



© 2026 Universiti Putra Malaysia Press
All rights reserved.
eISSN: 3141-1509
Vol. 1, Issue 1, Article e005

FULL-LENGTH RESEARCH ARTICLE

Fertility Decisions, Gendered Power, and the Shaping of Women's Lives in Rohingya Refugee Camps

FERDOUSI AKTER^{1,*}

¹ United Nations Population Fund (UNFPA), Cox's Bazar, Bangladesh

* Corresponding author: rekha_iqbal@yahoo.com

Published: 30 June 2026

Article History: Received 4 April 2026 · Revised 25 May 2026 · Accepted 12 June 2026

Editor-in-Chief: Nik Ahmad Sufian Burhan, Ph.D.

Handling Editor: Mohammad Mujaheed Hassan, Ph.D.

Cite this article: Akter, F. (2026). Fertility decisions, gendered power, and the shaping of women's lives in Rohingya refugee camps. *Pertanika Journal of Quality of Life Studies*, 1(1), Article e005. <https://doi.org/10.47836/jqols.2026.1.1.005>

Abstract

Reproductive decision-making is often framed as a service access or contraceptive uptake issue within humanitarian contexts, while its implications for women's broader quality of life remain under-theorised. This qualitative case study explored how fertility decisions are structured within Rohingya refugee camps in Cox's Bazar, Bangladesh, and how these arrangements influence women's lived well-being under protracted displacement. Semi-structured interviews were conducted with 12 Rohingya refugees and five humanitarian service providers, supported by contextual observations and field notes. Data were analysed thematically through inductive coding and interpretive mapping informed by empowerment theory and quality-of-life scholarship. Three interrelated themes emerged: cultural attitudes and gender norms shaping fertility behaviour; structural and contextual factors influencing reproductive practices; and perceived control and decision-making authority over reproduction. Findings showed that statelessness, demographic insecurity, patriarchal authority, and religiously framed norms shape reproductive decisions. Husbands and senior male family members usually hold decisive authority over childbirth and contraception, while women's agency often appears through negotiated compliance or covert strategies. These governance arrangements affect women's physical health, psychological security, social participation, and perceived life control. By conceptualising reproductive decision-making as a structural determinant of quality of life rather than solely a health behaviour, this study contributes a gendered reproductive power governance framework for analysing women's well-being in humanitarian settings. The findings underscore the need for interventions that address household authority and community norms alongside reproductive health service provision.

Keywords: reproductive decision-making; gendered power; quality of life; displacement; Rohingya refugees; reproductive governance

Sustainable Development Goals (SDGs): SDG 3: Good Health and Well-Being; SDG 5: Gender Equality

1. Introduction

When it comes to women's quality of life within the humanitarian contexts, reproductive decision-making is a central topic of discussion but has remained under-theorised. With the emphasis on service access and health outcomes, biomedical or demographic frameworks are often applied to explore fertility, birth spacing, and contraceptive use (Fernando et al., 2025; Pérez-Sánchez et al., 2024). However, reproductive decision-making is more than just maternal health, as it exerts substantial influence on women's physical endurance, emotional stability, economic participation, social positioning, and long-term life trajectories (Achola et al., 2024). When gender inequality is involved, reproductive decisions are often not individualised

choices, and these decisions become part of hierarchical systems of authority, undermining women's agency over their own bodies (Kabeer, 1999; Malhotra et al., 2002).

In quality-of-life scholarship, the multidimensionality of wellbeing covers beyond material conditions, such as psychological security, social participation, and perceived life control. Although perceived life control is widely recognised as a foundational element of empowerment and subjective wellbeing (Rappaport, 1987; Zimmerman, 1995), reproductive autonomy remains a discrete health indicator instead. Reproductive autonomy is not considered as a structural determinant of women's overall quality of life. Such vulnerability is further exacerbated by insecurity, economic dependency, and restricted mobility issues, resulting in the complex interconnectedness of control over fertility with dignity, safety, and the capacity to shape one's future.

The study was guided by empowerment theory and quality-of-life scholarship. Kabeer's (1999) formulation of empowerment as the interaction between resources, agency, and achievements, together with Malhotra et al.'s (2002) multidimensional view of women's empowerment, provided the basis for examining reproductive decisions as relational and structurally constrained rather than as isolated individual preferences. Quality-of-life scholarship further informed the analysis by treating perceived life control, psychological security, and social participation as central dimensions of wellbeing (Rappaport, 1987; Zimmerman, 1995). These perspectives were applied to interpret how household authority, social norms, and displacement-related insecurity shape women's reproductive agency and, consequently, their quality of life.

Such dynamics within a critical context of Rohingya refugee crisis warrant further research. As a Muslim ethnic minority from Myanmar's Rakhine state, the Rohingya have been subjected to decades of systemic discrimination, statelessness, and state-sponsored violence (Amnesty International, 2017; Human Rights Watch, 2020). Following the 2017 mass displacement, there have been more than 900,000 Rohingya refugees in camps in Cox's Bazar, Bangladesh (ISCG, 2023; UNHCR, 2023). Most of them are women and girls, facing overlapping complexities involving restricted mobility, limited education, early marriage, and gender-based violence (UNFPA, 2018; UN Women, 2018).

Rohingya's stance on gender norms positions men as the head of the household and the legitimate decision-maker and expects women to take on reproductive and caregiving roles. Empirical findings revealed low contraceptive uptake, male-dominated fertility decisions, and early marriage practices among the Rohingya in camps (Islam et al., 2021; Islam & Habib, 2024; Jannat et al., 2023; Khan & Khanam, 2023; Palattiyil et al., 2025). Entrenched patriarchal structures predate the mass displacement phenomenon for the Rohingya and profoundly influence their reproductive behavioural patterns.

