

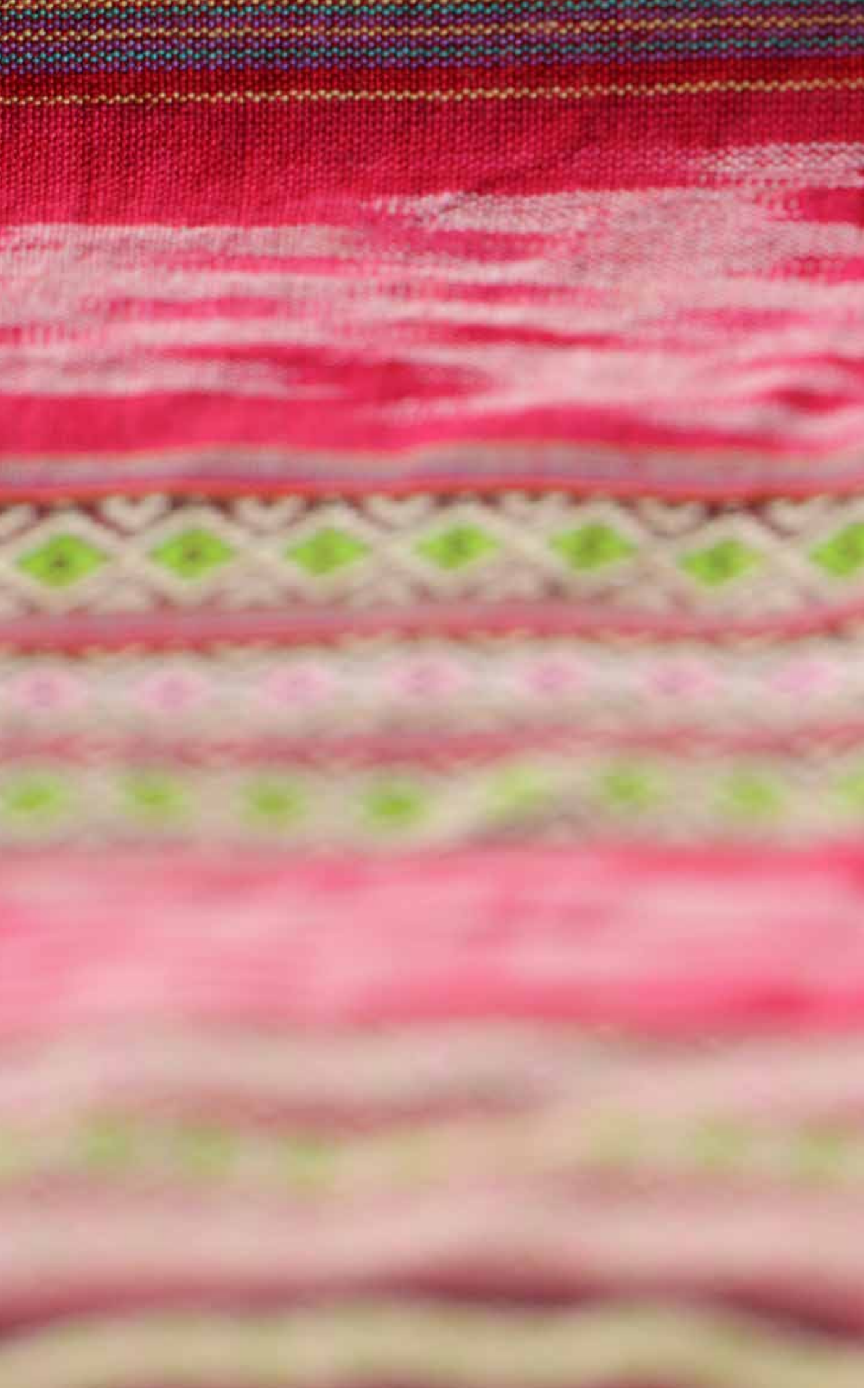
Powerful Myths Hidden Secrets



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United Nations Population Fund



Powerful Myths, Hidden Secrets

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List of Acronyms

ATS	Amphetamine-Type Stimulant
CEDAW	The Convention on the Elimination of All Forms of Discrimination Against Women
CHDN	Civic Health and Development Network
CSO	Civil Society Organization
DFID	Department for International Development (United Kingdom)
DSW	Department of Social Welfare
EAO	Ethnic Armed Organization
FGDs	Focus Group Discussions
GBV	Gender-Based Violence
IDPs	Internally Displaced Persons
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPV	Intimate Partner Violence
IRC	International Rescue Committee
KDHW	Karen Department of Health and Welfare
KII	Key Informant Interview
KNG	Kayan National Guard
KNLA	Karen National Liberation Army
KNLP	Kayan New Land Party
KNPLF	Karenni Nationalities People's Liberation Front
KNPP	Karenni National Progressive Party
KNU	Karen National Union
KNWO	Karenni National Women's Organization
KWEG	Karen Women's Empowerment Group
KWO	Karen Women Organisation
KYWO	Kayan Women's Organization
MANA	Myanmar Anti-Narcotic Association
MJC	Mawlamyine Justice Centre
MNLA	Mon National Liberation Army
MPF	Mon People's Front
MSI	Marie Stopes International
MSM	Men who have sex with men
MWAF	Myanmar Women's Affairs Federation
NCA	Nationwide Ceasefire Agreement
NGO	Non-Governmental Organization
NMSP	New Mon State Party
OAG	Office of the Union Attorney General
PEP	Post-Exposure Prophylaxis
TMOs	Township Medical Officers
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNSCR	United Nations Security Council Resolution
UPC	Union Peace Conference
WHO	World Health Organization

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This assessment is the first of its kind to be conducted in the south-eastern region of Myanmar. It is an important contribution to ensuring the full inclusion of women and children in Myanmar's political, social, and cultural systems, with a specific focus on the issue of gender-based violence (GBV) and its impact on these groups in south-eastern Myanmar. The United Nations Population Fund (UNFPA) is grateful for the participation of women, men, boys and girls from Mon, Kayin and Kayah States for sharing their views and experiences during the study. UNFPA also wishes to thank the representatives of the many International Non-Governmental Organizations, Non-Governmental Organizations, Civil Society Organizations and Government departments and institutions who took part in consultation meetings and interviews.

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DISCLAIMER

The views expressed in this publication are those of the authors and do not necessarily represent the views of the United Nations Population Fund, Myanmar, or the United Nations generally.

Executive Summary

This report presents the findings of a study on gender-based violence (GBV)¹ conducted by the United Nations Population Fund (UNFPA) in three south-eastern states of Myanmar: Kayah, Kayin, and Mon (including some limited consultation in Tanintharyi Region). The assessment was conducted during January and February 2016 by a team of three national and three international consultants. The purpose of the assessment was to: understand the context (including levels of understanding of the drivers and prevention of GBV among youth, community leaders, women and service providers) of GBV in the south-eastern region; identify existing GBV responses and services; and develop recommendations for future programming to be implemented by UNFPA and other development and humanitarian partners.

The south-eastern region of Myanmar is emerging from a long history of conflict. A new Government was elected in 2015 in the first democratic election in 50 years, witnessing a landslide victory to the National League for Democracy, and ending 50 years of military rule. Ceasefire agreements have been in effect to varying degrees, and the Nationwide Ceasefire Agreement (NCA) was signed in late 2015.

Regardless of the changes in the political landscape, people remain affected by a sense of insecurity and the residual effects of conflict. The limited inclusion of women and girls in meaningful participation in the peace process further exacerbates their sense of disenfranchisement. Only a fraction of bilateral ceasefire agreements mentioned women. The NCA makes a reference to GBV stating that any form of sexual violence should be avoided, but does not make any provision for accountability mechanisms.² Armed forces and groups are still present in many areas, and thousands of people remain displaced both within Myanmar and across the border in Thailand. According to the United Nations High Commissioner for Refugees (UNHCR), there were around 104,149 refugees in nine camps along the Thai border as of July 2016,³ with similar numbers believed to remain displaced within south-eastern Myanmar.

With improving security and perceived security in these states, new industries and businesses have started to open up, which has brought opportunities together with new challenges. Against this backdrop of political, social and economic transition, women and girls are facing new risks and vulnerabilities, while traditions and cultural norms still restrict them to conform to traditional gender roles. The development and humanitarian needs of the south-eastern region are often overshadowed by other humanitarian crises in the country, and little is known about the context of, and responses to, GBV in this region.

¹ Gender-based violence (GBV) is any harmful act that is perpetrated against a person's will and is based on socially ascribed differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. *IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action.*

² UN Women, *The Nationwide Ceasefire Agreement in Myanmar: A Gender Equality and Women's Rights Analysis.* 2016.

³ UNHCR, *Refugee and IDP Camp Population: July 2016.* UNHCR.

The assessment comes at a critical point in time as Myanmar continues its social, economic and political reforms. The findings of the assessment identified a region in crisis. Intimate partner violence among married couples, and sexual violence against children and young girls were found to be the most prevalent forms of GBV in all three states. Despite efforts made by the Government and civil society to address GBV, most GBV cases are either ignored or dealt with by the communities themselves, leaving survivors with limited access to life-saving services or the formal justice system. Key risk factors identified include outmigration of parents (leaving young children vulnerable), high levels of drug use, in-migration to service development projects and tourism, and increased access to the internet and social media. The assessment found that the region was characterized by a general malaise as a result of the lack of civic engagement of young men and women. Given that the population demographic indicates a high level of young people, their engagement in civil society is critical.

This report presents a snapshot of current available services, practices, capacity and challenges. The assessment was not able to cover the entire geographic area of all three states due to time and access constraints, and instead focused on the state capitals where most service providers were based. To gain a balanced understanding of the issues a number of rural villages in each state were assessed. The locations for the assessment and the groups engaged were guided by an analysis of the 2014 Census data which indicated both the high proportion of youth in the three states as well as the higher proportion of rural as opposed to urban populations. The assessment team ensured a conflict sensitive approach and met with Government stakeholders, civil society organizations (CSOs) and ethnic armed organizations (EAOs) and ethnic authorities.

This assessment is qualitative. It uses applied participatory research methodologies. Information was collected through a combination of desk reviews, key informant interviews, focus group discussions, consultations and orientations. In total, 73 interviews with duty bearers and service providers were conducted as well as 10 focus group discussions with 100 participants in communities. The information was validated through five multi-stakeholder consultations involving civil society organizations (CSOs) and Government representatives. GBV orientations were also held for state health care providers and Myanmar Police Forces to gain an understanding of their current practices and views, and how they deal with GBV cases. While the report is a consolidation of three individual state level reports with distinct findings, this summary combines common thematic issues across the three states.

The study did not seek to collect information on the prevalence of GBV in these states. It focused on common types of GBV, vulnerable groups, risks and contributing factors in order to support future programme design. In general, it is considered unethical to collect data on the prevalence of GBV unless this information is collected through existing services which survivors are accessing. It is difficult to gauge prevalence without the existence or access to services, which is the case for vast areas of the three states.

Key findings

The results of the assessment reveal a range of critical and urgent issues which require immediate intervention. The findings suggest that there is significant and widespread GBV throughout all three states. It impacts upon women, children and young people and marginalized groups including: sex workers; men who have sex with men (MSM); people living with disabilities; and men who are not conforming to traditional masculine gender norms. The types of GBV evident in this region include sexual violence, intimate partner violence, domestic violence, cyber violence, trafficking, and economic exploitation. The most prevalent forms of GBV were found to be intimate partner violence⁴ (IPV) mostly among married couples, and sexual violence against children, particularly young girls.

IPV, including physical, psychological and sexual violence (marital rape), appears to be a daily occurrence for many women to the extent it is accepted as the norm within the community. Violence is justified based on the belief that women are expected to be subordinate to men, and it is a “private family matter.” The prevalence and acceptance of IPV is a clear indicator of the gender inequality and subordination of women and girls entrenched in all aspects of the everyday life of communities across the region. Key triggers for IPV, which were also widespread, included drug abuse, poverty, and lack of livelihood options. The level of acceptance of IPV means that women and girls rarely seek support, including formal justice system responses, which results in it remaining a silent epidemic across the region.

Rape of children, particularly young girls, was raised consistently as a major concern by key respondents in all three states. Most perpetrators are reportedly family members of survivors and people who are close to them, such as neighbours and community members (frequently men over 60 years of age). It is suggested that this type of man is often trusted by neighbours; he is not expected to be somebody who would harm children. Frequently, the survivors do not tell their parents about the rape and it is reported to authorities only when the rape results in a pregnancy. While this was the predominant view across the assessment, there was also a high level of study participants who expressed a contradictory view that violence is perpetuated by outsiders, such as migrants. The risk of violence was found to increase when children were left alone at home due to the outmigration of their parents, and while their parents were working away from the family home.

Substance abuse, including alcohol and drugs, such as yaba (an amphetamine-type stimulant) was believed to be a major contributing factor to the perpetration of both sexual violence and IPV. Sex based on the promise of marriage was commonly reported among young women. Recent economic development in these states, including construction, tourism and extractive industries, was also seen to increase the vulnerability of women and girls to GBV.

⁴ IPV is defined as violence committed against a survivor by her intimate partner, whether cohabiting or not. It also includes refusal of money to cover basic necessities as well as controlling behaviours, such as constraining a woman's mobility or her access to friends and relatives. *Let Me Not Die Before My Time*. IRC. 2012.

Young people were consistently highlighted in the assessment as a demographic group requiring support and interventions. They were identified as both perpetrators and survivors of violence. Particularly evident in Mon and Kayin States was cyber violence targeting young girls, which occurred off and online. There were reports of online harassment, such as stalking and shaming of girls. Young girls were drawn into situations where they experienced sexual and physical violence as a result of meeting with perpetrators with whom they initially made contact with virtually.

Despite the evidence of many GBV incidences, survivors are not adequately supported by survivor-centred response services. Moreover, under-reporting of cases was apparent in all three states. As found in other parts of the country, low levels of formal reporting of GBV, a high probability of adopting informal coping mechanisms, and discriminatory gender norms are aggravating factors for GBV.⁵ A survivor is blamed for provoking violence, which is internalized and normalized by women and girls, creating and sustaining an environment where they are silenced and stigmatized. Under-reporting is partially attributed to a lack of trust in the Government system and a fear of reprisal by perpetrators. The assessment results indicate that most GBV cases are not managed by formal justice processes. Instead, cases are addressed by customary systems and support/coping mechanisms at the community level. This is compounded by a lack of legislative and policy frameworks (including medical treatment and referral protocols), complex reporting mechanisms, and geographic barriers. In addition, there are low levels of awareness both of what comprises GBV, and how to safely respond to cases within the health and police sectors. This further deters individuals from reporting GBV incidences.⁶

GBV survivors lack legal recourses. Both formal and informal systems fail to provide remedies which are sufficient to deliver justice and hold perpetrators accountable. Justice responses are critical to support both awareness-raising of the gravity of the offence as well as working towards nurturing an environment to end impunity. A response by the formal justice system involving the health system (to collect forensic evidence), police and justice actors has numerous limitations including: a lack of trained and/or female officers and staff; gender bias; and appropriate facilities to ensure privacy and resources to reach survivors. In all three states, CSOs specializing in providing paralegal and legal services are present. Nevertheless, only a fraction of GBV cases are brought to them due to a number of barriers, not least the normalization of GBV within these communities and the tacit belief that cases should be resolved at the community level.

The majority of cases are mediated by community leaders at the village level, such as elders, ward or village administrators and religious leaders (and Myanmar Women's Federation groups in some cases). Survivors rarely make reports to the Police.⁷ Mediators often advise survivors, in cases of IPV,

⁵ Kyu, N. & Kanai, A. (2005). "Prevalence, antecedent causes and consequences of domestic violence in Myanmar". *Asian Journal of Social Psychology*. Vol. 8: 244-271.

⁶ See also Akhaya Women. (2014). *Prevention and Response Services for Intimate Partner and Sexual Violence Survivors in Yangon. Summary of Findings*. December 2014.

⁷ See also, Justice Base. (2016). *Voices from Intersection: Women's Access to Justice in the Plural Legal System in Myanmar*.

to remain in the abusive relationship in order to maintain the integrity of marriage, while other cases result in a public apology from perpetrators at best. If the gravity of violence is considered “severe”, survivors may be allowed to leave the relationship. In addition, sexual violence cases are resolved through financial compensation or other remedies, such as being advised to marry the perpetrator. In Kayah State, for example, many communities practice what is called a “cleansing ceremony” to purify the village after an incident of sexual violence. This ritual, while deserving of a more detailed study, is often carried out at the survivor’s expense and appears to cause more harm and re-victimizes survivors. The lack of reporting to the formal justice system further embeds the crime of GBV into the fabric of communities, perpetuating the environment of impunity.

Survivors have limited access to life-saving medical and psychosocial support that meet international minimum standards. Government health facilities are not equipped with essential commodities such as post rape treatment kits, and an accompanying clinical protocol. Staff lack the capacity to administer treatment appropriately and safely. Awareness about the procedures to refer emergency GBV cases, as specified in the Emergency Care and Treatment Law 2014, is lacking among health as well as police duty bearers. For the most part, mandatory reporting is practised. However, the legal framework for mandatory reporting post medical treatment remains uncertain. The assessment revealed that medical staff and clinics continue to refer GBV matters to formal justice systems regardless of the wishes of the survivor, which is in clear contravention of the guiding principles for the management of survivors of GBV. There are parallel health systems in ethnic armed organization (EAO) controlled areas, which are supported or affiliated with EAOs. Their services, mostly through backpacker mobile teams, appear to have differing degrees of capacity to respond to GBV. Only some are technically supported by international organizations.

The assessment found vibrant civil society and active women’s groups in the three states that fill some of the gaps in service provision. CSOs and community groups are conducting a range of GBV services, including referrals, legal advice, awareness-raising in schools, community mobilization through male role models, and rehabilitation/emergency shelters, among other initiatives. Women’s groups also provide basic counselling, with the exception of a limited number of organizations who provide specialized counselling and case management services. The approach used by most organizations appears to be more of a one-off informal discussion, which is not always conducted by individuals with technical skills gained through professional training. Nor does this approach comply with GBV guiding principles of safety, confidentiality and respect. Despite the many anecdotes of child sexual violence, no specialized services were recorded for child survivors.

These organizations are operating with limited resources and their services often depend on short-term funding or sub-grants from larger CSOs. Some are starting to conceptualise GBV in a much broader context, beyond the need for better health, legal, and protection responses, to working directly with

perpetrators and youth (particularly boys) to discuss gender, GBV and on/off line cyber behaviour. Despite the presence and dedicated work of CSOs there is a strong need for the strengthening of Government systems, policies and legislation to support survivors of GBV.

GBV service providers coordinate with one another through formal and informal groups and networks to refer survivors, and work together to manage cases. Coordination systems are already in place in some areas, which are made up of CSOs and women's groups along with Government stakeholders. Examples include the Case Management Group in Mon State and the GBV Coordination Group in Kayah State. In Kayin, the assessment team did not find a formalized group, but did determine that women's organizations work through strong networks even though they may not be formally dedicated to GBV case management.

Existing services and coordination structures can be strengthened to ensure safe and confidential support and referral services for survivors. There is a common narrative among Government stakeholders across the three states denying the existence of gender inequality and GBV. GBV was viewed as a problem of "other states and regions" as their state was peaceful and free of violence. This attitude, combined with a lack of mutual trust between the Government and CSOs, in some cases, hinders the implementation of GBV programmes and coordination among GBV service providers to support survivors.

A range of challenges were identified that impede access to services for survivors, in addition to those already identified, including the normalization of GBV within communities. The south-eastern region is a predominantly ethnic area where women and girls face language and cultural barriers in accessing state services offered by Government duty bearers, who are mostly Myanmar speaking Burman. CSO and NGO support services are mainly based in state capitals, which cannot be reached easily by remote and hard-to-reach rural communities due to distance, transportation costs, and a lack of mobility by women and girls. Discriminatory gender norms in communities and among services providers also discourage survivors from reporting cases and benefitting from support services. Finally, even in situations where women, girls and communities may actually want to access support services, they lack the knowledge on where GBV services can be found.

Recommendations

A number of key areas for future interventions have been identified based on the assessment findings. The recommendations emphasize the need to understand and work within the local context to strengthen existing structures which have already garnered trust and support across communities. Previous research has identified the importance of working within the local context especially in a country such as Myanmar, where human rights and GBV may lack significant cultural relevance. An approach needs to be adopted which

allows for the creation of a localized understanding and response to GBV, to avoid the risk of rejection of change and in the event of future conflict.⁸

A key finding of the assessment in Mon State highlighted that resources and funding from INGOs and NGOs are mainly given directly to urban-based and larger CSOs, which then trickle some funds down and allocate activities to the smaller CSOs. This stifles capacity building opportunities for CSOs working in the villages. It also means that any understanding of GBV in Mon State is drawing on the knowledge and expertise of those who work for the larger CSOs. On the contrary the work and experience of the smaller CSOs may, in fact, offer a more accurate reflection of the context of GBV throughout the state, while the larger CSOs continue to play a leading role in political discussions about GBV and the empowerment of women in Mon State and at the Union level. A long-term and sustained approach to GBV is required in all three states. Specific and immediate responses can be provided to ensure availability of services, sustainable provision of health supplies (including post-exposure prophylaxis (PEP), better access to and awareness of services, and further training for state authorities and CSOs.

As the vulnerability of children and adolescent girls to sexual violence is particularly prevalent, this requires immediate intervention. Furthermore, the development or building upon existing youth networks is critical in order to support the future of the region. Youth will require a holistic approach with the provision of a range of services including drug rehabilitation, and access to formal and non-formal education and life skills, including sexual and reproductive health and rights training.

In order to ensure strong and effective interventions, improved coordination systems need to be put in place. This will strengthen the development of standard operating procedures for service providers, including developing area-specific referral pathways and safe information sharing protocols. There are numerous state and Government service providers operating in the south-eastern region of Myanmar. In some regions, these service providers are located and operate primarily in large urban areas and their services are not coordinated.

⁸ Chua, L. (2015). "The vernacular mobilization of human rights in Myanmar's sexual orientation and gender identity movement." *Law & Society Review*. Vol. 49, No. 2: 299-332.

This study indicates that the extent and severity of GBV across the south-eastern region of Myanmar cannot be addressed in the short-term. More research and studies are required to fully understand the local context and the ways in which gender inequality is embedded into cultural, traditional and emerging practices. On the basis of the findings of this study it is clear that as the region transforms socially and economically, GBV will increase related to the location of more extractive industries, tourism and internet accessibility.

It is recommended that there is a strong and sustained investment in both gender equality policies and laws which support women's human rights and GBV response and prevention interventions in the region. Without addressing underlying gender inequality and discrimination against women and girls, which manifests itself in the form of GBV, through The Convention on the Elimination of All Forms of Discrimination against Women⁹ (CEDAW) compliant policy and legislation, Myanmar will not achieve the desired level of development set out in the new Sustainable Development Goals. The policy and legislative environment must be addressed simultaneously to establish a commitment for the implementation of accessible and safe services (including health and justice responses). This is essential to ensure that women and girls achieve their full potential. The commitment of Government is necessary, as well as the continued engagement of other stakeholders, including civil society, non-governmental organizations and donors to address the problem.

⁹The Convention on the Elimination of All Forms of Discrimination against Women. 1979.

Introduction

Context of Gender-Based Violence: Myanmar and the South-Eastern Region

GBV is violence directed at a person because of their sex and/or socially assigned gender roles. While it can affect all people, including men and boys, it has a greater impact on women, young girls and children globally. Violence is perpetrated mostly by men to subordinate and control females.¹⁰ GBV can include, but is not limited to, sexual abuse, rape, genital mutilation, physical assault, psychological abuse, trafficking, forced sex work and sexual harassment.¹¹ As a practice, it violates international law and principles of gender equality as well as constituting a criminal offence in many countries around the world.¹² In Myanmar, GBV is one of the key barriers that prevents women from participating in the peacebuilding and political processes, which then serves to perpetuate the cycle of violence. Until GBV is addressed and women are empowered to participate in such processes, gender equality will continue to exist.¹³ Understanding the types and prevalence of GBV is particularly relevant in Myanmar today, where GBV and threats of GBV continue to prevent women's equal participation in the changing political and social systems.¹⁴

The democratic Government, elected in 2015, announced that building peace and national reconciliation is their top priority. More than 14 bilateral ceasefire agreements were signed during the period August 2011 through to October 2013, and the nationwide ceasefire agreement (NCA) was signed with 8 armed groups in 2015. The peace processes have, however, failed to be inclusive of civil society and women's participation. These bilateral ceasefire agreement frameworks, and their implementation, continue to fall short of addressing underlying gender roles and the associated power dynamics that lay the basis for institutional gender discrimination.¹⁵

Recent efforts to document the systematic use of violence against women and girls by armed groups and forces in conflict areas, and to explore GBV experiences of women and girls in Myanmar,¹⁶ illustrate the increased awareness about, and interest in this topic. This has created an opportunity to intensify the dialogue and efforts necessary to address the issue. The laws as they stand in Myanmar are inadequate and do not meet the needs of women.¹⁷

¹⁰ Inter-agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, 2015. P5.

¹¹ Definition is closely aligned with Article 2 of the United Nations Convention on the Elimination of Violence Against Women (1993).

¹² UNFPA, *Minimum standards for prevention and response to gender-based violence in emergencies*, 2015, p.ix.

¹³ Cate Buchanan and Antonia Potter Prentice, *Peacemaking in Asia and the Pacific: Women's participation, perspectives and priorities*, 2011.

¹⁴ AGIPP, *Women, peace and security policymaking in Myanmar*, 2015.

¹⁵ Isaac Khen & Muk Yin Haung Nyo, *Looking at the Current Peace Process in Myanmar through a Gender Lens*, 2014.

¹⁶ See, for example, Sarah Meger, *Sexual and gender-based violence in Myanmar/Burma*, 2014; Gender Equality Network, *Behind the Silence. Violence against Women and their resilience*, 2014; and, Karen Human Rights Group, *Dignity in the shadow of oppression: The abuse and agency of Karen women under militarisation*, 2006.

¹⁷ Gender Equality Network, 2014.

The exclusion of women from peacebuilding interventions undermines the legitimacy and sustainability of the work as supported by the United Nations Security Council Resolution (UNSCR) 1325.

Myanmar has seen positive developments in the policy landscape in the past few years. The Government released the National Strategic Plan for the Advancement of Women 2013-2022¹⁸ in 2013. This ten-year plan covers 12 priority areas, which correspond to the Beijing Platform for Action, and the principles of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to which Myanmar became a signatory in 1997. It lays out practical ways to improve the lives of women and girls, including addressing violence, health, and women's issues in emergencies, among other target areas. The plan is yet to be fully implemented as there has been limited funding allocation. Civil society organizations (CSOs) together with the Ministry of Social Welfare, Relief and Resettlement drafted the Prevention of Violence Against Women Bill in 2015; it is pending approval in Parliament. If the Bill is passed in a form advocated by CSOs, the law will criminalize different forms of violence, such as sexual harassment at the workplace and intimate partner violence, and will have the key provision of issuing a restraining order against perpetrators.

The Emergency Care and Treatment Law was passed in 2014, which mandates health care facilities to treat patients without filing a police report first¹⁹. Although this law does not specifically address GBV cases, it clarifies the role of the health and the police sector in responding to GBV cases.

The south-eastern region is defined as the states and regions adjacent to the Thai border, as well as East of Bago Region²⁰. However, for the purposes of this assessment, the focus is on the states of Kayin, Kayah and Mon in addition to Tanintharyi Region, although the information for this latter region is limited. The total population of Kayin, Kayah and Mon States is over 3.9 million, who predominantly live in rural areas²¹. The region has a higher fertility rate compared to the Union average, and a higher proportion of young people. The decade long conflict has left the region under-developed, stricken with poverty and with a literacy rate lower than the Union average.

Even though there has been a series of bilateral ceasefire agreements, the region still experiences on-going insecurity and the rule of law is weak. The Myanmar Armed Forces are present in the south-eastern region, while ethnic armed organizations exercise control in other parts of the region²². Thousands remain displaced both within Myanmar and across the border in Thailand. Some 104,627 refugees remained in nine camps along the Thai border at the end of 2015²³, with similar numbers believed to remain displaced in south-eastern

¹⁸ Government of Myanmar, *National Strategic Plan for the Advancement of Women (2013-2022)*.

¹⁹ Government of Myanmar. Emergency Care and Treatment Law. 2014.

²⁰ Myanmar Information Management Unit. Website: <http://www.themimu.info>

²¹ Department of Population, Ministry of Immigration and Population, *The 2014 Myanmar Population and Housing Census*.

²² Susanne Kempel and Aung Thu Nyien. Local Governance Dynamics in South East Myanmar: Assessment for Swiss Agency for Development and Cooperation. August 2014.

²³ UNHCR, Refugee and IDP Camp Population: August 2015. UNHCR.

Myanmar. This included some 12,162 internally displaced persons (IDPs) in six settlements in Kayin and Southern Shan States²⁴. With improving security in these states, space has started to open up for new industries and business, which brings new opportunities along with new challenges.

