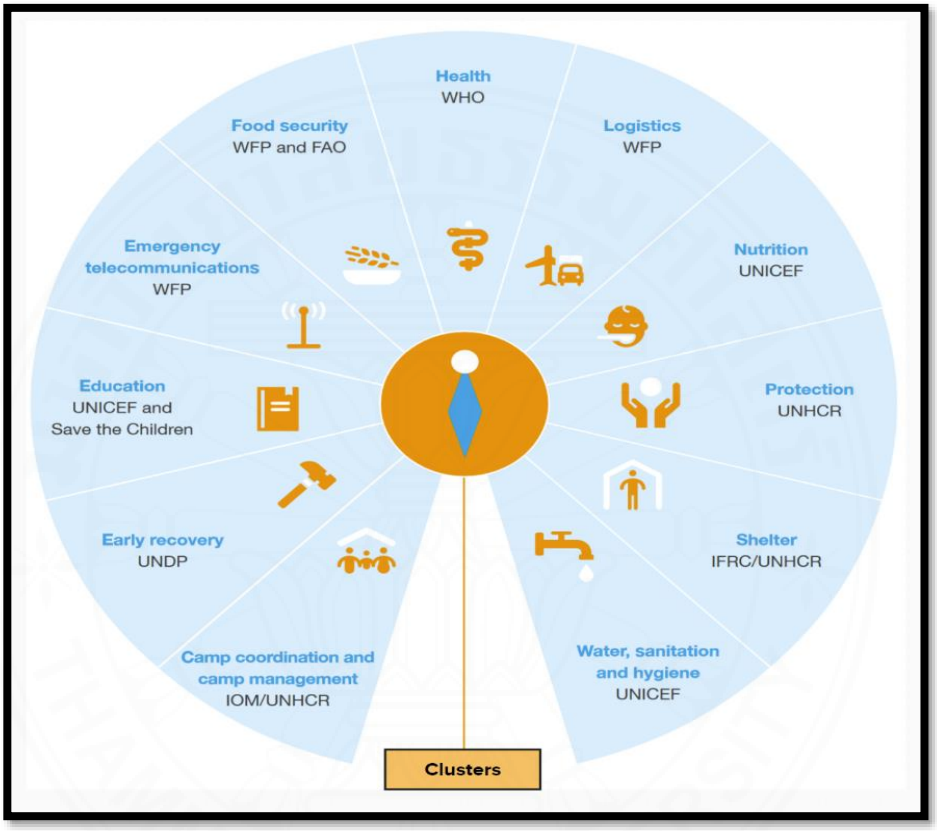


Figure 1.3 Humanitarian clusters system
Source: https://apps.who.int/iris/bitstream/handle/10665/334129/9789240004726-eng.pdf?sequence=1&isAllowed=y

Figure 1.3 shows the clusters involved in humanitarian settings. Clusters are humanitarian organizations aiding in different sectors such as education, shelter, clean water and food, health, telecommunication and logistics. These clusters coordinate in preventing, preparing, responding to humanitarian emergencies and also reconstructing (WHO 2020).

### 1.2.7 History of Refugees in Bangladesh, Thailand and Malaysia

Myanmar is renowned for its extensive ethnic and cultural variety. The primary causes of long-term conflict in Myanmar include authoritarian military rule, oppression based on ethnicity and religion, unequal development, communal and ideological tensions, local disputes over resources, and aspirations for separation and autonomy (The Asia Foundation, 2017).

The ongoing conflict in Rakhine State in Myanmar is deeply rooted in historical social stratification patterns among the Burmese, Rakhine, and Rohingya ethnic groups. The Rohingya population is disadvantaged through restrictive citizenship and mobility laws, unequal resource allocation, and a lack of political representation (PEBA, 2014). The displacement of Rohingya and other ethnic minorities from Myanmar to nearby nations is not recent occurrence. These people have historically fled to neighboring countries in order to avoid human rights violations, and political conflict (Yesmin, 2016).

The political situation following the 2021 coup has resulted in increased violence between opposition parties and the military junta, leading to massive displacement of people from Myanmar to neighboring countries such as Thailand, Bangladesh, and Malaysia ((Human Rights Watch 2023)Carleton University, 2023).


Figure 1.4 Displacement of people from Myanmar to neighboring countries.
Source: (Yesmin 2016)

Figure 1.4 above shows the displacement of people from Myanmar to Bangladesh, Thailand, and Malaysia. Rohingya people from Arakan state also use boats to flee into these countries because of their geographical proximity and they become the major host countries (Yesmin 2016).

But these countries do not ratify international refugee law and do not have a legal framework for refugees and asylum seekers (Yesmin 2016). These three countries are middle-income countries in the World Bank classification (World Bank n.d.). The socioeconomic status of host countries impacts the health expenditure and provision of services to refugees in these countries.

Bangladesh has hosted them in 34 refugee camps for 30 years and approximately a million Rohingya refugees were present in the camp in Cox's Bazar. In the 2022 report, the total number of Rohingyas in Bangladesh was 950,972 with 52% of them being women (UNHCR 2022).

Over the past forty years, Thailand has been hosting refugees in nine camps along the Myanmar border (CCSDPT 2021) (personal communication). In the 2022 September 2022 UNHCR report, the total number of verified refugees in Thailand was 91,040 of which 50.5% were female. There was also 5155 urban refugees and asylum-seekers in 2022 (UNHCR 2022).

Malaysia has hosted refugees for at least 25 years, but they are not housed in camps. The government provides refugees with low-cost apartments across the country. At present, around 181,000 Myanmar refugees and asylum seekers reside in Malaysia and 33% are women according to UNHCR (UNHCR, n.d.).

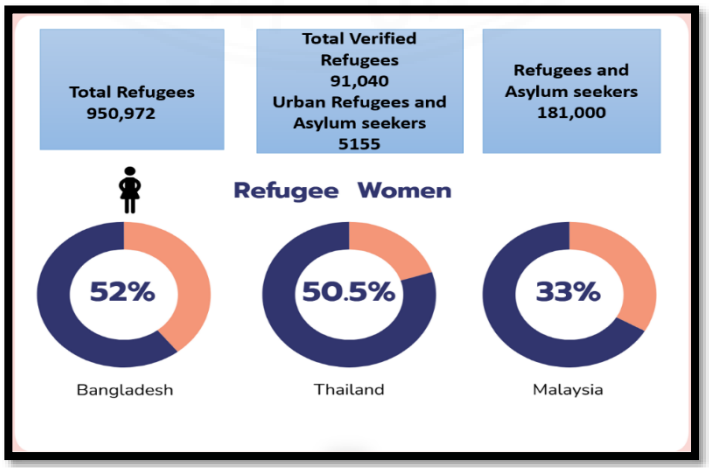


Figure 1.5 Refugee population in Bangladesh, Thailand and Malaysia.
Source: (UNHCR 2022, UNHCR 2022, UNHCR n.d.)

Figure 1.5 shows the number of refugees population and proportion of refugee women in Bangladesh, Thailand, and Malaysia. This significant number of refugee women in these countries reflects their SRH needs and informs humanitarian organizations and host governments in service provision.

All three countries ratified CEDAW, the Beijing Declaration and the Platform for Action for Women's Rights including SRHR and also the Convection on the Rights of the Child (OHCHR n.d., OHCHR n.d., UN Women n.d.). According to the 2019 UNFPA report, Malaysia only reported SDG indicator 5.6.2 for SRH among them (UNFPA 2020). In the progress reports on the implementation of the Beijing Declaration and Platform for Action in 2019, all three countries reported the challenges and improvements regarding SRHR. However, only Bangladesh included the Rohingya refugee situation in their report (UN Women n.d.).

### 1.2.8 SRH problems of Refugee Women in Bangladesh, Thailand and Malaysia

#### 1.2.8.1 Bangladesh

In Rohingya refugee camps in Bangladesh, SRHR services are provided through various channels, including fixed health facilities, women-friendly spaces, and community outreach. Approximately 200 health facilities are present within the camp, but only 17 percent of them provide 24-hour access, and only three have the capacity to perform surgical procedures. Furthermore, due to safety concerns and the risk of gender-based violence, Rohingya women face challenges in accessing 24/7 facilities during nighttime (Schnabel & Huang, 2019).

In Myanmar, marriage of Rohingya people and conception is restricted under national policy because of the misconception of Rohingya people as “spreading of Muslims by reproduction." Rohingya women also experienced rape and sexual assault in Myanmar and refugee camps and have no access to SRHR services in Myanmar because of widespread discrimination towards them in Rakhine State by healthcare providers, limitation of movement, physical abuse, and the expense of bribes for services (Parmar et al., 2019).

Rohingya women must follow the decisions of husbands’ and mothers-in-law on contraception, according to their level of adherence to religious and cultural practice. Oppressive policies and conservative social norms limit Rohingya women in accessing

education, and this impacts SRHR health literacy. Cultural and religious practice itself violate SRHR. This long-standing pattern of discrimination, coupled with experiences of rape and reproductive control, serves as a significant contextual factor influencing the deep reluctance of Rohingya women to seek ANC and facility-based births (Parmar et al., 2019).

The Joint Response Plan (JRP) report in 2018 of the interagency Intersector Coordination Group (ICG) in Bangladesh found that, only 43 percent of babies were delivered in healthcare facilities. This statistic serves as an indicator of low awareness and the presence of barriers to access. Referral pathways for Rohingya refugees within the camps are consistently weak. They have limited knowledge about referral pathways, and the cost of transportation to healthcare facilities remains a significant challenge. While the primary option for referrals was to the larger facilities within the camps, patients were sometimes required to go to higher-level facilities outside the camps for emergency care. Between August 2017 and November 2019, a total of 1,209 obstetric emergencies were referred to these higher-level facilities (Schnabel & Huang, 2019).

In the 2021 study of Hossain and Dawson, there were 316,000 Rohingya women of reproductive age and 63,700 pregnant women living in Bangladesh refugee camps. The study found that, there was a serious risk of GBV for these women. In Bangladesh, there are more than 60 births per day and many adolescent mothers had more than five babies by the age of 22 (Mohammad Mainul Islam et al., 2021; M Mofizul Islam et al., 2021).

WHO and the Dutch Ministry of Foreign Affairs have formed a strategic partnership to provide integrated SRH services to the most vulnerable populations, with a particular emphasis on refugee adolescent girls and women in Bangladesh (Cox's Bazaar), the Democratic Republic of the Congo (DRC) (Kasai), and Yemen (Aktar, Ahmed et al. 2020).

Among 34 refugee camps, four still could not provide minimal necessary GBV services such as accessing clinical treatment, social and legal support, mental counseling, safe spaces for refugee women and girls, and five refugee camps only offer 25-50% of GBV services in the 2019 JRP appeal in Bangladesh (Strategic Executive Group, 2019).

SRH services are available in the camp but their acceptability issues impact utilization of these services. Between September 2017 and August 2018, fifty-two maternal deaths were reported in the Rohingya refugee camps in the Bangladeshi Cox's Bazaar District's Ukhia and Teknaf (Parmar et al., 2019).

#### 1.2.8.2 Thailand

Abortion is legal in Thailand under a wide range of situations, such as when the pregnancy threatens the mother's life, physical or mental health, results from rape or incest, conceives at under 16 years old, or involves a fetal anomaly (Ball & Moselle, 2015).

The International Rescue Committee (IRC) conducted a reproductive health evaluation of refugee women in all camps in Thailand in 2016 and discovered that more than one in five women had suffered GBV at some point in their lives (UN Women, 2016).

In a cross-sectional study by Falb et al. in three refugee camps along the Thailand Myanmar border, 8.6% of the women participants had experienced intimate partner violence (IPV), 9.8% had experienced conflict-related violence, and 15.4% had experienced any violence. The last of these were three times more likely to have obstetric complications (Tanabe et al., 2019).

In the 2021 CCSDPT report on the SRH status of camp refugee women along the Thailand-Myanmar Border, only 6% were delivered by women less than 18 years old. Although there were 5 rape cases in the that report, no survivor received PEP, ECP, and STI treatment within standard time (CCSDPT, 2021) (personal communication).

Urban refugees are present in Thailand, but they are out of the political space. Some government officials are not aware of them. Most urban refugees cannot access any health insurance scheme, and these vulnerable women face challenges in accessing healthcare services (Kangkun, 2018). There is also no disaggregated data for urban refugee women (UNHCR, 2022d).

#### 1.2.8.3 Malaysia

Although Malaysia has prioritized MCH services in public healthcare system, SRH services is less focus area and still a taboo topic as a result of governmental, regulatory, and legislative impediments, as well as constrictive cultural and religious values and practices that cause stigma and humiliation (Lim et al., 2020).

Rohingyas are unable to access Malaysia's healthcare program since they are regarded as illegal migrants. Humanitarian organizations cannot provide delivery services of refugee pregnant women. Even though the UNHCR is negotiating with the government to give Rohingyas a 50% discount on healthcare-related fees, many refugees are unable to afford healthcare. Moreover, refugee women have to pay delivery fees with full foreigner price, and they have risk of detention and deportation after delivery. One of the major gaps identified by Doctors of the World (DoTW) in Malaysia is SRH (DoTW, 2022) In the study by Tahir et al. in 2019, 32 out of 85 Rohingya refugee women in Malaysia married at the age below 18 years (Tahir et al., 2022).

## 1.3 Problem Statement

There were 89.3 million forcibly displaced people globally at the end of 2021 and half of them were women. Thailand, Malaysia and Bangladesh are the countries which host the majority of refugees from Myanmar in Asia for long duration. However, these countries have not ratified the international refugee conventions and they do not provide legal protection to them.

Refugee women are vulnerable to SRH problems. There is significant variation in political commitments and assistance in providing SRH services to refugee women in these three countries even though three countries ratified international convection on women's rights and SRHR. Despite the efforts of numerous humanitarian organizations to provide assistance and services, refugee women in these countries are facing many challenges in accessing SRH services due to their legal status, linguistic and financial barriers, place of residence, availability of services and cultural limitations.

Sustainable Development Goals 3, 5 and 10 aim to ensure gender equality, population health and wellbeing and reduce inequities. These SDGs cannot be achieved unless SRH services are provided to all refugees and those services comply with the internationally accepted MSP objectives and SDG 17. However, significant inequities in SRH services for refugee women from Myanmar persist in each of these three countries. To address these effectively, it is important for policy makers and service providers in these three host countries to understand the strengths, weaknesses, and gaps in the SRH services currently being provided.

## 1.4 Research gap

Although there is much research on SRH services for refugee women and adolescents, there is a lack of research comparing their unique SRH issues with available SRH services from the same countries of origin in different host countries and comparing the those living in camps with those living in the community. Many refugees from Myanmar have sought protection in three Asian countries: Bangladesh, Thailand, and Malaysia. However, refugees have different experiences in these countries. A comparative analysis of refugee SRH services in these countries will provide policy makers and service providers in the Asia with the information needed to develop culturally appropriate and situation specific strategies to address SRHR issues faced by those and insights of host countries towards SRHR of refugee women.

# CHAPTER 2
# PURPOSE AND DESIGN

## 2.1 Purpose

The purpose of this research is to document the strengths, and weaknesses and of gaps in SRH services provided to refugee women from Myanmar in Bangladesh, Thailand and Malaysia.

## 2.2 Research Question

What are the similarities, differences and gaps in sexual and reproductive health services currently provided to refugee women from Myanmar in Bangladesh, Thailand and Myanmar?

## 2.3 Research Objectives

2.3.1 To describe the demographic and socio-cultural characteristics of the major refugee population from Myanmar and socio-cultural information of host population in Bangladesh, Thailand, and Malaysia

2.3.2 To identify sexual and reproductive health services available to refugee adolescents and women from Myanmar in each country and compare them between countries.

2.3.2.1 To describe the SRH services available to adolescent girls and women older than 19 years with the refugee background from Myanmar in each country.

