



Formative Assessment of Access to Sexual and Gender-Based Violence Services in Ethnic Areas in Kayin State

In Collaboration with the Karen Department of Health and Welfare and the Karen Women's Organization

January 2021

LIST OF ABBREVIATIONS

BGF	Border Guard Force	KDHW	Karen Department of Health and Welfare
CPI	Community Partners International	KNU	Karen National Union
CSO	Civil Society Organization	KWO	Karen Women's Organization
DKBA	Democratic Karen Benevolent Army	LNGO	Local Non-Governmental Organization
ECBHO	Ethnic and Community-Based Health Organization	OSSC	One-Stop Service Center
EHO	Ethnic Health Organization	PEP	Post-Exposure Prophylaxis
FGD	Focus Group Discussion	SRH	Sexual and Reproductive Health
GBV	Gender-Based Violence	SRHR	Sexual and Reproductive Health and Rights
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
INGO	International Non-Governmental Organization	WGF	Women and Girls First Program

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EXECUTIVE SUMMARY

In 2017, Community Partners International (CPI) and the Karen Department of Health and Welfare (KDHW) coordinated to provide the first program to integrate sexual and reproductive health (SRH) and gender-based violence (GBV) services in ethnic areas of southeast Myanmar. This collaboration takes a multi-sectoral approach to address the specialized health, legal and social welfare needs of survivors of GBV, as well as the SRH needs of women living in remote, conflict-affected, and hard-to-reach areas.

CPI established a One-Stop Service Center (OSSC) in Kyainseikgyi township, which acts as a walk-in SRH clinic, a referral center for GBV cases identified by 13 upgraded KDHW clinics, and a provider of outreach services to remote villages in collaboration with KDHW. CPI trained KDHW health staff on case management for GBV survivors and syndromic management of sexually transmitted infections (STIs). CPI and KDHW have conducted community education and awareness raising sessions about SRH, GBV, and the existence of these targeted services.

Despite the high level of unmet need for SRH and GBV services in the program's implementation areas, the uptake of formal clinical services remained low in the first year of implementation. In collaboration with KDHW and Karen Women's Organization (KWO), CPI conducted a formative assessment of the awareness, accessibility, and acceptability of these SRHR and GBV services through qualitative interviews and focus group discussions with KDHW leaders, KDHW health providers, GBV survivors and women of reproductive age in project areas to better understand patterns of care seeking for SRHR and GBV services and strengthen SRH and GBV programming. The assessment was conducted between May and September 2018.

The findings from the assessment demonstrated that women and girls face risks including rape, sexual assault, intimate partner violence, forced marriage, and emotional and psychological abuse. However, definitions of GBV in the community were more likely to reflect transgressions of social and gender norms, such as premarital sex and adultery. Intra-marital rape and other forms of violence were often considered a "fact of marriage."

Typically, the only support that would be sought for GBV would be mediation by the village leader(s) between spouses, or negotiation of a financial settlement and/or marriage between a rape survivor and the perpetrator. Parents and village leaders, who were considered to be the first or only source of support for GBV survivors, often acted as gatekeepers who would either facilitate or prevent women from seeking specialized care and support. Internalized shame was a powerful deterrent for women when it came to seek both general SRH services as well as GBV service needs.

Women reported that a survivor of GBV would avoid seeking health care unless her life were threatened, for fear of bringing shame on herself or her family. For women who did seek health care services for GBV, they reported service gaps included mental health and psychosocial support, and survivors emphasized the importance of the availability of a female service provider and consultation rooms that ensure audio and visual privacy.

The safety and security of women and their children remained an ongoing concern beyond the immediate GBV programmatic response, with fear of retribution and continued abuse by the perpetrator if he remained or returned to the village.

