CARE Rapid Gender Analysis
Myanmar – Rakhine State

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Cover page photo: A young woman in the processing of making masks in Rakhine

Photo credit: FCA Consortium (FCA, LWF and CERA), NuNu Aye.

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Abbreviations

DPO	Disabled Persons Organization
GBV	Gender Based Violence
ICoE	Myanmar's Independent Commission of Enquiry
HI	Humanity and Inclusion
IDP	Internally Displaced People
KII	Key Informant Interview
nRS	Northern Rakhine State
PoVAW	Protection of Violence against Women
RGA	Rapid Gender Analysis
R&R	Return and Resettlement
VAWG	Violence against Women and Girls
WHO	World Health Organization

Executive Summary

Despite the number of COVID-19 cases in Rakhine State being quite low, the impact on rural food production and the livelihoods of thousands of farm labourers, who are mostly women, is immense. The loss of food production in the State could potentially push families into further poverty and produce further malnutrition in a State of Myanmar that already has one of the highest malnutrition rates in the country. Additionally, the growth of women's empowerment, which is strongly linked to financial contributions to the household, will decline.

Women and girls in Rakhine State face inequalities in many areas, such as in employment and payment, division of domestic labour, decision making and participation. Those are likely to further increase in the course of the COVID-19 pandemic. An area of specific concern is in the education of girls and boys, from poor families, who do not have the technical infrastructure and capacity to support, especially with the continuous internet blackouts across the State. Deployed in an operational environment characterised by ongoing volatility, COVID-19 prevention, treatment and containment efforts have faced multiple difficulties. Mistrust of government officers by communities, restrictions on humanitarian access, limited health services, coupled with targeted attacks on healthcare workers and facilities have proved to be serious operational challenges.

The current health system does not have the capacity to deal with an increasing number of COVID-19 cases and Water, Sanitation and Hygiene (WASH) systems across the State (especially in the cramped conditions of Internally Displaced Persons (IDP) camps) require major upgrades in order to reduce the potential for spread of the disease. In addition, there is a lack of emphasis on ways to reduce the transmission of COVID-19 due to higher concern on the current conflict issues and upcoming elections, which causes fear and creates potential for rumours causing further stigmatisation and discrimination of certain population groups.

Many prevention measures for COVID-19 rely on access to safe places for self-isolation or quarantine. Women's limited agency within the family, gender-based violence and gender stereotypes remain widespread within both Rohingya and Rakhine communities, and women are underrepresented in decision-making bodies and lack ability to influence and impact decisions and programming that ultimately affect their lives and needs. The restrictions on movement, as well as social and cultural restrictions placed particularly on women and girls in communities within Rakhine State will be exacerbated by additional movement restrictions in place to curtail the virus and prevent transmission in communities. It is important that movement restrictions related to COVID-19 do not adversely affect humanitarian responses and humanitarian needs being met.

Gender based violence is common and widely accepted in Myanmar. Globally, intimate partner violence (IPV) may be the most common type of violence women and girls experience during emergencies.[1] In the context of COVID-19 quarantine and isolation measures, IPV has the potential to dramatically increase for women and girls. Life-saving care and support to Gender Based Violence (GBV) survivors is already extremely difficult to find in Rakhine, and may be disrupted even further when front-line service providers and systems such as health, policing and social welfare are overburdened and preoccupied with handling COVID-19 cases. Restrictions on mobility also mean that women are particularly exposed to intimate-partner violence at home with limited options for accessing support services.

The impact of the COVID-19 pandemic on top of the already existing humanitarian crisis in Rakhine state, as well as the existing prevalence of malnutrition, poverty, pre-existing health conditions and lower access to healthcare facilities compared to other parts of Myanmar, places communities residing

[1] International Rescue Committee 2015

in Rakhine at higher risk of COVID-19. This is especially in the many IDP camps in Rakhine, where overcrowded shelters and poor sanitation conditions pose a serious risk of the disease spreading quickly. Considering the significant expansion of the protection crisis across much of Rakhine State, outstanding challenges in addressing the root causes of the conflicts, challenges in humanitarian access in Rakhine, combined with the added impacts of the COVID-19 crisis and the increased risks for those most vulnerable in Rakhine State, significant humanitarian needs are expected to persist among all affected communities throughout 2020.

Key recommendations

There have been major setbacks in the progress towards gender equality and continued efforts are needed to strengthen programme implementation and institutional framework to accelerate gender equality and to support women's empowerment in Myanmar. The following measures are suggested to enhance inclusive and gender responsive programming:

- Institutional funders should commit to funding women and girls-centred programmes for longer periods (3-5 years) to allow momentum to be sustained towards gender equality and allow adaptive programming to respond to the needs of women and girls.

- UN agencies and INGOs should leverage their soft power as funders to work with the government to increase access to services by women and girls, including those from marginalised communities.

- Organisations working in Rakhine should continue to gather information to address the sex, age and diversity disaggregated data gaps across the response and by sectors.

- Organisations working in Rakhine should regularly consult with women and girls of different ages (recognising that COVID-19 disproportionately affects the elderly) from various ethnic groups living in Rakhine State to ensure that programming priorities and activities can be tailored to address their priority needs and activities designed in a manner to allow adaptation for various communities to support improvements in gender equality.

- The government, donors and organisations working in Rakhine should work together to provide continued and comprehensive WASH and healthcare, including sexual and reproductive health (in line with the Minimum Initial Service Package) and psychosocial support services, with specific targets to ethnic minority women and girls, including obstetric, prenatal and postnatal care, contraceptive information and services.

- Organisations working in Rakhine to support women's participation and representation in decision-making and leadership, including in the upcoming elections. Additional attention should be placed on ensuring women and girls are meaningfully engaged and participate in decision-making processes, and take on leadership roles in their communities to shape and implement interventions. Adapted efforts should also be made for people with disabilities, elderly, LGBTIQ individuals and people with chronic diseases.

- Communication, education and information materials should be accessible to all. The use of multiple modes of communication such as radio, phones, communication through women's

support or savings groups and women, religious and community leaders should be utilised to address gender gaps in access to information, literacy rates, barriers for rural vs urban communities and issues related to the internet shutdown in parts of the State.

- All actors to ensure that survivors of sexual and gender-based violence have access to safe, free, confidential multi-sectoral prevention and response services including both immediate services as well long-term social care and support.

- The government, donors and organisations working in Rakhine ensure that safety and security in all areas, including IDP camps and villages in the State, are considered more holistically.

- The government, donors and organisations working in Rakhine develop and prioritize mitigation strategies that specifically target livelihoods of the most vulnerable women and men, including informal sector workers, and build economic resilience to future shocks. Consider the increased care burden when designing strategies or programmes, as well as the target group and such roles will affect women, men and at-risk groups' access to, and the effectiveness of such initiatives.

Introduction

The present report intends to shed light on the intersecting age, gender and power dynamics of the crisis, evaluating the current and future impact of COVID-19 on women, men, girls and boys in Rakhine State. By capturing both constraints and potential opportunities, as well as lessons learned and best practices from present and previous public health emergencies, this analysis aims to contribute to increased gender- and conflict-sensitivity in the planning, coordination and implementation of COVID-19 prevention and response interventions. The resulting thematic analysis provides evidence to recognise and advocate for the need for an increasingly gender- and conflict-sensitive approach to present and future health crises in Rakhine State and elsewhere.

The analysis reviewed external and internal gender related documents governing CARE's work in Myanmar. Interviews, including key informant interviews (KIIs) with CARE technical project staff were also conducted online.