2.3.2.2 To identify similarities and differences between SRH services in each country by comparing the available services

2.3.2 To identify gaps in SRH services in each country by comparing them to the standard MISP objectives.

## 2.4 Conceptual Framework

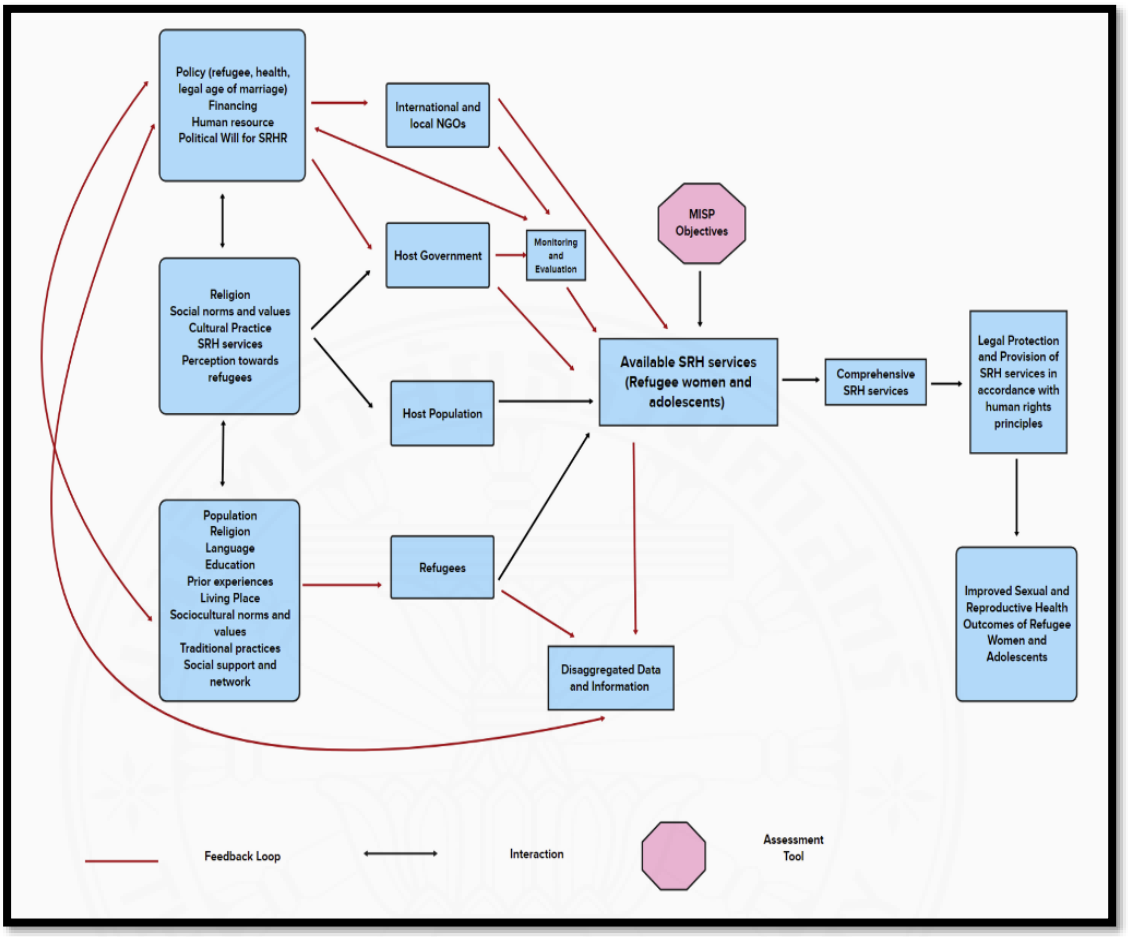


Figure 2.1 Conceptual framework

The purpose of this study is to identify the similarities, differences, and gaps in current SRH services to refugee women and girls from Myanmar in Bangladesh, Thailand, and Malaysia, the main actors involved, such as humanitarian organizations, host countries, the host population and refugee population itself and the factors shaping the actors will be analyzed. Different countries and humanitarian organizations have differing commitments toward refugees and SRHR. Levels of funding and the number and quality of the workforce also impact service provision. Moreover, socio-cultural values, religious practice, and SRHR services available to the host population define SRH service provision for refugees while socio-cultural norms and values, religions, the living place of refugees, previous experiences, education and social support networks shape their acceptability and influence SRH service provision.

The social determinants of health, such as job opportunities, secure living conditions, education and legal protection are also vital for good SRH outcomes. It is important that host countries refugee policies align closely with international human rights standards to ensure legal protection for the SRH of refugee women. Disaggregated data and information on refugees and SRH services are essential to inform policy and identify gaps to implement change. However, this cannot be done without monitoring and evaluation of not only the available services but also the policy towards SRHR of refugees. These are crucial steps to sustainable and improved SRHR outcomes.

MISP is the international standard for the provision of SRH services in humanitarian settings. This study will use the MISP objectives as an assessment tool to evaluate SRH services provided to the female refugee population in the three study countries.

# CHAPTER 3
# RESEARCH METHODOLOGY

## 3.1 Study Design

This study is a documentary review which compares and analyzes SRH services provided by host governments, humanitarian organizations and civil society to refugee women in Bangladesh, Thailand and Malaysia.

## 3.2 Countries and Assessment Tool Selection

Details of country selection criteria and analytic tools to be used in this study are available at Annex A.

## 3.3 Data Selection

### 3.3.1 Data Resources

Peer reviewed articles and grey literatures such as project and situation reports, important data and information were obtained from PubMed, Lancet, Science Direct, JSTOR, ResearchGate, Google scholar, Ministry of Health in Bangladesh, Thailand and Malaysia, UNHCR, UNFPA, Health Cluster, iRHIS, International Non-governmental Organizations, Local Non-governmental Organizations, Civil Society Organizations and Google. Documents from 2018 to 2023 were used for this research because MISP objectives were revised in 2017 by IAWG.

### 3.3.2 Data Search Strategies

For research objective (1)

The key words “Burmese refugee”, “Karen refugee”, “Karenni refugee”, “Chin refugee”, “Rohingya refugee”, “forcibly displaced people”, “illegal immigrants”, “Thailand”, “Bangladesh”, “Malaysia”, “socio-cultural factors”, were used for search strings in finding the articles. The findings were screened by reading the titles and abstracts first. The relevant abstract and literature were included for full review.

The grey literatures were searched from UNHCR, humanitarian organizations' websites such as KWO, Migration Research Network and other additional available information.

For research objective (2)

The key words "Burmese refugee women", "Rohingya refugee women", "Karen refugee women", "Chin refugee women", "maternal and child health", "sexual and reproductive health services", "humanitarian assistance", "sexual and reproductive health", "Thailand", "Bangladesh", "Malaysia", "MCH", "antenatal care", "safe motherhood", "obstetric delivery service", "MNCH", "Family planning", "HIV" and "STD", "abortion", "sexual violence" , "gender-based violence" and "SGBV" were used in creating search strings to find the literatures. The results were screened by reading the titles and abstracts first. The relevant abstract and literature were selected for full reading. The grey literature was searched from government websites, UNHCR, Health Cluster, UNFPA, humanitarian organizations' websites such as BRDCS, IRC, MSF, Ipas and other additional open-source information.

For research objective (3)

The key words "refugee women" "sexual and reproductive health services", "MISP", "Health Cluster", "SRH subsector", 'GBV subsector", "SRH working group" were used in creating search strings to find the literatures. The results were screened by reading the titles and abstracts first. The relevant abstract and literature were included for full review. The grey literature was searched from IAWG, UNFPA, Health Cluster, iRHIS websites and other additional open-source information.

### 3.3.3 Inclusion and Exclusion Criteria

Table 3.1 Inclusion and Exclusion Criteria

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Peer-reviewed literature, project and situation reports and grey literatures relevant to research question and objectives, from 2018 to 2023. | Published in other languages rather than English and official translation is not available. |
| Peer-reviewed literature, project and situation reports and grey literatures providing data and information of demographic characteristics and socio-cultural information of refugee women and host population in Bangladesh, Thailand and Malaysia | Published in other languages rather than English and official translation is not available. |
| Peer-reviewed literature, project and situation reports (personal communication) and grey literatures providing data and information of available SRH services to refugee adolescent and women in Bangladesh, Thailand, and Malaysia | Information from video, social media, newspaper, article without references |
| Peer-reviewed literatures, project and situation reports (personal communication) and grey literatures providing data and information of organizations, funding and workforce involve in SRH services of refugee adolescent and women from Myanmar in Bangladesh, Thailand, and Malaysia | |
| Peer-reviewed literature, project and situation reports (personal communication) and grey literatures providing data and information of MISP for sexual and reproductive health services in humanitarian situations | Source only providing contextual information of sexual and reproductive health services in humanitarian setting without MISP |

### 3.4 Data Management Plan

Data was stored, compared and analyzed using the data matrix method. The data from literature, government and organizations was categorized by research objectives and compared.

For research objective (1):

Comparison between religions and their norms, traditional practice and beliefs, patriarchal norms and values of major refugee populations from Myanmar and those information of host populations in Bangladesh, Thailand and Malaysia

For research objective (2):

Comparison between SRH services available to refugee adolescent and women in these selected countries

For research objective (3):

Comparison between SRH services available to refugee women in these selected countries with the MISP objectives.

The PRISMA flow chart was used to summarize the screening process to identify the evidence-based list of literatures in this systemic literature review.

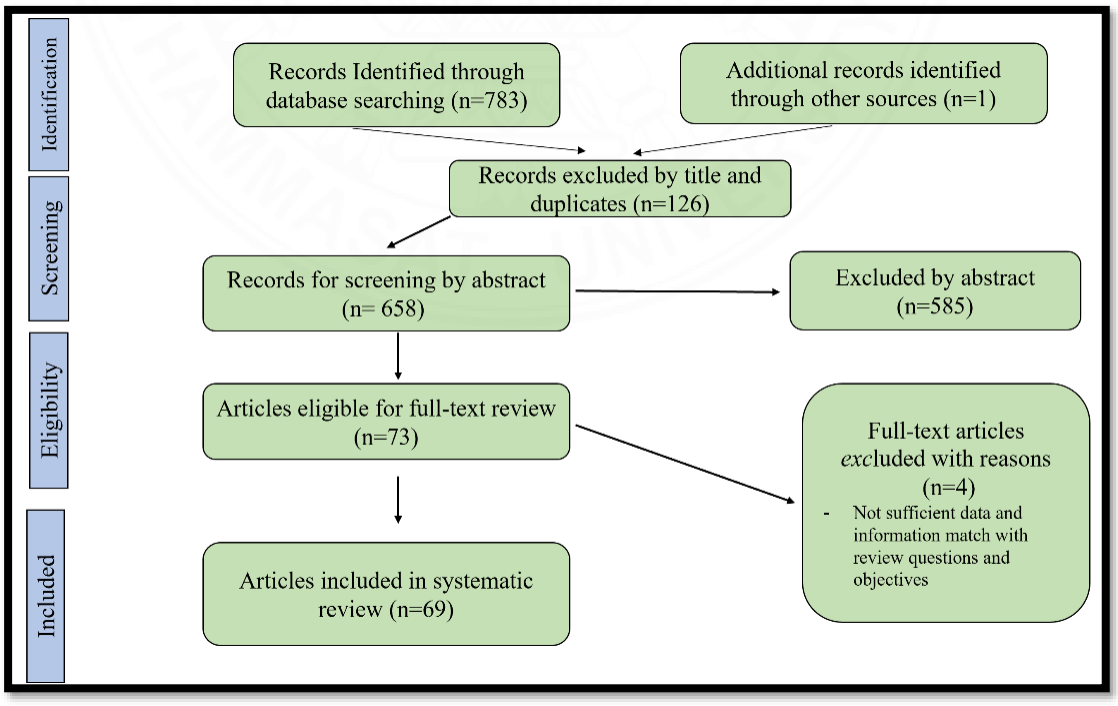


Figure 3.1 PRISMA chart

### 3.4.1 Data Matrices

Matrix tables were used to summarize the details data and information from the chosen resources such as literature, project reports, situation reports, etc., according to the inclusion and exclusion criteria already mentioned. The following matrixes were used in the process of the systemic documentary review.

#### 3.4.1.1 Data Processing Matrix

Table 3.2 Data Processing Matrix

| Author and Publication Year | Title | Source | Type of document | Country | Categories |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

#### 3.4.1.2 Data Analyzing Matrices for Research Objective 1

Table 3.3 Data Analyzing Matrix for Research Objective (1)

| Country and Refugee Population | Religion And Language | Patriarchal norms and values | Traditional practice/ beliefs | Religious norms |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Table 3.4 Data Analyzing Matrix for Research Objective (1)

| Country | Religion | Patriarchal norms and values | Other Sociocultural information | Relationship with refugees |
|---|---|---|---|---|
| Bangladesh | | | | |
| Thailand | | | | |
| Malaysia | | | | |

### 3.4.1.3 Data Analyzing Matrix for Research Objective 2

Table 3.5 Data Analyzing Matrix for Research Objective (2)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| Provided Institution | Humantiarian organization | Host | Humantiarian organization | Host | Humantiarian organization | Host |
| ANC | | | | | | |
| Delivery | | | | | | |
| PNC | | | | | | |
| FP | | | | | | |
| HIV | | | | | | |
| Adolescent SRH | | | | | | |
| STD | | | | | | |
| GBV (clinical service) | | | | | | |
| GBV (psychosocial support) | | | | | | |
| GBV prevention | | | | | | |
| Shelter | | | | | | |
| Safe space | | | | | | |
| Abortion | | | | | | |
| PAC | | | | | | |
| Referral | | | | | | |
| 24-hour services | | | | | | |

#### 3.4.1.4 Data Analyzing Matrix for Research Objective 3

Table 3.6 Data Analyzing Matrix for Research Objective (3)

| MISP | Bangladesh | Malaysia | Thailand |
|---|---|---|---|
| Ensure the Health Sector/Cluster identifies an organization to lead implementation of the MISP | | | |
| Prevent sexual violence and respond to the needs of survivors | | | |
| Prevent the spread of and reduce morbidity and mortality due to HIV and other STIs | | | |
| Prevent excess maternal and newborn morbidity and mortality | | | |
| Prevent unwanted pregnancies | | | |
| Plan for comprehensive SRH services and integrate into primary health care as soon as possible by working with the Health sector/ Cluster partners to address the six health system building blocks | | | |

### 3.5 Data Analysis Framework

After the data collection process, the following data analysis framework was used to justify the research objectives. The figure shows the complete process of data summarizing, analysis, and the study method to obtain the results of the research objectives.

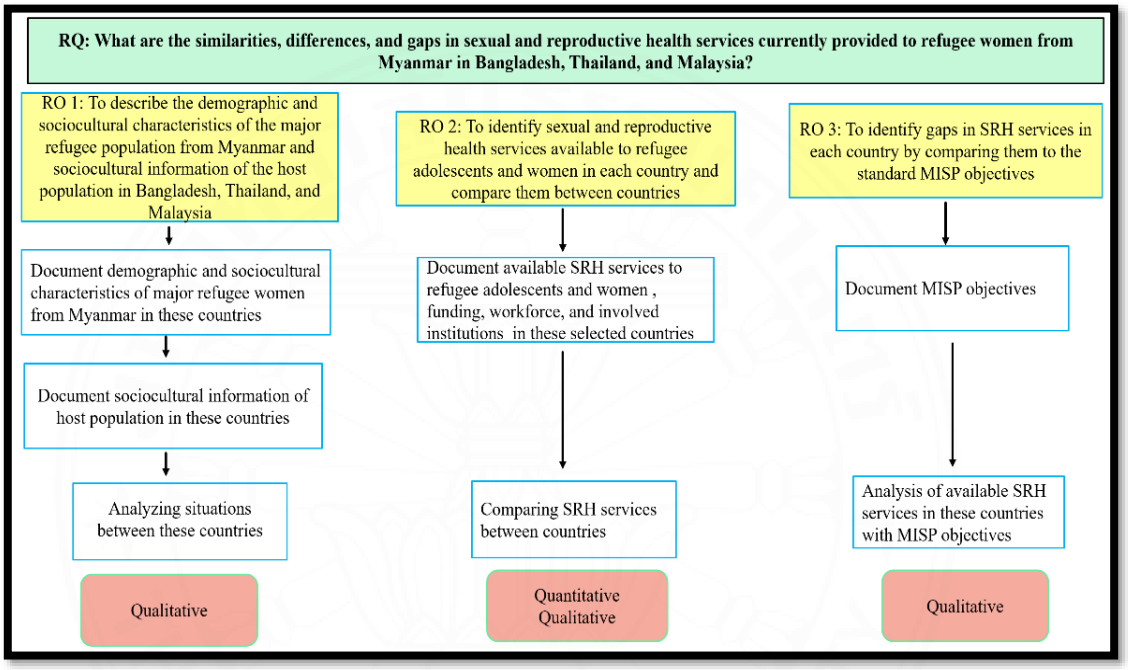


Figure 3.2 Data analysis framework

# CHAPTER 4
# FINDINGS

## 4.1 Demographic and Socio-cultural Characteristics

### 4.1.1 Refugee Population from Myanmar

Refugees from Myanmar were generally categorized as Rohingya refugees in Bangladesh (UNHCR, 2023e). In June 2023, major refugee population in Thailand was Karen , Karenni and Burmese in the UNHCR report (UNHCR Thailand MCO, 2023). In July 2023 report of UNHCR Malaysia, major refugee population was Rohingyas and Chins (UNHCR, 2023a).