Against this backdrop of political, social and economic transition, women and girls are facing new risks and vulnerabilities, while old traditions and cultural norms still restrict them. Development and humanitarian needs of the south-eastern region are often overshadowed by other humanitarian crises in the country, and little is known about the context of, and responses to GBV. Up until recent years, the Myanmar Government imposed restrictions on humanitarian access into conflict-affected areas. Consequently, local communities received very limited services from the Government or external agencies. The Government has lifted some restrictions against international agencies following the bilateral ceasefires. However, many areas remain hard to access due to insecurity and difficult terrain.

Overview of the Study

UNFPA has been responding to GBV in humanitarian settings in Myanmar since 2012; and is the lead agency within the United Nations system for both GBV and reproductive health interventions in the country. Since 2013, UNFPA has been scaling up its GBV prevention and response initiatives in humanitarian settings in Rakhine, Kachin and Northern Shan States. However, little is known about the context of, and responses to GBV in the south-eastern region, namely Kayah, Kayin, and Mon States, which are conflict-affected areas. These states are not included within the geographic ambit of the Humanitarian Response Plans²⁵. A number of documented cases of GBV are emerging²⁶, revealing a strong need for GBV response and prevention activities. Very few, if any, international organizations are, however, providing comprehensive and multi-sectoral GBV response and prevention activities in the south-eastern region. This leaves many survivors without access to life-saving services, and many organizations without adequate support to offer effective responses.

In 2015, UNFPA received support from the Foreign Commonwealth Office of the United Kingdom and the Department for International Development (DFID), United Kingdom, under the Prevention of Sexual Violence Initiative, to undertake an assessment of the type and prevalence of GBV across the south-eastern region of Myanmar. The findings of the study in each of the three states are outlined in this report, along with recommendations for further research and programming to give effect to sustainable initiatives to prevent and respond to GBV in Kayah, Kayin, and Mon States. This includes activities to support and encourage women's participation in peacebuilding processes in the region.

²⁴ The Border Consortium. Refugee and IDP Populations. June 2016.

²⁵ OCHA Myanmar Humanitarian Response Plan 2016.

²⁶ Karen Human Rights Group, *Truce or transition? Trends in human rights abuse and local response in Southeast Myanmar since the 2012 ceasefire*, 2014.

The objectives of the assessment were:

- To understand the particularity and nature of GBV, including common types, the extent, needs as well as attitudes, and practices and norms in the community.
- To map the main stakeholders in GBV response and prevention in the health, psychosocial, legal and security sectors, and current GBV related projects and activities.
- To identify gaps and opportunities in GBV response and prevention services both sectorally and geographically.
- To assess the capacity of organizations in implementing and/or mainstreaming GBV services, including the policies, practices and attitudes of service providers.
- To make recommendations on entry points for further GBV programming.

Limitations and Challenges

The assessment team faced a number of limitations and challenges during the study. While this report presents a snapshot of the present situation of GBV in these three states, it does not claim to present a systematic assessment of the quality of GBV prevention and response services covering the entire states. It was not possible to collect first-hand information in all areas of each state due to restrictions on travel for international consultants and time constraints of the project. The assessment teams visited up to three sites in each state. Information about townships not visited is, therefore, based on verbal accounts of interviewees, and the teams were not able to validate all of this information. The teams acknowledge that their findings may reflect only partial views and understanding of GBV issues in the studied states. The study focused on qualitative information about GBV, and it does not attempt to present quantitative prevalence data.

The assessment teams acknowledge the following limitations and challenges of the study:

- There was difficulty in accessing information about the number of reported GBV cases, especially from some Government institutions. The numbers of reported cases cited in the findings are those given to consultants during interviews with key state and non-state stakeholders, but these numbers were not always validated by referenced documentation. The assessment teams consider that these numbers do not offer an accurate reflection of the gravity of GBV in the three states, rather they provide an indication of barriers to accessing services and justice, which are the main sectors where reports of GBV are made.
- There was a lack of privacy in some interviews and focus groups discussions (FGDs). In most cases, a representative of the local Department of Social Welfare office accompanied assessment teams and was present during some discussions. Some participants, particularly representatives from CSOs and groups affiliated with

EAOs, may have felt unable to express their views, and this may have had some impact on the information they provided.

- In some states it was difficult to engage Government stakeholders. A few key Government officials were reluctant to meet with the assessment teams. Due to frequent changes in government positions, some key posts were also vacant at the time of the study. Some Government representatives had also recently arrived in the state, and were unable to offer detailed information about the local GBV context or their understanding of it.
- It was difficult at times to engage participants in focus group discussions. GBV is a very sensitive subject and it was a challenge to discuss this issue particularly with some of the younger and adolescent participants. The project timeframe made it difficult to build rapport and establish trust to create a conducive environment where participants would feel comfortable to open up and share their personal views. Some of the tools used in the study methodology, such as drawing and indicating views on a flip chart, proved somewhat useful in overcoming this challenge.
- There is a possibility that there are some inconsistencies in the findings across the three states. Three separate teams conducted an assessment in each state. Even though standard tools were utilized for data collection, there was a need for the teams to adapt and use them differently to ensure they were appropriate for the local context, including interviewees' level of education and understanding of GBV. The consultants also brought diverse expertise and prior experience to the project. The consultants acknowledge that analyses of the data may be impacted by this diversity.
- Data collection was mainly carried out in the Myanmar language or a local language. Information was interpreted into English during interviews, consultations, and focus group discussions. Some of the nuances of stories may have been lost in translation. Quotes cited in this report involved paraphrasing in some cases in order to provide a clear understanding of the narrative.
- The study of GBV is always challenging. Researchers who are involved in this kind of work have an obligation to ensure that no further harm is done to participants who may have personal experience of GBV. This study did not seek to ask participants about personal experiences or to validate these experiences, but often such experiences did come up in conversations. Researchers also therefore have a responsibility to ensure they look after their own emotional welfare during such a study. The role of the researcher is often challenged and compromised when investigating issues of GBV, and gender roles and practices. The assessment teams encountered situations where particular views of GBV and gender (that were outright discriminatory) were expressed by participants. They were therefore faced with the dilemma of whether to respond and challenge these beliefs and practices, or to maintain the position of an objective researcher. Some of the teams made the decision to challenge; others decided to record what was said without making comments.

Methodology

Information for this study was collected through a combination of desk reviews, consultations, trainings, key informant interviews (KIIs), and focus group discussions (FGDs). Data collection took place in the states of Kayah, Kayin and Mon (and Tanintharyi Region) over three weeks in February 2016.

Desk review

The initial stage of the study consisted of a desk review of existing reports and assessments of GBV in Myanmar and particularly the south-eastern region. The review also included a study of documents which provided the political and cultural background of each state. The desk review process was on-going throughout the research.²⁷

Conflict sensitivity planning

The team of consultants were provided with conflict sensitivity training and support in planning the assessment. The team ensured the incorporation of conflict analysis into the assessment and conflict sensitive design and planning. The training supported the team to identify the wider impact of planned activities on factors relevant to conflict. In addition, the training ensured that the dynamics of the conflict and the vested interests and relationships between stakeholders in the conflict were well understood and linked to the conduct of the assessment.

Census data briefing

A briefing was provided for the assessment team to understand the population demographics of the three states and Tanintharyi Region in which the assessment was planned. The briefing provided the team with the tools to structure the assessment. As a result of the briefing, for example, the assessment ensured a higher focus on rural areas and young people to ensure inclusion of the key findings of the 2014 Population and Housing Census.

Key informant interviews (KIIs)

Seventy-three KIIs were conducted, sometimes with more than one person in a single interview, with up to a maximum of eight persons. Each interview lasted between one and three hours. The interviews aimed to collect the following information:

- Structure of organization, mandate, geographical coverage, capacity, and networks.
- Past experiences in dealing with GBV cases.
- Knowledge, attitude and practices of individuals and organizations as they related to GBV.
- Capacity development needs for GBV prevention and response.
- Understanding of gaps in service delivery and GBV prevention programmes.

²⁷ A full list of reviewed documents is available in the references at the end of this report.

Multi-stakeholder consultations

- Six consultation meetings, with a total of 100 participants from state institutions and civil society, were organized in partnership with the Myanmar Anti-Narcotic Association (MANA.) The consultations involved participatory methodologies to discuss common types of violence, contributing factors, vulnerable groups as well as an analysis of local stakeholders and opportunities, challenges and gaps.

GBV orientations for duty bearers

- Six training sessions for Myanmar Police Forces and state health care providers, with a total of 254 participants, were organized in partnership with MANA. The orientation for police officers followed UNFPA Myanmar's training modules on survivor-centred response and prevention of GBV, the role of the justice sector, and the Emergency Care and Treatment Law. The orientation for health care providers focused on an introduction to GBV, the health sector response to GBV, and the Emergency Care and Treatment Law. These orientations were also used as an opportunity to listen to the views and experiences of the police and health care providers in order to gather information on the understanding and the capacity of duty bearers to respond to GBV.

Focus group discussions

- Twenty-seven FGDs, with a total of 346 participants, were conducted at the community level with women, adolescent girls and boys and community leaders/men. Two villages in different townships were selected based on existing information on population dynamics from the 2014 Census, as well as other reports. The discussions focused on gender roles, common types of violence, and available response services in the community. They also included an exercise of indicating agreement or disagreement with GBV and gender-related statements to facilitate discussions.

Different stakeholders were involved in the assessment, with some variations per state.

Government stakeholders included:

- Department of Social Welfare
- Ministry of Health (government hospitals, township medical officers)
- Myanmar Police Force (including anti-trafficking unit)
- Attorney General's Office
- Village and Ward Administration Offices
- Myanmar Women's Affairs Federation
- Myanmar Maternal and Child Welfare Association
- State Hluttaw Office

Other stakeholders included:

- Women's organizations and groups
- Community groups and networks
- Youth groups
- International and national non-governmental organizations
- Ethnic armed organization liaison offices
- Health departments
- UN agencies

Stakeholders were selected to ensure that a different range of perspectives were incorporated. They included rural and urban populations, duty bearers and civil society service providers, as well as community representatives at the state, township and village level. Stakeholders were also selected on the basis of their role in GBV programming including:

- Implementing direct medical/health and psychosocial/emotional support services (including case management and/or group support activities) for GBV survivors.
- Providing medical services.
- Providing legal aid or support in accessing justice.
- Providing security and safety services.
- Implementing initiatives specifically targeting women and girls (including the empowerment or protection of women and girls) which had a potential impact on, or synergies with, GBV prevention and response.
- Other general protection and/or broader activities that might help to prevent gender discrimination and GBV.

A description of the assessment tools and a summary of study participants can be found in the Appendices of this report.

Ethnic armed organizations (EAOs), where possible, and their affiliated organizations including ethnic health organizations, were consulted to ensure an inclusive and conflict sensitive approach. Due to time constraints and limited resources the team was not able to conduct a full conflict analysis prior to departure. Instead, a rapid informal analysis in the form of discussions/group work, combined with the use of analytical tools, (stakeholder mapping/conflict tree etc.) was undertaken internally with UNFPA personnel. This gave an improved understanding of the context to identify and mitigate against possible risks, and maximize as much as possible the positive impact of the assessment.

Ethical considerations

KIIs and FGDs were initiated by explaining the study and its purpose as well as highlighting confidentiality. For each interview, it was clearly outlined that the purpose of the meeting was for the assessment team to increase its understanding of GBV in the south-eastern region. It was also highlighted that only de-identified information was necessary.

Ethical concerns (including personal safety, confidentiality, anonymity, and informed consent) were taken into consideration, and as such, all standard ethical and safety guidelines for researching sexual violence as recommended by the World Health Organization were followed.²⁸ Interviewees were assured that all information shared during the interview or discussions would remain confidential. All participants agreed that no information shared during a discussion be disseminated outside the group. Interviewees and discussion participants were provided with an opportunity to ask questions. Where possible, private spaces were also used to protect confidentiality and to support open and honest discussions. Information about local support services was available to the team of consultants in the event that GBV survivors requested this during discussions. In addition, time was made for participants to speak with the interviewers after each discussion.

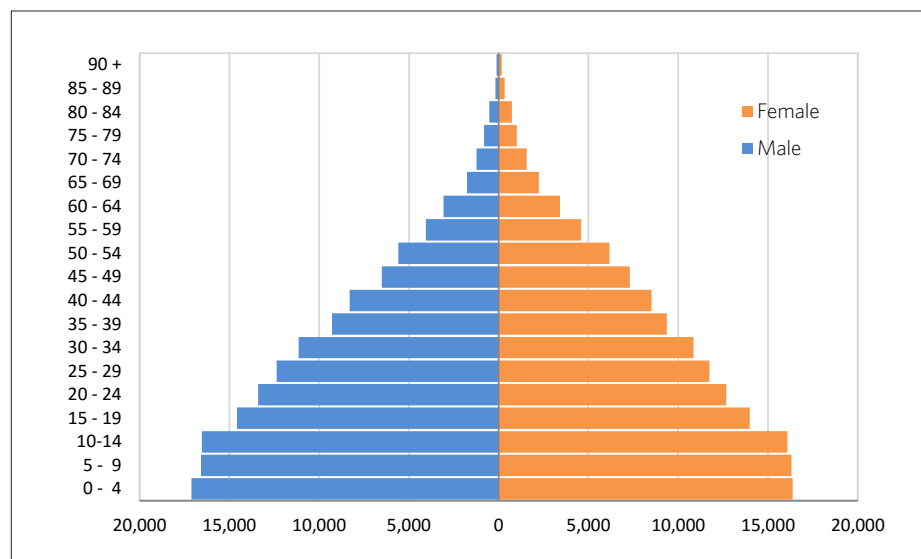
²⁸ World Health Organization, *Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies*, 2007. http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

1

Kayah State Findings

Kayah is the smallest state in Myanmar, both in its geographical size and population, according to the 2014 Myanmar Population and Housing Census. It is situated in the south-eastern region, bordering Shan State and Kayin State in Myanmar, and Mae Hong Son province in Thailand. It consists of two districts, Loikaw and Bawlakhe, and seven townships (Loikaw, Demoso, Hpruso, Shadaw, Bawlakhe, Mese and Hpasawng) with a total population of 286,627 people. Seventy-five per cent of people reside in rural areas. Unlike the Union level population trend, Kayah's birth rate has not declined, and the proportion of children and young people is relatively high. According to the 2014 Census, Kayah's population pyramid is broad-based. Kayah has a balanced sex ratio. However, the ratio of men between the ages of 15 to 39 is significantly higher in Bawlakhe District. Twenty-three per cent of households are headed by females. The literacy rate is much lower than the Union level at 82.1 per cent for men and 77.6 per cent for women, respectively.

Figure 1. Population pyramid of Kayah State*



* Source: Myanmar Population and Housing Census, 2014.

Kayah State has a diverse ethnic make-up. The Kayah (Karenni) and Kayan (Padaung) predominate, followed by numerous subtribes and other distinct groups with their own languages. According to the 2014 Census, Buddhists constitute 49.9 per cent of the state's total population, followed by Christians at 45.8 per cent, Animists at 1.9 per cent, Hindus at 0.1 per cent and Islam at 1.1 per cent.²⁹ The state was renamed Kayah from Karenni with its current demarcation in 1952.

The decade-long conflict between the Myanmar National Armed Forces and

²⁹ Department of Population, Ministry of Immigration and Population, *The 2014 Myanmar Population and Housing Census*.

various ethnic armed organizations has caused long-term displacement dating back to the mid-1990s in Kayah State. It is estimated that 34,600 people are internally displaced, with an additional 11,552 refugees in Thailand registered with UNHCR. The internally displaced persons (IDPs) figure has not been updated since 2012, and several sources suggest that the actual figures may be considerably lower.³⁰ Some of the internally displaced person (IDP) camps have already been integrated locally, while some populations intend to return to their original villages. The movement is quite fluid and complex.³¹

The Karenni National Progressive Party (KNPP), the political wing of the Karenni Army, is the most dominant ethnic armed organization in Kayah. They signed a bilateral ceasefire with the Government in 2013. However, they are not a signatory to the nationwide ceasefire agreement (NCA) signed by some armed groups and the Government in October 2015. The KNPP is a member of the United Nationalities Federal Council, which rejected the NCA. KNPP representatives did take part in the “21st Century Panglong” Union Peace Conference convened by the newly-elected National League for Democracy Government in August 2016. KNPP continues to control remote parts of the state near the Thai border. KNPP has a liaison office in Loikaw. Other ethnic organizations include the Kayan New Land Party (KNLP), the Kayan National Guard (KNG), and the Karenni Nationalities People’s Liberation Front (KNPLF). These groups all signed bilateral ceasefire agreements in the early 1990s; and the latter two are now Border Guard Forces³² under the Myanmar National Forces³³.

Since the ceasefire agreement in 2013 the state has been relatively peaceful with an improvement in government services, such as infrastructure, education and health. There has been a notable increase in the Union Government’s expenditure in the state. However, basic services, such as health services, continue to fall short of meeting the needs of citizens.³⁴ Health centres struggle to offer reliable and comprehensive primary level care.

There has been an increase of civil society organizations (CSOs) in Kayah State within the last three years. Some are diaspora Myanmar CSOs established in Thailand when Myanmar was closed. There has also been an increase in other government-based organizations (such as the Myanmar Women’s Affairs Federation) and faith-based organizations, which have become more active since the bilateral ceasefire. Newly established CSOs tend to be formed along ethnic group lines, and several were founded in Thailand. They define themselves in partisan terms in opposition to the previous Government, maintaining strong links to ethnic political parties and armed organizations. It is also noted that they are not registered organizations with the Government.

Limited information is available about gender-based violence in Kayah State.

³⁰ Kayah State Profile, UNHCR South East Information Management Unit, June 2014.

³¹ Interview with UNHCR representative in Loikaw, 2016.

³² They are armed actors which are supported by the State, often comprised of former armed groups/militias which are incorporated into the armed forces structure. Often at least one high ranking Myanmar military personnel is incorporated in to a leadership role within their ranks.

³³ The Carter Centre, *Kayah State Profile*, 2015.

³⁴ UNDP, *Local Governance Mapping Kayah State*, 2014.

The most comprehensive and recent report is the mapping and assessment conducted by Care Myanmar. This report, mapping and assessment of the response to gender-based violence in Kayah State identifies domestic violence, including intimate partner violence, sexual violence, harmful traditional practices, and cultural violence as common forms of GBV in Kayah State.³⁵ Multiple forms of violence occur in the same intimate relationship, and they are part of an on-going pattern rather than isolated incidents. According to the report a majority of sexual violence survivors are children and adolescents. Perpetrators are relatives, neighbours, and other villagers. Incestuous rapes are also documented in this report. The practice of bride price is also identified as a contributing factor to GBV, as it gives a sense of “ownership” of a wife by her husband.³⁶ Domestic violence and other types of GBV related to drug abuse are on the rise in Kayah State.³⁷

The prolonged insecurity in Kayah State has long-lasting consequences for gender relations and gender-based violence. Restricted mobility during the conflict has isolated women and increased their vulnerability. As a result they have less confidence, voice and decision-making power. Women use silence and submissiveness as a key coping mechanism with respect to the actions of both the military and ethnic armed organizations. This has contributed to perpetuating women’s subordinate position.³⁸ A number of GBV cases committed both during the conflict and since the ceasefire have been documented by women’s groups in the region.³⁹

1.1 Methodology

For Kayah State, data collection was mainly carried out in Loikaw city, as most stakeholders are located in the state capital. Focus group discussions were held in Demoso (a rural village). The assessment team completed the following activities:

- Twenty-seven key informant interviews (KIIs) were held with Government stakeholders, including the Department of Social Welfare, Myanmar’s Police Force, the Ministry of Health, the Attorney General’s Office, as well as non-government and civil society organizations. Interviews were also held with non-state parties and organizations affiliated with armed organizations, such as the Karenni National Progressive Party and the Civic Health and Development Network. More than one person was sometimes present in an interview. Each interview lasted between 45 and 90 minutes depending on the availability of the interviewees and the extent of the information they were able to provide. A few interviews were held with national level organization’s head offices in Yangon. Standard questions and an interview guide were used for most parts of the interviews.

³⁵ Care Myanmar, *Mapping and assessment of the response to gender based violence in Kayah State*, 2015.

³⁶ Ibid.

³⁷ Union of Karenni State Youth, *Echo of peace*, 2015.

³⁸ Agatha Ma and Kyoko Kusakabe, 2015, “Gender analysis of fear and mobility in the context of ethnic conflict in Kayah State, Myanmar”, *Singapore Journal of Tropical Geography*, Vol 36: 342-356.

³⁹ Karen Human Rights Group, *Truce or transition? Trends in human rights abuse and local response in Southeast Myanmar since the 2012 ceasefire*, 2014.

- Eight focus group discussions (FGDs) were held with a total of 92 participants. In a few groups, a local Kayah language speaker interpreted discussions into Myanmar for the assessment team member, and these discussions were subsequently translated into English.
- Two consultation meetings were held with a total of 29 participants from Government and civil society organization representatives for half a day for each group. The Government consultation also included a component of GBV orientation.
- Two trainings took place with a total of 86 participants. The main objective of the training was to orientate state duty bearers on basic GBV information, and their role in preventing and responding to GBV, and GBV guiding principles. Trainings were also used as a way to gain an understanding of current capacity, gaps in services, and opportunities to integrate GBV into the health and justice sectors.

1.2 Assessment Findings

The assessment found that the most prevalent cases of GBV in Kayah State are intimate partner violence among married couples, and sexual violence against young people and children. This finding largely confirms the findings of available literature on GBV issues in Kayah State. Traditional and customary practices, coupled with patriarchal and gender discriminatory attitudes, create an environment where GBV is condoned and normalized. This also contributes to obstacles survivors face to access justice and life-saving health and psychosocial counselling services.

A range of obstacles were identified, including a lack of appropriate services and information about how to access support, as well as transportation to services. Women's groups are providing response services to a varying degree, including emergency shelters, basic psychosocial counselling, case management, and referrals. More organizations are targeting GBV prevention through awareness-raising in schools and communities, and through male engagement initiatives. There is also a free legal service provided to GBV survivors by an NGO. On the state side, respondents articulated that the Government provided inadequate and limited GBV services in all sectors. However, there is a willingness from both state institutions and civil society organizations to receive GBV capacity development and to address the issues more effectively. Similarly, organizations affiliated with EAOs are motivated to integrate GBV into their work.

1.2.1 Common types of GBV

Throughout interviews and consultations, intimate partner violence and sexual violence against young people and children were identified consistently as the most common types of gender-based violence in Kayah State. More cases have been reported in the past few years as awareness-raising activities at the community level conducted by CSOs have increased demand for services and access to justice. Similarly, more cases have been reported in urban areas where communities have better access to information.

Table 1.1 indicates the number of GBV cases identified by key GBV responders in Kayah State, who were able to share the approximate number of cases that they have supported in 2015. The assessment team was not able to obtain exact disaggregated numbers by type of GBV. Reported numbers are very limited, and it is clearly just a fraction of the actual number of GBV incidents based on estimated prevalence rates and anecdotes discussed in interviews and focus group discussions. Under-reporting is a result of different factors, such as the capacity of duty bearers, and real and perceived barriers to access services and justice by GBV survivors.

As indicated in Table 1.1, there are differing levels of reporting for state and non-state organizations. The assessment team found that there was no systematic data collection of GBV cases by most organizations using standardized disaggregation by type of GBV. In addition, there were discrepancies in numbers between institutions. For instance, it would be expected that the numbers reported by the police should be higher than those reported by the Attorney General's Office, as police should investigate and refer those cases where there is sufficient evidence to prosecute. However, there is a significant difference. For areas under the control of EAOs, the assessment team was not able to obtain the number of reported GBV cases.⁴⁰

Table 1.1 Number of gender-based violence cases identified by key GBV responders

Service Providers	Number of Cases and Survivors in 2015	Types of Cases
Department of Social Welfare	0	
Myanmar Police, Loikaw District ⁴¹	4	<ul style="list-style-type: none"> Sexual violence
Attorney General District Law Office, Loikaw District	12	<ul style="list-style-type: none"> Sexual violence against adult women Two rapes of young girls Sexual harassment and assault
Local NGO	30	<ul style="list-style-type: none"> Sexual violence and intimate partner violence Cases involving minors
Local Women's Organization	50	<ul style="list-style-type: none"> Sexual violence including rape of children IPV (physical and emotional violence)

Intimate partner violence

Intimate partner violence (IPV) is prevalent across the state. When asked how common IPV is among married couples, respondents (including key informant interview and focus group discussion participants) estimated that 30 to 70 per cent of families are affected by IPV. Women experience regular incidents of IPV, including physical violence, psychological/verbal abuse, and marital rape. In a FGD with male community leaders, after denying the presence of domestic violence in the community, one participant stated: "Yes, of course we need to punish our wives when they do something wrong. We need to beat them

⁴⁰ In interviews, a few respondents said that there is a very low level of reporting in ethnic armed organization areas. In the past, they used to shoot perpetrators, and because of this legacy survivors are still reluctant to come forward.

⁴¹ Loikaw District is the more populated of the two districts in Kayah. It includes Loikaw, Demoso, Hpruso and Shadaw Townships

depending on what they have done.” In a FGD with adult women, a participant stated: “The husband usually accuses the wife of adultery or criticizes her for having relationships with other men. If the wife denies it or talks back to him, he beats or kicks her. It is worse when he gets drunk, and also beats his children.”

Both survivors and families consider IPV to be a normal part of family life. An adult female participant shared a story about her experience of violence at the hands of her husband; he threatened her with a knife. She put up with this for ten years. Her parents and community members only recently allowed her to go back to her family. Another woman stated: “My husband shouted very loudly in the early morning at around 4am when I refused to have sex with him. He asked me who I was having sex with, if I didn’t want to have sex with him. All my neighbours could hear him shouting.” Despite this, no cases of IPV were reported to the formal justice system as authorities do not consider IPV as a form of violence which requires support services.

Violence during “dates” was mentioned in one adolescent FGD. There was not an in-depth conversation on this issue, as the adolescent girls were reluctant to speak in more detail about their experiences. It was clear, however, that dating and having a boyfriend was a key part of their lives as represented in the depiction below of the life of a young person in Kayah. Interventions with children and young people to support safe and healthy relationships are critical.



Adolescent girls’ drawing from an FGD. Girls are depicted working (fetching water), studying, and having a boyfriend.

Sexual violence

Throughout key informant interviews and focus group discussions, sexual violence against young people and children, and in some cases even against children under ten, emerged as one of the main concerns in Kayah State. In most cases, as described by respondents, young girls are raped by family members, such as fathers, stepfathers or uncles, neighbours or other community members known to the survivor, and on rare occasions by an outsider. Cases often come to light only after the survivors become pregnant. According to an interview with a senior health staff, hospitals receive many patients who have attempted to induce an abortion. This is common in cases of rape, although it may also be related to the low rate of contraceptive use due to religious beliefs. Another health sector informant identified a high number of unsafe induced abortions as one of the major reasons for emergency referrals. This requires further investigation.

Sex based on a false promise of marriage is considered as sexual violence within the local context, and is punishable by the Myanmar penal code.⁴² This happens when a boy promises his girlfriend that they will get married. Later, after they have had sexual intercourse, he refuses to marry her. The girl is not able to get married if other people find out she has lost her virginity.

Other types of GBV

Social media, such as Facebook, has increased adolescent girl's exposure to potential GBV perpetrators. Perpetrators might use social media to identify adolescent girls. As telecommunication access improves in Kayah, this will be an emerging issue, evident already in Mon State (as discussed in Chapter 3 of this report).

Early marriage was not reported as an issue in most of Kayah, except on the border area with Thailand. The church sanctions marriage only over the age of 18. In some rare cases, young boys and girls leave their community to get married, or live together before officially getting married. No forced marriage or trafficking was mentioned in interviews and FGDs.

⁴² This is an offence punishable under section 417 of the Myanmar penal code of having sex with a girl on the false promise of marriage.

1.2.2 Vulnerable groups and risk factors

A range of factors were identified as increasing risk to gender-based violence in Kayah State as indicated in Table 1.2.