This report presents the findings and recommendations of the Rapid Gender Analysis that was carried out between January and February 2020, and then later updated in June 2020 during the COVID-19 outbreak. The analysis was carried out with two primary objectives: To understand the different impacts that the COVID-19 potentially has on women, men, girls and boys and other at risk or vulnerable groups in Rakhine State in Myanmar; and to propose a set of recommendations to responding agencies for implementing COVID-19 response activities within the current humanitarian context, such as: CARE, Donors, NGO partners, Government and local authorities.

Background information to conflict

Rakhine State is broadly divided into three parts - Northern Rakhine, Central Rakhine and Southern Rakhine - each with their own specific context.[1] While Northern Rakhine was the site of the recent Rohingya exodus and bears the marks of conflict with a much-depleted population, a new conflict has expanded into Central Rakhine between the Arakan Army and the Tatmadaw. Central Rakhine houses many displaced persons[2] with Southern Rakhine being the least directly affected by the conflict.[3]

The situation in Rakhine State represents many of the challenges that Myanmar faces during a period of transition. A widespread lack of access to capital, credit, land and agricultural inputs is compounded by high population density, weak or non-existent infrastructure, and vulnerability to natural disasters; rendering the common household extremely susceptible to food insecurity and chronic malnutrition.

Northern Rakhine State (nRS) has experienced recurrent natural disasters and intercommunity-conflict. Ethnic and religious differences combined with other factors, have led to violent confrontations causing loss of life and destruction of farms and infrastructure. Floods, mudslides and cyclones combined with outbreaks of violence have displaced many households over the years. Those who remain in their villages face similar risks, with limited support. Intercommunal conflict has continued to escalate since 2012, and August 2017 saw deadly attacks by the insurgent Arakan Rohingya Salvation Army against police and army posts and a violent military and inter-communal response that culminated in the forced displacement of more than 800,000 Rohingya into neighbouring Bangladesh[4] and 154,760 internally displaced people (IDPs) in Rakhine State (53% women, 47% men, 5% with a disability).[5] Humanitarian challenges in Rakhine State continue to grow, following

an upsurge in fighting between the Myanmar Armed Forces and the Arakan Army in December 2018 that has caused civilian casualties and the displacement of tens of thousands of people in nine townships of Rakhine State and one township of Chin State.

Restricted humanitarian access to the region and IDP camps severely restricts data verification and there is a lack of available sex and age disaggregated data. An estimated 600,000 stateless Rohingya remain in Rakhine State. In the central part of the State, Rohingya make up the vast majority of around 128,000 Muslim IDPs across 23 camps established following widespread violence in 2012. Children make up at least 37% of this population, while women and children together make up about 71%. These camps also host around 2,000 internally displaced Kaman Muslims, in rural Sittwe, Pauktaw and Kyaukpyu. The remaining estimated 470,000 non-displaced stateless Rohingya (53% women, 47% men, 37% children, 54% adults, and 9% elderly) remain subject to heavy restrictions on freedom of movement, limiting their access to livelihoods opportunities as well as health and education services.[6]

COVID-19

First detected in China's Hubei Province in late December 2019, the novel coronavirus 2019 (COVID-19) has spread to 188 countries/regions, with 15,265,081 confirmed cases (sex and age disaggregated data unavailable) recorded by the Centre for Systems Science and Engineering at Johns Hopkins University as of 1 July 2020.[7] The World Health Organization (WHO) declared the COVID-19 outbreak a pandemic on 11 March 2020.

In Myanmar, the first case of COVID-19 was recorded on 23rd March 2020[8], and as of 26 June 2020, 343 lab confirmed cases were recorded, with 6 deaths (sex and age disaggregated data unavailable)[9]. Approximate figures show that by 22 June, only 1,258 samples had been sent from Rakhine State to Yangon for testing. The country's largest city, Yangon, is the outbreak's epicentre, though cases have been detected in other states and regions.[10] There are now eight confirmed cases of COVID-19 in Rakhine State – all among returnees from overseas. Two cases in the south of the state were returnees from Malaysia, while the remainder in the north were returnees from Bangladesh.[11] Notably, the first case of local transmission in Rakhine State was confirmed on 18 June.[12] In terms of the gender breakdown of COVID-19 cases in Myanmar, more men have been infected by COVID-19 than women, with data from May 2020 indicating that 180 men versus 124 women. 255 of these cases are among the 18-60 age group, 31 cases are over 60 years old and 18 cases under 18 years old.[13] At risk groups such as IDPs are particularly exposed to outbreaks of COVID-19 due to their often difficult living conditions, limited access to basic services (including healthcare), as well as additional challenges they face in implementing precautionary measures, such as physical distancing[14] which can then in turn increase their risk to become infected with the virus. Limited testing capacity and reports of people under investigation dying before being tested have fuelled fears that Myanmar's outbreak could be vastly under-reported.[15] National and regional Governments in Myanmar, like countries globally, are imposing stay at home 'lock-down' measures, physical distancing[16] and, in some regions, curfews.[17]

Considering the significant expansion of the protection crisis across much of Rakhine State, outstanding challenges in addressing the root causes of the conflicts, challenges in humanitarian access in Rakhine[18], combined with the added impacts of the COVID-19 crisis and the increased risks for those most vulnerable in Rakhine State, significant humanitarian needs are expected to persist among all affected communities throughout 2020.

The Rapid Gender Analysis objectives

Rapid Gender Analysis (RGA) aims to provide information on the needs, capacities and coping strategies of women, men, boys and girls and how they may change during a crisis. The RGA provides essential information about gender roles and responsibilities, capacities and vulnerabilities, and aims to provide practical programming and operational recommendations to meet the different needs of women, men, boys and girls ensuring we 'do no harm'. This RGA aims to:

- Understand the different impacts that the COVID-19 potentially has on women, men, girls, boys, and other at risk or vulnerable and marginalized groups in Rakhine State in Myanmar.
- Propose a set of recommendations to responding agencies for implementing gender-responsive COVID-19 response activities within the current humanitarian context, such as: CARE, Donors, NGO partners, Government and local authorities.

This RGA should be read together with CARE's Rapid Gender Analysis of COVID-19 in Myanmar (7 June 2020).

Methodology

The Rapid Gender Analysis is built up progressively over time. The RGA uses the tools and approaches of Gender Analysis Frameworks and adapts them to the tight periods, rapidly changing contexts, and insecure environments that often characterise humanitarian interventions.

Research was initially undertaken from January 27, 2020 to February 28, 2020 and subsequently updated in June 2020 because of the COVID-19 crisis. The RGA will continue to be updated periodically as the crisis continues. When safe and feasible, primary data will be collected to increase current understanding of the needs, priorities and impacts on different groups. Research methods included a secondary data review, and KIIs with service providers: 4 women and 2 men**.**

This RGA should be read with the following considerations / limitations in mind:

- Limited primary data was collected during the research due to security concerns and lack of access, and the key informants that were interviewed were service providers and not community members.
- There is a lack of sufficiently available sex, age and diversity data in the majority of sectors.

