Cox’s Bazar Rohingya Refugee Camp 22.
Photo Credit: Rachel Yantzi

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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Conflict of Interest:
The author has declared no conflict of interest.

Background

- Maternal health indicators are poor within the densely populated Rohingya refugee camps in Cox's Bazar, Bangladesh.
- In June 2019, only 35% of all deliveries in the Rohingya camps were facility-based.
- Médecins Sans Frontières is the only provider of facility-based maternity care in Camp 22, a relatively isolated camp with a population of 23,000 refugees.

Study Objective

Due to the high prevalence of home births, this study seeks to explore perceptions, experiences and expectations in relation to delivery services, care and practices among women in child-bearing age, and the role of immediate family and community key-persons living in Camp 22.

Methods

Design: An exploratory qualitative study using in-depth and key-informant interviews.

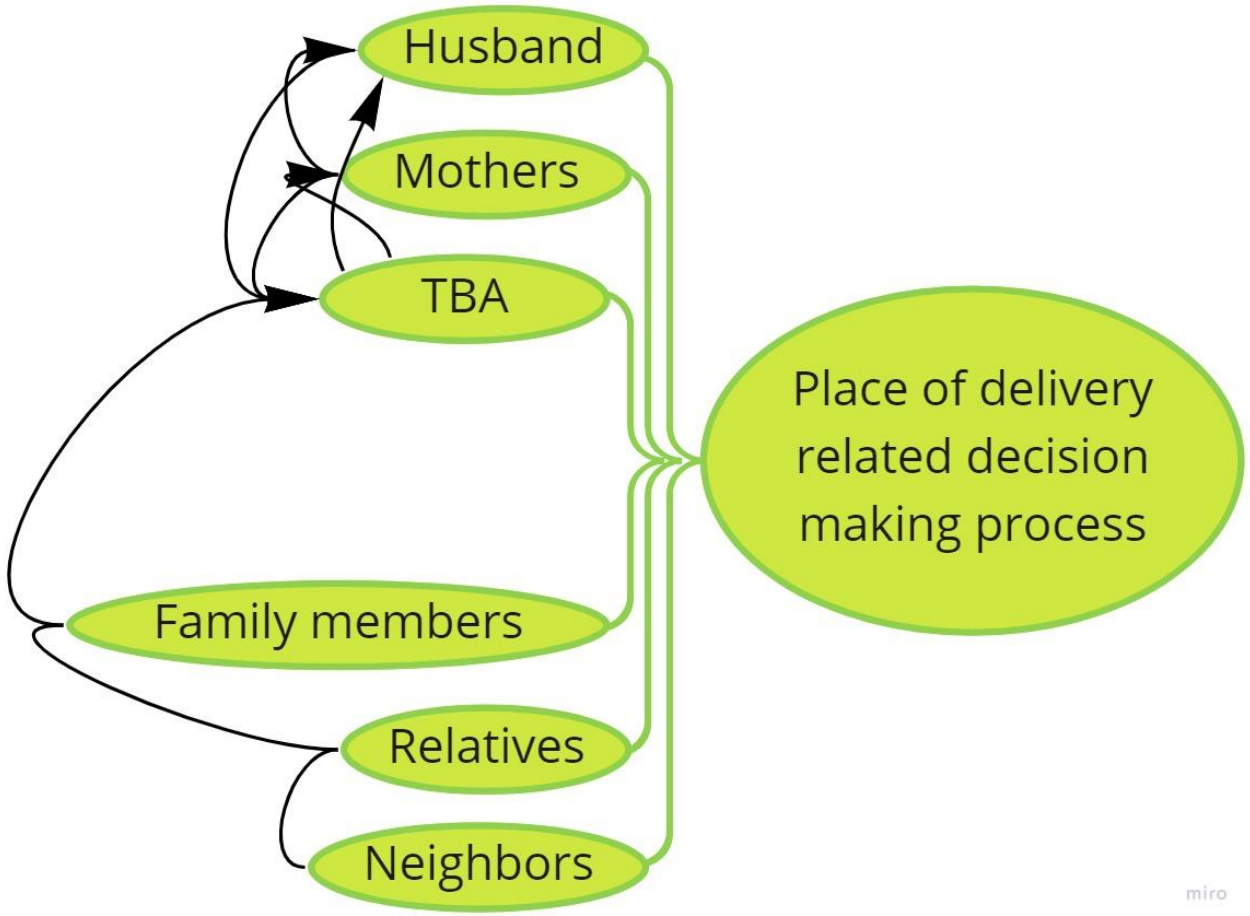
Sampling: Purposive, convenience and additional snowball sampling were used.