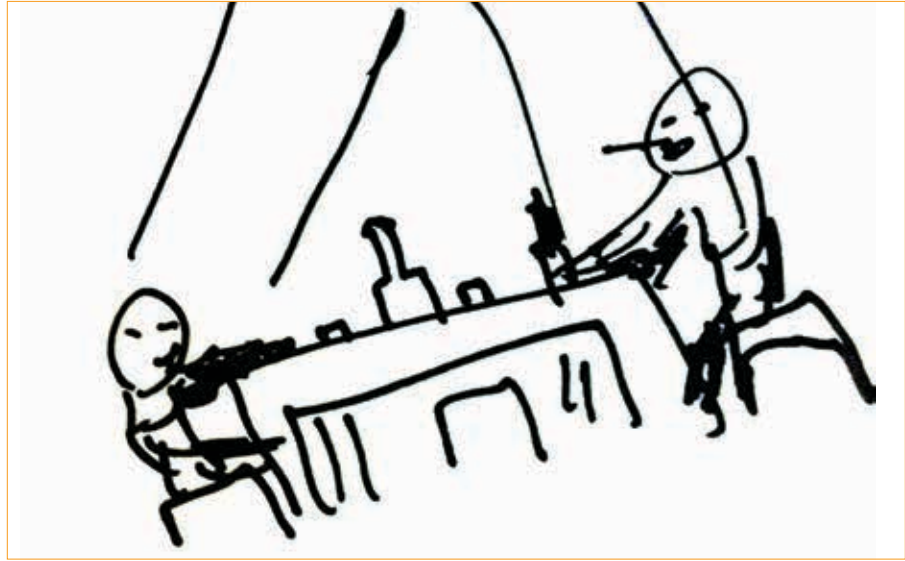
Table 1.2 Factors that increase risks to gender-based violence in Kayah State

Type of GBV	Geographical Area	Identified Risk Factors	Vulnerable Groups
Intimate Partner Violence	Across Kayah (particularly in rural areas)	<ul style="list-style-type: none"> Alcohol abuse Drug⁴³ abuse Lack of livelihood and income Low level of education 	<ul style="list-style-type: none"> Daily wage workers Families
Sexual Violence	Mawchi (Hpasawng Township)	<ul style="list-style-type: none"> Mining and construction Presence of migrant workers Drugs Armed groups 	<ul style="list-style-type: none"> Girls under 18
Sexual Violence	Bawlakhe Township	<ul style="list-style-type: none"> Presence of armed groups 	
Sexual Violence	Hpruso Township	<ul style="list-style-type: none"> Presence of armed groups 	
Sexual Violence	Mase Township	<ul style="list-style-type: none"> Drug abuse Border area 	
Sexual Violence	Loikaw Township	<ul style="list-style-type: none"> Construction projects 	
Early Marriage	Shadaw Township	<ul style="list-style-type: none"> Border 	

Alcohol abuse was quoted as a main contributing factor to domestic violence. Already abusive husbands’ violent behaviour escalates when they are drunk. A drug called “yaba” has become increasingly more available in the state in recent years. This was also identified as one of the risk factors for both IPV and sexual violence against minors, particularly in border areas where drugs are believed to be coming from Thailand.⁴⁴ In general, there is high substance abuse, and it appears to start at a young age. One respondent in an adult FGD stated: “Boys skip classes and smoke (cigarettes) together with friends. There are many young boys who smoke and drink alcohol.” This was also discussed in an adolescent male group.

⁴³ “Yaba” (crazy medicine) is an amphetamine-type stimulant (ATS) taken in a tablet format. “The use of ATS has become a significant health and social problem in East and Southeast Asia, in particular the use of methamphetamine, known as ‘yaba’ or ‘yama’, the most potent amphetamine derivative and most widely used substance in the region. ATS use is associated with a range of communicable diseases such as HIV, hepatitis B and C and sexually transmitted infections, tuberculosis, sleeplessness and mental health problems.” *Bouncing Back*, Transnational Institute. 2014.

⁴⁴ Although this may be a local perception, evidence indicates that Myanmar produces large quantities of methamphetamine. Presentation of World Drug Report 2016 at the launching event by the UN Office on Drugs and Crime (UNODC).



Adolescent boys in an FGD depict one of their daily activities as drinking and smoking.

Families who live in poverty, and who have limited livelihood options, were believed to experience GBV more frequently as couples tend to argue more. Low levels of education were also associated with increasing vulnerability to IPV.

In both urban and rural communities, men are often working away from home, leaving women and children behind. Similarly, men and women work in paddy fields in the hills away from their homes, leaving their children with neighbours or relatives. In a rural village where the assessment team held FGDs, the paddy fields were close to the village. However, most men go to Shan State to work in plank-wood production factories after they complete middle school. They stay there for four to five months at a time during the dry season. Women and children are left alone and are more vulnerable to GBV because they do not have the perceived protection of a man in the household.

Since the bilateral ceasefire agreement in 2013, the state has opened up to outside business, particularly mining and construction projects. There is a high influx of migrant workers from other parts of the country. In several discussions this was identified as a major factor contributing to a spike in the sexual abuse of minors and sex through false promises of marriage. However, respondents in the assessment were not able to substantiate this link with concrete GBV cases. Mawchi in Hpasawng Township was identified as a high-risk area due to migrants and the presence of an armed group.

Areas where armed forces were present were also identified as high-risk areas for incidents of sexual violence by a number of respondents. For instance, the training camp of the Myanmar National Armed Forces established in 2011 in Hpruso Township was associated with sexual violence cases. Similarly, in Bawlakhe, a sizeable presence of armed forces was viewed as threatening the security of women and girls. Women's groups cited some rape cases perpetrated by members and people related to the Myanmar National Armed Forces; while

one women's group discussed another rape case perpetrated by someone related to an ethnic political party.

Areas bordering Thailand were also seen as high risk, since there is drug trafficking and a fluid movement of people across the border. Early marriage was raised as a concern in Shadaw Township. Many of these areas are remote, and cases were only based on verbal accounts by civil society organizations that have worked in these areas. It was beyond the scope of the assessment to verify these claims, but this needs further investigation.

The traditional customary practice of cleansing ceremonies, which is discussed at length in the next section, could be deemed as a risk factor which exposes survivors to further harm and stigma. This aspect was not explored in depth in this assessment, and it requires further anthropological study.

In Kayah State, the underlying factor that increases vulnerability and contributes to the prevalence of GBV remains gender inequality and discrimination against women and girls.

1.2.3 GBV knowledge, attitudes and practice

There is a culture of silence around all types of GBV in communities. Survivors know that they will not receive justice, and will be judged on their character and behaviour. Many respondents told the assessment team that survivors do not disclose their case to anyone. A community leader stated: "The best course of action for a rape victim is to keep quiet, so no one will find out that she is not a virgin any more. Otherwise she can't get married." Another male leader said: "Only bad girls would report cases for money." When women were asked about reporting GBV cases, one FGD participant answered that survivors would not report cases and explained: "Women are afraid of being blamed for what has happened and that they would have to bear the cost [of a cleansing ceremony]."

The biggest challenge for GBV response and prevention in Kayah are prevailing customary practices. Most cases of GBV are resolved within a village by a village administrator or community leaders. In rural areas, the practice of a "cleansing ceremony"⁴⁵ is prevalent. This involves the survivor using either the compensation she receives, or her own money, to organize a feast for members of her village to "clean" the village. This is a unique ritual practice witnessed only in Kayah State. One incident was recounted in a key informant interview where the entire family of a rape survivor was banished from their village as they were deemed "unclean", and their house was set on fire. The family fled to a nearby forest without any belongings. This customary practice is very strong and persists in many communities. Even with NGO interventions to raise awareness, according to an NGO respondent, this ceremony is the first step to resolve a GBV case.

⁴⁵ The cleansing ceremony differs from village to village, and it is practiced regardless of religion. Sex outside of marriage including rape, sex before marriage and sleeping with sex workers is considered a serious offence for men, which requires a ceremony involving the larger community. Families also perform a ritual with a shaman for other types of incidents, such as a car accident or a theft in the house, as they see it as a sign of bad luck.

Village leaders pressure survivors and their families not to report cases to Government authorities. One representative of a women's group shared her experience of helping a survivor who had been sexually harassed.

A girl was molested by a boy. She was not satisfied with the compensation of 50,000 kyats determined by a villager leader and went public about the case. Similar cases had happened in the village before, but women never got justice. She wanted to take it further for the sake of other women. The village leader found out the CSOs were helping the survivor. He got angry and tried to exert pressure through many different organizations, including a major political party in the ethnic area. He also threatened to kill her for defaming their ethnic group. The political party intervened, and the leader stopped his threats and retracted his actions.

Another CSO representative stated: "Some paralegal women face threats from village leaders. These leaders think paralegal women are causing problems for what is normally a non-issue."

Both formal and informal village leaders assume the role of a mediator, and the cases often result in compensation, if any, ranging from 60,000 to 500,000 kyats. This is in addition to performing a cleansing ceremony. An NGO representative stated: "There are no consequences for perpetrators. In some communities, compensation for a rape is just one pig. If he has ten pigs, he can afford to rape ten times." Positive changes are being observed, particularly in urban areas where cleansing ceremonies are being discarded.

Rape survivors are often blamed for what has happened to them. If the perpetrator is married, the survivor is accused of sleeping with a married man. Community leaders and members first look at the character of a girl or woman before they make a judgment on GBV cases. If she is considered "loose", they will not deal with the case seriously. Most rape cases are not identified unless the survivor becomes pregnant, in which case it may be too late to report it or seek medical care.

Many KII respondents maintained that patriarchal and discriminatory attitudes towards gender roles are causes of GBV, and hindering factors to accessing justice and support services. They particularly attributed GBV to inheritance and marriage practices. Women do not inherit property in Kayah State, and families tend to neglect daughters as they will be married off. Husbands pay a bride price or pay for the cost of the wedding. One informant from a CSO explained in an interview: "A wife is considered as a purchase because the husband pays the bride price. The husband owns her. So, when the wife experiences domestic violence, she is expected to tolerate it. Her family will not accept her back. It is worse in a Roman Catholic community where they do not encourage couples to get divorced. There is one husband for one wife." A male community leader stated in a FGD: "A wife is worthless. We [men] pay for the whole thing, and she gets nothing." IPV is normalized, and is seen as a private family matter by the family, community and duty bearers. Women usually do not get any kind of support when they suffer from this type of violence.

1.2.4 GBV services per sector

The following case highlights some challenges and strengths of GBV response and coordination in Kayah State. While this is a rare case, which was reported and addressed through the formal justice system, it highlights some of the critical barriers that women and girls face.

One day, a mother overheard her seven-year old daughter telling her friend it hurt when she urinated. The mother spoke to her and found out that she had been raped five times over the past two months by a man who was a neighbour. The family of the girl managed to contact a women's group. The survivor was taken to Loikaw Hospital (she is from a remote township). She was then treated by a female gynaecologist who produced a medical report to certify signs of rape. The perpetrator was arrested. However, he was close to the local police, and the family feared for the security of their daughter: that the perpetrator might not be in police custody. She stayed in one of the safe houses run by another women's group for seven months, where she received psychosocial support. The case was brought to the township court. The survivor was assigned a state lawyer. This lawyer refused to allow interpretation for the girl into her ethnic language during the court hearing, insisting that her comprehension of Myanmar was good enough.

She was questioned on technical issues about the rape in Myanmar and she could not answer. She was terrified by the lawyer's questions and the way she was questioned. Due to the medical report and a statement by a witness (the survivor's friend), the perpetrator was sentenced to 11 years in jail. The girl now lives in a church away from her family, and her expenses are supported by a woman's organization.

There has been some effort to coordinate GBV responses in the state. A group called the GBV Coordination Group has regularly convened for a year. This group has a rotational chairship, and it is currently led by the Karenni National Women's Organization (KNWO). Membership encompasses women's organizations, civil society organizations, UNHCR, INGOs such as Care, the International Rescue Committee (IRC) and Action Aid, and Government stakeholders including the Department of Social Welfare, police, judges, the Attorney General's Office, and Loikaw Hospital social workers. Technical support has been provided mainly by Care and IRC. The group has not received any systematic GBV training but is currently developing a manual on GBV referrals in Kayah State.

In general, there is good coordination and referral among the CSOs in Kayah State. For example, non-GBV focused CSOs share contact information of women's groups in their awareness-raising activities in communities, and they work together. There are many networks, such as the Karenni State Civil Society Network and the Karenni State Youth Network, in which CSOs have membership across partisan and non-partisan lines. INGOs, UNHCR, and CSOs also participate in inter-agency meetings and sector-wide working groups,⁴⁶ one of which focuses on social protection. Several women's organizations have attempted to form a network of the Karenni Women's Organization since 2014. However, this has not been formalized, and a few major groups have dropped out of this initiative. The remaining members are still discussing how to operationalize this network. On the Government side, the DSW and Myanmar Women's Affairs Federation convene the Childs Right Committee, but according to CSOs this structure is not very effective in dealing with child sexual abuse cases.

⁴⁶ Other working groups are on education, health, livelihood and mine risk. They are chaired and co-chaired by different NGOs based on their programme focus.

GBV actors from both Government and non-state stakeholders are starting to work together. This is seen as a very positive and welcome step by CSOs. However, a certain level of animosity is still observed between Government and non-government stakeholders, and a lot more needs to be done to foster trust between them. For example, one Government officer told the assessment team: “NGOs and CSOs beef up the number of GBV cases, because they want to get funding from donors.” One senior Government official cautioned the assessment team to use judgment when non-registered and “illegal” organizations talked about GBV cases. The relationship between the Government and partisan CSOs is not always stable, and is further exacerbated when Government representatives are transferred. CSOs are hopeful that the new Government will bring a positive change in their operational space.

The assessment mapped 22 organizations and a network working in key sectors of GBV response and prevention in Kayah State, namely health, psychosocial support and rehabilitation, access to justice and protection, and a further 11 groups and networks which operate across the state to support different population groups. Each sector has varying levels of capacity to respond to, and prevent GBV, as well as to mainstream GBV into their current programmes and services.

Health

The Government health system response to GBV is limited. The Ministry of Health has different types of medical facilities. They have a tertiary level hospital in Loikaw, township hospitals, station hospitals, rural health centres, and sub-centres that cover the whole state. Government health staff have not been trained on the clinical management of rape or GBV. Loikaw Hospital is the best-staffed facility in Kayah State, with two female obstetricians/gynaecologists, four social workers,⁴⁷ and one psychiatrist. According to a senior official of the Health Department stationed at Loikaw Hospital, there is no specific protocol for the treatment of rape survivors. Rape cases are not recorded as a separate category for internal reporting in hospitals, and a senior official could not report the number of cases saying: “Rape cases are very rare in Kayah.” This statement is contrary to what other stakeholders reported. There is currently one rape case being heard at court where hospital staff were asked to testify. Emergency contraceptives are not available in any government health facility and can be purchased in pharmacies without a prescription only in Loikaw.⁴⁸ Similarly, out of the entire government health system throughout the state, post exposure prophylaxis (PEP) is only available in Loikaw Hospital.⁴⁹

In theory, any doctor on duty can collect forensic evidence when a rape case is brought to their facility. The evidence is analysed locally or sent to a medical

⁴⁷ Social workers’ main responsibilities are to support poor patients and their families to cover medical expenses. They also provide HIV testing and counselling services.

⁴⁸ One box with two pills costs 850 kyats. The currently available brand only has instructions in English, and pharmacists provide information about dosage and side effects only when clients ask them. According to one pharmacist many married women and women in their early 20s come to buy the pills.

⁴⁹ It was explained that Loikaw Hospital has HIV/AIDS related services, and this is why PEP is only available in this facility and is administered by health staff.

laboratory⁵⁰ in Nay Pyi Taw. At the township level, the first point of contact for GBV survivors is, in most cases, township medical officers (TMOs). However, in reality, it is difficult for survivors to access services. Most TMOs are men, and there are no dedicated staff to deal with GBV cases even at Loikaw Hospital. Rural health centres are operated by a health assistant and a lady health visitor, and they can only provide first aid care for rape cases. Sub-centres have a midwife. All the midwives are local Kayah women, and most of the lady health visitors are also local. The assessment team was not able to receive a clear answer from key health respondents on whether a rape survivor can be treated at township hospitals or needs to be referred to Loikaw Hospital. Based on discussions with GBV orientation participants, health care providers enforce mandatory reporting, and all except one TMO were not aware of the Emergency Care and Treatment Law. Health care providers were receptive to the GBV orientation. Although they had not previously exercised a survivor-centred approach to GBV, participants found the guiding principles and the law useful.

Women's group representatives maintained that health staff are not sensitive to the needs of survivors. In some instances, doctors refuse to produce a medical report because they do not want to testify in court. When physical evidence cannot be documented, the case is assumed to be an attempted rape, regardless of the survivor's account.

There is a parallel health system in areas where EAOs have more influence than the Government. Non-state health stakeholders (i.e., health care organizations from ethnic armed organizations) provide medical services through mobile clinics and backpacker teams. Civic Health and Development Network (CHDN) is an umbrella organization for these medical service providers. The network is supported by six ethnic armed organizations (KNPP, KNPLF, KNLP, Karenni National Peace Development Party, Karenni National Solidarity Organization, and KNG). According to a CHDN representative, they have around 300 staff with 3 offices in Loikaw, Hpasawng, and Hpruso. They have 20 mobile clinics across the state with 48 mobile backpacker teams.⁵¹ They are not recognized by the Government, but are trained in Thai-Myanmar border areas. They reportedly provide a range of health services in the community including child delivery.

Some mobile teams have post rape treatment kits, but this is not consistent as different support comes from different armed groups. For instance, it was reported that the teams supported by KNPP are better equipped. Serious cases, such as rape or severe injury, are referred to Loikaw Hospital. They have a general emergency referral guideline, but this does not address GBV cases specifically. They have good coordination with Loikaw Hospital. A CHDN representative was not aware of any reported rape cases. Some mobile health providers have been trained previously by the IRC on the clinical management of rape, but the CHDN was not able to validate this information.

⁵⁰ The medical laboratory does not have the technology to conduct a DNA test. Rather, they test for the presence of semen.

⁵¹ The backpacker teams serve remote areas which mobile clinics cannot reach. Each team consists of two medical officers (medics) and a trained traditional birth attendant, as well as some support staff.

The IRC, the International Organization for Migration (IOM), and CHDN are implementing a maternal, newborn and child health project funded by the 3MDG Fund. IOM supports the Government health facilities with a team of 44 staff in 4 sub-offices covering Loikaw, Demoso, Shadaw, and Bawlakhe Townships. CHDN provides services through their usual network, and refer patients to Government health facilities in severe cases. The project supports emergency referrals and training of midwives and community health workers, and has a wide coverage across the entire state. IOM staff have received some training on gender, equity and inclusion from the IRC, which is responsible for the project's accountability. GBV is not part of the project's focus, and both IOM and CHDN staff and members have not received GBV training.

There is no affordable and reliable transportation in the state, despite its small size. Recently, the road connecting township capitals has improved, and the furthest township of Mese can be reached within five hours from Loikaw. However, it is hard to access other areas in townships, and some villages can only be reached on foot. Kayah State is predominantly hilly on the south and east sides. Often transportation from villages to a township capital, where Government services are available, is by motorbike or tractor.

Psychosocial

Of all the necessary services required for survivors of GBV, the most capacity was found in the provision of psychosocial support and rehabilitation. That said, strong capacity building is needed to provide more focused and specialized counselling and case management services. Extensive GBV work has been carried out by women's organizations, which are often volunteer-based and operating on small project and activity-based funding. These women's groups have received a one-off training on GBV from a few organizations, such as IRC, the Women League of Burma, and other Thai-based organizations. The training has been on issues such as case management, counselling, gender, access to justice, CEDAW, and UNSCR 1325.

Karenni National Women's Organization (KNWO) is technically and financially supported by the IRC to provide GBV response and prevention services covering all seven townships in Kayah. They are the most established group, and have the capacity to work on case management and referral in Kayah. They are currently chairing the GBV Coordination Group, and spearheading the process of drafting a referral manual. They have a safe house in Loikaw where survivors can stay for up to six months and receive psychosocial support. This is the only organization in Kayah identified by the assessment team that has professional capacity for counselling. They also organize therapeutic group activities, such as gardening, and discussions. They have provided intensive training of trainers to both men and women at the community level. Education and awareness-raising sessions are conducted by the KNWO in villages, and this is how most cases are referred to them.

Women Safe House Group, a smaller women's group, operates another safe house in Loikaw. They offer similar services to GBV survivors, and have accommodated, on average, 20 to 30 women and girls per year since they

opened in 2013. Their shelter can house up to five survivors at a time, and their four staff live in the same building, which also functions as their office. They are well aware of the need to have a separate and confidential location for the shelter. However, they are unable to do so due to lack of resources.

There are other women's groups, such as the Kayan Women's Organization (KYWO) and Future Women Association, which are responding to GBV cases. These groups mainly focus on referral, awareness-raising, and some types of psychosocial counselling.

Counselling is defined in broad terms by most organizations. This includes a one-time talk session, and not necessarily professional and continuous psychosocial and counselling support. Psychological counselling was often confused with psychiatric treatment, and many KII and consultation participants were of the opinion that the presence of a psychiatrist at Loikaw Hospital was a strength for GBV response.

These women's groups handle challenging cases, such as child rape, which require specialized care. However, women's groups do not have a technical person who can advise them on case management or coach them. One group identified staff self-care as a concern. In an interview with one women's organization, it was observed that they do not fully understand the "do no harm" principle. They said that they invite perpetrators to a counselling session in order to "hear both sides of the story."

Access to justice was emphasized as the main concern by different women's organizations as opposed to life-saving health and psychosocial care. This focus may undermine the survivor-centred approach. For example, a very well-intentioned organization tried to force the parents of a minor who was raped to report the case to the police.

While immediate support is provided to GBV survivors by these organizations, there is no long-term rehabilitation programme, such as income generation or vocational training. They often turn to churches to provide long-term housing for child survivors.

Care Myanmar has recently received funding to establish a GBV response programme in Kayah State. They plan to support local organizations with case management, referral, and psychosocial services. They will work with KNWO, KYWO, Community Youth Centre, Future Women Association, and Kayah State Youth Network. Care's office in Loikaw will have four national staff to support this programme starting in late 2016.

IRC has supported women's groups from the Thai side of the border over the years. Their current GBV project in Kayah State is supported by a technical expert in the local Loikaw Office. They are gradually shifting their support to KNWO to be more technical in nature, as KNWO is receiving financial support from other donors. IRC is starting a more comprehensive GBV prevention programme encompassing communication skills and relationship building.

In the Government system, the Department of Social Welfare (DSW) has a mandate to support women's issues including gender-based violence. However, their capacity to respond to GBV is very limited, and reportedly they did not receive any GBV cases in 2015. The DSW office in Loikaw has two case managers with no gender or GBV training. They also have one caseworker stationed in Bawlakhe Township in the so-called "One Stop Shop", where state services are integrated. These caseworkers handle a number of portfolios encompassing children, the elderly, and people living with disabilities across the entire state. The DSW office has one staff trained on psychosocial counselling (one month training in Singapore), with another trained in gender equality. However, they are not mobilized to work on GBV cases, as they have other priorities.

Myanmar Women's Affairs Federation (MWAFF)⁵² in Kayah State works on preventing and responding to GBV and human trafficking. They organize educational talks in communities, and cooperate with legal officers and the police. They receive letters from survivors requesting their support and involvement in their cases. MWAFF selects cases from these letters, and provides counselling or legal support. They reported to the assessment team that they received 25 such letters in 2015. They have an office room in the General Administration Department Office, and they use this office as a counselling room, which is not a survivor-friendly space, as most survivors would not feel comfortable in this space.⁵³

Legal

In contrast to many key informant accounts about the prevalence of GBV, very few cases pass through the formal justice system. According to a respondent from the District Law Office under the Office of the Union Attorney General (OAG), 13 cases were brought to the courts (township courts and district courts)⁵⁴ in 2015. All of the rape cases have resulted in prosecution with sentences of seven to ten years in jail, and other less severe offences, such as sexual harassment, have resulted in a one year jail sentence. According to police representatives, even though there was a delay in reporting by the survivors, police were able to collect enough physical evidence and witnesses to enable prosecution.

Police, the OGA, and hospitals coordinate with one another to prosecute perpetrators. The OGA also joins other organizations including Care and the Myanmar Women's Affairs Federation to give educational talks at schools as a GBV prevention initiative. The OGA representative shared that one girl kept her underwear after being raped because she heard about the importance of preserving evidence in an awareness-raising session.

Survivors are supported by a law officer (lawyer) free of charge during the trial process. In Kayah State there are 13 law officers, and they are all currently men. They have attended some GBV awareness sessions organised by Care.

⁵² MWAFF is a Government affiliated organization, where executive members are spouses of high ranking officials, and they have offices in states and regions. Their network extends to village and to ward levels.

⁵³ The General Administration Department (GAD) was responsible for surveillance during the authoritarian regimes.

⁵⁴ Township courts can give a sentence of up to seven years, and district courts up to 10 and 20 years. Statutory rape cases (under the age of 18 under current Myanmar law) are tried in district courts to ensure a severer punishment.

According to a key informant in the legal sector, on average, cases last around six months⁵⁵ from the time of reporting until a verdict is reached, unless the survivor or the accused makes an appeal to the higher-level courts.

Cases involving Myanmar Armed Forces personnel are tried in the military court. However, the process is opaque. A few cases quoted by KII respondents were never tried in the court. This supports an environment of impunity for cases involving the military and ethnic armed organizations due to a fear of retaliation by perpetrators. It was also stated by respondents that influential and wealthy families avoid prosecution as they can afford to pay compensation or a bribe to the justice system. Corruption was identified as an issue linked to the impunity of perpetrators.

Law Home is the only known legal aid service provider in Kayah State that responds to GBV cases. They supported a number of cases in 2015, a few of which resulted in the prosecution of perpetrators. It is a small organization with only one lawyer specializing in women's issues. They receive referrals from women's groups and NGOs. Their caseload seems to be more than they can handle in terms of both financial and human resource capacity.

Legal support is also provided through a paralegal approach. Law Home has 30 paralegals trained on GBV issues across the state. Action Aid works with a Kayah-based NGO, Local Development Network, on a small GBV project in ten villages in Demoso and Hpruso. Ten female paralegals and ten male role models engage with communities to raise awareness about GBV issues. The paralegals also provide basic psychosocial counselling and referrals to other organizations. They are trained on case documentation and basic legal literacy. The first and largest obstacle in accessing justice lies in the initial reporting. As discussed in the previous section, survivors are pressured to settle cases in the village without involving Government authorities and CSOs. Communities, women and girls lack basic legal awareness about the criminality of GBV, and about where and how to report cases. There is a certain level of misconception about the actual length and cost of the legal process. Most survivors prefer to receive financial compensation rather than going through the formal justice system due to a lack of knowledge, mistrust in the system, and intimidation by perpetrators in some cases.

Village administrators or village advisors (elders or other respected individuals) mediate GBV cases with or without charging a fee. Compensation is the most common remedy for rape, and the amount varies according to different factors. Compensation ranges from 60,000 to 500,000 kyats. If the survivor knew the laws and that GBV cases take place at a private hearing, she could negotiate a better settlement with the perpetrator. In urban areas where people have better access to information, the amount of compensation is increasing. Other

⁵⁵ According to a respondent in the legal sector this is how a GBV case passes through the system. The first incident report is filed with the police which triggers an investigation, including collecting forensic and other evidence and finding witnesses. If a survivor is able to identify the alleged perpetrator, he will be arrested and kept in custody for one month. The first court hearing takes place one week after the initial one month period expires. By then the alleged perpetrator will have been transferred to a prison. Due to the nature of the crime, the hearing is organized by video. The survivor needs to appear in the court only once during the whole trial period. The trial is prolonged if there are many witnesses.

likely verdicts given by community leaders include banishing (expulsion) the perpetrator from the village or, in the case of domestic violence, making him sign an agreement not to repeat the act. Marrying the perpetrator is seen as another option. For women and girls with limited livelihood options, these inadequate remedies are sometimes the only way to survive and remain in their village.

The current legal process, both formal and traditional systems, does not serve to hold perpetrators accountable, thereby perpetuating an environment of impunity in which GBV remains a silent epidemic.

Protection

Myanmar Police has ten police stations in the state, and each police station has at least one female officer. According to one district police station there is usually one domestic violence case per day and they handled four rape cases in 2015. These cases resulted in seven and nine year jail sentences respectively, while two cases are still pending in court. It is difficult to ensure privacy and sensitivity to survivor's needs. In police stations there are normally three officers who can interview a survivor and open a file, and currently they are all men. Furthermore, they do not have a separate room where a survivor can be interviewed. Depending on the severity of the offence, an alleged perpetrator can be in police custody or bailed with two guarantors. According to a senior police officer, they do not require mandatory reporting before medical treatment of a survivor. That said, the police officers also reported that they attend health facilities to process the case simultaneously if a survivor needs medical attention before processing the official report. This is important, as survivors often prefer to access health services but do not necessarily want to report a GBV case to the police for a number of reasons. These include, fear of reprisal, stigma and mistrust in the system. Although medical treatment is supposed to be prioritized, according to the needs of the respondent, not one of the 50 police officers who attended the UNFPA GBV Training was aware of the 2014 Emergency Care and Treatment Law. They indicated a continued practice of mandatory reporting.

However, there has been a positive development. The Myanmar Police are trying to recruit more female officers, and in 2016 they recruited six local women and five local men from Kayah. Their intention is to assign them to stations in Kayah after they complete training, so they can serve in the local language.

CARE Myanmar has implemented a community-based women's empowerment programme covering 44 villages in Demoso. They have peer groups and 25 GBV volunteers at the community level. They raise awareness on gender equality and GBV issues, and they also advocate for GBV cases. They advocate mainly on domestic violence cases, which are otherwise ignored by village authorities. Where awareness about GBV and its criminality is raised, there is less IPV according to organizations implementing this type of community mobilization initiative.

There are a few organizations that work on child protection, including Metta Development Foundation, World Vision, and Yangon-Kayah Baptist Women's Organization. They mainly focus on awareness-raising and material support for basic needs; responding to child sexual abuse is not a key component of their programmes.

Other

Many civil society organizations in Kayah State focus on peacebuilding activities as this area of work is driven by donors. A few organizations implement women, peace, and security-related projects, which mainly target women's participation in local peace processes. Addressing GBV, although an integral component of the women, peace and security agenda, does not seem to be a strong priority. Organizations such as Shalom and the Union of Karenni State Youth who are working on a peacebuilding project, document cases related to human rights violations and peace process issues. Gender equality and GBV are integrated as cross-cutting issues in their work. They have good coordination with women's organizations, and they refer cases to them when they encounter survivors through their work.

