No One Left Behind

Gender Analysis for Inclusive Humanitarian Response to the 2025 Myanmar Earthquake

August 2025

GENDER
IN HUMANITARIAN ACTION
Myanmar

Acknowledgements

This Gender Analysis was developed under the leadership of the Myanmar Gender in Humanitarian Action (GiHA) Working Group, with the valuable support and contributions of its members and humanitarian partners responding to the 2025 Myanmar earthquake.

We extend our sincere appreciation to the field enumerators and coordination teams—including representatives of local women's organizations and protection actors—whose dedicated efforts enabled the meaningful participation of women, men, girls, boys, persons with disabilities, older persons and LGBTIQ+ individuals.

The GiHA Working Group gratefully acknowledges the support of the Finnish Refugee Council and the contributions of the Gender Analysis Task Force, whose members include representatives from UN Women, CARE, PLAN, the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP).

Most importantly, we thank the women and community members who generously shared their time and perspectives during this challenging period. This report amplifies their voices and priorities and reflects a shared commitment to ensuring humanitarian assistance respects the dignity, safety and rights of all.

About the Myanmar Gender in Humanitarian Action Working Group

The Myanmar GiHA Working Group is a coordination platform that brings together humanitarian and gender equality actors to ensure the needs and rights of crisis-affected women, girls and marginalized groups are effectively addressed in Myanmar's humanitarian response.

Co-led by UN Women and UNFPA, the Working Group includes local women-led and women's rights organizations, civil society and community-based groups, international non-governmental organizations (NGOs), UN agencies, donor gender focal points (as observers), and cluster coordinators and focal points.

The GiHA Working Group promotes the integration of gender equality and technical expertise across all sectors and supports coordinated, evidence-based approaches to advancing women's empowerment, leadership and inclusive humanitarian action.

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ABBREVIATIONS AND ACRONYMS

AAP	Accountability to Affected Populations
CBO	Community-Based Organization
CSO	Civil Society Organization
EQ	Earthquake
GBV	Gender-Based Violence
GiHA	Gender in Humanitarian Action
HH	Household
HoH	Head of Household
HNO	Humanitarian Needs Overview
IDP	Internally Displace Person
LGBTIQ+	Lesbian, gay, bisexual, transgender, queer, and other people with diverse sexual orientation, gender identity, gender expression and sex characteristics.
MHPSS	Mental Health and Psychosocial Support
MIRA	Multi-Cluster/Sector Initial Assessment
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PWD	Person with Disability
PSEA	Protection from Sexual Exploitation and Abuse
SRH	Sexual and Reproductive Health
SOGIESC	Sexual orientations, gender identities and expressions and sex characteristics
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WASH	Water, Sanitation, and Hygiene
WGSS	Women and Girls' Safe Spaces

EXECUTIVE SUMMARY

On 28 March 2025, a 7.7 magnitude earthquake struck Myanmar, causing widespread devastation—particularly in and around the densely populated regions of Sagaing and Mandalay. To date, 17.2 million people have been affected, more than 3,700 people have died and over 5,000 have been injured. Among those affected are nearly 9 million women and girls.[1]

This disaster occurred against a backdrop of deep humanitarian need, compounding the effects of ongoing conflict, protracted displacement and economic instability. The crisis has intensified existing vulnerabilities and placed additional stress on already fragile systems, with disproportionate impacts on women, girls and other marginalized groups.

In response, the Myanmar Gender in Humanitarian Action (GIHA) Working Group conducted this Gender Analysis to examine how the crisis has differently impacted women, girls, men, boys, older persons, persons with disabilities and people identifying as lesbian, gay, bisexual, transgender, queer and other people with diverse sexual orientation, gender identity, gender expression and sex characteristics (LGBTIQ+). It aims to inform a more inclusive, equitable and coordinated response that prioritizes rights, safety, dignity and meaningful participation.

Drawing on 2,136 household interviews and 298 site observations, the analysis outlines key risks, barriers and coping strategies, and reflects the voices of affected communities. The findings reinforce the need for inclusive programming that integrates diverse perspectives and strengthens local, women-led responses and leadership.

The findings have been shared with humanitarian partners, including local organisations operating in the affected areas and coordination groups responsible for key sectors of the response (Clusters and working groups), to help guide immediate and longer-term actions. By providing timely, evidence-based insights, this report supports efforts to ensure that the humanitarian response is inclusive, gender-responsive, and reflective of the diverse needs and experiences of affected communities.

See the interactive dashboard[2] for the full dataset and additional insights.

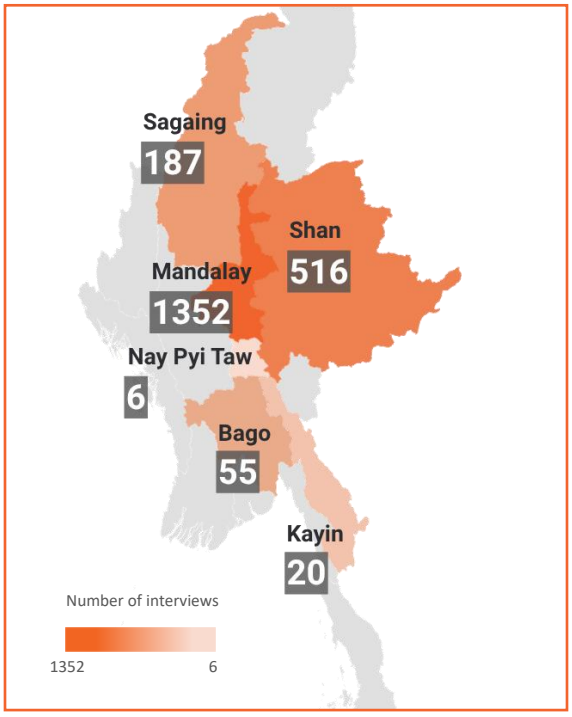


Figure 1. Geographic scope of in-person interviews.

Boundaries and names do not imply official UN endorsement.