Demographic profile

Rakhine: Quick facts

- **Average household size:** 4.5[19]
- **Median Age:** 26[20]
- **Female-headed households:** 23.7%[21]
- **Adult illiteracy rate in rural areas:** 23% for women, 8% for men[22]
- **Fertility rate (average number of children per woman):** 2.8[23]
- **Highest level of education completed:**
  Primary School: 27% women, 40% men
  High School: 4% women, 7% men
- **Adolescent fertility rate (aged 15-19):** 38.5%[24]
- **Life Expectancy:** 61 for men, 69 for women[25]
- **Infant Mortality rate:** 65/1000 live births[26]
- **Religions:** Buddhism (63%), Christianity (1%), Islam (35%)[27]

Myanmar's last census was conducted in 2014. During this process, in Rakhine State, members of some communities were not counted because they were not allowed to self-identify using a name that was not recognized by the Government.[28]

Sex and Age Disaggregated Data

According to the 2014 Myanmar Population and Housing Census, the total population for Rakhine State was estimated at 2,098,807 persons. Of the total population of Rakhine State, 989,702 male and 1,109,105 female[29]. The total population of Rakhine State represents 6.2 % of the total population of Myanmar.[30] 83% of the population in Rakhine live in rural areas.[31]

	Sex and Age Disaggregated Data[32]			
	Female breakdown by age			
Rakhine	**0-14**	**15 to 64**	**65 and above**	**Total #**
#	481,042	1,071,057	123,917	1,690,068
	Male breakdown by age			
Rakhine	**0-14**	**15 to 64**	**65 and above**	**Total #**
#	500,677	912,381	89,733	1,498,739

Of the total population in Myanmar, 37% of the population are children below the age of 18.7% of women are pregnant or lactating and 5% of the total affected registered population has a disability (physical, sensory, psychiatric, neurological, cognitive and/or intellectual), with a prevalence of 5.1% men and 5.6% women in Rakhine State.[33] However, according to Disabled Persons Organizations (DPOs) such as Humanity and Inclusion (HI), this number is questionable as the WHO reports that up to 15% of Myanmar's population has a disability with a higher prevalence in conflict areas, which perhaps means that people with disabilities are not officially registered. Approximately 23% of the population (or 12.4 million) have one or more chronic health conditions (such as cardiovascular, neurological, or respiratory diseases) which is thought to lead to more severe COVID-19 outcomes.

Women head one in four households (23.7%). This proportion increases with the age of the head, and among those aged 65 and over, women head 42% of households.[34]

Myanmar has over 100 different languages and dialects. The official language is Burmese, with the three other main languages most spoken being Karen, Kachin and Chin. In Rakhine State, there are several different religious groups, the two largest being the Buddhist Rakhine who constitute the majority within the State, and the Muslim Rohingya, which constitute 35%.[35] While Myanmar officially recognises 135 ethnic groups,[36] the Rohingya ethnic minority[37] are not recognised under law (specifically the 1982 Burma Citizenship Law[38]) as one of the national races of Myanmar, which effectively renders the Rohingya stateless.

The lack of mobility, assembly, and freedom of speech, compounded by a deeply entrenched national rhetoric of ethnic division and mistrust has rendered access to and participation in basic social institutions such as education, health, justice, finance, and self-determination extremely difficult for the Rohingya. Rohingya women are further marginalised by cultural and religious norms, as well as concerns over their security, making them often confined to the home, unable to complete a reasonable level of education, and restricting them from engaging in social and economic activities.[39] Myanmar's gender inequality index stands at 0.458, with 10% of seats in parliament held by women in 2017.[40]

Key statistics for Rakhine State

- The total fertility rate (TFR) for all women aged 15 – 49 in Rakhine State is 2.2 children per woman.
- A person in Rakhine State lives on average until the age of 66.1 years, lower than the Union life expectancy of 66.8 years.[41]
- Childhood mortality rate in Rakhine State is 65 out of 1,000 infants die before their first birthday (Infant Mortality Rate IMR) which is higher than the Union level IMR of 62.[42]
- The Under-5 Mortality Rate for Rakhine State is also higher than the Union level rate of 72; 75 out of every 1,000 children die before reaching their fifth birthday.[43]

Findings and analysis

Gender Roles and Responsibilities

Division of labour

Domestic work is primarily viewed as women's work in both Rohingya and Rakhine communities; a role that is conveyed to girls from a young age. Women and girls carry the burden of cooking, cleaning, looking after the family, elderly parents, caring for children, housework as well as searching for and storing water.[44] "*[According to] local practices, women are doing household works and taking care of children. Men earn money for family. But some women do both household works and earn money as well. Women are usually doing unpaid works and are not recognized what they have done".*[45]

Due to their disproportionate role in unpaid, domestic labour, women's engagement in paid work outside the home, is less than that of men. However, those that do participate in paid work outside

the home, have a 'double burden' of work; in that they are working for an income whilst maintaining reproductive responsibilities in household. Nationally, 41% of women are underemployed and only 53.7% of women participate in the labour force compared to 85.2% of men.[46] Conflict-related displacement only amplifies these gender disparities, particularly as specific tasks become more difficult to accomplish (collecting water or firewood, for example). There are also gendered divisions among children - girls are oriented towards the home e.g. washing, cleaning and feeding backyard animals, whilst boys perform tasks such as fetching water and are more likely to play and engage outside.[47] Previous analysis has noted that displacement, inter-communal relations and under-development in Rakhine state has impacted the constructions of masculinities in both Rohingya and Rakhine communities. Barriers to livelihood opportunities (and therefore men's ability to maintain their role as the "provider") has led to men losing self-esteem and feelings of resentment. This has had serious implications for the safety of women and has in some cases lead to an increase in cases of GBV.[48]

The COVID-19 pandemic has seen an increase in the demand for unpaid care work, with the closure of schools creating additional hours of childcare work; more family members self-isolating at home; and increased focus on hygiene, which creates additional cooking and cleaning work. Given the existing gender division and women's relegation to the home, it is likely (as is already being seen in Asia Pacific) that women have to absorb this additional domestic and care work.[49] The CARE Rapid Gender Analysis of Myanmar indicated that men have been taking on a greater share of the household responsibility since the outbreak of COVID-19, in part due to the lack of paid employment. However, this was seen as men 'helping' women rather than a shift in gender roles. We need to be aware that the loss of livelihoods due to the existing conflict as well as the additional barriers that may be caused by COVID-19 could be compounding and lead to additional risks for women and girls, as men's traditional role and their ability to live up to notions of masculinity are not being met. More in-depth and context-specific analysis of the dynamics in Rakhine households in terms of both the risks and potential shifts in gender-roles would be needed.[50]

Control of resources

Displacement and increased restriction of movement by the government since August 2017 have severely limited access to and control over land, capital and healthcare for most people in Northern Rakhine. Furthermore, the denial of citizenship to the Rohingya, as well as the loss of documentation (through displacement and conflict) has led to the loss of land ownership. For both Rakhine and Rohingya communities, men primarily have control of resources, and have better access to them than women, as they are more likely to have official documents in their possessions (if they are Rakhine) and inherit property (for both Rakhine and Rohingya).[51] In both communities, women do not traditionally inherit property but widowed women are socially allowed to have businesses or earn income and thus are more likely to own and control resources than single or married women.

However, it is expected that a widow's deceased husband's resources will be inherited by her male children or male relatives.[52] Notably, the Farmland Law, and the Vacant, Fallow and Virgin Lands Management Act, 2013 requires the land to be registered in the name of the head of household and a mechanism for joint ownership of property between husbands and wives is not available in the current legislative framework. This imposes barriers to seeking restitution of land and property, for single

women who are not considered the household head. This barrier would be amplified for Rohingya women due to high levels of displacement that have left many without husbands as a result.[53]

Inheritance customs, mobility, access to work and citizenship constraints are a few of the various factors that contribute to challenges for women to access and control resources. In the context of COVID-19, many prevention measures for COVID-19 rely on access to safe places for self-isolation or quarantine.

Participation and decision making

Within the household

Women in Rohingya and Rakhine communities are not perceived as the primary decision makers within the household, with men being regarded as the head of the household. "*Mostly men did major decision-making. Women are subordinates."*[54] There is the exception of female-headed households in Rakhine, where women, who are predominantly widows, are largely in control of decision-making in their household.[55] For single or married women (whether or not their partners live with them), it is not socially acceptable for them to make decisions regarding the finances/resources of the home. Those decisions are instead conceded to a male family member. Women are also culturally disempowered to negotiate sexual intercourse with their husbands or the number or spacing of children.[56] Women's limited agency within the family also impedes women's ability to influence decision-making processes with external stakeholders, such as community leaders, local authorities, aid workers and service providers, where only heads of households are consulted.

