

Case study

Delivering integrated services for gender-based violence, and sexual reproductive health and rights to conflict-affected communities in Myanmar



KEY FINDINGS AND LESSONS LEARNED



IP selection

- The **IP selection is critical**. It includes matching IPs that have complementing core skill sets, a potential to grow in non-core area, and that are working in the same geographical area.



Innovative implementation

- Implementation approaches need to be **tailored to the context**. For example, lack of privacy in the mobile clinic setting is a challenge for GBV consultations and service provision. The project demonstrates different and complementary implementation approaches.



Costs and funding

- The integration approach is **human resource intensive** due to the high level of technical assistance and coordination. It requires additional staff resources both in field offices and in the country office.
- The long start-up phase and high human resource investments can only be justified for a **multi-year project**. Hence, funding must be secured for several years.



Technical assistance

- The integration approach requires **extensive technical assistance** from UNFPA.
 - When building the capacity of IPs in their non-core areas, UNFPA staff need to address **lack of confidence and hesitation/resistance** of IP staff.
- **Formal guidance notes** can be used as an instrument to support and maintain the capacity and knowledge that has been developed in non-core areas.



Monitoring, evaluation and agility

- Regular monitoring visits; **sustained support** to IPs by UNFPA staff; continuous and joint evaluation of approaches; and the agility to make adjustments throughout the project are essential for reaching the objectives.
- Though improvements to women's access to sexual and reproductive health care and GBV services are strongly perceived by UNFPA and IP staff, it is **difficult to conclusively measure** and evaluate to what extent the project has improved women's health; has reduced maternal mortality and morbidity; and has reduced unmet demand for modern contraceptives. An end line assessment is needed to give further insight into the impacts.



Coordination

- The integration approach requires **intensive coordination** before and throughout the project.
- UNFPA plays a crucial role in ensuring that **all partners interact optimally** and work towards the same goal in a coordinated manner. UNFPA must support IPs from different sectors to overcome suspicion and to develop a commitment to new partnerships.
- From the very start, all **IPs need a clear view of the project as a whole**, the overall objectives, the strategy and the practical approaches. Without this, IPs can perceive that only explicitly joint activities are part of the integration. They need to be made aware that many of their other activities – information sessions covering the non-core area, screening, referrals, and demand-generation – also contribute to the integrated service delivery.
- In addition to opportunistic communication, there is a need for **formal and regular meetings** to **evaluate** working practices and progress, and to **improve and adjust** implementation approaches.



Cross referrals and demand generation

- **Referrals and demand generation** flow almost uniquely from GBV to SRHR. The mobile clinics benefit from the GBV IP's firm and unique presence in the camps. **Innovation** is needed to stimulate more referrals and demand-generation from the mobile clinics to the Women and Girls Centres and GBV services.
- The project has resulted in a huge improvement to GBV survivors' **access to urgent and life-saving medical post-rape care**.

1. Introduction and context

Myanmar is situated in a complex context of new, emerging and on-going humanitarian crises, armed conflict, natural disasters, and displacement in several areas of the country.

More than 240,000 people across Myanmar are displaced, and over 940,000 people are in need of humanitarian assistance. Women and girls of childbearing age in Myanmar carry extraordinary burdens as armed conflict and displacement compounds deep poverty and gender discrimination. At least 77 per cent of internally displaced people are women and children, and many of these live in camps for internally displaced people (IDPs) in Kachin, Kayin, Rakhine, and Shan States (2019 Humanitarian Needs Overview).

Women and girls have specific needs that are often ignored during crisis. While on the run or while living in shelters, women and girls continue to become pregnant, but they often lack access to basic sexual and reproductive health care. Without assistance by midwives or access to contraceptives, women and girls are at increased risk of unsafe sex, unwanted pregnancy and unsafe delivery, and are at a higher risk of infection by HIV and other sexually transmitted infections. In addition, displaced women have virtually no access to protection, security, justice, and other services related to gender-based violence (GBV).

