Sexual and Reproductive Health Working Group Bulletin

Rohingya Refugee Response, Cox's Bazar

January – June 2025

Situation Overview

From January to June 2025, the **Sexual and Reproductive Health Working Group (SRHWG)**, led by UNFPA in Cox's Bazar, remained focused on preventing excess maternal and perinatal deaths in the Rohingya response, even as critical funding interruptions threatened essential health services. The sudden suspension of U.S. government funding as well as reduced funding by other donors for the response significantly disrupted essential health service delivery across the response**.** Multiple health posts (HP) and primary health centers experienced service interruptions, nine HPs were affected in April (one closed, eight reduced in capacity), along with several PHCs and host community health facilities. Health service data shows notable declines in most SRH services during the first half of 2025, reflecting the broader funding crisis.

Policy and Standards

The SRHWG has initiated the revision and update of the existing Family Planning Strategy for the Rohingya response (2022–2025). The revised strategy will cover the period from 2026 to 2030. During the first and second quarters of the year, the SRHWG developed a roadmap for the revision process and organized a stakeholder consultation meeting with key partners. Participants included government officials, such as representatives from the Refugee Relief and Repatriation Commissioner (RRRC), Deputy Director of Family Planning (DDFP), and Civil Surgeon's offices, as well as actors from the Health Sector, SRH Working Group partners including UN agencies, national and international NGOs involved in the Rohingya response.

A Strategy Steering Committee and a Technical Committee were established to guide the process. The draft strategy has since incorporated inputs from various stakeholders. These inputs will be consolidated into a zero draft through a multi-stakeholder workshop, after which the draft will be submitted to relevant local and national authorities for review and final approval.

Allegations of Coerced Family Planning in Rohingya Camps (Oct 2024 – May 2025)

Focus group discussions led by the Communication with Communities (CwC) team revealed that some Rohingya women were coerced into accepting long-acting reversible contraceptives (LARCs), notably implants or IUDs, as a precondition for receiving Birth Information Notification (BIN) forms and other essential services. These actions, reportedly enforced by service providers across health, nutrition, and registration sectors, triggered an urgent response.

An inter-agency task force led by the Sexual and Reproductive Health Working Group (SRHWG) and composed of UN partners across protection, health, and nutrition sectors was established to address these allegations. The issue became a standing agenda item at the SRHWG monthly meetings, the health sector forums, and bi-weekly task force sessions.

- ***Actions Taken:***
  - Development and translation of key messages promoting voluntary, rights-based family planning. These messages were distributed to health workers, community health workers, and beneficiaries, and displayed at service points to raise awareness and reinforce action standards.
  - SRHWG led a re-orientation initiative for health workers, covering informed consent, voluntary family planning, respectful care, and ethical conduct, across more than 100 health facilities in the response area.
  - Health services data show an observed increase in implant uptake from July to November 2025, unlike trends in previous years.
  - The SRHWG rolled out a monitoring tool via Kobo for reporting and monitoring complaints in real time.

- ***Reporting Outcomes (to date):*** 48 incident reports logged, representing 36 unique cases (deduplicated; 17 had multiple reports; 4 lacked case specifics).

The sources of the reports include:

- 51.61% via hotline or client feedback
- 19.35% from protection sector
- 12.90% of GBV Safe Spaces
- 12.90% via site management/site development (SMSD)
- 3.24% from Housing, Land & Property sector

The most recent reported incidents occurred in May 2025 in Camps 4 and 13.

The SRH WG will continue to work with all health partners as well as other sector humanitarian partners to ensure that this practice stops completely and that all humanitarian services especially Family planning continue to be free, voluntary, rights based and unconditional.

Service Disruptions due to Funding Suspension

The year 2025 has been marked by a significant decline in donor funding, with particularly substantial cuts from the United States. These reductions have led to a scaling back of services and disruptions in critical, life-saving activities, including food assistance and health services. Additionally, following the reclassification of community health services as Priority 2 by the health sector, there has been an increasing trend among donors to fund only Priority 1 activities within the camps. This shift has severely affected demand generation for sexual and reproductive health (SRH) services, reduced referrals from the community, and consequently diminished service uptake and utilization. These gaps continue to pose serious risks, potentially leading to life-threatening health outcomes.