Most Karren follow Buddhism or Animism, while some follow Christianity (KWO, 2021). Karen and Karenni are closely related and Karenni also follows diverse religions (Niwitkulnipa, 2019). The religions of Chin and Burmese are Christianity and Buddhism respectively (Lian, 2021). Karen languages are Pwo and Sgaw (KWO, 2021). Karenni and Chin speak their native languages (Lian, 2021; Niwitkulnipa, 2019). Most Rohingyas follow Islam and their language is similar to Bangladeshi (Hossain & Hossain, 2023). Premarital sex and intimacy are not allowed in the Christian, Muslim, and Buddhist religions, and also in Burmese culture. Single pregnant women are stigmatized. They are reluctant to discuss SRH information in their culture. Gender inequality and strict gender roles are present in all ethnicities (Asnong et al., 2018; Jannat et al., 2022; Kumar et al., 2021).

#### 4.1.1.1 Distinct Karen Sociocultural Information

Karen women felt a social bonding with the Karen Women's Organization (KWO) (Bloomfield-Wong, 2021). The social hierarchy of age is present. Doctors are perceived as having high social status. Home delivery is a traditional practice, and women are convenient with female healthcare providers (Migrant Information Centre, 2018).

#### 4.1.1.2 Distinct Karenni Sociocultural Information

Karenni use traditional healing practices and sickness is perceived as losing souls among them (Niwitkulnipa, 2019).

#### 4.1.1.3 Distinct Burma Sociocultural Information

The customary practice of restricting women's entry to temples persists in Burmese (Naujoks & Ko, 2018).

#### 4.1.1.4 Distinct Chin Sociocultural Information

The bride price is the traditional marriage practice. In customary laws, men are permitted to initiate divorce and use physical violence against their wives. If women initiate divorce, their family must return the bride price, leaving men in ownership of all property and children's custody. Violence was considered a forgivable act (Soe, 2021).

#### 4.1.1.5 Distinct Rohingya Sociocultural Information

Contraception was considered a sin and permitted only to pause. High fertility, arranged early marriage, home delivery, and dowry are traditional practices. Restriction of movement and exposing the body of women, allowance of polygamy, following husband decision and strict gender roles were present in religious norms (Hossain and Hossain 2023). SGBV is a privacy issue and examination of private areas of the body by a younger doctor is taboo in local culture (ISCG 2019, Jannat, Sifat et al. 2022). The harmful practice of taking survivors to the place of their assault to corroborate their complaints was seen in Rohingya (UNHCR CARE and ActionAid 2020).

### 4.1.2 Host Population

Population in Malaysia and Bangladesh follow Islam and Thais practice Buddhism (Bangladesh Bureau of Statistics 2022, Office of International Religious Freedom 2022, Office of International Religious Freedom 2022). Premarital sex is not allowed in all countries (Ali 2018, Zulkarnain, Fariduddin et al. 2021, Wiwatkamonchai, Mesukko et al. 2023) HIV stigmas were present in all host societies (Sern 2018, Alifah Zainuddin 2022, Chautrakarn, Ong-Artborirak et al. 2023). Framing of SGBV was a private matter and patriarchal norms and values were present in all countries(WAO 2021, Jirada Phetlam 2022, Hossain and Hossain 2023). There was victim blaming attitudes in Thailand and Malaysia regarding SGBV (Elle 2021, WAO 2021). Abortion is taboo in Bangladesh and Malaysia (Ali 2018, Zulkarnain, Fariduddin et al. 2021). Normalization of SBV in entertainment industry was present in Thailand (Elle 2021). Prevalence of child marriage, contraceptive opposition and improvement of social status after child birth were seen in Bangladesh society (Hossain and Hossain 2023).

Movement restriction was present in Bangladesh society (Sarker, Saha et al. 2020). Misconception of menstruation, contraception and MCH services still remained in indigenous communities of Bangladesh (Ahmmed, Chowdhury et al. 2022). Herbal medicinal use and TBA delivery are traditional practices in Bangladesh(Aktar, Ahmed et al. 2020). Laws restricting marriage between citizens and refugees are present in Bangladesh, and the registration of new marriage has been suspended in Malaysia (Razali & Mamat, 2019; UNHCR CARE and ActionAid, 2020). Discrimination and xenophobia against refugees are pervasive in Malaysia (UNICEF Malaysia 2022).

### 4.1.3 Analysis of Sociocultural Information

Table 4.1 Data Analyzing Table of Sociocultural Information of Refugees from Myanmar

| **Country and Refugee Population** | **Religion And Language** | **Patriarchal norms and values** | **Traditional practice/ beliefs** | **Religious norms** |
|---|---|---|---|---|
| Bangladesh, Rohingya | Islam Rohingya | Strict gender roles, Son preferences, Upholding strict adherence of Shariah regulations for women by male | Arranged early Marriage, Polygamy, Dowry, High fertility, Physical examination of private areas by younger healthcare provider (taboo), Home delivery with female TBA, | Contraceptive usage and premarital sex (sin), Child (blessing, protection), movement restriction Permission of one man to marry four wives, carrying disabled women in public spaces is inappropriate. |
| Malaysia, Rohingya | Islam Rohingya | | | |

Table 4.1 Data Analyzing Table of Sociocultural Information of Refugees from Myanmar (Continue)

| **Country and Refugee Population** | **Religion And Language** | **Patriarchal norms and values** | **Traditional practice/ beliefs** | **Religious norms** |
|---|---|---|---|---|
| | | | Institutional delivery (lack of courage), SGBV (private matter) SRH discussion (shameful) | |
| Malaysia, Chin | Christian Chin | Rigid gender roles, | Bride price (legal marriage), In Chin customary law, men can initiate divorce and have the property ownership and child, and women have to return the bribe price, Silence of SGBV | rape as a forgivable Prohibition of premarital sex |
| Thailand, Karen | Buddhism Animism Christian Pwo and Sgaw | Rigid gender roles, social hierarchy of age, doctors (high social status) | misconception of contraception, prefer to same gender, home delivery with TBA | Prohibition of premarital sex |

Table 4.1 Data Analyzing Table of Sociocultural Information of Refugees from Myanmar (Continue)

| **Country and Refugee Population** | **Religion And Language** | **Patriarchal norms and values** | **Traditional practice/ beliefs** | **Religious norms** |
|---|---|---|---|---|
| Thailand, Karreni | Christian Buddhist Animism Karreni | Rigid gender roles | traditional healing, Sickness is perceived as losing souls, Kay Jar (authority) | Prohibition of premarital sex. Single pregnancy (stigma) |
| Thailand, Burmese | Buddhism Burmese | Rigid gender roles, | | Restriction to temple. Prohibition of premarital sex Unmarried pregnant (stigma). |

Table 4.2 Data Analyzing Table of Sociocultural Information of Population in Bangladesh, Thailand and Malaysia

| **Country** | **Religion** | **Patriarchal norms and values** | **Other Sociocultural information** | **Relationship with refugees** |
|---|---|---|---|---|
| Bangladesh | Islam (91.04%) | Strict gender roles, improvement of social status after childbirth, movement restriction | Child marriage Misconception of abortion, institutional delivery, contraception Home delivery with TBAs, movement restriction | prohibition of marriage between citizen and Rohingya refugees and result in detention, Perceived |

Table 4.2 Data Analyzing Table of Sociocultural Information of Population in Bangladesh, Thailand and Malaysia (continue)

| **Country** | **Religion** | **Patriarchal norms and values** | **Other Sociocultural information** | **Relationship with refugees** |
|---|---|---|---|---|
| | | from husband and mother-in-law | Traditional medicinal use for SRH<br>stigma of HIV<br>Prohibition of premarital sex and contraceptive usage,<br>Postponing first birth after were labeled as infertile.<br>Abortion is not acceptable. | Rohingya as the culprit and their religion as regression. |
| Thailand | Buddhism (85-95%) | rape between relationships (right of men), preventing SGBV is the duty of women. | stigma of accessing SRH services by single and adolescents.<br>Premarital sex is not allowed.<br>Society judgment.<br>Perception of SGBV as a private matter.<br>entertainment industry normalizes SGBV,<br>Victim blaming attitude.<br>HIV stigma is present.<br>Abortion is acceptable. | No data |

Table 4.2 Data Analyzing Table of Sociocultural Information of Population in Bangladesh, Thailand and Malaysia (continue)

| **Country** | **Religion** | **Patriarchal norms and values** | **Other Sociocultural information** | **Relationship with refugees** |
|---|---|---|---|---|
| Malaysia | Islam (61.3%) | Strict gender roles, believing men stories in the relationship | Violence (a temporary emotional act) and victim blaming attitude, SGBV as a private matter, premarital sex and abortion is not permitted, HIV stigma | Xenophobia, Discrimination, Suspension of marriage between citizen and refugees |

Patriarchal norms and values are present in all societies. Of all the refugee communities, gender inequality was the strongest in Rohingya communities. Polygamy and high fertility preference was only present in Rohingya communities. Physical examination was taboo only in Rohingya communities. TBA preference was seen in Rohingyas and Karens. Chin and Rohingya communities shared similar traditional marriage practices. Similarity of language was only seen between Rohingyas and Bangladeshi among the host countries in the study.

Bangladesh was the strictest in patriarchal norms and value among the host countries. Moreover, TBA preference, child marriage, contraceptive opposition were only visible in Bangladesh. Misconception of menstruation, contraception and MCH services were only prevalent in Bangladesh. Thailand has flexible gender roles among three countries. However, normalization of SBV in entertainment industry is the distinct phenomenon in Thailand. Regarding marriage between citizens and refugee communities, restriction was present in Thailand and Malaysia but (Razali and Mamat 2019, UNHCR CARE and ActionAid 2020). There was no data for this issue in Thailand. Abortion was acceptable only in Thailand among the host countries.

## 4.2 Available SRH Services to Refugee Women and Girls from Myanmar

### 4.2.1 Bangladesh

The health facilities in Cox's Bazar were 77 health posts, 45 primary health centers (PHCs), three comprehensive emergency obstetric and newborn care (CEmONC) facilities, and 8 secondary facilities. With 82% facility-based deliveries and 2,556 facility-based births, the current ratio of one PHC facility per 7,628 individuals adheres to the standard of 1 per 10,000. All health facilities remain within a 30-minute walking distance (Health Sector 2023).

The Gender-Based Violence Sub-Sector (GBVSS) operates within the Inter-Sector Coordination Group (ISCG) comprehensive humanitarian coordination structure, functioning under the Protection Sector led by UNHCR. In Cox's Bazar, GBVSS comprises over 60 member organizations spanning UN, INGO, NGO, and government agencies. The GBVSS maintains close cooperation with various groups, including the Health Sector (UNFPA 2022). Regular attendance at monthly meetings is anticipated from GBVSS members. Reporting to the Protection Sector and ISCG is the responsibility of the GBVSS lead, covering received reports, decisions, and actions taken (UNFPA 2022). Data on the reproductive health of refugee women and girls in Bangladesh was present in the Integrated Refugee Health Information System (iRHIS) data portal system (UNHCR 2023).

UNFPA leads the Sexual and Reproductive Health Working Group (SRH WG), which consists of more than 40 partners, including government entities, NGOs, INGOs, and UN agencies. The group conducts quarterly meetings and reports on SRH data, including the availability of SRH services, utilization rates, and capacity-building efforts within the Health Sector (SRH Working Group 2023). Various SRH services were offered by many humanitarian organizations from their facilities and local health infrastructures in Cox's Bazar and Bhasan Char.

In Cox's Bazar, ANC (antenatal care) was offered by UNHCR, Green Hill, IRC, and MSF. MSF, UNHCR, and IRC provided delivery services. UNHCR offered 24-hour services from 28 healthcare facilities, and BDRCS offered from a field hospital and MHCH at Tenaf in Cox Bazar. Referral service was provided by IRC, BDRCS, UNHCR, and Green Hill organizations. IRC supported thirteen referral hubs and

BDRCS provided services from 13 health infrastructures in Cox's Bazar. PNC was provided by UNHCR and Green Hill in Cox's Bazar. UNHCR, Green Hill, IRC, BDRCS, MSF, IOM, and Ipas provided comprehensive family planning (UNHCR 2021, UNHCR 2022).

Ipas offered family planning from 49 healthcare facilities and BDRCS also offered from 5 health posts (Ipas 2022). HIV counseling and testing services were offered by IOM and STD services were provided from the health facilities of IRC in Cox's Bazar. In 2021, there were 13 government hospitals offering PMTCT services with the help of UNICEF (The Bangladesh Today 2021)UNHCR, IRC, and MSF provided adolescent-friendly SRH services in Cox's Bazar. IRC also provided post-abortion services. GBV services were provided by Green Hill, UNICEF, IRC, IOM and BDRCS (CPI 2021, IRC 2022, BDRCS 2023, MSF 2023). IRC established 42 women-friendly spaces and three women and girl safe spaces (WGSS) for GBV survivors. Integration of SRH and women's protection services were available at WGSS. BDRCS also offered child-friendly spaces, a DAPS center, and a Community safe space (IRC 2022). IOM provided comprehensive GBV services in Ukhiya and Teknaf (IOM 2023).

In Bhasan Char, ANC and PNC were offered by UNFPA, Friendship, and Caesarean delivery was provided at one facility by Friendship. Family planning was offered by UNFPA, Friendship, and Ipas. Ipas also provides abortion services at a 20-bed hospital. Only UNHCR provided safe space and GBV risk and SRH awareness programs (Raeed Abd-Allah Chowdhury 2022, UNFPA 2023).

UNHCR supported supplies and human resources to MOH hospitals in Bhasan Char and also opened Ukhiya Specialized Hospital and new OPD at Sadar District Hospital in Cox's Bazar (UNHCR 2022). MSF supported nine healthcare facilities comprising three hospitals, four primary health centers, and two specialized clinics within the Cox's Bazar district. (MSF 2018, MSF 2023) BDRCS supported thirteen health infrastructures in Cox Bazar for SRH services, referral services, and MHPSSA provision (BDRCS 2023). Friendship has established a 12-bed PHC, accompanied by three units at a 20-bed government hospital in Bhasan Char (Raeed Abd-Allah Chowdhury 2022). IOM assisted 39 primary and secondary healthcare establishments in Cox's Bazar. IOM established 78 accessible entry points for GBV case management, including 52

safe spaces for women and girls at the end of 2018 (IOM 2023). IRC supported four PHCCs and one comprehensive SRH infrastructure in January 2022 (IRC 2022).

