The Role of the Private Health Sector in Responding to Gender-Based Violence in Myanmar

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Significance

Gender-based violence (GBV) has significant reproductive health (RH) consequences.

- GBV survivors have higher rates of unintended pregnancy, unsafe abortions and adolescent pregnancy.1
- In some countries, one out of every four women (25%) experiences violence during pregnancy, posing immediate risks to mother and child.2
- Survivors of GBV utilize the health sector more than others, but often not for reproductive health care or psychological treatment.3

Recent research with survivors in two cities (Yangon and Mandalay) demonstrated that GBV is pervasive and patterned.4
- Survivors experience multiple types of violence, repeatedly, and rarely seek support services.5

In Myanmar, the private health sector remains an underutilized resource.6
- PSI’s Sun Quality Health network provided 2 million RH consultations last year; these represent valuable opportunities to address GBV.
- Yet little is known about what health providers know or how they feel about responding to GBV.
- Further, no analysis exists of how RH clients perceive GBV, or whether they consider it safe places to seek support.

Main question

How can the knowledge, experiences, and perceptions of GBV among Sun Quality Health providers and clients inform the design of an effective health sector response to GBV in Myanmar?

Methodology

Beginning in February 2015, PSI/Myanmar undertook a qualitative inquiry to understand the landscape of survivor support services in Yangon and Mandalay, and how Sun Quality Health providers and clients perceive GBV and GBV support-seeking.

- 20 key informant interviews with researchers, advocates, and programmers working for organizations (14 national, 6 national addressing GBV
- 5 in-depth interviews (IDI) with SQH providers in Yangon (3 female, 2 male) and
- 3 IDI with SQH providers in Mandalay (2 female, 1 male) to understand their knowledge, experiences with, and perceptions of providing GBV services.
- 12 in-depth interviews (IDI - 8 in Yangon and 4 in Mandalay) and 4 focus group discussions (FGDs) - 2 in Yangon and 2 in Mandalay with female clients of SQH to investigate how RH clients perceive GBV and support-seeking in the private health sector.

Since most women are not prepared to talk about their own experiences of violence, particularly in groups, the FGD used story-completion methods and thematic questions to disass a hypothetical situation that participants can relate to.

Key findings

Providers

Despite unfamiliarity with the concept of GBV and an initial response that GBV is not a problem in Myanmar, health providers described a range of behaviors that fit the accepted definition including high rates of unintended pregnancy due to reproductive coercion and forced sex, symptoms of anxiety, depression, hyperventilation and nervousness as a result of “family problems,” and high levels of alcohol use among men and alcohol-related violence.

Providers acknowledge the trust they build with clients, who often reveal much about their private lives during visits. However they feel ill-equipped to provide counseling for women experiencing violence, are overburdened with patients, resistant to getting involved with the police, do not know of available GBV support services, and recognize that communities lack information about where survivors can go for support.

Many believe that violence in a relationship is natural and advise female clients to respond with patience.

- “I’m a doctor. I look, examine, give treatment. I’m weak at counseling. I’ve tried to learn but I failed.” Male provider, Mandalay.
- “It’s common for women to talk to me about their problems. Once they trust me, they feel comfortable.” Female provider, Yangon.
- “I tell them that it’s natural for this to happen between husbands and wives.” Female provider, Yangon.

Clients

While none of the study questions asked about women’s own experiences of violence, many disclosed that they and their peers indeed experienced GBV.

- “For me, he punched me twice here (pointing at her cheeks). I was dizzy and vomited three to four times. After that, I had no courage to go outside because I was ashamed because I was bruised. My mom asked ‘What happened?’ I replied ‘It’s ok. I accidentally hit myself with wood when I lifted the bag of charcoal.’” FGD participant who had experienced violence.

Women in Yangon and Mandalay perceive GBV to have multiple causes – mainly financial problems, alcohol and women’s disobedience. They describe a culture of patriarchy and men’s control or “ownership” of their wives. Many feel that despite the pain, survivors should remain silent.
- “In my experience, I never fell my family. My family doesn’t know about my problems. I suffer alone. My parents don’t know.”
- “We sometimes need to permit his violence... and be patient. Although he hits, we need to reduce our anger and please him.”
- “My husband is so good if he isn’t drunk.”

Most clients acknowledge the trusting relationship they have with their health providers, and the need for providers to support them with understanding their options and their rights.
- “I wouldn’t be okay if this doctor who supported me and told me the right thing to do wasn’t here.”
- “The kinds of help I wanted was help and support when deciding how to live, how to act and solve the problem. It would be good if we could get that kind of consultation.”

Implications for Programming

PSI will design a GBV case management model that uses the health care provider as an entry-point into a circle of support for integrated health, psychosocial, legal and economic empowerment services.

- Partner with community-based organizations and build their capacity to sustain social services over the long term.
- Train SQH providers to open conversations about GBV and provide a first-line response to survivors (i.e. prophylactic and injury care, basic counseling, and referrals to a case manager).
- Community-based case manager will provide counseling, safety-planning, referrals and follow-up.
- Leverage its existing communication channels, such as a RH hotline and mobile application for pregnant women, to integrate messages about GBV and promote the GBV services.