Moreover, due to persistent funding shortages, many health partners have had to operate at the bare minimum with both community- and facility-level staffing being drastically reduced. This has always significantly compromised service coverage.

E-stock and Commodity Distribution

As a follow-up to the establishment of the e-Stock software last year, **45 logistics personnel from 22 SRHWG partner organizations were trained** on the system to support its operationalization down to the last mile. Following the training, each partner was provided with login credentials to facilitate effective management of SRHWG supplies through the e-Stock system at all levels. Additionally, 27 logistics personnel from 15 Community Health Working Group partner organizations were trained on the software to support the community-based distribution of family planning commodities. During the first and second quarters of 2025, Mama Kits, family planning supplies, and reproductive health (RH) commodities, including RH kits for Comprehensive Emergency Obstetric and Newborn Care (CEmONC) centers, were distributed to 20 SRH TWG partners through the e-Stock system.

Capacity Building

- ➔ **Midwifery Mentorship and capacity Strengthening of Midwives and Medical Officers:** Maternal and neonatal mortality in the Rohingya refugee camps remains alarmingly high, primarily due to insufficient clinical capacity among health workers and a cultural preference for home births attended by traditional birth attendants. To address these gaps, UNFPA and the SRHWG have launched a structured **mentorship program** focused on enhancing midwifery skills and elevating the quality of maternal and newborn care services. Delivered by **International Midwife Mentors**, the program includes both practical, hands-on training and

remote support. It targets critical causes of maternal and perinatal death, such as obstetric hemorrhage, obstructed labor, newborn resuscitation, sepsis, and hypertensive disorders, while integrating **Respectful Maternity Care (RMC)** as a core component. The program also fosters stronger collaboration between midwives and doctors, encourages emergency teamwork, and builds client trust.

In the first half of 2025, under continued leadership from the midwife mentorship team: **109 healthcare professionals** (70 midwives and 39 doctors) were trained in life-saving obstetric interventions, strengthening both individual skills and facility-level emergency coordination. **78 midwives** received training in **Midwifery Life Saving Skills (MLS)**, particularly supporting newly deployed or less experienced professionals. A dedicated **RMC training** reached **31 midwives and 16 doctors** across SRHWG facilities, including Bhasan Char. **On-site clinical mentorship** was carried out in **14 health facilities**, reinforcing emergency protocols and peer learning with guidance from international and national mentors. These efforts have led to noticeable improvements, including enhanced collaboration, quicker recognition and referral of complications, and better maternal and newborn outcomes, demonstrating the potential to elevate quality of care even in complex humanitarian settings.

➔ **Training in Health Response to Gender Based violence and Intimate partner Violence:** In February 2025, the Sexual and Reproductive Health Working Group (SRHWG), in collaboration with the International Rescue Committee (IRC) Bangladesh and UNFPA, trained 20 medical doctors from 10 SRH partner organizations on the clinical management of rape and intimate partner violence (IPV). The training aimed to equip healthcare providers with the essential knowledge and skills to effectively respond to the needs of survivors.

Key focus areas included core concepts of gender-based violence (GBV), distinguishing myths from facts about GBV and IPV, comprehensive history-taking, conducting physical and clinical examinations, adhering to the Clinical Management of Rape (CMR) treatment protocol, and providing basic psychosocial support. The training also emphasized trauma-informed clinical care, empathetic documentation, and the establishment of effective referral pathways to ensure timely and holistic support for survivors.

➔ **Training on Family Planning for medical doctors:**

A four-day capacity-building training on long-acting reversible contraceptives (LARCs) was conducted for 15 physicians (2 male, 13 female) from six SRHWG partner organizations, including RTMI, IRC, IOM, BRAC, Friendship, and PHD. The training covered key topics such as LARC methods, client counseling, provision of voluntary family planning services, management of side effects, removal techniques, and Value Clarification for Action and Transformation (VCAT). The sessions combined theoretical instruction with hands-on practice to ensure skill acquisition. By the end of the training, all participants had achieved the competence required to provide LARC methods and deliver comprehensive, voluntary family planning services.