Sampled population: 36 Rohingya women above 15 years who have given birth in the camp and one of their family members, and 9 traditional birth attendants (TBAs), community and religious leaders.

Data collection: All interviews were conducted by the PI and one of the female authors experienced in qualitative methods and with a trained female translator's support. Interviews were recorded, translated and transcribed into English.

Analysis: Five steps framework method was used. Thematic-content analysis was performed, whereby codes and emerging themes were identified.

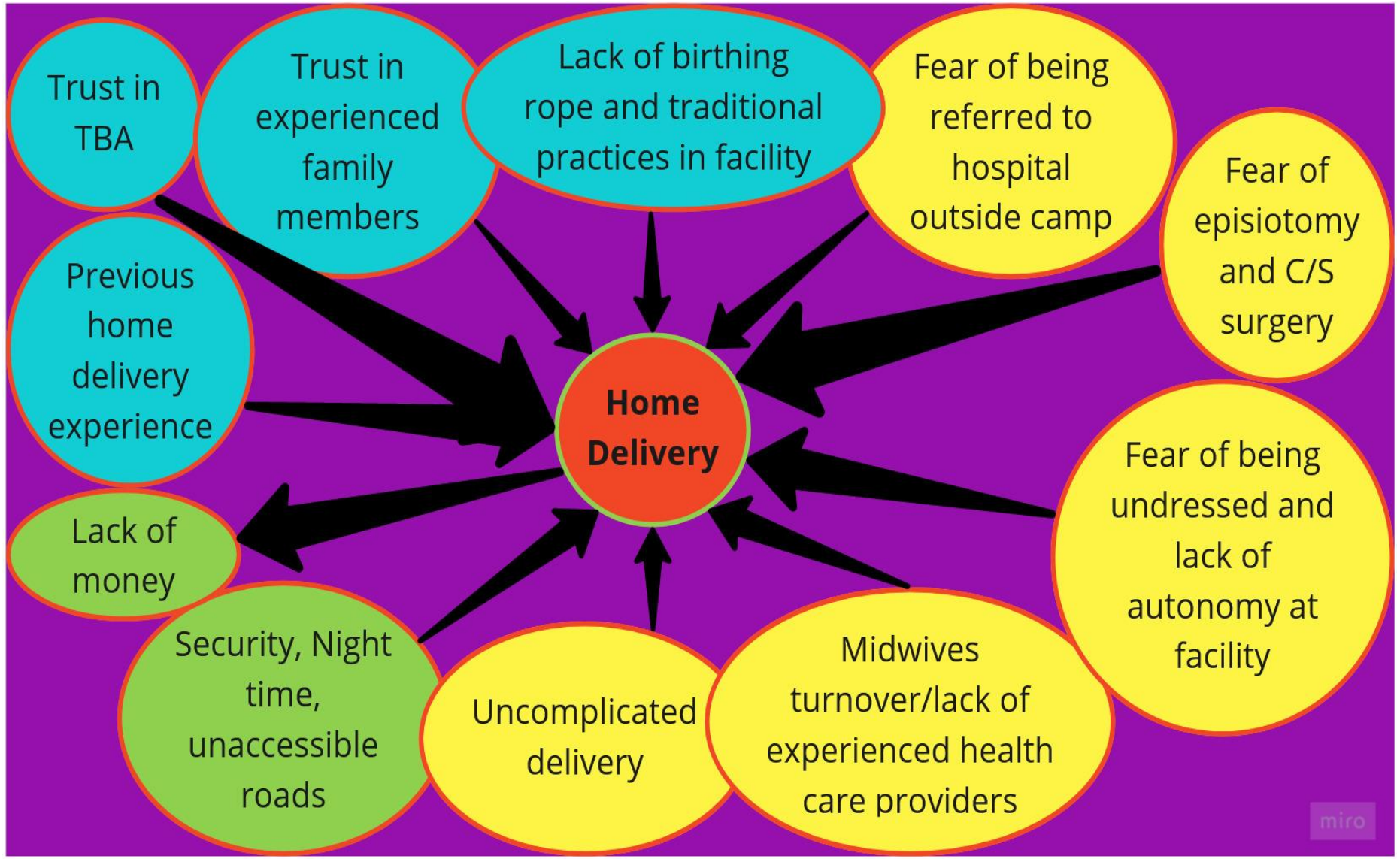
Findings: Decision-making processes



- "During the labor pain of the pregnant women, when we go to their house and after seeing everything, some of the women have difficulties during delivery and some don't have. The women who have problem or emergency, at that time we call their husband and tell them that 'your wife needs medications and you should go to the doctor, bring the doctor or medication.'" (TBA, 4 years in the camp)

- "I have to make these decisions (home versus facility-based maternity services). If I don't let her go, how will she go?" (Husband, father of 8 children)

Findings: Factors associated with delivery decisions



Findings: Cultural experiences and beliefs

The trust in Traditional Birth Attendants (TBAs) was very high during uncomplicated deliveries as this was normal practice for them in Myanmar. The lack of understanding by facility staff towards Rohingya birthing practices and beliefs such as the use of birthing ropes, and the guaranteed privacy at home were key influencers for choosing home births.

"So, I am a TBA. In Myanmar I used to help people with baby delivery and in camp right now, most of the people call me at the time when they would deliver their child. So, I can't find them, they find me . Then I go to their house and help them to deliver their child if they want." (TBA; 4 years in camp)

"Nothing bad has happened so far. My sister-in-law has delivered two children at home, and my sister similarly delivered two children at home." (Mother of 2 children)

"TBA supported me by holding from the backside and helped me to hold a hanging rope so that I can push to deliver baby when I felt contraction during home delivery in Myanmar." (Mother of five children)

Findings: Perceptions of facility-based maternal care

