



**Existing Provision of
Gender-based Violence (GBV)
and
Sexual and Reproductive Health (SRH)
initiatives in Penang:
Planning for 2026 and beyond**

JANUARY 10th 2026
Ixora Hotel, Perai, Penang

CONTEXT



The Workshop was planned in an environment where GBV and SRH services and outreach programmes with and for Penang refugee communities are undergoing potentially significant changes.

This is partly due to some stakeholders facing (severe) funding cuts, leading to reduction or closure of their services.

It is partly due to some new initiatives (including new initiatives being undertaken with funding from UNFPA), which will see an injection of new activity. And it is partly due to an emerging atmosphere of partnership between refugee community representatives and non-refugee service providers.

It was therefore considered to be timely to bring together stakeholders - refugees and non-refugees - to share current provision, perceived challenges, and ways forward that can be mutually beneficial and reinforcing and as appropriate as possible to and for the women, men and children in the refugee and asylum-seeking communities.



PROGRAMME

WELCOME and CONTEXT

- 10.00 Welcome: Jason Yeo and Joshua Teh Honguan, UNFPA
Introduction to the Needs Assessment Study: Dr Prema Devaraj
- 10.15 Context of the Workshop: James Lochhead

GENDER-BASED VIOLENCE: PROVISION and CHALLENGES

- 10.30 Input 1: Michelle Fong, UNHCR
- 10.45 Input 2: Elena Platani, MSF
- 11.00 Input 3: Sarah Jane, Tenaganita
Mason Tan, SWWB
- 11.20 Input 4: Dilnuaz & Mohd. Ali, Penang Refugee Network (PRN)

BREAK 11.40 – 11.55

- 11.55 GROUP DISCUSSIONS
Seven Groups discussing GBV challenges and potential for initiatives
Keywords: Accessibility; Acceptability; Partnerships; Sustainability

- 1.00 Feedback on Partnerships with Government agencies

1.15 – 2.00 LUNCH

SEXUAL AND REPRODUCTIVE HEALTH: PROVISION AND CHALLENGES

- 2.00 Input 5: Christine, FDHA: plans and perceived SRH challenges
- 2.15 Input 6: Qamar Omar: SRH from a refugee perspective
- 2.30 GROUP DISCUSSIONS (contd)
- 3.30 Feedback and Sharing
- 4.40 Round-up and Next steps: Jason, Joshua
- 4.50 Closing remarks
Jason Yeo and Joshua Teh, UNFPA
Cherine Hegazy, Canada Fund for Local Initiatives Coordinator

Acknowledgments are due to UNFPA and the Canadian High Commission (through the Canada Fund for Local Initiatives (CFLI)) for the support and funding that allowed this Workshop to happen.





Jason Yeo and Joshua Teh Honguan, UNFPA

Jason and Joshua welcomed participants to the Workshop.

They led a round of introductions by group, highlighting the presence of a range of stakeholders, including strong presence from the refugee communities in Penang. The introductions showed refugee representatives from the Arakanese community, from the Penang Refugee Network, and from refugee-run learning centres. Also in the room were representatives from UNFPA, UNHCR, the Canada Fund for Local Initiatives, HOST International Malaysia, Tenaganita, Social Work Without Borders (SWWB), Medecins Sans Frontieres (MSF), Family Health Development Association Penang (FHDA), the Malaysian Relief Agency (MRA), BreatheLife, Humankind, Geutanyoe Foundation, Universiti Sains Malaysia, and the Penang Working Group.

Jason shared that UNFPA is the United Nations’ SRH agency. It has four key pillars: ensuring universal access to reproductive health and rights; eliminating GBV and harmful practices; child marriage; and addressing population ageing.

It has received funding from the Australian government for a regional response programme to the Myanmar refugee crisis. As part of this,



UNFPA is partnering with Tenaganita, SWWB and FHDA to provide GBV and SRH services to Myanmar refugees in Malaysia.

As a result, it would be good to explore how to expand access to services and create more equitable partnerships amongst those delivering activities. Today will be a good chance to do this and come to some consensus on how to move forward together.

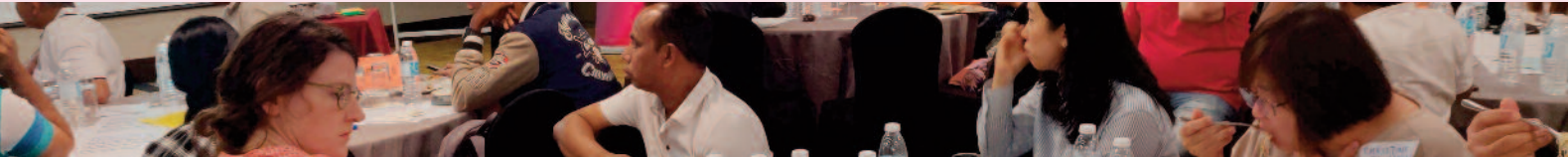
Joshua thanked James, Cherine, and Joshua (HOST) for the hard work in organising the workshop.