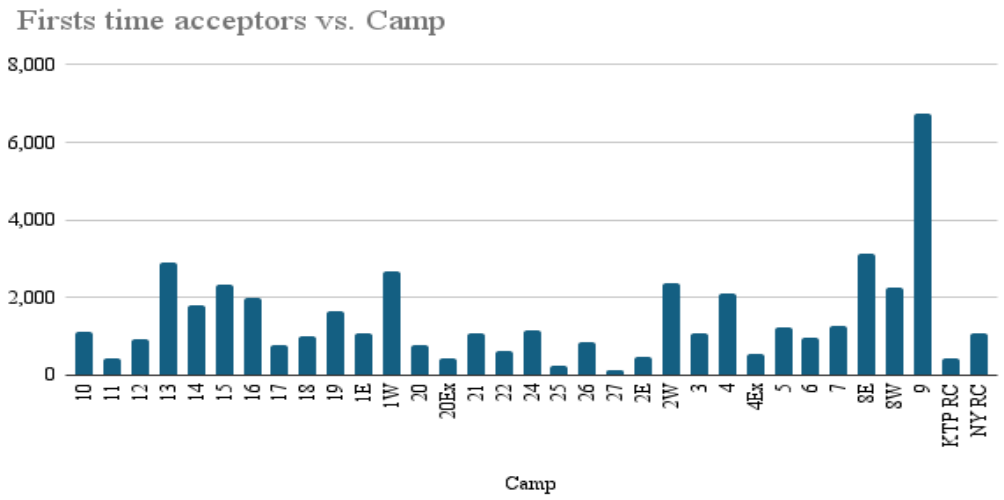
Data Overview: January – June 2025

This bulletin is based on data reported by SRH Working Group partners through the Health Sector's 4W reporting tool[1] for the period of January to June 2025. During this period, the Health Sector recorded a total of 46 Primary Health Centers, 48 Health Posts, and 2 Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities.

[1] As of 3rd August 2025

The first half of 2025 presented a mixed picture for SRH service delivery in Cox's Bazar. Despite facing operational challenges, particularly following the sudden US funding suspension, key maternal and reproductive health indicators remained relatively stable. Service volumes across family planning, antenatal care, deliveries, and postnatal care are largely on track to match or exceed 2024 figures, though some early signs of decline in follow-up services and family planning method-specific uptake suggest emerging gaps. While facility-based deliveries and PNC coverage held steady, the reduction in ANC 4+ visits, rising stillbirths, and continued home births highlight areas needing immediate attention to sustain progress.

Family Planning



A total of 56,428 first-time family planning users were recorded in Q1- Q2 of 2025, representing 43% of the total reported in 2024 (132,101). Of these, 86.4% were from the Rohingya community and 13.6% from the host community, figures closely aligned with the 2024 distribution of 85.2% Rohingya and 14.8% host. Although there was a gradual decline in the overall uptake of family planning methods from January to June 2025, combined oral contraceptive pills (COCs) remained the preferred method, accounting for 42% of new acceptors, followed by injectables at 29% and progesterone only pill 21.4%. Long-acting reversible methods, including implants (5.6%) and intrauterine devices (IUDs) (2%), were the least utilized. There was no significant change in the uptake trends of long-acting reversible methods, implants and IUDs, between Q1 and Q2 of 2025 compared to the same period in 2024. The SRHWG and CHWG jointly implemented community based family planning commodities distribution (Pill & Condoms) in the Rohingya camps. A total of 10,165 Combined oral Pill, 1279 Progesterone only pill and 43,894 condoms were distributed during the reporting period.

The SRHWG and Health sector recommend provision of rights based and voluntary family planning services provision while ensuring there is informed consent and choice provided by the refugee for the uptake of the chosen contraceptive method. The SRHWG continues to ensure availability of trained personnel on the provision of family planning as well as availability of a method mix of family planning methods.

Antenatal Care (ANC)

During the first and second quarters of 2025, SRHWG partners continued to provide antenatal care (ANC) in accordance with the national ANC protocol for Bangladesh. A total of 54,926 first antenatal care (ANC1) visits were recorded in Q1- Q2 2025, representing a 12.7% decline compared to the same period in 2024. Of the ANC1 visits recorded in 2025, 74% were from the Rohingya community and 26% from the host community, consistent with 2024 trends, where 71.8% were Rohingya.