KEY RECOMMENDATIONS

Based on the findings of the focus groups and interviews with women in Kayin State, CPI makes the following recommendations:

- The provision of specialized and holistic services for GBV case management by EHO clinics is an important resource for women in remote and conflict-affected areas. However, GBV-related service availability and accessibility are not sufficient in settings where health clinics are generally under-utilized and health care seeking is universally low. **Provision of specialized services must be part of broader health system strengthening for EHOs** to provide high-quality, comprehensive, and integrated primary health care to increase overall trust in and utilization of the clinics.
- **Opportunities for patients and beneficiaries to participate in program design and implementation should be increased** to ensure that services are accessible and appropriate. The key recommendations from GBV survivors in this assessment highlighted the need for trusted (preferably female) providers who can speak local languages and private patient care settings. Mental health and psychosocial support services for GBV survivors also need to be strengthened as an urgent priority. Safety and security remain long-term and unmet needs for GBV survivors and their families.
- Outreach services remain an essential tool for reaching adult women and especially adolescent girls who may have limited access to clinics and should be combined with health education activities to increase awareness of the available health, social, and legal support services for GBV. **Outreach services**

must be delivered in a way that protects the safety and confidentiality of GBV survivors, as well as the security of health care providers.

- Community members need to be better informed about which services are available and how to access them. Given that village leaders are important entry points for services, there needs to be **stronger engagement of village leaders as well as local authorities** to support women with clear and accurate information about the scope of services available.
- As frontline providers, **EHO health workers need to be empowered to provide effective awareness raising messages about GBV and the availability of GBV services.** Specific recommendations include replacing flipcharts and vinyl posters with educational videos featuring actors who speak local languages.

INTRODUCTION

In 2017, Community Partners International (CPI) and the Karen Department of Health and Welfare (KDHW) coordinated to provide the first program to integrate sexual and reproductive health (SRH) and gender-based violence (GBV) services in ethnic areas of southeast Myanmar. This collaboration takes a multi-sectoral approach to address the specialized health, legal and social welfare needs of survivors of GBV, as well as the SRH needs of women living in remote, conflict-affected, and hard-to-reach areas.

CPI established a One Stop Service Center (OSSC) in Kyainseikgyi township, which acts as a walk-in SRH clinic, a referral center for all GBV cases that are identified by 13 upgraded KDHW clinics, and a provider of outreach services to remote villages in collaboration with KDHW. CPI trained KDHW health staff on case management for GBV survivors and syndromic management of sexually transmitted infections (STI). CPI and KDHW have conducted community education and awareness raising sessions about SRH, GBV, and the existence of these targeted services.

Despite the high level of unmet need for SRHR and GBV services in the program's implementation areas, the uptake of formal clinical services remained low in the first year of implementation. In collaboration with KDHW and Karen Women's Organization (KWO), CPI conducted a situational analysis of the awareness and perceived appropriateness of these SRHR and GBV services through qualitative interviews and focus group discussions with KDHW leaders, KDHW health providers, survivors of GBV and women of reproductive age in project areas to better understand the patterns of care seeking for SRHR and GBV services and how services can be improved.

METHODS

From May to September 2018, CPI conducted a formative assessment using qualitative data collection methods. Separate FGDs were organized for unmarried women aged 18 to 24 years old and married women aged 25-49 years old in order to understand how SRH needs and perceptions of GBV services may differ based on age and marital status, and to ensure that the voices of younger women would be heard in a setting where younger, unmarried women may have less power and authority to speak about their experiences in front of married women.

CPI and KDHW coordinated with village administrators, religious leaders, and clinic staff to select FGD participants. Through four FGDs, CPI spoke to 36 women in four villages in Kyainseikgyi and Kawkareik Townships. FGDs were conducted in Burmese with the assistance of a translator for Karen languages. A semi-structured interview guide was developed to capture general experiences of marriage for women and girls, the types of violence experienced by married women and girls, and the availability of and access to services and support for SRH and GBV needs.