UNFPA Needs Assessment Study: Nessie Sdn Bhd

Joshua introduced Dr Prema Devaraj, who is leading a team of four persons undertaking a Needs Assessment on GBV and SRH services for Myanmar refugees and asylum seekers in Malaysia. The project is under UNFPA. Prema introduced her team and noted that they will be in touch with most people in the room, to arrange interviews! The project runs until August.



The UNFPA Needs Assessment study team



James Lochhead, Penang Working Group

James put this workshop into the context of the on-going work in Penang. Here ,for the past ten years and more, considerable efforts have been put in to create opportunities and possibilities for collaboration amongst the many and various Penang stakeholders. Absolutely crucial to this work has been the commitment to support the voices, experience, ideas and wisdom of those women, men and youth in the refugee community who have been consistently active in helping tackle some of the issues faced by persons in their communities.

Hence, the Penang Working Group, the collaborative forum that brings people together twice a year and on a WhatsApp group.

Hence too the presence in this room of so many refugee representatives, including women, men and youth, and including persons from refugee-run learning centres, community leaders and from the Penang Refugee Network.

Why collaboration? Because it offers a way to pool scarce resources, optimise programmes, avoid parallel universes and overlaps, and try to encourage people to avoid what are so often one-off initiatives taken in isolation. The collaboration in Penang has been framed in creating a strategic framework where the efforts of each and every person and organisation helps build towards a common goal. This has been done for child protection issues (on-going work being done here) and hopefully can be done for GBV and SRH initiatives. And the recognition that it is the experience and knowledge of the refugee community that should be at a minimum included in, and at the best at the forefront of, endeavours would also mean that gaps in approach, understanding and delivery of activities (including for SRH and GBV) could more immediately and better be bridged.

James reported that this Workshop was motivated by the knowledge that the delivery of SRH and GBV services in Penang (as elsewhere) has always faced challenges, and that the present cutbacks in the funding environment was severely affecting capacity to provide such services. So it was timely that we get together to look at how best to go forward. This was made more urgent when it became known that UNFPA are funding some new initiatives with regard to SRH and GBV in Penang. So today is a chance to review where we are up to, to look at what is planned for 2026, and to look for areas where collaboration and mutual support and involvements with persons in the refugee community might offer more sustainable ways forward. Onwards!





Michelle Fong, UNHCR

Michelle highlighted the current challenges being faced by UNHCR Malaysia and the general GBV ecosystem in Malaysia, not least following some serious funding cuts.

She highlighted the shifting operational realities. This included the impact of underfunding, with cuts to programmes being a global reality. It also included the resource constraints that anyway exist. She noted this meant that we need a sharper prioritisation process.

She highlighted 2026 Priorities Ahead. Here she highlighted advocacy for safe access, urgent case management, ensuring live-saving referral pathways, risk mitigation mainstreaming and supporting community-led solutions.

She talked about the importance of Sustaining Collective Responses. Here she highlighted the need to regular communication, transparent communication, engage with the government and amplify refugee voices.

She stressed the importance of working together. She suggested the next steps to be regular coordination meetings, developing good casework protocols, and engaging with government.

Elena Platani, Medecins Sans Frontieres (MSF)

Elena explained the scope of MSF, which is twofold. One is to provide appropriate medical care for survivors but the second is to help raise awareness within the community about GBV. The care is provided following strict survivor-centred MSF guidelines. Elena noted that at the moment there may be up to 60+ people a day at the clinic. In 2025, MSF assisted some 214 GBV cases, the majority of which were IPV. 10 cases were referred to OSCC in 2024 but only 4 in 2025.

Elena highlighted the barriers to access and follow-up for survivors. These include: Stigma and discrimination, including fear of being seen at the clinic and fear of police; Not knowing about IPV or MSF services; MSF especially now trying to engage with men; Communication and language barriers, despite the presence of interpreters (and sometimes the survivor does not want to say out loud); Perceived hopelessness about support.

She described MSF's response, which has been to address barriers by raising awareness, targeting women, men and children, adolescents and community leaders. This is done via an MSF team engaging with the community using (a) the story of change which has been co-created with the community. Set of stories covering possibility of trauma and how to overcome the trauma; (b) Women health ambassadors; (c) Comprehensive sexual education in schools – trying to restart this; (d) Service promotion as a lot of people don't know what we provide.

She highlighted some key challenges, which include potential for overlapping activities with others, both thematically and geographically (she lauded the maps in the room!), the possibility that increased awareness would lead to increase in demand on already overstretched services, the lack of clear referral pathways or resources (eg shelter or emergency funding), and the challenges around hoping for an increase in community/survivor-led support.



Sarah Jane: Tenaganita

Sarah Jane presented as one of the UNFPA-funded organisations brining some new initiatives to Penang for the first six months of 2026. She outlined the components of Tenaganita's work, most of which is based in KL. This included migrant rights protection, anti-trafficking initiatives, refugee actions, shelter provision and business accountability.

She outlined that in Penang, there will be some case management capacity, potentially 5 shelter placements, and access to appropriate services for those in the shelter.

