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Cultural Attitudes of Rohingya Men and Women on Reproductive Decision-Making

Ferdousi Akter[1], Nik Ahmad Sufian Burhan[1,2], Nobaya Ahmad[1] & Ishrat Hossain Rifa[3]

[1] Department of Social and Development Sciences, Faculty of Human Ecology, Universiti Putra Malaysia, [2]Institute for Social Science Studies (IPSAS), Universiti Putra Malaysia, [3]Bangladesh Red Crescent Society (BDRCS), Dhaka Bangladesh.

Email: nikahmadsufian@upm.edu.my

Corresponding Author's Email: rekha_iqbal@yahoo.com

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Abstract

The main objective of this study is to assess the cultural attitudes of the Rohingya community, and the role of gender to define the responsibilities of Rohingya men and women in their Reproductive Decision Making. Qualitative research methods were applied where Focus Group Discussions (FGDs), Key Informant Interviews (KIIs), and in-depth interviews were conducted to collect data from participants. Gender segregated FGDs and KIIs with service provider representatives and in-depth interviews with Rohingya couples were facilitated given the cultural sensitivity of the community talking about reproductive health. Results revealed that early marriage is one of the major cultural practices in Rohingya society. There are different reasons behind girl's early marriage of Rohingya girls. Rohingya parents believe that having more daughters living at home is a burden, and the community uses harsh language and makes offensive comments to the families. Second, having a large family increases the family's strength to work in their own agriculture and protects them from neighbourhood conflicts. In addition, having a larger family would strengthen their community to fight the Burmese army. Finally, cultural attitudes of Rohingya men and women toward reproductive decision-making were discussed, emphasizing key factors and participants' perspectives.

Keywords: Cultural Attitude, Rohingya, Reproductive Decision-Making, Early Marriage, Family Planning

Introduction

Refugee women have a higher rate of complications during childbirth and poor pregnancy outcomes. Women in poor health and in a traumatic situation have more chances of getting complicated when they give birth. Among humanitarian crises, the maternal mortality ratio has taken the highest position in the world due to the limited availability of health services, disruptive networks, unhygienic WASH and violence (Riggs et al., 2017). The increasing refugee problems in South Asia are indicated by the deteriorating security situation in Afghanistan and the ethnic cleansing of Rohingya in Myanmar (Ahmed et al., 2019). The predominantly Muslim Rohingya ethnic minority in Myanmar's Rakhine state, which is dominated by Buddhism, has long been persecuted in a nation that neither accepts nor wants them. Although having resided in Myanmar for several generations, the government has refused to grant them citizenship, hence they are classified as illegal immigrants. Due to the Burmese Government's failure to publicly recognize them and their absence from the national census, the Rohingya minority has historically been understudied and devalued (Mahmood et al., 2017). Hence, the Rohingya refugees are already very vulnerable, without a state, without a home, and without the resources or possibilities to create independent lives.

The ethnic minority of Cultural Rohingya, which includes other refugees, live in a patriarchal environment where women's empowerment is ignored, and their Sexual and Reproductive Health Rights are not upheld (SRHR). Since the 1960s, they have been fleeing to Bangladesh because they are being persecuted in Myanmar by both the government and the indigenous populace. The number of Rohingya refugees reported to have arrived in Cox's Bazar, Bangladesh, since August 2017 has increased to 914,998, making it the world's largest refugee camp. In the two Bangladeshi sub-districts of Ukhiya and Teknaf, the swift and significant flood of Rohingya refugees has caused a roughly three-to-one indigenous population to displacement (UNHCR, CARE and Action Aid, 2020). The traditional roles of Rohingya women as mothers, housewives, and caregivers have left many of them without access to a source of income. The danger of gender-based violence (GBV) is increased for adolescent girls due to a number of circumstances, such as cultural norms, camp security issues, a lack of opportunity for family self-development and portable skill development, and insufficient access to school (Zafari, 2019).

