Community-based options to providing medical care for survivors of sexual violence: Results from a pilot project in Karen State, eastern Burma

Women's Refugee Commission
Global Health Access Program/ CPI
Burma Medical Association
Karen Department of Health and Welfare

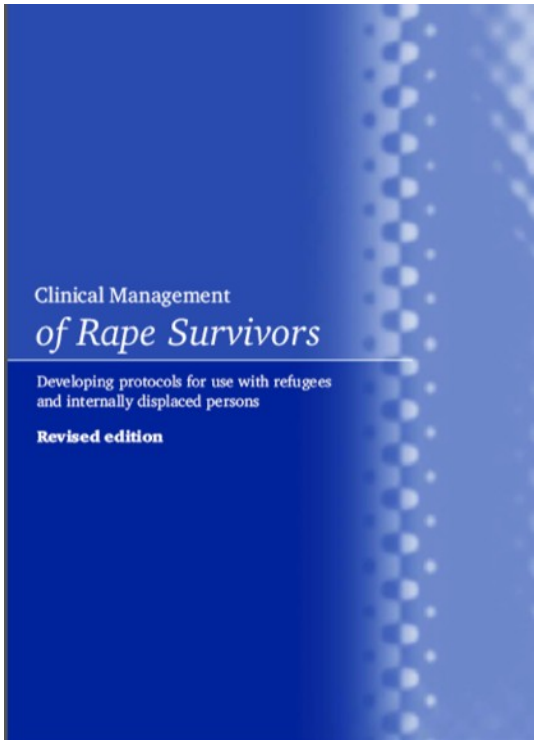
Research. Rethink. Resolve.

Background

- Increased risk of sexual violence for women and girls in crisis settings.
- Medical care for those who have survived sexual violence is often limited in humanitarian settings.
- Consequences for survivors include:
  - Unwanted pregnancy, unsafe abortion, and related death and disability.
  - Sexually transmitted infections, including HIV.
  - Psychosocial and mental health concerns.

WHO protocol for clinical care for survivors of sexual violence

- Minimum medical examination
- Minimum forensic evidence
- **Compassionate and confidential treatment**
- Comprehensive treatment



Pilot study questions

- Can community-based medical care be a **safe and feasible option of care** for survivors where insecurity and other challenges act as barriers to facility-based care?
- What are the challenges to providing care in this manner and how can they be addressed?

Pilot project

- Pilot partners
  - Global Health Access Program (GHAP)
  - Burma Medical Association (BMA)
  - Karen Department of Health and Welfare (KDHW)
- Built off existing task-sharing tiered model for maternal care:
  - Maternal health workers
  - Health workers

Pilot Sites

- Eastern Burma
- Conflict with Central Govt for 63 years
- Ceasefire agreement in 2012
- 2010 data

	Eastern Burma	Burma	Thailand	MDG Target for Burma for 2015
Maternal mortality ratio (deaths per 100,000 live births)	721	240[a]	48[a]	50
Under-5 mortality rate (per 1,000 live births)	138	71[b]	14[b]	39
Infant mortalty rate (per 1,000 births)	73	54[b]	12[b]	28