Similar to SWWB, she noted the challenges of not having enough casework capacity, fragmented referral pathways, the difficulty of working with PoCs from different ethnicities at the shelter, and post-shelter re-integration.

She too welcomed the chance for collaboration, to try to optimise appropriate referral pathways, to pool data to help identify gaps and issues, and to reach out to communities in Kedah and Perlis that may also need support.

Mason Tan: Social Work Without Borders

Mason also presented as a recipient of UNFPA funding. He described the background to SWWB. He explained its approach, aiming at comprehensive and holistic care and transformation. He talked about the way SWWB goes about promotion, prevention, intervention and development/empowerment.

He outlined the recent SWWB programmes in Penang, partnering with Penang Refugee Network. Programmes have included running a Multidisciplinary Case Management Training in December 2025, with the idea of supporting casework in Penang through monthly additional supervision and additional training until June. The target is to respond to 40 Myanmar refugees or asylum seekers.

The challenges he highlighted include the challenge of SWWB having to monitor Penang-based casework remotely from KL; that many referrals may not fit the criteria; and the many funding and resource limitations, including limited options for shelter and emergency financial support.

At the same time, he emphasised the opportunity for collaboration which will help better identify referral pathways and share resource networks.



Dilnuaz & Mohd Ali, Penang Refugee Network

Dilnuaz and Mohd Ali clearly articulated the need for all of us to be aware of the potential gap between the understanding of UN agencies and NGOs as to what the issues around SRH and GBV are, and what the perspectives and realities lived by women, men and youth in the community might be.

They highlighted that this might be particularly relevant to the experience or the expectation on a woman. Some agencies and NGOs may expect her to speak up, fend for herself, and be ready to start a new independent life. But this may be far from the reality.

Dilnuaz and Mohd Ali talked of how there is still a prevailing power imbalance between men and women. Men are often the breadwinner, the decision maker, the protector, and the leader. The woman is often dependent on her husband and is unlikely to have been encouraged in education or in independent employment/activity.

This limits her perspective of the potential options that may be offered to her.

Further, 'social norms' in the community may lead many families to choose to "protect" a young woman/daughter by arranging their marriage. Again, the young woman may be socialised to listen to the husband, and be a good homemaker.

Disrespecting the husband may be seen as sinful, and there is a social stigma especially for a divorced woman.

Dilnuaz and Mohd Ali stressed that being aware and sensitive to this reality may help us to support a survivor better, especially if she is a woman.

They emphasised that dealing with GBV cases is challenging, because we are trying to support the survivor while being aware of prevailing perspectives and realities. Working with persons in the community who know their community may help us minimise the situation where we alienate families, community leaders and even whole communities.

Such awareness will also tell us that long-term, consistent work within the community is essential if things are to change, involving ALL PARTIES: community and religious leaders, men, women and youth.



Dilnuaz and Mohd Ali explained that the Penang Refugee Network (PRN), like other refugee leaders and persons in the community, has always informally been responding to situations of GBV within the community.

Most cases remain unreported because the community prefers to handle on its own. But PRN has been increasingly exploring whether it can take on more 'formal' casework, in partnerships with HOST International Malaysia and more recently, SWWB. They noted that PRN directly helped 22 GBV survivors between August and December 2025.

They highlighted the limitations faced by refugees in undertaking such work (especially engagement with government agencies and hospitals, etc).

They also highlighted the lack of shelter and emergency support options, faced by all involved in trying to support GBV survivors.

Long term, PRN has been consistently designing and delivering community talks at different locations, men to men, women to women, youth to youth. This is seen as essential for long-term change.

PRN has also been active in documenting (from the community's perspective) issues and strategies on a variety of topics, including child marriage, has conducted numerous focus group discussions and surveys within the community, and have always been at the forefront of the organising of the Penang Working Group meetings and initiatives.

Dilnuaz and Mohd Ali asked us to

Challenge our assumptions!

Involve others in the community as appropriate!

Before making decisions, try to hear from both sides!

Make it clear what we can and can't help with (not to give false hope)!

Help get more resources for GBV work, including for shelter and emergency assistance.

Look at the potential of partnerships.

But they stressed that partnerships are not necessarily so easy: how can we make sure that a partnership is really a partnership, when power differences between partners are so often are so great? But we must try, if we are to make our support for GBV survivors the best it can be.

Participants were split into seven groups.
The discussion topics were as follows:

GROUP 1 - Accessibility

What physical and cultural barriers exist to accessing GBV services and how can stakeholders address them?

GROUP 2 - Accessibility

What financial and information barriers exist to accessing GBV services and how can stakeholders address them?

GROUPS 3 & 4 – Acceptability

How are GBV services seen by refugee communities? What will make communities more likely to access GBV services?

GROUP 5 – Partnerships

How can partnerships between NGO GBV providers and refugee communities be strengthened? What makes a "good partnership"?

GROUP 6 - Partnerships

How can partnerships with OSCC, police, and JKM be strengthened?

GROUPS 7 – Sustainability

Can we identify funding sources to sustain GBV programmes long term? What role can community ownership play in sustaining GBV initiatives, and how can this be encouraged?