The integration of reproductive behaviour within broader social norms and authority structures has been extensively discussed in literature. Hossain and Dawson's (2022) systematic review highlighted the persistence of stigma, cultural expectations, and restrictions imposed by family members on women's reproductive health experiences within the refugee settings. Despite their intention to delay or limit pregnancies, many Rohingya women are unable to use contraception openly because of pressure from husbands, community norms, and fear of marital conflict or separation (Achola et al., 2024; Islam & Habib, 2024). The approval of the husband for any reproductive decisions, including pregnancy termination, reflects the prevalence of patriarchal authority over women's reproductive choices in refugee camps (Moore et al., 2025). Recent studies have discussed the reproductive practices of Rohingya in camps. For instance, Khan and Khanam (2023) highlighted that nearly 50% of the surveyed Rohingya women were not part of fertility decision-making, resulting in a higher likelihood of short birth intervals. Likewise, Islam et al. (2021) found low contraceptive uptake even though reproductive health services in Rohingya camps in Cox's Bazar have improved.

However, Rohingya's reproductive practices are more than just cultural tradition. For survival and demographic continuity, fertility serves as a crucial key. When protracted conflict and marginalisation are concerned, reproduction becomes a political drive of resilience against historical persecution and demographic erasure (Fargues, 2000; Ibrahim, 2016). The framing of a large family as protection and strength pushes these women to bear multiple children, no matter the cost. The intersection of these collective narratives with household-level authority influences who holds decisive authority over reproductive decisions (Khatun et al., 2025; Palattiyil et al., 2025; Wuermli et al., 2025).

Besides that, contraceptive behaviour and service access have been widely discussed in literature, but most of these studies isolated reproductive practices from the broader systems of authority within which they operate (Islam et al., 2021; Islam & Habib, 2024). This literature is valuable in documenting low contraceptive uptake, knowledge gaps, and service barriers, yet it is less explicit about how access, agency, and wellbeing interact under conditions of statelessness and patriarchal household control. In humanitarian contexts, reproductive health services and contraceptive prevalence are often prioritised, but access to services does not necessarily introduce meaningful autonomy, particularly in male-dominated household structures where decision-making authority remains unequal. This distinction was analytically significant from a quality-of-life perspective in the present study. Wellbeing is shaped not only by reproductive outcomes but also by the degree of agency women possess over the processes that affect those outcomes.

Addressing these gaps, reproductive decision-making in this study was conceptualised as structured regulation of fertility decisions through intersecting layers of patriarchal authority, collective survival narratives, and displacement-related insecurity or in other words, a form of gendered reproductive power governance. Fertility was explored as reproductive authority across structural, household, and relational levels, not just a private family matter. In this study, Rohingya women and men and humanitarian service providers in Cox's Bazar were interviewed to capture their perspectives on the influence of gender roles and power relations on reproductive decision-making and the influence of these governance arrangements on women's quality of life. This study posited reproductive decision-making as a structural determinant of wellbeing, shaping women's physical health, psychological safety, social participation, and perceived life control. Empowerment theory (Kabeer, 1999; Malhotra et al., 2002) and quality-of-life scholarship (Rappaport, 1987; Zimmerman, 1995) were integrated to establish a theoretically grounded framework on gendered power within the humanitarian governance contexts.

2. Methods

2.1 Study Design

Based on a case study of Rohingya refugees in Cox's Bazar, Bangladesh, this study qualitatively explored reproductive decision-making through gendered power relations. This study opted for a qualitative approach to capture Rohingya's lived experiences, social norms, and authority structures and how these influence their fertility decisions under the condition of protracted displacement through the conceptualisation of reproductive decision-making as a structural determinant of quality of life, rather than solely a health behaviour. The selection of a case study allowed the study to obtain in-depth insights on reproductive authority under everyday social relations and displacement-related constraints.

2.2 Study Setting

Two Rohingya refugee camps in Ukhiya Upazila, Cox's Bazar, Bangladesh were selected. The collaboration with a national organisation in reproductive health and community development programming provided this study the needed accessibility. With high population density and prolonged displacement conditions, these camps are overcrowded, provide limited mobility and livelihood opportunities, and depend on humanitarian assistance, which provided a critical context for this study to grasp how household authority and broader governance arrangements shape reproductive decision-making.

2.3 Participants and Sampling

A purposive sampling strategy was employed to recruit individuals with direct experience or professional insights on reproductive decision-making in Rohingya camps. With that, six Rohingya women and six Rohingya men of reproductive age and five humanitarian service providers with direct working experience in sexual and reproductive health, gender-based violence prevention, or community engagement were selected to capture different perspectives on reproductive decision-making for triangulation, adding rigor to the study. The selected Rohingya refugees were either married or previously married and resided in these camps since the 2017 influx.

The inclusion criteria for Rohingya refugee participants were: being aged 18 years or above, being married or previously married, having resided in the selected camps since the 2017 influx, and being able to discuss reproductive decision-making based on personal or household experience. Refugees who were unmarried, below 18 years of age, recently arrived after the main 2017 influx, or unable to provide informed consent were excluded. For humanitarian service providers, the inclusion criteria were direct involvement in sexual and reproductive health, gender-based violence prevention, or community engagement programming in Rohingya camps for at least six months. Service providers without direct programme experience in the selected camps, or those whose roles were purely administrative without community or service-delivery exposure, were excluded.