To safely and confidentially reach GBV survivors, CPI partnered with Karen Women's Organization who identified and interviewed nine women (ages 33 to 52 years) who were willing to speak to KWO about their experiences accessing health, social, and legal services for GBV. All interviews with GBV survivors were conducted in the local language of the respondent and in a private location chosen by the respondent. The semi-structured interview guide focused on the decision-making around care seeking for GBV services rather than the history of the GBV incident(s) itself.

To understand the challenges of delivering SRHR and GBV services in the program area and the specific health system strengthening needs to better respond to GBV cases, CPI also interviewed 10 KDHW leaders in Mae Sot (Thailand) and Hpa-An, and conducted two FGDs with 17 KDHW clinic- and community-based health care providers from Kyainseikgyi, Kawkareik, Myawaddy, and Hlaingbwe townships who had been trained by CPI to deliver SRH and GBV services under the Women & Girls First project.

All participants gave informed consent to participate in the study.

FINDINGS

Even in project areas and among trained GBV service providers, "GBV" was considered to be a "Western" or "urban" term that is difficult for individuals to engage with, both because it has no salient local meaning and because abuse of any kind can be difficult to discuss openly in Karen and Burmese culture.

There was a lack of common understanding of what the term "GBV" referred to. Reported incidences of GBV within respondents' villages tended to reflect transgressions of societal and cultural norms—such as premarital sex, adultery, (a wife's) desire to prevent pregnancy, (a wife's) infertility, or verbal disrespect of parents by their children—rather than forms of physical, sexual, verbal, psychological, or economic abuse. For women who had experienced GBV, they reported the prevailing definition of the physical, sexual, and emotional abuses that they had experienced:

"The community or the neighbors don't see this as GBV. They say this is karma."
-Interview, GBV Survivor

"They don't understand this to be GBV. This is fate."

-Interview, GBV Survivor

While social media (i.e., Facebook) was believed to play a positive role in raising awareness about GBV in Karen communities, it was also perceived to contribute to forms of (locally defined) GBV including early dating, premarital sex, and early marriage.

The taboo nature of discussing GBV played out at the communal level, with some variation between FGD groups. Some FGD groups reported that there was no incidence of GBV of any kind in their village, "though it may happen elsewhere," while other FGD groups reported that GBV was very common, with "8 or 9 out of 10 households" having household members who experienced GBV.

Despite these reported differences in perceived prevalence, there were widespread reports of non-consensual sex between married partners in all FGD groups. Non-consensual sex between married partners did not appear to be considered rape by any of the participants, and was discussed as "a fact of marriage." Similarly, there were widespread reports of men controlling or influencing a woman's ability to use family planning, which reflects that some women in these communities did not have agency to consent to protected sex due to prevailing gender norms.

"Men have to earn money. Women have to stay at home and look after the children. He has to earn money to feed his wife, so she has to listen to what he has to say."
-FGD, health workers for the WGF program in Kayin State

Intra-household conflict also reflected prevailing gender norms. Respondents described that most tension arose because

men could not or would not provide financially for their family or because women were perceived to be neglecting their childcare responsibilities. Some women reported being the primary or sole breadwinner for the family, yet arguments and physical abuse could arise if the woman complained when her husband spent the earnings outside of the home against her wishes. Discordance over pregnancy intentions was another commonly reported source of tension that could trigger verbal or physical abuse. Physical abuse against women and girls was almost always perceived to be tied to alcohol use by men.

"If the man is addicted to alcohol, the marriage will not be happy. The economy, the schooling, the children, and the livelihoods will all be affected.

It [violence against women] is almost impossible if you are not drunk."

-KII, KDHW Leadership

CARE SEEKING PATHWAYS FOR GBV SERVICES

Among women, there was no reference to GBV as a "health issue" or as a phenomenon which has health consequences. Instead, GBV was described universally as a "family issue," a phenomenon which has consequences for the marriage and reputational risks for children. The difference between GBV as a "family issue" instead of a "health issue" was reflected in the choice of a confidante/counselor, if a woman sought outside help at all. When prompted, respondents agreed that a woman might go to the nearest clinic if she sustained severe or life-threatening injuries, however they also expressed that most women who experienced physical or sexual abuse would prefer to "get better by themselves."