It was emphasised to the groups that the same group/topic would continue into the afternoon, albeit with a focus on SRH. But many of the challenges and potential ways forward would be similar, so much of the discussion was likely to be developed through the course of the afternoon too.



GROUP SIX FEEDBACK

How can partnerships with OSCC, police, and JKM be strengthened?

The feedback from Group 6 emphasised the crucial importance of engaging with and involving the appropriate government agencies on GBV (and other) matters. There has been positive work done on this perhaps especially over the last two years. It was noted that there have been meetings with JKM, health authorities and state government representatives brokered by UNHCR, UNICEF, MASW and others. There have been the exchanges at the Penang State government's Refugee Consultative Council. This has created plenty of opportunities going forward for increasing involvements and dialogue.

Participants in the room were urged to make the most of these opportunities. They were encouraged to invite government agency representatives to, for example, meetings of Penang Working Group, to share experiences and exchange possibilities for joint collaboration. This will continue to build and strengthen meaningful relationships. It was suggested that there could be an annual exercise to share updated referral pathways or services that are being provided: they will appreciate it. And it is good if we can do this collaboratively rather than bilaterally.

It was noted that there is still room for basic sharing of information of what refugees face in Malaysia. Framing the refugee issue is important, and it was noted this should be done positively, whereby the contributions of the refugee community are highlighted rather than 'the problems'. Initiatives that showcase the culture and 'human face' of refugees, like food or music festivals, can help bridge ignorance or misunderstanding.

Participants were reminded of the importance of working with refugee community representatives on this. The power differentials are significant and the fear of people in the community of government agencies remains very real. Working out appropriate and 'safe' interactions with community representatives will help build support and trust and gradually support each party to make the optimum connections and suggestions.

Christine, FDHA

Christine introduced the Family Health Development Association Penang (FHDA), which is a Malaysian-based organisation catering to much more than the refugee population. It is a member of the national body, FHRAM. It has only recently become more involved with refugees and asylum seekers, providing SRH basic screening in the community in Perlis, Kedah and Penang. Some counselling is offered, including referral on to other appropriate agencies, as well as tests conducted, including B/P check, STI rapid test, Hep C rapid test, and HIV rapid test, as appropriate.

FHDA also offers Life Skills Education for teenagers above 10 years old and unmarried, under the title *Growing Up Healthy for Boys and Girls*. there are separate sessions for each sex, each taking between 2-4 hours. The course will include modules on Understanding My Body and Feelings; Personal Hygiene and Self-Care; Psychological and Emotional Changes; and Safety, Support and Respect.

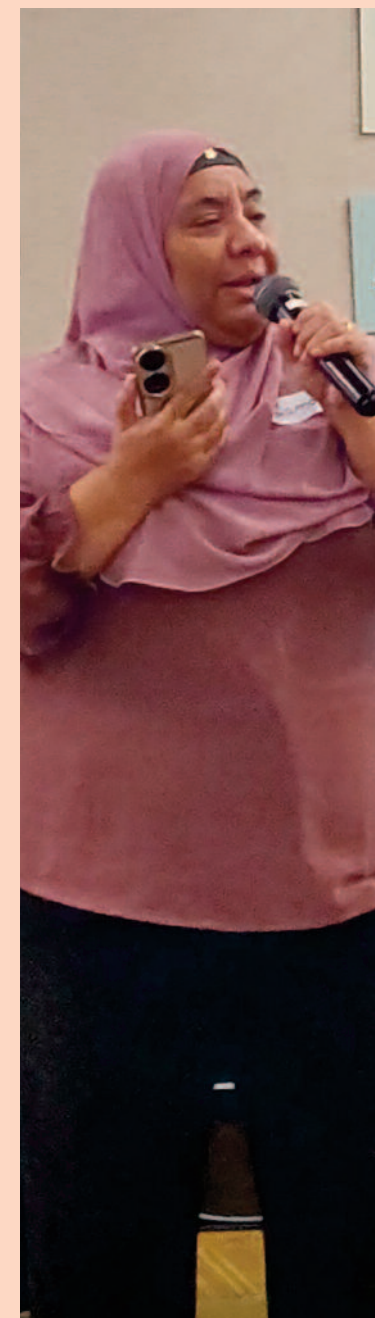
There are also courses offered on SRH awareness for adults/married in the community, again split between topics covered for women under Women's Health, and for men under Men's Health. Christine produced a comprehensive list of topics which are covered in both.

She highlighted some of the constraints faced by FHDA. One is the constraints of staffing and resources (funding) and FHDA's many commitments elsewhere (not just serving refugees). Christine also mentioned that FHDA is a women's organization and is not based on an Islamic model. Communication to (for example) the Rohingya men religious and community leaders is therefore not always straightforward.

Christine highlighted the opportunities. This included collaboration, including finding partners to co-host outreach provision of services and/or trainings. Christine also highlighted the possibilities for beneficiary engagement and for new pathways of networking.