A few other international organizations including the Danish Refugee Council, Mercy Corps, and Pact Myanmar are also present in Kayah, and they predominantly work to improve the livelihoods of local communities. They were not interviewed for this assessment.

Activities of CSOs tend to focus on Loikaw, Demoso and Hpruso as these areas are easier to access. Due to security and transportation problems, CSOs have not been able to work in remote areas.

1.3 Recommendations

Gender-based violence is undoubtedly a serious concern in Kayah State. There is strong evidence of a high GBV prevalence rate. Overall, there are many opportunities to launch a GBV response and prevention programme in Kayah State. There are existing structures and programmes where support and capacity development interventions could go a long way to ensure safe and confidential services for GBV survivors. Recommended areas for interventions include engaging Government stakeholders, improving the health system response to GBV, and expanding psychosocial support. Lessons can be drawn from current GBV programming in the country. Certain risk factors need further investigation, such as drug use and traditional customary practices, to better understand the local context and its links with GBV.

Table 1.3 Recommended actions to improve GBV response and prevention programmes

Coordination
UN agencies and INGOs can play an intermediate role between Government stakeholders and civil society organizations to promote coordination and referral.
Engagement with the GBV coordination group should begin immediately to provide coordination, technical assistance, and capacity development.
There should be coordination with the main GBV technical and financial supporters of local CSOs in particular, as well as CARE Myanmar and the International Rescue Committee, on GBV programming.
Psychosocial Support
Partnerships should be established with local organizations to expand the coverage of psychosocial and case management support for women and girls, focusing on IPV and sexual violence beyond Loikaw. This should be through both individual and group support, combined with support for referral to other services, and referral funds to cover the costs of transportation and other related costs. Services should be made available locally, ideally in all seven townships including remote areas, in coordination with other GBV service providers. The model of the Women and Girls Centre could work in the Kayah context to offer case management, and individual and group psychosocial support.
Supporting child survivors, as well as staff self-care, should be key components in capacity development.
GBV programmes in Kayah should also include the southern part of Shan State (namely Pekon, Pin Laung) and Then Taun Gyi (Kayin State), as these areas have strong ethnic affiliations with Kayah. CSOs include these in their programme target areas.
Health Sector Response
Health organizations, including the IOM, state health facilities, and the Civic Health Development Network, should be supported as they have comprehensive coverage across the state. GBV orientation and clinical management of rape training should be provided to their staff. The training should focus on the role of the health sector specified in the Emergency Care and Treatment Law for state health care providers.
Reproductive commodities (such as contraceptives) and post rape treatment kits should be provided to health care providers, as well as training to equip them with the skills to utilize these commodities.
Health staff should be trained on psychological first aid as they can be the first point of contact for GBV survivors.
Village health visitors and midwives should be engaged to raise awareness on GBV, as they are mainly from local communities. Awareness-raising around GBV should target both men and women and include available services and the basics of GBV. These health care workers can be a point of referral. The 3MDG Fund project of the IOM, the IRC and CHDN consortium supports emergency referral which can be applied to rape cases.
Government Engagement and Capacity Development
Small women's organizations could benefit from organizational development support, including proposal writing skills.
Advocacy should be conducted at both the national and state level with relevant ministries to hire local and female health care providers, and make interpretation services available.

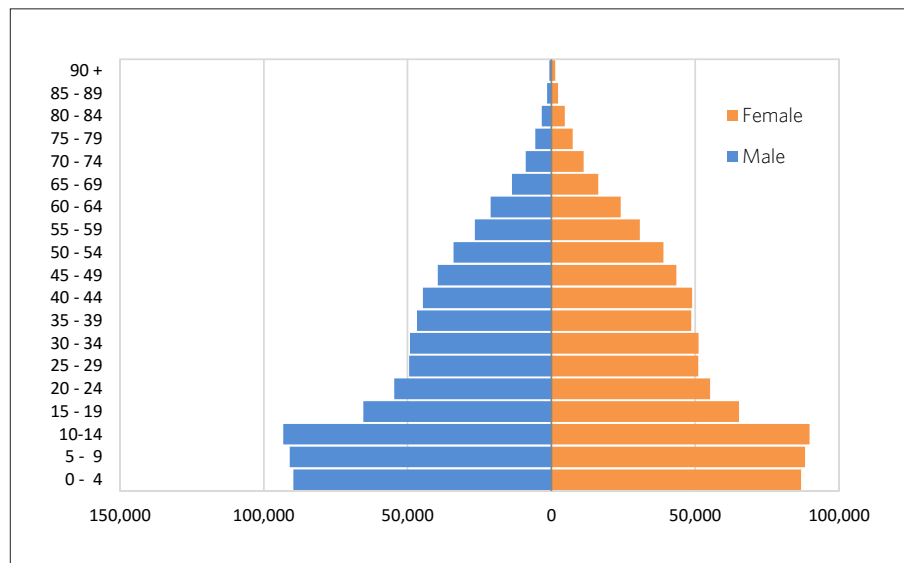
Programme Approach
Due to entrenched local practices, the GBV response in Kayah should take a longer-term development approach rather than a humanitarian response. Intensive and sustained community-based programming is required to address gender discriminatory attitudes and to raise awareness about GBV, particularly targeting community gate-keepers, such as village/tract and village/ward administrators and traditional village advisors.
There should be coordination with community level women’s empowerment groups to target women’s vulnerability and lack of economic independence. Linkages with organizations specializing in livelihood programmes should be explored.
Advocacy for men to engage in GBV initiatives is essential from the community to the state level, to address both the root causes of GBV, and patriarchal and discriminatory attitudes towards gender roles.
Prevention initiatives should address substance abuse issues in the community. Young people, especially, should be engaged in substance abuse prevention where GBV should be integrated.
Community and male engagement should be well planned as men, in particular, are away from their villages for extended periods of time.
Strict adherence to “do no harm principles” and a survivor-centred approach should be promoted in all sectors.
As peace-related initiatives may be more of a priority for some donors, GBV prevention and response activities should be positioned in the overall agenda of women, peace, and security, not only for conflict-related sexual violence but also for intimate partner violence and women’s increased vulnerability in post conflict settings. This is an important issue for women in addition to supporting women’s participation in the peace process.
Areas of Further Study
Anthropological studies are needed to gain a deeper understanding of traditional customary practices, particularly the “cleansing ceremony”. The reasons behind this practice should be identified as well as its impact on GBV survivors, and how to reduce harm while being sensitive to the local culture.
More study is needed to understand drug and alcohol abuse within the local context and ways in which GBV prevention and response programming can be integrated within rehabilitation programmes.

2

Kayin State Findings

Kayin State is bordered by Thailand to the east, Mon State and Bago Region to the west, and Kayah and Shan States to the north. Kayin State has a population of 1,574,079 people across four districts and seven townships (Hpa'an, Hlaingbwe, Hpapun, Thandaunggyi, Myawaddy, Kawkareik, and Kyain Seikgyi). Nearly 51 per cent of the population are female and 49.3 per cent are male. Seventy-eight per cent of the population live in rural areas.

Figure 2. Population pyramid of Kayin State*



* Source: Myanmar Population and Housing Census, 2014.

Kayin State’s population pyramid has a broad base. A comparison with the 1983 census indicates an increase in birth rates. There is a decline in the working age population (15-64 years), most likely due to migration to other parts of the country or abroad. Kayin State has the second highest number of people in the country migrating internationally, according to the 2014 Census.

The average household size is 4.7 across the state. One quarter of households are headed by a female. The literacy rate is among the lowest in Myanmar at 78 per cent for men and 70.9 per cent for women, respectively. Disability prevalence is 6.6 per cent; this is approximately 0.9 per cent higher than the Union average. Seeing, walking, and mental or intellectual disabilities are the most common types of disabilities. It is also relevant to note that 40 per cent of the population of Kayin State does not have access to any of the following communication amenities: radio, television, landline phone, mobile phone, computer and internet.⁵⁶

The state is inhabited primarily by the Karen people, a broad umbrella identity

⁵⁶ Department of Population, Ministry of Immigration and Population, “The 2014 Myanmar Population and Housing Census, Kayin State” Census Report Volume 3-C, May 2015.

that includes a multiplicity of ethnic groups such as the Sgaw, Pwo, and Pao, many with unique cultures and distinct languages. While the vast majority of Kayin State is comprised of Karen people, some sources suggest the majority of Karen may live outside of Kayin State, including elsewhere in south-eastern Myanmar and the central Delta region, at least until 2012 when a bilateral ceasefire was signed.⁵⁷ The Government of Myanmar and the Karen National Union (KNU) both committed to a bilateral ceasefire agreement in January 2012. Since then, the relationship between the Myanmar Government and Karen Armed Groups has improved, but trust is still being built.

The KNU is a political organization with an armed wing, the Karen National Liberation Army (KNLA) which represents the Karen people of Myanmar. It operates in mountainous eastern Myanmar, and has underground networks in other areas of Myanmar where Karen people live as a minority group. The KNLA and Government forces have been engaged in armed conflict intermittently since 1949. The aim of the KNU at first was independence, but since 1976 they have called for a federal system with more autonomy for Karen State.

Alongside the Kayin State Government, the Karen National Union continues to play a significant role in public affairs, most notably through the establishment and administration of alternative health and education services for Karen people in parallel to government provided services.⁵⁸ On most social development indicators, with the exception of water and sanitation, Kayin State fares comparably to, if not better than, the Union average according to the 2014 Census.

Kayin State has strong and well-organized civil society organizations (CSOs). There is a strong network, the Karen Peace and Support Network, made up of 28 CSOs from state and border regions. The network is working to advance human rights, land use, environmental protection, the peace process, and the provision of medical and social services, both in Government and EAO controlled areas.

There is limited literature available specifically addressing GBV in Kayin State. One study conducted by the NGO, Karen Women Organisation, “Salt in the Wound”, addresses legal and justice outcomes and sexual and gender-based violence cases in Kayin refugee camps on the Thai-Myanmar border. This study examined outcomes of 289 cases of GBV, of which 72 per cent were physical, 21 per cent were sexual and 7 per cent were other types of violence. The broad conclusion was that the justice system provided an inadequate outcome for survivors of GBV in 80 per cent of cases in six of the seven camps in the study.⁵⁹

Convergence activities in both the health and education sectors are underway in Kayin State, and have been for some considerable time. Some examples include training of auxiliary midwives jointly organized by the Back Pack Health Worker Team, based in Mae Sot, Thailand, a local development

⁵⁷ “*Kayin State Profile*” UNHCR Myanmar 2014.

⁵⁸ UNICEF “*Kayin State: A Snap Shot of Child wellbeing*”

⁵⁹ “*Salt in the wound*” Karen Women Organisation, 2011-2013 <https://karenwomen.org/2015/11/24/kwo-new-report-salt-in-the-wound/>

organization, Phlon Education Development Unit, and Kayin State Township Health Authorities, as well as joint service delivery during the floods of 2013⁶⁰.

2.1 Methodology

In consultation with the Kayin State Government, it was agreed that the GBV assessment and mapping exercise would be conducted in Hpa'an and Kawkareik Townships. For the Kayin State Study, the following activities were conducted:

- Twenty interviews were held with service providers. Seven were interviews with one person; the other 13 had more than 1 person in a single interview.
- Nine focus group discussions (FGDs) were held with a total of 105 participants. The FGDs targeted groups from Hpa'an Townships and Kawkareik city. Additionally, one more adolescent girl's FGD was spontaneously conducted with the Karen Department of Health and Welfare (KDHW) affiliated members.
- Two trainings took place, with a total of 78 participants, with Myanmar Police Force (MPF) and state health providers.
- One consultation meeting was held with a total of 32 participants.

As per a Government request, an official from the Department of Social Welfare accompanied the assessment team and participated in every interview. Interviewees were assured that no names would be included in the report.

The assessment team stressed the need for reporting on GBV as they understood GBV to mean locally, noting there was no right or wrong answer and that responses would not be judged. Nonetheless, and following the UNFPA Minimum Standards for Prevention and Response to GBV in emergencies,⁶¹ feedback was provided throughout the process at every opportunity to promote positive gender and social norms.

Initially, the team planned to conduct two consultations, one with Government and one with CSOs. However, at the Government's request, only one combined consultation was conducted. The Government suggested that it was a good opportunity to bring all actors together, and to get to know who does what and where. This was in spite of a concern that this would curtail CSOs from speaking freely. It was observed that the consultation occurred in an open atmosphere and people spoke frankly. Once the consultation was over, informal interviews were conducted with national and international NGOs.

2.2 Assessment Findings

The assessment shows GBV is rampant in Kayin, particularly in the form of intimate partner violence (IPV) and sexual violence against girls. GBV cases are under-reported partly because IPV and domestic violence are normalized and seen as a common practice. Other factors, the long-lasting conflict, feelings of guilt or shame, and the importance of virginity also contribute to under-reporting.

⁶⁰ Christian Aid "Working Towards Health Convergence: Case Study" October 2014.

⁶¹ UNFPA. November 2015.

GBV services for survivors are not in place or are weak, and where they are present they are also based on traditional harmful practices and entrenched gender roles. Survivors may seek mediation or counselling support but will not file a case against the perpetrator. To put an end to the abuse the survivor may seek a divorce, but divorce is not accepted in communities, which further marginalizes survivors. The majority of GBV cases are addressed through informal village-based justice processes. The village-based informal justice system lacks gender sensitivity and is based on unequal gender roles and harmful traditional practices. In addition to cultural norms and beliefs, lengthy legal processes, a lack of knowledge of, and trust in the formal justice system, and related expenses prevent survivors from filing cases against perpetrators.

The women's civil society organizations in Kayin State are well organized and politically active. Some GBV services are provided by several organizations, but there is a lack of coordination between these organizations. The Karen Women Organisation is the strongest organization working on protection for women, with a focus on EAO controlled areas and refugee camps in Thailand. There is a need to reinforce coordination and networking among CSOs and Government departments. There are also a few international organizations present, including the IRC.

There is no properly established referral system. The existing structures need to be developed and enhanced significantly to provide support for survivors. There are strong national and state NGOs which could support a referral network which would potentially be supported by the Government, which was positive about the undertaking of this GBV assessment and welcomed further programming.

2.2.1 Common types of GBV

Gender-based violence is a common practice in Kayin State. The assessment team tried to ascertain numbers of reported GBV cases in 2015⁶² while interviewing key GBV stakeholders. Despite the reported prevalence of GBV cases, the number of official reports is comparatively low. This suggests the under-utilization of services and under-reporting more broadly for the reasons outlined previously.

Table 2.1 Number of reported GBV cases by type

	Total Reported GBV Cases	IPV	Trafficking	Sexual Violence (including rape and attempted rape)
Department of Social Welfare	5	0		5 (All children & young people)
Myanmar Police Force	58	0	4	54 (Majority children & young people)
Myanmar Women Affairs Federation	37	35	-	2 (All children & young people)
INGO	3	-	-	3 (All children & young people)
NGO	5		3	2 (All children & young people)
NGO	7			7 (All children & young people)

⁶² The total number of cases cannot be estimated by adding individual organization's reports, as there may be duplication as well as under-reporting.

Intimate partner violence

Intimate partner violence (IPV) is the most common form of GBV. It happens both within married and among non-married couples. From the FGDs, two groups of women and two groups of girls said that approximately 94 per cent of them had suffered or witnessed at least one incidence of intimate partner physical violence. For some of these women and girls, IPV was a common occurrence. The most common type of IPV is psychological/verbal abuse, followed by physical violence.

Within communities, IPV is considered to be a private matter that should be dealt with at home, internally, unless the violence is very severe. When the assessment team asked what severe violence meant the common response was a “severe beating.” When more specifics were requested, the response was “a black eye would not be a severe beating.”

IPV is integrated in to the day-to-day life of people; everybody knows it exists but there are no reported cases to the police. Survivors of IPV might seek psychosocial support or counselling, but generally they do not want to file a case against the perpetrators. There are a number of reasons that survivors do not report an IPV case to police authorities: economic dependency; fear of stigma (e.g., being criticized by the community as “couple matters are private”); fear of retaliation; the length of the legal process and lack of funding; normalization of the abuse; mistrust in the authorities; and emotional dependence, among others.

Generally, the village administrator or village leader, sometimes with the support of the village elders or women affair’s group, mediate IPV cases in the village. One example was shared: “A man suspected his wife was having a love affair; he got really angry and beat her up repeatedly. The survivor and her children could not stand it any longer and left the house. After negotiations by village elders and women’s groups, the survivor returned to the house.”

In some villages religious authorities can also mediate and negotiate. If the case “cannot be solved at the village level”, the village administrator can share the information with the police. In 2015, the police did not intervene in any cases, as shown in the GBV reported cases and types (see Table 2.1). One respondent stated: “Sometimes the victim goes to the police station and files a case but closes it the following day. Because the following day the couple might get along again and then the case is closed.”

Police, village leaders, and other service providers also consider IPV as an internal family matter. This further entrenches the normalization of IPV and sustains an environment of impunity. Myanmar Women Affair’s Federation (MWAF), a government-based organization operating at the state, township and village level, receives the majority of cases related to IPV (35 in 2015). They provide counselling support and mediate to enable the couple to resolve the matter. MWFA usually advises women to go back to the marriage and provides problem solving skills. They also offer other services such as counselling support, mediation, and livelihood skills training.

Sexual violence

The second most common form of GBV is sexual violence (SV), particularly against children and adolescent girls. SV is also the most commonly reported form of GBV. Most of the cases are reported because they result in pregnancy or severe internal injuries. Otherwise survivors tend to remain silent. One such example was shared by a respondent: “There was a case of the rape of a 14 year old girl by her 60 year old neighbour. She got pregnant and had the child. The family of the girl filed a case and the man was sentenced to ten years in jail.” The main perpetrators are men and, according to most KIIs, old men, relatives or family friends.

Sex based on false promises of marriage was also commonly reported. Some young couples want to have sexual relationships and, to do so, they feel they have to get married. One respondent quoted an example.

A migrant man and a woman were living together in Thailand. When the father of the woman found out, he requested that she marry the man. The couple came back to the village and arranged everything to get married. The night before the wedding, the man left for Thailand. The father of the woman asked for compensation (five million kyats).

There are misconceptions about rape, particularly among boys and girls. Many thought men cannot be raped, and that there is no rape if the woman does not fight back. Raping a sex worker is not a crime, which is a view shared by the police. There are no reported cases of marital rape as it is not a criminal offence, but there are reported cases by divorced couples where the ex-husband rapes the ex-wife.

Rape cases can be “solved” at the village level. If a girl is raped, the family of the girl can ask for compensation from the perpetrator. The village leader, elders, and women affair’s group will mediate so that compensation can be paid to the survivor. Village leaders can also offer marriage with the perpetrator as a solution to repair the honour of the survivor and their family. Virginity is highly valued, and survivors might not be able to marry if they are not a virgin. Compensation might be requested when the survivor or perpetrator does not want to marry. It used to be a common practice to receive a white chicken as compensation after a rape case. Nowadays it is more common to request and receive financial compensation. If a survivor knows her rights and the protection mechanisms, she can go to the police after trying to resolve the case at the village level.

Women and girls are believed to be partly responsible for rape if they do not dress properly or are in the wrong place at the wrong time. This attitude was demonstrated clearly in a statement by a respondent: “A man raped a university student on her way back from school to her village. She was wearing a short, tight skirt. The road between the school and her village is very quiet with limited traffic in the evening. It was a good opportunity for the perpetrator.”

Trafficking

Many cases of trafficking were mentioned during the KIIs and FGDs, but this assessment was not able to identify if trafficking cases are linked with sexual violence or other types of GBV. Some interviewees mentioned trafficking was a problem as they were close to the border with Thailand. Others, however, asserted that traffickers' lives were made difficult in Kayin State, as people are very aware of the situation in Thailand.

Trafficked women who are able to come back to Kayin State can choose to stay in a shelter for one month. After that month she can decide if she wants to go back to her village or find another place where she can live and work. Trafficked men do not have the opportunity to stay in a shelter in Kayin State.

Cyber-violence

Although 40 per cent of Kayin State's population does not have access to radio, television, a landline phone, a mobile phone, a computer or internet,⁶³ forms of offline violence have been reported. Offline violence refers to violence related to internet use, but where the actual violence occurs offline and not online. Most reported cases of offline violence relate to false promises of marriage in exchange for sex. There are also reported cases of internet dating that end up in robbery and extreme physical violence to the survivor. One example was quoted: "A man and a woman fell in love with each other on the internet but they never met. The man came to the village and they ran away together to Nay Pyi Taw. After one night, he left her and she called her relatives in Yangon. They brought her back and she is in the village." Internet usage will grow exponentially in the coming years, and attention needs to be paid to these emerging trends. Cyber violence is a potential and growing risk which requires immediate action.

2.2.2 Vulnerable groups and risk factors

All interviewees agreed that the most vulnerable groups at risk of GBV are women and girls. Some of the interviewees also knew of cases of women and girls living with disabilities who had suffered violence. These responses are consistent with the findings from all the groups in the FGDs.

When asked about men sleeping with men, lesbians, or transgenders, the response was quite unanimous: "There are no such people here in Hpa'an. If there are, they are hiding because of the culture. In our community they tease that type of people. They face discrimination." IOM is working with men who have sex with men (MSM) and sex workers, but they have a large area to cover within Kayin State, with their base in Myawaddy.

With respect to the profile of the perpetrator, the response was also unanimous: most perpetrators are men. In particular, the study was able to identify, in the case of the rape of young girls, that they are often older men, around 60 years old (or more), and usually known or close to the survivor.

⁶³ Department of Population, Ministry of Immigration and Population "The 2014 Myanmar Population and Housing Census, Kayin State" Census Report Volume 3-C, May 2015.

The following risks were identified as possible contributing factors to GBV:

- Drug and alcohol abuse.
- Children being left at home alone, under the supervision of neighbours or relatives.
- Young girls traveling alone from school.
- Poverty and lack of livelihood.
- Unemployed men.
- Lack of the rule of law.
- Lack of knowledge of basic rights.

2.2.3 GBV knowledge, attitudes and practice

Gender roles are highly unequal in Kayin State. Men are believed to be more capable than women, stronger and more powerful. The role of women within their family or community indicates that they are constrained by social norms limiting their power. Men are supposed to have control over their families and to be the head of the family, the decision-maker, and the breadwinner.

One interviewee said: “Men are more powerful than women, and men need to dominate and be the heads of the family. Men’s salaries are higher than women’s salaries even if they do the same job.” This is exacerbated by the views expressed by Government authorities who do not acknowledge the existence of gender inequality or GBV. One Government representative stated: “There is gender equality in Kayin State. It is a characteristic of our society and our state. Men and women are equal, and women benefit even more than men.” Another representative shared a similar view: “There is no gender inequality in Myanmar, women and men are equal. Violence is more related to the use of alcohol and drugs. Alcohol leads to wife beating and quarrels with neighbours.” Attributing GBV solely to alcohol and drugs is dangerous, as it takes attention away from the underlying cause of violence; gender inequality.

Intimate partner violence is considered a private matter and is a common practice. In 2015 police did not investigate a single case of domestic violence. Some CSOs working on GBV differentiate on the severity of the cases in order to decide whether to take action or not. Violence among married couples is usually resolved by women being persuaded to forgive the perpetrators. One informant shared a story: “A village woman wanted to divorce her husband, a man who frequently beat her up. She went to discuss this with the village elders and they mediated. After that she decided not to divorce him. The husband still beats and insults her and tells her that she is more worthless than a dog.” Another example illustrates how IPV cases are mediated and a survivor does not leave the violent relationship: “A man beat up his wife frequently. The woman could not handle it any longer and decided to divorce him, supported by her family. She went to the village elders and explained her situation. During the meeting with the village elders, she changed her mind; she did not want other people talking about her or criticizing her.”

Different women’s groups and FGD participants consistently asserted that IPV happened in nine out of ten houses. Frequently women said: “It also happens to me”. When discussing GBV with service providers, they confided that they also experience GBV.

Survivors are judged on their behaviour which leads to a culture of silence for all types of GBV, particularly in the villages. The prevailing attitude of blame attributed to the survivor because of her behaviour or how she dresses is common. There were different understandings about the causes of GBV. One informant shared: “Women should dress properly because they can arouse men. Especially here as “light dressing” (exposed shoulders and legs) is not very common. If men cannot fulfil their instincts they can harm young girls who are more vulnerable. But most of the violence occurs in close relationships and is not due to clothing.” Women and girls usually internalize trauma and keep silent for fear of retaliation, stigma and/or a lack of trust or knowledge of their rights and the system.

Many respondents said that survivors do not report GBV cases to anyone. Non-reporting may be attributed to a number of factors including: GBV is seen as a common/normal practice; there is a lack of knowledge of survivor’s rights; and because most of the time mediation does not provide justice. Groups of women volunteers who mediate and are consulted on GBV cases told the assessment team that it was acceptable for a man to push his wife if she was nagging him. Even service providers replicate community gender roles and misconceptions to a certain extent.

When a GBV survivor decides to seek justice, she first talks to a family member or trusted person. Then, she will see the village leader, village elders, and MWAF groups. They will take a mediator’s role in the case of domestic violence and request compensation in the case of sexual violence.

2.2.4 GBV services per sector

In general, coordination and referral structures are weak in Kayin State. Although some coordination mechanisms do exist, the current coordination structures need to be strengthened. There are no formal referral mechanisms for GBV coordinated responses in Kayin State. Government and CSOs are disconnected. For example, women’s organizations stated that the Government does not understand the work that they do.

A certain level of coordination exists between local government units and state government units. Village leaders, administrators, or local MWAF groups are the first entry point for survivors of GBV. Local women’s affairs groups and MWAF are well coordinated, and they might refer cases to the police if they cannot be resolved at the village level.

There is a good network of well-organized women’s groups with a wide range of services. Moreover, there are strong national and international organizations offering GBV related services. NGOs are particularly strong in legal support and advice, and are well-versed with the legal system. INGOs have more capacity in providing health-related services, such as Marie Stopes International (MSI) and IRC (providing case management). The Karen Women Organisation is the strongest organization working on women’s protection, focusing on EAO controlled areas as well as refugee camps in Thailand.

Health

Primary health care in Kayin State is partly provided by private health facilities (private clinics, dispensaries, traditional doctors and auxiliary midwives) and partly by the Ministry of Health with support from various non-governmental organizations. At the same time, in Kayin State, various Karen national organizations (either affiliated to the KNU or independent) provide health services in more remote villages mainly through their mobile teams.⁶⁴

The Government health system's response to GBV is limited. The Ministry of Health has different types of medical facilities: a tertiary level hospital in Hpa'an, township hospitals, station hospitals, rural health centres, and sub-centres covering the whole state. Hpa'an State Hospital is the only provider of post-exposure prophylaxis (PEP) out of the entire Government health system in the state.⁶⁵ Emergency contraceptives are not available in state hospitals or rural health centres.

In many instances, survivors do not go to a health centre, and when they do, it tends to be for general health issues and not for support for GBV related incidences. If they visit a health centre when they are pregnant as a consequence of rape, they tend not to report the rape. Women are inclined to take care of their injuries at home and lie if they do go to hospital. Shame, lack of time, and money are among the factors preventing women from accessing health facilities. When the situation is critical and a survivor decides to seek health care she is faced with language barriers, no trained staff to handle GBV cases, no private room for examination, and no PEP kits or emergency contraception.

As in Kayah, Government health staff have not been trained on the clinical management of rape or GBV, and there is no specific protocol to treat survivors of rape. In addition, there are no standard operating procedures for GBV. Theoretically, any doctor on duty can collect forensic evidence when a case is brought to their facility and send it for DNA analysis. Nonetheless this does not always happen.

Alongside the Kayin State Government, KNU continues to play a significant role in public affairs, most notably through the establishment and administration of alternative health services for Karen people in parallel to government-provided services.⁶⁶ The assessment team intended to interview the Karen Department of Health and Welfare (KDHW), which has a strong GBV programme on the border with Thailand, but due to time constraints and travel restrictions, the team was not able to assess the quality of the programme.

Marie Stopes International (MSI), with the support of UNHCR, provides health services to GBV survivors. Their clinic is well equipped and staff members are

⁶⁴ "The State of Local Governance: Trends in Kayin" UNDP Myanmar 2014. http://www.burmalibrary.org/docs21/UNDP-2014-The_State_of_Local_Governance-Trends_in_Kayin-en.pdf

⁶⁵ Information obtained from the health training: all participants came from the State Hospital but 80 per cent had previously worked in other health facilities across the State.

⁶⁶ UNICEF, *Kayin State: A Snap Shot of Child wellbeing*.

well trained. Despite their capacity however, they only provided services to three survivors in 2015.

Psychosocial

Psychosocial counselling for GBV is the weakest service sector in Kayin. There are no specialized organizations providing psychosocial support to GBV survivors. Most survivors would normally need some type of psychosocial support. In particular, survivors of intimate partner violence are more inclined to look for some kind of counselling or psychosocial support.

The highest number of qualified staff working on case management is at the Department of Social Welfare (DSW) in Kayin State. They have five trained staff working on case management. UNFPA, MSI and DSW have conducted case management trainings in the past. Despite having a significant number of trained staff, DSW only provided support to five GBV survivors in 2015; all of them cases of sexual violence against minors. DSW first collect information and then coordinate with the health department. Counselling takes place afterwards at the survivor's request.