[1] GiHA Working Group. *Myanmar Earthquake: Gender Situation Report No. 1 – 9 May 2025*. (reliefweb.int/report/myanmar/myanmar-earthquake-gender-situation-report-no-1-9-may-2025)

[2] Interactive Dashboard: https://tinyurl.com/49nxdevc

Overview of key findings and recommendations

PROTECTION, SAFETY AND GENDER-BASED VIOLENCE

Key findings	Priority recommendations
• Women and Girls' Safe Spaces (WGSS) were found in just 2% of assessed sites, with low levels of reported use. • Women and girls face heightened protection and gender-based violence (GBV) risks in overcrowded, mixed-gender shelters with limited privacy. • Fewer than one in five shelters have internal locks; 30% of respondents said women and girls lacked safe places to sleep, and one in three households reported feeling unsafe in their current shelter. • More than half of surveyed women avoid public areas (including toilets) due to fear of GBV; 11% report that male family members restrict their movement. • Less than half of surveyed women know how to report GBV and over 50% say they do not know or have no way to report it safely. • Most women rely on informal reporting pathways: 45% would turn to a family member, while only 7% would approach health staff or WGSS.	• Expand access to WGSS, especially in underserved sites. • Improve safety, privacy and dignity in shelters by ensuring internal locks and partitioned living spaces. • Improve safety and privacy in bathing and toilet facilities, especially for women, girls, persons with disabilities and LGBTIQ+ individuals. • Strengthen community-based awareness of, and reporting systems for, protection risks, including prevention of sexual exploitation and abuse (PSEA). • Ensure information and services related to GBV, sexual exploitation and abuse and survivor support are accessible, well-communicated, and clearly signposted in all locations.

> **"When we slept on the streets, some men would circle around on motorbikes watching—especially near where girls slept."**
>
> *23-year-old woman in Mandalay*

MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING

Key findings	Priority recommendations
• 33% of women report difficulty sleeping, anxiety or persistent sadness, compared to 29% of men. • Only 15% of respondents report access to mental health and psychosocial support (MHPSS) services, with women and LGBTIQ+ individuals facing the greatest barriers to safe, confidential care. • Only 6% identify WGSS as a source of psychological support.	• Provide targeted psychosocial support for GBV survivors, female-headed households, persons with disabilities and those identifying as LGBTIQ+. • Improve trust and confidentiality in GBV and MHPSS services by strengthening survivor-centred approaches and ensuring safe, confidential reporting systems. • Strengthen local capacity by training community-based counsellors and facilitating peer support groups through WGSS.

ACCESS TO ESSENTIAL SERVICES: FOOD, HEALTH, SHELTER, WATER AND SANITATION

Key findings	Priority recommendations
• 47% of female-headed households report receiving food aid, compared to 51% of male-headed households. • Women and LGBTIQ+ persons are more likely to eat less or skip meals due to lack of resources: 54% eat less (vs. 39% of men), and 36% go without eating (vs. 28% of men). • Maternal and sexual health services are under-resourced and often inaccessible, particularly in areas lacking female health staff. • Overcrowding is widespread: 48% of shelters house two or more families, increasing GBV risks and stress, especially for women and children. • Fewer than one in four women and girls report having access to necessary menstrual hygiene materials or safe, private sanitation spaces.	• Prioritize food aid for households headed by women and persons with disabilities. • Address gendered risks in food collection and distribution, including exposure to harassment and violence. • Ensure maternal health services are safe, accessible and well-communicated in all locations. • Improve shelter conditions by reducing overcrowding and ensuring accessibility, privacy, lighting and space for assistive devices. • Integrate menstrual hygiene management into water, sanitation and hygiene (WASH) and protection programming, and provide menstrual hygiene materials as part of non-food item distributions. • Ensure sectoral data collection and reporting are disaggregated by sex, age and disability to identify and address inequities in access and impact. • Ensure services are clearly communicated, inclusive, and contextually relevant, with information accessible to all population groups.

> **"Girls feel ashamed because there is no safe or discreet way to manage menstruation."**
>
> *22-year-old woman in Nay Pyi Taw*

CASH-BASED ASSISTANCE AND LIVELIHOOD RECOVERY

Key findings	Priority recommendations
• While widely preferred, cash assistance poses specific safety risks for women, including theft, coercion and harassment at distribution points. • 62% of respondents cite cash as critical to meet food needs; 59% need it for healthcare and 17% for physical rehabilitation or assistive devices. • Half of respondents report they cannot improve shelter or living conditions without cash, while 26% prioritize it for livelihood recovery.	• Expand access to cash assistance using delivery models that address the safety, mobility and digital access needs of women and vulnerable groups. • Promote inclusive financial literacy and digital tools to ensure safe, equitable use of cash. • Ensure cash programmes are tailored to meet both immediate needs and longer-term recovery goals.

> **"People lack information about available aid and don't know who to ask."**
>
> *35-year-old woman in Mandalay*

PARTICIPATION IN AND ACCESS TO HUMANITARIAN ASSISTANCE

Key findings	Priority recommendations
• Households headed by women and persons with disabilities face greater barriers to accessing aid, health services and safe shelter. • Women and girls are underrepresented in decision-making, under-consulted by humanitarian actors and more likely to report emotional distress or rely on negative coping strategies.	• Strengthen inclusive community-level consultation and feedback mechanisms by actively engaging women, youth, persons with disabilities and other marginalized groups in decision-making. • Use accessible tools to inform and adapt programming based on community input. • Support the leadership and participation of local women-led and women's rights organizations in site management and coordination forums. • Apply the Washington Group Short Set of questions on functioning to strengthen outreach to persons with disabilities and gather inclusive, disaggregated protection data.

BACKGROUND

On 28 March 2025, a 7.7 magnitude earthquake struck Myanmar, causing widespread devastation—particularly in and around the densely populated regions of Sagaing and Mandalay. It impacted communities already experiencing multiple, overlapping crises, including protracted conflict, economic hardship and mass internal displacement.

The earthquake resulted in more than 3,700 deaths and over 5,000 injuries. It affected more than 17.2 million people, including nearly 9 million women and girls,[3] and thousands of homes, health facilities and public infrastructure were damaged or destroyed. Women and girls—particularly those who are displaced, widowed, pregnant, or living with disabilities—face heightened protection risks, loss of livelihoods and reduced access to health, education and social services.

The crisis has exacerbated pre-existing inequalities and deepened vulnerabilities among marginalized groups. Women, girls, persons with disabilities and older persons, continue to face additional barriers to mobility, shelter and access to essential services.

In response, the Gender in Humanitarian Action (GiHA) Working Group initiated this Gender Analysis to assess the gendered impacts of the earthquake and provide evidence-based recommendations to inform a more inclusive and equitable response.

This report complements a series of gender-focused updates issued by the GiHA Working Group since the onset of the crisis, including:

- Gender-Impact Flash Update: Myanmar Earthquake, No. 1
- Gender-Impact Flash Update: Myanmar Earthquake, No. 2
- Gender Situation Report: Myanmar Earthquake, No. 1

These resources can be accessed from the *MIMU 2025 Myanmar Earthquake Resource Page*[4]

Methodology

Data for the analysis was collected through 2,136 household surveys and 298 site observations administered between 24 April and 2 May 2025.

A purposive, convenience-based sampling approach was used, meaning households and locations were selected based on the severity of earthquake impact and accessibility (as identified by UN OCHA). While this limits statistical generalizability, the data offers a meaningful snapshot of conditions in affected areas.

