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Comment

Why is the use of contraception so low among the Rohingya displaced population in Bangladesh?

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A recent article published in the Lancet Regional Health – Western Pacific refers to the factors affecting child marriage and contraceptive use among the adolescent Rohingya girls (10-19 years) who married before 18[1]. Though this study provides valuable insights into the factors that influence and determine the widespread prevalence of child marriage and the low use of contraceptives among the married Rohingya adolescents, some fundamental limitations exist. This study did not adopt a probability sampling technique, and also the sample size was relatively small. Another demographic profiling and needs assessment study found that 86.3% of the Rohingya women knew about at least one modern method of contraception[2]. Almost half (48.9%) of the currently married women knew the place of service delivery for family planning methods where the most cited delivery points were the NGO hospitals or clinics (93.1%)[2]. Although the first cited article referred to the contraceptive prevalence rate (CPR) at 34.37% among the currently married adolescents aged 10-19[1], it was 33.7% among the married women aged 13-49[2], which is quite similar. Therefore, given the evidenced low CPR among the Rohingya couples, a pertinent question that needs immediate attention – 'why is contraception so low among the Rohingya displaced population in Bangladesh?'

A review of the available literature shows that religious prohibition is one of the vital causes behind low contraception usage among the Rohingya community[1–3]. Views such as "women are born to bear children," "a child is a gift of Allah (God)," and "trying to limit the number of children is a sin" are common among the Rohingya community. Their common view toward contraception is reinforced by the misbelief that family planning methods are associated with immoral behaviors[2,3]. This does not exist only among adolescent girls but also the other reproductive-aged women and their family members in the decision-making role[4]. Also, the fear of side effects of using contraceptives restricts Rohingya couples from family planning methods uptake[2,4]. Along with, misperceptions about contraceptive methods may cause infertility and even death; some other causes need to be considered for adolescents and entire reproductive-aged (15-49) women. A literature review also shows that the long history of domination, oppression, and persecution of the minority Rohingya in Myanmar act them not to receive family planning services, grounded on the religious-political motivations of expanding the Rohingya community to sustain the 'Rohingya' identity[4,5]. Also, Rohingya women get social pressure not to use contraceptives[2]. Regarding peer pressure, husbands and mothers-in-law directly play a critical role in decision-making for contraceptive and reproductive health services seeking behavior for women and girls[4].

Moreover, the barriers from both the demand and supply sides further explain the low use of contraception among the Rohingya community. The demand side barrier includes the lack of awareness for family planning among the community[6]. Transportation and restricted mobility of women and girls were also identified as barriers[4]. The significant supply-side barrier is the enormous shortage of family planning services at the Rohingya settlements[7]. In addition, the outreach teams and staff of different organizations on sexual and reproductive health (SRH) at the camps- sometimes do not share a uniform understanding of referral points for essential SRH services[8].

Thus, there are opportunities from the public health research perspective to understand better in-depth reasons to improve the low use of CPR. Considering the low contraceptive prevalence rate in the Rohingya community, it is necessary to design effective interventions urgently. In this regard, family planning services, provided in a limited and scattered way, should be coordinated across the camps. Facility workers' way of spreading information needs to be improved as girls and women do not understand why they

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need contraception, especially before the first birth. This is an important practice area in the public health to understand behavior change communication. Particular attention should be given to the religious leaders and Majhi (local Rohingya leaders) due to their influence on religious preaching and community rules related to contraception. No doubt, the challenges are evident. Nevertheless, it must be remembered that family planning is voluntary and a right-based approach that underscored the 1994 International Conference on Population and Development (ICPD). Thus, advancing family planning or reproductive health of the Rohingya displaced population can positively influence and advance sustainable development goals (SDGs) where no one will be left behind.

Declaration of Competing Interest

The authors declare no conflict of interest.

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