The number of survivors handled by DSW is low, compared to the 37 cases handled by MWAF. MWAF have volunteer members working to support women and girls in their communities. The counselling approach provided at the community or state level by MWAF is a mediation/coping approach.

Some CSOs provide informal counselling support to survivors while they are accessing other services (e.g., legal support, medical treatment). IRC do not work directly in psychosocial support but provide training on issues such as communication skills, bullying, being appreciative, and problem solving to families to reduce IPV. They also provide anger management and peaceful family sessions at the village level. Although several organizations provide some kind of formal or informal counselling support, there is no specialized agency providing psychosocial support to survivors.

Survivors can also receive some counselling support at the village level. This counselling is not based on GBV guiding principles, but on coping strategies that do not adhere to a human rights-based approach. One such case was cited by a respondent: "A girl was raped by her grandfather. She reported the case and sought support once her family found out she was pregnant. The mother of the girl took care of the baby. Nothing happened to the perpetrator because he was too old; nothing could be done to him. Our organization was asked to provide some counselling support. The girl did not talk to anyone because she was afraid. The parents felt very guilty because they had left the girl alone in the house. Our organization provided some counselling support from a Buddhist perspective (we told her) we know this happened because of destiny, there is a reason for it... It happened but you can move on."

Legal

The legal sector was found to have the most capacity compared to other GBV response sectors in Kayin State. From the 20 organizations interviewed, at

least 6 were working to provide legal advice and support to survivors. The organizations provide advice on the different laws relating to GBV and provide support in the prosecution process. Some of these strong and well-versed organizations are the Karen Women's Empowerment Group (KWEG), the Karen Women Organisation (KWO), the Karen Lawyer's Network, the Karen Human Rights Group, and the Yangon-Karen Baptist Legal Association. It is a relatively large number of organizations, considering the small number of cases reported and filed.

Yangon-Karen Baptist Women Association specializes in providing legal advice and support to minors. The Karen Women Organisation works mainly on the Thai border supporting survivors living in refugee camps. The Karen Lawyer's Network provides support for any type of human rights violation, including GBV. KWEG provides legal advice and support to survivors and informal counselling support. KWEG is well versed on GBV and adopts a human rights-based approach. Their main geographical coverage is Hpa'an and Kawkareik. The organization had a specialized case management worker in the past, but the position was not continued due to a shortage in funding.

The Yangon-Karen Baptist Women Association's targeted populations are children and youth. They receive funding from UNICEF, and technical advice and support from Save the Children. Their main sector of work is protection, but they also provide some informal counselling support.

There is a "parallel legal system" or informal legal system that deals with most GBV cases. GBV cases are dealt with by the village administrator and leaders. For a case to be heard at the township or state level, the village administrator, village elders, and MWAFF must all agree. Usually GBV cases end with some sort of compensation being paid by the perpetrator. Compensation will depend on how powerful the perpetrator is, and the girl's and/or woman's degree of knowledge about the law and their rights.

In the formal legal system the penalty for rape cases is up to ten years imprisonment for rape if the survivor is a minor, and seven years if the survivor is an adult. The death penalty exists for raping and murdering a victim. Under Myanmar law there is no specific definition of attempted rape, although the police classify incidents as rape or attempted rape. Attempted acts are punishable under the penal code and attract up to half of the full sentence, meaning a conviction for attempted rape can be punishable by up to five years imprisonment.

Proving rape is not always easy. Obtaining forensic evidence is only possible if survivors access health facilities soon after the attack. Survivors do not usually seek medical assistance unless the attack has life threatening consequences or the survivor is pregnant. Whether or not the case will succeed depends on how powerful the perpetrator is in the absence of forensic evidence.

Protection

Protection services for GBV survivors are very limited in Kayin State. There are very few female police officers. There are 3 female police officers and 19 at the administration level. The Myanmar National Police has requested that more female police officers are recruited to handle GBV cases, and the Kayin State Police is very supportive of this initiative. The Hpa'an State Police Office has a private room for testimonies, which is not solely for GBV. Other police stations in the state do not have a private room.

There are no special procedures for dealing with survivors of GBV if the survivors are minors. The police refer such cases to the DSW or the MWAF to provide special support. Although special laws and a special court exist for perpetrators against minors, the police regularly proceed in the same manner as for perpetrators against adults. If an adult abuses a minor, the perpetrator may receive a more severe sentence, but the police generally follow the same protocol as for perpetrators against adults. The police also confirmed that they make referrals to health centres, DSW and MWAF.

According to senior officers, police do not require mandatory reporting before medical treatment, which is stipulated in the Emergency Care and Treatment Law. Police officers can also go to health facilities to process cases simultaneously if a survivor needs medical attention. However, the participants at UNFPA's GBV Training for Police were not aware of the Emergency Care and Treatment Law, and seemed to practice mandatory reporting. Similarly, GBV survivors and the community at large are not aware of this law. This contributes to under-utilization of legal support services, as many survivors do not want to file a case against perpetrators.

The police reported that they need further support from the UN and INGOs. They acknowledged receiving training from World Vision, Save the Children and IOM. However, they stated that after the training there was no additional support provided for the survivors in their areas. To build trust in the community on existing protection mechanisms, the police believe there is a further need for awareness-raising campaigns, especially for adolescents.

There are several international and national NGOs working on protection issues in Kayin State. Some of these are UNHCR, UNICEF, Save the Children, IRC, KEO, The Adventist Development and Relief Agency (ADRA) and the Yangon-Karen Baptist Association. UNICEF, Save the Children, ADRA, and the Yangon-Karen Baptist Association work primarily with children, including adolescents. IRC and KEO target both women and girls.

Currently, there is no safe house for GBV survivors in Kayin State. A few cases have been referred to a safe house in Mon State. MWAF, IRC, and KEO are all advocating for the construction of a safe house in Kayin State. A respondent highlighted the need for a shelter as an important rehabilitation service for survivors.

In a rural health centre, a girl arrived in the late afternoon with vaginal bleeding. The doctor asked about the cause of the bleeding and the survivor reported that it was due to having been penetrated by a stick. The doctor could not stop the bleeding and planned to make a referral to the township hospital. While waiting for the car to refer the patient, the health staff tried to talk to the survivor. The survivor explained her cousin had repeatedly raped her. As she was a minor, the case was brought to court. After some time the girl wanted to close the case because she was an orphan and her cousin was the person taking care of her. There is no safe house in Kayin State.

Other

Kayin State has strong and well-organized CSOs. There is a strong network including the Karen Peace and Support Network made up of 28 CSOs from both state and border regions. The network is proactively working to advance human rights, land use, environmental protection, the peace process and the provision of medical and social services both in Government and non-government controlled areas.

The women’s civil society organizations in Kayin State are also well organized and politically active. They work on gender empowerment, awareness-raising sessions, and livelihood activities. On GBV, they conduct awareness-raising campaigns to promote behaviour change and make services to survivors more accessible.

2.3 Recommendations

Table 2.2 Recommended actions to improve GBV response and prevention programmes

Coordination
Coordination mechanisms should be established at the state level under the protection cluster.
Standard operating procedures should be developed for multi-sector response and referral pathways.
Referral pathways should be created and defined, and awareness-raising activities conducted around these, including referrals for different language groups.
Case record forms should be improved and standardized, and data should be collected systematically.
Government Engagement and Capacity Development
Coordination efforts with village and township administrators and community leaders should be increased to ensure a survivor-centred approach to GBV.
There are three key state Government players working on GBV: the Police, DSW, and the Department of Health. The three have received GBV training from UNFPA, and all of them have indicated an interest in more training. At least five days of training per sector is highly recommended as detailed below: <ul style="list-style-type: none"> ▪ MoH: Clinical management of rape and the Emergency Care and Treatment Law. ▪ Police: Role of police in tackling GBV and the Emergency Care and Treatment Law. ▪ DSW: Case management.
Joint consultations should be held between civil society organizations and state Government departments for networking, and to build trust among the different sectors. UNFPA can be the catalyst for these interactions.
CSOs, Government-Based Organizations and INGO Engagement and Capacity Development
Engagement with the Myanmar Women Affairs Federation should increase at both the national and village level. Community women’s groups should receive capacity building on GBV guiding principles and survivor-centred approaches.
Capacity building and financial support should be provided to civil society organizations, particularly the Karen Empowerment Organization, the Women’s Organization Network, and the Yangon-Karen Baptist Association.

Psychosocial
Partnerships should be forged with the Myanmar Women Affair's Federation at the state, township and community level, as they receive the majority of cases, including IPV. MWAF should receive capacity building on GBV guiding principles and a survivor-centred approach.
DSW and local NGOs should be supported to expand the coverage of psychosocial and case management support for women and girls, focusing on IPV and sexual violence.
Safe places for psychosocial support and a counselling space should be available.
Safe referral pathways should be established for survivors who speak in different languages.
Health
GBV training should be provided for service providers, including the clinical management of rape.
A rapid health assessment should be conducted to assess different facilities and their capacity to respond to GBV survivors.
PEP kits and emergency contraception should be available at all health centres.
Protection
The police should be supported in the hiring and training of additional female police officers.
Police station rapid assessments should be supported, and a separate room should be designated to attend to GBV survivors.
There should be advocacy for the inclusion of GBV in police officials' curriculum.
Crisis shelters and safe houses for women who have experienced abuse should be funded and developed. These shelters/houses should have established links with the police, health care and legal service providers, and psychosocial counsellors.
An interview protocol and standardized case report form should be created.
Legal
There are established CSOs providing legal advice and support to GBV survivors in Kayin State. Linkages between these organizations with GBV specialized service providers, such as MSI, should be strengthened.
The informal justice system should be included in GBV programming so that a survivor-centred approach is adopted.
Other: Behaviour Change, Women's Empowerment
Gender transformative programming should be implemented to raise awareness about human rights, available GBV services, and to address gender inequality. Awareness-raising should particularly target community leaders such as village leaders, elders, religious leaders, and Women's Affairs Groups.
Men and boys should be engaged in awareness-raising sessions at the community, township and state level to address gender insensitive attitudes and norms.
A strict adherence to the "do no harm" and survivor-centred approaches should be promoted in all sectors.
There should be coordination with, and support to organizations working on women's livelihood programmes, as women often remain in abusive relationships due to lack of income.
There is a need for coordination with CSOs to implement gender transformative programmes targeted at young couples to explore healthy and equitable parenting practices and address risks of violence.

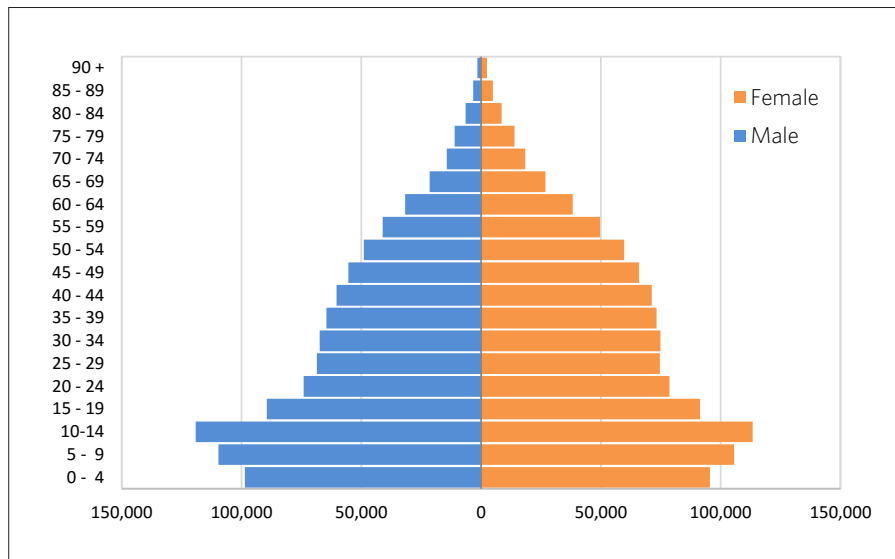
Mon State Findings



Mon State is located in the southern part of Myanmar. It borders Kayin State to the east and Thailand to the south. It is made up of ten townships: Kyaikhto, Bee-lin, Paung, Thaton, Moulmein, Chaing-zon, Kyaikmaywa, Mudon, Ye, and Thanbyuzayat. It covers approximately 8 per cent of the total land area of Myanmar.

According to the 2014 Census, the population constitutes 4 per cent of the total population, and is predominately rural (72 per cent), with a sex ratio of 93. This means that there are 93 males for every 100 females.⁶⁷ It has a declining birth rate, with the largest population group between the ages of 10-14, for both males and females. The mean size of households is 4.6, only 0.2 higher than the Union rate. Around 28 per cent of households identify as having a female head of house; 4.8 per cent more than the Union rate.⁶⁸ The marital rates of men and women in Mon are 61.3 per cent and 58.7 per cent, respectively, in line with the Union rate. The fertility rate is 2.43, which is slightly higher than the Union average (2.29). The infant mortality rate (43 per 1,000) is less than the Union level of 62 per 1,000 live births.

Figure 3.1 Population pyramid of Mon State*



* Source: Myanmar Population and Housing Census, 2014.

Literacy levels (86.6 per cent) are lower than the Union rate (89.5 per cent), and are slightly higher for men than women in the state. Around 17 per cent of the population have no formal education; 46.5 per cent have completed primary

⁶⁷ Information relating to population and demographics is taken from the 2014 Myanmar Population and Housing Census: Mon State (2015), Department of Population; and from the presentation delivered by UNFPA in February 2016 on "Key highlights of census results: Kayah, Kayin and Mon State."

⁶⁸ The high number of female households, as well as the sudden decline in population numbers after the age of 15, may be attributed to high rates of migration (of males in particular) to neighbouring countries for work. Participants in the study regularly identified outmigration as a factor that was impacting on their communities, with young children often being left at home alone or under the supervision of grandparents.

education. Unemployment stands at 6.2 per cent and is above the Union rate (4 per cent). Life expectancy is 71.7 years, which is approximately 5 years higher than the national average. Around 78 per cent of the population have access to improved sanitation. Disability prevalence is 5.3 per cent; this is 0.7 per cent higher than the national rate: seeing and hearing disabilities are the most common types of disabilities.

The recent history of Mon State is characterized by on-going conflict. After the independence of Myanmar in 1948, the Mon people demanded protection of their ethnic rights and culture. The Mon People's Front (MPF) was formed, and fought against the Myanmar Government until 1958 when it accepted the Government's invitation to exchange their arms for democratic change. Soon after, however, some of the MPF's leaders were arrested and jailed by the new military regime. The Mon National Liberation Army (MNLA), which had refused to give up arms, continued the armed struggle for the next 40 years.

In 1995, MNLA reached a ceasefire agreement with the Myanmar Government, but this agreement did not hold due to disagreements over the role of MNLA in Mon. The Myanmar Government began to increase its military presence in Mon in areas formerly under the control of MNLA, primarily to protect new developments and infrastructure (e.g., a gas pipeline and railway in Tenasserim Division and in the southern part of Ye Township). In 1997, the military launched an offensive against a small splinter group which had formed to oppose this increasing military presence. In 2000, the central Government also started the development of the Kanbauk-Myaing-Kalay gas pipeline. In February 2012, a new bilateral ceasefire agreement between NMSP and U Thein Sein's central Government came into force. KNU, which controls some areas in Mon State, has since signed the nationwide ceasefire agreement (NCA), but MNLA has not.

The relative stability of the state since 1995 has resulted in the development of some industry and local economies (e.g., mining, rubber). The state capital Mawlamyine is today considered an important trading and shipping hub, and tourism to and around this area is increasing. There have also been some identifiable improvements in the livelihoods and freedoms of the Mon people over the past few decades.⁶⁹ However, a history of on-going conflict has generated a general wariness of the central Government by the Mon people. The majority of the participants in the study said they did not believe there were going to be any significant changes in their lifestyle as a result of the peace process or the election of the new central government.

The Mon people tend to see themselves as separate and distinct from the Bamar/Burmese ethnic group. Mon National Day, first established in 1947, is widely seen to be more relevant to Mon people than the country's celebration of Myanmar Union Day; and there are calls for this day to be made a public holiday in Mon.

⁶⁹ Julia Federer, Julie Hansen & Salai Isaac, *Why gender matters in conflict and peace: Perspectives from Mon and Kayin states Myanmar*, 2015.

The displacement of civilians from Mon State started in the early 1990s. Approximately 10,000 refugees fled Mon State to Thailand between then and the mid-1990s, almost all of whom returned around the time of the 1995 ceasefire. As at August 2013, there were 3,952 registered and unregistered refugees in Thailand who listed their place of origin as Mon State, approximately half of whom had arrived since 2006. There is still considerable internal displacement in Ye Township, with estimates ranging from 35,000 to 80,000; although many of the displaced persons may now have permanently settled in their new locations.⁷⁰

Mon society is distinctly patriarchal, with a strict separation of public and private duties for men and women, including separation of work tasks in agriculture and business.⁷¹ Females are discouraged from going outside their home alone because they are seen to be at risk of sexual violence. The right of a husband to beat his wife is considered by most men and women to be acceptable. It has been identified that women in the state suffer from multiple types of violence, including economic and emotional intimate partner violence; sexual violence; early marriage; and the violence is most often carried out by somebody known to the woman.⁷² Rape and shaming of young girls, again by somebody they know, also occur. The main triggers for the violence include false promises of marriage, drugs and alcohol, gender norms, and economic stress.⁷³

There are also very recent stories of women and girls who have been forced to entertain and provide sexual services for military personnel, leading to displacement, economic abuse, unwanted pregnancies, forced abortions, and forced marriages.⁷⁴ Female survivors of sexual violence are often encouraged to marry the perpetrator to reduce shame for themselves and for their village, or, in the case of military personnel, the perpetrator simply disappears (i.e., is transferred to another location), leaving the girl to live with the consequences of the abuse (including pregnancy) and on-going shame.⁷⁵

Women have been playing a limited role in the peace process in Mon State. Both KNU and the New Mon State Party (NMSP), both of which operate in Mon, have included women in their negotiating and legal teams. Women have also been involved as facilitators and coordinators of meetings between the various armed ethnic organizations. The total number of women involved in peace negotiations and work, and certainly the proportion of women to men, is nevertheless small.⁷⁶ At the CSO level, more women than men are involved in work to address GBV issues and women's empowerment, including advocacy for legal change and political participation. In the interviews with CSOs, all but one of the interviewees were women.

⁷⁰ UNHCR, Mon State Profile, 2014.

⁷¹ Federer et al., 2015.

⁷² Gender Equality Network, *Behind the silence. Violence against women and their resilience*, 2014.

⁷³ Annami Löfving, *Gender-based violence in the rubber sector in Mon State: Situation analysis and strategic interventions*, 2015.

⁷⁴ Chaw Su Ma, *Gender-based violence in the context of increased militarization in Ye Township, Mon State, southern Burma* (MSC thesis, Asian Institute of Technology), 2012.

⁷⁵ See also WCRP, 2005.

⁷⁶ Federer et al., 2015.

3.1 Methodology

The study was carried out in Mawlamyine, Du Yar village (Ye Township), and Taw Kanar village (Chaung Zone Township). The study also intended to include Tanintharyi Region. While visiting Tanintharyi Region was not possible, representatives from local CSOs were invited to the CSOs consultation meeting, and the assessment team held a short discussion with these representatives to discuss local GBV issues. The extent of information on Tanintharyi Region is limited in this report. The study included:

- Twenty-six key informant interviews (KIIs), sometimes with more than one person in a single interview. Each interview lasted between one and two hours depending on the availability of the interviewees and the extent of the information they were able to provide about GBV.
- Twelve focus group discussions (FGDs), with a total of 149 participants. More FGDs were held for adolescents than for adults because the most recent Census data for Mon State shows that people aged 10-14 and 15-19 are the first and fourth largest demographic population groups by age. The age range of the adolescents participating in the FGDs was 13 to 22. Two of the adolescent FGDs were for currently enrolled university students. Only one person attended one of the FGDs. This FGD was slightly different, engaging in more of an informal chat with the participant about violence in their community.
- Two consultation meetings were held, one with Government stakeholders and another with civil society organization representatives, with a total of 41 participants.
- GBV orientations to Mon Police Force officers and state health providers were conducted and used as an opportunity to understand their views and practices in responding to GBV cases and supporting survivors.

The assessment team also engaged in some informal conversations with relevant stakeholders to better understand more sensitive GBV areas (e.g., sex workers and men who have sex with men (MSM)).

3.2 Assessment Findings

The study discovered that the context and rates of GBV in Mon State are probably similar to those found elsewhere in Myanmar. The study concluded that GBV in Mon State is impacted by underlying issues of low levels of reporting, informal responses and prevailing gender attitudes. Only a combined total of 60 cases of GBV were reported to the State Hospital, State Police, and Department of Social Welfare (DSW) in 2015⁷⁷. The low level of reporting is likely to be the result of significant practical and cultural barriers, which make it unlikely that a case of GBV would be discussed outside the village and made known to the urban-based authorities or GBV service providers.

⁷⁷ It is likely that this figure includes duplication of cases.

Village-based CSOs are actively involved in providing a range of informal quasi-psychosocial services and support to survivors. Young girls adopt a practice of silence as a response to GBV. Men, women, and adolescent boys strongly identify with traditional gender roles, and support the need for females to follow strict gender roles and behaviours to avoid GBV. Some adolescent girls identify with gender equality and women's empowerment, and seek to challenge gender roles; but this is not the dominant view of this group.

3.2.1 Common types of GBV

The following table indicates the numbers of GBV cases, which some interviewees were able to provide. These are approximations, as the assessment team did not see documentation to validate the numbers.

Table 3.1 Approximate number of gender-based violence cases provided by interviewees

Organization	Number of Cases in 2015	Types of Cases
NGO	Approx. 100 (since 2010)	Sexual violence Domestic violence
Department of Social Welfare	19	Rape of girls under 16 Male rape
Mon State Women and Children Upgrade Team	48	Rape of young children and girls under 18 Rape of boys and men
State Hospital	10	Rape
State Police	31	Rape (rural and urban) Domestic violence
INGO	10	Rape
NGO	Approx. 20	Rape Coerced into sex Domestic violence Forced marriage
NGO	13 (since July 2013)	Rape False promises of marriage Enticement to meet under false pretences
New Mon State Party	Approx. 30	Rape Domestic violence

The study identified that the following types of GBV commonly occur in Mon State:

- Intimate partner violence.
- Sexual violence (including marital rape; the rape of women; the rape of adolescent girls, children, and young boys; the rape of normative gender non-conforming men; rape under the threat of prosecution from the police; rape to avoid public shaming; through bribery; and demanding sex in exchange for work or money etc.).
- Domestic violence (including violence against mothers by sons, grandchildren by grandparents, normative gender non-conforming boys by older brothers and uncles, and aunts by nephews).
- Economic exploitation (e.g., refusal of wages, seizing of wages).
- Cyber violence (shaming, bullying, misuse, circulation of images, and harassment).

The assessment team also heard about the following types of GBV:

- Gang rape (as a result of internet dating, and at public festivals).
- Forced and/or early marriage (of girls aged around 14).
- Targeted mutilation or disfigurement of the genitals as part of the violence, and not as a customary practice (e.g., to “punish” gender non-conforming boys).
- “Spiking” or similar drug-related incidents leading to the rape of young girls (particularly at large public celebrations and festivals).
- Trafficking (of children) for organ transplants and labour. Children are reportedly trafficked to China, under the guise to be adopted as orphans, and then used in sex and other work.

3.2.2 Vulnerable groups and risk factors

The study identified the most vulnerable groups to be:

- Adolescent girls (under the age of 15).
- Children (of parents who spend time out of the home for work).
- Women.

Other vulnerable groups identified in the study were:

- Men who have sex with men (MSM).
- Sex workers.
- Young boys (at certain public places, such as large cultural festivals).
- Women and children with disabilities.
- Boys who are not conforming to masculine gender norms.

A customer negotiated with the sex worker’s boss for a sex worker to go with a client. The sex worker agreed to go to the guest house with him. Instead, he took her to a cemetery and forced her to have sex with 15 men.

In addition, the police often fabricate evidence to arrest sex workers; they set a trap. They make a mark on some cash, for example, then a police officer will use that cash to pay for sex. After sex, they raid the sex worker’s home and find the cash. This then becomes their evidence.

The study was further able to identify a profile for the most likely perpetrators of GBV, particularly in the case of the rape of young girls: an older male, often around 70 years old, and usually known to the survivor (e.g., a neighbour). One example was shared by an informant: “There was a case of a 70 year old man who raped a young child. It was a clear rape case. The judge took a bribe from the man, who was then only charged with attempted rape. We took this to the media and invited them to respond.”

The Mon State population pyramid (Figure 3.1) shows that girls between the ages of 10 and 14 are the majority population demographic. Men above the age of 70 are, in contrast, a minority population group. It is worth considering, therefore, how the two relate, and why the study suggests that one of the most common types of GBV in Mon State is the rape of girls under the age of 15 by men over the age of 70.

Anecdotal evidence provided in interviews and FGDs indicates that this type

of man is often trusted by neighbours; he is not expected to be somebody who would harm people. When a young girl is left at home alone, therefore, it is expected he (along with other neighbours) will not harm the girl. Further stories tell of a growing use of drugs by this age group of men. The drugs they are using appear to differ to those being used by young people (e.g., yaba). Instead, they are using energy enhancers and other similar stimulants. One participant described the impact of this: “It means they cannot stop themselves from having sex.”

Data provided by one CSO also shows there are multiple survivors of single perpetrators. In closed cases involving coerced sexual intercourse through deception and cheating, legal support organizations identified two accused and five survivors. In interviews with CSOs, some people referred to the ability of older men, in particular, to avoid prosecution because they are able to afford the compensation and/or because they use their power in the village to intimidate the survivor into not reporting or pursuing a case, thereby enabling the perpetrator to continue committing offences.

However, it may not be the case that the majority of GBV is being committed by this particular age group. There are, for example, far more males in the 10-14 age bracket, and, as the study found, carrying out online violence against girls is normalized within this age group. However, the cultural and economic status of men over the age of 70, and the general respect that people have towards old people in the local communities, mean that men of this age may carry a higher risk of being a perpetual perpetrator. Indeed, the older aged demographic do not appear to fear the consequences of carrying out sexual assault or the rape of young girls in their villages.

In the case of male GBV survivors, earlier reports emphasize the lack of data on sexual violence against men and boys and consider that concerns over threats to masculinity (at both the cultural and individual levels) may work to generate silence surrounding this issue.⁷⁸ In the study, the Police Chief said he had never heard of a case of rape against a male in his 33 years of service. However, health service providers indicated that their data on rape cases included a small number of rapes against boys.

In the consultation meeting with the CSOs and in the interviews with organizations which target MSM, the assessment team heard that young boys are at risk of violence, especially if the boy is perceived to be behaving in ways considered to be insufficiently masculine. In such cases, the boy would be punished by older male relatives; and the site of the punishment was often the boy’s genitalia. In FGDs, further stories of boys increasingly becoming vulnerable to physical assault at large festivals and public celebrations were heard.

MSM suffer violence at the hands of police officers. If they have broken the law, they are placed in the lock-up, and the police officer may then force the person to perform oral sex. This is to satisfy the officer. The arrested person has no idea about their rights; they believe if they do it, they will get off.

⁷⁸Federer et al., 2015.

The following were identified as significant risk factors which increase the likelihood of GBV occurring:

- Outmigration: children being left at home alone, with a lack of parental supervision or under the supervision of grandparents.
- Young girls being at home alone.
- Drugs and alcohol.
- Poverty and livelihood, including the (mis)use of money.
- The cultural normalization of GBV in the home.
- Normative gender non-conforming behaviours (e.g., wearing “sexy” clothes, and not acting “manly”).

The fact that outmigration and drug use are impacting on rates and practices of GBV is not a surprising finding. The literature on GBV regularly points to these links. In the recent briefing of the International Organization for Migration (IOM), the youth networks in the region identified that 54 per cent of youth in Ye Township have taken drugs, and that there is no evidence of any formal intervention into the rising use of drugs among this demographic group because the practice has been “unofficially sanctioned”. They also identified that outmigration is causing “social structure breakdowns”, as men, women, and children move out of their communities, and sometimes do not return. This study did not make or explain any evident links to GBV. This current study is also unable to provide details on the exact extent of the impact of outmigration and drug use on GBV.

The assessment team, nevertheless, heard that men and women were migrating to Malaysia and Thailand for work, and that sometimes this was undocumented migration. Some of the women said their husbands often got angry with them when they returned to the village and discovered that all the money they had sent back had been spent. The women said it was difficult to convince their husbands that the money had been spent on regular household expenses (e.g., food, utilities). Outmigration also results in children being left alone, which makes them vulnerable to older men in the community. Or, they are left to be supervised by grandparents who appear to be less tolerant of the behaviours of young people, and more likely to carry out severe corporal punishment. In-migration was also identified by participants in the FGDs as a main cause of increased community violence against women and girls. It is important to consider such claims about “bad foreigners” alongside the dominant narrative that all violence in the community is caused by “others” (as discussed later in this report).