During the globalization and SDG 2030 era, the goal was to ensure that "no one was left behind." It has been observed that Rohingya women have faced challenges regarding their sexual and reproductive health issues, as well as reproductive decision-making power, which affects their Sexual and Reproductive Health Rights (SRHR). According to Parmar et al (2019), Human rights abuses in Myanmar, such as sexual violence and government-sponsored population control initiatives, have disproportionately affected Rohingya women and girls. The Burmese government has imposed a two-child limit on Rohingya women who are living alone, ordered them to space their pregnancies by 36 months, and forbade religious conversion and interfaith union (UNHCR, 2019; UN Women, 2018). Following their arrival in Bangladesh, the Rohingya community adopted their own culture of having large families, including early marriages and multiple pregnancies, which is likely the reason for the host government's reluctance and lack of a strategic plan to regulate the refugee family size. The researcher argues that there is a need to determine the cultural attitudes and practices of Rohingya families regarding their reproductive decision-Making so that the service providers and policymakers can design the future project, intervention plans and alternatives in addressing the potential factors to reduce gender inequality toward Rohingya women's SRHR. Second, there is no government census or published study on the demographic profile of the

Rohingya people, including their Sexual Reproductive Health (SRH).

The knowledge gained from this work could improve preventative measures aimed at preventing poor reproductive decision-making outcomes in Rohingya refugee families. Finally, given the denial of human rights, including women's empowerment, this line of research is especially pertinent to and appropriate for the Rohingya group. In a nutshell, the male-dominated, large family traditioned and religiously conservative Rohingya community have been culturally practised multiple pregnancies, overlooking women's participation in decision-making. As a result, the specific objective of this study is to explore the cultural attitudes triggering factors, which include the cultural beliefs, and experiences of Rohingya men and women for their Reproductive Decision-Making.

Literature Review

Women's reproductive decision-making power is one aspect of gender equality that has been identified as a critical factor in family planning, reproductive, and sexual health. Culturally, Rohingya girls are frequently expected to stay in the family home until marriage, and frequently even after that life milestone, even though females up to the age of 12 are frequently seen outdoors in the villages, often looking after younger siblings. The ideology of the patriarchy does not allow Rohingya women to contribute to their socioeconomic, community development, education for children, and a better future, except for cooking, household work, and taking care of cattle. Women and girls seeking access to reproductive health care confront additional obstacles because of the Rohingya community's conservative culture. It is required that Rohingya women and girls stay at home and avoid interacting with unrelated men. According to a Burma 2015 Human Rights Report (U.S. Department of State, 2015), in 2014, the maternal mortality among Rohingya was almost 400 per 100,000 live births, which was twice the rate for the rest of Myanmar's population (200 per 100,000 live births). According to the Human Rights Watch 2018, many Rohingya women are likely to have passed away in their homes unrecorded as they have been mostly left out of government statistics. Rohingya women claim to have little decision-making authority and typically will not go to the doctor unless a male relative or spouse is with them. When women can use birth control or receive reproductive care, including facility-based deliveries, is primarily up to their husbands and mothers-in-law (Ripoll, 2017). Moreover, Thaddeus and Maine (1994) listed a number of factors, such as women's decision-making abilities, standing in society, access to care, perceived severity of sickness, and travel time to facilities, as examples of what influences the first delay in seeking care.

Based on the researcher's community experience, In Bangladeshi refugee camps, it is presumable that Rohingya women are less in control of their sexual and reproductive health and that Rohingya males are authoritarian about controlling women's reproductive choices. Women are urged to procreate as frequently as possible. In Rohingya society and families, it is frequently observed that women are heavily pressured to get pregnant and give a child soon after getting married. As a result of their marginalization and exclusion as an ethnic minority, Rohingya people have low levels of official education and literacy, among other factors. Together with the traditional position of women in their households and relatively early marriage, women's agency and autonomy are also impacted (Tazreiter et al., 2017). Although they tend to make decisions regarding their wives' pregnancies and reproductive health, Rohingya males seem to be visible decision-makers.

The majority of families lack adequate food and a stable source of income. The refugees must live in fragile constructed shelters made of bamboo, brick, and mud, where extreme heat and

a lack of ventilation make it extremely unsanitary and dangerous to stay. Women face discrimination in terms of bathing and toilet facilities, where many women face a lack of water and privacy issues, as well as violence from men in terms of livelihood conflicts (Karin et al., 2020). The United Nations Population Fund (UNFPA) has assisted 3500 Rohingya women who have been sexually assaulted since late August 2017. According to reports, only about 6% to 7% of women seek medical attention following sexual violence (UNFPA, 2018). Eventually, a critical lack of food, scarce housing, and limited access to healthcare services combine to create a public health crisis said (Peacocks et al., 2017). According to UNHCR (2019), more than half of all Rohingya refugees in Bangladesh (55%) are under the age of 18. Several temporary learning centers have been established in this regard, where learners are taught early-grade lessons in the Burmese language, mathematics, and English. There are countries and cultural contexts where women's participation ignores inequality including the Rohingya ethnic minority. Gender roles in Rohingya society are linked to unequal power structures that are influenced by cultural tradition. Most facets of public life, such as education and sexual and reproductive health, are off-limits to Rohingya women. Devi (2019) stated that girls and women are confined to their own spaces, while men take up the public area. Fewer girls are forced to attend school because of the limitations on a girl's movement and the lack of restrooms close to the learning centers. Since women are seldom seen as the family's head, they struggle to manage a household without a male.