For these reasons, the delivery of sexual and reproductive health and rights (SRHR) as well as GBV services to conflict-affected communities – most of whom are living in protracted displacement – is a key part of UNFPA's [Women and Girls First Programme](#) (WGF). The initiative is a commitment to prevent and respond to violence perpetrated against women and girls in Myanmar, and to realize their sexual and reproductive health and rights.

“ This kind of project requires a great deal of technical assistance from UNFPA in the start-up phase to build the capacity of partners in areas that are novel to them.”

Dr Ei Khaine Zin, UNFPA programme analyst, GBV



UNFPA specialists are the ground, providing technical assistance to both medical and GBV partners.

1.1 Pervasiveness of gender inequality, GBV, and poor SRHR outcomes

- Gender inequality is deeply rooted in Myanmar. In the 2018 gender inequality index, Myanmar is ranked 148 of 189 countries (*Human Development Index 2018*). As an example, only 50.5 per cent of women are in the work force, compared to 85.2 per cent of men (2014 Myanmar Population and Housing Census). Women who have less decision-making power in the home are more likely to accept GBV and have less access to SRHR services.
- GBV is prevalent throughout the country. There is a high degree of acceptance of intimate partner violence. Women's acceptance of this as a cultural norm is highest in Sagaing (67.8 per cent) and Mandalay (69.9 per cent). Men's acceptance is highest in Rakhine (68.8 per cent), Mandalay (61.9 per cent) and Chin (60.3 per cent) (*Demographic and Health Survey 2015-2016*).
- At 282, Myanmar's maternal mortality ratio is the second-highest in the region. The total fertility rate is 2.51. However, fertility among married women is significantly higher at 4.99. (2014 Myanmar Population and Housing Census). The antenatal care coverage rate is 81 per cent, while skilled birth attendants are present at 60 per cent of deliveries. The contraceptive prevalence rate is 52.2 per cent, and the unmet need for family planning is 16 per cent (*Demographic and Health Survey 2015-2016*).

1.2 Links between SRHR, GBV and gender inequality

In addition to sharing the same primary client base – women and girls – there are many links between SRHR and GBV that merit integrated service delivery:

- Sexual and reproductive rights include the right to bodily integrity; to choose one's partner; to decide to be sexually active or not; to have consensual sex and marriage; and to decide if and when to have children. These rights are firmly linked to GBV, making GBV prevention and response an essential part of SRHR.
- GBV has negative health consequences – including for sexual and reproductive health – at individual as well as at community level, with both mental and physical repercussions for survivors of GBV. Responding to both physical and emotional effects of GBV should be an integral part of health care, but this is seldom the case. Many health workers are not trained to recognize abuse, and will miss signs of GBV. Few have the appropriate training to manage GBV ethically and effectively. Even so health professionals are often a first point of contact for survivors.
- While GBV services respond to immediate sexual and reproductive health consequences, such as the risk of unwanted pregnancy and sexually transmitted infection, they may also be an entry point for addressing longer-term sexual and reproductive health needs, such as access to family planning.
- Gender inequality is recognized as the root cause of GBV, as well as to women's lack of access to security and justice services. But gender inequality is also closely related to maternal mortality and unwanted pregnancy. Gender inequality underpins the social cultural and structural barriers that prevent women from accessing sexual and reproductive health services, such as modern contraceptives and safe delivery with the assistance of skilled birth attendants.

Taking these links into account, the decision was made at the outset of the WGF initiative to deliver SRHR and GBV services through an integrated approach.



1.3 Geographical areas

The integrated approach is implemented in several parts of Myanmar, including in Kachin, Kayin, Rakhine and Shan.

This case study focuses on the implementation in and around the city of Myitkyina, in the government-controlled part of Kachin. In Kachin, there are an estimated 97,000 IDPs living across 140 sites (2019 *Humanitarian Needs Overview*). Most of these IDPs have been living in protracted displacement since an escalation in 2011 of armed conflict between government and non-government forces in Kachin.