Instead, respondents reported that the first

person a woman who has experienced GBV will contact is the Village Head, or she will first seek advice from her parents who will then contact the Village Head on her behalf. Parents, especially, are sought out first because they are perceived to be the most likely to keep the information confidential due to a perceived mutual interest in protecting the "dignity of the family."

Village Heads were generally perceived to be effective mediators who can usually "solve the problem." If the Village Head cannot resolve the marital dispute, the woman, or more typically, the Village Head on her behalf, will go to the Village Tract Group. If the Village Tract Group cannot bring about an acceptable solution, the woman can seek justice at the Township level by consulting the Township Police and Township Women's Affairs.

Justice systems for addressing both sex and sexual assault outside of marriage tended to be similarly informal and were highly dependent on whether a girl or woman was a virgin at the time of assault and whether she became pregnant as a result of the assault. As noted above, discussions on GBV tended to incorporate ideas outside of the traditional definition of GBV, including premarital sex between boyfriends and girlfriends. For both premarital sex and rape, the man or boy was expected to go house-to-house, "confessing" his wrongdoing.

According to FGD respondents in one village, in the case of premarital sex, the male partner would pay the female partner's family one million MMK (US\$760) to 30 million MMK (US\$1520) if she became pregnant, with the amount conditional on whether the couple would later marry. In the case of rape, the perpetrator would pay the survivor's family 50 million MMK (US\$3,800), and if the rape resulted in a pregnancy, he would also be responsible for paying for the

child's living expenses and tuition until the child reached the age of 15.

The perpetrator could also be detained by the KNU for up to 1 year or forced to leave the village by the leaders. One GBV survivor who was interviewed reported that her parents arranged a marriage to her rapist as a measure to protect their daughter's reputation in the village.

The perception that sexual assault, within or outside marriage, is not a health issue has significant consequences for women's health, wellbeing, and opportunity to seek justice. Among all FGD respondents, there was limited knowledge of the importance of seeking health care within 3 days from skilled providers to access emergency contraception, post-exposure prophylaxis (PEP) to prevent HIV infection and receive a forensic exam.

BARRIERS TO CARE SEEKING

Among all FGD groups, there was limited knowledge of causes and treatments for common gynecological and genitourinary health issues for women. Women and girls preferred to treat themselves in private out of a sense of "shyness" which stemmed from not knowing what to say about their symptoms to the health care provider and "shame to have someone touch them" or see their bodies, especially in cases of infection. Instead, women would sometimes purchase medications or traditional remedies at local shops, and trusted female family members were the preferred source of medical advice.

"I did not go [for treatment of genital itching and white discharge]. I was ashamed. I did nothing. I asked my mother for help."
-FGD, unmarried women 18-24 years old
Care seeking for GBV mirrors care seeking for SRHR, in which internalized shame acts as a powerful deterrent against accessing

services, with a strong preference for self-treatment.

"Even if they dare to tell the village leader, they don't dare to go to the clinic."
-FGD, married women 25-49 years old

"I am ashamed to tell the 'sayarma' [health provider] and I am ashamed that my neighbors will find out."
-FGD, married women 25-49 years old

Concerns about the long-term safety and security of her whole household influenced women's decisions about seeking support in the first place. Respondents described that some women would be too afraid of their husbands' response, including continued violence, if she were to report him. Other women were afraid that living without a husband would expose her to greater risk from criminals in her community.

"I wanted to ask for support but my life was in danger. I was afraid that my family would get hurt."
-Interview, GBV survivor

"If the judge does not convict him [the husband], it [intra-household violence] will be the same as before. The other issue is security. Other people will see that she is living alone. How can she feel safe if she has to worry about being hurt by others after he's gone? She has a family, she has children, so she just puts up with it, or else the children will be in trouble and it will be difficult for her to get along on her own. You see a lot of that."
-FGD, health workers for the WGF program in Kayin State

Other women might not report because they would not want their husbands to face any formal consequences, such as detainment.