The Rohingya women are especially at risk for gender-based and sexual violence. UN Women (2018) studied that 53% of Rohingya refugee women surveyed believed that women should not leave the home, with 42% of women reporting they stayed in their homes 21–24 hours per day. According to the researcher's observations, Rohingya girls are forbidden from attending school and have their primary education interrupted when they reach puberty. Therefore, the Rohingya girls and women are facing tremendous challenges in their SRH due to their confinement and lack of knowledge about their sexual and reproductive health. Karin et al (2020) reported that the refugee women reportedly had a fair knowledge of pregnancy but insufficient knowledge of sexual and reproductive health. In camps, Rohingya girls and women face prejudice in decision-making, and problems with safety, access to information, and services. Women and girls are especially vulnerable to GBV due to restrictions on their freedom of movement, cultural and societal barriers, illiteracy, and a lack of adequate community and legal protections (Shair et al., 2019). Generally, Rohingya females follow their husbands who believe contraception is faithfully forbidden and many others assume it causes sterility.

Methodology

A qualitative research method has approached in this study where Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) and in-depth interviews have been applied for capturing detailed descriptions of various life experiences of Rohingya and understanding the meanings of Rohingya males and females' behaviour, beliefs, decisions and values. A total of 108 Rohingya males and females participated in In-depth interviews, gender-segregated Focus Group Discussions (FGD), and Key Informant Interviews. Five key informants from the service providers were interviewed to gather their observation information about the Rohingya community's Reproductive health and family planning practices.

For Rohingya couples whose marital age is 5-10 years and the age of the wife and husband is between 20 and 40 years, purposeful sampling has been used. The age range of a wife and husband was limited to 20-40 years. To recognize their particular cultural problems and the

factors that keep them from determining their family size, the FGD and In-depth interviews had facilitated in different camps. A total of 10 FGDs (men-5 and women-5) were carried out, while each FGD accommodated 10 male and 10 female participants. Secondly, in particular, 4 Rohingya couples (8 respondents) were selected separately for an in-depth interview after the FGDs. The FGDs and in-depth interviews were facilitated using semi-structured Questions

Table 1 shows a demographic profile of 108 participants, half Rohingya males and half of the females who participated in the study. The Rohingya participants were between 22 and 60. The youngest participant was 22 years old Rohingya woman.

Table 1
Participant demographic (N=108)

Characteristics	**Category**	**Number of Respondents**	**Percentage (%)**
Gender	Male Female	54 54	50.0% 50.0%
Age	22-40 years 41-60 years	78 30	72.2% 27.8%
Race/Ethnicity/Religion	Rohingya (Islam)	108	100.0%
Origin/Township	Mongdaw Buchidong Sittwe Akiab	33 32 18 25	30.6% 29.6% 16.7% 23.1%
Number of children	1-3 Children 4-8 Children 0 (no children)	26 81 1	24.1% 75.0% 0.9%
Education	No schooling Elementary school(1-5th grade) Middle school(6th to 8th grade) High school/college	84 20 4 0	77.8% 18.5% 3.7% 0.0%
Relationship status	Married Other (widow)	106 2	98.1% 1.9%
Occupation	No service Voluntary job (kind service)	103 5	95.4% 4.6%

The third phase of the study was the Key Informant Interview (KII) which facilitated the collection of information on the family planning and reproductive health practices of Rohingya refugees among NGO/aid workers working for Rohingya refugee family planning in the camps. A total of 5 organizational personnel (mid-level management staff) were interviewed for data collection.