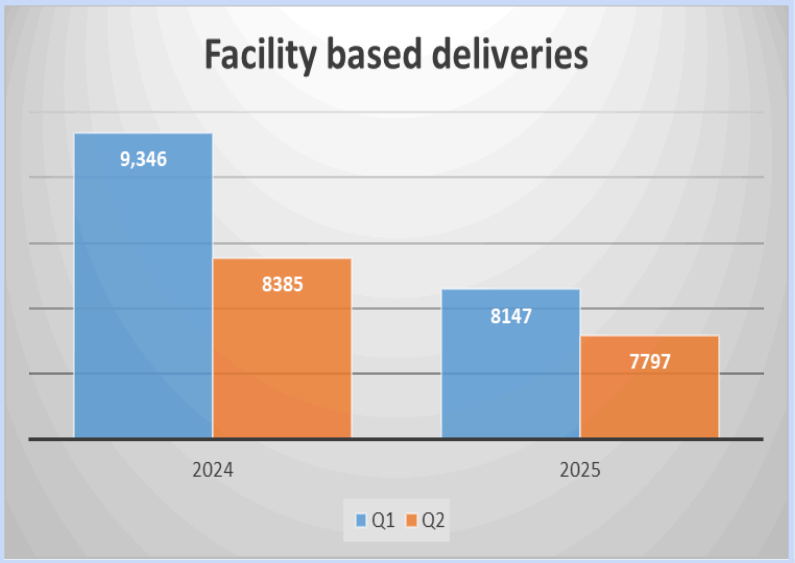
Meanwhile, a total of 14,648 ANC4+ visits were conducted in Q1 - Q2 2025, marking a 9.4% increase from the 13,384 visits recorded during the same period in 2024. This figure represents approximately 45% of the 2024 annual total of 32,367 ANC4+ visits. Of those reached in 2025, 64% were from the Rohingya community and 36% from the host community, reflecting a slight improvement in host community participation compared to 2024.

Despite the high antenatal care coverage at both ANC1 and ANC4, the quality of antenatal care could still be improved as over 59% of all maternal deaths have attended at least 4 or more antenatal care while 91% had attended at least one ANC visit. While this indicates a relatively high level of ANC service coverage, the continued occurrence of maternal deaths among women who had regular ANC suggests potential gaps in the quality and effectiveness of antenatal care services. Specifically, it points to:

- *Inadequate identification and management of high-risk pregnancies.*
- *Weak follow-up mechanisms for at-risk mothers at health facility and community levels.*
- *Insufficient birth preparedness and complication readiness counselling.*
- *Possible failures in early detection and referral of danger signs during pregnancy.*

This finding highlights the need to continue strengthening the quality of ANC, not just the coverage, through targeted capacity building and mentorship of healthcare providers, improved supervision, and ensure the use of the developed MCH card which contains the standardized risk assessment and counselling protocols across all facilities.

Facility-Based Deliveries



Like other sexual and reproductive health (SRH) services, facility-based deliveries declined in the first half of 2025 compared to the same period in 2024. A total of 15,944 facility-based births were recorded in Q1 - Q2 2025, representing a 10% decrease from the 17,731 deliveries conducted during the same period in 2024. Of these, 75% were from the Rohingya community and 25% from the host community.

A total of 1,375 caesarean sections (C-sections) were conducted in Q1 - Q2 2025, accounting for 8.6% of all facility-based births. This reflects a 7.7% decrease in the number of C-sections performed across the response compared to the same period in 2024. The C-section rate during the same period in 2024 was 8.4%, and the full-year rate stood at 8.2%, all of which remain within the WHO-recommended range of 5–15%. Of the mothers who underwent C-sections in the first half of 2025, 54% were from the host community and 46% from the Rohingya community. This marks a slight increase in access to C-section services among the host population compared to 2024, when the host share was 51.6%.

There were 374 still births reported, of which 344 were delivered to the health facility and 30 were delivered home. This is a decrease from the 505 still births reported in 2024 of which 331 were delivered at the health facility. Of the facility based still births**,** 80% were among Rohingya.