Qamar Omar, Spring Learning Centre



Qamar speaks as a Burmese Muslim refugee with long experience as a leader in her community not least in running the Spring Learning Education Centre. She highlighted eight (8) points related to her perspective on SRH.

- * **The legal and systemic barriers** - refugees still have no status in Malaysia
- * **The high costs** - unaffordable healthcare; insurance often excludes pregnancy/maternity
- * **The maternal health crisis**- higher than average rates, late presentation of problems because of fear, costs, ignorance
- * **The increase in GBV** - 'normalised' behaviour, lack of legal protection,
- * **Delayed and incomplete care** - fear, stigma, cost, poor cultural competency
- * **Mental health** - trauma,, insecurity, risk, violence
- * **Lack of integration** - healthcare systems are not culturally flexible, and are not inclusive, eg OSCCs for GBV survivors
- * **Sensitivity of the topic** - delivery of SRH information risks traumatising target audiences unless we are all fully aware of cultural sensitivities and contexts

Qamar proposed five major initiatives for 'solutions': Policy reforms, Targeted gender-responsive interventions resulting in culturally competent care; Better Financial Support including through insurance; Wider community involvement and education; Better partnerships for more culturally effective content.

She noted that the consequences of not finding better solutions would continue to be: Higher maternal morbidity; Increased prevalence of untreated conditions; Severe perinatal issues; and continued financial hardship because of health-related expenses.



Group 1 Physical and Cultural Barriers

What physical and cultural barriers exist to accessing GBV/SRH services and how can stakeholders address them?



Physical barriers

- Undocumented, newcomers or those who have been here a long time face difficulties and fear of arrest.
- Refugees are mostly from Myanmar and have shame stigma and face community backlash.
- Communication – language barrier (Rohingya). Literacy challenges.
- Lack of clarity on information, where to go and who/how to reach out to.
- Remote areas – some are staying far from facilities like hospital and police station
- Remote facilities - for example shelters. Survivors are from Penang but shelter is in KL. Not enough shelters.



Cultural barriers

- There is a power imbalance between women and men. Life restriction. Mostly in Rohingya we must listen to husband who say we cannot go outside. We can't do anything without husband's support.
- Fear because this is a new place. Lack of awareness of the community. We must learn about the Malaysian culture. Some orientation or cultural classes will be better for the newcomers.
- No interaction for new arrivals. They are hiding in the rooms. In fact, a lot of people do not go out – not going to school.

How to address

- Training will help: ToT and train community persons who can then pass on to other refugees.
- Liaising with the government agencies. We don't know how easy / difficult that is going to be.
- Also liaise with community agencies, e.g. temples,

- churches, mosques - get the local people together to help.
- Working with the men is important. It is a circle that comes back to the men. Encourage and support them to speak up and take a stand and talk about this issue. SRH - family planning etc. We always talk to the women but we need to also talk to the men.
- Working with youth is also important. And for the children we can start talking about SRH in terms of basic hygiene, respecting their bodies. We want our children to make informed and good choices for your body and your life.
- Also work with the older generation. If they are more aware of where the younger people are at, they may be aware of the need to change mind-sets.
- If the elderly can become our advocates, then they can help the community to adapt and not follow the fixed idea.

Group 2: Financial and Information barriers

What financial and information barriers exist to accessing GBV/SRH services and how can stakeholders address them?



Financial barriers

- Medical fees, legal fees and limited shelters.

Information barriers

- Language. Cultural background.
- A lot of need to do awareness building.

Information on SRH

- Starting puberty, start education on personal hygiene and information on sex, so that before marriage, they have some exposure to SRH education.
- Malaysians have *kursus kahwin* but there is nothing for the refugees. There is often a lack of information or understanding about family planning and birth control. Some women may think they are not having their period and therefore can't get pregnant.
- It was noted that MSF is supplying some kinds of birth control and FDHA also provides at a low cost. But information needs to be better disseminated.

One suggestion is that UNFPA or someone funds the development of a whole curriculum on SRH for adoption as part of the curriculum in the schools. In Penang we see an increase in enrolment of girls in the secondary schools. We need to target the most educated members of the community, which would increasingly include the older boys and girls, because then that knowledge resides with the community. If we are relying on NGOs, we face uneven outreach which can at any time be affected by funding cuts.

Ways forward to make sure of cultural appropriateness were suggested. Starting with the schools is important. This may be an easier avenue to reach important target groups (boys and girls in education) and can outreach too to the parents. Reaching the girls is potentially important: for those girls who made it to secondary school, the parents are quite open and chances are they might listen to what their daughters are saying. And we have good example of girls who can be good ambassadors. Working with the community may be more difficult for some of us because sometimes they don't accept you. It is worth trying to get endorsements from religious leaders.

It was stressed that whatever work we do, we need to work as a team and not individually. We need a long-term plan and especially a plan on increasingly working with/ listening to women, men and youth from the community. The more we can engage with the community, the better.





Group 3 Acceptability

How do cultural, religious or social norms influence the acceptability of GBV/SRH services in the community?

What will make communities more likely to access GBV/SRH services?