The studied area selected the Rohingya refugee camps (camp 1E and Camp 2W) considering the researcher's direct working experience with Rohingya refugee of camps. In addition to this one old registered refugee camp (Camp 1E) and one newly extended camp for an influx

of 2017 refugees have been covered to fold the difference between old and new refugees. Group discussions and in-depth interviews have been recorded for numerous analyses of the findings. The themes categories that provide answers to the research questions of the study are explained in detail in the information on the Rohingya men and women's cultural attitudes. As for language used during the FGD and in-depth couples interview, all participants spoke the Rohingya dialect (Chittagonian dialogue) while the researcher fluently spoke this dialect. Although the researcher is a local language speaker, there was man gatekeeper for male FGDs and a female gatekeeper (social mobilizer) for female FGDs.

Data Analysis

To eliminate missing or inconsistent data, the interview questionnaire was checked for completeness, accuracy, and consistency. The researcher began data analysis with a theoretical approach in which initially coded for a specific research question and then used an inductive approach in which the research questions evolved throughout the coding process (Braun and Clarke, 2006). Braun and Clarke outlined the six stages of analysis that the data went through. The first step was to become acquainted with the data, which was accomplished through listening to audio recordings and writing the transcripts. The researcher read the transcripts line by line in the second phase of analysis, noting content related to the research questions, and initial codes were generated. The third phase involved collapsing and categorizing codes into larger themes. ATLAS.ti was used to organize and categorize coding. In phases four and five, reviewed and refined the details of each theme, as well as named/renamed themes with supervisor committee members. The study team discussed review themes (online) and identified dominant emergent themes. The findings of the data analysis became the final focus of the ten FGDs and four in-depth interview manuscripts. In phase six, the themes were consistently aggregated, reported, summarized, and the findings were described.

Results and Discussion

The section presents the findings and discussion of this qualitative research which was carried out through Focus Group Discussions, in-depth couples and key informant interviews (KII) in the refugee camps, Cox'sBazar. This study aimed to identify and understand the factors of the cultural attitudes of Rohingya men and women on reproductive decision-making at the Rohingya refugee camp in Bangladesh.

Two sub-themes emerged during the data analysis process. The sub-themes provided a framework for understanding the reproductive decision-making experiences of Rohingya women. The subcodes are used to describe and classify themes as needed throughout the analysis. The themes are considered in terms of their interconnection. Table 2 illustrates how grouped a sample of common codes into one developed theme.

Table 2

Themes and sub-themes coding

Themes	Sub-Themes	Selection of Codes	Sample Quotes
Cultural Attitudes of the Rohingya Community	• Ethnicity context • Early marriage • Large family concept • Gender role	• Child bride and early pregnancy is a systematic practice to control women's life • Large family to make a bigger community • Bigger community for preventing labour shortage • Responsibilities: Men - power holders, Decision makers and finance control Women-Men's sexual amusement, Household activities, Reproductive work	"We need many children for going back to Burma and making our community bigger to prevent the torture of the Burmese military". "All husbands want a minimum of 10 children, one will be labour, driver, teacher, and a lawyer or even will travel to different countries to earn foreign money." "In Burma, we had many lands where we need many people for working to cultivate crops. So, our parents took many children. Rohingya family in Burma had 20 children even though the Burmese government had restrictions on family size (2 children policy)". "My young baby is 16 months old and I am again pregnant for 4 months. My husband wants the baby. So, I cannot prevent birth. I do not want many children. My husband wants it because he is older age than me. I had two abortions before".

Participants described their cultural attitudes, including ethnic context (e.g., early marriage, large family, making the community bigger issues) and gender roles for defining the Rohingya man's and women's responsibilities to their families and the community.

Early Marriage

The early marriage of girls in Rohingya society has a variety of causes. First of all, families with more daughters tend to have this attitude more often because they believe having more daughters still living at home is a burden and want all of their daughters to get married while they are still alive. The parents want to marry off their daughters as soon as possible because, in addition to using various sorts of harsh language and making offensive comments, others in the community also do so if they have more than one young lady living with them. The Rohingya community's practice is not only limited to early marriage but includes early and multiple pregnancies without any space between children. Figure 1 shows the child bride and early pregnancy trend among participants.