"Religious leaders are the most influence persons who used to make decisions directly or indirectly"[57]

Within the community

Volatile security conditions as well as pushback from male community members when women do take on leadership roles in the community, further hinders their participation. However, there have been experiences of women being recognized as leaders within Rohingya and Rakhine communities, which have slowly begun to change perceptions around gender roles.[58]

Women and gender rights organizations have been developing rapidly in Myanmar since the end of direct military rule in 2011, when the government loosened restrictions on the establishment of civic organizations. Now there are dozens of women's groups, some of them actively campaigning for legal reforms to ensure gender equality. However, they have been largely unsuccessful when lobbying the government to investigate the use of sexual violence as a weapon of war.[59]

While the government has requested the participation of women's organizations in the development of key gender responsive documents such as the National Strategic Plan for the Advancement of Women 2013-2022 (NSPAW) and the draft Prevention and Protection of Violence against Women (PoVAW) Law, and has started to act on international recommendations regarding implementing the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), it has

been slow to act on some issues, such as the prosecution of perpetrators of GBV.[60] This has been further exacerbated by delays in discussions within parliament, due to the impact of COVID-19 this year. In reality, women's organizations feel that women's equality is not the highest priority of the Myanmar government, and there is reported backlash against civil society groups like the Gender Equality Network for standing up and having a voice, particularly on violence against women and girls in conflict- affected areas of Myanmar.

The importance of local women's leadership has been highlighted throughout the COVID-19 response and must continue to be supported and strengthened, including through relevant women's organizations or networks. According to new analysis by Charter for Change, the level of funding to national and local NGOs stands at just 0.1%% of total funding reported for COVID-19 response to date, and it is likely that women-focused organizations comprise an even smaller percentage of this.[61] This is particularly problematic in Rakhine State, where women's political representation and civic participation remains weak across all communities, but particularly within the Rohingya community. No female parliamentarians were elected to the Rakhine State Parliament in 2015, and only three were elected from Rakhine State constituencies to the Union Parliament in Naypyitaw.)

There are only six female ward/village tract administrators (W/VTAs) or township/district administrators in the state[62], though women do sometimes hold more junior civil service positions.[63] While some women's civil society groups have demonstrated some degree of influence, for example by intervening on behalf of survivors of GBV in high-profile cases, their impact on policymaking is otherwise limited.[64]

Access to services

Education and literacy

There are low levels of education in Rakhine State, with approximately 74.7% of adults having received only primary school or no education.[65] According to the 2014 Rakhine Census, 84.7% of the people (92.2% men and 78.7% women) in Rakhine state are literate, with this being higher in urban areas (94.3% male and 87.3% female) than in rural areas (91.8% male and 76.9% female).[66]

Out of 1,391,311 people aged fifteen years and over, 85% (1,178,295 people) reported that they were able to read and write. Due to social and cultural gender norms in Rakhine, it is common practice for boys and girls to be prevented from integrating with one another as they reach puberty. Therefore, this can lead to parents stopping sending their daughters to school in mixed-gender environments.[67] This along with security concerns, including risks of harassment and GBV are barriers for girls to continue their education.[68] It was reported that of the total 141,948 Rohingya students in Rakhine, only 52,697 are female, with major disparities being reported at lower and upper secondary levels (lower secondary: 13,937 boys versus 4,974 girls, upper secondary: 3,972 boys versus 1,214 girls).[69]

As boys reach adolescence, they are often expected to stay in school (in IDP camps, they stay if there is a humanitarian actor supporting education) or accompany their father to find work (in Myanmar or in neighbouring countries), to financially support the family. Girls progressively drop out of school once they reach grade 5 to assist their mothers/female guardians with domestic work. Marrying off Rohingya girls at an early age is further used as a negative coping mechanism to protect girls from

potential harassment and abuse given the aggravated security situation in Rakhine state, and as a strategy to achieve a sense of socio-economic security.[70]

There are long term impacts of not ensuring girls receive an education. With fewer Rohingya girls in school this leads to fewer educated women, which leads to fewer female teachers; further exacerbating the opportunities for education for girls because of parents' unwillingness to send their girls to classes taught by men.[71]

In the context of COVID-19 and the increase in unpaid domestic and care work being largely undertaken by women, it is likely that there will be an increased need for girls to support their mothers in such work, therefore making it more challenging to stay in school or continue once the crisis is over. COVID-19 has negative economic impacts for families (as described in the section below). In times of hardship, it has been reported that boys were removed from school so they could undertake income generating activities to support the household.[72]

WASH

Only 40% of the population in Rakhine has access to improved water in both the dry and rainy seasons; this is nearly half the national average.[73] In Rakhine, few people live in households that draw upon rainwater, with many drawing their drinking water from a river, pond, pool or stagnant water source during both the rainy and dry season. This may reflect a lack of rainwater storage facilities as well as preferences over water from different sources.[74] Only two in ten people in Rakhine (18%) have on-site water, under half the rate of the next lowest access rate seen in Ayeyarwady where 43% of households have year-round on-site water access.[75] As women are the ones who are mainly responsible for water collection in 80% of households in Rakhine[76], the impact of not having on-site water, and the need to travel to collect water for the household, predominately falls to women.

People in Rakhine and Magway have to make longer round-trips to collect water and appear to do so throughout the year; in Rakhine nearly a quarter of households face an 11 to 30 minute round-trip for water collection.[77]

Only 31.8% of all households in Rakhine have toilets that are classified as improved sanitation facilities, at the Union level the figure is 74.3%.[78] The share of households with no toilet facilities and thus who use open defecation practices declined from 14 % in 2014 (Census) to 6% in Myanmar in 2017. In Rakhine state, this indicator decreased from 63%in 2014 to 46 % in 2017. 46% is almost four times higher than the second worst performing state in Myanmar, which is Kayin state.[79]

Hand washing is central to the prevention of COVID-19. Therefore, the lack of households with on-site water facilities requires families to collect water, which is typically the role of women and girls. As a consequence, the emphasis on hand washing as an effective measure to prevent the spread of COVID-19, can inadvertently increase women's already high burden of domestic work. This can also expose women and girls to heightened GBV risks on their journeys when collecting water. Fetching the additional water required to perform more frequent handwashing may also be a particular challenge for people with disabilities.[80]

Concerns were raised about the lack of basic infrastructure in IDP camps, such as the water drainage infrastructure needed for washing hands. Overcrowded shelters and poor sanitation conditions pose a

risk of disease spreading quickly in the camps, with one study finding the incidence of tuberculosis was nine times higher in camps than in nearby villages.[81] Consequently, the existing lack of space in IDP camps further renders IDPs highly vulnerable to contracting COVID-19.[82]

Many IDPs in Rakhine rely heavily on government and donor support for sustenance due to extreme movement restrictions. The Ministry of Social Welfare, Relief, and Resettlement mobilized response teams for IDP camps to construct wash basins, conduct education sessions, and distribute essential supplies. However, it has been noted that with resources stretched even in Yangon's main hospitals, it will be an extreme uphill battle to mitigate the risks of COVID-19 and to treat COVID-19 cases in camp settings; such as those in Rakhine State.[83]

Health, including sexual and reproductive health

Availability of and accessibility to essential health and protection services is very limited in parts of Rakhine State with only 53.3% of ill or injured individuals seeking treatment at medical facilities, including at those run by NGOs (sex, age and diversity disaggregated data not available).[84] This is due to several factors, including a shortage of skilled health professionals and social workers; geographical and administrative restrictions on mobility; financial and cultural barriers; and poor community awareness of services; lack of adequate time for women to access services due to other productive or reproductive work; and women's lack of decision-making autonomy to be able to seek health care in a timely manner.[85]