A total of 1,444 home births were reported in the first half of 2025, marking a 21% decrease from the 1,834 home births recorded during the same period in 2024. This decline may be attributed to several factors, including the consistent efforts of community health workers and the strategic engagement of traditional birth attendants (TBAs) as sexual and reproductive health (SRH) referral assistants and non-clinical labor support rather than as delivery attendants. Despite this progress, the number of home births remains unacceptably high. Greater efforts are needed to further reduce home deliveries. While the high number of home deliveries may also reflect improved access to health facilities, persistent demand-side barriers, such as transportation challenges, safety concerns, and cultural norms, continue to limit some women's ability to seek facility-based care.

Postnatal Care (PNC)

Like other SRH services, there were **21,127** postnatal visits conducted in Q1 - Q2 2025, which is a 12.6% decrease

from the 24,172 PNC visits conducted in 2024. Of the PNC visits conducted, 80% were by Rohingya and 20% by the host community.

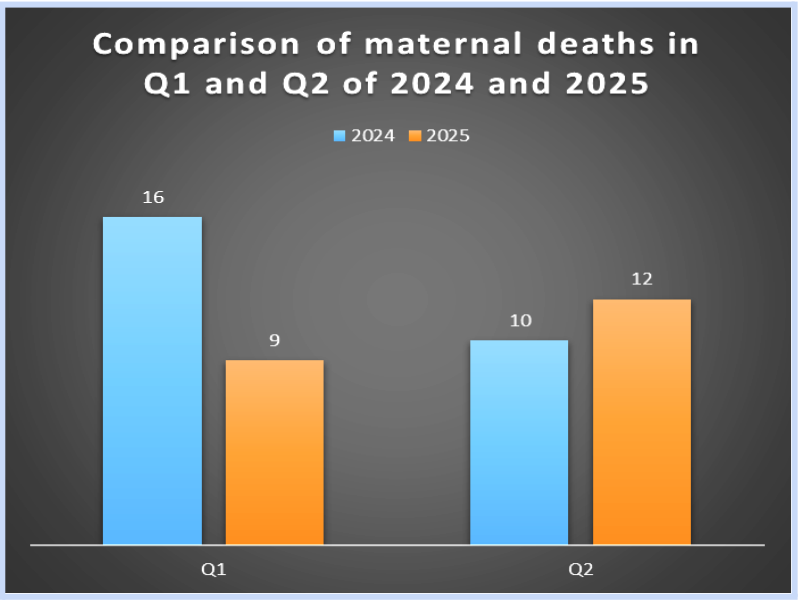
According to the maternal and perinatal death audits, nearly half (48%) of the mothers died within the 42 days postpartum period after delivery. This indicates that the early postpartum period is the most critical window for maternal survival.

This suggests inadequate/gaps in and therefore need to strengthen postnatal follow-up by community health workers including identification of danger signs, the management of postpartum complications such as hemorrhage, sepsis, or hypertension and gaps in discharge counselling and home-based follow-up care by CHWs.

Updates from the SRH WG sub-committees/technical teams

Maternal and Perinatal Mortality Surveillance and Response [MPMSR]

In Q1 - Q2 2025, 21 maternal and 242 perinatal deaths were reported, averaging 3.5 maternal and 40 perinatal deaths per month, like 2024 trends. While Q1 2025 showed a 43.8% reduction in maternal mortality compared to the same period in 2024, this positive trend reversed in Q2 2025, which saw a 20% increase in maternal deaths compared to Q2 2024. This reversal was largely driven by a spike in June, when 9 maternal deaths were reported.



The increase is likely linked to funding constraints and partner-related staffing reductions, which have compromised the ability to maintain full-time service delivery coverage. These gaps have disrupted the provision of essential maternal and newborn health services at both community and facility levels.

The leading direct obstetric causes of maternal deaths in Q1 - Q2 2025 were obstetric hemorrhage (33.3%), hypertensive disorders (28.6%), and sepsis (14.2%). These figures underscore the continued need to strengthen the capacity of midwives and medical doctors in managing obstetric emergencies and complications through targeted mentorship and training.