Men's perspective

Encourages marriage separation. Encourages wife to go against the husband. It reduces the influence of men. It promotes western culture rather than the community rooted culture that has been practiced generation by generation. Terms like *equal rights*, and *equal voice in the family*, are not our terms. Some women fake their case or vulnerability for their own benefit (to get attention of UNHCR, for resettlement, for example). Need to talk from both parties before making any decision.

Women's perspective

Going to hurt men's ego. Some of us feel supported, safe and protected. We have somewhere to go if we have a problem. Have a safe place to share openly. Normally women don't share things like this openly. This will help them. Some feel disobeying their husband as a sinful thing. Culture shows you need to listen to your men. Husband will be more hostile if we go and ask for help. For sure, as soon as you go back home, will be questioned.

What will help communities access more GBV services?

Awareness and promotion within the community but respecting confidentiality and safety. Also encourage supporters /survivors to share with others about accepting services.

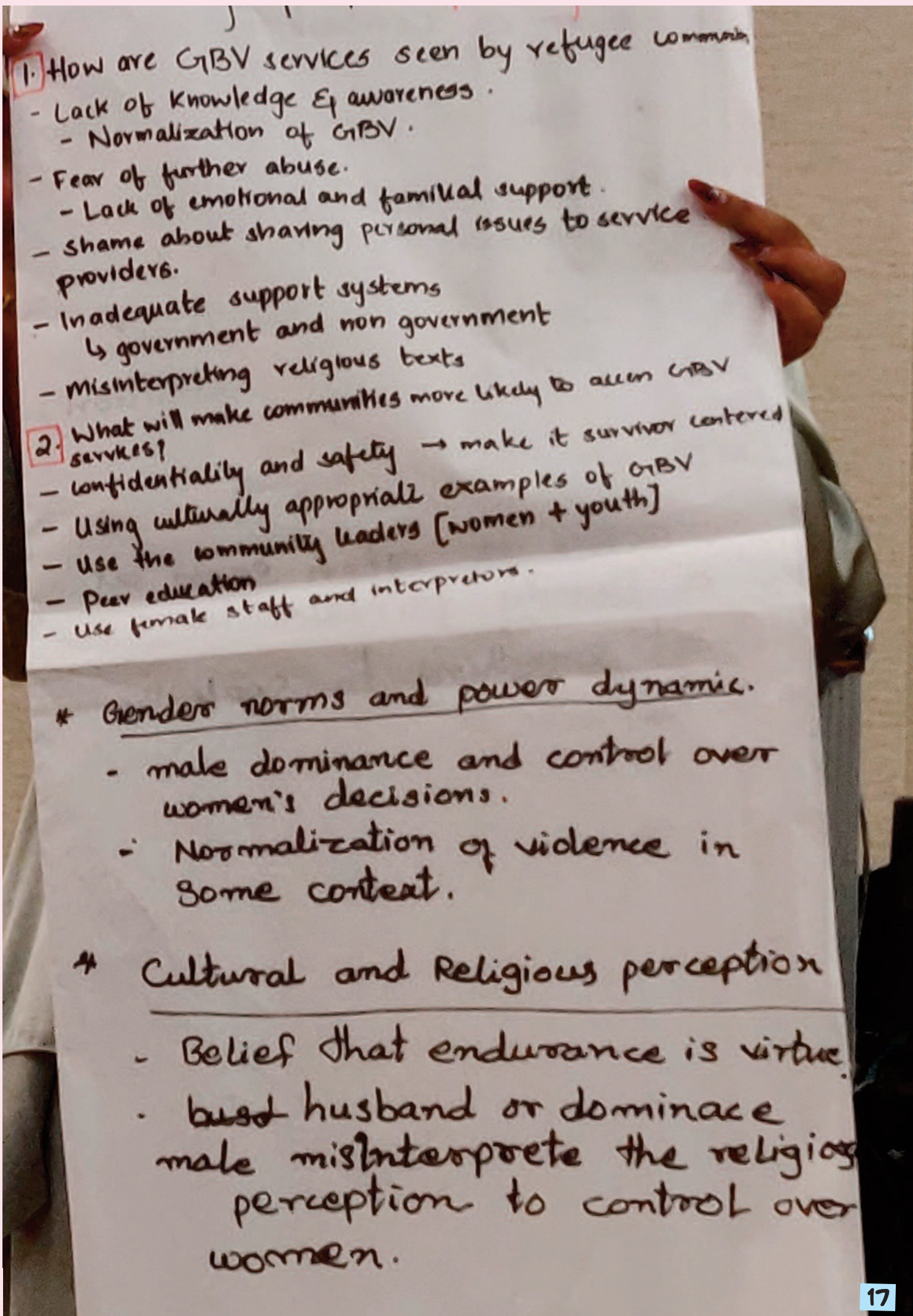
How does culture, religion and social norms influence access to SRH services?

Contraception method is considered sinful by some in the community. Not for everyone. Things are changing. Some think it is not aligned with religious, social and cultural practices. But with awareness and education ... Some accept SRH fully for family well-being. Very sensitive for those with diagnosis like STD etc because of cultural. Some women prefer to talk with a woman instead of a man.