The uptake of maternal health services in Rakhine State is the lowest in the nation with only 19% of women give birth in professional health facilities, compared to 37% nationally.[24] Rohingya women and men in Rakhine generally have limited options or knowledge regarding family planning or contraception, with only 20-25% of new generation parents using contraceptives.[25] The maternal mortality rate in Rakhine (314.3/100,000) is among the highest in the country. According to analysis by UNFPA, 12 out of 17 of Rakhine's townships fall in the top quintile of townships for maternal mortality rates.[86] A significant cause of maternal mortality among women is recognised as resulting from unsafe abortions, reported as 15% for all of Rakhine state compared to the national average of 10%.[87]

There is a strong correlation between conflict, displacement, forced migration and higher rates of mental health disorders. The collective impact of traumatic events on groups of people has been found to change the ways in which families and communities function, create higher levels of mistrust between individuals, and erode societal norms, ethics and social capital.[88] According to studies on the mental health of Rohingya refugees in Bangladesh, feelings of tension and nervousness were widely reported by adults (over 74%) and children (over 58%), while 62% of women reported suicidal ideation.[89] Another assessment in IDP camps in Rakhine found that due to lack of activities and restricted movement in the camps (particularly the Muslim camp), both men and women reported feeling very depressed about their current situation, feeling hopeless and fear for the future.[90] Women are at increased vulnerability in such circumstances with one-in-three survivors of gender-based violence developing a depressive or anxiety disorder. While no national statistical analysis of mental health needs for Myanmar exists, data from comparable contexts show that women are twice as likely to experience depression or anxiety as men are.[91] It has been noted in other context within Asia Pacific that the significant increase in unpaid care and domestic work for women could be a major

contributing factor to the pandemic disproportionately affecting women's mental and emotional health.[92]

The impact of the COVID-19 pandemic on top of the already existing humanitarian crisis in Rakhine state, as well as the existing prevalence of malnutrition, poverty, pre-existing health conditions and lower access to healthcare facilities compared to other parts of Myanmar, places communities residing in Rakhine at higher risk of COVID-19.[93]

Vertical health programs have already curtailed their activities and diverted overstretched resources toward COVID-19 prevention and response.[94] The closure of the Ah Pauk Wa station hospital, in Kyauktaw Township, central Rakhine State will have implications for rural Kyauktaw communities' access to healthcare. While travel for all civilians has become increasingly difficult since civil war escalated towards the end of 2018 in Rakhine State, the Rohingya will be particularly affected by the closure of a rare rural health facility, such as Ah Pauk Wa station hospital is.[95] Closures of health facilities disproportionately affect women and girls, who are more likely to have additional restrictions on their movements imposed by their families.[96] Women and girls may also suffer from SRH-related complications if they do not have access to health facilities in a timely manner. This lack of access is particularly concerning given the increasing spread of COVID-19. Those who may be or may become wounded or sick, as well as persons with disabilities, and IDPs, may face additional barriers in accessing adequate medical care and attention.[97] Lockdowns and border closures designed to prevent the outbreak's spread also contribute to this disruption to health services, and have affected medical supply chains in some parts of the country, including Rakhine State.[98] The lack of personal protective equipment for hospitals and medical centres has also been raised as a concern in Rakhine.[99] The Myanmar health workforce is highly feminized (75%) with almost all nursing professionals and over half of medical practitioners being female. With the majority of the frontline staff in the health sector being women, places them at particular risk of becoming infected by COVID-19.[100] For people residing in IDP camps, conditions of overcrowding is a concern regarding the transmission of the virus and it has been noted that in camps for the Rohingya in Rakhine, health outcomes are notably worse than those outside of camps.[101]

Further, the death of Pyae Sone Win Maung, a World Health Organization driver of a marked UN vehicle in a security incident on 20 April 2020 illustrates the continued current insecurity and need for deeper engagement, as well as the increased risk for health workers during the time of COVID-19.[102]

Capacities and coping mechanisms

Livelihoods

The ongoing humanitarian crisis in Rakhine has led to a considerable deterioration of the already poor socio-economic situation, characterized by poor agriculture productivity. According to the 2014 Myanmar Population and Housing Census, 58.8% of all people who are of working age (15-64) were in the labour force.[103] The proportion of males in the formal labour force is significantly higher (83.2%) than the proportion of females (38.1%).[104] The majority of the Rakhine economy comprises farmers, fishermen, and family-run businesses, while wages in the agricultural sector are low, yet 58% of agriculture employment is conducted by women, compared to 44% by men across Myanmar.[105]

Landlessness is more common in Rakhine than other parts of the country, especially in the northern part of the state, where 60 % of households are landless.[106] Further, damage to crops, livestock and arable land, the inability to plant due to lack of land, the reported increased presence of landmines and unexploded ordnance in areas of fighting, pose threats to the security of the civilian population, as well as to their immediate food needs and longer-term food security. [107]

The threat of continued instability and violence, combined with a general lack of employment opportunities, has encouraged significant out-migration, resulting in labour shortage in various sectors. Some communities complain about "brain drain", as the better educated and resourceful part of the work force have been the first to seek opportunities elsewhere. Within the Rakhine community, many unskilled labourers have also left, for instance for the jade mines in Kachin (mostly males) or the garment industry in Yangon (mostly females). Moreover, poverty and discrimination have encouraged tens of thousands of Muslims to immigrate to other countries in the region, such as Malaysia and Indonesia.[108] In comparison to other ethnicities in Myanmar, Rohingya experience increased consequences due to being stateless (having no right to citizenship) and having been cut off from major areas where there is farmable land. This has led to 41% of people in Rakhine (and 78% of the Rohingya) living under the poverty line, as compared to 24.8% in the rest of the nation.[109] Prior to the conflict, their main source of livelihoods was rice, cultivation and dried fish and prawn. Lack of farmable land and the ability to travel, to fish and access markets, has caused a breakdown of value chains, losses in food production and destruction of assets.[110]

Women in Rakhine State face additional challenges, and continue to suffer from unequal pay, particularly in the agricultural sector. Within the Rakhine community, more women than men migrate to find employment outside the state. Migration of men tends to increase the workload of women left behind.[111] Barriers exist for women seeking loans and credit, especially for those who are unmarried or widowed, and the lack of women's rights to inheritance in some communities poses serious problems for women's livelihood opportunities. Muslim women have even fewer choices; their education levels are lower, and severe restrictions on their movement make it difficult to engage in livelihood activities other than in their immediate neighbourhood.[112] Rohingya women find work in IDP camps, which range from unpaid tasks, such as construction activities within the home, cooking, camp cleaning, and food distribution. Since August 2017, there have been a few opportunities for women to work as casual farm labourers; however, these jobs are usually poorly paid with wages half of that paid to workers from the host communities or the capital accumulated through village and saving loan associations set up by NGOs.[113] Women and girls with disabilities, those who are pregnant or breastfeeding, adolescent girls and female-headed households are at higher risk of unemployment, poverty and face barriers to access to essential services and livelihoods.[114]

It is clear that COVID-19 will have a devastating economic impact for Rakhine State. A lockdown will seriously affect urban families who rely on daily labour, and will restrain rural communities who are now preparing to plant the monsoon paddy.[115] Other industries will also be affected. This year is expected to be the worst on record for Myanmar's fisheries industry due to a drop in global demand.[116] Demand for diverse goods such as gold have dropped, affecting small business owners including jewellery producers and distributors. Some metalworkers report a loss of almost all income due to reduced demand, driven by both armed conflict and COVID-induced economic slowdown.[117]

Because of COVID-19, families in Rakhine State who previously relied on remittances from migrants working overseas or elsewhere in Myanmar have reported financial difficulties as economies slow globally. Rohingya communities in particular have few safety nets, although families from all communities are affected by the economic slowdown.[118]