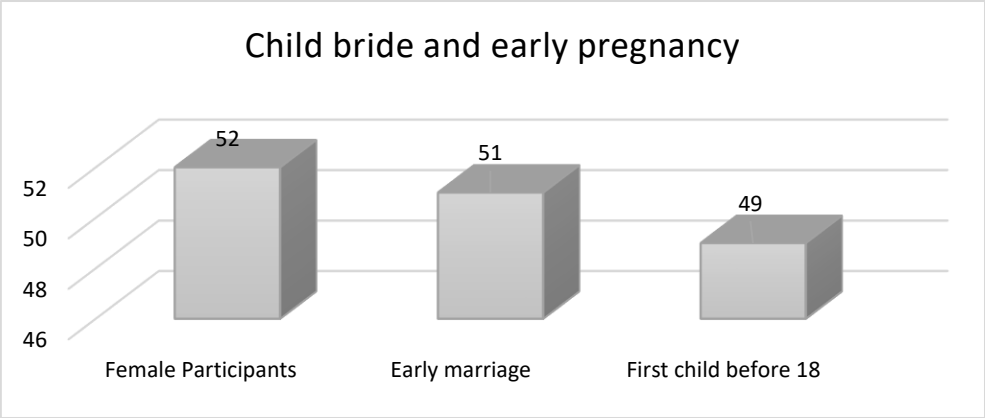

Figure 1: Status of child bride and early pregnancy

The graph has shown that 98% of participants had early marriage and 96% of participants had their first baby before 18 years old. This data has been evidenced by the Rohingya community's child bride and early pregnancy practice.

Eventually, this relates to their religious beliefs. Till adolescence, girls are considered suitable for marriage. Parents believe that keeping young girls at home unmarried for an extended period of time is a sin expressed in the community perspective about early marriage by (Azad et al., 2021).

Asma Akter, an NGO representative working for the Rohingya community, mentioned the Rohingya community's normative beliefs and practices; *Early marriage is a common phenomenon for the Rohingya community.* 98% (51 participants among 52 female) of female participants said that they married before 16 even immediately after puberty and 96% (49 among 51 female participants) conceived before 18 years of age.

Large Family Concept

Large family sizes are a common cultural phenomenon among Rohingya communities. According to NGO representatives (KII), the average family size in Rohingya society is 4.8. Ajzen and Klobas (2013) said that women's belief systems and reproductive goals are likely to differ throughout their reproductive life cycle. Rohingya women are belief free among themselves because they act for many generations as a childbearing machine for their community. Figure 2 represents key informant comments about family size in the Rohingya community.