Groups 1 and 2 talked about SRH services in the hospital, it is expensive, because of this, they have the idea that having birth control is helpful, as it can reduce finances.

Strategies

For youth can do some workshop, awareness sessions for teachers and community leaders. Men to men and woman to women workshops. Awareness videos for social media. Have to respect cultural sensitivities.



Group 4 Acceptability

How do cultural, religious or social norms influence the acceptability of GBV/SRH services in the community?
What will make communities more likely to access GBV/SRH services?

How are GBV services seen by refugee communities?
Lack of knowledge and awareness. Normalisation of GBV. Fear of further abuse. Lack of emotional and family support. Shame about sharing personal issues to service providers.

Inadequate support systems. Government and non-government. Misinterpretation of religious texts.



How are SRH services seen by refugee communities?
Lack of awareness of SBV services. SRH topics like contraception are often taboo in the community. Stigma and cultural sensitivities. Talking about sexual health is seen as shameful for women and adolescent. Fear and legal insecurity. Fear of arrest and discrimination. Mistrust of system and confidentiality.

What will make communities more likely to access GBV services?
Trust and safety. Confidentiality. Make it survivor centred. Clear explanation that services are free.

Culturally appropriate examples of GBV.
Community engagement via community or youth leaders. Men to men / youth to youth/ women to women. People from the same background so that people can relate. All refugee backgrounds and traditions are not the same. Focusing on those with the same will help. Simple explanation of what is SGBV. Use of first language and culturally appropriate examples. Flexible appointment for service providers, female staff and interpreters. Be aware of misinterpretations which control and dominate women.

What will make communities more likely to access SRH services?
Need to focus on education and create awareness within the community. Refugee communities are from so many different backgrounds, traditions and cultures. Which community are we going to give services to? We need to understand the cultural sensitivities. Respect the opinion from the refugee community. Maintain confidentiality. Find out the key words. What feeling or thoughts come to mind on this?

What makes it difficult to talk about SRH?
Who decides? Gender sensitivity – what challenges are specific to women / men? How can we involve men in SRH? How can we use the Malaysian context and culture to help us?

Need to find the trusted leader. Female staff. Use of community language and pictures. SRH services are most effective when they are respectful, confidential, and shaped by the community needs.

Group 5 Partnerships

How can partnerships between NGO GBV providers and refugee communities be strengthened?
What makes a "good partnership"?

When we talk about partnerships we think of about being on the same page. There are a few ways to strengthen partnerships and have a triple win situation that benefits the donor, NGO and communities that get services. Key is to co-design community-based approaches. Support community input and see what assets the community has. Assess each others’ strengths and weaknesses.

Collaboration is possible with religious scholars, academics, teachers, community focal points, leaders. We often overlook community members like neighbours. Outreach will help standardise awareness about GBV and SRH programmes.

Good partnerships mean that there is an understanding of each other strengths and limitations. The challenges are managing expectations and setting boundaries. There is extra challenge when partnering with CBOs since it is difficult for them to sustain and get funding (no right to a bank account).

To establish a good partnership with the community on SRH, for example, an assessment needs to be done. The target audience will be women, men, children, religious leaders, etc. FGDs can be conducted to better understand needs and to be mindful of cultural sensitivity. We need to anticipate language barriers and have ways to overcome them.

Creating a feedback and accountability loop is important. This means that we avoid one off activities but make sure they are on-going. Continual monitoring and reviewing of the initiatives and services will help adapt the partnership and each other’s roles. Training of community members and co-design of topics will also help.

It would be good to have a curriculum for sexuality education for all the learning centres. Training learning centre/ school teachers on SRH topics and the involvement of parents in the initiative would be positive. Topics could include Good Touch & Bad Touch; male and female reproductive health; and online safety.

Further comments included: nice to see something on feedback and accountability – usually an afterthought. Of course it is feedback for what? Accessibility of services, complaints? Plus, there are a lot of mechanisms you can set up - doing short surveys, and talking to beneficiaries and going back to ask was this helpful for you. This keeps people involved and helps extends partnerships.

A further comment stressed the importance of independent monitoring and evaluation to ensure authentic data.



GROUP FEEDBACK - PARTNERSHIPS

Group 6 Partnerships

How can partnerships between SRH and GBV providers, schools, and government services be strengthened?



Group 6 in the morning had discussed partnerships with government agencies and had already reported back on that (see above, p 11).

How best to deliver life skills education to children at school?

We agree that if we go straight to them there are obstacles. E.g. If talk about menstruation we have to mention potentially ‘difficult’ words like ‘vagina’.

So we agree that we need a group of people with skills and knowledge and who are willing to share. They need to come from a cross-section of people, with different skills and insights. Working together, and especially working with the gate keepers into the community.

We are eager to proceed but how do we best approach young people?

Have an activity among ourselves where we use activities and games to introduce to each other how to make it acceptable through the partnerships of a few organisations. (The group reported that there had shared a few games just now and were excited to explore this more!).