In the case of drug use, the growing practice of young people taking yaba at public ceremonies and large festivals was indicated in the assessment. This information was provided primarily by young people in FGDs, who also said that the drug was available for sale in their schools and via social media. There appeared to be some misinformation about this particular drug, and other drugs, in the general discourse. Some identified that the drug was ingested, others that it was injected, while others spoke about how it was passed

through touch.⁷⁹ CSOs are generally aware of drug use in the state and in local communities, but it has not been a major focus of their work. Similar to the issue of social media and online violence (discussed later in this report), they do not have a full understanding of what is happening, and are not equipped to respond. In an interview with Care Myanmar, it was learned that university students are using lots of drugs and that this is impacting on their sexual behaviours. The assessment was unable to validate this claim in the FGDs with university students in Mawlamyine. However, similar to the issue faced by IOM it may have been that the type of youth who were willing and/or able to attend the discussion sessions were not the same youth who are using drugs.

3.2.3 Future risk factors

In addition to the identified current and on-going risk factors, findings conclude there is the risk of a significant increase in GBV in Mon State and Tanintharyi Region due to the potential for further conflict, the impact of planned economic development (particularly in extractive industries), and the current online practices of young people.

The risk of future ethnic conflict

As Figures 3.2 and 3.3 show, certain areas of both Mon State and Tanintharyi Region continue to be under the shared control of previously oppositional armed groups (e.g., KNU, NMSP, and the Government). There are concerns about the fragility of the peace process, particularly among people living in the border regions, who have developed a strong distrust in governing powers based on experiences of conflict spanning more than half a century.⁸⁰ The situation for females is said to be particularly disturbing because they have been faced with rape as a “systematic weapon of war”⁸¹. While denied by the Myanmar military regime, this is supported by other research.⁸² In Mon State specifically, women have been recognized to have been disproportionately affected by sexual violence and GBV in conflict areas.⁸³ The outbreak of further conflict in the state, therefore, poses a high risk to the safety of women and will undoubtedly result in an increase in GBV.

The risk resulting from development

Figures 3.2 and 3.3 show some of the major development and infrastructure projects that currently exist in Mon State and Tanintharyi Region. Mon State has the potential to see further development particularly in the extractive industries sector, including plans to open a new coal mine near Ye Township. The increase in military presence in resource-heavy areas has occurred in Myanmar in the past to protect the economic interests of powerful stakeholders, and this has had implications for GBV against women and children.⁸⁴

⁷⁹ When explaining how *yaba* is passed through touch, participants may have been confusing it with another less well known drug in Myanmar called *doh-zei*, which appears to be some kind of root extract with anesthetic and/or amnesiac properties.

⁸⁰ HURFOM, 2012.

⁸¹ Ibid. p.36.

⁸² WRCP (2005).

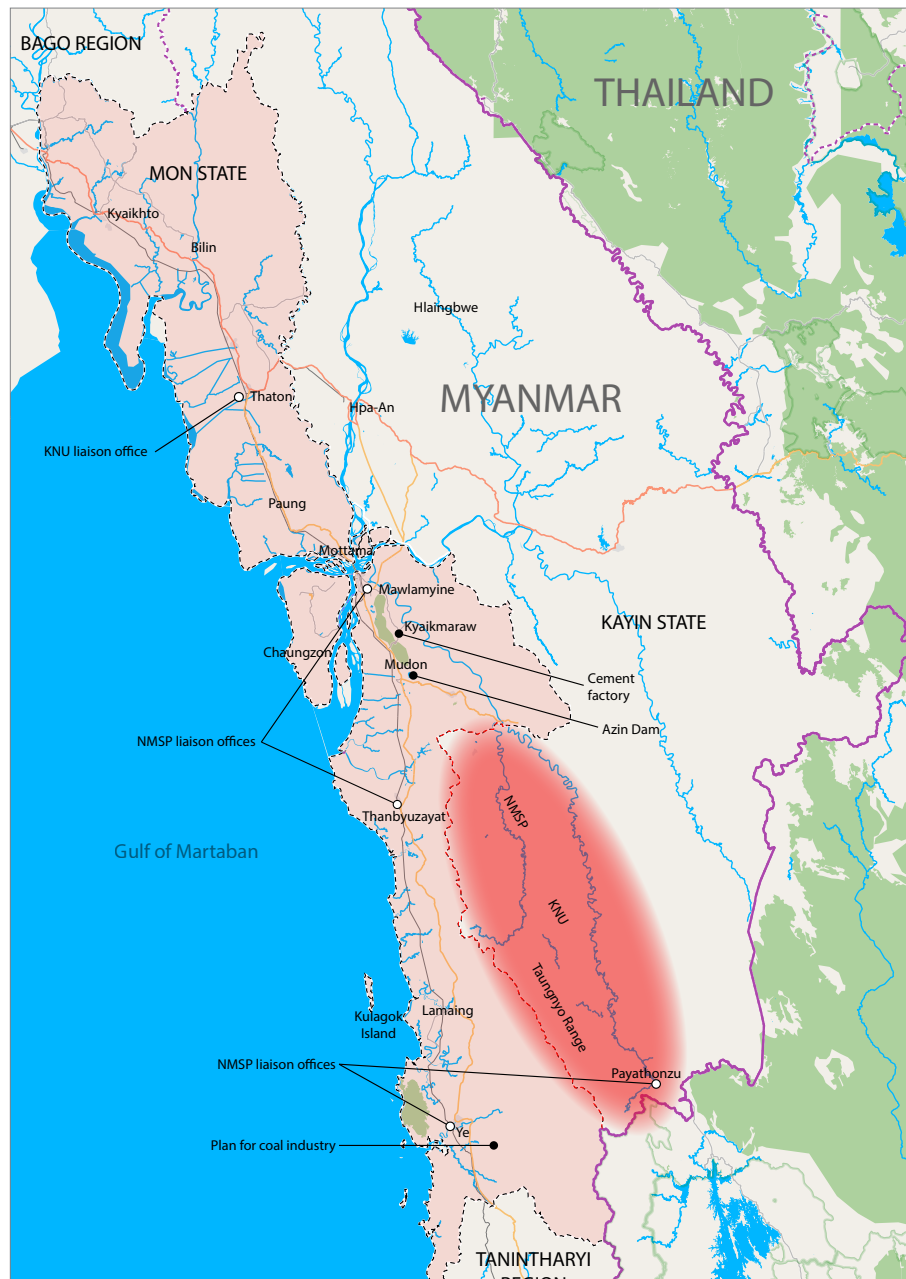
⁸³ Federer et al., 2015.

⁸⁴ See Ma. (2012).

The presence of extractive industries can also introduce or increase a number of social/cultural issues already known to be related to GBV, including: male-dominated cultures and hyper-masculinized norms; a highly transient workforce with few connections to local communities; environmental impact on existing livelihoods; and inequalities in income distribution and land ownership. Women and children have been identified as at-risk groups when their communities are impacted by extractive industry development projects in Myanmar.⁸⁵ CSOs from Tanintharyi Region specifically identified the special economic zone of Dawei as a known hotspot for GBV. Some local organizations in Mawlamyine expressed their concern that a growth in development is already linked to a growth in tourism in the region, and that this will lead to greater economic exploitation of children, and a growth in the sex industry.

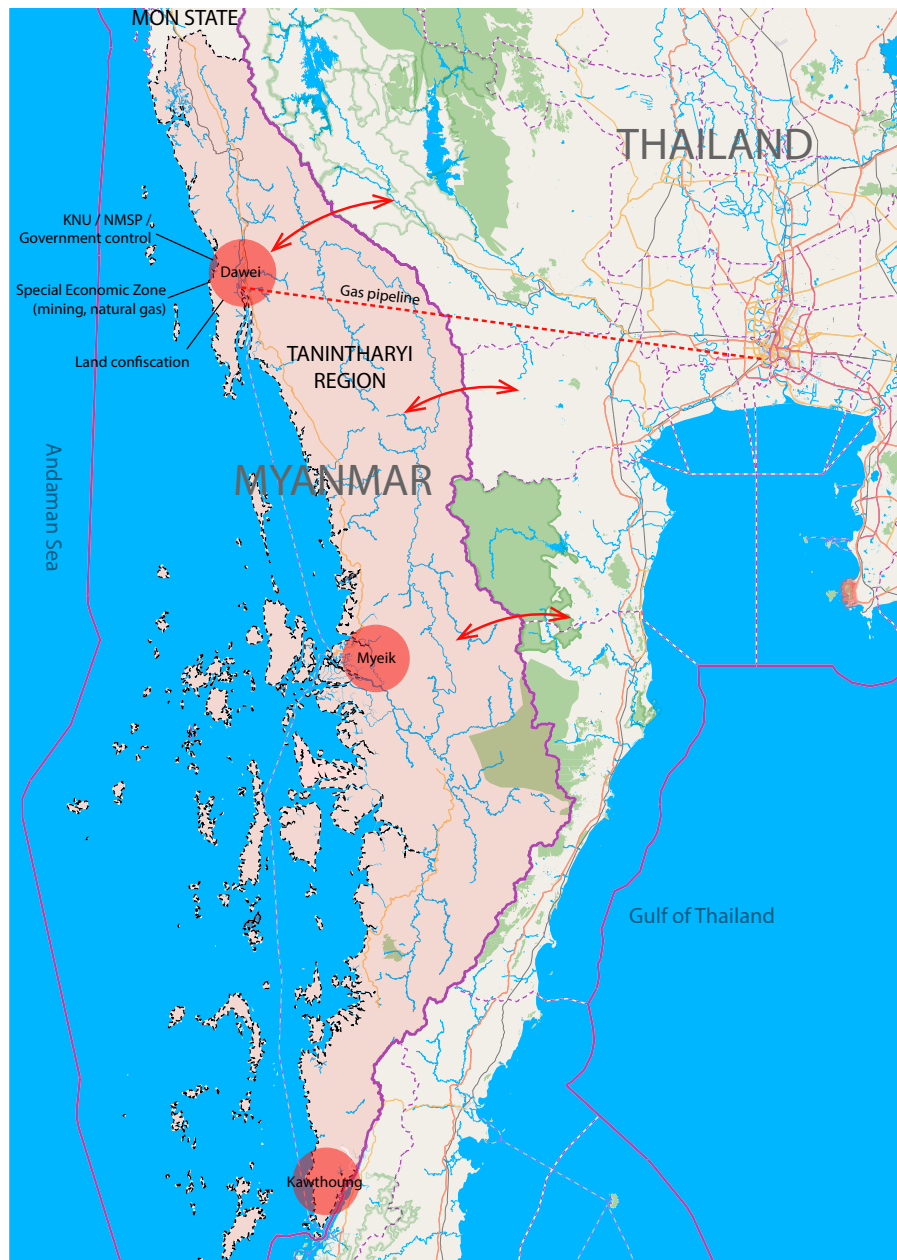
Figure 3.2 GBV risk factors in Mon State

This map of Mon State shows some of the existing and planned development projects. There is already some concern in local villages about the plan for a new coal mine in the southern part of the state. The red highlighted area is considered to be a conflict-risk area. This area is under the shared control of KNU and NMSP, and ethnic communities who live there are particularly wary of the peace process. It is also a high in- and outmigration area.



⁸⁵ Myanmar Centre for Responsible Business, *Myanmar oil & gas sector wide impact assessment*, 2014.

Figure 3.3 GBV risk factors in Tanintharyi Region



The risk factors in the areas circled in red are economic development and in-migration. Control in the townships of Dawei is shared by KNU and NMSP. In Tanintharyi Region, there is a high level of migration on the eastern border with Thailand. Drug trafficking and human trafficking are identified as on-going concerns along this border region.

The risk of online practices

There is no information available to determine the extent to which the online practices of young people in Mon State are perpetuating existing, or creating new avenues for GBV. Studies in other countries suggest that this form of GBV is high, and that young people are left to navigate harassment and violence online with no understanding or guidance as to their rights, choices, and consequences.⁸⁶ Only 35.7 per cent of households in Mon use electricity as their

⁸⁶ See, for example, Abidin, C. (2016; forthcoming). "#sexbait: Sex talk on commercial blogs as informal sexuality education." In L. Allen & M. L. Rasmussen (eds.), *Palgrave Handbook of Sexuality Education*; Jonsson, L., Bladh, M., Priebe, G. & Gören Svedin, C. (2015). "Online sexual behaviours among Swedish youth: Associations to background factors, behaviours and abuse". *European Child and Adolescent Psychiatry*. Vol. 24, No. 10: 1245-1260; Ojanen, T., Boonmongkon, P., Samakkeekarom, R., Samoh, N., Cholratana, M. & Guadamuz, T. (2015). "Connection between online harassment and offline violence among youth in central Thailand". *Child Abuse & Neglect*. Vol 44: 159-169; and, Priebe, G. & Sveddin, C. (2012). "Online or offline victimisation and psychological well-being: A comparison of sexual-minority and heterosexual youth". *European Child & Adolescent Psychiatry*. Vol. 21, No. 10: 569-582.

primary source of lighting, yet 34.2 per cent of households have access to a mobile phone, which provides access to an online world relatively new to Myanmar culture. In the most remote villages with no running water, young boys and girls are using mobile phones. In one FGD, a participant shared: “I make friends with boys on Facebook and exchange photos. But then the boys photo-shop the photos to make me look naked. They send me the photos or send them to others to shame me. They threaten to send them out if I don’t have sex with them or meet them. It’s easy for boys to find my phone number; they can search for it.” Both girls and boys in the study said it was easy to buy adult literature and videos at phone shops, and that the sharing of such material was common practice. Boys identified that they sent messages to girls they did not know online to try and connect with them, and that this was just “normal” boy behaviour. Overwhelmingly, it is girls who are more likely to be shamed and to receive unwanted sexual invitations online. Adolescent boys are more likely to be the perpetrators of cyber violence against girls, including harassment, stalking, and photo-shopping images to shame a “naked” girl. Cultural discomfort around talking about sex and sexuality is extremely difficult to overcome in Myanmar culture.⁸⁷ The risk of doing nothing, however, is that existing online practices (which may themselves constitute GBV) will translate into offline behaviours in the future, and this will result in an increase in accepted male perpetrators and silent female survivors of GBV in local cultures.

We need education for youth; nobody is doing this. Sexual problems are related to online activities, and this is how young people get their information about sex and sexuality. There was a boy who spoke to a girl online, then on the phone. They agreed to meet up. She agreed to sleep with him, and then she was gang raped by his friends.

3.2.4 GBV knowledge, attitudes and practice

GBV is believed to be absent from Mon State. This is reflected in the general attitudes of community members who do not consider many behaviours and actions typically identified as GBV (within a human rights discourse) to be unusual or unacceptable. The general position held by state authorities is that GBV is mainly an issue of concern outside the state. The stories shared during FGDs, and information received through interviews and consultations with CSOs, contradict this position: they indicate a very different picture. One respondent stated: “GBV is not a big issue in Mon State. There are no major challenges. Maybe in Kachin there are more problems because that is a conflict state. Sexual violence in Myanmar is very rare because it is a traditional culture. Changes in the culture are not resulting in more GBV.”

The assessment heard common narratives about GBV, which indicate how GBV is understood and why the practice of GBV is often normalized in Mon State. Domestic violence is considered primarily a private matter, and one that usually involves acceptable behaviour. Police do not get involved in cases of domestic violence unless the violence is identified by individual officers as “severe”. The State Hospital did not have records for domestic violence cases;

⁸⁷Fletcher, G. (2011). “The cultural queasiness factor: Intersections of gender, sexuality, and HIV prevention in Burma/Myanmar”. *Asian Studies Review*. Vol. 35: 189-207.

it maintains data only on rape cases. The vast majority of adult respondents in FGDs agreed it was acceptable for a husband to beat his wife, and that a wife did not have the right to refuse to have sex with her husband, “unless she is sick; in which case he will have to ask again.” Some of the younger participants questioned whether a woman should always obey a man, but they too mostly agreed that a husband had power over his wife. Physical violence against children was also considered natural, because it was seen as a normal disciplinary response to children who disobeyed their parents, or a normal response from grandparents who were frustrated because they had to look after young children while their parents were out at work.⁸⁸

Young girls are considered to be vulnerable, and communities are more likely to recount cases of sexual violence in this instance. The assessment team heard many stories of young girls being raped by neighbours or other people known to them. These stories were told in groups and by individuals who denied the existence of violence in their communities. This contradiction indicates that GBV does, in fact, exist in what is otherwise claimed to be a peaceful society. Admitting that young girls are vulnerable and are being raped was, however, not accompanied by an outright condemnation of this practice. On the contrary, the raped girl was often seen to be at fault because she had stayed at home alone, gone out alone after dark, or because she made it impossible for the man not to want to have sex with her (i.e., through her clothing, willingly participating in online chatting, and willingly agreeing to meet up with a man).

At first glance, there appears to be a contradiction here: our village is safe, and our young girls get raped. This contradiction, nevertheless, reveals an attempt to perpetuate the disempowerment of females. The rape of young girls is said to happen because all girls are weak and vulnerable; it is their weakness (contradictorily combined with their apparently powerful sexual allure) which encourages their rape. The actual rape and the retelling of the story thereby both serve to reaffirm the naturalness of the otherwise culturally constructed position for girls/women as the weaker sex. The potential for the independent empowerment of young girls is therefore non-existent in the narratives of vulnerability and safety for girls. The girl remains weak even in the discourse of rape, and must therefore always be protected, or risk being exposed to what is otherwise seen to be quite normal harassment and abuse.

We can say that girls are more at risk of violence in our communities, and are not as free as boys to move around at all times of the day. This is normal because girls are weak. We shout at them, chase them, or follow them because we are just testing, to see if they are interested; and this is what boys do. If girls want to be safe, she should always be with a boy. A girl should not go out alone and we boys have a responsibility to remind her of this so we can protect her.

Violence in general, and GBV specifically, regularly take place outside of the home and outside of the village. The assessment team did not ask for personal stories of GBV, and certainly did not seek to identify perpetrators. However, narratives of where GBV occurred and who the typical type of perpetrator was

⁸⁸ The disciplining of children might fall outside the dominant understanding of GBV. Many CSOs, however, identified corporal punishment as a significant GBV concern. Some also spoke about how children with mental and physical disabilities were at particular risk of physical abuse within the home.

regularly included references to a distant location and person, away from the normal village culture and away from people native to the village. Participants referred to migrants and “strangers” as those who were responsible for GBV, particularly against children, which occurred at local festivals and celebrations. Children were said to be trafficked across the border to China for organ transplants. These narratives contradicted the facts of reported cases which identified the most common perpetrators of GBV as somebody known to the survivor (e.g., a neighbour). Drugs and alcohol, which only “other” people were using, were also cited as causes of violence against women; and older men were said to be taking “energy enhancers” which “forced them” to rape young girls. GBV is perceived as being located outside the everyday culture of the village, and a result of “foreign elements”. This reduces the need of the community to reflect on their local practices and gender norms to understand and respond to GBV.

3.2.5 GBV services per sector

In Mon State, there is a coordinated system of GBV reporting and case management in which many of the state organizations, NGOs, INGOs, and CSOs participate. A case management group meets monthly to discuss rape cases, and to determine appropriate courses of action in regard to individual cases. It covers health and legal responses to cases. It is only operational in Mawlamyine.

This case management group is made up of individuals from CSOs, NGOs, and INGOs. The members from CSOs are evidently committed to responding to GBV, and do so in diverse ways. Some members are involved in advocating for better legal support for GBV survivors, while others use their connections with the Government and the media to promote GBV awareness and corruption issues (e.g., the sale of medicines that should be freely available, and the failure to prosecute older powerful men who rape). The members from CSOs target women, children, MSM, sex workers, and people living with disabilities who are survivors of GBV, as well as other vulnerable groups. In some cases, they also work with perpetrators, and engage men and boys to promote GBV prevention. It is not clear who decides which cases are discussed in the case management group, or if there is a specific protocol that is followed before bringing a case to the attention of the group. In addition, there does not appear to be a unified and agreed referral pathway which all participating organizations follow. Some CSOs, for example, refer cases to the State Hospital for medical assistance, while others refer cases to NGO clinics. These different referral pathways often seem to depend on the level of trust between the referring organization and the Government.

The group appears to lack any formalized structure to guide members on what they should focus on, or how the group can adopt a unified and uniform approach to GBV throughout the state. It is not evident that there is a particular format or methodology used to organize the case management meeting discussions. The group does not appear to follow any standard operating procedures to provide guidance on their GBV work. This means there are also no established methods of recording and measuring trends or levels of GBV.

The assessment team had some concerns about the case management group in respect to confidentiality, capacity, and internal power dynamics. During some of the KIIs, a few individuals linked to CSOs and state institutions (many of whom attend the monthly case management meeting) revealed specific details of rape cases, and the assessment team had to reaffirm the need for confidentiality. It was not possible to identify the existence of any policy or guidelines governing confidentiality at the case management meetings or between the various CSO members.

There are discrepancies between the levels of training on GBV that CSOs receive relative to their profile. Those who appear to have more formalized training tend to focus on high profile work, such as political dialogue and legal change. Those who appear to be doing more immediate work in the villages to support GBV survivors have not received as much training on GBV (even though their experiential learning is higher). The smaller, village-based CSOs do not have on-going support to help them build financial and management capacity, and much of their work appears to be done on an ad hoc project basis only when funded through the larger CSOs.

Resources and funding from INGOs and NGOs are mainly given directly to the urban-based and larger CSOs, which then trickle some funds down and allocate activities to the smaller CSOs. This stifles capacity building opportunities for CSOs working in the villages. It also means that any understanding of GBV in Mon State is drawing on the knowledge and expertise of those who work for the larger CSOs. On the contrary the work and experience of the smaller CSOs may, in fact, offer a more accurate reflection of the context of GBV throughout the state, while the larger CSOs continue to play a leading role in political discussions about GBV and the empowerment of women in Mon State and at the Union level.

Health

Health services are provided by the State Hospital, a clinic operated by an NGO, and in some cases at the village clinics. Health services include the provision of emergency medication (e.g., PEP), pregnancy testing, counselling, and gathering material evidence for the prosecution of rape. The study was unable to determine the extent or quality of these services. In addition there were no local doctors or nurses available in village clinics, which meant that the assessment team could not explore their awareness about GBV.

In the case of a private NGO run clinic, there is a GBV reporting and response process in place, and confidentiality is guaranteed. In the case of the State Hospital, cases are reported to the police without the consent of the survivor. Medical staff did not appear to have any knowledge of the guiding principles for dealing with GBV survivors, particularly in the areas of confidentiality and no blame. There is an emphasis in the State Hospital on gathering material evidence after rape. Sometimes this is done by male doctors. Although counselling was available, it was not clear whether it was considered to be a key part of GBV services, and the State Hospital does not participate in any GBV awareness or health campaigns at all.

Some CSOs have a strong relationship with the State Hospital, whereas others prefer to refer cases where GBV survivors are in need of medical attention to the NGO clinic. The decision as to which health service provider to refer to appears to depend on the level of trust between the individual CSO and the Government. Those CSOs that have strong relationships with the Government and the Department of Social Welfare, and those that adopt a more conservative approach to GBV prevention, refer to the State Hospital; whereas the smaller CSOs that are more engaged with local villages primarily refer cases to the NGO clinic.

There was some concern expressed by CSO members about corruption relating to the sale of medicine that should be available free of charge. Medicine and other health provisions were, however, said to be readily available (except in the case of medicine for people living with HIV which is sometimes in short supply).

CSOs were aware of the availability of health services in urban areas, and sometimes at the local village clinics. However, this did not mean that all cases would be referred or that all survivors would access these services. Health services available in urban locations (e.g., Mawlamyine) are mainly inaccessible to many survivors of GBV due to the distance from their homes and an inability to pay for transportation. GBV cases also tend to be dealt with at the village level, and the survivor may not be allowed to travel outside the village to seek assistance. An improvement in, or an extension of the health services in urban areas would therefore not necessarily result in more survivors accessing these services. The primary barrier is accessibility which is hindered by cultural norms, lack of transportation, and lack of economic means.

Psychosocial and Rehabilitation

Many organizations and CSOs offer some kind of psychosocial support to survivors of GBV. Most of this support would, at best, be considered counselling only: informal, quasi-counselling (e.g., listening and providing advice), as opposed to professional, accredited counselling services. No evidence was found of the provision of any formalized rehabilitation services. The only exception was in religious institutions where women could stay to “calm their mind” and engage in meditation based on religious principles. This was described as “becoming a nun for a while” while the woman decided if she wanted to go back to her village.

The study concluded that the psychosocial support services currently offered by CSOs are not in line with established best practices. This is because these support services have been set up and are being offered out of necessity, and not because of any formal management of the introduction of psychosocial support. It is, however, important not to destabilize the work that is currently being done. For many survivors of GBV, particularly those who live in more remote areas, the existing informal psychosocial support services are the only immediate and long-term support they are able to access.

Some temporary accommodation is provided by DSW and by religious institutions for women and girls who need to leave their homes due to fear of, or actual violence. This is not a formalized part of the GBV response in the state, and is only available on a case-by-case basis. Many of the CSOs were unaware of the existence of this kind of accommodation for GBV survivors. Some suggested it might be possible for women to stay in shelters that were available for people living with HIV, but this did not appear to be the case when CSOs who work with people living with HIV were consulted. One CSO said that a shelter for women used to exist on the Mon-Kayin border, but this is no longer functioning due to lack of funds.

The assessment team were unable to determine if such places are/were intended to provide protection and/or rehabilitation for survivors. In the case of religious institutions, the latter would appear to be the case given that women arrive of their own free will, and that the perpetrators (often their husbands) come to speak to them in what was described as a “non-threatening” way. This means they come to engage in dialogue and mediation, and not to commit further violence or to force the woman to return home. The formerly functioning shelter on the Mon-Kayin border did have a security guard and a full-time live-in worker. It was reported that men would often come to the shelter believing that the women inside were available for sex. Similar to the assessment of psychosocial services provided by CSOs, the assessment team concluded it would be unlikely that the rehabilitation services available could be considered services which meet minimum standards for safety.

Legal

The Mawlamyine Justice Centre (MJC) provides free legal advice to help with the prosecution of perpetrators. Other organizations and CSOs provide information and guidance on the legal process, but most refer legal cases to MJC; and some provide transportation costs to access this service. MJC has a clear procedure in place for taking on cases, and one that aims to ensure confidentiality for the survivor. When a survivor presents to MJC, some administrative details are recorded by a paralegal who then refers the case to the General Director, who in turn appoints a legal representative to take on the case. Lawyers who take on rape cases include six women and two senior male lawyers. Funding for this organization is on a short-term basis.

The split system of law enforcement throughout Mon State and Tanintharyi Region (i.e., shared control by the centralized Government, KNU, and NMSP) means that it is unlikely that there is consistency in prosecutions of GBV. This is particularly evident when the perpetrator is a soldier. A Mon soldier, for example, is dealt with by NMSP, while a Myanmar soldier is dealt with by the central Government. It was reported that the closed courts reduce transparency and accountability which creates mistrust between the various governing parties. NMSP, for example, said they do not have full trust in the prosecution of Myanmar military personnel, believing that perpetrators may simply be moved to another state and not charged. CSOs also identified that perpetrators, and especially military personnel, are often encouraged to move out of the village temporarily to avoid prosecution.

The study found that most GBV cases are dealt with by the village administrator. In Mon State, there is only one female village administrator, and this is a relatively new appointment. The village administrator must agree for the case to be dealt with at the township or state level (formal justice). This does not appear to happen often given the low level of numbers recorded at the state level by MJC. There are also cultural barriers which prevent the survivor from accessing legal services outside the village. Domestic violence, for example, is considered a private matter. One participant in a FGD said that the village administrator is tasked with “keeping the peace” inside the village, and it might therefore be seen as a failure on his part if a GBV case has to be referred elsewhere. CSOs also identified that in many rape cases powerful men intimidate the survivor by wielding their status in the village (e.g., “who will believe you?”) and they are often able to afford compensation pay outs to avoid prosecution.

Some participants spoke about the economic impediments to securing legal proceedings, even at the village level. The village administrator may demand a fee to initiate an investigation, and then a bonus fee if compensation is paid to the survivor. It is not clear where this money goes. The assessment team heard stories of older men being able to influence the survivor to drop a complaint, or the village administrator encouraging the survivor to accept a compensation payment that the perpetrator could easily afford. In some cases, the mother of the perpetrator would also advocate on behalf of her son, and negotiate to pay compensation to ensure he did not go to jail. One CSO representative said that NMSP has ruled that the survivor should now pay to cover the costs of keeping the perpetrator in jail.

People are not aware of the law. Adults trust their neighbours too much. The family don't expect they will harm their children. Also, the perpetrators know that the children don't know the law.

The inability of the legal system to play a more visible and dominant role in addressing GBV is seen to be an impediment to bringing about cultural change supporting accountability and better prevention of GBV in communities. This is confirmed by the insistence of the Mon Women’s Organization and Mon Women’s Network that the primary solutions to reducing GBV are strengthening the law, more severe punishment for perpetrators, and more successful prosecutions.

Protection

The State Police responds to cases of rape that are referred to them. The Police Chief said they generally do not get involved in domestic GBV cases, unless the injuries are deemed to be “severe”. What constitutes “severe” is determined by the extent of the injuries, and appears to be a judgment made at the discretion of individual officers. The Chief of Police also insisted he did not require health service providers to issue police with a report without the consent of the survivor. This is in contrast to the views of the State Medical Chief who said a report was always issued to the police irrespective of the survivor’s consent. There are 23 female officers in the state. The Police Chief insisted these officers

were encouraged to attend GBV training, but only a couple of female police officers attended the GBV orientation training. It is also not guaranteed that survivors will speak to a female police officer.