In the Cox's Bazar refugee camps, CHWG collaborates with community health workers in providing information about available health services, monitoring high-risk pregnancies, and facilitating hospital delivery and referrals. So, the percentage of facility-based deliveries has significantly risen from 12% in 2018 to 70% in 2021 in the UNHCR report (UNHCR, 2021a). UNICEF also offered training on HIV and STD prevention and transmission for healthcare workers of four Upazila Health Complexes and camps health facilities (UNICEF 2023). IOM is also involved in the capacity building of GBV services. Friendship also conducted community health awareness programs (Raeed Abd-Allah Chowdhury 2022). BRAC, RTM International, and Plan International offered SRH improvement awareness and training programs. Some NGOs offered sanitary napkins (Jannat, Sifat et al. 2022). UNICEF initiated the Reaching Every Pregnant Mother and Newborn (REMN) strategy in Ramu Upazila to ensure quality ANC services and safe deliveries (UNICEF 2023). UNFPA introduced the SASA! Together approach for GBV and established An Adolescent and Youth Centre for MHPSS support and information on GBV and SRH (UNFPA 2023).

### 4.2.2 Thailand

UNHCR partners with the Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT), a coalition of NGOs responsible for providing essential services including SRH services to refugees in nine border camps (UNHCR 2023) .

Thirteen NGOs, operating under CCSDPT and the Ministry of Interior, deliver humanitarian aid across various sectors to camp refugees. The Health Sub-Committee and HIS Coordinator operated under CCSDPT. The HIS tracks the health status of these people. H IS database was transitioned to iRHIS in 2019 (CCSDPT 2021). The Health Sub Committee under CCSDPT comprises MI, IRC, COERR, DARE, and HI. Typically, meetings are convened every two months in Mae Sot. (CCSDPT 2023).

IRC and MI are the main service providers for MCH services at their health facilities in the camps. MI provided ANC, delivery, PNC, HIV and syphilis testing during ANC, clinical GBV services and referral services in the Mae La Oon and Mae Ra Ma Luang

shelters and IRC also delivered these services with additional comprehensive family planning in Ban Mai Nai Soi, Ban Mae Surin, Mae La, Umpiem, Nupo, Ban Don Yang, and Tham Hin (CCSDPT 2021). The referral rates in Mae Ra Ma Luang and in Mae Ra Ma Luang were 38% and 54% respectively.

For SGBV services, no reported survivor received PEP, ECP and STI treatment within standard time (CCSDPT 2021). MTC provided comprehensive family planning focusing on LARC, gynecology, delivery, ANC, PNC, PAC, delivery services, neonatal care, counseling, free testing for HIV and syphilis, PMTCT and referral services. The inpatient Department comprises 52 beds and is well equipped with laboratories and USG. MTC facilitated in registering positive PMTCT cases to government hospital for free HIV testing. MTC cannot offer free for full MCH care (MTC 2019).

KWO conducts training TBAs and providing single use maternity kits to TBAs in Mae Ra Ma Luang and Mae La Oon. KWO also conducted community education sessions on MCH (KWO 2023). BHF delivered MCH services together with screening of HIV, syphilis, adolescent SRH awareness, locally accepted family planning methods delivery assistance with TBAs and referral services along the Thailand-Myanmar border. The medical staff were trained to be sensitive to refugees' language and culture (BHF 2023). Tzu Chi Thailand launched a monthly medical outreach program including gynecological care and SRH education with interpreters to urban refugees in Bangkok (Buddhist Tzu Chi Foundation 2023). UNHCR offered comprehensive GBV services including legal counselling and interpreter support in the camp refugees. UNHCR partnered with COERR in facilitating medical referrals and psychosocial counselling to urban refugees and initiated EMAP project in five camps and urban. Serious SGBV survivors received OSCC services from government hospitals (UNHCR 2023,). Safe abortion referral system was present in Northern Thailand to public hospitals or private clinics (IAWG n.d.).

#### 4.2.3 Malaysia

UNHCR collaborated closely with partners involved in health initiatives in Malaysia in planning, coordination, monitoring, and evaluation, focusing on PHC and facilitating secondary hospital care. UNHCR was proactive in securing affordable HIV medications (UNHCR 2023). UNHCR coordinated with relevant stakeholders to enhance service coverage and quality convened SGBV Working Group meetings,

and fostered discussions on service delivery. In GBV sector collaboration, UNHCR and the International Catholic Migration Commission (ICMC) are working on case management, expanding the reach of the relevant SOP through community dissemination and skill development. UNHCR led the implementation of the Gender-Based Violence Information Management System (GBVIMS) to manage effectively SGBV survivors with partners by disseminating collected and stored data(UNHCR 2023).

ANC was provided by NGO clinics in KL, Selangor, Pulau Pinang and Johor for free and 2.15-5 USD per visit. Comprehensive family planning was provided by Federation of Reproductive Health Associations, Malaysia (FRHAM) across Malaysia and NGO clinics also offered in KL, Selangor and Johor with free and costs (UNHCR 2023, FRHAM 2023,). 7 shelters by NGO and one shelter by WAO for SGBV survivors were present in Selangor and these were overcrowding and inadequate resources (Lee Wei San and Yasmin Masidi 2019).

HIV testing and counselling was provided by PT foundation in KL with cost and also by FHRAM across Malaysia (UNHCR 2023). UNHCR established virtual safe spaces, psychosocial support with native language, referral services and assistances (UNHCR 2022). Tenaganita provided legal and psychosocial services, GBV prevention services (Tenaganita 2022). MSF also involved in referral services as focal points and HCV services (MSF 2022). FRHAM also offers specialist SRH care, abortion referral services, STI testing and cervical cancer screenings and offering all services from 13 primary centers and 13 sub centers across Malaysia (FRHAM 2019). Malaysian Social Research Institute (MSRI) also involved in GBV prevention and response services, capacity building and community based program, Women and Girls Protection Project (WAGAR) and Enabling Men through Accountable Practices (EMAP) projects (MSRI 2023).

### 4.2.4 Analysis of Available SRH Services

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| ANC | Cox's Bazar - UNHCR, Green Hill, IRC (4), MSF Bhasan Char- UNFPA, Friendship | | Camp refugees MI-Mae La Oon and Mae Ra Ma Luang , IRC - the rest 7 camps, MTC, BHF- along Thailand Myanmar Border | | Tzu Chi Clinic, Mercy Malaysia (2.15 USD per visit) in KL & Selangor, NGO- Pulau Pinang, IMARET -Johor (2.15 USD), !2NGO -Selangor (1 NGO provide 5 USD per visit), MSF, FHRAM | |
| Delivery | Cox's Bazar- UNHCR, IRC (1), MSF Bhasan Char - UNFPA, Friendship | | Camp refugees MI-Mae La Oon and Mae Ra Ma Luang, IRC - the rest 7 camps, MTC, BHF- along Thailand Myanmar Border | Advanced Obstetric case | | Normal delivery (1072 USD), Caesarean (2144 USD), Deposit (700-850 USD) |

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia (continue)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| PNC | Cox's Bazar - UNHCR, Green Hill Bhasan Char- UNFPA, Friendship | | Camp refugees MI- Mae La Oon and Mae Ra Ma Luang, IRC - the rest 7 camps, MTC, BHF- along Thailand Myanmar Border, | | | |
| FP | Cox's Bazar - UNHCR, Green Hill, IRC, BDRCS (5), MSF, IOM, Ipas (49) Bhasan Char - UNFPA, Ipas, Friendship | | Camp refugees IRC - the rest 7 camps, MTC- along Thailand Myanmar Border | | 1 NGO- Selangor, Tzu Chi Clinic, Mercy Malaysia in KL & Selangor, IMARET - Johor (2.15 USD), 2NGO -Selangor (1 NGO provide with cost), FHRAM (comprehensive) | |

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia (continue)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| HIV | IOM (counselling and testing) | 13 ho-spitals | Camp refugees MI-Mae La Oon and Mae Ra Ma Luang, IRC - the rest 7 camps (testing ANC), MTC, BHF (testing)- along Thailand Myanmar Border | Free HIV testing | FHRAM (testing), PT - KL (screening and counselling) | Treatment free |
| Adolescent SRH | UNHCR, IRC, MSF | | BHF- along Thailand Myanmar Border | | | |
| STD | IRC | | Camp refugees MI-Mae La Oon and Mae Ra Ma Luang, IRC - the rest 7 camps (testing syphilis ANC), MTC, BHF (testing)- along Thailand Myanmar Border | | FHRAM (testing) | Syphilis treatment free |

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia (continue)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| GBV (clinical service) | MSF, IOM | | | OSCC | | OSCC (police report demanding) |
| GBV (psychosocial supoort) | UNHCR, BDRCS (3), MSF, IOM | | UNHCR-camp and urban | | MSRI, Tenaganita, UNHCR (native language) | |
| GBV prevention | Green Hill, UNICEF, IRC, IOM | | UNHCR _ camp and urban | | MSRI, Tenaganita, UNHCR | |
| Shelter | IOM | | UNHCR | | NGO (7), WAO (1)- Selangor | 35 - Selangor |

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia (continue)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| Safe space | IRC - 42 women's - friendly spaces, 3women and girl safe spaces (integrated SRH and women protection services), BDRCS- Child-friendly space, DAPS center, Community safe space, IOM- (raise awareness), WGSS (9), UNFPA (safe space, risk and SRH awareness in Bhsan Char), IOM | | UNHCR | | UNHCR (virtual) | |
| abortion | Cox's Bazar- IRC, Ipas Bhasan Char - Ipas (20 bed hospital) | | | | | |
| PAC | IRC | | MTC- along Thailand Myanmar Border | | | |

Table 4.3 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia (continue)

| **Countries** | **Bangladesh** | | **Thailand** | | **Malaysia** | |
|---|---|---|---|---|---|---|
| **Provided Institution** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** | **Humanitarian Organizations** | **Host** |
| referral | UNHCR, Green Hill, IRC (13), BDRCS (13) | | Camp refugees MI-Mae La Oon and Mae Ra Ma Luang, IRC - the rest 7 camps, MTC, BHF, - along Thailand Myanmar Border, | | MSF, UNHCR and MSRI (GBV survivors), FHARM (abortion) | |
| 24-hour services | UNHCR, BDRCS (field hospital and MHCH | | | | | |

### 4.2.5 Similarities and Differences in Available SRH Services

Humanitarian organizations are the main providers of SRH services and a wide range of GBV services were available in all countries. MCH and family planning were another focused area. Comprehensive MCH services were available to camp refugees in Bangladesh and Thailand. HIV testing and treatment were free in Thailand and Malaysia. HIV prevention and training program were observed in Bangladesh and MTC only. TBA training and support were found in Bangladesh and Thailand. Inequities in available services to refugee women and girls were present in all countries.

Of the three countries, SRH services provision through local healthcare infrastructures are present in Bangladesh only. Integration of SRH and GBV, abortion services and comprehensive SRH services are available in Bangladesh only. Moreover, significant number of adolescents friendly SRH services, right based approach and, disability inclusivity was found in Bangladesh only. UNHCR established virtual safe spaces for GBV survivors in Malaysia only(UNHCR 2022).

### 4.2.6 Gaps in Available SRH Services

#### 4.2.6.1 Bangladesh

Most of SRH reports for Bangladesh refugee women and girls were focused on Cox Bazar. Inequitable distribution of services was seen in Bhasan Char. Most of SRH services were shared by host and refugee women and girls in Bangladesh. There are also inequities in delivery facilities between BEmONC and CEmONC in Cox's Bazar. This imbalance also applied to Bhasan Char. There were limited HIV and STD treatment services even in Cox's Bazar.

#### 4.2.6.2 Thailand

There were inequities in available SRH services to camp refugees and urban refugees in Thailand.

**(1) Camp Refugees**

No abortion and PAC were not available in camps. There was no data for HIV and STD services of refugee women and girls apart from ANC screening in the camps. Moreover, lack of data and information for 24-hour services and supplies and workforce at referral hospitals. Contraceptive needs of Mae La Oon and Mae Ra Ma Luang were not met because of lack of services.

Access to clinical services for SGBV survivors was zero percent in the refugee camp in Thailand in 2021(CCSDPT, 2021). There were referral services to government hospitals for complicated labor, HIV and OSCC service but there was no information specifically for available SRH service for them in government hospitals. Poor referral service in Mae La Oon and Mae Ra Ma Luang camps can delay timely intervention for complicated cases.

**(2) Urban Refugees**

Unfortunately, urban refugee women and girls were outside of the SRH service arena in Thailand except for GBV services provision by UNHCR.

**4.2.6.3 Malaysia**

NGOs do not offer 24-hour services, PAC, abortion services, PNC and delivery services in Malaysia. Accessing delivery services and OSCC in government hospital was pricey for them. Most NGO clinics offering SRH services were not free and prevalent in KL and Selangor. FHRAM is the main NGO offering a wide range of SRH services and wide geographical coverage (FRHAM, 2023). There was inequitable presence of safe shelter for SGBV survivors.

## 4.3 Analysis of Available SRH Services in Bangladesh, Thailand and Malaysia with MISP Objectives

Table 4.4 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia with MISP Objectives

| MISP | Bangladesh | Thailand | Malaysia |
|---|---|---|---|
| Ensure the Health Sector/Cluster identifies an organization to lead implementation of the MISP | UNFPA leads SRH working groups in Bangladesh. Regularly meet with SRH stakeholders in Bangladesh virtually or in person. Quarterly reporting SRH data (availability of SRH services, utilization, and capacity building) to the Health Sector. | No data | No data |
| Prevent sexual violence and respond to the needs of survivors | GBV sub-sector was also led by UNFPA and had monthly regular meetings for operations updates, GBV-SRH integration. Relevant data from the GBV sub-sector were reported to the | **Camp refugees** OSCC service (+) in government hospital. Safe space, shelter, psychosocial support, emergency medical care, legal assistance, referral services (+) | OSCC service was available in government hospital. |

Table 4.4 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia with MISP Objectives (continue)

| MISP | Bangladesh | Thailand | Malaysia |
|---|---|---|---|
| | protection sector and ISCG. Both subsectors closely worked with health sectors. Safe space, shelter, psychosocial support, referral services and clinical services of GBV survivors were available. | **Urban refugee** Referal services and psychosocial support (+) | |
| Prevent the spread of and reduce morbidity and mortality due to HIV and other STIs | HIV counseling, testing and services, STD services, and PMTCT services (+) Condoms were accessible. STD services (+) in the GBV survivor response. | PMTCT services, HIV counseling and STD services (+) and referral to a Thai government hospital. Condoms were also accessible. | HIV counseling, testing and services, PMTCT, and STD services (+) in government hospitals and some NGO clinics. Condoms were accessible. |
| Prevent excess maternal and newborn morbidity and mortality | 3 CEmONC and 28 BEmONC (+). PAC (+) in Cox Bazar and Bhasan Char. | BEmONC and CEmONC and referral services (+) in the camps and along Thailand Myanmar border. | No BEmONC and CEmONC., 24-hour service and referral system. |

Table 4.4 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia with MISP Objectives (continue)

| MISP | Bangladesh | Thailand | Malaysia |
|---|---|---|---|
| | 24-hour services (+).<br>referral system (+) but limited in Bhasan Char.<br>community engagement and facilitation for facility delivery (+) | Single use maternity kits were provided in the camps. | |
| Prevent unwanted pregnancies | Comprehensive FPs (+) in 49 health facilities in Cox Bazar and a 20-bed hospital in Bhasan Char. Adolescent-friendly SRH services (+)<br>FP services and counselling (+) | **Camp refugees**<br>Comprehensive FP (+) in 7 out of 9 camps and along the Thailand-Myanmar border,<br>no data about FP counselling in the camps.<br>no data of FP in Mae La Oon & Mae Ra Ma Luang<br>Adolescent SRH awareness program (+)<br>**Urban refugees**<br>SRH information sharing | Comprehensive FP (+) only in FRHAM.<br>no adolescent friendly services |

Table 4.4 Data Analyzing Table of Available SRH Services in Bangladesh, Thailand and Malaysia with MISP Objectives (continue)

| MISP | Bangladesh | Thailand | Malaysia |
|---|---|---|---|
| Plan for comprehensive SRH services and integrate into primary health care as soon as possible by working with the Health sector/ Cluster partners to address the six health system building blocks | SRH data (+) at iRHIS Comprehensive SRH service was integrated into PHC. | SRH data of camp refugees (+) at iRHIS | No data. |

Among the three countries, Bangladesh partly fulfilled six MISP objectives. Data in Malaysia and Thailand was lacking and showed poor quality for some objectives in MISP. Malaysia only fulfilled three MISP objectives. Thailand fulfilled five objectives for camp refugees and only one objective for urban refugees.