2. Concept development, project design and pre-implementation phase

When it comes to integrated delivery of different services, the concept development and project design stages are crucial. They must include both a vision and a practical approach to integrated service delivery.

In the case that this study explores, the pre-implementation phase included a call for expressions of interest and proposals from a wide range of implementing partners (IPs) with very different sets of expertise: One in the medical sector, the other in the social services sector. The selection of IPs was complex:

- Firstly, it involved qualifying service providers which met the criteria for technical skills and experience in their core area (medical or protection).
- Secondly, it entailed assessing which prospective IPs had a clear potential to build expertise in the related non-core area. Which social services providers had the best potential to build expertise in the area of sexual and reproductive health and rights? Which medical providers would be able to develop capacity in the area of gender-based violence? UNFPA also identified the level of risk that prospective IPs would be carrying in order to establish new programmes with little or no existing internal capacity.
- Thirdly, it meant identifying for close collaboration very diverse providers who had never before worked together. Among other things, this took into account their existing and potential geographical presence across a complex political and physical map with clear lines of fire between government-controlled and non-government-controlled areas.

“Preparation and expectation is key. The integration aspect must be included in the work plan of each implementing partner.”

Dr Ye Mann Tun, Medical Officer, Myanmar Medical Association (SRHR partner)

All this meant that the pre-implementation phase took significantly longer than for most projects.

These extended design and pre-implementation phases – as well as the start-up with the significant human resource investments required for capacity-building and coordination – can only be justified for projects that will run over a longer period of time. It requires that funding is secured for several years.

UNFPA Myanmar was able to adopt the integration approach thanks to the fact that the project is funded under the Women and Girls First Programme, which is a multi-year initiative. WGF garners financial support from multiple donors in addition to core funds from UNFPA. This arrangement has provided the funding predictability needed for the integrated approach.

UNFPA's added value

Vision

Formulate the concept.

Resource mobilization

Secure multi-year funding from several donors and UNFPA core resources.
Pool funding to support flexibility.

Implementing partner selection

Call for and match implementing partners with complementary skills.

Design

Develop a practical approach suited to the specific conditions.

Technical assistance

Build capacity of partners in non-core areas that are novel to them.

Coordination

Steer collaboration between implementing partners in different sectors.



Mobile clinic teams are trained to identify GBV survivors among their clients.

3. Start-up stage

The geographical configuration of the people in need – with dozens of small IDP camps, each of just a few hundred people, and each situated far from the other – has made it impractical to set up stationary SRHR clinics. Instead, mobile health teams visit camps on a rotating schedule. This ensures access to health services for pregnant, breast-feeding, and child-caring women who cannot travel the distance to the nearest stationary clinic.

In this situation, the classic set-up of a one stop shop, where the SRHR and GBV IPs can each provide their core services, was not a viable option. Instead, the main part of the integration of services was designed to take place by building the capacity of:

- SRHR staff to provide GBV information, screening and referrals, primarily from mobile clinics; and
- GBV staff to provide SRHR information, screening and referrals, primarily at Women and Girls Centres and through outreach staff and volunteers in the camps and host communities.

It is essential that all partners have a clear understanding of the integration at the beginning of the project. So at this stage, it is important to clearly explain and anchor the integration strategy with partners: What are we integrating and why; where are the entry points; how exactly will it be implemented, and by whom.

UNFPA was already working locally with the IPs selected for the integration project. This meant that start-up activities, such as capacity building in the non-core area and IP coordination, could be done in parallel with continuous delivery of already existing services in the core area. In other situations, it may not be practical to begin service delivery until relationships and basic capacity have been built.

3.1 Capacity building

To enable the integrated delivery of services with this approach, it was critical that all IP staff were given training in the areas that were entirely novel to them. All staff of the GBV IP were trained in basic SRHR, and all the staff of the SRHR IP were trained in core concepts of GBV as well as basic GBV prevention and response interventions.

There was great hesitation among IP staff to stretch their capacity into non-core areas. An important part of the training was to build not only their knowledge, but also their confidence, in the non-core area.