Religious beliefs may also play a role in limiting care seeking behavior.

"Other women assume that marriage is God-given and God does not want a couple to split up, so they bow their heads and accept it [GBV]."

-KII, KDHW leadership

Despite being the most trusted entry points for care seeking, a survivor's parents as well as the Village Heads could also be gatekeepers who discouraged women from accessing health, social, or legal services. For example, the parents of a GBV survivor who was repeatedly raped by her husband told her, "Don't leave the house. You're a woman. If you run away from your home, it won't be good for you." Respondents from one village reported that the Village Head advises any woman who seeks his counsel to wait three years before deciding whether or not to separate/divorce, which conveys a prioritization of preserving family structures over ensuring women's safety. One survivor of GBV reported that the Village Head had discouraged her from reporting the incident to avoid involving local security forces. Other GBV survivors reported that the Village Head could give them only vague, unactionable guidance on how to proceed with making a formal complaint.

Both health care workers and villagers expressed concern about how opaque referral pathways for GBV-related services would be from the perspective of a GBV survivor. While INGOs/LNGOs, local ECBHOs, and CSOs may coordinate at the State and Township levels to prevent gaps and overlaps in service delivery and outline referral pathways, there remains confusion at the community level about which organizations are providing different GBV-related services and where. While some clinic staff and village leaders may be aware of (full or partial) referral pathways, the

survivor's decision-making about whether to seek care at all may be influenced by familiarity and confidence in all potential points of care.

More fundamental barriers to access relate to women and girl's relatively restricted mobility. When asked if someone in their village who had experienced physical or sexual assault would be likely to seek services at the OSSC in Kyainseikgyi Township, one respondent replied that not only did she not know about the types of services provided at the OSSC in Kyainseikgyi, she did not know where Kyainseikgyi was nor how to get there. The cost and challenges a woman would face to arrange transportation without someone to accompany her were also reported as barriers to seeking care at the OSSC. One GBV survivor reflected on the challenge of traveling to the clinic after sustaining severe injuries.

PRIORITIES FOR IMPROVING GBV SERVICES

Among survivors of GBV interviewed for this evaluation, multiple women requested that female service providers be available for any examination and treatment of (female) GBV survivors. Given the importance of confidentiality to survivors, they advocated for more privacy in clinical care settings, noting that rooms with audio privacy were especially difficult to access.

Mental health and psychosocial support services as part of GBV case management were reported to be inadequate. For one survivor, emotional and psychological abuse by her husband continued throughout her medical treatment, and the mental health support from health care providers was noticeably lacking. Beyond the immediate GBV case management response, women

reported that safe housing for their children and themselves was a long-term requirement.

SUPPORTING HEALTH WORKERS

Both KDHW leadership and health workers emphasized the importance of advocating to local authorities (e.g., KNU, DKBA, BGF, and other forces) to gain their support of community engagement on GBV and SRHR. After these central meetings, advocacy could take place at (KNU) district and township level meetings to disseminate information and get feedback from local stakeholders, including Village Health Committees, on safe and effective approaches for outreach. According to one health worker,

"The main thing for improving GBV services will be to mobilize the village leaders, because whatever you want to do at the village level, it is up to the village head."
-FGD, health workers for the WGF program in Kayin State

Building and maintaining positive relationship with village leaders was considered important because health workers recognized that they had no authority on their own to mobilize and speak to villagers. Health workers also recognized the importance of building trust with villagers over the course of multiple outreach visits to lose their status as "strangers" to the community.

Health workers expressed concerns for their personal safety when they reached out to women who had been identified by the Village Head as having experienced GBV, as well as when they conducted house-to-house visits for awareness raising about GBV, especially if husbands or male household heads were present at the time of the visit who would accuse the health

worker of trying to break up marriages in their community. Health workers were especially concerned when, due to the distance between remote villages and the clinic, they would have to sleep overnight in the village following GBV outreach and awareness raising activities. In some cases, the health workers had to seek protection and stay overnight in the home of the village leader.