The household survey comprised approximately 100 questions covering:

- Demographics and household composition
- Disability and functional limitations (based on the Washington Group Short Set of questions on functioning)
- Community decision-making and participation
- Access to food, health, shelter, cash and water, sanitation and hygiene services (WASH)
- Protection concerns, including risks of gender-based violence (GBV)
- Emotional wellbeing and psychosocial stressors
- Freedom of movement and related safety constraints
- Priority needs as expressed by affected populations

[3] *Gender Situation Report No. 1*, GiHA WG

[4] MIMU 2025 Myanmar Earthquake Resource Page themimu.info/emergencies/sagaing-earthquake-2025

In the immediate aftermath of the earthquake—amid insecurity and access constraints—trained enumerators used observational methods to rapidly capture qualitative insights into gendered impacts. This approach enabled the collection of indirect data in a sensitive, non-intrusive manner, and helped highlight the overall situation on the ground. While not used for quantitative analysis, these observations complemented the household survey by cross-checking key trends and helping to provide a deeper understanding of the crisis context.

Observation surveys, conducted by enumerators using a mobile Kobo application, assessed:

- The physical conditions of shelters and facilities
- Privacy, security risks and accessibility
- Visible gender dynamics at key locations (such as in queues and at food distribution points)
- Presence and visibility of different groups (women, girls, men, boys, older persons, and persons with disabilities)
- Visibility of public messaging and support services

The full dataset and additional insights are available in the **interactive dashboard**.[5]

To strengthen the analysis, findings were compared with other emergency needs assessments conducted after the earthquake (see Appendix 1 for comparative analysis).

At a 95% confidence level, the calculated margin of error is approximately ±2.1% for the household survey and ±5.7% for the observation survey, based on standard assumptions of maximum variability. These margins reflect sampling size alone and do not account for other sources of potential bias such as nonresponse or field conditions. Findings should therefore be interpreted as indicative rather than representative of all earthquake-affected areas in Myanmar.

Data collection

Data was collected over a nine-day period across townships in Mandalay, Sagaing, Magway, Kayin and others. Surveys were conducted by GiHA Working Group members, staff from civil society organizations, community volunteers and youth from affected areas. All enumerators received two days of training, including on GBV, child protection and prevention of sexual exploitation and abuse (PSEA). They collected data in both formal and informal displacement sites, religious compounds, host communities and temporary evacuation centres in urban and rural settings.

Demographics

The survey captured detailed household information, including the gender, age and accommodation status of household heads. This lens helps identify which groups face greater risks of prolonged displacement and inadequate housing.

- **66% of survey respondents** were women—likely reflecting caregiving roles or the availability of women during the assessment period.
- **67% of reported household heads** were men.
- **30% of households** were headed by women—a substantial minority, highlighting the need to address their specific protection and livelihood challenges.
- **2% of households** were headed by LGBTIQ+ persons.
- **1% of households** were persons with disabilities.
- **Children** were present in over 80% of households and **older persons** in 41%.
- **22% of households** were headed by adults aged 61 years or older, suggesting older people are playing a significant role in supporting households during the crisis.

[5] Interactive Dashboard: https://tinyurl.com/49nxdevc

Disability and inclusion

The Washington Group Short Set of six questions on functioning was used to identify persons with disabilities across multiple domains. Among respondents who disclosed their gender, the proportion meeting the WGSS threshold for disability was:

- 12% of women
- 10% of men
- 11% of LGBTIQ+ individuals

When disaggregated by gender, disability prevalence was linked with lower levels of consultation and access to humanitarian assistance—suggesting that persons with disabilities, especially women and LGBTIQ+ individuals, remain underserved in the humanitarian response.

Key findings on functional difficulties are presented in the main report, with a more detailed breakdown provided in Appendix 2.

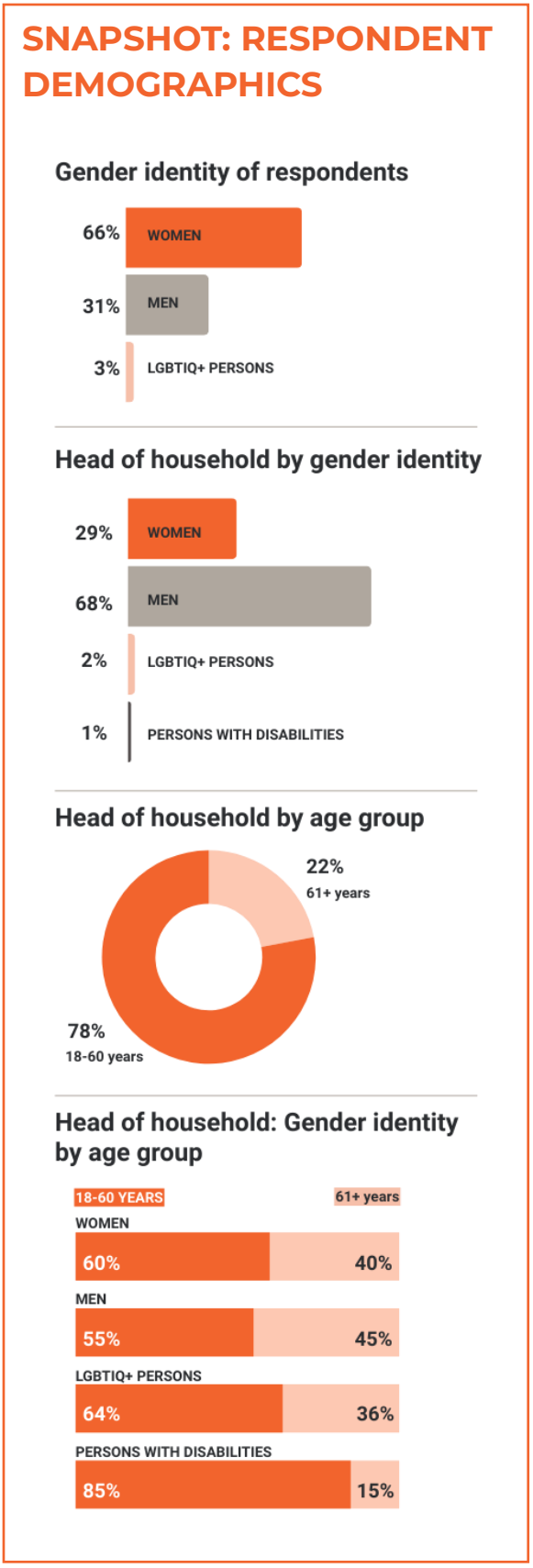


Figure 2. Demographic profile of respondents.