3.1.1 Training of SRHR staff on GBV

The GBV staff at UNFPA Myitkyina field office led multiple workshops and training sessions with the staff of the SRHR IP, Myanmar Medical Association, to improve their knowledge of basic concepts of GBV; mental health and psychosocial support (MHPSS); facilitation skills; basic principles of community mobilization; and main areas of GBV interventions. Some of the training sessions were also facilitated by staff from the GBV IP, Metta Development Foundation.

In 2018, the Myanmar Ministry of Health and Sports launched the country's first-ever GBV guidelines specifically tailored for healthcare providers. Supported by UNFPA, the guidelines are uniquely focused on the medical, emotional and legal needs of the patient. Based on international standards set out by the World Health Organization, they establish a protocol for the clinical management of rape and other gender-based violence. UNFPA supports the nationwide roll-out of the guidelines with training of health staff. In Kachin, this also included training of staff from Myanmar Medical Association.

Understanding integrated service delivery

In the health area, service integration is the management and delivery of related types of health services in an interconnected and coordinated manner. It means that clients can access related services from the same provider and/or from the same physical location. For example, the linking of HIV services with sexual and reproductive health and rights services is an important part of the global response to HIV.

Integration focuses on the coordination of service delivery, as well as on the actual delivery of the services themselves. The integration approach benefits clients because it is people-centred: it gives them better access to a wider range of related services. On the provider side, a well-implemented integration improves the efficiency of both management and service provision.

“Coordination between IPs is a real challenge.”

Dr Gin Sian Lun, Senior Medical Project Officer, Myanmar Medical Association (SRHR partner)



UNFPA brings partners together and steers coordination.

3.1.2 Training of GBV staff on SRHR

The UNFPA's field office in Myitkyina took the lead on building the SRHR capacity of the GBV partners. The training focused on building the capacity of Metta Development Foundation staff to facilitate SRHR education and information sessions, and to make safe referrals.

3.2 Coordination, collaboration and partnership

However, technical capacity is only one part of this approach to integrated service delivery. Diverse IPs need support to develop a commitment to new partnerships. The coordination of and the collaboration between of multi-sectoral IPs, as well as the IPs' appreciation of the overall project, are as important as their core and non-core skills. These are all aspects where UNFPA's role is crucial to ensure that all partners are interacting optimally and working towards the same goal in a coordinated manner.

All organizations that are part of implementing integrated programmes need help to develop a clear view of the bigger picture and the overall objectives. This includes an understanding of the project design and the roles of all participating IPs, not just their own.

UNFPA brought the IPs together at the start of the programme to discuss strategy, practicalities, opportunities and challenges. Once the integration is up and running, much of the communication and planning can take place opportunistically as activities intersect, but there is also a need for formal and regular meetings to evaluate progress and to improve implementation. In addition to monthly monitoring visits and meetings, UNFPA holds quarterly programme review meetings with all IPs in Kachin to discuss progress, challenges, lessons learned, and ways forward. The quarterly meetings are also a platform where partners together develop messages that help each IP articulate information in the non-core area.

Coordination is also facilitated by the GBV Working Group, which is chaired by UNFPA under the protection cluster. In addition, UNFPA has established an SRHR Working Group under the health cluster.

4. Service delivery implementation

4.1 Access to SRHR services through GBV providers and service points

In Myitkyina, UNFPA provides GBV services through Women and Girls Centres (WGC) since 2014 in collaboration with implementing partner Metta Development Foundation (Metta). Over the years, UNFPA has invested in significantly building the capacity of Metta and its staff in the area of GBV. By 2016, Metta was providing comprehensive GBV prevention and response services through the stationary WGCs, which are located outside of IDP camps, and with each WGC serving several camps as well as host communities. The WGC staff also work on an outreach basis in the IDP camps, both through Metta GBV staff and through a network of female volunteers who are themselves IDPs and live in the camps. This gives Metta a firm and unique presence in the camps, as well as in-depth knowledge about the needs of female camp residents. There is also a network of male volunteers with the aim to raise awareness and engage men and boys in GBV prevention activities.