Other

CSOs provide a range of educational and response services which aim to promote the prevention of GBV. These include youth groups; awareness-raising; working with local men; engaging with the media; social media campaigns; promoting political and legal change; and advocating for the empowerment of women. Much of this work is not sustained over the long-term due to limited capacity and funding for these organizations. The work is not coordinated, and individual CSOs often have their own agenda in terms of focus areas (e.g., legal change, media engagement, promoting traditional culture, and empowering youth).

One CSO was particularly active in promoting youth engagement. They offered education to youth on human rights, political participation, environmental awareness, and gender issues, including GBV. The extent of the work this particular CSO undertakes, does not correspond to their low level of funding and capacity. It is an example of insufficient support and ineffective funding mechanisms to assist CSOs that are doing extensive work throughout the state.

Peer education is very important to us. We involve young men and women as volunteers. The young might fear speaking to older people, so this way they can talk to somebody their own age. They are free to talk. Some young boys will also not listen to older people, but we invite them to the teashop to talk to their peers. We have a responsibility to educate people so they do not go the wrong way.

The complexity of the relationship that exists between the INGOs, NGOs, and CSOs in Mon State, and the high number of CSOs in existence (estimated to be 240), means that diverse and often conflicting relationships have formed between individual organizations. The assessment team determined that CSOs can be divided into two main types: larger, more politically active, urban-based CSOs, and smaller, village-based CSOs, which are more directly connected to the everyday GBV experiences and needs of survivors.

INGOs and NGOs currently prefer to have more direct contact with the large CSO groups. This is perhaps due to the fact that these CSOs have more capacity to manage projects, and because they are run by individuals who have more formalized training in GBV. It is also determined by whether or not a particular organization is registered and therefore able to accept funding. This, nevertheless, means that the smaller CSOs are not targeted for capacity building, and their ability to respond to GBV needs in local communities is always dependent on strategies determined by INGOs and NGOs, and then filtered through the larger CSO groups. Smaller CSOs need support to build capacity and to be more actively involved in decision-making, particularly in regard to suitable GBV programmes and projects. This needs to be done, however, in a way that larger CSOs do not feel excluded, as their current power and reach (particularly in terms of their ability to engage Government, legal

service providers, and the media) are strong; and they are unlikely to want to relinquish this power. There also appears to be some unspoken competition between some of the larger CSOs who want to be seen as the dominant GBV and women's empowerment groups, despite the fact that many of them work alongside each other in the case management group.

3.3 Recommendations

The following recommendations seek to eliminate the key deficiencies in current GBV response and services in Mon State and Tanintharyi Region.

- CSOs, and particularly the smaller, village-based CSOs, are not receiving an adequate level of support to enable them to meet local GBV needs and to grow in capacity.
- There are significant cultural barriers and myths, which hinder sustainable and evidence-based responses to, and the prevention of GBV.
- The existing relationship (including funding arrangements) between INGOs and local NGOs or CSOs is ineffective in terms of meeting GBV needs, and may, in fact, prevent sustainable change.

Seeking to resolve cyber violence by advocating limited usage, or abstinence from the internet, an approach suggested by some of the larger organizations in the assessment, could mean that the links between online and offline GBV cannot be explored or determined. This could prevent effective educational responses to this contemporary issue.⁸⁹

Providing training programmes which emphasize increasing knowledge about GBV (e.g., guiding principles) over engagement (e.g., mapping informal response mechanisms) could lead to the agencies, which local women already access for GVB responses, feeling underappreciated. In addition, the women who access these services may feel that their experiences are belittled, and this could impact on their sustainable empowerment.⁹⁰

Sex education isn't popular because it is seen to promote sexual behaviour, and some people just expect everybody not to have sex. Telling women not to have sex is also unfair.

⁸⁹ Ojanen, T., Boonmongkon, P., Samakkeekarom, R., Samoh, N., Cholratana, M. & Guadamuz, T. (2015). "Connection between online harassment and offline violence among youth in central Thailand". *Child Abuse & Neglect*. Vol 44: 159-169; and, Mitchell, K., Finkelhor, D. & Wolak, J. (2001). "Risk factors for and impact of online sexual solicitation of youth". *Journal of the American Medical Association*. Vol. 285, No. 23: 3011-3014.

⁹⁰ Peletz, M. (2012). "Gender, sexuality, and the state in Southeast Asia". *The Journal of Asian Studies*. Vol. 71: 895-917.

Table 3.2 Recommended actions to improve GBV response and prevention programmes

Recommendations for Capacity Building
Technical support and capacity building should be provided to develop standard operating procedures and information sharing protocols to ensure a survivor-centred approach, which is compliant with GBV guiding principles.
Recommendations for Education
A GBV awareness and response training programme should be developed (or adapted) to address the immediate learning needs and capacity gaps of those working at the state level in the areas of health, protection, justice, and governance. This training programme should use recognized adult learning techniques to ensure interactive and participatory discussions on GBV. It should be a multi-day training programme. Representatives should come from CSOs (particularly those who work in close proximity to regional hospitals), so they are able to learn, participate in the delivery of the programme, and roll out the training in their regions.
GBV prevention training programmes should be developed (or adapted) targeting men and boys at the community level. These programmes should be developed in consultation with selected CSOs to ensure that they are relevant to the local male populations of Mon State, and to ensure CSO's involvement in the delivery of these programmes. The programmes should include measurable impacts and a longitudinal study of changes in attitudes and behaviours of the men and boys who participate.
Village administrator's capacity should be built. The aim should be to develop an agreed policy and process for responding to GBV cases, as well as action plans to improve GBV awareness and prevention education within the villages. It should also encourage changes to existing practices, to ensure that GBV cases are dealt with in a fair and equitable survivor-centred way that supports survivors.
A series of factsheets should be created which draw on contemporary research and practice, and disseminated to CSOs to help them gain a brief and immediate understanding of new and emerging GBV risk factors. This series should cover drug use, social media, and migration, among other factors. The factsheets should aim to dispel myths and encourage debate about these GBV-related topics. The factsheets should be issued with templates that CSOs can use to record factual information as to how these issues actually affect GBV in urban and rural areas, and this information should be used to inform future evidence-based responses. ⁹¹ Factsheets should be available in local languages.
Recommendations for Prevention
Targeted research should be conducted to determine how young people in Mon are engaging in normalized GBV in their online communities, and how this is impacting on offline GBV attitudes and behaviours. The information should be used to inform the development of effective and relevant educational programmes. This research, and the resulting programmes, should draw on available work and literature in this field, and should promote empowerment for young girls, in particular, in how to navigate their online world through informed consent and choices. It should also target boys to understand existing online GBV practices and to help shift their behaviours.
Research into the actual relationship between drug use and GBV in local areas is necessary. This research should seek to find out who is using which drugs; what the specific and diverse impacts of the drug use are; how the drug use impacts on actual GBV; and where the hotspots are for drug-related GBV. This research should address potential differences in drug use, and identify which users are engaging in GBV as a result. It should inform the development and delivery of programmes in areas where drug use is high, and be targeted at users who engage in GBV, to promote harm minimization of those affected.
Recommendations for Health Sector Response
A more in-depth mapping of available GBV health services throughout the state should be undertaken, especially outside the major urban areas. This should include locations of clinics where GBV survivors can receive medical assistance; the type of medical assistance available; as well as information on the capacity of the clinics (e.g., trained staff, confidentiality, materials). This information should be used to inform the most effective ways to improve access to services for GBV survivors (e.g., ambulance transportation, CSO funded transportation, mobile clinics, and supplies to local clinics).
Recommendations for Partnerships
A business case should be created for employers that explains why they should be aware of, and respond to GBV, and its impact on their employees and local communities (e.g., low productivity levels of affected employees; financial costs to businesses of not responding; inability to meet equity targets; impact on workplace culture of in- and outmigration). The aim of this business case is to initiate a dialogue with the major industries already operating, or likely to operate, in Mon State and Tanintharyi Region, and to encourage their involvement in tackling GBV.
Research should be conducted into the impact of extractive industry development projects on rates and experiences of GBV in affected communities, in order to better inform and work with private stakeholders to address the issue. This research should draw on available work and literature in this field. It should aim to seek buy-in from private enterprises that GBV is relevant to their everyday work as it impacts on their workplace culture and business profits.

⁹¹ These factsheets should be seen as a precursor to the additional research which is required, as indicated in the long-term recommendations.

4

Challenges faced by GBV service providers across Kayah, Kayin and Mon States

Each of the states had unique strengths and challenges. The political, economic, cultural and geographical landscapes are vastly different. Certain common threads, however, can be identified. Many of the issues are not unique to the south-eastern region but are similar to those in other areas of the country. Most importantly, a high level of acceptance of gender inequality exists across all three states.

The following challenges were identified by GBV stakeholders across different sectors in Kayah, Kayin and Mon States.

Traditional customary practices and beliefs

This issue came up constantly in many discussions. It is the biggest barrier to preventing and responding to GBV. Unless customary practices and beliefs are addressed, even if life-saving services are available, survivors will not access them. Decision-making about handling GBV cases continues to reside in the hands of older, powerful men. Community leaders strongly believe in their traditional customs of mediation, and they do not see any benefit in taking GBV cases to outsiders, regardless of whether it is one of the women's organizations or the Government. This maintains the impunity of perpetrators, and does not create any deterrent against GBV in communities. Interventions to change attitudes are often hindered by more formalized and conservative approaches to sex, sexuality, and gender.⁹²

Complex systems are a barrier to reporting

The reporting system is complex and deficient for GBV, particularly for rape cases. There is no "one-stop centre" for survivors who, in order to report their case, must discuss their GBV experience multiple times with, among others; the local women's group and/or CSO; the village administrator; a referral organization, such as a larger urban-based CSO; a medical institution (e.g., the State Hospital); the State Police; and a legal service provider.

Limited capacity of service providers

The majority of organizations interviewed showed some understanding of GBV. This understanding was, however, not consistent across organizations, including CSOs, in terms of content or extent. In some cases, the understanding of GBV that informed the organization's response to GBV came from experiences rather than any formal training. The low number of female staff in both the health and police sectors could also be a barrier to ensuring survivor-centred services.

⁹² Fletcher, G. (2011).

Language barriers

The personnel of most state service providers, such as the police and health care providers, are Burman and Myanmar language speakers, who do not speak local ethnic languages. Women, girls and people in the community are not all fluent in the Myanmar language, and therefore are not willing, or do not feel comfortable, to report cases and access services. There is also a certain level of mistrust in the Government due to the legacy of conflict.

Lack of awareness

There is a lack of awareness about GBV at both the community and the response level. Community members, women, and girls do not know where and how to access services. Many do not recognize GBV cases as a crime. Women's organizations are not familiar with often very complex legal processes to support survivors effectively. Dominant cultural attitudes relating to the relationship between men and women limit the possibility that GBV or rape would be considered as something to discuss or complain about (e.g., a husband's right to beat his wife; a wife's obligation to have sex with her husband on demand; women's subservience to men) and these cultural norms are widely accepted.

Access to services

There is no freely available form of transportation for survivors to access medical and protection services, which are primarily only available in major urban areas. Service providers also lack means of transportation to get to survivors, or to visit communities to raise awareness on GBV issues. The livelihood and economic capacity of a survivor are likely to mean that they cannot take time off from work, or cannot afford to travel out of their village, to access urban-based services. They may also be prevented from leaving their home due to the stigma attached to what has happened to them, as well as the practice of keeping GBV issues within the home or village. The reach of available services is not able to meet the needs of GBV survivors throughout the states, creating a geographical and social disconnect.

Lack of resources

A small number of GBV responding organizations are operating with very limited funding, which does not ensure sustainability of services. To see through and follow up on one single GBV case is a lengthy process in terms of legal procedures and other support. It is also costly. These organizations need further resources to handle their caseload effectively. There are limited referral funds for survivors to access services.

Delays in accessing services

There are delays at different stages for a survivor to access life-saving GBV services. Primarily, survivors do not know where to go. In focus group discussions, most participants had no idea where they could find services. The most likely person to report a GBV issue to is the village leader, who does not have any information about services, and would normally be resistant to refer survivors outside of their community. In cases where the survivor does try to access services, there are delays at the hospital or police station. Mandatory reporting is still practiced for the most part.

Relationship and coordination between civil society and the Government

Although coordination is improving, there is a certain level of animosity between Government institutions and CSOs in Kayah and Kayin States. In Kayah State, women's organizations, which are delivering key services, are mainly not registered with the Government. In some instances this puts them in a difficult position when they need to coordinate with the Government on GBV cases, especially when Government officials do not recognize them as legitimate organizations. CSOs are looking to international NGOs and other partners to engage and strengthen state level actors.

There are no laws to protect the work of CSOs. This means that people who advocate for change or who seek to highlight corruption and unfair treatment, as many of those connected to the CSOs do, are at risk of harassment and prosecution. In Mon State, several CSOs reported that they have had to move premises to avoid vandalism and threats of violence against staff.

Lack of local responses

Established responses to GBV and prevention programmes, including human rights-based training, does not (and often cannot) address some of the broader underlying risk factors, including poverty and lack of jobs. They often do, however, seek to challenge cultural norms in relation to gender roles and expectations, and this content can be seen as "foreign" to local people. CSOs have not been encouraged or supported to develop locally relevant GBV training content.

Conclusions and Recommendations



The gender-based violence assessment carried out in the south-eastern Myanmar states of Kayah, Kayin, and Mon (including some consultations in Tanintharyi Region) concludes that there is significant and widespread GBV occurring throughout all three states. Women, adolescent girls, children and young boys, sex workers, MSM, people living with disabilities, and normalized gender non-conforming men are most at risk. The types of GBV evident in this region include sexual violence, intimate partner violence, domestic violence, cyber violence, trafficking, and economic exploitation.

The extent and complexity of GBV occurring are not captured by existing reporting mechanisms. Many survivors do not seek medical, legal, or psychosocial support; and are often prohibited from doing so because of transportation difficulties and family/community pressure. A strong cultural silence surrounds discussions about GBV. This silence is strengthened by the wider cultural reluctance to speak openly about sex, sexuality, and intimate relationships. Those who experience GBV, particularly those who have been raped, are encouraged to keep quiet in order to avoid personal shame and to protect the reputation of their local community.

The cultures of local communities, and broader society, have been significantly impacted by decades of conflict, widespread abuse, and economic poverty. This has created a cultural space in which GBV has simply become prevalent, and has become integrated into everyday life. Survivors of GBV do not have the resources to seek assistance. There is a general distrust of outsiders in favour of reliance on support offered to survivors locally (even if this may not be in their best interests). A history of conflict, entrenched gender inequality, and cultural and social norms create a context in which GBV has become a normalized and accepted practice within local communities, and one that is not widely seen to be a “problem” worthy of significant discussion or response.

More recently, these same communities have had to deal with a number of emerging issues which further impact on the rates and practice of GBV. These include: increased drug use; high rates of outmigration; the development of industry; and access to a new online world. The study cannot provide a detailed explanation of the full impact of these specific issues, individually, on the GBV context in these states or in specific areas. However, sexual violence against adolescent girls and young children appears to be increasing because parents are absent from home due to work. The attitudes of young boys towards their (online) relationships with girls suggests the development of future behaviours which risk further normalized GBV. Activities which may once have helped to unite a community (e.g., public festivals, cleansing ceremonies) are now increasingly becoming events where GBV is perpetrated or where GBV survivors are further shamed.

In many ways, domestic and sexual violence are functioning as a replacement for the practice of power in communities and states whose social structures have disintegrated. This has produced new localized and state-wide cultures in which the potential for the empowerment of girls and women is severely restricted.

There are some unique differences between the states in terms of the current context of GBV and risk factors. In Kayah, for example, the prevalence of the cleansing ceremony to “clean” a village after a rape has occurred presents a significant barrier to implementing responses which advocate support for the survivor. In Kayin State, there are very few female police officers, and the existing GBV service providers do not have extensive knowledge of the guiding principles for responding to GBV. In Mon, the power dynamics and relationships that exist between various organizations and CSOs are complex, and pose a risk to ensuring delivery of effective prevention and response programmes in local villages. The online activities of young people in this state, and particularly the extent of online sexual harassment, indicate that there is likely to be increased GBV activities in the future if this issue is not addressed urgently.

A long-term and sustained approach to GBV is required in all three states. Some immediate responses can be taken to ensure better provision of health supplies, better access to services, and further training for state authorities and CSOs. The vulnerability of children and adolescent girls to sexual violence is particularly prevalent, and requires an immediate intervention. The study shows, however, that the extent and severity of GBV across the south-eastern region of Myanmar cannot be fully addressed in the short-term. More research and studies are required to fully understand the impact of specific issues including cultural practices, online behaviours, drug use, and industry development on the rates and types of GBV. Such research will ensure future programming is better informed and more accurately targets the needs of people living in these states.

The local communities of all three states have experienced decades of disregard for their local cultures and traditions. Women, in particular, have been isolated from political discussions and from the current peace process; and their stories and experiences continue to be ignored. Responses to the current context of GBV and prevention interventions must therefore be developed together with local communities, and particularly local women. Lessons can be learned from existing agencies and how they respond and prevent GBV in their communities.

Kayah, Kayin, and Mon States represent a significant social problem for GBV response and prevention. The south-eastern region of Myanmar is, however, an important part of the country in terms of migration, development opportunities, and the peace process. Therefore, an investment, both in terms of time and funding, is essential to fully understand why GBV has become so normalized in this region, and what local people can do to bring about changes that will benefit their communities. This work necessarily involves challenging

cultural myths that are harmful to many people. The silence surrounding GBV needs to be lifted, and it needs to be acknowledged that GBV is happening at home, in community spaces, and in workplaces. It is time for some powerful gender norms and practices in this region to be addressed and challenged, so that all people can enjoy an equal and peaceful place in a future Myanmar.

A number of key areas for future interventions have been identified based on the assessment findings. The recommendations also emphasise the need to understand and work within the local context to strengthen existing structures which have already garnered trust and support across communities. Previous research has identified how important this is in a country such as Myanmar, where human rights and GBV may lack significant cultural relevance. An approach needs to be adopted which allows for the creation of a localized understanding and response to GBV, to avoid the risk of rejection of change, and in the event of future conflict.⁹³

These recommendations call for a strong and sustained investment in both gender equality policies and laws which support women's human rights, and GBV response and prevention interventions in the region. Without addressing underlying gender inequality and discrimination against women and girls, which manifests itself in the form of GBV, through CEDAW compliant policy and legislation, Myanmar will not achieve the desired level of development set out in the new Sustainable Development Goals. The policy and legislative environment must be addressed simultaneously to ensure a commitment for the implementation of accessible and safe services (including health and justice responses) in order to ensure that women and girls have the confidence and capacity to achieve their potential. The commitment of Government is necessary, as well as the continued engagement of other stakeholders, including civil society, non-governmental organizations and donors to address the problem.

A collaborative approach is essential to improve awareness of GBV, and to build local capacity. At all stages of planning and development of programmes and activities, vulnerable groups (particularly women and adolescent girls) should be at the centre of discussions to determine the best approaches to respond to, and prevent GBV in their communities, and across the three states. Young boys and male village leaders should also be engaged to explore localized practices of masculinity which are hindering efforts to empower women.

⁹³ Chua, L. (2015). "The vernacular mobilization of human rights in Myanmar's sexual orientation and gender identity movement". *Law & Society Review*. Vol. 49, No. 2: 299-332.

5.1 Overall recommendations for the south-eastern region for practitioners, Government, policymakers and donors

Practitioners

Build capacity of current service providers and duty bearers

There are existing GBV support services across the region which must, and should be provided with capacity building support to ensure safe and confidential services for GBV survivors. This capacity building support should include responsible community-based awareness activities, life skills support, and response and prevention services. It must also include capacity building to ensure specialist GBV programme delivery is available. Such specialist services include case management services, psychosocial counselling, and rehabilitation for adult and child survivors, as well as post rape medical treatment.

Capacity building needs to be implemented in a way that addresses both informal and customary systems for managing GBV (which include community women's groups and village level justice mechanisms) and formal systems (including the Department of Social Welfare case managers and the Myanmar Police Force).

Capacity building support needs to extend to organizations and Government partners operating in rural areas outside of state capitals.

Capacity development should be a sustained effort over at least three years with refresher training and on the job coaching/mentoring, rather than standalone workshops. In addition, staff self-care should be integrated into these trainings

Strengthen coordination and referral mechanisms

In each of the locations of the assessment, coordination systems could be identified with varying degrees of efficacy and compliance with minimum standards for coordination (including confidentiality).

These systems must be strengthened through the development of terms of reference for each of the groups to ensure compliance with minimum standards, as well as standard operating procedures. These standard operating procedures should include referral pathways and safe information sharing protocols. This will ensure the best possible delivery of a package of services for survivors of GBV.

Strengthening of coordination and governance structures will ensure quality, safe, non-discriminatory and confidential services for women and girls.

Ensure a holistic approach

GBV programmes must include a range of stakeholders and services, including response and prevention programming. This will ensure that a GBV survivor has a community to support her, and safe services to address her needs, wherever she is located.

GBV must be addressed through the provision of a package of services that both prevent and respond to GBV. There must be investment in direct response services for life-saving health care, psychosocial support, case management (including counselling) and legal needs.

Any investment in response service provision must also contain prevention programming support. This would include scaling up awareness-raising activities, which were identified to be on-going in the region, to include duty bearers at the village, district, state and region levels.

All duty bearers from Government and non-government organizations must be encouraged to establish networks, and supported with the capacity to respond to and prevent GBV. Programming must not be limited to Government authorities. All civil society, including small rural women's groups, must be engaged to make sure that survivors from across the region have access to safe services.

Integrate substance abuse issues

Substance abuse, including alcohol and yaba, was identified in the assessment as a key risk factor for escalating GBV both in terms of the severity and frequency of violence. Investment in response services must also include consideration of available drug rehabilitation services to provide safe referrals for perpetrators. Investment in prevention programming should include a minimum of initiatives to increase awareness of substance abuse issues and its role as a risk factor for GBV.

There is a need to engage the health sector, and both state institutions and CSOs and I/NGOs to explore establishing rehabilitation services at both the national and state level, and integrating referrals to GBV services within these.

Invest in youth and children

Young people were identified as a large demographic group who are both perpetrators and survivors of GBV. In order to support young people in the south eastern region to become responsible and productive adults, all GBV programming must focus on the particular needs of young people. This is essential to break the cycle of violence. Young people should be engaged directly in GBV prevention and gender equality programmes. Sexuality education components should be included in both formal and non-formal education and peer support programmes.

There is also a critical need for specialized care for child survivors of rape.

Further research

The assessment provides an overview of the incidence of GBV and the context within which it occurs. It has identified a range of risk factors and drivers of violence. The assessment has also identified areas where more information is needed to better understand the needs of, and empower women and girls. Further areas of research should focus on:

- The linkages between GBV and substance abuse.
- The use of cleansing ceremonies as an informal response to GBV in Kayah State.
- The emerging issue of cyber violence among youth, and GBV prevalence among youth.
- The impact of industry development (e.g. extractive industry) on GBV.

Finally, there is no systematic data collection of GBV cases to inform policies and programmes in the country. A GBV information management system should be established to safely capture and share data, and analyse existing and emerging trends.

Policymakers

Enact the Prevention of Violence against Women Law

This is one of the most important pieces of legislation to advance GBV prevention and response in the country. As intimate partner violence was found to be highly prevalent in the south-eastern region, the law that criminalizes it and provides for necessary protection measures is critical to ensure women can be protected from sexual violence at home and in the community.

Develop and adapt standard operating procedures with a multi-sectoral and survivor-centred approach

Standard operating procedures (SOPs) must be developed through coordination and governance structures in strong coordination with key Government ministries and institutions, including the Department of Social Welfare; the Ministry of Health; the Myanmar Police Force; the Union Attorney General's Office; ethnic health organizations; international and national organizations; and civil society groups. The SOPs should outline how each sector coordinates with each other to support GBV survivors to access services, including health and justice responses, in a safe and confidential way.

Ensure that relevant laws are widely disseminated and implemented

Despite the enactment of the Emergency Care and Treatment Law in 2015, most duty bearers are not aware of it and are not compliant with its provisions when they respond to cases of GBV. The law needs to be widely disseminated with clear guidance as to its implementation at the township and village levels. Service providers should be trained on the application of the law through the coordination and governance structures.

Raise awareness among Government officials about gender and gender equality
Understanding what gender equality means is a precursor to GBV prevention and response programming, as gender inequality is the underlying cause of GBV. Policymakers and Government duty bearers, as well as ethnic organizations, need to recognize and acknowledge gender inequality to understand the causal effects of the normalization of violence. The use of Government endorsed policies and research, including the National Strategic Plan for the Advancement of Women 2013-2022 and the Gender Situational Analysis 2016, should support awareness-raising and advocacy for policies and laws that realize women's human rights, including their right to live free from violence.

Development partners

Integrate GBV into cross-cutting programming including development, humanitarian and peacebuilding activities

GBV interventions must be implemented across the humanitarian, peacebuilding and development spectrum. Sustainable outcomes for GBV programming require long-term funding to enable engagement that facilitates cultural change. GBV programming must be developed so it can address both rapid response needs during periods of conflict as well as be integrated into state and ethnic health facilities, social welfare programming and at the policy levels.

GBV must be situated as an integral component of national and local peace processes, both in terms of addressing accountability as well as promoting women's participation. Sustainable peace cannot be achieved without addressing gendered dimensions of the conflict. Women and girls should be enabled to both participate and be included in local and national peace dialogues and negotiations. This can be addressed by both the provision of GBV response programming to empower women to enable participation and leadership, as well as enforcing accountability mechanisms to end impunity. There are opportunities to address GBV through civilian ceasefire monitoring systems and other accountability mechanisms. Strong linkages with the range of peacebuilding efforts across the region are critical in order to ensure that GBV is addressed as a core issue.

Ensure that GBV programmes are integrated

Integrated approaches are much more effective to prevent and respond to GBV. There are multiple entry points to address GBV: through sexual and reproductive health and rights programmes and services; livelihood support programmes; education and youth programming; drug rehabilitation services; and child protection. As the assessment highlights, gender inequality is entrenched in communities across the region. To address the impact of GBV, interventions must be targeted across communities and across the spectrums of response (emergency, peacebuilding and development processes). The risk factors associated with GBV, as identified in this assessment, are varied and impact on different target populations. GBV interventions to support women and girls must be integrated at both the service and structural and institutional levels.

Leverage influence

Development partners must advocate with other donors and policymakers to invest in comprehensive GBV response and prevention programmes. Mainstreaming GBV and gender into other programming has the potential to mitigate risks, while supporting the empowerment of women and girls to ensure at least a minimum participation in decision-making forums, assessments and consultations. The goal of sustained and targeted advocacy by development partners should be to forge strategic alliances. These alliances should place women's human rights at the centre of the national agenda for development, humanitarian response and peacebuilding efforts.

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Appendices

Powerful Myths, Hidden Secrets

1

Summary of assessment participants

Multi-Stakeholder Consultations

	Government Consultation (Mon, Kayah)	CSOs Consultation (Mon, Kayah)	Government and CSOs Joint Consultation (Kayin)
Participants	33	35	32
Representatives	<ul style="list-style-type: none"> Department of Social Welfare Ministry of Health Ministry of Education Myanmar Police Force Attorney General's Office State coordination office Village administrators Immigration officers Narcotics officers Police officers Myanmar Women's Affairs Federation 	<ul style="list-style-type: none"> Women's groups Civil society organizations Women leaders International and national non-governmental organizations Youth groups UN agencies 	<ul style="list-style-type: none"> Ministry of Health Ministry of Education Myanmar Police Force Attorney General's Office State coordination office Village administrators Immigration officers Narcotics officers Police officers Myanmar Women's Affairs Federation, National (including state and local) and International NGOs
Content	<ul style="list-style-type: none"> Introduction to GBV Discussions on current GBV response services and practices 	<ul style="list-style-type: none"> Group work on GBV consequences, risk factors, gaps and challenges Plenary discussion 	<ul style="list-style-type: none"> Group work and plenary discussion on contributing factors to GBV, common types, barriers, gaps in services, and opportunities Brief orientation component

Focus Group Discussions

	Number of FGDs	Number of Participants	Theme	
Females	Adult	6	78	<ul style="list-style-type: none"> Gender roles, perceptions of GBV Types of GBV and access to services
	Young people (10-24)	8	119	<ul style="list-style-type: none"> Gender roles Perceptions of GBV Types of GBV Access to services
Total Female		14	197	
Males	Adult: Religious leaders, community leaders	6	69	<ul style="list-style-type: none"> Gender roles Perceptions of GBV Knowledge, attitude and practices
	Young people (10-24)	7	80	<ul style="list-style-type: none"> Gender roles Knowledge, attitude and practices
Total Male		13	149	
TOTAL		27	346	

GBV Orientation to State Duty Bearers

	Myanmar Police Force Training	State Health Providers Training
Participants	150	104
Content	<ul style="list-style-type: none"> UNFPA Myanmar's training modules of survivor-centred response and prevention on GBV Role of justice sector Emergency Care and Treatment Law 	<ul style="list-style-type: none"> Introduction to GBV Health sector response to GBV Emergency Care and Treatment Law
Duration	1 day	Half day - 1 day

Assessment Tools



2.1 Focus Group Discussion Guides

These tools should be used during small focus group discussions.