2.4 Data Collection

Semi-structured interview sessions were conducted in the selected Rohingya refugee camps between November 2022 and October 2023. A private face-to-face approach was employed to ensure confidentiality. Based on the integration of empowerment theory and reproductive health scholarship (Kabeer, 1999; Malhotra et al., 2002), interview guides were developed for these interview sessions. For context-specific probing, there were different interview guides for women, men, and service providers. Either Rohingya language or Bengali was used during the interview sessions, depending on the preference of the participants. Interview sessions took about 45 to 50 minutes. Informed consent was obtained from all participants. Interview sessions were audio-recorded, transcribed verbatim in the source language, and translated into English where necessary. Translated excerpts were checked against the original transcripts and audio recordings to preserve participants' intended meanings. Contextual observations and non-verbal cues relevant to interpreting power dynamics were captured using field notes.

2.5 Data Analysis

Thematic analysis was conducted. In the first stage, recurring patterns related to fertility norms, authority structures, contraceptive practices, and perceptions of control were identified through inductive coding. For data familiarity, transcripts were read repeatedly. ATLAS.ti software was used to manage data coding. In the second stage, based on the empowerment theory and quality-of-life scholarship, emergent themes were interpreted and analytically mapped onto the interrelated layers of structural conditions, patriarchal household authority, and relational negotiation. Through this interpretive stage, a conceptual explanation of gendered reproductive power governance, beyond a descriptive account of reproductive practices, was developed. The different perspectives of women, men, and service providers were constantly compared to remain grounded in participants' narratives and for enhanced analytical rigor.

Data collection continued until thematic saturation was reached. Saturation was assessed during concurrent data collection and preliminary analysis by comparing incoming interviews with the existing coding framework. After the final interviews with Rohingya participants and service providers, no substantially new codes emerged in relation to fertility norms, household authority, contraceptive negotiation, or quality-of-life consequences. The final interviews mainly confirmed and refined previously identified patterns, indicating that the data were sufficient for the study's analytic purpose.

2.6 Trustworthiness of the Study

Prolonged engagement with the Rohingya community and the familiarity with the cultural context contributed to the credibility of the study. Furthermore, dependability was ensured through an audit trail of coding decisions and analytic development. There were reflexive memos to acknowledge positionality and minimise interpretive bias. Transferability was strengthened through a rich descriptive account.

2.7 Ethical Considerations

Ethical approval was obtained from the research ethics committee of Universiti Putra Malaysia prior to data collection (Approval No.: JKEUPM-2021-387). The study was conducted in accordance with established ethical principles for qualitative research involving human participants. Before the interviews, participants were informed of the study's purpose, the voluntary nature of their participation, and their right to withdraw at any stage without penalty. Informed consent was obtained from all participants.

Confidentiality was ensured through the use of pseudonyms and the removal of identifying information from the data. Given the sensitivity of reproductive and gender-related issues, particular care was taken to safeguard participants' privacy, safety, and emotional well-being. Data collection was also conducted with attention to cultural sensitivity and respect for participants' personal experiences.

3. Results

3.1 Demographic Profile of Informants and Overview of Thematic Structure

Table 1 presents the demographic profile of the participants in this study. Most Rohingya participants had limited formal education. Meanwhile, the professional roles of the participating service providers within national and international organisations provided contextual insights on the programme implementation and community dynamics.

Table 1. Profile of study participants

Participant Category	Age	Gender	Education	Marital Status	Affiliation	Participant Code
Rohingya refugee	23	Female	Grade 6 (Myanmar curriculum)	Married	–	RF1
	24	Female	No formal education	Married	–	RF2
	40	Female	No formal education	Married	–	RF3
	32	Female	No formal education	Married	–	RF4
	35	Female	Primary education	Married	–	RF5
	25	Female	No formal education	Married	–	RF6
	27	Male	Grade 8 (Arabic curriculum)	Married	–	RM1
	42	Male	No formal education	Married	–	RM2
	30	Male	Below primary education	Married	–	RM3
	42	Male	No formal education	Married	–	RM4
	38	Male	No formal education	Married	–	RM5
	35	Male	No formal education	Married	–	RM6
	35	Male	Master's degree	Single	NGO Forum	SP1
	32	Female	Master's degree	Married, no children	UNFPA (GBViE)	SP2
Service provider	38	Female	Master's degree	Married, two children	IFRC	SP3
	37	Female	Master's degree	Married, two children	BDRCS	SP4
	34	Female	Master's degree	Single	UNFPA (SRH)	SP5

Acronyms: NGO = Non-Governmental Organization; UNFPA = United Nations Population Fund; GBViE = Gender-Based Violence in Emergencies; IFRC = International Federation of Red Cross and Red Crescent Societies; BDRCS = Bangladesh Red Crescent Society; SRH = Sexual and Reproductive Health. Participant codes: Rohingya women: RF1-RF6; Rohingya men: RM1-RM6; service providers: SP1-SP5.

Three interrelated core themes that reflected the structural, household, and relational dimensions of gendered reproductive power governance emerged, forming the thematic structure of this study: (1) cultural attitudes and gender norms shaping fertility behaviour; (2) structural and contextual factors influencing reproductive practices; (3) perceived control and decision-making authority over reproduction. Findings revealed reproductive decision-making within patriarchal family structures, community expectations, and displacement-related constraints, directly impacting the quality of life of Rohingya women.

Contextual observation data were used to support the interpretation of interview narratives rather than presented as a separate theme. Field notes recorded the visible restrictions on women's mobility, the crowded household environment, the presence of family members near interview spaces, and the gendered organisation of movement around service points. These observations were consistent with

participants' accounts of surveillance, restricted privacy, and the difficulty of making reproductive decisions independently.