Nearly half (47.6%) of the maternal deaths occurred within 42 days after delivery, highlighting the urgent need to improve postnatal care at both the community and facility levels. Additionally, 19% of maternal deaths occurred during pregnancy, while 33.3% took place within the first two hours after delivery. Notably, 95% of the deceased mothers had received at least one antenatal care (ANC) visit, and 57% had completed four or more ANC visits, pointing to a need to enhance the quality, not just coverage, of ANC services. Perinatal deaths also rose in the first half of 2025, with 242 deaths reported, a 1.7% increase compared to 238 deaths in the same period of 2024. Of these, 31% were associated with low birth weight. Stillbirths accounted for 64.5% (156), while 35.5% (86) were early neonatal deaths (within 0–7 days). The primary causes included birth asphyxia (hypoxia), prematurity, and infections, often exacerbated by low community awareness, home deliveries, and delayed referrals. The Sexual and Reproductive Health Working Group (SRHWG) will continue to prioritize capacity-building efforts for health workers in managing neonatal emergencies and improving the overall quality of maternal and newborn care services.

Social Autopsy in Camp 8E: April 2025

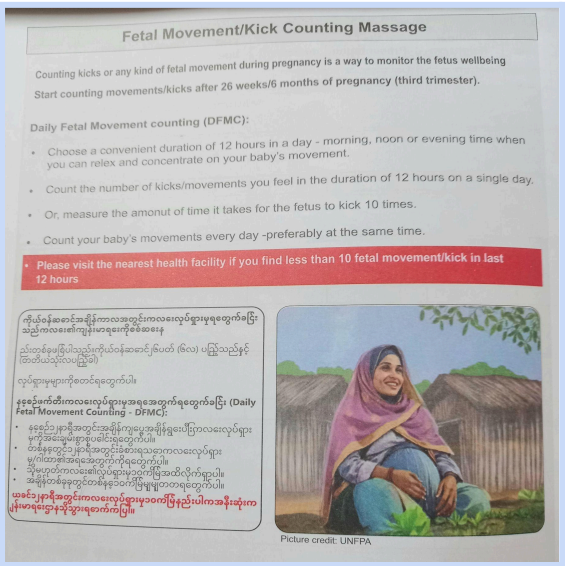
In April 2025, a **Social Autopsy** session in Camp 8E engaged 79 community members including CiCs, majhis, religious leaders and partner stakeholders from the SRHWG and health sector as well as community health working group to reflect on and analyze recent maternal and neonatal deaths. The process resulted in several key recommendations:

- *Strengthening **counseling capabilities** of Community Health Workers (CHWs)*
- *Enhance **male engagement** in maternal health matters*
- *Integrate **Traditional Birth Attendants (TBAs)** into formal health systems*
- *Improve **emergency transport mechanisms** for timely referrals*

This session was supplemented by two expert review meetings involving OBGYN specialists, whose technical guidance helped partners refine actions to address critical gaps. Despite ongoing challenges, the observed decline in maternal deaths underscores the value of continuous efforts focusing on timely care-seeking, tracking high-risk pregnancies, and ensuring facility readiness for emergencies.

Newborn Technical Sub-Committee

Courtesy of UNICEF



During the first half of 2025, the Newborn Technical Sub-Committee, chaired by UNICEF under the SRH Working Group, played a key role in coordinating and advocating for improved newborn care services across the Rohingya response. Regular monthly meetings brought together stakeholders such as UNFPA, WHO, MSF, SCI, IOM, and others to share best practices and address challenges. Notable interventions included the rollout of Daily Fetal Movement Counting (DFMC) IEC materials, Community Kangaroo Mother Care (KMC) training for 600 CHWs across 16 camps, and job shadowing programs by MSF that trained 29 healthcare providers to strengthen neonatal care in camps. PHCs and secondary hospitals maintained 24/7 maternal and newborn services, while organizations like PHD, RTMI, and Hope Hospital continued operations through Newborn Stabilization Units.

In parallel, capacity building efforts were scaled up through Essential Newborn Care and Resuscitation training for 80 healthcare staff, co-facilitated by UNICEF and RTMI. Expert review meetings and knowledge-sharing workshops were conducted by UNFPA and the MPMSR committee to improve service delivery and audit maternal and perinatal deaths. Continued advocacy by partners like UNHCR through CHW networks helped improve newborn referral systems, contributing to enhanced neonatal care and a collective push to reduce preventable deaths.