The team should assure participants that all information shared within the discussion will remain confidential; if the secretary takes down notes, s/he will not have any information identifying or associating individuals with responses. Some of these discussion topics are sensitive. The team should take all potential ethical concerns into consideration before the discussion, considering the safety of respondents, ensuring that all participants agree that no information shared in the discussion will be divulged outside of the group, and obtaining informed consent from participants.

The group should be homogenous – community leaders, adult women, youth, adolescent girls, adolescent boys etc. – and should not include more than 10 to 12 participants, and should not last for more than one to one-and-a-half hours (for adults) or 45 minutes (for children or adolescents).

The term “violence” is often used in this document. This does not diminish the importance of gender to the study. Rather, it is used to help obtain initial views about violence as gender-based violence as a term and practice may not be well understood by participants. The facilitator should keep this in mind, and ensure that the activities and questions guide the participants to talk about gender-based violence by connecting violence to gender in their communities. The Minimum Standards advocate the need to pay attention to, and challenge social and gender norms in all parts of the process. The facilitators have a responsibility to both learn and challenge in the process of gathering information from FGD participants.

In order to increase acceptance and ensure that participants are not the targets of community suspicion, threats or violence, be sure to consider:

- (1) If you do not feel it is safe to have this discussion, or that it may cause risk for staff or participants, do not proceed.
- (2) Before mobilizing participants, meet with community leaders and/or local government to explain the purpose of the focus group discussions – to better understand the health and safety concerns affecting women and girls, and other vulnerable groups – and the presence of the assessment team in the community.
- (3) Where possible, link with a range of local women’s leaders – formal and informal – during participant mobilization. Women leaders may be involved in one focus group, but should not be present in all groups to ensure that women feel free to speak openly.
- (4) Ensure that staff facilitating focus group discussions do not ask probing questions in an effort to identify the perpetrators of violence (e.g., one specific armed group).

Essential steps and information before starting the focus group discussion

Introduce all facilitators and translators

Explain the purpose of the discussion:

- General information about UNFPA
- Purpose of the focus group discussion is to understand concerns and needs for women and girls
- Explain that this information will be used to improve services for women and girls
- Participation is voluntary
- No one is obligated to respond to any questions if s/he does not wish
- Participants can leave the discussion at any time
- No one is obligated to share personal experiences if s/he does not wish
- If sharing examples or experiences, individual names should not be shared
- Be respectful when others speak
- The facilitator might interrupt the discussion, but only to ensure that everyone has an opportunity to speak and no one person dominates the discussion.

Agree on confidentiality:

- Keep all discussions confidential
- Do not share details of the discussion later, whether with people who are present or not
- If someone asks, explain that you are speaking about the health and safety of women and girls.

Ask permission to take notes:

- No one's identify will be mentioned
- The purpose of the notes is to ensure that the information collected is accurate.

Introduction and Conclusion to Focus Group Discussion

Please read this to participants before the start of every focus group discussion.

My name is _____ and this is my colleague _____ . I work for _____ and she/he works for _____ . We thank you for participating in this focus group discussion today.

We would like to ask you to discuss and share some issues affecting boys, girls, women and men in your community so that we can better understand your needs and concerns.

We are not asking for your personal stories; please do not use any names. We are asking about things that you have heard or know to be happening. We are also asking for your attitudes. The questions we are going to be asking you today are about the way that you live every day.

Participation in the discussion is completely voluntary and you do not have to answer any questions that you do not want to answer. If you feel uncomfortable at any time you can leave.

We do not want your names, and we will not be writing your names down. We also will not present any other potentially identifying information in anything that we produce based on this conversation. We will treat everything that you say today with respect, and we will only share the answers you give as general answers combined with those from all the people who speak to us.

We ask that you keep everything confidential, too. Please do not tell others what was said today.

_____ is taking notes to make sure that we do not miss what you say. I hope that this is ok with you?

We really want to hear what you have to say, and I want you to answer our questions however you want. There is no wrong answer to any question.

I expect our discussion to last for a maximum time of ***.
Do you have any questions before we begin?

Please follow these guidelines for concluding a focus group discussion.

- Thank participants for their time and their contributions.
- Remind participants that the purpose of the discussion was to better understand the needs and concerns of people in respect to violence.
- Explain the next steps. Explain what you will do with this information and what purpose it will eventually serve. Also inform participants if you will return.
- Remind participants of their agreement to confidentiality.
- Remind participants not to share information or the names of other participants with others in the community.
- Ask participants if they have any questions.
- Let them know that if anyone wishes to speak in private, the facilitator will be available after the meeting.

Facilitator's Guide to Focus Group Discussion

ADULT WOMEN: 90 MINUTES

About Your Community (20 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We will first start with a general discussion about your community. We want to find out what everyday life is like for men, women, and children in your community.

Please form small groups of 3 or 4 people. We will provide you with some paper and pens.

We will ask you some questions, and you can write down or draw your answers on the paper. Try to make a picture (in words or drawings) of your community. The picture shows the relationships between men, women, boys, and girls in your community.

As we ask you more questions, you can add to this picture of your community.

- (1) Describe the relationships between men and women in your community.
- (2) Describe the relationships between adults and children in your community.
- (3) At what age do girls and boys get married in your community?
- (4) Who is considered powerful in your community? What gives people power in your community?
- (5) How do women spend their time in your community? What type of work do they do? What about girls? Are they in school? Are they working?
- (6) How do men spend their time in your community? What type of work do they do? What about boys? Are they in school? Are they working?

About Violence in Your Community (20 minutes)

We first want to ask you a question for general discussion. Please answer as best you can. We are seeking to learn from your way of thinking.

- What do you understand by gender-based violence?

The facilitator can explain gender-based violence if they are asked. However, the questions below will also help to tease out how the participants understand the links between gender and violence.

The facilitator should ask one question at a time, and ensure that all responses are written down.

We are going to ask you to give us some information about violence that occurs in your community. Please remember that we are not looking for your personal stories. We want to learn about how violence affects people in your community. Sometimes, there may be many different answers. Please provide all the answers you can think about.

- (1) What groups of people suffer from violence in your community? Identify which groups are most likely to suffer from violence.
- (2) What types of violence do people experience in your community? Identify which are the most common types of violence that people experience.
- (3) Where does this violence take place?
- (4) What types of violence affect women and girls specifically in your community/area?
- (5) What types of violence affect men and boys specifically in your community/area?
- (6) What kinds of factors might put women at risk in your community?
- (7) When and where does sexual violence occur in your community?
- (8) How is the problem of sexual violence now? How is it different from last year and previous years?
- (9) Why does violence occur in your community?

About Responses to Violence in Your Community (15 minutes)

The facilitator should provide the scenarios one at a time, and allow approximately 5 minutes for the participants to respond.

We are going to give you some scenarios to consider. We would like to discuss your responses to these scenarios, and to write down a summary of your response.

For this activity, you can work in pairs.

Scenario 1: A woman in your community has been beaten and raped by her husband at home. Explain what will happen.

Scenario 2: A young girl or boy is being persuaded to enter into a sexual relationship without their consent. This relationship is with somebody powerful in the community. What should they do?

About Improving Responses to Violence in Your Community (15 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We want to go back to look at your community picture. We want to ask you about what might help to prevent and respond to violence in your community.

Please work in the same small groups as before.

We will ask you some questions, and you can write down or draw your answers on the paper.

- (1) If a woman or young girl suffers violence (use the different forms/types that were mentioned) is she likely to tell anyone about it? Who is she likely to talk to (family members, other women, health workers, community leaders, police/security or other authorities or anyone else)?
- (2) Are there any services in your community that currently offer help to people who have suffered from violence?
- (3) What are the barriers to accessing these services?
- (4) How could these services be improved?

About Your Attitudes to Violence (10 minutes)

The facilitator should ask one question at a time, and ask people to mark their response on the answer line: very true – unsure – very false.

We will share some statements with you. We will then ask you if you believe this statement to be very true or very false, or if you are unsure. Please place one dot on the answer line to identify your answer.

- Men should share the work around the house with women, such as doing the dishes, cleaning and cooking.
- A woman can refuse to have sex with her husband.
- If a wife does something wrong, her husband has the right to punish her.
- When a woman is raped, she is usually to blame for putting herself in that situation.
- If a woman doesn't physically fight back, it's not rape.
- Women should be careful about what they wear, or they might get raped.
- Only women can be raped.

Facilitator's Guide to Focus Group Discussion
ADOLESCENTS (BOYS/GIRLS): 45 MINUTES

About Your Community (10 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We will start first with a general discussion about your community. We want to find out what everyday life is like for boys and girls in your community.

Please form small groups of 3 or 4 people. We will provide you with some paper and pens.

We will ask you some questions, and you can write down or draw your answers on the paper. Try to make a picture of your community. The picture shows the relationships between boys and girls in your community.

As we ask you more questions, you can add to this picture of your community.

- (1) How are young people spending their time in your community? Are they in school? Are they working? What are their hobbies and interests?
- (2) What problems do young girls/boys face in your community? (Ask for specific examples).
- (3) What are the challenges that young girls/boys face when they move around in your community?

About Violence in Your Community (20 minutes)

The facilitator should ask one question at a time, and ensure that all responses are written down.

We are going to ask you to give us some information about violence that occurs in your community. Please remember that we are not looking for your personal stories. We want to learn about how violence affects people in your community. Sometimes, there may be many different answers. Please provide all the answers you can think about.

- (1) What types of incidents of violence take place against girls/boys in your community?
- (2) Where does this violence take place?
- (3) Who are the main perpetrators of violence against girls/boys in your community?
- (4) Which groups are most at risk of sexual violence in your community?
- (5) Are there ever times when girls/boys have to provide sexual favours to meet their basic needs (school fees, protection, food, housing, health care, etc.)?

We also want to ask you a question for general discussion. Please answer as best you can. We are seeking to learn from your way of thinking.

- What do you understand by gender-based violence?

The facilitator can explain gender-based violence if they are asked. However, the questions below will also help tease out how the participants understand the links between gender and violence.

We are now going to give you a scenario to consider. We would like to discuss your responses to these scenarios, and to act out your responses.

Scenario: A girl/boy in your community has been attacked by somebody they know. Show us what would happen if this took place in your community. What would the response be?

About Improving Responses to Violence in Your Community (10 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We want to go back to look at your community picture. We want to ask you about what might help to prevent and respond to violence in your community.

Please work in the same small groups as before.

We will ask you some questions, and you can write down or draw your answers on the paper.

- (1) What would help to make your community safer for girls/boys?
- (2) What could be done to prevent violence against girls/boys?
- (3) What services already exist to help girls/boys respond to violence?

About Your Attitudes to Violence (10 minutes)

The facilitator should ask one question at a time, and ask people to mark their response on the answer line: very true – unsure – very false.

We will share some statements with you. We will then ask you if you believe this statement to be very true or very false, or if you are unsure. Please place one dot on the answer line to identify your answer.

- If a girl/boy doesn't physically fight back, it's not rape.
- Girls should be careful about what they wear, or they might get raped.
- Only females can be raped.
- Women should always obey men.
- Sometimes girls/boys do things or say things to encourage other people to be violent towards them.

Facilitator's Guide to Focus Group Discussion
COMMUNITY LEADERS/MEN: 90 MINUTES

About Your Community (20 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We will start first with a general discussion about your community. We want to find out what everyday life is like for men, women, and children in your community.

Please form small groups of 3 or 4 people. We will provide you with some paper and pens.

We will ask you some questions, and you can write down or draw your answers on the paper. Try to make a picture of your community. The picture shows the relationships between men, women, boys, and girls in your community.

As we ask you more questions, you can add to this picture of your community.

- (1) Describe the relationships between men and women in your community.
- (2) Describe the relationships between adults and children in your community.
- (3) Are there any particular cultural rules or norms which impact on the relationships between men and women in your community?
- (4) At what age do girls and boys get married in your community?
- (5) Who is considered powerful in your community? What gives people power in your community?
- (6) How do women spend their time in your community? What type of work do they do? What about girls? Are they in school? Are they working?
- (7) How do men spend their time in your community? What type of work do they do? What about boys? Are they in school? Are they working?

About Violence in Your Community (25 minutes)

The facilitator should ask one question at a time, and ensure that all responses are written down.

We are going to ask you to provide us with some information about violence that occurs in your community. Please remember that we are not looking for your personal stories. We want to learn about how violence affects people in your community. Sometimes, there may be many different answers. Please provide all the answers you can think about.

- (1) What groups of people suffer from violence in your community? Identify which groups are most likely to suffer from violence.
- (2) What types of violence do people experience in your community? Identify which are the most common types of violence that people experience.

- (3) Where does this violence take place?
- (4) What types of violence affect women and girls specifically in your community/area?
- (5) What types of violence affect men and boys specifically in your community/area?
- (6) What kinds of factors might put women at risk in your community?
- (7) When and where does sexual violence occur in your community?
- (8) How is the problem of sexual violence now? How is it different from last year and previous years?
- (9) Why does violence occur in your community?

About Responses and Improving Responses to Violence in Your Community (25 minutes)

The facilitator should allow the groups a few minutes to respond to each question.

We want to go back to look at your community picture. We want to ask you what is currently available to support survivors of GBV in your community.

Please work in the same small groups as before.

We will ask you some questions, and you can write down or draw your answers on the paper.

- (1) Are there any services in your community that currently offer help to people who have suffered from violence?
- (2) Who would access these services and why?

We are now going to give you a scenario to consider. We would like to discuss what would happen in this scenario.

Scenario: A woman in your community has been attacked by somebody she knows. Explain in detail what would happen.

We want to go back to look at your community picture again. We want to get your ideas about what could be done to help prevent and respond to violence in your community.

- (1) You have identified some services that are available to help people who have suffered from violence. What are the barriers to accessing these services?
- (2) How could these services be improved?
- (3) You have identified who accesses the available services. What could be done to make access easier for these groups?

About Your Attitudes to Violence (10 minutes)

The facilitator should ask one question at a time, and ask people to mark their response on the answer line: very true – unsure – very false.

We will share some statements with you. We will then ask you if you believe this statement to be very true or very false, or if you are unsure. Please place one dot on the answer line to identify your answer.

- Men should share the work around the house with women, such as doing the dishes, cleaning and cooking.
- A woman can refuse to have sex with her husband.
- If a wife does something wrong, her husband has the right to punish her.
- When a woman is raped, she is usually to blame for putting herself in that situation.
- If a woman doesn't physically fight back, it's not rape.
- Women should be careful about what they wear, or they might get raped.
- Only women can be raped.

2.2 Key Informant Interview Guides

These tools should be used during key informant interviews.

The interviewer should assure interviewees that all information shared within the interview will remain confidential; if the interviewer takes down notes, s/he will not have any information identifying or associating individuals with responses. Some of these discussion topics are sensitive. The interviewer should take all potential ethical concerns into consideration before the interview, considering the safety of respondents, ensuring that all participants agree that no information shared in the discussion will be divulged outside of the group, and obtaining informed consent from interviewees.

The term “GBV” is used throughout this document. We recognize that this term may not mean anything to some interviewees. We may need to ask about specific types of GBV and use the types they identify in the remainder of the interview.

We have decided to leave the questions in a technical format for the purpose of offering a guideline to the interviewers. We recognize the need to be flexible when asking questions. In some cases, not all questions will be relevant. In other cases, the term GBV may be replaced by a specific kind of GBV which the interviewee has identified as occurring in their community. Flexibility is important in the interviews, and the primary aim should be to gather information.

In order to increase acceptance and ensure that participants are not the targets of community suspicion, threats or violence, be sure to consider:

- (1) If you do not feel it is safe to have this interview, or that it may cause risk for staff or participants, do not proceed.
- (2) Ensure you do not ask probing questions in an effort to identify the perpetrators of violence (e.g., one specific armed group).

Essential steps and information before starting an interview

- Introduce all interviewers and accompanying persons.

Explain the purpose of the discussion:

- General information about UNFPA
- Purpose of the interview is to understand concerns and needs for survivors of GBV
- Explain that this information will be used to improve services for survivors of GBV
- Participation is voluntary
- No one is obliged to respond to any questions if s/he does not wish
- Interviewees can leave the discussion at any time.

Gender-Based Violence Assessment in South-Eastern Assessment Tools
 KEY INFORMANT INTERVIEW QUESTIONS POLICE

1. Introduction

- What does gender-based violence (GBV) mean to you? *(If the respondent does not seem to know, you might want to ask: What about sexual violence or domestic violence?)*

2. Questions about types of gender-based violence

- What types of cases of GBV have you seen in your state?
- What are the 3 most frequent types of GBV in your state (e.g., sexual violence, marital rape, physical violence)?
- Who are the main survivors of GBV in your state?

3. Questions about reporting on gender-based violence

- Do you have a system of recording cases of GBV? And is there a special category in your reporting system for identifying offences which amount to GBV?
- How many cases of GBV were recorded in 2015? (Please use the table below. If you do not have data for the different types of GBV, please provide a total only. Identify if this is an exact figure or an estimate)

Type of Violence	Number in 2015 in the State
Victims of sexual violence (including rape and attempted rape)	
Victims of physical assault	
Victims of trafficking	
Total number	

- What happened in these cases of GBV? How many resulted in prosecution?

4. Questions about responding to gender-based violence

- Do you provide any services for a survivor of GBV?
- Do you have any special procedures for dealing with survivors if they are minors?
- Do you currently follow mandatory reporting before a survivor receives medical treatment? *(Check whether they are aware of, or are implementing the Emergency Care and Treatment Law).*
- Are there designated officers who handle these GBV cases?
- Do you have female officers? How many?
- Do you provide private rooms to gather testimonies and information from survivors of GBV?
- How do you ensure confidentiality and protection for GBV survivors?

5. Questions about support required to address gender-based violence

- Have police officers in your state received training on sexual violence or other forms of GBV? If so, what was the training about, who received it, who provided it, and how many days did it last? Are the individuals who were trained still in their posts?
- What involvement do you have with other service providers (such as NGOs, Government departments, health facilities, legal sector etc.) on the issue of GBV?
- What other structures, activities, and forums are police involved in to address the needs of victims/survivors of GBV in your state?
- What are some of the challenges you face in responding to GBV?
- How do you think these challenges could be addressed?
- What is your strategy for building trust in the community?
- What support would you like to help you to respond to GBV?

6. Questions about attitudes towards gender-based violence

- What do you think should be the police's role to prevent GBV?
- How can you tell if a woman has been raped?
- Do you think rape always leaves obvious injuries?
- Do you think GBV cases among married couples are a private matter and should not involve the police?
- Do you think a woman's prior sexual relationships have anything to do with rape?
- Do you think a woman is partly responsible for rape if she wears certain clothes or behaves in certain ways?
- What do you think is the most important thing to consider when responding to GBV cases?

Gender-Based Violence Assessment in South-Eastern Assessment Tools
KEY INFORMANT INTERVIEW QUESTIONS HEALTH CARE PROVIDERS

1. Introduction

- What does gender-based violence (GBV) mean to you?
(If the respondent does not seem to know you might want to ask: What about sexual violence or domestic violence?)

2. Questions about types of gender-based violence

- Does your facility treat survivors of GBV (e.g., survivors of sexual violence)?
- What are the most common types of GBV that you see in people who attend your facility?
- What are the most common types of violence that women and girls receive services for at your facility?

3. Questions about reporting on gender-based violence

- How many GBV survivors have you treated in 2015? (Please use the table below. If you do not have data for the different types of GBV, please provide a total only).

Type of Violence	Number in 2015 in the State
Victims of sexual violence (including rape and attempted rape)	
Victims of physical assault	
Total number	

- Were there any children under the age of 17?
- Were there any other vulnerable groups?

4. Questions about responding to gender-based violence

- What kinds of services does your facility provide for survivors of GBV?
- Who is the first point of contact in your facility when a survivor needs medical treatment?
- What pregnancy-related services do you routinely offer survivors after rape? Do you provide emergency contraceptives?
- Is post-exposure prophylaxis (PEP) provided to survivors?
- Is it possible for survivors/victims to receive counselling at your facility?
- Are there private examination spaces in your health clinics?
- How many female gynaecologists or doctors do you have?
- What is the cost to receive medical treatment?
- Do you collect physical evidence from survivors/victims (e.g., clothing, footwear, hair, fibres, or debris, etc.)? If so, where do you store it?
- Have you ever been asked to provide any of this as evidence in court?
(Question for township medical officers).
- Does this facility have protocols/guidelines for the management of rape survivors?

- How do the staff ensure confidentiality?
- Do you follow mandatory reporting to police before giving medical treatment? (*Check whether they are aware of, or are implementing the Emergency Care and Treatment Law*).

5. Questions about support required to address cases of gender-based violence

- Has anyone in your institution received training on GBV? If so, what was the training about, who received it, who provided it, and how many days did it last? Are the individuals who were trained still in their posts?
- Do you refer survivors of GBV to other service providers, police, and courts?
- Where else are survivors referred to (NGOs, support groups)? (*Try to get the names of the institutions*).
- How would you describe the relationship between this health care facility and NGOs and the police when addressing GBV cases?
- What other structures, activities, and forums is your facility involved in to address the needs of victims/survivors of GBV?
- What are some of the challenges that you face in responding to cases of GBV?
- How do you think these challenges could be addressed?
- How do you think the health sector can be supported to improve GBV responses?

6. Questions about attitudes towards gender-based violence

- Do you think it is important to treat survivors/victims of rape as urgent cases?
- Do you think rape always leaves obvious signs of injuries?
- Do you think a woman's prior sexual relationships have anything to do with rape? Does rape hurt women who are sexually experienced?
- Do you think GBV cases among married couples are a private matter and should not involve outsiders?
- Do you think a woman is partly responsible for rape if she wears certain clothes or behaves in certain ways?

Gender-Based Violence Assessment in South-Eastern Assessment Tools
KEY INFORMANT INTERVIEW QUESTIONS PROTECTION, PSYCHOSOCIAL
(I/NGO, CSOS, DSW, MYANMAR WOMEN'S ASSOCIATION FEDERATION)
AND OTHER DUTY BEARERS (LOCAL ADMINISTRATORS)

1. Introduction

- What does gender-based violence (GBV) mean to you? (*If the respondent does not seem to know you might want to ask: What about sexual violence or domestic violence?*)
- What types of GBV do you think are most prevalent in this community?

2. Questions about the organization and its responses to gender-based violence

- What kinds of programmes is your agency implementing to respond to GBV?
- What kinds of services are provided (e.g., case management, counselling, drop-in visits, group support)?
- Do you have specific programmes which are targeted at the prevention of GBV?
- Do you have any activities targeting women and girls or gender equality issues specifically (e.g., empowerment, women, peace and security, education, vocational training, and male engagement)?

3. Questions about the organization and its capacity to respond to gender-based violence

- What is the geographical coverage of your programmes?
- How many staff do you have?
- Do you have staff who work specifically on gender or GBV issues?
- Has anyone in your institution received training on sexual violence or other forms of gender-based violence (e.g. general, counselling, case management)? If so, what was the training about, who received it, who provided it, and how many days did it last? Are the individuals who were trained still in their posts?

4. Questions about types of gender-based violence (for GBV service providers)

- What types of GBV do you handle in your organization?
- How many GBV survivors do you support monthly (approximately)?
- How many did you support in total in 2015 (approximately)?
- Were there any children under the age of 17?
- Were there any other vulnerable groups?
- What are the most common types of violence that women and girls receive services for at your facility?

5. Questions about referrals of gender-based violence

- Who is the first point of contact in the community when a survivor of GBV needs support services? Who do survivors or family members usually contact?
- Do survivors access medical treatment and file a police report? If they don't, what are the obstacles or reasons (e.g. no service, distance to facilities, stigma)?
- What do you think are the major gaps in terms of preventing and responding to GBV?
- If your staff come across a case of GBV during their work, what would they do?
- How would you describe the relationship between your office and NGOs, health care providers, and the police in GBV cases?
- What other structures, activities, and forums (or other coordination systems) is your institution involved in to address the needs of victims/survivors of GBV?
- What kinds of actions/activities do you think are important in terms of reducing women's and children's vulnerability to violence?

6. Questions about support required to address cases of gender-based violence

- What are some of the challenges you face in responding to sexual violence or other forms of GBV?
- How do you think these challenges could be addressed?
- What is your strategy for building trust in the community?
- If a GBV programme were to start in this state, where do you think the focus should be to improve prevention and responses?

7. Questions about attitudes to gender-based violence

- Do you think a woman's prior sexual relationships have anything to do with rape?
- Do you think GBV cases among married couples are a private matter and should not involve police or other outsiders?
- Does rape hurt women who are sexually experienced?
- Do you think a woman is partly responsible for rape if she wears certain clothes or behaves in certain ways?

Training and Consultation Agendas



3.1 GBV Consultation with Government Stakeholders

Time	Session	Methodology
9:00-9:20	Welcome and introduction	Welcome by the facilitators Objectives of the assessment
9:20-10:45	What is GBV?	Orientation on GBV key issues using a Power Point presentation, definition of GBV, types, causes and contributing factors and guiding principles (Please see the Power Point and training manual).
10:45-11:00	Tea break	
11:00-2:15	GBV response - opportunities, gaps, challenges	<p>Methodology: Stakeholder mapping, group discussion and plenary session.</p> <ul style="list-style-type: none"> ▪ In the plenary, ask participants to identify key GBV responders/stakeholders in the four sectors of: health, justice, protection and psychosocial support. Draw four large circles on a flip chart and write down names. If some stakeholders do not fit within the four circles write them outside. ▪ Break out into 4-5 groups. Ask each group to discuss opportunities, gaps, challenges and recommendations for one sector. ▪ Each group will present their discussion in plenary. <p>After the presentations, discuss how these sectors/stakeholders work together or do not work together to see if there are referral mechanisms and coordination. If there is time, ask how referral and coordination can be improved.</p>
12:15-12:30	Closing	Way forward

3.2 GBV Consultation with Civil Society Organizations

Time	Session	Methodology
9:00-9:20	Welcome and introduction	Welcome by the facilitators Objectives of the assessment
9:20-10:00	GBV in Kayah/Kayin/ Mon States	Methodology: Small group discussion, gallery walk and plenary session. <ul style="list-style-type: none"> Form 3-4 groups. Ask each group to discuss common types of GBV in the state and vulnerable groups. Ask them to draw a map of the state and identify (if any) high risk villages/townships. After 20 mins, ask each group to post their list/map on the wall. Take a few minutes to allow everyone to see other group work. Review commonalities and ask for clarifications if needed in plenary.
10:00-10:15	Tea break	
10:15-11:00	Contributing factors and consequences	Methodology: Problem Tree (group work), gallery walk and plenary session. <ul style="list-style-type: none"> Use the main types of GBV that came up in the previous session and develop a problem tree to analyse the causes, contributing factors and consequences in as much detail as possible. If some people are not familiar with this methodology, show an example. (E.g. child malnourishment). Provide a flip chart and a few markers to each group. Ask one person in each group to draw a large tree trunk and to write their assigned GBV type on the trunk. Ask the groups to brainstorm some of the causes. This can be as broad or as narrow as the group desires. On the problem tree, each cause should be depicted as one of the roots of the tree. After mentioning each cause, the group should think about what else can contribute to that initial cause. For example, if a cause is "lack of education among women," then the group should think about what contributes to the lack of education among women. The second step focuses on identifying the different consequences. In their picture of a problem tree, the consequences will be depicted as the branches of the tree. As they did with the causes, the groups should brainstorm and identify the primary and the secondary consequences. <p>After the group work, ask them to post their tree and ask for clarifications or discuss main issues in plenary.</p>
11:00-12:15	GBV response - opportunities, gaps, challenges	Methodology: Stakeholder mapping, group discussion and plenary session. <ul style="list-style-type: none"> In the plenary, ask participants to identify key GBV responders/stakeholders in the four sectors: health, justice, protection and psychosocial support. Draw four large circles on a flip chart and write down names. If some stakeholders do not fit within the four circles write them outside. Break out into 4-5 groups. Ask each group to discuss opportunities, gaps, challenges and recommendations for one sector. Each group will present their discussion in plenary. <p>After the presentation, discuss how these sectors/stakeholders work together or do not work together to see if there are any referral mechanisms and/or coordination. If there is time, ask how referral and coordination can be improved.</p>
12:15-12:30	Closing	Way forward

3.3 GBV Orientation to Health Care Providers

Time	Session
9:00-9:15	Welcome and introduction
09:15-10:45	Understanding GBV
10:45-11:00	Tea break
11:00-12:00	GBV guiding principles
12:00-13:00	Lunch break
13:00-14:00	Consequences of GBV
14:00-14:30	Overview of GBV response
14:30-14:45	Tea break
14:45-16:00	GBV response in health sector
16:00-16:15	Closing (evaluation)

3.4 GBV Orientation to Myanmar Police Force

Time	Session
9:00-9:30	Welcome and introduction
9:30-10:45	Tea break
10:45-11:00	Gender and sex
11:00-11:30	Understanding GBV
11:30-12:00	Justice continuum: Process of seeking justice for survivors - prevention and initial contact
12:00-13: 00	Lunch break
13:00-14:30	Five key messages on how to respond to the needs of GBV survivors
14:30-15:30	GBV and Police response
15:30-16:00	Closing (evaluation)



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