3.2 Cultural Attitudes and Gender Norms Shaping Reproductive Decision-Making and Women's Quality of Life

For Rohingya families, findings revealed reproductive decision-making to be deeply embedded in cultural attitudes and gender norms, where men hold decisive authority within the household, and women primarily serve as childbearers. Fertility decisions are not individual choices or couple-based preferences. Long-standing social expectations and norms influence how communities understand, justify, and approach reproduction, which collectively shape these decisions.

Findings revealed a dominant belief within the Rohingya communities. Driven by the historical persecution in Myanmar, having more children symbolises strength, protection, and future support, as shared by a female participant:

"We need many children to go back to Burma and make our community bigger to prevent the torture of the Burmese military." (RF1)

Likewise, male participants linked large families to resilience and communal power. Fertility decisions extend beyond personal family matters, as these decisions are culturally viewed as a symbolic response to collective marginalisation. Gender norms reinforce this belief of having a large family. Men, as the head of the household, hold decisive authority over fertility decisions, which must be obeyed by women, regardless of the physical or mental state they are in:

"My husband wants the baby. So, I cannot prevent birth. I do not want many children, but I have to follow my husband because he is my guardian and decision-maker in the family." (RF2)

Such an authority structure is further consolidated by social pressure from husbands, in-laws, and neighbours. Attempting to delay pregnancy or space births may be scrutinised. Mother-in-law surveillance as a mechanism of control was a recurring point brought up during the interview sessions:

"If there was a natural gap, my mother-in-law used to call neighbours to ask why I did not have a baby for one year." (RF3)

This reflects the collective monitoring and enforcement of reproductive expectations.

Overall, these findings revealed Rohingya's cultural norms as informal governance mechanisms that legitimise male authority and restrict women's autonomy in reproductive decisions. The cultural expectations and structured power arrangements directly impact Rohingya women's quality of life, restricting their rest, mobility, and personal development opportunities.

3.3 Structural and Contextual Factors Influencing Reproductive Practices and Well-Being

Apart from cultural norms, structural and contextual factors associated with displacement, poverty, and historical exclusion influence reproductive practices within the Rohingya communities. The consistent comparison between the experiences in Myanmar and camp experiences in Cox's Bazar among the participants illustrated the influence of past deprivation and current humanitarian arrangements on their reproductive behavioural patterns.

The extremely limited access to reproductive health services in Rakhine state was highlighted. Participants described movement restrictions, fear of harassment, and the absence of local facilities. One of the male participants shared:

"There was no health care service in Arakan state. All health facilities were in another township except Arakan, where Rohingya were not allowed to travel." (RM2)

Such an environment normalises repeated pregnancies and low contraceptive knowledge.

The structural exclusion was further exacerbated by limited formal education. Most of the interviewed female participants reported no formal education. Illiteracy and the lack of awareness of reproductive health options are often linked. Intergenerational patterns reflect structural marginalisation, not voluntary resistance to family planning:

"In our parents' time, they did not know any method; women stayed at home only caring for children and cooking." (RF3)

Furthermore, new structural dynamics form within the communities following the provision of humanitarian assistance in these refugee camps. Both community members and humanitarian service providers highlighted the partial influence of relief distribution on family size, where access to resources improves when there are more children:

"More children will bring more food and other items distribution." (SP1)

Although this is not the primary reason for Rohingya to have more children, such perception still influences their fertility decisions to a certain extent, especially under economic constraints.

With displacement in place, physical access to reproductive health services improves for the Rohingya communities. However, the availability of clinics, community health workers, and family planning programmes does not influence how the communities approach reproductive decisions due to the persistence of male resistance. As shared by several interviewed male participants in this study, they were sceptical about the use of contraception and considered it to be unnecessary or externally imposed:

"Bangladesh is a small country; NGOs are educating us to take fewer babies, but we have a big country to go back to." (RM1)

Structural and contextual factors exert influence on the reproductive practices of Rohingya communities, where men possess autonomy over the decisions within the households. These factors include historical exclusion, current humanitarian arrangements, and demographic insecurity, alongside patriarchal authority. Therefore, policies that solely focus on improving reproductive health services are inadequate to transform these governance arrangements for the Rohingya communities in refugee camps.

3.4 Male-Dominated Reproductive Decision-Making and Its Impact on Women's Wellbeing

Rohingya men hold dominant power over matters of pregnancy, birth spacing, and contraceptive use, resulting in non-existent or highly restricted autonomy for Rohingya women within the households. According to several female participants, men unilaterally make fertility decisions, and their consultation is typically conditional in nature, with no shared authority between the husband and the wife:

"My husband decides when I should have another child. I cannot say no because he is the head of the family"; (RF5)

"He asks me what I think, but in the end he decides. If I disagree, he becomes angry." (RF6)

Moreover, there are expectations surrounding male offspring, pressuring couples to have a son that lead to multiple pregnancies:

"After two daughters, my husband said we must try again because we need a son." (RF2)

As a result, women experience prolonged physical strain and critical physical and mental health implications.

Through implicit mechanisms, such as emotional pressure, threats of remarriage, and social stigma, men reinforce their authority over decision-making. Husbands make abandonment threats if pregnancy expectations are not adhered to:

"If I refuse, he can marry another woman. I have nowhere to go." (RF3)

Such dynamics clearly reflect that reproductive compliance is not a mutual agreement but driven by power asymmetry.