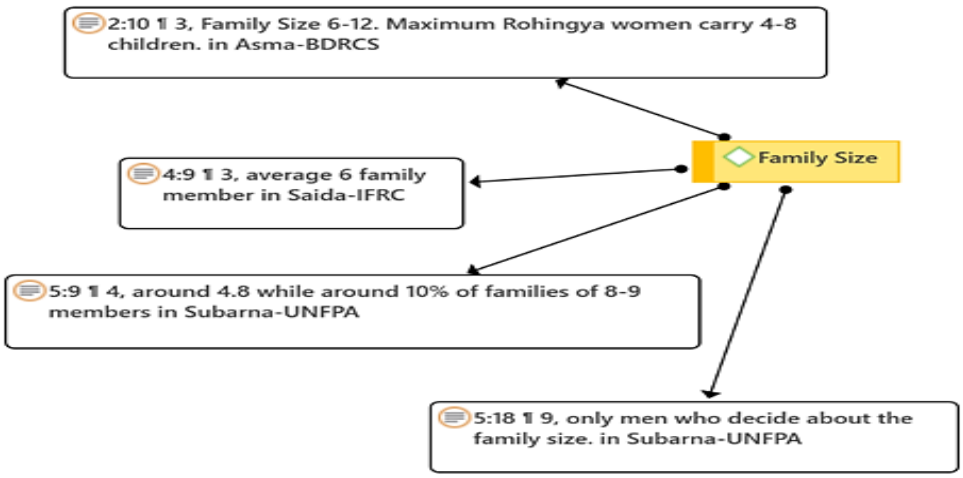

Figure 2: Key informant's comments on family size

In ten focus groups discussion (FGDs), a total of 33 participants shared their family size, with the minimum number of children being two and the maximum number being ten. According to a recent study Azad et al (2021), about 50% of women over the age of 30 had six or more children. Despite having 5-6 children, the Rohingya women want even more. Besides, it can be estimated from key informants' information that the average family size among camp participants was discovered to be 4.5. Many participants also discussed how their grandparents had 20-25, even 30 children, while their mothers had 15 to 20 children. "*Rohingya women had 10, 20, even 30 children in Burma*," said a female participant in a focus group discussion (FGD #5 F). Another male group member (FGD#4 M) stated, "*In Burma, our mother and aunties had ten children in ten years.*" During the discussion, female participants shared their memories of growing up in Burma, where their grandparents didn't know how to prevent pregnancy and couldn't express their feelings about their bodies or health. The Rohingya community in Arakan state, Burma, had vast land and property that required labour to cultivate and maintain. A participant in FGD#8 (F) explained, "*They (grandparents) had a large family." Because of their land and property, every family has many children*". Second, it was brought up in the group that the Arakan state of Myanmar did not provide any health services, such as family planning or access to contraceptives. Without the approval of the local government, Rohingya women were not permitted to travel to another township for medical treatment in Myanmar. Rohingya women are negatively impacted when the cycle of poverty is maintained due to unemployment, while pregnant women who are unable to access hospitals are severely harmed by a lack of health care and freedom of mobility (George, 2014). According to a male participant of FGD #4 (M), *"They (the older generation) did not know any contraceptives to avoid pregnancy*. *That is the reason why our mother and grandmother had 10, 20, or more kids".* The big family tradition is the result of several restrictions and unreasonable constraints. Key Informant Asma, BDRCS said *more children will bring economic solvency like day labour, other relevant work opportunities, and more relief facilities*, Saida from IFRC mentioned "*In their culture, the Rohingya community believe that those who have many children are more powerful because of gender inequality, lack of education and religious misconception exists in the community".* Subarna from UNFPA stated *" this big family size is an answer to the persecution they are going through for ages. something like – some majoritarians are trying to eradicate us through genocide, why should not we continue making our community bigger, bigger enough to vanish?"* Tasnuva from UNFPA explained the reason for big family sizes in camps *"the more number of children ensured more amount of food and other items distribution. They want to grow more population so that they can go back to Myanmar and fight against the Burmese".*

The husband detailed in the couple's in-depth interview # 2 *"Many children are helpful in protecting the family. For example, if there is any conflict between neighbours, a big family means many populations can fight against neighbours. Neighbours will be afraid of making a clash with us".* Husband of in-depth interview# 4 added, *"We will take many children since we do not need to think about food in camps".*

Female FGD # 1 participant said*; "Rohingya women in Burma did not know the contraceptive method. There is no community health worker in Burma to teach women about birth spacing or family planning".* Another female participant opined that *"all husbands want a minimum of 10 children, one will be a labour, driver, teacher, and lawyer or even will travel to different countries to earn foreign money".* Participant of FGD# 3 (F) mentioned,*" the Rohingya community like many children do not think about children's future and education. They just wanted to make the community bigger".* Another participant of FGD # 5(F) stated, *"There was*

big land and cattle in every family in Myanmar. So, they need more manpower to cultivate and look after livestock". FGD # 6 (M) stated that "Rohingya *were living in Arakan state where no support from the government. So, we had to manage our food and everything. We need more population for cultivating land, working as a labour and increasing manpower for fighting against the Burmese military".* Female FGD #8 participant said that *"the Maximum number of Rohingya men want sons, they want many children to get more sons".* Another participant of FGD # 8(F)mentioned*" Women cannot speak against Rohingya men. If women or wives speak over their husbands. They become angry, and torture their wife".*

A participant of FGD #10 (M) expressed his opinion about the Rohingya community and cultural practice in Burma *"Our thinking was different from Bangladeshi e.g. I had 10 decimals of land. I need 10 children to cultivate the land. So, I do not need to hire extra labour. Labour in Burma was expensive and rare because outsiders could not enter in Rohingya area. Therefore, we had many children in Myanmar"*. A participant of FGD # 9 (M) said "*we have to go back to Burma (our homeland), Burmese military killed many Rohingya. Now our community is smaller. We need more people as many as they killed our people to fight against the Burmese military".* Another Rohingya male participant of FGD#4 (M) opined that*" we will take many children since we do not think about food in Camps".*

On the other hand, one male participant FGD # 7(M), shared his different opinion regarding his community and women's reproduction; *"Rohingya husbands want to have children every year. After giving many children wife become old, weak and ugly. Then the husband goes for second marriage. Husbands never think their wife also needs care and rest to keep themselves healthy and pity".*

