SCIENTIFIC DAYS 10-12 May 2022

MEDECINS SANS FRONTIERES

Why mothers give birth at home: exploration of Rohingya refugees' perceptions, experiences, and expectations regarding maternity services in Cox's Bazar, Bangladesh

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Introduction

Maternal health indicators remain unacceptably poor within the densely populated Rohingya refugee camps in Cox's Bazar, Bangladesh. With a high prevalence of home births, we sought to explore perceptions, experiences, and expectations around delivery care of women of reproductive age. We also examined the potential roles of family and key community members within Camp 22, a relatively isolated camp with 23,000 refugees where MSF is the only provider of facility-based maternity care.

Methods

In 2021, we selected 45 participants from Camp 22 through purposive and snowball sampling for in-depth interviews. Participants included 36 Rohingya women and their family members, three traditional birth attendants (TBA's) and six community and religious leaders. Interviews were recorded, translated and transcribed into English by trained staff fluent in Rohingya. Thematic-content analysis was performed, whereby codes and emerging themes were identified.

Ethics

This study was approved by the MSF Ethics Review Board (ERB) and by the ERB of Bangladesh University of Health Sciences.

Results

Findings showed that delivery choices were made as a family, with husband and parents-in-law being primary decision-makers. An uncomplicated birth was not perceived as requiring facility-based assistance; many women preferred to give birth at home assisted by TBA's, family, or local healers, due to placing greater trust in their own community. Lack of security and transport were crucial determinants in repudiating facility-based care at night. Concerns about male staff and being undressed during facility-based births, as well as the possibility of onward referrals should surgery or episiotomies be required, drove hesitancy. Separation from family and children added more anxiety. Lack of understanding by facility staff towards Rohingya birthing practices and beliefs, and the Rohingya's unfamiliarity with formally-trained midwives and medical procedures, featured heavily in decisions for home births. Factors such as utilising birthing ropes and guaranteed privacy at home were key influencers for choosing home births. Additionally, perceived inexperience of midwives and lack of autonomy while in the facility, were other common reasons for apprehension.

Conclusion

This study emphasises community trust as a factor in collective decision-making regarding birth choices. Trust was higher in TBA's than in formally-trained midwives and this negatively affected perceptions regarding competence. Perceptions may also be affected by rapid midwife turnover, a factor endemic to non-governmental organizations working in Cox's Bazar. The persistent gap in cultural understanding and adaptation by facility-based staff, even after three years of presence, suggests the need for a more iterative, inclusive and reflective approach, with community engagement strategies founded on beneficiaries own explicitly stated needs, beliefs and practices.

Conflicts of interest

None declared.

Md Hadiuzzaman, RN, BSN, MPH is originally from Bangladesh and has been working with MSF since May 2017. He is an epidemiologist and a registered nurse. Currently he is working as a Mission Epidemiology Activity Manager for MSF's Sudan mission. Previously he worked with MSF in Bangladesh, based in Dhaka and the Cox's Bazar Rohingya refugee projects. In these projects he worked in different positions as a nurse, nurse supervisor, medical coordinator support, and epidemiologist. Along with his clinical nursing, coordination, and field epidemiology activities, he also carried out operational research with MSF. Currently he is involved with the SORT-IT (structured operational research and training) initiative with MSF in Luxembourg and in collaboration with WHO and The Union. He is passionate about operational research, epidemiology, and global public health.