This particular distinction from a quality-of-life perspective was deemed particularly critical. When men hold the decisive authority, the inclusion of women in the husband-and-wife discussion does not imply perceived life control, yielding multidimensional implications on women's wellbeing. Women experience physical exhaustion and various health complications when they undergo multiple pregnancies and limited birth spacing. Fear, insecurity, and lack of decision-making power subject them to psychological distress. With continuous caregiving responsibilities, women's mobility is restricted, and opportunities for education, income generation, and social engagement are limited.

Findings revealed the dominance of patriarchal authority in a Rohingya household. Men's decisive authority over fertility decisions directly constricts women's perceived life control and independence. Under this framework of gendered reproductive power governance, reproductive authority operates as a mechanism that promotes broader gender inequality under protracted displacement.

3.5 Women's Agency and Covert Negotiation Within Reproductive Governance

Findings clearly revealed the dominance of male authority in reproductive decision-making. However, this study found that Rohingya women are not entirely passive. They attempt to negotiate and show resistance against patriarchal governance, but their strategies rarely translate into openly recognised authority, as shared by most of the interviewed participants.

Several participants shared that they attempted to delay pregnancy through discussion, persuasion, and emotional appeal, suggesting women's relational agency:

"I tell him that my body is weak and I need rest, but sometimes he listens and sometimes he does not." (RF4)

Instead of direct confrontation, they make efforts to gain incremental influence, but these attempts are not effective against the dominance of power asymmetry. The decisions ultimately depend on the disposition of the husband.

Besides that, women attempt to exercise concealed forms of agency, such as covert contraceptive use. Some of the interviewed participants confessed using secretly acquired family planning methods from the clinics:

"I took the injection without telling him because I was afraid of another baby"; (RF5)

"If he knows, he will be angry. So I go quietly." (RF6)

Although they have access to services, this does not necessarily equate to shared decision-making, as women rely on secrecy and risk-taking to gain reproductive control.

Women experience psychological and social consequences from all these attempts of covert agency. Findings revealed recurring points of fear of discovery, anxiety over potential conflict, and moral dilemmas regarding obedience to husbands among the female participants. The secret contraceptive use put them in constant distress, fearing being caught:

"I feel scared every day that he might find out." (RF5)

Findings showed that constrained agency does not necessarily enhance perceived life control and is more likely to intensify stress and insecurity.

These observed patterns showed the existence of a relational layer from a governance perspective. Such narrow margins of manoeuvre create conditional, fragile, and hidden agency for Rohingya women. When it comes to dealing with patriarchal authority, Rohingya women can only make covert attempts to influence reproductive decisions without openly challenging the dynamics. In this case, behavioural autonomy and structural autonomy are distinctly different. Reproductive outcomes can be altered for some women, but the underlying authority structure in place allows their attempts to work temporarily only.

With these findings, it is evident that the narratives are not exactly straightforward, of either complete oppression or full empowerment. Instead, this study found a negotiated terrain in the reproductive decision-making among the Rohingya in camps. Rohingya women's constrained agency is evident within a broader system of gendered reproductive power governance. Their reliance on covert strategies is indicative of the restricted service-based interventions that do not simultaneously address household authority and social norms. With structural shifts in power relations, women's agency can be transformative, rather than adaptive, which can improve their overall quality of life.

3.6 The Impact of Reproductive Decision-Making on Women's Quality of Life

Findings collectively demonstrated the profound multidimensional impact of reproductive decision-making on women's quality of life. Gendered reproductive governance affects multiple domains of physical health, psychological stability, social participation, and perceived life control simultaneously.

When women undergo multiple pregnancies and insufficient recovery between births or short birth intervals, they experience poor physical health and chronic exhaustion, as shared by the interviewed female participants:

"After each child, I feel weaker, but there is no time to rest because another baby comes." (RF1)

Their limited autonomy over birth spacing greatly compromises their quality of life, alongside the risks for critical long-term health complications.

Women live in constant fear, anxiety, and emotional distress. The restricted authority they have over reproductive decisions, especially under financial constraints, results in constant psychological loop—they are concerned about becoming pregnant again against their wishes and fear for marital conflict or abandonment if they express refusal:

"I worry about another pregnancy because I am already tired, but I cannot say no." (RF2)

Women, without meaningful decision-making power, are psychologically affected with no sense of security and predictability in their daily life.

They also do not have the opportunities to socially engage in community activities and to pursue education and income generation, as they are compelled to the continuous childbearing role. Many participants highlighted their restricted mobility beyond the household due to the need to take care of children most of the time. Such caregiving burden takes away women's autonomy for personal development and social interaction. Having to heavily rely on male family members and the assigned reproductive role reinforces the restrictive position of Rohingya women in refugee camps.

Perceived life control is a key quality-of-life determinant. For Rohingya women, reproductive governance critically impacts their perceived life control, restricting their ability to shape their future. Their sense of agency greatly diminishes despite the availability of reproductive health services:

"My life follows what my husband wants. I just accept it." (RF3)

This clearly reflects broader patterns of gender inequality and reproductive authority, impacting women's overall quality of life and wellbeing.

Overall, reproductive decision-making in the Rohingya camps functions as a structural determinant of quality of life. Fertility control functions as a mechanism beyond health behaviour, structuring Rohingya women's bodily experiences, social roles, and perceived autonomy.

4. Discussion

This section discusses the presented empirical insights within broader theoretical debates on gendered power and quality of life under protracted displacement conditions. In this study, reproductive decision-making among Rohingya refugees in camps was conceptualised as a system of gendered reproductive power governance. Findings revealed various ramifications on women's quality of life under protracted displacement. For Rohingya communities, there is this multilayered structure of collective survival narratives, patriarchal dominance, and relational negotiation. Fertility decisions are embedded within broader governance arrangements; these decisions are critically restrictive towards women's bodies and life trajectories.