Desensitisation workshop

We need a desensitisation workshop with the gatekeepers, so that we better understand the culture in which we are working and can find the right words and activities. So when we go to the school we will have an impactful workshop with the children. For the children we call it a class and for the teachers we call it a training of trainers.

Collaboration

The Group stressed the benefit of sharing, and strongly encouraged anyone who wanted to share resources on more creative ways of addressing SRH/GBV to share.....



GROUP FEEDBACK - SUSTAINABILITY

Group 7 Sustainability

Can we identify funding sources to sustain GBV/SRH programmes long term?

What role can community ownership play in sustaining GBV/SRH initiatives, and how can this be encouraged?

What role can community leadership play for sustaining GBV partnerships?

Can offer safe house for survivor. Mediator – solving small things in community. Create safe space for women. Fundraise in community. What we can do – help to raise awareness and do referrals. Build social connection. Volunteer for community. Provide role models.

Factors for sustainability: SRH

Most already mentioned. Commitment is important. Need to have the heart for helping. Must be working as a group. If one resettles then the other knows what to do. We need to share also share good community examples. Good models. Develop partnerships between CBOs and local NGOs.

What role does community organisations play and how can this be encouraged?

Introducing SRH in community schools. Getting the endorsement from religious teachers. Raise awareness through social media and in community (outreach). Raise awareness through social influence. Influencing through peer networks including social media. Don’t talk enough about mental health - so when doing SRH intervention we should also talk about mental health.



Closing Remarks: Jason Yeo and Joshua Teh Honguan, UNFPA



Joshua thanked everyone for their participation in the workshop, and the discussions that have resulted in so many sharings and ideas. He particularly highlighted the emphasis from all the groups about the importance of working with CBOs and communities, with plenty of opportunity for co-designing initiatives and activities.

He stressed also the emphasis of collaboration and noted the possibility of reaching out to some non-traditional actors, including religious bodies, zakat, or philanthropic organisations. He also noted the amount of times the role of parents was mentioned, and how important it was to reach out to parents in a way that they can accept the messages and encouragements. This is important for most issues, and is important for SRH and GBV.

Joshua noted that cultural change takes time, so overcoming the barriers of stigma and taboos (two things raised consistently across the day) is not easy. An understanding of where they come from, the areas of sensitivities, and the approach needed to tackle them is paramount. Again, working with CBOs and persons from the communities will help. He also noted the potential of a snowballing approach.

Joshua also highlighted the importance of data. He shared that for UNFPA, a lot of the work is data driven, which is why UNFPA have engaged the Needs Assessment study to be done by Dr Prema and her team. He mentioned that data also often helps with fundraising. And it helps us understand what trends and impacts are relevant, helpful especially for the long run.

Joshua finished by saying that when doing this work, it has to be something that comes from the heart. He thanked everyone for their heart, thanked the refugees in the room for their heart, and thanked everyone for the privilege of working alongside you.



Jason also thanked everyone for the discussions and sharings over the day. He looked forward to the next steps. He noted that MSF had made a suggestion of a further specific meeting on SRH/awareness outreach, which is a very positive and Jason hopes all will support.

He also noted that there is always room for better coordination on the ground, more conversations, sharing of information, ongoing updates and referral pathways. But he also noted that Penang is a very matured market. There are already platforms for such sharings and collaborations to take place.

So, taking forward today's conversations and recommendations, Jason suggested setting up a 'monitoring group' devoted to GBV and SRH, which could meet regularly and support on-going initiatives that may have been referred to today.

This might best be done under the Penang Working Group (similar to initiatives on Child Protection), and he offered to work with James and others to set this up. Anyone was welcome to volunteer and 'we will be in touch'.

Closing Remarks: Cherine Hegazy, Canada Fund for Local Initiatives



As the Coordinator for the Canada Fund for Local Initiatives (CFLI), Cherine expressed how much she had enjoyed the workshop. She thanked everyone for their excellent participation and support. She noted that for her, this was one of a very few times when she had seen so many different stakeholders come together. She reflected on some of the points of the discussion, notably that the difficulties in funding cuts are forcing prioritisation of the most critical cases; that legal insecurity fragments the referral pathways; that deep rooted gender norms continue to place women and girls at risk; the persistence of stigma, fear of detention and language barriers.

She highlighted the hope that women and youth from the refugee communities would not just be beneficiaries but also leaders. She endorsed the journey towards strengthened coordination, and investment in community led and culturally sensitive pathways. And she congratulated everyone for the great example of today, coming together and setting up a working group and come up with actionable items.

Cherine finished by saying that Canada has a strong refugee programme and, through the CFLI iprogramme, invests in local civil society organisations. It will soon open its call for 2026 proposals. She encouraged anyone interested to apply. She is here today as part of the CFLI support for the HOST International/Penang Refugee Network partnership, one of the successful applications in 2025.



Thanks to Tashia Petersen, beng hui and James Lochhead for notes.
To James Lochhead and Cherine Hegazy for photographs
and to James and the Penang Refugee Network for layout.