Lack of livelihoods for men and women can have knock-on effects that increase risks for women and girls in a crisis. Consultations with women (pre-COVID-19) noted that when there are barriers to men performing traditional notions of masculinities, this has had serious implications for the safety of women. Impacts on men's loss of self-esteem, and a resentment of not being able to fulfil their "role" have, in cases, led to an increase in cases of GBV.[119]

Savings

A contemporary labour survey by the World Bank estimated that 62 % of the population also reported not having any savings, highlighting a lack of safety nets, should men and women's livelihoods become at-risk due to the COVID-19 pandemic.[120] Women have benefited from savings groups where they can access training from humanitarian organizations. As a result, there have been incremental improvements in their access to microfinance and microcredit since August 2017, however, the money saved from these groups may be spent by the economic decision maker in the household, who is most likely not the woman.[121] Additionally, migration and limited access to humanitarian services limit how much a woman can save. The pandemic has the potential to seriously affect these savings groups, more than 80% of whom are female. As COVID-19 affects members' businesses, they may no longer be able to invest in their groups or repay loans, leaving some savings groups decapitalised. With COVID-19 prevention mechanisms imposing physical distancing and limiting movement outside the home, this is also likely to limit women's ability to physically engage in savings groups in the same way.

Impact of secondary disasters

Rakhine State, with its long coastline, is vulnerable to natural hazards and climate change. In addition to limited investment in disaster risk reduction, much of the state's farmland is poorly adapted to these new challenges, including increased salinity from flooded tidal waterways.[122] Cyclone season typically begins in May. This, coupled with the monsoon's arrival in June, is likely to bring major public health challenges such as dengue, influenza, and malaria, factors that will further strain the health and disaster response systems. In July 2019, some 150,000 people in Rakhine State were affected by flooding and some 70,000 acres of paddy fields were destroyed.

Following recent incessant rainfall and high tides in mid-June 2020, 14 sites hosting persons displaced by armed conflict in Rakhine State were flooded, submerging approximately 400 shelters.[123] With affected persons being evacuated to the village monastery; without immediate safe shelter to return to, this raises challenges concerning measures for the prevention of COVID-19 transmission e.g. physical distancing and safe shelter. The internet shutdown, as well as lack of access to information (through radio, TV and newspapers) for persons in rural areas created challenges in being able to prevent and respond appropriately to flooding and other disasters, especially in preparing for COVID-19.

Access and mobility

Heavy restrictions on movement and activities by the Government of Myanmar on humanitarian organisations have limited and forced conflict-affected communities to survive without adequate access to food, healthcare, shelter, and other aid and assistance.[124] Programming resources in Rakhine State are dwindling due to the frustrations of agencies working in areas where access has either been revoked or severely restricted. Formal and informal checkpoints and unofficial fees also increase the cost of resourcing programmes in the area as additional financial resources to facilitate security is required.[125] While different agencies are offering different services, the quality of services is often not comprehensive due to the inability to bring people or resources into Rakhine State. While there is a coordinating body for government and aid agencies (The Government of Myanmar-Development Partners Group), it has largely been unable to address issues of access in Rakhine State. This has implications on the quality of services that women and girls can access, particularly timely GBV services.[126]

Traditionally women are not allowed to interact with strangers or with men outside the home. For the most part, women are restricted to the home and are increasingly staying home for their own protection and safety.[127] While there are variations based on levels of education, wealth, and the urban/rural context, gender segregation and social barriers amongst Muslim communities can negatively impact on the freedom of movement of Rohingya women.[128] Rohingya women face significant restrictions to their movement based on cultural and religious practices such as *purdah*, which change according to age and other factors such as marital status. Rakhine women and girls also face restrictions to their movement based on cultural and religious beliefs such as *ein-da-ray*, which determine appropriate behaviour. The word *ein-da-ray* has both physical and spiritual meanings in the Myanmar context, according to which women are expected to have a certain appearance and behave in a "decent, silent and obedient" manner. *Ein-da-ray* leads to submissiveness and being controlled, which as a result limits women from participation in many spheres of the social, political and religious affairs.[129]

Rohingya women have suffered disproportionately under the arbitrary restrictions on humanitarian aid as men largely have more access to services. Due to cultural and religious traditions, Rohingya women are generally not allowed to access services or resources without the knowledge and/or permission of a spouse or male relative/guardian. While Rakhine women are able to access more services due to fewer restrictions on movement, they still experience barriers such as availability of public services.[130] Rakhine women and girls are affected by informal movement restrictions stemming from perceived and actual threats to personal safety, including GBV, and notions of vulnerability. This affects women and girls in both Rakhine and Rohingya communities, while Rohingya women and girls remain most severely impacted.[131]

Rohingya women are less likely to leave the camp than men due to safety and security concerns. Further, as they are the primary caregivers of the home and are unable to secure travel authorization due to their statelessness, and lack of documentation to confirm citizenship. While undocumented persons can obtain travel authorizations from the local administration, there are unofficial fees that they have to pay which, because of the limited livelihoods opportunities, most are unable to afford them. This is likely to be compounded due to the economic downturn being experienced because of COVID-19. Rakhine women are also restricted in their movements due to conflict dynamics and security issues.[132]

Limitations in access to services and participation in community events are seen as even bigger challenges for people with disabilities. There are unadapted shelters and WASH facilities (uneven footing and narrow stairs) which are worsened during the rainy season and in remote areas, which is a safety concern for these groups.[133] This leads to women's, girls' and persons with disabilities' reliance on family members, which in turn reduces their participation in social activities and limits their access to employment and services.

The increased presence of armed actors also limits mobility and access to services. The United Nations has received multiple reports of military use of schools and hospitals in Rakhine, further fuelling concerns over the safety and security of civilians, especially women and children.[134]

During COVID-19, the restrictions on movement for humanitarian agencies, as well as social and cultural restrictions placed particularly on women and girls in communities within Rakhine State will be exacerbated by additional movement restrictions in place to curtail the virus and prevent transmission in communities. It is important that movement restrictions related to COVID-19 do not adversely affect humanitarian responses and humanitarian needs being met.[135]

Information and technology

Traditionally, the Rohingya community's mode of communication is oral and thus they have no formal written language. They also tend to be monolingual (apart from a few highly educated Rohingya who know Rakhine) which consequently limits their access to quality humanitarian services.[136] Rohingya women as a whole, due to their limited access to education, are most likely to be monolingual and due to humanitarian responders not being able to speak the Rohingya language, monolingual Rohingya depend crucially on bilingual intermediaries. Without them, they cannot make their needs and concerns known, access information, or engage with decision-makers.[137] Moreover, women with disabilities from both communities face further attitudinal and communication barriers as information is unavailable or inaccessible (no Braille, no pictograms etc.) and service providers do not always know how to communicate with people with disabilities. The needs of people with disabilities are not accommodated in information and communication campaigns, counselling, and psychosocial support interventions, participatory interventions such as focus group discussions. According to HI, 76% of community members and 80% of people with disabilities surveyed believe that "[i]t is better for a family of a woman or girl with disabilities to keep her at home. She could be exposed to violence outside and she is safer inside the house".[138]

There is widespread geographic ownership of phones across Myanmar's rural areas. Phone ownership is lower among female-headed households and among those with less educated household heads. More limited smartphone penetration in rural areas than in urban areas is highly linked to socio-economic indicators. Since the telecommunications rollout has included both data and voice calls, the different rates of smartphone ownership is likely linked to cost rather than the form of network in rural areas. The households who remain disconnected from the phone network have less educated household heads and are potentially worse off than those who are connected.[139] However, 21st June marks the one-year anniversary of the mobile telecommunication network shutdown imposed by the Government of Myanmar in Rakhine and southern Chin states. Amid the COVID-19 pandemic, civilians from internet shutdown areas are the most vulnerable and have little access to timely and reliable information to prevent transmission or access humanitarian assistance.[140] The internet

shutdown has had additional impacts for people needing to receive remittances as well as for continuity of education and may affect participation in the upcoming elections.