A member of the Myanmar GiHA Working Group speaks with a woman affected by the March 2025 earthquake in Myanmar. Photo: UN Women.

FINDINGS & RECOMMENDATIONS

KEY FINDINGS

Impact on households

The survey responses help provide an understanding of how conflict and disaster have affected households across Myanmar.

Respondents described both the structural damage and social impacts of the earthquake and identified their priority needs.

Findings are disaggregated by gender and household type to show intersecting vulnerabilities:

- **Displacement** due to the earthquake, was reported by 37% of male-headed and 37% of female-headed households, and by 38% of households headed by individuals identifying as LGBTIQ+. Rates were even higher among households headed by persons with disabilities, reaching 50%.
- **Loss of income**, although not directly asked about, was mentioned by nearly one in five households as a constraint.
- **Household separation** affected 14% of LGBTIQ+-headed households and 9% of female-headed households, compared to 7% of male-headed households.

These findings indicate that displacement and social fragmentation disproportionately affect households already facing structural barriers, such as those led by women, persons with disabilities and LGBTIQ+ individuals (see Appendix 3 for more detailed recommendations regarding LGBTIQ+ inclusion).

Community decision-making and consultation

Survey responses reveal gender disparities in decision-making roles and access to community consultation mechanisms.

- **Local government** was the most cited decision-maker across all gender groups.
- **Elders and religious leaders** (predominantly male) continue to play prominent roles in community governance and coordination, particularly during crises.
- **LGBTIQ+ respondents** were slightly more likely to mention military and religious authorities as decision-makers.
- **Male-headed households** were the most likely to be consulted about humanitarian assistance (31%). In comparison, only 29% of female-headed households, 26% of older persons, and 20% of persons with disabilities were consulted.
- **Less than 60% of respondents** knew how to provide feedback on the assistance or services they received.

These findings highlight the gender imbalances in leadership, with women, persons with disabilities and marginalized gender and age groups facing barriers to influence and representation in formal leadership roles in recovery efforts. The findings also show a troubling gap in inclusive, two-way communication between affected populations and service providers, reinforcing the need for more inclusive community engagement.

Priority needs of affected populations

Across household types, respondents consistently identified cash and food as their highest needs, with some variation in needs reflecting gender roles, caregiving responsibilities and barriers to service access (see Figure 3).

- **Cash assistance** was the most cited need, followed by food and health care, with shelter and household items close behind.
- **Support for pregnant or lactating women, nutrition for infants and sanitation and hygiene needs** were emphasized by households headed by women and persons with disabilities.

- **Mental health and psychosocial support (MHPSS), protection and education** were noted by a small proportion but remain relevant for inclusive response planning.

These findings underscore the compounding effects of marginalization during crises. Female-headed and LGBTIQ+-headed households face multiple, intersecting hardships, reinforcing the urgency of needs for dignified shelter, document recovery and reunification support.

Access to humanitarian assistance

Access to aid varied by household type:

- 60% of female-headed and 62% of male-headed households reported receiving humanitarian assistance in the previous 30 days.
- LGBTIQ+-headed households had the highest reported access, at 67%.
- Only 47% of households headed by a person with a disability received assistance—significantly lower than in other households.

Among surveyed households, a significant proportion included only one adult caring for children under 18. Given the heightened vulnerabilities of these households, further detail is provided in Appendix 4, and additional child-related findings by gender are provided in Appendix 5.

Distribution within households also revealed gendered patterns:

- In male-headed households, aid was most often received by men and boys.
- In female-headed households, women and girls were more likely to receive aid.
- In LGBTIQ+-headed households, men and boys were slightly more likely to receive the assistance than other members.

Key barriers to aid access included:

- **Gender-based exclusion:** 21% of female-headed households reported that women and girls were not permitted by their families to access aid.
- **Lack of female staff:** Between 8% and 14% across all groups cited this as a barrier.
- **Service inaccessibility:** Households headed by LGBTIQ+ individuals and persons with disabilities more frequently reported that

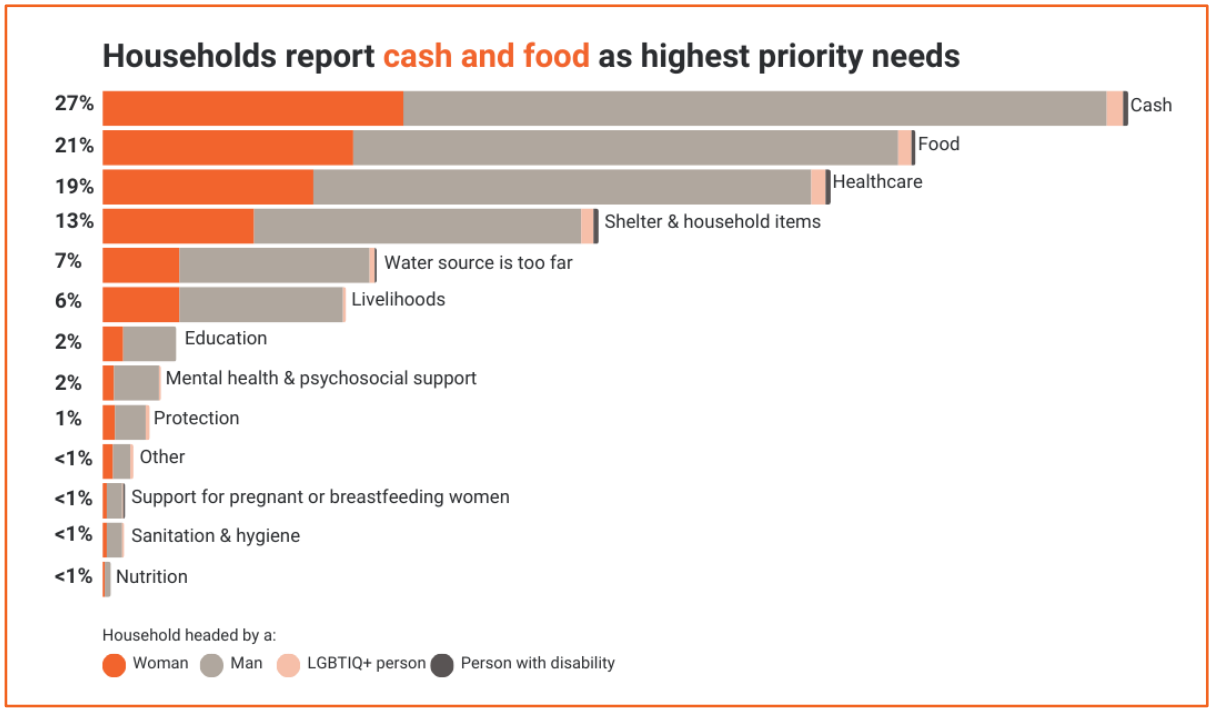


Figure 3. Ranked distribution of priority needs identified by households (%).

services were not adapted or accessible to them.