There was no comprehensive data and information about HIV and STD services, safe blood transfusion in all countries and there was limited data and information of SRH services in Bhasan Char in Bangladesh.

In Malaysia, information of services provided by NGO was poor. There was lack of comprehensive information for clinical service of SGBV, HIV and STD in Thailand refugee camps. There was no information and data for urban refugees except provided GBV services by UNHCR. Moreover, there was lack of data for SRH governance and leadership for implementation MISP in Thailand and Malaysia. In summary, Bangladesh has the highest potential to provide comprehensive SRH services and Cox' Bazar had been progressed.

# CHAPTER 5
# DISCUSSION

## 5.1 Research Objective 1

Research objective 1 was to describe the demographic and sociocultural characteristics of the major refugee population from Myanmar and sociocultural information of host population in Bangladesh, Thailand and Malaysia.

Sociocultural factors play a critical role in determining SRHR and also impact the acceptability and accessibility of SRH services. Understanding sociocultural factors is essential for tailoring services to meet the distinct needs and preferences of individuals and communities.

### 5.1.1 Refugee Population

Among the Rohingya, male preferences may result in the oppression of and even violence against women due to the birth of daughters. The prevalence of teenage pregnancies is attributed not only to sociocultural practices but also to the lack of a defined legal age for marriage. Although international human rights law prohibits child and forced marriages, there are still gaps in upholding these rights by duty bearers. Movement restriction of Rohingya women impacts access to information about SRHR and the services available to them.

The acceptance of GBV in Chin and Rohingya communities, hindering reporting and seeking help. The marriage customs in Chin and Rohingya reinforces patriarchal norms, limiting women's agency in matters of SRH. Misconceptions of SRH services impact their health capability. The presence of distinct age hierarchies in Karen may limit access to SRH information and services among adolescents.

Karenni preference for traditional healing practices could undermine the importance of SRH services and deter them from accessing. These traditional practices are influenced not only by ancestral norms but also by experiences of inadequate or poor healthcare infrastructure in their places of origin and limited education, leading to low health literacy. The practices of TBA among Rohingya and Kayin communities point out the importance of providing culturally accepted SRH services.

The study uncovered significant disparities in the availability of disaggregated age and gender data for Rohingya refugees and urban refugees in Thailand, reflecting a lack of acknowledgment in policies and a disregard for their unique needs. Notably, the presence of the KWO among Karen refugees in the camps and the high satisfaction of refugee women with this organization highlights the strong social bonds within the same ethnic group and same gender. It underscores the organization's focus on women and its provision of culturally sensitive services tailored to their specific requirements.

### 5.1.2 Host Population

#### 5.1.2.1 Bangladesh

Shared language between Rohingyas and Bangladeshi facilitate social interactions and access to information about available services. Traditional medicinal practice is a barrier to accessing modern SRH services. A unique finding was the prohibition of marriage between refugees and citizens, irrespective of their shared religion. This reflects a discriminatory policy under the notion of nationality, undermining SRHR within the policy framework. Additionally, there was a notable trend of the host population expressing criticism towards refugees, potentially stemming from competition over resources and services due to the country's challenging economic situation.

#### 5.1.2.2 Thailand

Thailand exhibits more flexible gender roles compared to others in the study, possibly due to evolving perceptions over time and the influence of Western and modernized cultures. However, the societal criticism towards adolescents utilizing SRH services and premarital sex potentially results in unsafe abortions and complications. An exceptional discovery of normalization of SGBV in the entertainment industry has the potential to spread widely as harmful norms to future generations and can exacerbate gender inequality.

#### 5.1.2.3 Malaysia

Prohibition of abortion and victim blaming attitude can facilitate rape survivor into unsafe abortion. Moreover, the societal pressure to endure SGBV reflects a community attitude that undermines the SRHR of women, restricting their ability to raise the voices and affecting their overall well-being. The escalation

of xenophobia and aggression towards refugees in the report pointed that human rights of refugees were often obscured under the categories of nationalities (Fishbein, 2020).

In conclusion, various communities have unique SRH issues and preferences. Realization of their SRHR and accessing the available SRH services will be vital for improved SRH outcomes. SRH service provision should focus on their cultural preferences and needs. However, certain cultural practices affect SRHR, and some harmful practices arise from unequal development in meeting fundamental needs, such as a lack of school and healthcare services and a lack of legal protection in their place of origin. These factors can shape attitudes and behaviors. Although these countries ratified international conventions, child and adolescent SRHR are undermined in these countries. So, regular monitoring and evaluation of policies and services is crucial in countries ratifying SRHR and child rights.

## 5.2 Research Objective 2

Research objective 2 was to identify sexual and reproductive health services available to refugee women from Myanmar in each country and compare them between countries.

The availability of SRH services for citizens in these countries significantly influences the access to these services for refugees, reflecting the government's commitment to SRH provision. However, in Malaysia, services for adolescents and abortion are limited, despite extensive MCH and HIV services being available to all citizens without additional costs (Lim et al., 2020). In Thailand, comprehensive SRH services are accessible to citizens under universal health coverage schemes (Panichkriangkrai et al., 2020). In Bangladesh, MCH services are primarily provided to economically disadvantaged pregnant citizens in select districts, and out-of-pocket expenses for healthcare services remain a prevalent issue (Ministry of Health and Family Welfare 2019).

### 5.2.1 Bangladesh

In the study, SRH service provision under the oversight of the Health Cluster, SRH Working Group, and GBVSS demonstrates the implementation of a multisectoral approach in the realm of SRHR, with significant efforts made to prevent coordination issues and service overlap. Notably, integration of GBV into SRH services

exemplifies best practices in healthcare provision and prevents delay in accessing clinical services. Additionally, the inclusion of abortion as part of family planning empowers women to exercise their SRHR. The findings also highlight the commendable inclusion of adolescents and disability and right based approach in SRH services. These reflected SRH service focus is on the social determinants of health. The presence of adolescent SRH and abortion services in the camp regardless of conservative cultures reflected the change of attitude and perception. It may also be the achievement of behavioral change program and advocacy. It was evident in the Ipas report 2022, Rohingya women who utilize the abortion services reported that they got the information about and recommendation of service from relatives (Ipas, 2022).

NGO provision of services through the local health infrastructure pointed out the coordination and collaborative efforts between host countries and humanitarian organizations for the well-being of refugees, possibly aligning with the shared objectives of both hosts and refugees. Pregnant women assisting by TBAs in healthcare facilities reflected respecting patient preferences and their culture and advancing SRHR. Success of facilities deliveries with CHW effort was the important lesson learnt and this application may be useful for other areas.

Furthermore, it's noteworthy that SRH services continued without interruption through temporary facilities following a fire incident. It reflected the commitment and capacities of SRH service providers and disaster response plan in that place. One Caesarean facilities with significant number of females in Bhasan reflects unmet SRH needs. Limited HIV and STD treatment services may be limited funding and undermining of the needs.

The closure and transition of SRH services to pandemic-related facilities, with the government permitting only clinical services for rape survivors as essential, reflects a significant shift. It underscores the government's perception of SRH service availability, potentially undermining the pressing needs.

### 5.2.2 Thailand

Various organizations provided SRH services to only camp refugees because of available data, significant refugee population, and the recognition of refugees in country policy. Lack of abortion services may be due to the non-acceptability of services among the refugees and humanitarian organizations and funding as abortion

is legal and misoprostol is widely available in the country. The absence of such services can have adverse implications for health, well-being, and the rights of individuals. However, presence of safe abortion referral system in Northern Thailand to government hospital may be due to accessible nature to them (IAWG, n.d.).

In addition, limited HIV and STD services together with legal status and stigma, may discourage seeking services outside the camps. TBA training, delivery by TBA and culturally accepted family planning signify a commitment to respected culture and patient-centered service provision. Lack of adolescent SRH services in the camp reflected undermining the unique needs and challenges of specific age and all SRH services are not prioritized on rights except culture.

To access comprehensive SRH at MTC, the affordability was a critical concern, transportation expenses and service cost. Referral to government hospitals suggests a level of coordination between humanitarian and government sectors but also raises questions about the extent of the government's commitment.

### 5.2.3 Malaysia

Lack of 24-hour services and prevalence of SRH services in KL and Selangor deter accessing women from other areas. High foreigner price together with the risk of detention prevent from accessing services in government hospitals and reflected unsafe and non-refugee friendly (OHCHR, 2022). This also reflects discrimination in health policies based on nationality, which has a detrimental impact on SRHR. It was supported by the report of humanitarian workers in Malaysia. Service provision to refugees as no concerning issue and the organizations representing refugees as illegal in Malaysia in the Pandemic in that report (Fishbein, 2020).

The absence of specialist attendance without a deposit fee reflects a concerning aspect of healthcare providers, suggesting a lack of respect and potential discrimination towards refugees (Lee Wei San and Yasmin Masidi, 2019). Nevertheless, free HIV and syphilis treatment for pregnancies in government hospitals highlights political commitment to these diseases.

Lack of abortion services and illegal abortive medication in policy presents additional challenges for rape survivors who are unable to access timely EC pills (Lim, Yap et al. 2020). Limited shelter duration, specific eligibility criteria and presence in one place limit access to survivors from different regions and the potential impact

on their protection and health capabilities. UNHCR establishment of a virtual safe space, facilitated by refugee women is a commendable practice for the pandemic.

Lack of information of PNC in Malaysia may be poor data and lack of focus in Malaysia. Absence of adolescent friendly SRH services may be influenced by the country's culture and undermining of their needs.

To summarize, data from Thailand and Malaysia is poor in identifying the SRH situation of refugee women in these countries. So, refugee data should be integrated into the national health information system. The country's healthcare expenditure and doctor-patient relationship ratios do not reflect the quality and availability of specific SRH services to refugees because of the unrecognizing of refugees in the healthcare policy. The economic and pandemic crisis in host countries has impacted SRH service provision to refugees and is more pronounced in Malaysia under xenophobic perception.

## 5.3 Research Objective 3

Research objective 3 was to identify gaps in SRH services in each country by comparing them to the standard MISP objectives.

Refugees have been living in Bangladesh, Malaysia, and Thailand for many years, so not only should comprehensive SRH services be available to them because unlike many other refugee situations, there has been time to establish them, but also because these services meet basic human needs. However, the SRH needs were not met comprehensively in the study countries. Moreover, there were still gaps in early-phase SRH services (as defined by the MISP) which given the long-established refugee situation, should have been addressed long ago.

### 5.3.1 Bangladesh

Bangladesh has made significant progress in meeting six of the MISP objectives. However, certain gaps for HIV and STD remain. Additionally, the absence of information on trained specialists and supplies in CEmONC facilities may doubt the full functioning and quality of services because shortages of anesthetic agents and vacuum extractors in the MCH program was revealed in the study (Sarker, Saha et al. 2020).

Limitation of data in Bhasan Char after 3 years of relocation reflected negligence, resource limitation and lack of timely intervention. This also highlights an oversight in addressing SRH needs based on population quantities. However, it may also result from logistical challenges to Bhasan Char location. These disparities in service distribution and capacity can exacerbate existing gaps in HIV and CEmONC services in Bhasan Char.

### 5.3.2 Thailand

There were significant disparities in MISP objective fulfillment between camp and urban refugees due to the lack of established SRH and GBV sectors to monitor and implement. Data on accessing clinical GBV services also revealed poor coordination between various GBV services. Only HIV and STD screening of pregnancies highlighted the lack of comprehensive nature of HIV and STD services. HIS data system pointed out the priority nature of SRH in the camp and the unrecognizing need for comprehensive SRH. The lack of contraceptive data from the two camps reflected unmet needs and negligence. The MTC's target on LARC may not align with the preferences of their clients and undermine their rights (MTC, 2019). Moreover, limited SRH data will impede comprehensive SRH services planning to meet their needs in a protracted state.

### 5.3.3 Malaysia

Malaysia revealed poor fulfillment in MISP. The refugee health sector in Malaysia did not prioritize SRH due to the presence of delivery services exclusively offered by government hospitals at foreign prices. Numerous ANC services with limited PAC and no PNC services are examples of service delivery gaps in separated service provision by different NGOs and poor governance. The lack of a 24/7 referral system also imposes challenges to safe delivery. Despite restrictions on delivery services, there is no data regarding the availability of clean delivery kits and TBAs, reflecting limited capacities and commitment within humanitarian organizations for MCH services. Although there was commitment and progress on GBV services by GBVSS, this sector alone cannot meet the clinical needs of survivors with the constraints of OSCC in government hospitals. The lack of data and information is another challenge. So, Malaysia needs to address numerous gaps in SRH services for refugees in both availability and comprehensiveness.

To conclude, there are some reasons for visible progress in SRH service provision to refugees in Bangladesh. The prevalence of SRH problems and the remarkably increased numbers of refugees in Bangladesh shed light on the need for SRH service provision in the humanitarian sector. The SRH data on refugees in Bangladesh report and research might also inform decision-making for resource allocation and service provision. Moreover, out-of-pocket health expenditure, economic status, and poor healthcare services also make Bangladesh the focus country for funding and assistance among the three countries.

However, the absence of comprehensive SRH data and limited research in Thailand and Malaysia mask their SRH issues and the gaps in available SRHR services. Health status, various health schemes, and well-established health systems in these countries also conceal limited refugee services in their restrictive policies. The prolonged refugee situations and rapidly increasing global humanitarian needs are additional barriers to adequate funding and reinforce the existing gaps in SRH service provision to them in these countries. Therefore, specific resource allocation, data, and information for comprehensive SRH services to refugees are vital to meeting their SRHR needs. So, humanitarian organizations, host countries, and countries of origin need to recognize their SRHR needs as basic human rights and fulfill these needs. These duties should not be weakened by data limitation, inadequate resources, or notions of nationality.

### 5.4 Limitation of the Study

The methodology of this study is to document SRH services available to refugee women and girls from Myanmar in Bangladesh, Thailand and Malaysia and to identify similarities, differences, and service gaps by employing the MISP as the analytical framework. However, there was limited information and data available on the current sociocultural context of the refugee population in Thailand and Malaysia. This limitation may have implications for understanding distinct SRH issues, as sociocultural values can evolve over time and adapt to changing circumstances.

Additionally, the study faced challenges due to the scarcity of peer-reviewed articles and reports concerning current SRH services in Thailand and Malaysia. This challenge is attributed to the complexities surrounding refugee populations in these

countries and the limited number of organizations in this area. Consequently, the analysis of SRH services in Thailand and Malaysia primarily relied on reports and data provided by humanitarian organizations. This may impact the precision of quantities of services for refugees. Therefore, conducting primary investigations to acquire updated sociocultural information on refugees from Myanmar in Thailand and Malaysia and to assess the availability of SRH services to them in these countries will be required.

# CHAPTER 6
# CONCLUSIONS AND RECOMMENDATIONS

## 6.1 Conclusions

This study aimed to identify similarities, differences, and gaps in available SRH services for refugee women and girls from Myanmar in Bangladesh, Thailand, and Malaysia by using MISP. Each country showed distinct SRHR problems and preferences. They offered various SRH services, primarily through humanitarian organizations, focusing on GBV services across all countries. MCH and family planning were focus areas in all three countries.