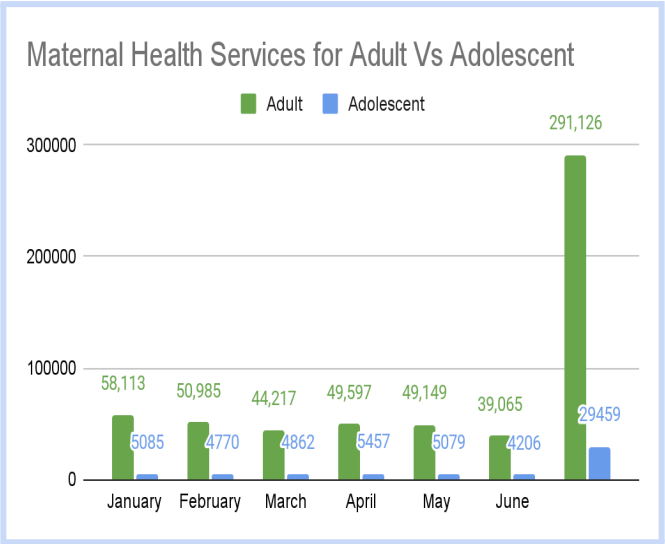
Picture: Newborn Technical Sub-Committee meeting

Picture: Adolescent girls from the prevention of child marriage program programme in the camps

Adolescents living in humanitarian settings face a myriad of challenges, and girls are especially vulnerable. They bear disproportionate risks, including maternal mortality, sexual violence, exploitation, and other forms of harm, due to a combination of factors: fragmented health service delivery, restrictive socio-cultural norms, limited autonomy, and inadequate access to information.

To overcome these barriers, the **Sexual and Reproductive Health Working Group (SRHWG)** and its partners are implementing coordinated, innovative, and integrated strategies. These approaches engage not only adolescents themselves but also their gatekeepers and community opinion leaders, both in the community and within health facilities, to bolster adolescents' access to sexual and reproductive health (SRH) services. The SRH Working Group (SRHWG) partners ensure equitable access to healthcare for adolescents by promoting the provision of adolescent-responsive sexual and reproductive health services both at health facilities and within the community

Within health facilities, SRHWG partners have introduced **"Adolescent Service Hours"**, dedicated time slots designed in consultation with communities to ensure focused, confidential care for adolescents. While adolescents may visit at any time, these scheduled hours help reduce waiting times and enhance privacy. Additionally, referral systems support adolescents who require specialized services, such as **psychosocial support**.



In community-based settings, such as Women-Friendly Spaces and Safe Spaces for Girls, partners have adopted an integrated **GBV–SRH model**. Here, a midwife is embedded within the safe space to provide SRH and adolescent-focused information and basic services: family planning, clinical management of rape, syndromic STI management, and referrals for specialized care. This sensitive, discreet environment significantly improves adolescents' access to essential SRH services. Several partners have launched Young Mothers' Support Groups targeting pregnant adolescents and their gatekeepers, including spouses and mothers-in-law, to improve both maternal and neonatal outcomes. The program incorporates integrated SRH and GBV information, counseling, and referral services emphasizing at least four antenatal care visits (ANC), Facility-based delivery, at least three postnatal care visits (PNC), Proper nutrition during pregnancy, Post-delivery family planning. Crucially, both the adolescent and her caregiver receive this guidance, fostering family

support and informed decision-making. Follow-up data demonstrates remarkable outcomes. Of the adolescents that had this program, 98.29% delivered in health facilities, 95.43% completed four ANC visits, 85.71% received three PNC visits and 98.86% adopted postpartum family planning. Additionally, from January to June 2025, 29,459 adolescent maternal health services (including ANC, PNC, and facility-based delivery) were recorded in DHIS2, accounting for 9.19% of all maternal health services for adolescent mothers.

SRH Working Group Coordination

Meetings are held fortnightly at UNFPA Office, Hotel Sea Palace. To find the next meeting date, please reach us at srh-wg-cxb+owners@unfpa.org.

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