Freedom of Expression

Extremely male-dominated Rohingya societies do not admit their wives participate in decision-making and share their opinion. Men are the whole authority of a family and the wife is a loyal order follower. Wife never can raise their opinion even about their reproductive health e.g giving a space between children, giving childbirth in a hospital and else. Male and female participants were asked to share their experiences in separate focus group discussions. There were four in-depth interviews with couples in which wives followed their husbands' opinions during the interview, and a few of the wives referred to their husbands for answers. As a result, all participants' active participation in the couple's in-depth interview was not fully achieved. Rohingya wives are hesitant to express their views or speak with strangers in front of their husbands. Husbands do not like it when their wives talk to outsiders. The researcher thanked for the wife's participation in the interview, the husbands answered the majority of the questions. This situation reflects the cultural context of the community, particularly gender equality and freedom of expression. Figure 3 illustrates the husband's and wife's significant opinions of the couple's in-depth interview

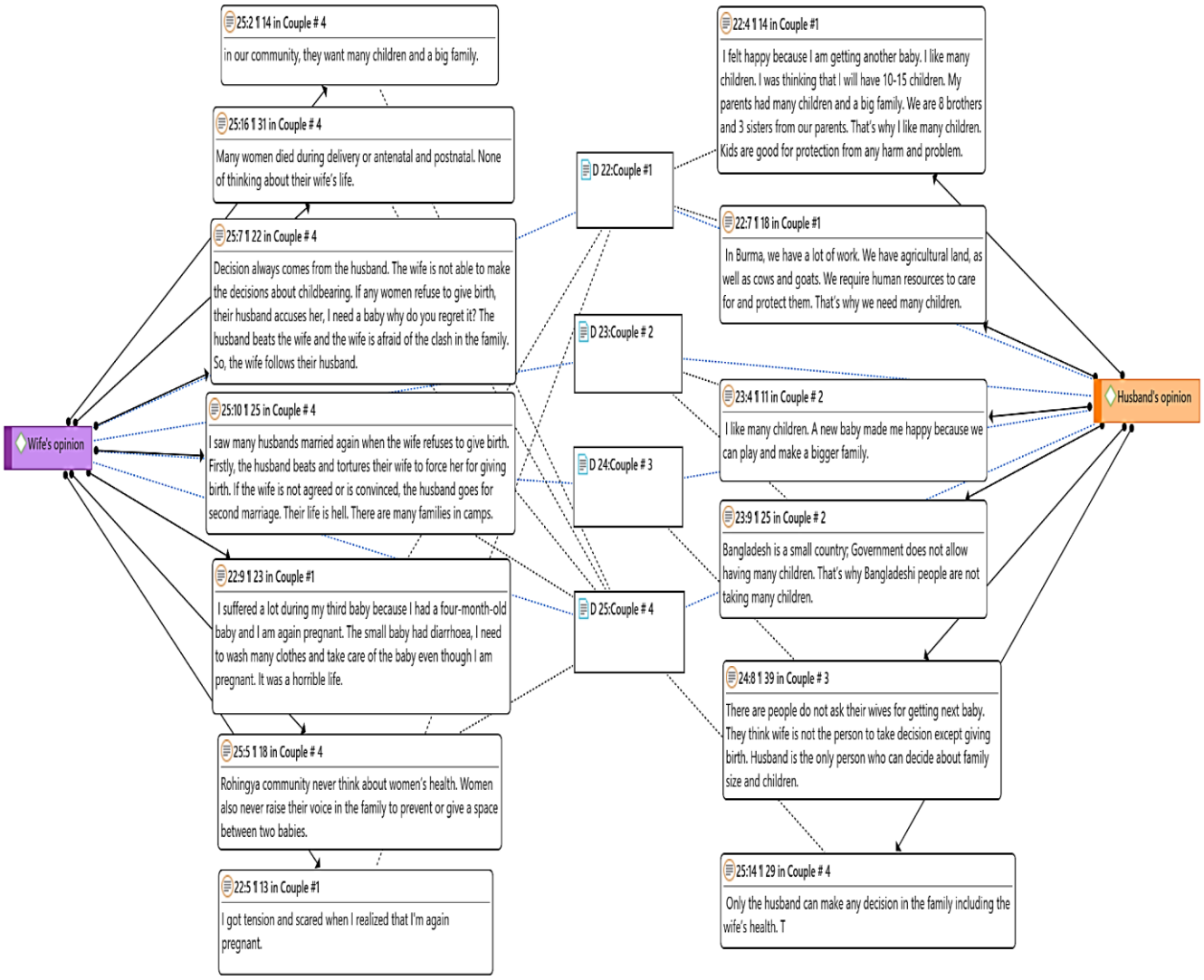

Figure 3: Opinions of husbands and wives

Males and females are separated during group discussions. Women, as a result, openly and fearlessly expressed and discussed their opinions. One FGD#5(F) participant claimed that *"Rohingya women behave like a machine for breeding. They simply carried out their husband's directions. Because there were no health facilities in Arakan state and Rohingya women had no voice in the family, many gave birth to 10, 20, or even 30 children in Burma"*.