Bangladesh was the only country providing comprehensive SRH services, including abortion services, through government hospitals. The best practices such as integration of GBV into SRH, right based approach, disability inclusive and extensive adolescent SRH services were observed in Bangladesh. However, disparities in attention and services, particularly in CEmONC and referrals, were observed between Cox's Bazar and Bhasan Char. In Malaysia, delivery and 24-hour services were only available in government hospitals and were not refugee-friendly. Four NGO clinics offered free ANC and family planning services during specific hours, while comprehensive family planning services were provided by one organization. In Thailand, there was only GBV services for urban refugees.

For camp refugees in Thailand, abortion services were unavailable, and there were weak clinical services for GBV and HIV services. Furthermore, there were inequities in service availability among the camps. In terms of the MISP analysis, Bangladesh only partially met six objectives, and services were established through health clusters, SRH, and GBV subsectors. Malaysia partly fulfilled three MISP objectives and needs substantial improvement. Thailand partially fulfilled five MISP objectives for camp refugees and only one for urban refugees.

In conclusion, there were some gaps in SRH services even for the MISP in all countries regardless of protracted situations. Different host countries demonstrate varying political commitments to these refugees and SRHR services. To enhance their SRHR,

ensuring the availability of SRH services is fundamental for true access. Malaysia and Thailand can learn from Bangladesh's good practices and apply them to expand SRH services to meet the needs of protracted refugees. It is crucial for both humanitarian organizations and host countries to identify and meet SRHR needs of refugees using a rights-based approach and to routinely evaluate their work against an international standard such as the MISP.

### 6.2 Global Relevance of the Study

This study highlighted the gaps in comprehensive SRH services for refugee women and girls in protracted humanitarian settings and even in the MISP objectives designed for the early humanitarian stage. The refugee women and girls population is increasing globally because of ongoing political crisis in the country of origin, the failure of integration into host countries, and the reduction of resettlement opportunities. However, limited data and information obscures their SRHR needs, which impacts securing funding and assistance. They become a less prioritized population for resource allocation, technical guidance, and monitoring and evaluation over time in the humanitarian sector. Moreover, the provision of comprehensive GBV services to refugee women and girls by humanitarian organizations in the study countries found that different political wills for specific SRH services and undermined comprehensive SRHR. A community health worker-based service delivery approach, well maintained emergency response plans and provision of virtual safe spaces are good practices to be applicable regardless of living place and culture.

## 6.3 Recommendations

The following recommendations are made for humanitarian organizations and host countries to improve SRH services for protracted refugee women and girls.

### 6.3.1 For Bangladesh

1) Humanitarian organizations and governments should ensure the provision of CEmONC and establish efficient referral services in Bhasan Char.

2) Regular monitoring and evaluation of safe blood transfusion practices and capacities should be conducted by humanitarian organizations and the government.

3) Adequate supplies at referral hospitals should be maintained, and data and information about these supplies should be disseminated.

### 6.3.2 For Thailand

1) UNHCR should collect disaggregated age and sex data of urban refugees.

2) Universal health coverage schemes should extend to refugees, regardless of UNHCR cards, ensuring their access to SRH services.

3) Governance structure for the SRH and GBV subsectors should be established for the monitoring and evaluation of SRH services.

4) Humanitarian organizations should adhere to international guidelines when providing clinical services for survivors of GBV.

### 6.3.3 For Malaysia

1) Governments should prioritize the provision of affordable, refugee friendly SRH services in public hospitals.

2) Humanitarian organizations should establish an SRH working group to enhance coordination and collaboration among service providers.

3) A 24/7 referral system and facilities for BEmONC should be established for urban refugees.

4) Adequate funding for SRH services to urban refugees should be secured to ensure affordable access to SRH services at NGO clinics.

### 6.3.4 For MISP

1) MISP should include adolescent friendly SRH services as part of its objectives.

2) Disability-friendly SRH services should also be incorporated.

3) The provision of abortion pills should be added to the objectives of MISP.

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# APPENDICES

# APPENDIX A
# CRITERIA FOR SELECTED COUNTRIES AND ANALYTIC TOOL TO INCLUDE IN THIS STUDY

**Countries Selection**

It was based on geographic proximity of Myanmar, long duration of hosting Myanmar refugee, presence of significant refugee women from Myanmar and refugee policies.

**First criteria**

Myanmar, Thailand, and Malaysia are Southeast Asian Countries, and Bangladesh is a South Asian country.

**Second criteria**

The duration of hosting refugees in Thailand, Bangladesh, and Malaysia is over forty years, thirty years, and twenty-five years respectively.

**Third criteria**

There are 91,040 (verified Myanmar refugees) and 5155 urban refugees and asylum seekers in Thailand, 950,972 refugees in Bangladesh, and 181,000 (refugees and asylum seekers) in Malaysia. Refugee women are 55% in Thailand, 52% in Bangladesh, and 33% in Malaysia (CCSDPT 2021, UNHCR 2022, UNHCR 2022, UNHCR n.d.).

**Fourth criteria**

These countries do not ratify the 1951 Refugee Convection and 1967 Protocol and have no legislative framework for refugees in these countries (Yesmin 2016). This also reflects political will towards refugees and the provision of assistance and SRH services to them in these countries. Moreover, refugees cannot move freely and work. So, refugee women have to depend on their husbands and communities for economic and accessing healthcare services. There is no legal protection for refugee women who fall into the vicious cycle of SRH threats.

**Analytic Tool Selection**

For the selection of an assessment tool for evaluating SRH services for refugee women, MISP is the accepted international framework for planning, organizing and evaluating SRH services in humanitarian situations. The study will use the MISP objectives as a framework to identify the gaps in SRH services available to refugee women in Bangladesh, Thailand and Malaysia.

The Objectives of MISP are as follows (UNFPA 2020):

1) to ensure that the Health Sector/Cluster is assigned as an institution to oversee the implementation of the MISP by appointing an SRH coordinator responsible for offering technical and operational support to all health service providers. Relevant stakeholders regularly meet for coordination to execute MISP. Moreover, operation updates and accessibility of SRH services and supplies must report to the health cluster, and GBV sub-cluster, with or without HIV national coordination meetings regarding any MISP-related issues and collaborate with them in mapping and assessing current services. Moreover, community awareness raising of available SRH services and places of service provision to them.

2) to prevent SGBV and address the needs of survivors by collaborating with other clusters, especially the protection or GBV sub-cluster in establishing preventive measures at the community, local, and district levels, including health facilities. Moreover, safeguarding affected populations, focusing on women and girls from SGBV, and ensuring the availability of clinical care and referrals to other support services for survivors of SGBV are to be in place. Confidential and secure space must be present within health facilities for receiving survivors of SGBV, where they can access appropriate clinical care and referrals.

3) to prevent transmission and reduce symptoms and death caused by HIV and STI by securing safe blood transfusion practices and enforcing standard precautions. In addition, free lubricated male condoms and female condoms must be accessible, and ART must be offered for the continuous treatment of people enrolled in ART programs, including women from PMTCT. PEP for survivors of SGBV and occupational exposure cases, and co-trimoxazole prophylaxis for opportunistic infections for people with HIV should be supported. The health facilities must have the capacity for syndromic diagnosis and treatment of STI.

4) to prevent maternal and newborn death and complications. To fulfill this objective, hygienic and secure delivery, essential care for newborns, and EmONC services must be accessible. Referral hospitals must have trained medical personnel and adequate supplies for CEmONC to manage complex cases. Skilled birth attendants and necessary supplies for vaginal deliveries and BEmONC services must be available at health facilities. The community must be informed of the availability of safe delivery and EmONC services, emphasizing the importance of seeking care from healthcare facilities at the community level. Clean delivery kits must be distributed to pregnant women and birth attendants to promote hygienic home deliveries in the limited facilities. A 24/7 referral system for transportation and communication from the community to healthcare centers and hospitals must be established. Life-saving post-abortion care services in health centers and hospitals must be present. Supplies and resources for clean delivery and immediate newborn care must be present when access to health facilities is impossible.

5) to prevent unintended pregnancies by ensuring the availability of various contraceptive methods, both LARC and short-acting, including male and female condoms (where already in use) and EC pills, at PHC to meet the demand. Moreover, comprehensive information, including the utilization of IEC materials must be provided. Family planning counseling must be delivered on informed choice, consent, and effectiveness with privacy and confidentiality, non-discrimination, and respectful manners. The community must be aware of the availability of contraceptives for women, adolescents, and men.

6) to develop a strategy for comprehensive SRH services and their integration into primary healthcare at the earliest opportunity, achieved through collaboration with Health sector/Cluster partners to address the six fundamental elements of the healthcare system, including delivery of services, health workforce, health information system, medical commodities, financing and governance, and leadership.

# APPENDIX B

# FINDINGS FOR RESEARCH OBJECTIVE 1

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information of Refugee Population | Ethnic group of Refugee |
|---|---|---|---|---|
| UNHCR Thailand MCO. (2023). RTG/MOI-UNHCR Verified Refugee Population. | Report | Thailand, camp | Karen (84%), Karenni (9%) and Burmese (4%) refugees present in refugee camps. | |
| UNHCR. (2023a). Figures at a Glance in Malaysia | Report | Malaysia, urban | 105,960 Rohingyas, 23,700 Chins, and 28,840 other ethnicities were present as refugees in Malaysia | |
| Bloomfield-Wong, S. (2021). Understanding Karen women's experiences in refugee camps on the Thai-Myanmar border and in Canada | published master's thesis | Thailand, camp | Men's social status is superior to women and strict gender roles of men and women. Women were limited in decision making. Women did not report violence because of fear of leaving them by their husbands in the insecure camp environment. Karen women felt empowerment, social bonding, and securing the culture with CSO like KWO. | Karen |
| Migrant Information Centre. (2018). Karen Cultural Profile. | Grey Literature | Thailand, camp and Australia, resettled | Young people must accept and follow and they also reluctant to ask about or express their experiences in consultation under the notion of doctors as high social status, Home delivery is a traditional practice, and women are convenient with female healthcare providers. | Karen |
| Asnong, C., et al. (2018). Adolescents' perceptions and experiences of pregnancy in refugee and migrant communities on the Thailand-Myanmar border: a qualitative study. | Peer reviewed article | Thailand (camp and along the Thailand-Myanmar Border) | Unmarried pregnancy is criticized. Sometimes an encounter with a young couple in the absence of a chaperone can lead to a compelled marriage. Early marriage by female-headed households is founded as a negative coping strategy to secure economic challenges, urricula is taboo for unmarried adolescents and the culture does not accept . There are misconceptions about contraceptives such as infertility and shrinkage of uterus. | Karen |
| Jannat, S., et al. (2022). Sexual and reproductive health conditions of women: Insights from Rohingya Refugee Women in Bangladesh | Peer reviewed article | Bangladesh (camp) | Women are reluctant to talk SRH information and consulting their SRH problems with the doctor is also a shameful act in the religion. Reporting SGBV is considered as shame to the family | Rohingya |

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicties /Nationalities |
|---|---|---|---|---|
| Niwitkulnipa, K. (2019). Space-making of Karenni refugee identity: a case study of Ban Mai Nai Soi camp | Peer reviewed article | Thailand (camp) | The people in Karenni State are often seen as closely related to the Karen ethnic group, sometimes considered a subset and the religions are also the same, Limited development and infrastructure in Karenni states prevent modern medical practice and promote deeply rooted traditional healing practices using natural remedies and spiritual rituals like animal sacrifices. Sickness is perceived as losing souls. There was limited interaction among various sub-Karenni groups in Myanmar, but these groups had engaged with each other and shared experiences during displacement. Kay Jar or traditional leader holds authority like a district governor, managing sociocultural and juridical matters in the social system and also in the refugee camp. | Karenni |
| Naujoks, J., & Ko, M. T. (2018). Behind the Masks: Masculinities, Gender, Peace and Security in Myanmar. | Peer reviewed article | Myanmar | Male dominance is grounded in the form of masculinity perceived as unattainable for women. This perspective is linked to traditional interpretations of menstruation as 'impure,'. Customary practise of restricting women's entry to temples in the Burmese culture persist | Burmese |
| Forced Migration Research Network UNSW, I. o. H. R. a. P. S., Mahidol University and Asia Pacific Refugee Rights Network (2019). Refugee Women and Girls: Key to The Global Compact on Refugees | Report | Thailand (camp and along the Thailand-Myanmar Border) | Cultural beliefs of strength of men encourages the early marriage of adolescent girls, often seen as a protective measure. School-age girls are unable to attend the school because of caregiving duties in traditional gender roles. They also perceived that education is vital for men to be family leader and provider. | Karen |
| Kumar, J. L., et al. (2021). Pathways to sexual health among refugee young women: a contextual approach. Sexuality & Culture | Peer reviewed article | along the Thailand-Myanmar Border | Premarital sex and intimacy are not allowed in the Christian, Muslim, and Buddhist religions, and also in Burmese culture. Single pregnant women are stigmatized. They are reluctant to discuss SRH information in their culture. Gender inequality and strict gender roles are present in all ethnicities | Burmese, Karen, Karenni |

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicties /Nationalities |
|---|---|---|---|---|
| Soe, N. (2021). The Impact of Bride Price on the Lives of Married Women in Two Southern Chin Communities (Falam and Hakha) | Peer reviewed article | Myanmar | They speak their native ethnic language. The bride price holds legal marriage and negotiations are typically conducted by senior men in families, shaping women's behavior and roles within the marriage. Men perceive as superior due to the bride price, leading to imbalanced decision-making, and this power imbalance can escalate to domestic violence. Chin customary laws, strip women of property ownership rights and force them to rely on male guardians and allows men to initiate divorce. If women do, their family must return the bride price, leaving men in ownership of all property and children's custody. women remained silent about abuse, fearing societal judgment. The Chin Customary Law allows husbands to discipline their wives physically. Violence was considered as forgivable act in the religion. | Chin |
| Hossain, M. A., & Hossain, M. B. (2023). Understanding fertility behavior of the Forcibly Displaced Myanmar Nationals in Bangladesh: A qualitative study. | Peer reviewed article | Bangladesh, camp | Most Rohingya follow Islam and adherence to Islamic Shariah is obligatory. Their language is quite similar to Bangladeshi. Women should stay in their homes and wear Barkha to cover the body in the religion. Men in the society took it upon themselves to uphold this regulation for women and strictly practiced in Myanmar, deviation from this norm would result in a devastating situation. Strict menstrual practice was also observed. Fathers and husbands' strict movements, such as even consulting with doctors under the notions of these women's honor in their hands. In Sharia regulation, one man is allowed to have four wives. Girls should marry just after puberty to avoid illegal relationships. Arranged early marriage is a traditional practice and societal pressure is visible in the culture. Practices in Rohingya society like child marriage and polygamy reinforced the prevalent high fertility pattern. Polygamy driven by the desire for more children, notably sons, was linked to this behavior. Conception is the will of Allah and the normal process. Contraception was generally considered as sin in the Islamic religion. The notion of high fertility was linked to parental happiness, blessings and protection from punishment in the afterlife. Furthermore, they believed that from political perspective to maintain the existence of the "Rohingya" identity and to reclaim the land and this notion coupled with son preferences. So, the community criticizes contraceptive usage. Contraceptive usage is only permitted to space out consecutive childbirths in the religious law and decision depends on the husband. Women have to obey their husbands. Women would face violence if they used without husband approval. In addition, men can divorce for any issue. Dowry was a common tradition within Rohingya marriage and sons held economic advantages for the family. | Rohingya |