These findings highlight a critical gap in inclusive humanitarian engagement. Many persons with disabilities—especially women and gender-diverse individuals—remain underserved and unheard in current humanitarian programming. Addressing these gaps will require inclusive outreach strategies and tailored distribution mechanisms.

Cash-based support

Cash assistance was the most widely preferred form of support across all household types and age groups, though key differences emerged in intended use, access preferences and household control over cash (see Figure 4).

- Cash was the preferred modality across all groups, though some female-, older-person- and disability-headed households favoured in-kind support.
- Service-based assistance was more often preferred by disability-headed households but overall remained the least favoured option.
- Digital transfers—especially via KP and Wave Money—were the most preferred access method.
- Food, healthcare and shelter were the top intended uses of cash assistance, with slight variation across groups.
- LGBTIQ+-headed households uniquely prioritized shelter first, then health, followed by food.
- While 73% of respondents said women, girls, or persons with disabilities could access markets, 27% cited significant barriers—including mobility, safety and cost.

The findings highlight a strong preference for flexible cash assistance, yet access barriers persist for many, particularly related to mobility, safety, and digital exclusion. Humanitarian cash programmes must integrate financial literacy, establish safe and accessible distribution points and apply inclusive strategies at the household level. Multi-purpose cash should be designed to meet both immediate lifesaving needs and longer-term recovery priorities, while addressing transport, communication and protection-related constraints.

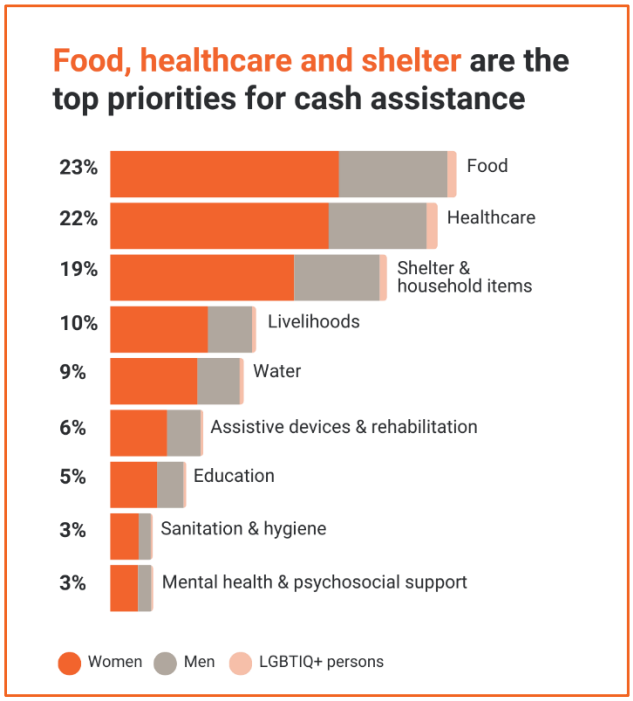
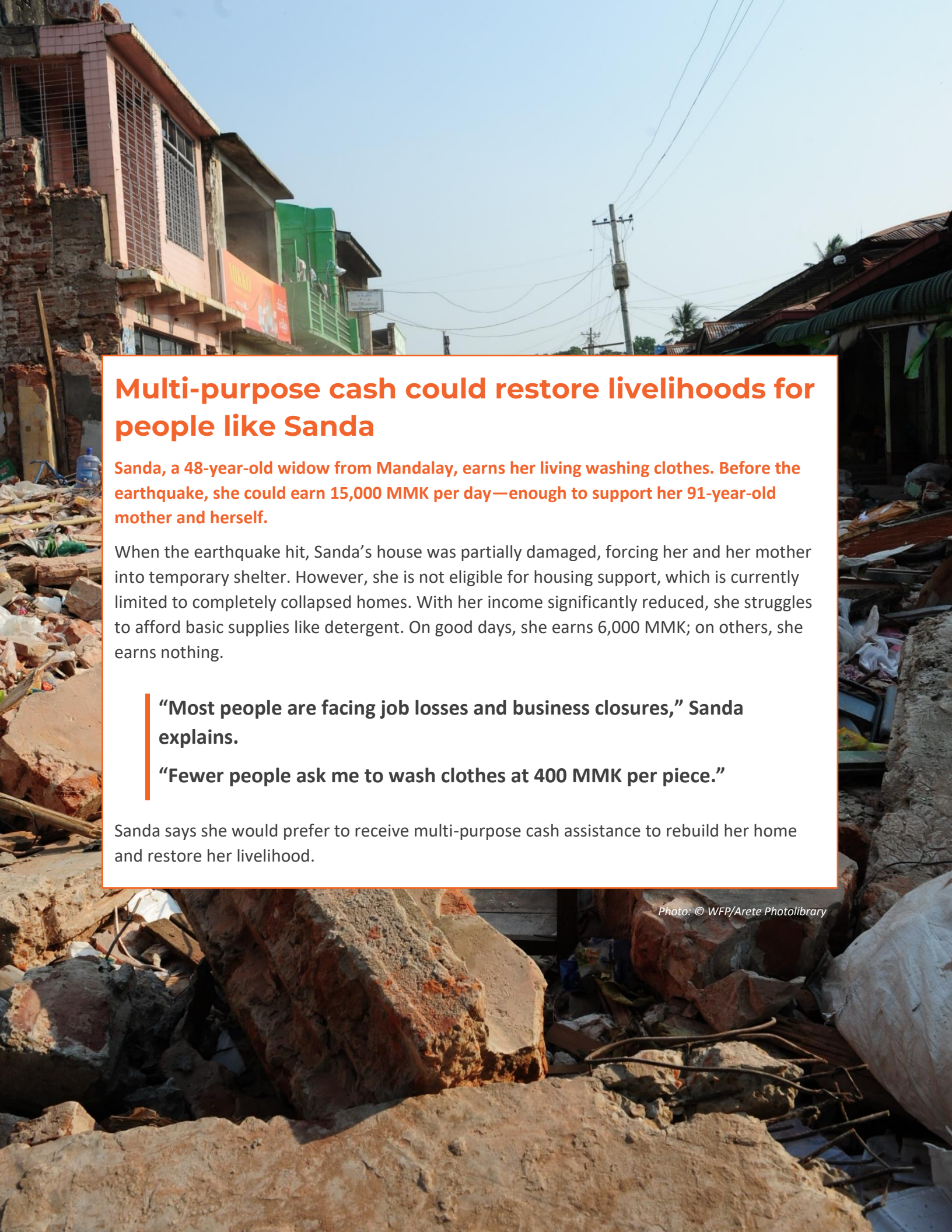


Figure 4. Planned use of cash, by share of respondent selections (%).