More importantly, reproductive decision-making is not a mere service-access issue but a governance structure that shapes multidimensional wellbeing. Unlike prior studies that highlighted low contraceptive uptake and male-dominated decision-making in refugee camps (Islam et al., 2021; Islam & Habib, 2024; Khan & Khanam, 2023), this study demonstrated how these patterns operate within intersecting systems of demographic insecurity, gender hierarchy, and displacement-related constraints. Findings introduced the concept of gendered reproductive power governance, which analytically bridged gendered power theory to quality-of-life scholarship within the humanitarian contexts.

Compared with previous studies that primarily reported low contraceptive uptake, limited knowledge, or service barriers among Rohingya women, this study highlights the authority structures that make these barriers durable. For example, earlier work has shown that service availability does not automatically translate into contraceptive use (Islam et al., 2021; Islam & Habib, 2024), while studies on childbearing decision-making have shown the consequences of women's exclusion from fertility decisions (Khan &

Khanam, 2023). The present analysis extends this knowledge by showing how demographic insecurity, patriarchal legitimacy, and covert negotiation operate together as a governance system that shapes both reproductive outcomes and wider quality-of-life domains.

Under this multi-layered governance structure, fertility decisions are regulated, subject to patriarchal authority, collective narratives, and structural insecurity. The manifestation of demographic anxieties from statelessness and historical persecution normalises large family size at the structural level (Fargues, 2000; Ibrahim, 2016). Gendered authority, stigma, and family-level restrictions, which have also been identified in broader reviews as critical barriers of Rohingya sexual and reproductive health, influence reproductive decision-making at the household level (Achola et al., 2024; Hossain & Dawson, 2022). Meanwhile, women's attempts to negotiate or conceal, which rarely transform the underlying authority structures, are indicative of constrained agency at the relational level.

These layered dynamics exert substantial impact on women's quality of life, particularly perceived life control, a foundational dimension of wellbeing in quality-of-life scholarship (Rappaport, 1987; Zimmerman, 1995). Findings linked constrained perceived control of life among Rohingya women to their lack of reproductive authority. Repeated pregnancies, restricted mobility, and psychological insecurity manifest from the gendered reproductive governance structures. These outcomes are clearly not isolated cases. Under protracted displacement conditions, such as in the case of Rohingya refugees in camps, the present findings indicate that reproductive decision-making functions as a structural determinant of quality of life.

Theoretically, the findings extend empowerment and quality-of-life frameworks by showing that reproductive agency in displacement cannot be assessed only through service use or individual intention. Within Kabeer's (1999) resources-agency-achievements formulation, available clinics and contraceptive commodities represent resources, but women's capacity to transform these resources into autonomous achievements remains constrained by male authority, fear of conflict, and community surveillance. Similarly, perceived life control, psychological security, and social participation are directly shaped by reproductive governance. This connection demonstrates how reproductive governance operates as a quality-of-life mechanism rather than merely a reproductive health issue.

Importantly, this study's findings complicated the binary narratives of empowerment versus oppression. The manifestation of Rohingya women's agency through negotiation and covert contraceptive use within such narrow margins of manoeuvre does not reflect women's autonomy, even with the access to services, as the existing authority remains asymmetrical, with husbands holding the decisive authority over reproductive decisions (Moore et al., 2025). As posited in the empowerment theory (Kabeer, 1999; Malhotra et al., 2002), agency must be relationally and structurally understood, rather than as individual behaviour alone. Improving service provision may not necessarily improve women's lived wellbeing, especially when the existing household authority and social norms persist.

With the emphasis on the interaction between humanitarian governance and household power, findings revealed a persistent dominance of patriarchal structures within the humanitarian systems despite the improved access to reproductive health services. The implemented service-based interventions may have overlooked the underlying mechanisms that govern reproductive decision-making, unintentionally expecting that service access translates into choice—such distinction in decision-making authority was similarly noted in broader assessments of sexual and reproductive health among Rohingya refugees (Hossain & Dawson, 2022). There should be a more integrated policy approach that addresses social norms, male authority, and structural insecurity alongside clinical provision in order to address this governance issue of reproductive autonomy (Fernando et al., 2025; Talukdar et al., 2025).

The findings are also relevant to SDG 3 on health and wellbeing and SDG 5 on gender equality, particularly because reproductive autonomy, prevention of gender-based harm, and women's participation in decision-making are central to both goals. In Bangladesh, the SRH Working Group's Family Planning Strategy for the FDMN Humanitarian Crisis 2022-2025 already emphasises voluntary, rights-based family planning, community engagement, male involvement, and facility-based services (Directorate General of Family Planning [DGFP] & Sexual and Reproductive Health Working Group, 2022). The present findings suggest that these priorities should be strengthened through household-level counselling, couple-based communication where safe, engagement with religious and community leaders, and stronger links between family planning, GBV response, and women-friendly spaces. The findings also align with the National

Strategy for Adolescent Health 2017-2030, which identifies adolescent sexual and reproductive health, violence against adolescents, social and behaviour change, and health systems strengthening as priority areas (Ministry of Health and Family Welfare [MoHFW], 2016). The National Plan of Action to End Child Marriage 2018-2030 is also relevant for prevention-oriented programming that addresses gender norms before they become embedded in marital and reproductive expectations (Ministry of Women and Children Affairs [MoWCA], 2018).