[a] Source: Trends in Maternal Mortality: 1990 to 2008, WHO 2010. Ratio for 2008

Ethical and practical concerns

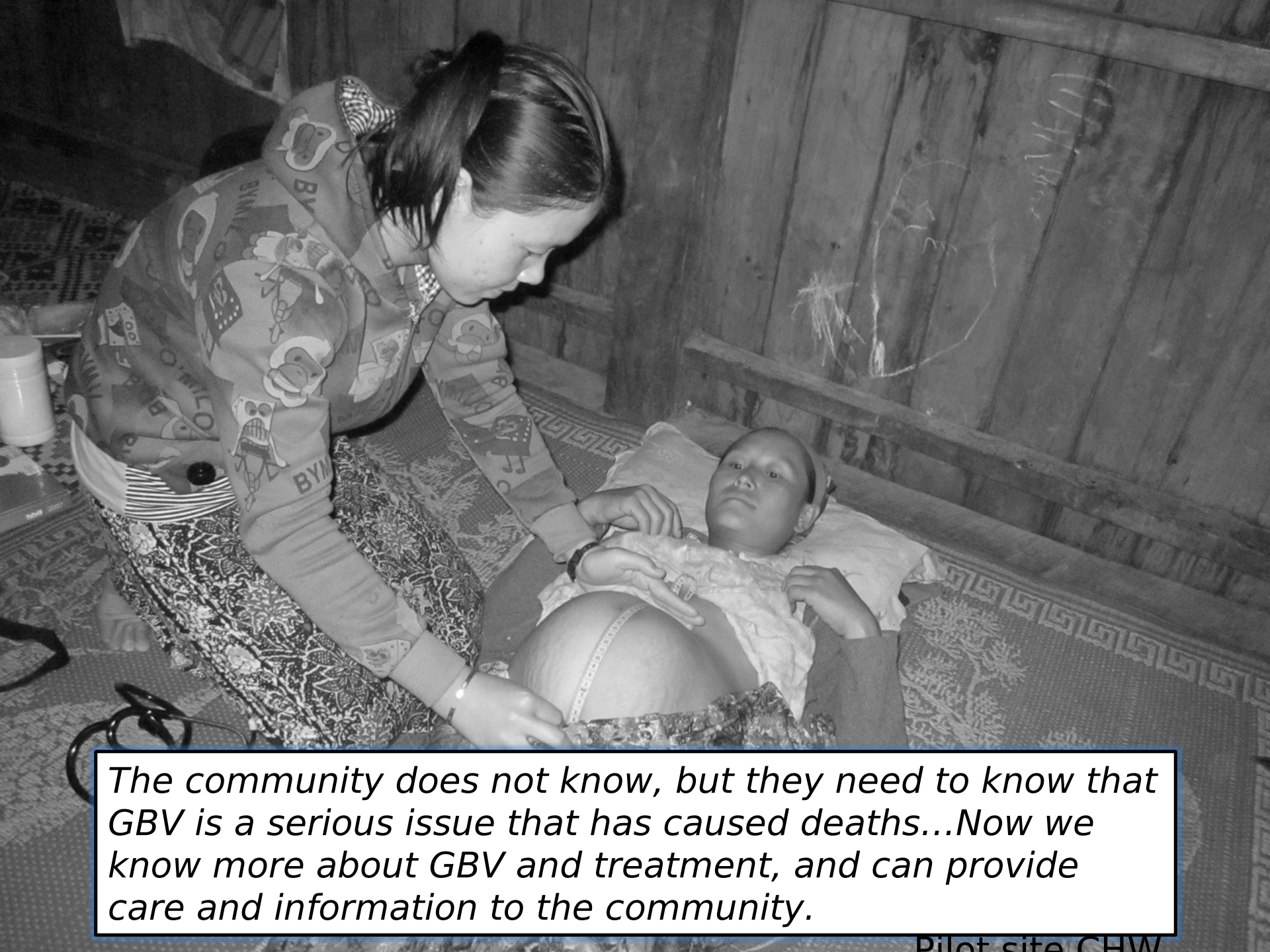
- Providing **minimum care** per WHO protocol and focusing on medical care where multi-sectoral services are not feasible.
- Maintaining **confidentiality and security** by reducing documentation in the field and spelling out information sharing procedures.
- Thinking through legal ramifications of community-based care and access to justice for survivors.

Process evaluation (July-October 2011)

- In-depth interviews with key stakeholders
- Focus group discussions
  - Mae Sot, Thailand
    - Pilot site CHWs
    - Non-pilot site CHWs trained in clinical care
  - Karen State, Burma
    - TBAs
    - Community members, primarily women of reproductive age and men

Select findings: Pilot site CHWs

- Showed knowledge of clinical care.
- Comfortable with topic of GBV, including sexual assault.
- Less confident in history-taking and psychosocial care.
- Understood well the concept of confidentiality.
- Did not report health worker safety as an excess concern.
- Discussed domestic violence within the scope of sexual assault.



The community does not know, but they need to know that GBV is a serious issue that has caused deaths…Now we know more about GBV and treatment, and can provide care and information to the community.

Pilot site CHW

Select findings: Non-pilot site CHWs

- Interested in providing treatment for sexual assault survivors.
- Showed some confusion about definition of sexual assault and their role in caring for survivors.
- Reported domestic violence as the most common type of GBV in the community.
- Noted no reported cases or other issues to suspect sexual assault in the community.

Select findings: Traditional birth attendants

- Understood role as providers of encouragement and referrals.
- Need to maintain confidentiality was not reported as a major challenge, although understanding of confidentiality was mixed.
- Showed mixed feelings regarding safety in assisting survivors.
- Shared interest in learning more about GBV and how to help the community.
- Reported domestic violence as the most common type of GBV in the community.

We feel happy about our ability to support those that have been sexually assaulted and we want to learn more about GBV in our work.

Select findings: Community members

- Shared primary barriers and challenges for survivors to accessing care as **shyness; fear of others' opinions; shame; and concerns** that they may not receive help.
- Agreed **trusted persons** in the community exist from whom survivors may seek care.
- Suggested the community needs to feel comfortable in seeking care from a CHW or TBA.

They are not telling to other people because they are shy, afraid other people look down [on] them, afraid [that] other people don't care [about] them or help them.

Community member

Lessons learned from the pilot project

- While feasibility of the model has been explored, lack of survivor reporting is a major barrier to assessing the safety of the approach.
- Intensive awareness-raising is needed to inform communities about the benefits and availability of care.
- The possibility to respond to sexual violence has opened avenues to discuss other forms of GBV in the community, including domestic violence.

Developments since the process evaluation

- Continued implementation of community-based care in Karen State.
- Publication of article in *Conflict and Health*.
- Development of a community-health training tool on managing survivors of sexual violence with UNICEF.
- Replication of the model in Somalia and South Sudan by UNICEF to further the evidence-base.

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- Community health care workers of pilot study
- Community members in pilot sites

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