Multi-purpose cash could restore livelihoods for people like Sanda

Sanda, a 48-year-old widow from Mandalay, earns her living washing clothes. Before the earthquake, she could earn 15,000 MMK per day—enough to support her 91-year-old mother and herself.

When the earthquake hit, Sanda's house was partially damaged, forcing her and her mother into temporary shelter. However, she is not eligible for housing support, which is currently limited to completely collapsed homes. With her income significantly reduced, she struggles to afford basic supplies like detergent. On good days, she earns 6,000 MMK; on others, she earns nothing.

> **"Most people are facing job losses and business closures," Sanda explains.**
>
> **"Fewer people ask me to wash clothes at 400 MMK per piece."**

Sanda says she would prefer to receive multi-purpose cash assistance to rebuild her home and restore her livelihood.

Photo: © WFP/Arete Photolibrary

SECTORAL ANALYSIS & RECOMMENDATIONS

This section highlights gendered disparities in access, decision-making and support across humanitarian sectors. Differences linked to gender, age, disability and household type underscore the urgency of inclusive, targeted approaches that meet the distinct needs of marginalized groups across all areas of humanitarian response.

Food security and access to nutrition

Nearly half of surveyed households reported receiving food assistance following the earthquake. However, access was uneven: only 43% of households headed by persons with disabilities and 42% of those headed by LGBTIQ+ individuals reported receiving aid, compared to 51% of male-headed and 47% of female-headed households.

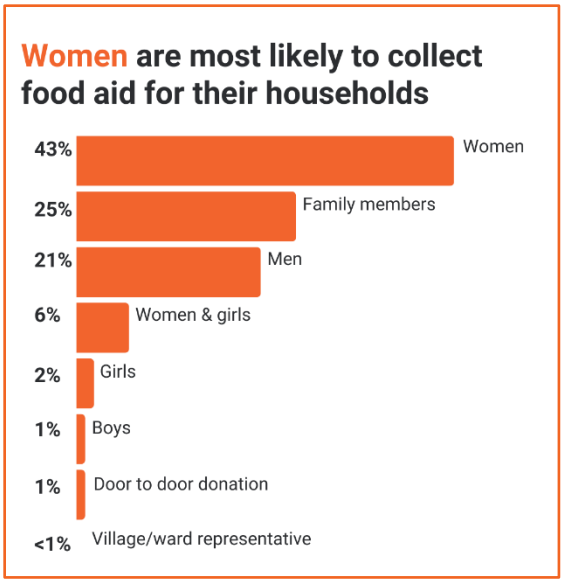


Figure 5. Person reported to have collected food aid.

Women and girls play a critical but often under-recognized role in household food management. In 41% of households, women were the primary aid collectors, compared to 23% for men. Girls and boys also contributed, in 16% and 6% of households, respectively (see Figure 5).

Despite their additional work burdens and caregiving roles, women's nutritional needs are not always prioritized: 14% of households reported that women ate last. Yet, women also often bear the responsibility for decision-making on how food is used and shared in households, particularly in food-insecure households (see Figure 6).

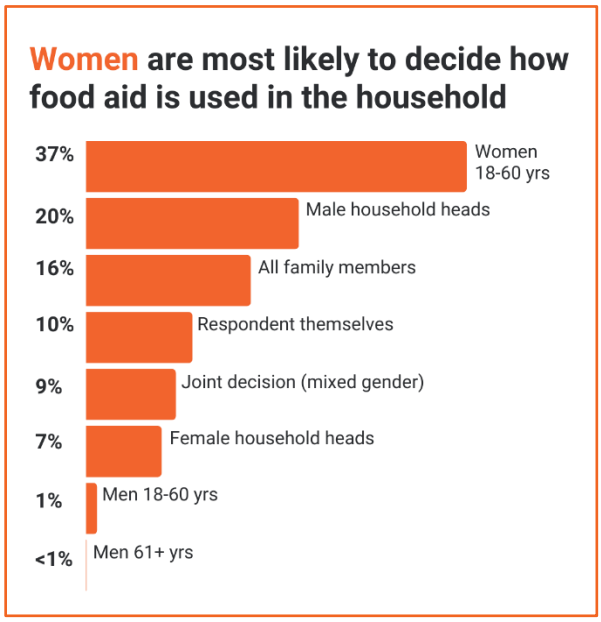


Figure 6. Reported household decision-makers on food aid use (% of respondents).

Food assistance often fell short of meeting household needs. Only one-third of respondents said food aid was sufficient, while over two thirds

reported it was not enough, only sometimes sufficient, or that someone in the household had gone hungry.

Coping strategies reflected this scarcity. Among over 1,000 narrative responses describing changes in eating habits since the earthquake, nearly 100 people said they were eating less to prioritize children, and 43 explicitly mentioned that "women have to reduce meals." These responses suggest women may be taking on a disproportionate burden during times of food insecurity.

Over one-third of households exchanged food for other needs, underscoring the economic strain on households and the fragility of household food security, particularly for those already marginalized by disability or gender identity.

Addressing food insecurity requires more than food distribution. It demands targeted, inclusive strategies that confront the gendered dynamics of food access and distribution. Programs must prioritize direct aid to households headed by women, persons with disabilities and LGBTIQ+ persons, while ensuring culturally appropriate and accessible delivery mechanisms.

Recommendations: Food security and nutrition

To ensure equitable access to food and nutrition support for all affected populations:

- Prioritize inclusive targeting of food assistance for households headed by women, persons with disabilities and LGBTIQ+ individuals, who face heightened exclusion.
- Strengthen culturally appropriate distribution by recognizing and supporting the roles women and girls play in food collection, preparation and decision-making.
- Ensure nutritional adequacy of food aid, particularly for pregnant and lactating women, infants and persons with specific dietary needs.
- Introduce feedback mechanisms so affected populations can report shortages or quality concerns and participate in programme improvements.
- Address negative coping strategies by pairing food distribution with multipurpose cash and livelihood support, particularly for those at risk of self-deprivation.
- Improve accessibility and safety at food distribution points, ensuring they are physically accessible, well-lit, and staffed by trained, gender-diverse personnel.
- Monitor intra-household distribution and reinforce messaging on equitable food sharing to reduce risks of hidden deprivation.

Barriers to health services and wellbeing

The earthquake significantly disrupted access to health services, exposing and deepening existing gender and disability-related inequities. Financial hardship was the most frequently cited barrier to accessing health services reported by women and slightly less often by men. However, access challenges extended far beyond cost. Physical inaccessibility, cost of transportation, long distances and safety concerns were disproportionately reported by women, LGBTIQ+ individuals and persons with disabilities (see Figure 7).