This study's multi-layered governance framework contributed to the expansion of literature on quality of life in relation to reproductive decision-making under forced displacement conditions. Findings clearly underscored the profound impact of gendered authority over reproduction on health outcomes, dignity, autonomy, and perceived life control. Exploring reproductive governance as central to women's quality of life provides a robust basis for the analysis of wellbeing within the humanitarian contexts.

5. Conclusion

Through the integration of empowerment theory and reproductive health scholarship and the conceptualisation of fertility control as gendered reproductive power governance system, this study qualitatively explored reproductive decision-making among Rohingya refugees in Cox's Bazar. Findings revealed a multilayered system of demographic insecurity, patriarchal dominance, and constrained relational negotiation and its impact on the reproductive authority under protracted displacement. Such governance system places women's autonomy over their reproductive trajectories under socially legitimised authority structures.

With reproductive decision-making as a structural quality-of-life determinant, this study significantly contributed to literature by expanding quality-of-life research within the humanitarian contexts through the identification of reproductive autonomy as a central domain of perceived life control and presenting a theoretically grounded framework that connects gendered power relations with multidimensional wellbeing. This study demonstrated that the ramifications of reproductive governance extend beyond maternal health, covering various domains of psychological security, social participation, mobility, and long-term life opportunities.

This study also presented significant practical contributions, particularly with regard to humanitarian policy and practice. Access to improved reproductive health services does not necessarily warrant autonomy for Rohingya women. Instead of making recognised choices, women rely on secrecy and negotiation; men ultimately make the fertility decisions. Focusing on enhancing contraceptive uptake solely may risk overlooking the existing governance structures within the Rohingya communities. It is imperative that policies and interventions take into account household power relations, community norms, and male involvement alongside service provision to provide women meaningful autonomy.

Several stakeholders can act on these findings. The Directorate General of Family Planning, the Refugee Relief and Repatriation Commissioner, the Health Sector, the Sexual and Reproductive Health (SRH) Working Group, United Nations Population Fund (UNFPA), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), Non-Governmental Organization (NGO) and International Non-Governmental Organization (INGO) health partners, Gender-Based Violence (GBV) actors, majhis (Rohingya community/block leaders), religious leaders, and women-friendly space facilitators should coordinate interventions that address household-level power relations and community norms. Recommended actions include gender-transformative family planning counselling, safe couple communication where appropriate, male engagement sessions on shared reproductive responsibility, referral pathways between family planning and Gender-Based Violence (GBV) services, and community dialogues that challenge son preference and the normalisation of repeated pregnancies. These actions should be implemented without coercion and with attention to women's safety, privacy, and informed choice.

In order to enhance women's quality of life under protracted displacement conditions, reproductive decision-making must be recognised as a governance issue, as this is clearly not a biomedical concern. There must be a shift in power relations that structure reproductive authority to expand the coverage of reproductive health programmes for sustainable improvements in women's lived wellbeing. Recognising

the governance dimension of fertility would present a more comprehensive framework for improved dignity, autonomy, and quality of life among displaced women.

6. Limitations

Several limitations should be acknowledged. This study focused on two Rohingya refugee camps in Ukhiya Upazila, Cox's Bazar, Bangladesh, and therefore does not aim to represent all Rohingya refugees or all humanitarian camp settings. The sample included 12 Rohingya refugees and five humanitarian service providers, which allowed in-depth exploration but limited broader generalisability. The sensitive nature of reproductive decision-making, contraception, and household power may also have shaped what participants felt able to disclose during interviews. As the study was cross-sectional, it could not examine how reproductive decision-making and women's quality of life change over time. Future research could include longitudinal designs and wider comparisons across camps, age groups, marital arrangements, and service-access conditions.

Declarations

Funding declaration: This research received no direct external financial funding. The United Nations Population Fund (UNFPA) provided technical and programmatic support for the broader project.

Declaration of interest: The author declares no conflicts of interest associated with this study.

References

- Achola, R., Atuyambe, L., Nabiwemba, E., Nyashanu, M., & Garimoi Orach, C. (2024). Barriers to contraceptive use in humanitarian settings: Experiences of South Sudanese refugee women living in Adjumani district, Uganda; an exploratory qualitative study. *PLOS ONE*, 19(3), Article e0278731. <https://doi.org/10.1371/journal.pone.0278731>
- Amnesty International. (2017). *"Caged without a roof": Apartheid in Myanmar's Rakhine State*.
- Directorate General of Family Planning & Sexual and Reproductive Health Working Group. (2022). *SRH Working Group's strategy on family planning for the Forcibly Displaced Myanmar National (FDMN) humanitarian crisis 2022–2025*.
- Fargues, P. (2000). Protracted national conflict and fertility change: Palestinians and Israelis in the twentieth century. *Population and Development Review*, 26(3), 441–482. <https://doi.org/10.1111/j.1728-4457.2000.00441.x>
- Fernando, G., Khafiyya, A. N., Tricesaria, A. A. I. D., Watterson, J., & Puspita, S. S. (2025). Healthcare access and outcomes for refugee women in transit: A scoping review of facilitators and barriers in South and Southeast Asia. *Journal of Immigrant and Minority Health*, 27(6), 1051–1073. <https://doi.org/10.1007/s10903-025-01722-w>
- Hossain, M. A., & Dawson, A. (2022). A systematic review of sexual and reproductive health needs, experiences, access to services, and interventions among the Rohingya and the Afghan refugee women of reproductive age in Asia. *WHO South-East Asia Journal of Public Health*, 11(1), 42–53. https://doi.org/10.4103/WHO-SEAJPH.WHO-SEAJPH_144_21
- Human Rights Watch. (2020). *"An open prison without end": Myanmar's mass detention of Rohingya in Rakhine State*.
- Ibrahim, A. (2016). *The Rohingyas: Inside Myanmar's hidden genocide*. Hurst & Company.
- Inter Sector Coordination Group. (2023). *Joint response plan for the Rohingya humanitarian crisis 2023*.
- Islam, M., & Habib, S. E. (2024). "I don't want my marriage to end": A qualitative investigation of the sociocultural factors influencing contraceptive use among married Rohingya women residing in refugee camps in Bangladesh. *Reproductive Health*, 21, Article 32. <https://doi.org/10.1186/s12978-024-01763-8>
- Islam, M. M., Hossain, M. A., & Yunus, M. Y. (2021). Why is the use of contraception so low among the Rohingya displaced population in Bangladesh? *The Lancet Regional Health – Western Pacific*, 13, Article 100246. <https://doi.org/10.1016/j.lanwpc.2021.100246>
- Jannat, S., Sifat, R. I., & Khisa, M. (2023). Sexual and reproductive health conditions of women: Insights from Rohingya refugee women in Bangladesh. *Sexuality Research and Social Policy*, 20(3), 855–868. <https://doi.org/10.1007/s13178-022-00758-z>
- Kabeer, N. (1999). Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and Change*, 30(3), 435–464. <https://doi.org/10.1111/1467-7660.00125>
- Khan, M. N., & Khanam, S. J. (2023). Women's participation in childbearing decision-making and its effects on short-interval births in Rohingya refugee camps of Bangladesh. *The Lancet Regional Health – Southeast Asia*, 15, Article 100250. <https://doi.org/10.1016/j.lansea.2023.100250>