The Rohingyas were still very unfamiliar with formally-trained midwives and medical procedures. The perceived inexperience of midwives and lack of autonomy while in the facility were other common reasons for apprehension.

"I was feeling pain because the child got stuck, and I was shouting. So, they told me about the surgery, I was literally scared about the surgery, when I heard the name of it. And I was just thinking that maybe they would cut my body, so that's why I was scared. I said, no I don't want to do the surgery." (Mother of 2 children)

"They [Rohingya mothers] say that 'some midwives know about how to conduct delivery, but some don't know how to do it by saying: 'They [hospital staff] will kill my son.'" (TBA; 4 years in camp)

Findings: Barriers to access maternity care

Distance and therefore less family support, insecurity, and difficulty of obtaining permission from authorities to go to the facility outside the camp were often mentioned as barriers to access facility-based maternity services. On the other hand, lack of financial resources was often mentioned as a reason to choose an MSF facility-based delivery.

"During delivery, if anyone faces any kinds of complications including breech presentation of baby, bleeding, stuck baby inside that time we need to go outside. In that situation, we don't get permission from CIC and Majhi timely and easily. Also, sometimes, police don't allow us to go outside the camp. If MSF was not here, we would be like the dead people". (Mother of 2 children)

"Most of the time people live in the mountainside, that time it becomes very difficult [at night]. At that time, we need lights to bring them. But it becomes very difficult [insecure] to bring them to the hospital." (Mahji for 3 years)

"So, [earlier] I decided to come to the hospital but at midnight the labor pain suddenly started, and I had to deliver at home." (Mother of 3 children)

"Yes, if I have money, I will prefer to visit local doctor, TBA, local pharmacy regarding maternal issue but right now, I am poor that's why I came to the hospital." (Mother of 2 children)

Conclusions

- This study emphasises community trust as a factor in collective decision-making regarding delivery 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 turnover of midwives, 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 working in Cox's Bazar, 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

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