For many persons with disabilities, health facilities were not only physically inaccessible but also lacked health personnel trained to support their needs. LGBTIQ+ respondents noted additional challenges, such as the lack of gender-sensitive or female staff—further limiting their access to care.

Access to sexual and reproductive health (SRH) services remains limited: half of women reported no access to maternal health care and almost two thirds could not access family planning. Access to sexual and reproductive health (SRH) services remains limited: half of all women reported no access to maternal health care, and nearly two-thirds could not access family planning. These gaps affect all women, compromising their ability to manage their reproductive health, and are especially harmful in the aftermath of a crisis. They also heighten risks for survivors of sexual violence and increase vulnerability to sexually transmitted infections, HIV transmission, and unintended pregnancies.

Illness was widespread. Forty percent of male-headed and 50% of female-headed households reported at least one family member falling ill in the three days prior to data collection. Health concerns—particularly respiratory infections, skin diseases and diarrhea—were more frequently reported among LGBTIQ+-headed households, who also face the most structural barriers to treatment, suggesting a compounded health risk. Among households headed by older persons, 30% reported dealing with a health issue immediately preceding the survey.

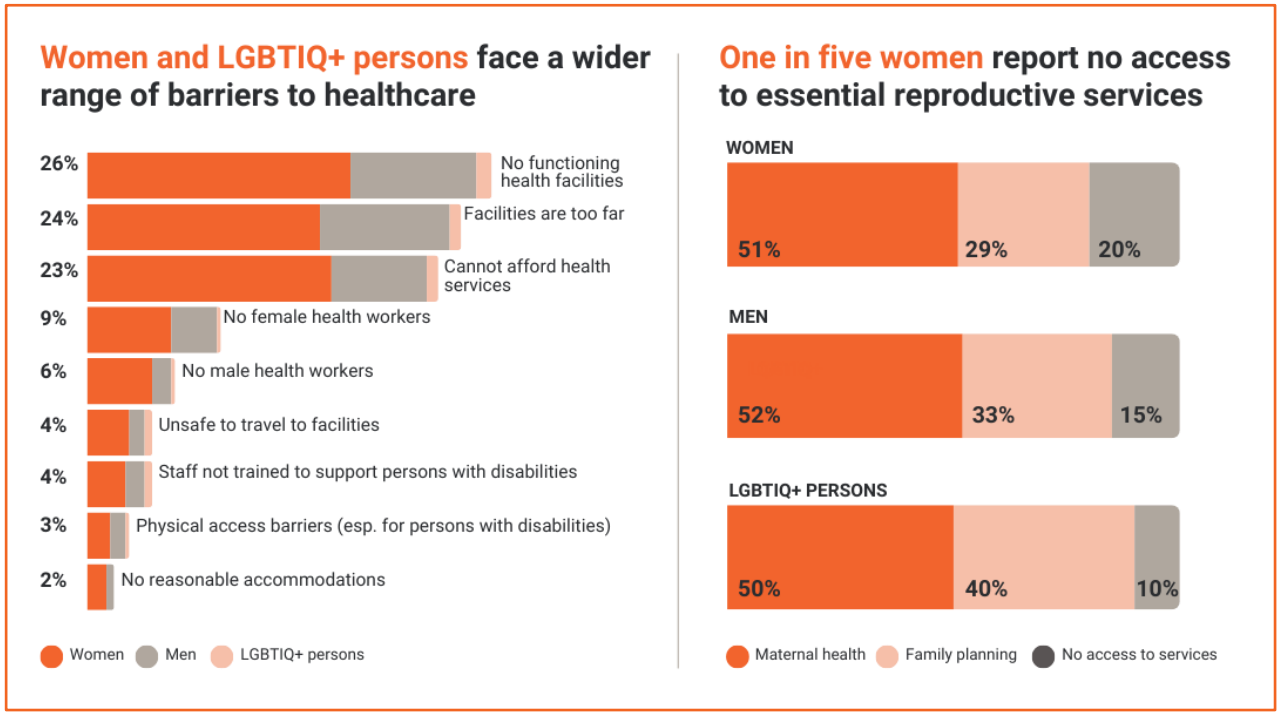


Figure 7. Barriers to healthcare and gaps in reproductive services by gender and identity.

Multiple and overlapping barriers—including lack of trained staff, distance, transportation costs, insecurity, stigma and lack of accommodations—prevented many from receiving care. These inequities are particularly harmful for groups with high health risks and low access to services.

A diverse gender- and disability-inclusive health response with links to other support services is essential to ensure care for all. This means expanding mobile and community-based health services, investing in infrastructure repairs and ensuring meaningful community consultation. Multi-purpose cash should also be leveraged to reduce access barriers to health services, including transportation costs. Health systems must be accessible, trusted and responsive to the needs of all genders and abilities.

Recommendations: Health services and wellbeing

To ensure equitable access to healthcare in disaster-affected areas, humanitarian actors must:

- Strengthen outreach and mobile health services to reach underserved groups, including women, persons with disabilities and LGBTIQ+ individuals.
- Invest in infrastructure upgrades to ensure health facilities are physically accessible and equipped with trained staff to respond to diverse needs.
- Expand sexual and reproductive health services, including maternal health care and family planning, with a focus on privacy, cultural sensitivity and gender-responsive delivery.
- Integrate health services with protection and MHPSS programming, to support holistic care for survivors of violence and individuals facing compounded risks.
- Use multi-purpose cash assistance to address indirect barriers to care, such as transportation costs and the cost of medication.
- Ensure meaningful consultation with marginalized groups in the design and delivery of health services to promote trust and accountability.

> **"Even clinics have collapsed, so we have to travel far [for treatment]."**
>
> *45-year-old woman in Sagaing*

> **"They (aid and medical teams) don't come to our villages anymore. Even when they do work at big hospitals, we only hear about it after they've already left."**
>
> *53-year-old man in Mandalay*

Access to mental health and psychosocial support

Access to mental health and psychosocial support services (MHPSS) remains critically limited, with urgent needs spanning both earthquake-related trauma and the impacts of gender-based violence. Nearly 90% of respondents either lacked access entirely or were unsure whether such services existed in their area. This absence of care infrastructure leaves many individuals to cope in silence or rely on unqualified informal systems.

Among those who did access MHPSS, support came primarily from informal or under-resourced channels. Community leaders and local NGOs were the most common providers, with health clinics and Women and Girls' Safe Spaces offering very limited availability. This highlights the need to scale up formal and trusted avenues of emotional and psychosocial care.