- Khatun, H., Kabir, M. H., & Haque, M. (2025). Unveiling the inherent struggles and adjustments of Rohingya women in the camp environment. In M. Zaman, R. Anderson, & K. Ahmed (Eds.), *Rohingya stories: History and geopolitics in a multipolar world* (pp. 207–226). Springer Nature Singapore. https://doi.org/10.1007/978-981-96-7929-4_13
- Malhotra, A., Schuler, S. R., & Boender, C. (2002). *Measuring women's empowerment as a variable in international development* (Background paper). World Bank.
- Ministry of Health and Family Welfare. (2016). *National strategy for adolescent health 2017–2030*. Government of the People's Republic of Bangladesh.
- Ministry of Women and Children Affairs. (2018). *National plan of action to end child marriage 2018–2030*. Government of the People's Republic of Bangladesh.
- Moore, A. M., Afsana, K., Mondal, P. P., Tignor, M., Mulhern, O., Hussain, R., Hossain, A., Rahman, A., & Strong, J. (2025). Rohingya women's knowledge and perceptions about pregnancy termination in Cox's Bazar, Bangladesh: A community-based study. *Global Public Health*, 20(1), Article 2583145. <https://doi.org/10.1080/17441692.2025.2583145>
- Palattiyil, G., Limon, M. T. I., Mowla, S. M. N., Kadery, R. M., Mitra, D. K., Rahman, H., Muztahid, P., Sidhva, D. P., & Nair, H. (2025). Sexual and reproductive health needs, knowledge, access, and barriers to services among Rohingya adolescent refugee girls in Cox's Bazar, Bangladesh. *Social Sciences*, 14(9), Article 532. <https://doi.org/10.3390/socsci14090532>
- Pérez-Sánchez, M., Immordino, P., Romano, G., Giordano, A., García-Gil, C., & Morales, F. (2024). Access of migrant women to sexual and reproductive health services: A systematic review. *Midwifery*, 139, Article 104167. <https://doi.org/10.1016/j.midw.2024.104167>
- Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology*, 15(2), 121–148. <https://doi.org/10.1007/BF00919275>
- Talukdar, I. H., Tarannum, S., Smith, I., Rifat, M. A., Boga, P., Mumin, J., Veronés, P. A., Mahdi, Z., Alam, S. S., & Khan, A. F. (2025). Challenges of healthcare financing in the world's largest refugee camp: A mixed-method study among healthcare stakeholders for Rohingya refugees in Bangladesh. *BMJ Open*, 15(1), Article e083021. <https://doi.org/10.1136/bmjopen-2023-083021>
- United Nations High Commissioner for Refugees. (2023). *Global trends: Forced displacement in 2022*.
- United Nations Population Fund. (2018). *Rohingya refugee crisis: The situation of women and girls in Cox's Bazar*.
- UN Women. (2018). *Gender brief on Rohingya refugee crisis response in Bangladesh*.
- Wuerml, A. J., Hiott, M. C., Ugarte, E., Rahman, M. S., Elahi, M., Rahim, A. K., Dutta, G. K., Ahamed, M. S., Roy, B. R., Akhter, R. M., Hossain, E., Michael, D., Aydin, T. K., Haseen, S. H., Alam, R. B., Ratul, T. I., Horaira, M. A., Gladstone, M., Sanin, K. I., . . . Tofail, F. (2025). Cohort profile: A prenatal birth cohort study of intergenerational risk and resilience after conflict and forced displacement. *BMJ Open*, 15(11), Article e099052. <https://doi.org/10.1136/bmjopen-2025-099052>
- Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology*, 23(5), 581–599. <https://doi.org/10.1007/BF02506983>

PUBLICATION INFORMATION

Peer review: This article underwent double-blind peer review by two independent subject specialists.

Established by the Department of Social and Development Sciences, Faculty of Human Ecology, Universiti Putra Malaysia.

© 2026 Universiti Putra Malaysia Press. All rights reserved.