Another challenge raised by health workers was related to the format and content of awareness raising materials for SRHR and GBV. The posters and flipcharts used by health workers conveyed most information by text in Burmese language in Karen settings with high levels of illiteracy, and their illustrations of women with severe injuries may unintentionally reinforce patterns of low care seeking except in life-threatening emergencies.

Health workers emphasized the importance of keeping awareness raising sessions as short as possible, using awareness raising materials in local languages, and diversifying the messages at each session to keep community members' attention.

"The longer the session, the less people will listen."
-FGD, health workers for the WGF program in Kayin State

It is important to note that some SRHR messaging related to STIs or family planning (e.g., demonstrations of putting a condom on a banana) can be highly embarrassing both for health workers to deliver and for community members to observe in the standard mixed group format of community awareness raising sessions.

"Some communities do not like the awareness raising campaigns. The villagers are also embarrassed. They say that there

is no such thing [GBV] happening in our village."

-FGD, health workers for the WGF program in Kayin State

Developing educational videos using Karen languages was recommended as a way to relieve this embarrassment as well as to keep community members engaged during awareness raising sessions.

In addition to providing feedback on the content of SRHR and GBV messaging, health workers also advised on the timing of awareness raising activities. Opportunities for one-on-one and group education at the clinic are limited, because health workers may have to attend to other patients or patients themselves may prefer to return to their own work and household responsibilities as soon as possible. Conducting awareness raising sessions at local religious celebrations was considered inappropriate and ineffective. Health workers recommended that all community-based awareness sessions be timed according to harvest schedules and the time of day when members would be most willing to take time to participate in the sessions.

Health workers also emphasized the importance of improving both the consistency and appropriateness of care for all SRHR services to increase uptake. Health workers reported that patients stopped coming to EHO clinics that experienced stock outs of medicines and family planning supplies. Women in KDHW's catchment areas were also starting to seek care at public facilities that offered their preferred (longer-term) family planning methods, because at the time of the assessment few EHO clinics could provide long-term methods.

SUMMARY

The findings from the assessment demonstrated that women and girls face risks including rape, sexual assault, intimate partner violence, forced marriage, and emotional and psychological abuse. However, definitions of GBV in the community were more likely to reflect transgressions of social and gender norms, such as premarital sex and adultery. Intra-marital rape and other forms of violence were often considered a "fact of marriage."

Typically, the only kind of support that would be sought for GBV would be mediation by the village leader(s) between husbands and wives, or negotiation of a financial settlement and/or marriage between a rape survivor and the perpetrator. Parents and village leaders, who were considered to be the first or only source of support for GBV survivors, often acted as gatekeepers who would either facilitate or prevent women from seeking specialized care and support. Internalized shame was a powerful deterrent for women when it came to seek both general SRH services as well as GBV service needs.

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LIMITATIONS

This study was conducted as a formative assessment with a limited sample size to inform program design and was not designed to be comprehensive. The study's definition of "GBV," the way respondents were selected, and the way questions were asked led to dialogues about GBV that focused on men as perpetrators and women as survivors. While women and girls are at higher risk of experiencing GBV, this study did not capture the experiences of men, boys, and persons of diverse sexual orientations and gender identities (SOGI). While there was no purposive sampling of GBV survivors based on age, the experiences of younger survivors were not captured by this assessment.

The FGDs of women of reproductive age were conducted in Burmese with the assistance of a translator who spoke local Karen languages, but future assessments should emphasize collecting data in the respondents' native language. Finally, the data were collected in 2018 as part of a programmatic assessment, and the reported findings do not reflect the adaptations to programming in the catchment areas of the 13 clinics and OSSC to better meet the needs of the communities within the project area since the study was conducted.

their personal stories, perspectives, and recommendations.

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