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicities /Nationalities |
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| UNHCR CARE and ActionAid. (2020). An Intersectional Analysis of Gender Amongst Rohingya Refugees and Host Communities Ic Cox's Bazar, Bangladesh. | Report | Bangladesh, camp | There is also a custom of taking female survivors to the place they suffered from sexual assault for a period of time. Unemployed men frustrated within the constraint of legal status and camp environment and resulted in violence and oppression of partners because of strict gender roles. Religious leaders claimed that the carrying of disabled women is an inappropriate act in public space. There is prohibition of marriage between citizens and refugees and can result in detention for up to six years. Married refugee women result in abuse and oppression by the husbands and their relatives. Host communities perceived Rohingyas as culprits and received judgments regarding their religious practices as regressive in nature | Rohingya Bangladesh |
| SCG. (2019). Gender Profile No.2 For Rohingya Refugee Response Cox's Bazar, Bangladesh (as of March 2019). | Report | Bangladesh, camp | The physical assessment of sensitive body regions by a younger doctor is regarded as taboo. Pregnant women delivered baby with healthcare experts were perceived as ladies without courage | Rohingya |
| NIPORT and ICF. (2023). Bangladesh Demographic and Health Survey 2022: Key Indicators Report. | Report | Bangladesh | Approximately 50% of females enter into marriage before 18 years old, while more than a quarter of them (27%) are married off before turning 16. | Bangladesh |
| Bangladesh Bureau of Statistics. (2022). Population and Housing Census 2022 Preliminary Report | Report | Bangladesh | 91.04% of the population follows Muslim in Bangladesh | Bangladesh |
| Ahmmed, F., et al. (2022). Sexual and reproductive health experiences of adolescent girls and women in marginalised communities in Bangladesh | Peer reviewed article | Bangladesh | Indigenous communities believed MCH services and facility delivery were for complicated labor. It also was considered a sign of bad luck for a woman to require facility delivery due to complications. They also believed that it is natural processes that do not require healthcare services. There was traditional practice of movement and diet restriction after delivery and menstrual blood was perceived as poisonous | Bangladesh |
| Razali, R. M., & Mamat, Z. B. (2019). The intractable rights to marriage and a legal identity: law, practice, and implications for Muslim Rohingya in Malaysia. | Peer reviewed article | Malaysia | Regarding marriages between residents and refugees possessing UNHCR cards, the process was temporarily suspended. | Malaysia |

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicties /Nationalities |
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| Ali, M. (2018). Boyshondhi Shikka is Obligatory for Religious and Medical Reasons: Bangladeshi Imams' perceptions about Adolescent Sexual and Reproductive Health Education: An In-depth Interview Study in Bangladesh. | Peer reviewed article | Bangladesh | Premarital sex is not permitted but child marriage is neither prohibited nor permitted in their religion. Some religious leaders have portrayed contraceptives as sin and permission is also same as in Rohingyas. SRH discussion has historically been a sensitive topic. Both parents and teachers experienced stigmatization and discomfort when addressing SRH matters with adolescents | Bangladesh |
| Samandari, G., et al. (2020). Understanding individual, family and community perspectives on delaying early birth among adolescent girls: findings from a formative evaluation in rural Bangladesh. | Peer reviewed article | Bangladesh | Adolescents who postponed their first birth after marriage and their husbands were labeled as infertile and considered their married families to be of lower reputation. The married adolescents' social status improved after childbirth, and their husbands did the same at the community level. They faced movement restrictions and need permission of their husbands and mothers-in-law. Mothers-in-law, mothers, and senior community members prohibit the usage of contraception before the first delivery | Bangladesh |
| Hossain, M. I., et al. (2022). Social stigma and vulnerabilities of HIV/AIDS-positive people: Reconsidering social work education and NGOs' role in Bangladesh | Peer reviewed article | Bangladesh | In Bangladesh, PLHIV was viewed as a disgrace to the family. They perceived HIV infection from commercial sex or illegal relationship. Both PLHIV and their family members faced discrimination. Female individuals are subject to more negative judgments. The communities blamed and discriminated PLHIVs. | Bangladesh |
| WAO. (2021b). A Study on Malaysian Public Attitudes and Perceptions towards Violence Against Women (VAW). | Report | Malaysia | Violence against women is perceived as a temporary emotional act in Malaysia. These attitudes favor the shift to victim blaming in society. Regarding IPV, remaining in an abusive relationship becomes the women's responsibility. Most Malaysians (74%) in this study do not trust the women's reports on violence, and they prefer to believe one-sided stories from men in the relationship. The expectation of no complaints from women are prevalent. Regarding rape, half of the participants perceived that it occurs due to improper dress and behavior of women. One-fourth of respondents believed that women should bear children. However, most Malaysians opposed child marriage in this study. In Malaysia, men can control and lead the family in relationship and women also accept | Malaysia |



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| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicties /Nationalities |
|---|---|---|---|---|
| Office of International Religious Freedom. (2022b). 2021 Report on International Religious Freedom: Thailand. | Report | Thailand | Approximately 85 to 95 percent of Thais practices Buddhism | Thailand |
| Wiwatkamonchai, A., et al. (2023). Youths' Perceptions Regarding Access to Sexual and Reproductive Health Services. | Peer reviewed article | Thailand | Premarital sex is also regarded as shameful. Society judges not only adolescents accessing the SRH services as troubled children but also parents as bad parenting. | Thailand |
| Jirada Phetlam. (2022). Spinning in the Void: The Data Black Hole of Sexual and Gender-Based Violence in Thailand. | Peer reviewed article | Thailand | SGBV is a private matter. Moreover, entertainment industry normalizes sexual violence as romantic interaction in movies. In addition, conservative culture and patriarchal norms prevent the recognition of different categories of SGBV in sex education in school | Thailand |
| Akter, S., et al. (2020). Barriers to accessing maternal health care services in the Chittagong Hill Tracts, Bangladesh: A qualitative descriptive study of Indigenous women's experiences | Peer reviewed article | Bangladesh | They also preferred unskillful TBAs over healthcare workers for home deliveries. They also used medicinal plants for contraception, delivery, and abortion | Bangladesh |
| Elle, K. (2021). The Perceptions of Date Rape in Thai Patriarchal Society: A Case Study of Female University Students in Bangkok | Peer reviewed article | Thailand | Most respondents in the study believed that forced sex without physical violence between couples was normal. This perception was encouraged by the movies and love became the permissible reason. One of the key informants mentioned that forcing sex between relationships became the right of men, and women blamed themselves for rape. Sex education by the instructor was also that preventing SGBV is the duty of women. styling hair in a certain manner was labeled as provoking boys' arousal. | Thailand |
| Office of International Religious Freedom. (2022a). 2021 Report on International Religious Freedom: Malaysia | Report | Malaysia | Islam was followed by 61.3% of Malaysians | Malaysia |

| Author, Publication Year and Title | Type of Document | Country And Type of Refugee | Demographic Characteristics and Socio-cultural Information | Ethnicties /Nationalities |
|---|---|---|---|---|
| Chautrakarn, S., et al. (2023). Stigmatizing and discriminatory attitudes toward people living with HIV/AIDS (PLWHA) among general adult population: the results from the 6th Thai National Health Examination Survey (NHES VI) | Peer reviewed article | Thailand | (78.5%) responded hesitation for HIV testing because of stigma and 66.6% believed that PLHIV would lose respect in society, 41.0% responded disgusting to buy food for PLHIV, 28.2% claimed that they would be ashamed if one of the family members had HIV or AIDS and 20.8% asserted to isolate school children living with HIV or AIDS. So, HIV stigma and discriminatory practices are still present in Thailand, but they declined from 58.6% in 2014 to 48.6% in 2019-2020 | Thailand |
| WAO. (2021b). A Study on Malaysian Public Attitudes and Perceptions towards Violence Against Women (VAW). | Report | Malaysia | Violence against women is perceived as a temporary emotional act in Malaysia. These attitudes favor the shift to victim blaming in society. Regarding IPV, remaining in an abusive relationship becomes the women's responsibility. Most Malaysians (74%) in this study do not trust the women's reports on violence, and they prefer to believe one-sided stories from men in the relationship. The expectation of no complaints from women are prevalent. Regarding rape, half of the participants perceived that it occurs due to improper dress and behavior of women. One-fourth of respondents believed that women should bear children. However, most Malaysians opposed child marriage in this study. In Malaysia, men can control and lead the family in relationship and women also accept | Malaysia |
| Zulkarnain, A. R., et al. (2021). Awareness, Knowledge, Attitude, And Practices Towards Sexual And Reproductive Health Among Secondary School Students In Malaysia | Peer reviewed article | Malaysia | (89%) of participants claimed that premarital sex is a signifiant social issue and (66%) also viewed abortion must be avoided unless they were pregnant outside marriage. Abortion is considered moral offense in the Muslim religion | Malaysia |
| Sern, T. J. (2018). The Knowledge, Perceptions, Attitudes, And Perceived Risk in Hiv/Aids among Women in Malaysia: A Cross-Sectional Study. | Peer reviewed article | Malaysia | 63.7% of Malaysian female participants responded isolation of PLHIV, and 68% perceived that PLHIV were impure. 68.6 % of the participants perceived to blame PLHIV for bringing HIV into the communities. 73% of the survey respondents refused to disclose HIV information to friends or families. | Malaysia |
| UNICEF Malaysia. (2022). Left Far Behind: The Impact of COVID-19 on Access to Education and Healthcare for Refugee and Asylum-Seeking | Report | Malaysia | Discrimination and xenophobia are pervasive at all levels of society. The pandemic, fueling hate speech and targeted xenophobia against refugees, exacerbate this problem | Malaysia |



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# APPENDIX C

# FINDINGS FOR RESEARCH OBJECTIVE 2

| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
|---|---|---|---|---|
| UNHCR. (2022). Rohingya Refugee Response In Bangladesh Public Health Factsheet - as of 31 December 2022. | Fact sheet | Bangladesh | UNHCR | UNHCR is at the forefront of the Health Sector's leadership on Bhasan Char, collaborating closely with health authorities and the Assistant Refugee Relief and Repatriation Commissioner. UNHCR also supported the MOH hospital through medical supplies, equipment, human resources, and trained refugee volunteer community health workers. In Cox's Bazar, UNHCR oversees 28 healthcare facilities and 10 mental health and psychosocial support centers. These establishments offer comprehensive primary and secondary healthcare services, focusing on sexual, reproductive, maternal, neonatal, child, and adolescent health and including mental health and psychosocial support, comprehensive laboratory services, and medication provision. SRH are accessible to women and adolescents through clinics and drop-in centers for ANC, PNC, and family planning. Health facilities offer 24-hour services for BEmONC, while complex cases are referred. UNHCR continued to assist the local health system within and beyond the camp. The newly operational Ukhiya Specialized Hospital and the recently opened OPD at Sadar District Hospital in Cox's Bazar contribute significantly to healthcare provision for refugees, relieving pressure on existing facilities in Cox's Bazar District. |
| UNHCR. (2021)2021 Annual Public Health Global Review | Report | Bangladesh | CHWG | In the Cox's Bazar refugee camps, CHWG collaborates with over 1,400 CHWs from various health partners to provide essential information about available health services, to closely monitor high-risk pregnancies, to facilitate referrals. The CHWs play a pivotal role in tracking the expected delivery dates of pregnant women, encouraging ANC according to WHO guidelines, and ensuring women and their families in preparation for delivery and considering facility-based deliveries. Moreover, community leaders actively engage in advocacy. So, the percentage of facility-based deliveries has significantly risen from 12% in 2018 to 70% in 2021. |
| PI. (2021). New CPI Health Post Opens to Serve Rohingya Refugees and Bangladesh Host Communities | Grey Literatures | Bangladesh | Green Hill, CPI | In 2021, CPI funded the establishment of a new health post in Camp 1W of Kutupalong Refugee Camp in Cox's Bazar. The local partner Green Hill managed the health post, providing a range of services that encompass ANC, PNC, safe birth referrals, family planning, GBV prevention and care, a general pharmacy, and basic laboratory facilities |
| UNICEF (2023). UNICEF Bangladesh Humanitarian Situation Report No. 63. | Report | Bangladesh | UNICEF | With UNICEF support, the development of REMN strategy was initiated in Ramu Upazila to ensure quality ANC services and safe deliveries at union and Upazila level Health facilities. The strategy is to ensure timely referral after the initial stabilization complicated pregnancies at the PHC level Cox's Bazar. UNICEF offered training on Universal Precaution, training on HTC, training on PEP, and training on PMTCT and Syphilis Management for health care workers of four Upazila Health Complexes and refugee campsites health facilities. In Cox's Bazar, 9,358 female were accessed GBV prevention, risk mitigation, or response interventions |

| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
|---|---|---|---|---|
| IRC. (2022). Access to sexual and reproductive health services during the COVID-19 pandemic A mixed methods assessment: COX'S BAZAR, BANGLADESH. | Report | Bangladesh | IRC | IRC offered women empowerment, skill training, GBV awareness and established mobile medical teams to harder-to-reach areas of the camp. IRC offers FP, menstrual regulation, PAC, and STD services. ANC was accessible through IRC's PHCC and BEmONC center, but delivery service was available at only one IRC-supported facility. Moreover, the RCCE program by IRC supported the local healthcare services in the Ramu and Chakaria districts in Cox's Bazar in adolescent friendly SRH service delivery. IRC supported four PHCCs, one comprehensive SRH infrastructure (including BeMONC), forty- two women's women-friendly spaces, three women and girl safe spaces (integrated SRH and women protection services), and thirteen referral hubs for emergency transport in SRH service provision in Cox Bazaar in January 2022 |
| BDRCS. (2023). Population Movement Operation (PMO) Cox's Bazar, Bangladesh Monthly Situation Report No. 86 May 2023. | Report | Bangladesh | BDRCS | Thirteen health infrastructures in Cox Bazar provided SRH services, referral services, and MHPSSA through in-patient and outpatient services in the BDRCS report in 2023. A Field Hospital and MCHC at Teknaf offered 24 hours services. Additionally, five HPs offered FP counseling and various contraceptives including condoms, implants, injections, and oral pills on weekdays. The healthcare services are delivered with utmost respect for patient dignity, safety, and privacy within an environment that promotes inclusivity for all genders and disabilities. Child-friendly spaces, DAPS Centre, Community safe space, and three PHCs serve as focal points for psychosocial support activities in specified camps (Camps 2E, 12, 13, 14, 15, 17, 19, and 20) in Cox Bazar in Bangladesh |
| Health Sector. (2023). Health Sector Cox's Bazar: March 2023 Bulletin. | Report | Bangladesh | Health sector | The fire in Camp 11 in Cox Bazar also destroyed a health facility operated by BDRCS, IOM, and MoHFW and supported by the Swiss Red Cross. BDRCS ensured the immediate resumption of basic services like OPD, SRH (ANC, PNC, Family Planning), GBV referral, provision of essential medicines, community outreach, and 24/7 ambulance services, in collaboration with IOM and UNFPA. One PHC of IRC was destroyed in a fire in Camp 11 in March 2023. IRC rapidly established temporary tents and resumed SRH |
| MSF. (2023). Bangladesh. | Grey Literatures | Bangladesh | MSF | V. Health facilities by MSF in Cox's Bazar and Dhaka offer diverse medical and psychological support tailored for survivors of SGBV. MSF's reproductive health initiatives encompass adolescent friendly services, ANC, delivery assistance, and family planning services |
| IOM. (2023b). IOM Bangladesh: Rohingya Humanitarian Crisis Response Monthly Situation Report. | Report | Bangladesh | IOM | IOM assisted 39 primary and secondary healthcare establishments in Cox's Bazar, offering services including FP, MHPSS, HIV counseling and testing<br>Moreover, IOM also provided GBV risk awareness programs, case management, psychosocial support, outreach sessions led by mobilizers and community efforts, delivering dignity kits, and capacity-building on GBV and protection. |
| IOM. (2023a). IOM Bangladesh Appeal 2023: Rohingya Humanitarian Crisis. | Report | Bangladesh | IOM | IOM serves as GBV camp level focal point in six camps and also as mobile medical teams, PERUs, and PRA. IOMs extended in providing a comprehensive GBV program in Ukhiya and Teknaf sub-districts. WGSS initiative involves direct case management and support across nine sites, including emergency shelters for GBV survivors. WGSS also served as structured psychosocial support, educational activities, skills training, and forums for information exchange |

| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
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| ISCG. (2019). Gender Profile No.2 For Rohingya Refugee Response Cox's Bazar, Bangladesh (as of March 2019). | Report | Bangladesh | IOM | By the end of 2018, 78 accessible entry points for GBV case management, including 52 safe spaces for women and girls, were established. These spaces serve as access points for SRH information and services with comprehensive GBV care |
| Jannat, S., et al. (2022). Sexual and reproductive health conditions of women: Insights from Rohingya Refugee Women in Bangladesh. | Peer reviewed article | Bangladesh | NGO | Organizations like BRAC, RTM International, and Plan International offered SRH improvement awareness and training programs. Some NGOs offered sanitary napkins |
| Raeed Abd-Allah Chowdhury. (2022). Expanding Health Services in Bhasan Char | Grey Literatures | Bangladesh | Friendship | Friendship has established a 12-bed PHC in Bhasan Char, accompanied by three units at a 20-bed government hospital, serving as the sole facility for cesarean section deliveries on the island. The PHC provided ANC, PNC, vaginal deliveries, family planning, SRH support, mental health services, psycho-social assistance, and in-patient care with a pathology laboratory. Additionally, Friendship operates gynecology and obstetrics units at the island's hospital, in collaboration with government and NGO partners. Friendship also conducted community health awareness programs. Prior to establishing the clinic, Friendship had operated a health post on the island since December 2020 |
| Ipas. (2022). Training Health Workers in Rohingya Refugee Camps. | Grey Literatures | Bangladesh | Ipas | Ipas offered comprehensive FP, abortion, and PAC services at Friendship Hospital in Cox's Bazar. In collaboration with UNFPA, Ipas has extended its support to 49 health facilities serving refugees, mainly in Cox's Bazar District. Ongoing training initiatives target service providers emphasizing rights-based care and addressing societal stigma. Ipas also conducted community engagement to ensure widespread access to contraception and safe abortion procedures. Ipas-trained health workers to deliver comprehensive SRH services, including contraception and abortion on Bhasan Char after relocation. The 20-bed hospital on the island offers comprehensive FP services including abortion |
| UNFPA. (2023). On a remote island in Bhasan Char - the essential Sexual and Reproductive Health and Protection needs of refugees are being met. | Grey Literatures | Bangladesh | UNFPA | A team from the OGSB conducted training emphasized on child marriage, institutional delivery, and FP for 35 health staff at Bhasan Char Island with the assistance of UNFPA (Health Sector, 2023). UNFPA assisted Rohingya refugee women and girls in providing SRH services, and there were 2,850 ANC visits, 99 facility-based deliveries, 348 PNC visits, 4,440 family planning consultations including modern contraceptives, and 2,960 counseling sessions on family planning in Bhasan Char. UNHCR supported capacity building such as training midwives and ensuring essential supplies Bhasan Char. It also established a safe women-friendly space, offering sessions on GBV, SRH, and PSEA awareness and skill development activities. UNFPA introduced the SASA! Together approach for GBV. By integrating SRH with GBV services, pregnant women received essential care at health posts and the women-friendly space. An Adolescent and Youth Centre provided MHPSS support and information on GBV and SRH |

| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
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| CCSDPT. (2021). CCSDPT report. | Report | Thailand | CCSDPT (MI and IRC) | Thirteen NGOs, operating under CCSDPT and the Ministry of Interior, deliver humanitarian aid across various sectors to camp refugees. The Health Sub-Committee and HIS Coordinator operated under CCSDPT. The HIS tracks the health status of these people. HIS database was transitioned to iRHIS in 2019.IRC and MI are the main service providers for MCH services at their health facilities within the shelters. Specifically, MI extended healthcare services to the Mae La Oon and Mae Ra Ma Luang shelters and IRC administered healthcare services to remaining shelters, including Ban Mai Nai Soi, Ban Mae Surin, Mae La, Umpiem, Nupo, Ban Don Yang, and Tham Hin. SRH services provided by MI and IRC included ANC, delivery, PNC, FP, referral services, clinical service of GBV survivor, HIV testing and syphilis test during ANC. The referral rates in Mae Ra Ma Luang and in Mae Ra Ma Luang were 38% and 54%. Notably, the referral rate in the rest reached over 96%. There was no family planning service data from Mae La Oon and Mae Ra Ma Luangin in the HIS report in 2021 due to the absence of services provided by MI in these two camps. In the context of contraceptive methods adopted by refugee women in shelters during 2021, the options encompassed COC pills, Depo injections, IUDs, EC pills, progesterone-only pills, sterilizations, and implantables (Norplant) . |
| CCSDPT. (2023). Structure. | Grey Literatures | Thailand | CCSDPT | The Health Sub Committee under CCSDPT comprises MI, IRC, COERR, DARE, and HI. Typically, meetings are convened every two months in Mae Sot. Insights from the WASH working group and Psycho-Social Health working group sessions are integrated into the Health Sub Committee discussions. |
| MTC. (2019). Reproductive Health. | Grey Literatures | Thailand | MTC | The RH Department of MTC provided family planning, gynecology, delivery, neonatal care, PAC and free testing for HIV, PMTCT. The ANC program offers screening for various conditions such as malaria, anemia, blood group typing, HIV, and syphilis. Inpatient Department comprises 52 beds. Regarding Pregnancies requiring advanced emergency obstetric care, pregnant women, and mothers with HIV, MTC refers to Mae Sot Hospital or Myawaddy Hospital. MTC offers HIV screening during the initial ANC visit and for pregnant women arriving for delivery without prior ANC attendance. The RH OPD operates with a team of 9 medics for delivering comprehensive SRH services. Early diagnosis for PMTCT babies' HIV status is facilitated by registering in Thai government hospitals for regular PCR tests. MTC also provides counseling, prenatal lab screenings, ultrasound examinations, immunizations, antihelminth treatment, and dietary supplements to refugee pregnancies. MTC offered FP from emergency to short and LARC. The clinic's goal is to extend LARC usage to 10% of FP patients (MTC, 2019). Regarding delivery services, the department provides specialized midwife training, bolstered clinical supervision, and enhanced infection control measures to ensure safe deliveries. Referrals are rigorously evaluated and closely monitored for their outcomes. Unfortunately, MTC's funding has been diminishing, MTC cannot offer free for full MCH care . |
| KWO. (2023). Traditional Birth Attendant training and support | Grey Literatures | Thailand | KWO | KWO conducts training and assisting TBAs as culturally respected MCH care in two predominant Karen refugee camps, Mae Ra Ma Luang and Mae La Oon. KWO provides single use maternity kits TBAs to ensure safe deliveries KWO's Health Program coordinators actively support TBAs in refugee camps. KWO also conducted community education sessions on Maternal and Child Health |
| BHF. (2023). BHF's Humanitarian activity along the border. | Grey Literatures | Thailand | BHF | BHF collaborated with SMRU in establishing MCH clinics along the Thailand-Myanmar border. These clinics has both outpatient and inpatient services. The MCH care package encompasses various services, including ultrasound examinations, screenings of HIV, Syphilis, and Hepatitis B and others. SRH program focuses on SRH awareness including adolescents, offering locally accepted FP methods delivery assistance with TBAs and referral services. The medical staff were trained to be sensitive to refugees' language and cultural backgrounds |



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| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
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| Buddhist Tzu Chi Foundation. (2023). Buddhist Tzu Chi Foundation Provides Care for International Refugees in Thailand | Grey Literatures | Thailand | Tzu Chi Foundation | Tzu Chi Thailand launched a monthly medical outreach program for essential medical services, including gynecological care and SRH education, to urban refugees in Bangkok. BASRAM and its affiliated organizations supported information exchange, connecting with refugees and arranging interpreters. In January 2021, the Tzu Chi Foundation established a free medical clinic clinic operating every weekend. The clinic offers general medical services and psychiatric care through an appointment-based system |
| UNHCR. (2023,). Annual Results Report 2022: Thailand Multi Country. | Report | Thailand | UNHCR | UNHCR also initiated the EMAP project five refugee camps and urban areas and conducted the psychosocial workshop and PSEA workshops in camps. Survivors of serious GBV received assistance from the OSCC under Thailand's MOH. In 2022, UNHCR provided legal counseling and supporting interpreters. In Tak province, UNHCR strengthened GBV committees to promote timely services and referrals for survivors. UNHCR also provided counseling, case management, emergency medical care, temporary shelter, and mental health referrals for GBV survivors. UNHCR partnered with COERR to run the Bangkok Refugee Centre, facilitating medical referrals , psychosocial counselling and sharing information about medical services, including the Tzu Chi free clinic for urban refugees |
| UNHCR. (2023). Public Health in Malaysia. | Report | Thailand | UNHCR | UNHCR collaborated closely with partner organizations involved in health initiatives for refugees in Malaysia in planning, coordination, monitoring, and evaluation, focusing on PHC and facilitating secondary hospital care. UNHCR was proactive in securing affordable HIV medications |
| UNHCR. (2023). Sexual and Gender-based Violence in Malaysia. | Report | Thailand | UNHCR | UNHCR coordinated with relevant stakeholders to enhance service coverage and quality convened SGBV Working Group meetings, and fostered discussions on activities, challenges, and opportunities in service delivery. In GBV sector collaboration, UNHCR and ICMC are working on case management, expanding the reach of the relevant SOP through community dissemination and skill development. UNHCR led the implementation of the GBVIMS to manage effectively SGBV survivors with partners by disseminating collected and stored data |
| Mercy Malaysia. (2022). 2022 Annual Report. | Grey Literatures | Malaysia | Mercy Malaysai | The Malaysia Refugees Healthcare Programme (January 2020 - August 2024), organized by Mercy Malaysia in KL and Selangor, was launched and financed by QFFD to provide ongoing SRH services at established PHC in Ampang and Kajang. |
| UNHCR. (2023). Refugee Malaysia: NGO Clinics and Services. | Grey Literatures | Malaysia | NGO | NGO clinics in KL and Selangor by Mercy Malaysia provide ANC, FP, mental health and counseling services costing 10 RM per visit on weekdays and Sundays, but no ANC is available on weekends. Tzu-Chi Foundation provides free ANC, FP in KL on first and third Sunday of each month. Mental services can access in Tzu Chi Free Clinic in Kuala Lumpur on Monday, Tuesday, Thursday, and Friday and in Selangor on Tuesday Only. Refugee women and girls can access free ANC & mental health counseling at NGO clinic in Pulau Pinang on weekdays. NGO clinics by IMARET in Selangor and in Johor also provide ANC, FP, mental health and counseling services costing 10 RM per visit on weekdays.NGO clinic at Selangor offers free ANC, mental health & counseling, FP services only on weekends. Another clinic at Selangor provides ANC services with 20 RM per visit on weekend, and contraceptive fees may vary.ACTS Clinic in Kuala Lumpur offered mental health services, voluntary counseling, and testing for HIV on weekdays and Sundays with 10 RM per visit.HIV screening and counselling to refugee women and girls were provided by the CHCC from PT Foundation in Kuala Lumpur on Tuesday, Thursday, and Saturday and counseling is by appointment only. Moreover, the cost depends on the treatment |



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| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
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| FRHAM. (2023). Services: Health Centres | Grey Literatures | Malaysia | FRHAM | FRHAM delivers contraception, HIV and STI testing, ANC, cervical cancer screenings through 13 primary centers and 13 sub centers across Malaysia. PrEP, hormonal injections, and counseling services could be accessible following consultations at relevant health facilities |
| FRHAM. (2019). 2019 Annual Report. | Report | Malaysia | FRHAM | FRHAM also offers specialist SRH care for urology, obstetrics and gynecology, and subfertility, abortion referral services. Contraception, such as IUDs, implants, Depo injections, OC pills, condoms, diaphragms, and EC pills, could be accessed from FP services after counseling |
| Tenaganita. (2022). Refugee Action Program | Grey Literatures | Malaysia | Tenaganita | Tenaganita provided legal and psychosocial aid to GBV survivors. It also collaborates with refugees, to address GBV within their communities. Tenaganita also support eight CBOs representing diverse ethnic nationalities from Burma to mobilize, assist, and empower women, awareness of rights, and psychosocial service provision |
| UNHCR. (2020) Creating Virtual Safe Spaces Led by Refugee Women to Prevent and Respond to Gender-based Violence During COVID-19 Related Movement Restrictions | Report | Malaysia | UNHCR | UNHCR Malaysia has established virtual safe spaces to share concerns, receive psychological first aid, learn about available GBV services, professional counseling, and mental health support in the COVID-19 movement restrictions. Refugee women have been trained to offer psychosocial first aid in their native languages and provide assistance within their community to ensure culturally relevant service at focal points. This program also offer transportation fees, referral services with survivor consent, case management and professional support |
| MSRI. (2023). Women And Girls Protection Programme. | Grey Literatures | Malaysia | MSRI | MSRI is currently engaged in GBV services, specifically through projects like WAGAR and EMAP. WAGAR aims to create a secure space. The WAGAR case coordinators offer professional counseling, mental health support, group sessions, emergency financial aid, and referrals to relevant partners. In addition, capacity-building sessions and community-based program are provided. EMAP represents a preventive intervention strategy developed in partnership with the IRC. |
| WAO. (2021). Sexual and Gender-Based Violence Among Refugee Communities in Malaysia: A Policy Brief By Women Aid's Organization. | Policy Brief | Malaysia | WAO | Although police report isn't mandatory for receiving medical assistance at standard OSCC guidelines, each hospital had internal SOPs and demanded a police report. In specific cases, refugee women without related police report were not attended to by the OBGYN before medical pre-payment in WAO's study in 2020. Protection and legal services are also limited. Moreover, women without marriage certificates would not get protection under the Domestic Violence Act (DVA). |



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| Author, Publication Year and Title | Type of document | Country | Provided Institution | SRH Services |
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| Ministry of Health Malaysia. (2019). Validation of Elimination of Mother-to-Child Transmission of HIV & Syphilis | Case study | Malaysia | Government | Under the infectious disease policy, HIV and syphilis treatment is free for refugees. Pregnant women are entitled to free ART during her pregnancy and exposed infant receives free ART prophylaxis, eligible ART, and complimentary infant formula up to 24 months. UNHCR card holder receive a 50% discount for lifelong ART after childbirth. AIDS Council also engage in outreach programs for ANC services. GBV services have been incorporated into the ETDs of 129 hospitals under the Ministry of Health (MOH) |
| Lee Wei San and Yasmin Masidi. (2019). The Shelter Needs of Domestic Violence Survivors and the Availability and Accessibility of Shelters and Related Services in Selangor and Kuala Lumpur By Women s Aid Organisation (WAO). | Needs assessment | Malaysia | NGO, WAO and Government | Among 45 shelters in Selangor in 2019, 35 were managed by the Welfare Department. Merely three shelters offered long-term stay, with only one without residency duration restrictions. A few shelters had specific criteria like citizenship status, police or medical reports, or husbands' contact details for verification before admission. Religious divisions are presented in some shelters. Notably, shelters for unmarried mothers often applied religious-based correction. As of March 2019, 7 shelters by NGO and one shelter by WAO were present in Selangor. Some NGO shelters occasionally accommodated survivors from other areas, albeit with limited data available. Shelter placements were initiated independently and through referrals from NGOs, governmental bodies, and UN agencies. Mutual referrals among shelters occurred when full or lacking resources to handle specific cases. In the WAO study, all NGO-operated shelters encountered difficulties due to overcrowding and inadequate resources |
| OHCHR. (2022). Malaysia's Racism And The Right To Health | Grey Literatures | Malaysia | Government | Refugees (UNHCR) cardholders are eligible for medical treatment at 50% of the foreigner's fee rate in 2014 and it also applies to delivery services. Correspondingly, the deposit rate is set at 50% of the cost. |
| Rajaratnam, S., & Azman, A. (2022). Refugee and Asylum Seeker Women's Experiences with Healthcare and Social Environment in Malaysia. | Peer reviewed article | Malaysia | Government | The cost for normal delivery and cesarean section for refugee pregnant women at public hospital was around RM5000 and RM10,000 respectively, and the deposit fees was approximately 3000-4000 for delivery. Non-Malaysian survivors could not access medico social services. However, refugee girls under 18 years old were eligible for these medico-social services under the Child Act regardless of legal status |