Gender Role

Gender roles play a vital character in community development, including ethnicity and displaced status. In the community, women's rights and equality are largely ignored. Through group discussions and couple interviews, it has been revealed that the male-dominated Rohingya society practices patriarchal philosophy, with women's responsibilities limited to reproductive work and providing sexual pleasure to their husbands.

The Rohingya patriarchal society forces their wives to have multiple pregnancies until they have a son. During the discussion, participants shared their old-style practices, such as the preference for boys over girls. According to Azad et al. (2021), 58% of participants believed that a couple should carry children till a boy is born. Aside from that, there is a dowry system for bridal families in camps, which the government strictly prohibits. A girls father (participant)

of FGD#10(M) articulated, *"There is a dowry system in the camp. Parents must pay a large sum of money for their daughter's wedding. Groom's family requests a large amount of money. That is why we really want son".*

In Table 3, key informants from four different organizations and five different sectors shared their findings and observations about gender roles among the Rohingya community.

Table 3
Gender role among the Rohingya community

NGO representative	**Gender role**
Naim Ahmed from NGO Forum	They (Rohingya) are a male-headed family
Saida from IFRC	Females are the caregiver of the child and mostly do household chores, women's main role of child-rearing, males control females and they are the head of the house, every essential decision has made by the head of the household who is male.
Subarana Dhar, UNFPA	The women in the community take care of the families and need to worry about how they will feed their children or manage families. As the men are not very actively engaged in that part they do not see the various aspects/negative impacts of having a big family.
Tasnuva, UNFPA	Rohingya males are responsible for earning and all social leading positions. females are responsible for all the household chores as well as taking care of children and other family members.
Asma, BDRCS	Rohingya women are responsible for household activities like child caring, cooking, water collection, vegetable planting, educating babies, and cleaning homes while men are in the decision-making.

On the other hand, unmet gender equality is a major stressor in the Rohingya household community. Rohingya men are the family's financial and economic leaders. Rohingya women request their needs or necessary items for their husbands to purchase because they are not permitted to work outside earning money in their country Myanmar. Hoddinott et al (2020) reported that There are some women who have never left the house without a male family member in Myanmar, but they are now routinely required to interact with camp managers in order to collect rations. They must wait in line to collect rations and show the humanitarian actors their biometric ration cards to prove their eligibility. A female participant of FGD#5 voiced her views that *"Rohingya women never see money in Burma. Now we can spend money in Bangladesh. Bangladesh is a more freedom country for women".* Nonetheless, active discussions among participants revealed that Rohingya women have been shifting from their traditional role to the current situation, particularly in reproductive work, while Rohingya men have also begun to notice this, even after their ancient traditions. FGD#6(M) said, *"In Burma,*

Rohingya women were afraid of their husbands for all family matters including childbearing. Nowadays Rohingya women have been changing in camps. Community health workers are coming house to house to educate to prevent childbearing. Women are following community health workers more than their husbands".

Conclusion

This study has found that Rohingya girls' education is not given as much priority as it should be because of concerns about the culture of early marriage after immediate puberty and post-marriage pregnancies. Therefore, one major implication of this study is for educating like-minded organizations about how to approach intervention that focuses on girls' education is highly suggested. As a result, the neighbourhood will have female teachers who can also contribute to other fields in society. Secondly, the organisations providing sexual and Reproductive health services in camps will be able to take new interventions for awareness of new couples to prevent multiple pregnancies and child pregnancy as well as make a decision regarding family planning.

To be concluded this section, the findings about the cultural attitudes of Rohingya men and women toward reproductive decision-making were discussed, emphasizing key factors and participants' perspectives. A significant portion of women still lacks the capacity to regulate their own reproductive decisions, despite the fact that some women are starting to obtain contraceptive support from organizations without their husbands' knowledge. Men in the Rohingya community, such as block Majhi (leaders) and religious leaders, are less interested in attending events to raise awareness. Males tend to feel that maternal health issues are ones that men might overlook.

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