The GBV services provided cover both prevention and response: Awareness raising; information sessions; mobile outreach activities; safe spaces; case management with psychological first aid, counselling, individual safety planning and referral to other services such as legal/para-legal support; and psychosocial support, including recreational activities such as life skills training, empowerment sessions and emotional support groups.

“ In rape cases, the referral to urgent medical care is much quicker and more efficient now that we are working directly with a medical partner.”

*Gi Bawm Wang, GBV Case Worker,
Metta Development Foundation (GBV partner)*

GBV outreach workers reach deep into the IDP camps and generate demand for both GBV and SRHR services.

The integration of non-core SRHR services into the core GBV services include demand-generation through awareness-raising and information sessions; provision of IEC material; outreach, screening and referrals; and transport support to SRHR service points.

4.1.1 Information and awareness-raising

The WGC staff and volunteers conduct regular education sessions on SRHR in the WGCs. There are also occasions where these sessions are facilitated by staff of the Myanmar Medical Association (MMA), the SRHR IP. As the WGCs are safe spaces, only women and girls can attend these sessions. However, when GBV staff hold awareness-raising sessions on GBV in the IDP camps, these are also open to men, and SRHR information is integrated into these sessions. There are also sessions that are especially designed for men and boys. Whenever possible, GBV and SRHR IP staff coordinate their schedules to allow for jointly held information sessions.

In addition, GBV prevention officers and case workers provide SRHR information as part of their GBV outreach at the individual level in the camps. All GBV staff are able and comfortable to discuss SRHR issues with clients, and can answer basic questions. They consistently stress the importance of receiving medical care within 72 hours of sexual violence to avoid unwanted pregnancy, HIV, and other sexually transmitted infections. They also create demand for SRHR services, including family planning.

4.1.2 IEC material

At the WGCs, printed information, education and communication (IEC) materials about SRHR are visible and available.





Mobile clinic staff follow the international protocol for the clinical management of rape.

4.1.3 Screening

GBV staff have been trained to identify SRHR needs among their clients, including the need to access family planning advice, and preventative and emergency contraceptives; antenatal and postnatal care; and safe birth assistance. They can also identify women who are at increased risk of contracting sexually transmitted infections, including HIV. This screening is now an integral part of client interaction both at the WGCs and in the outreach activities.

4.1.4 Referrals

As a result of continuous screening, the GBV staff proactively identify a wide range of both preventative and emergency SRHR needs among women and girls in the camps. Thanks to training as well as a close collaboration with the SRHR IP, the GBV staff are able to swiftly, confidently and accurately refer camp residents to the most appropriate SRHR provider. Often this is the SRHR partner, but depending on schedules and location, referrals to other public and private health care providers are also made. The WGCs have access to UNFPA funds to support clients' transport to SRHR service points, and to accompany them if needed to facilitate and negotiate access.

In addition to the proactive screening, there are also acute cases of where survivors of GBV, including sexual violence and rape, need urgent medical care. This urgent care can be difficult to access through the public health service, where many staff erroneously believe they must refuse care until the crime has been reported to the police. In such cases, the GBV staff can draw upon resources and connections of the SRHR IP. Together, they can ensure that women and girls are given life-saving care before it is too late, and without forcing them to report the assault, should they not wish to. Treatments that must be started within a 72 hours of a rape include post-exposure prophylaxis to prevent HIV transmission, and emergency contraceptives.

4.2 Access to SRHR services through GBV providers and service points

In Myitkyina, UNFPA provides SRHR services through mobile clinic teams in collaboration with implementing partner Myanmar Medical Association (MMA). In this partnership UNFPA has built the capacity of the teams to provide quality sexual and reproductive health and rights services that focus on the needs of each individual. By 2018, the clinic teams regularly visited 50 camps and 17 villages. The mobile clinics ensure access to sexual and reproductive health services, including antenatal and postnatal care, for over 50,000 people. Most of these live in protracted displacement from armed conflict, but the mobile clinics also serve host communities who are absorbing the shockwaves of conflict and displacement.