Women's economic status and livelihood activities relative to men could further impede their access to information delivered via radio. Men within the household dominate often purchase and use of radio and batteries. Moreover, women working outside of the home during the day (cultivating fields, for example) would miss the opportunity to listen to sensitization messages or programmes that took place during the daytime on the radio. Given movement restrictions and the suspension of many face-to-face awareness activities, there is a greater reliance on critical hygiene information being shared online and/or by telephone. This is likely to be less accessible to women, older age groups with weaker digital skills, those with low literacy levels, and especially difficult in the current context with the mobile network shutdown.[141]

According to the findings of the Sittwe CwC Community Perception Survey, all persons interviewed for the survey reported to have basic knowledge about COVID-19 however, other analysis showed that communities in Rakhine State continue to report little awareness of the virus and a preoccupation with the immediate concerns of armed conflict and food insecurity. Civil society leaders in Sittwe and other urban areas perceive a limited and insufficient response from Naypyidaw amid intensifying conflict and an ongoing internet blackout. Perceptions of a Yangon and Mandalay-focused response will only drive further discontent with the Naypyidaw government among communities in Rakhine State, with implications for armed conflict and electoral positioning.[142]

Safety and Protection

Gender Based Violence

Gender based violence is often underreported in Myanmar where overall data for violence against women and girls (VAWG) is severely lacking. Currently, national data highlights as many as "17% [of] women will experience violence in their lifetime."[143]

Women and girls bear the brunt of the crisis in Rakhine due to restrictive socio-cultural norms and high levels of sexual and gender-based violence that have been further exacerbated by the conflict and crisis context of protracted displacement combined with a policy of segregation, overcrowding and lack of privacy in IDP camps, and overall lack of safety and sense of fear of violence. Marginalization is further compounded for women and girls with disabilities, pregnant and lactating women, adolescent girls, female-headed households and older women who are at higher risk of unemployment, poverty, exclusion from humanitarian aid, facing barriers to access to sanitation facilities, healthcare, and clean water, and to community participation, and obtaining assistive devices, and face higher risk of GBV.[144] Boys, who spend more time outside of the home are also, as a result exposed to protection risks such as engagement in unsafe casual labour as a coping strategy for the economic security of the family.[145]

Additionally, host communities and areas not affected by the conflict also report domestic violence as the most common form of GBV experienced by women and girls. However, these cases are still seen as private matters to be settled within the family and thus women and girls are socially discouraged from discussing it outside the home.[146] This social norm creates a barrier for survivors in accessing

safe spaces and increases their risk during times of crisis, as they are even more isolated and thus less likely to reach out.

A report on Violence against Women and their Resilience in Myanmar outlines the range of coping strategies employed by women and girls, such as women talking to their friends and family about abuse and reporting the abuse to authorities/legal counsellors.[147] However, under COVID-19 with physical distancing and lockdown measures implemented, it would be challenging for these coping strategies to be used by women who are experiencing violence.

Access to services remains a challenge due to gaps in capacity of service providers and duty-bearers in many areas of the country. Where services are available, they may not be safe for women and girls to access, or they may have gaps in the services they offer (e.g. availability of the minimum initial service package of GBV).[148] For Rohingya women and girls, this situation is further complicated due to lack of access to government services due to discrimination and/or fear, and lack of confidence of the survivor in the treatment they will receive. This often creates a situation where informal response mechanisms at the community level are relied upon, to some extent, for resolution (in many cases with cultural norms contributing to 'resolution' of issues in a negative way for the survivor).[149]

By virtue of an existing lack of access to formal justice, most of the affected populations rely on village/camp leaders and committees to mediate and solve disputes. The majority of such committees are male dominated.[150]

Within Rohingya camps, the most prevalent form of GBV reported has been intimate partner violence, which has been largely attributed to socio-religious practices of women 'needing to be disciplined'. Cramped accommodation and a shortage of resources have also exacerbated the risk of GBV. Since the escalation of the crisis in 2017, there has been renewed pressure to enact a Prevention and Protection of Violence against Women (PoVAW) Law but that does not include prosecution of VAWG as acts of war.[151] However, in January 2020, Myanmar's Independent Commission of Enquiry (ICoE) concluded, based on the information available to it and of the investigations carried out in northern Rakhine State that war crimes, serious human rights violations, and violations of domestic law took place during the security operations between 25 August and 5 September 2017.[152] The Myanmar Government announced its position to conduct investigations and prosecution on any criminal acts, based on the recommendations of the ICoE.[153]

Life in overcrowded IDP camps is extremely difficult and safety is a major concern, especially at night and during the monsoon and cyclone seasons. Generally, IDPs feel unsafe due to hostility from the surrounding Rakhine villages. These hostilities between Rakhine host communities and Rohingya IDPs are particularly exacerbated in areas with no WASH facilities or ability to travel to collect firewood.[154] The restrictions on access to livelihood opportunities for Rohingya men in IDP camps also creates risks of family friction, tension, domestic violence, and depression among men due to their inability to fulfil their gender role as the breadwinner of the family.[155]

Since the outbreak of COVID-19, domestic violence increased across Myanmar, as elsewhere in the world. During the lockdown in April and May 2020, the Akhaya Women organisation reported a 7.5 fold spike in case reports (mostly of domestic violence) across Myanmar. However, ensuring that support services reach women experiencing domestic violence is especially challenging in informal

settlements, where migrant women often live in insolation and without networks connecting them to the community.[156] Particularly with the internet shutdown in Rakhine this would restrict awareness raising efforts, as well as create barriers for women to seek information and seek support.

Sexual Exploitation and Abuse

The Rohingya crisis has fuelled the exploitation of different genders in different ways, with reports of all forms of GBV across genders. As the crisis continues, men and boys are predominantly trafficked for forced labour in neighbouring countries and recruitment into different ethnic armed groups. Women and girls are predominantly trafficked for the purpose of sexual exploitation, forced marriage, organ donation and forced surrogacy.[157] From analysis in the region and globally, emerging evidence suggests that the COVID-19 pandemic has the potential to increase risks of sexual exploitation and violence.[158]

Child marriages

The forced displacement of hundreds of thousands of people, much of which was accompanied by sexual and gender-based violence, is having compounding negative consequences on the rights of girls; with a greater number of early marriages being seen. Nationally, 30% of all child marriage cases are of unaccompanied or separated children. There was a decline in child marriage between 2017 and 2018 but as fresh conflicts arose across the country, an increase of 3.1 % in child marriages was reported between 2018 and 2019.[159] Early marriages limit the development of girls and often result in early pregnancy and social isolation. In some cases, families see child marriages as a form of protection and security from rape, although such forms of protection make girls vulnerable to rape and other forms of sexual violence in the home.