The mobile clinics provide comprehensive SRHR services including sexual and reproductive health and rights information and education; family planning counselling and contraceptives; adolescent sexual and reproductive health and rights services; antenatal and postnatal care; support for safe births; access to emergency obstetric care; prevention and management of sexually transmitted infections, including HIV; clinical management of rape; and referrals to specialized SRHR care.

The clinics benefit from GBV IP Metta's firm and unique presence in the camps. The in-depth knowledge of Metta staff and volunteers about the needs of female camp residents is an important contributor to generating demand for the clinics' SRHR services. Metta staff also make health workers aware of possible safety concerns of women who would like to use modern contraceptives without involving their partner in the decision.

The integration of non-core GBV services into the core SRHR services include awareness-raising, information and demand-generation at individual client level; provision of printed GBV IEC materials; screening; and referrals to GBV service points.



GBV volunteers who are themselves IDPs are able to identify both GBV and SRHR needs in the camps.

4.2.1 Information and awareness-raising

The SRHR staff provide GBV information as part of their SRHR services at the individual level on an as-needed basis and within the constraints of the privacy limitations of the mobile clinic setting. All SRHR staff are able and comfortable to discuss GBV issues with clients, and can answer basic questions.

GBV IP staff often hold GBV information sessions in the waiting area of the mobile clinic, while the clinic is setting up. Joint GBV and SRHR sessions are also held in this way.

4.2.2 IEC material

At the mobile clinics, printed IEC material about GBV is visible and available.

4.2.3 Screening

SRHR staff have received GBV sensitization and have been trained to identify GBV survivors among their clients. This screening is slowly becoming part of the SRHR services, although lack of privacy remains a challenge in the mobile clinic setting.

4.2.4 Referrals

Thanks to the GBV training, mobile clinic staff are able to provide sympathetic, safe and effective referral of GBV survivors to support services, primarily to WGCs as a first point of call. Though the mobile clinics and GBV services are not integrated into a one-stop shop, GBV IP staff are often present in the IDP camps where the mobile clinic operates. This provides an additional referral option, which may be used depending on the sensitivity and confidentiality requirements of a referral.

4.2.5 Clinical management of rape

An important part of the GBV training for the mobile clinic staff is the clinical management of rape. Mobile clinic staff have been trained to follow a protocol which is based on international standards set out by the World Health Organization.

In acute cases, where survivors are not able to access urgent care in a hospital, the mobile clinics are able to deliver all the critical components called for by the protocol:

- Examination and collection of forensic evidence.
- Treatment, including care of wounds and injuries; emergency contraception; and prevention of HIV and other sexually transmitted infections, and tetanus.
- Supportive communication.
- Referral to psychosocial and comprehensive case management services; financial and in-kind support; legal assistance; and safety/security services.



Lack of privacy at mobile clinics is a challenge for both SRHR and GBV consultation.

“ UNFPA field staff do need to steer the project closely for the integration to be successful.”

Dr Mahkawnghta Awng Shar, UNFPA programme analyst, SRHR

5. Impact on women's health

The project has increased women's access to sexual and reproductive health care. The basic SRHR information provided by Women and Girl Centre staff generates demand for a wide range of SRHR services, all of which are met by the mobile clinics: Family planning advice, contraceptives, antenatal and postnatal check-ups, safe birth support, and HIV infection risk reduction and treatment. This is evident by the uptake, which has increased significantly from 2016 to 2018.

The impact is that more women are healthier and are better equipped to make informed health and life choices: They can access the information and contraceptives they need to control if and when to become pregnant, and they can access support that protects their life and health during pregnancy and delivery. A further benefit is that rape survivors have increased access to professional, stigma-free and life-saving medical treatment without delay.



Healthy mothers make for healthy families. The impact of integrated service delivery is healthier women who are better equipped to make informed life and health choices.



Ensuring rights and choices for all

Delivering a world where
every pregnancy is wanted
every childbirth is safe and
every young person's
potential is fulfilled

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