The median age for women's marriage in Rakhine state in 2016 was 20.7 years.[19] There is evidence that child and forced marriage is commonplace among the Rohingya population, and that both child marriage and polygamy have been increasing in recent years due to the scarcity of men and economic difficulties that force girls into adult roles sooner.[160]

In Rakhine State, parents that are unable to afford the cost of sending girls to school, or who are unwilling to do so due to traditional gender norms and fears for their safety, are more likely to keep their daughters at home, engage them in household work or other types of domestic labour, or marry them off as a negative coping mechanism.[161] The economic instability caused by COVID-19 could further create an increased risk for girls concerning early and child marriage.[162] Early and forced marriage increases the risk of domestic and sexual violence, disruptions to girls' education, and economic prospects.[163]

For survivors looking to report sexual violence, official government sections and social norms hamper their safety. For example, due to the current status and displacement situation of the Rohingya, access to security services is extremely limited and for GBV cases, mediation is used if it takes place within the community. If persons from outside the community were involved, the village leader/committee

decides on behalf of the survivor on actions to be taken, e.g. report the incident to police/military, providing patrol in the camps, or refer the case to humanitarian agencies. This has implications on the survivors' ability to take the decision according to their best interest, as well as to access timely services. It further poses risks to the survivor's safety and confidentiality, as information is shared across actors, many of whom do not follow the ethical recommendations on GBV interventions. Concerns remain for cases where mediation is used which can cause further violence to the survivor (e.g. retaliation for reporting) and the community members who seek to support the survivor, particularly given the lack of shelters or safe homes for relocating survivors who face security and safety risks.[164]

Conclusion

Although gender gaps in reproductive health, empowerment and the labour market have narrowed in Myanmar as a whole over the past year, inequalities persist and challenges remain for IDPs, most significantly in Rakhine State in several critical areas. Significant gender gaps still exist which negatively affect women in the economy, livelihoods, education and political participation including decision-making bodies at state, township and village level, as well as in safety and security. As a result, women and girls face a higher risk of being affected by the crisis compared with men. For Rakhine, the risks and effects are particularly severe due to the government sanctions highlighted in the report such as restrictions on freedom of movement and citizenship; limiting their access to livelihoods opportunities, access to land and capital, as well as health and education services

Moreover, men remain under-represented in fields such as domestic and unpaid work, leaving women to carry the triple burden. Meanwhile gender-based violence and gender stereotypes remain widespread within both Rohingya and Rakhine communities, and women are underrepresented in decision-making bodies and lack ability to influence and impact decisions and programming that ultimately affect their lives and needs.

Different agencies, the government and CSOs in Myanmar implement a number of interventions to address gender specific needs, but overall gaps remain in relation to gender disaggregated data collection and programme analyses to bring transformative change to the lives of IDPs and people from conflict-affected villages throughout the country since the beginning of the conflict. COVID-19 is unfolding, amid persistent gender inequalities, complex conflict, and humanitarian dynamics, which shape and intensify the impacts of the pandemic on different groups, in particular population groups who have already been marginalized and vulnerable before the outbreak of COVID-19. Women and girls, as well as other marginalized and vulnerable groups have been, and will continue to be disproportionately affected, and face greater risks to their livelihoods, health and safety.

Recommendations

Overarching recommendation

This Rapid Gender Analysis should be updated and revised as the crisis unfolds and relief efforts continue. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure humanitarian assistance is tailored to the specific and different needs of women, men, girls and boys. It is recommended that CARE Myanmar continue to invest in gender analysis using primary data that new reports are shared widely and that programming will be adapted to meet changing needs.

Targeted recommendations

- **Ensure continued participatory assessments to address gendered data gaps.** This may be in the form of stories (case studies), interviews or safety audits. Ensure that sex, age, disability and diversity-related data is collected to understand the changing needs, priorities and expectations of women, girls, men, boys, people with disabilities and at-risk groups. Engagement with local women's rights organisations, disabled persons organisations and other groups working with at-risk groups should be part of the process.

- **Donors should actively support long-term engagement with existing partners and ensure that funding and support allows for adaptive programming.** Donors should be flexible with partners as they implement programmes. The complex dynamics of the conflict, particularly now in the context of COVID-19, pose challenges for partners supporting communities**.** Additionally, access issues prevail in Rakhine with changing requirements that are largely political and are out of the control of implementing partners. Prioritise an intersectional approach to gender, and mainstream across all phases of the project cycle.

- **CARE, and other humanitarian agencies (UN, INGOs, Local Partners) to support women's participation and representation in decision-making and leadership**, including in the upcoming elections. Work with civil society organisations, women-led and women's rights organisations in the State to identify barriers to meaningful engagement of women in the existing humanitarian and COVID-19 response (e.g. in the assessment, design, implementation, and monitoring and evaluation of programmes within all sectors, including WASH, Shelter and Livelihoods), the return and resettlement process and in their communities, and support women-led solutions to overcoming them. Additional attention should be placed on ensuring women and girls are meaningfully engaged and participate in decision-making processes, and take on leadership roles in their communities to shape and implement interventions. Adapted efforts should also be made for people with disabilities, elderly, LGBTIQ individuals and people with chronic diseases.

- **Communication, education and information materials should be accessible to all**. This includes the need to hire local female and male translators and interpreters for beneficiaries to ensure information is safely accessible to women and girls. The use of multiple modes of

communication such as radio, phones, communication through women's support or savings groups and women, religious and community leaders should be utilised to address gender gaps in access to information, literacy rates, barriers for rural vs urban communities and issues related to the internet shutdown in parts of the State. Services referral pathways including GBV and sexual and reproductive health rights should be clearly communicated by government agencies, as well as humanitarian and development actors.

- **All actors to ensure that survivors of sexual and gender-based violence have access to safe, free, confidential multi-sectoral prevention and response services** including both immediate services as well long-term social care and support. It should be ensured that funding and resources for GBV prevention and response services are not diverted because of other health needs due to COVID-19, and additional resources are planned for, considering the increased risks of GBV due to COVID-19.

- **Provide continued and comprehensive healthcare, including sexual and reproductive health (in line with the Minimum Initial Service Package) and psychosocial support services, with specific targets to ethnic minority women and girls**, including obstetric, prenatal and postnatal care, contraceptive information and services.

- **All actors to focus on a coordinated response at all levels.** In some areas, a variety of support services are available, but are not well coordinated amongst service providers. Therefore, a mapping and coordination of government agencies (including the police and health professionals), CSOs and faith-based institutions at the township or ward levels is required to build up trust, share information, coordinate resources and strategies.

- **Ensure that safety and security in all areas, including IDP camps and villages in the State, are considered more holistically**: ensuring codes of conduct are available, staff/volunteers trained and Feedback and Accountability Mechanisms (FAM) are in place and communities are consulted and sensitised on final reporting mechanisms. Ensure adequate GBV risk mitigation measures are provided in terms of safe shelter and WASH services and facilities, including access for people with disabilities.

- **Develop and prioritize mitigation strategies that specifically target livelihoods of the most vulnerable women and men**, including informal sector workers, and build economic resilience to future shocks. Consider the increased care burden when designing strategies or programmes, as well as the target group and such roles will impact women, men and at-risk groups' access to, and the effectiveness of such initiatives.

- **CARE Myanmar to increase coordination with CARE Bangladesh** as they receive and support refugees in Cox's Bazar. This will aid in tracking trends of the crisis i.e. a decrease in the number of IDPs reported in Rakhine vis-à-vis an increase in the number of refugees received in Cox's Bazar. Quarterly or biannual informal information-sharing sessions within CARE agencies would help to strengthen advocacy efforts of CARE Myanmar.

- **Cash or voucher assistance (CVA) support be made available** to affected populations in both the urban and rural areas of Rakhine State to alleviate suffering and allow communities to address their current needs due to the conflict, the COVID-19 pandemic as well as additional impacts due to flooding. When implementing CVA, actors should take into account the challenges accessing vulnerable populations in rural areas compared to urban,[165] as well as ensuring appropriate assessments are conducted to ensure a GBV risk mitigation approach is adopted to all CVA programme design, implementation and monitoring.

- **Work with development and humanitarian agencies to lay the foundation for justice and accountability from state actors**, including, but not limited to, reparations, through their work – building the confidence of GBV survivors in the justice system and creating a safe platform for survivors and civil society to advocate for their justice demands

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