Emotional distress was reported across all gender groups, with approximately two-thirds of respondents noting sleep disruption and anxiety among family members. However, these figures likely underestimate the true scale of emotional hardship as stigma, gendered social norms and lack of safe reporting channels may discourage full disclosure—particularly among men and marginalized populations.

Only 20% of respondents reported having safe access to health facilities—further compounding mental health challenges, as the ability to seek support is often tied to basic safety and mobility.

In the context of disaster recovery, the emotional toll must be treated as a core component of well-being. Investment is urgently needed in accessible, inclusive and gender-sensitive MHPSS services. Community leaders and frontline staff should be trained in psychological first aid and survivor-centred MHPSS and GBV services. Safe, confidential spaces must be expanded to ensure support for all genders and identities who may face unique stigma in seeking support.

Recommendations: Mental health and psychosocial support

To address the critical gap in emotional and psychological support, humanitarian actors should:

- Scale up access to formal, inclusive MHPSS services, especially in underserved areas where reliance on informal channels remains high.
- Train community leaders, health workers and frontline responders in psychological first aid, survivor-centred MHPSS and GBV response.
- Expand safe, confidential and gender-responsive spaces for emotional support, prioritizing privacy, accessibility and trust for all genders and identities.
- Integrate MHPSS into health, protection and shelter programming to ensure a holistic, cross-sectoral approach to well-being.
- Address stigma and raise awareness of available services through community engagement and inclusive outreach strategies.
- Ensure access for marginalized groups, including persons with disabilities and LGBTIQ+ individuals, by addressing mobility, safety and cultural barriers to care.

Shelter conditions and risks

The earthquake severely disrupted shelter and living conditions, including across existing displacement sites. In temporary sites, overcrowding, lack of locks or lighting, and inaccessible facilities raise serious concerns about the privacy, safety and dignity of women, girls, lactating mothers, older persons and persons with disabilities.

Female- and LGBTIQ+-headed households were overrepresented in insecure shelter types. Among LGBTIQ+-headed households, 42% were in temporary camps and 12% were living in the open. Nearly half of all households said they planned to move within weeks, often due to pressure to vacate from local authorities. Short-term displacement was most common among households headed by women, LGBTIQ+ individuals and person with disabilities, who also had the least access to adequate or private shelter.

Nearly one third of households shared shelter with multiple families. Many women and girls lacked adequate bedding or space to sleep saf% of households, with another third expressing concern about unsafe or structurally compromised shelters. Only half of all households felt safe in their current shelter (see Figure 7). Major safety concerns were reported by 35

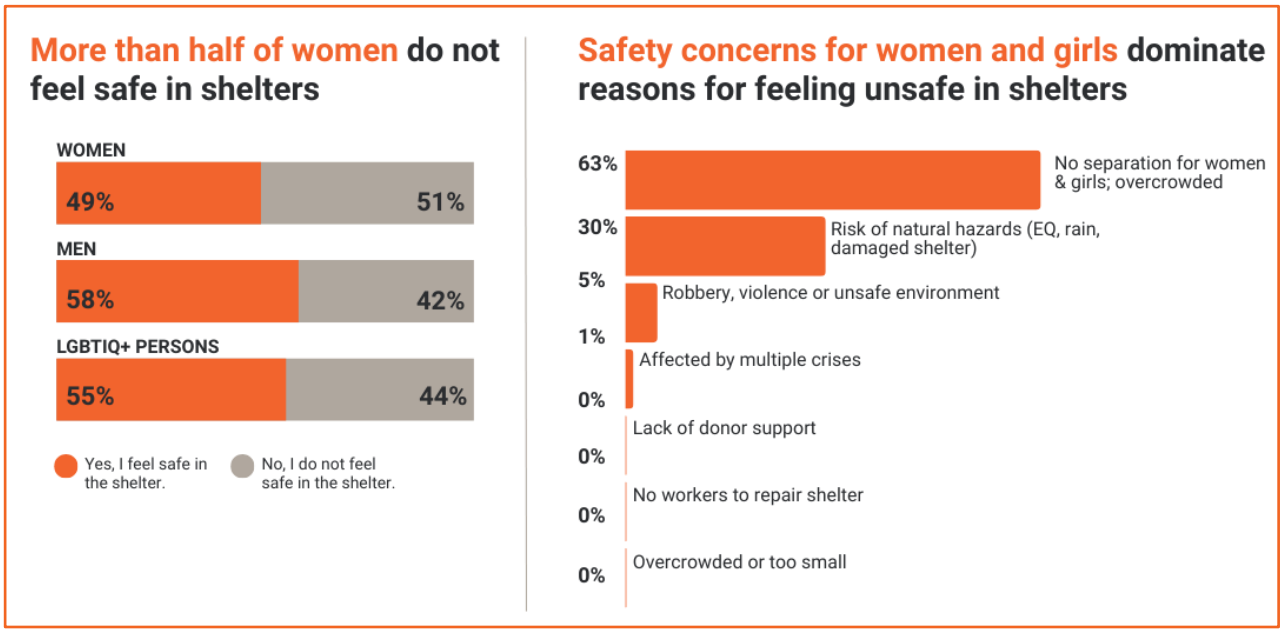


Figure 7. Reported perceptions of safety and reasons for feeling unsafe in shelters.

Unequal access to shelter materials

Although most respondents said the materials were available, most reported barriers. For male-headed households, key barriers included distance to markets and lack of income. In contrast, female- and LGBTIQ+-headed households more often cited a lack of money as the primary constraint. Other frequently reported barriers were non-functioning markets, blocked roads and personal safety.

Roles in shelter repair and recovery

Before the earthquake, responsibility for building and maintaining shelters appears much more diverse and varied by location, except for Kayin and Nay Pi Taw where men and boys did most of the work. Post-earthquake, women and girls appear to have taken on expanded roles in shelter repair and maintenance, reflecting both the resilience and increased burdens placed on them during crisis recovery. In male-headed

households, men and boys were cited most often; in female-headed households, women and girls were mentioned more, followed by boys and men (see Figure 8).

Priority needs and vulnerable groups

When asked what was most needed to provide safe shelter, over 80% of respondents across all genders cited cash support, either on its own or alongside other material assistance such as tarpaulins, construction tools, bedding, mosquito nets, and cooking equipment. Women were the most likely to request cash alone.

Groups identified as requiring additional shelter support included older women and men, persons with disabilities and to a lesser degree, LGBTIQ+ persons. These overlapping vulnerabilities highlight how age, gender and disability intersect to influence shelter security, safety and autonomy.

These gendered risks and roles must be central to shelter programming. The shelter crisis is not gender neutral—women, girls and LGBTIQ+ persons are driving rebuilding efforts while facing the greatest barriers to safety and dignity.

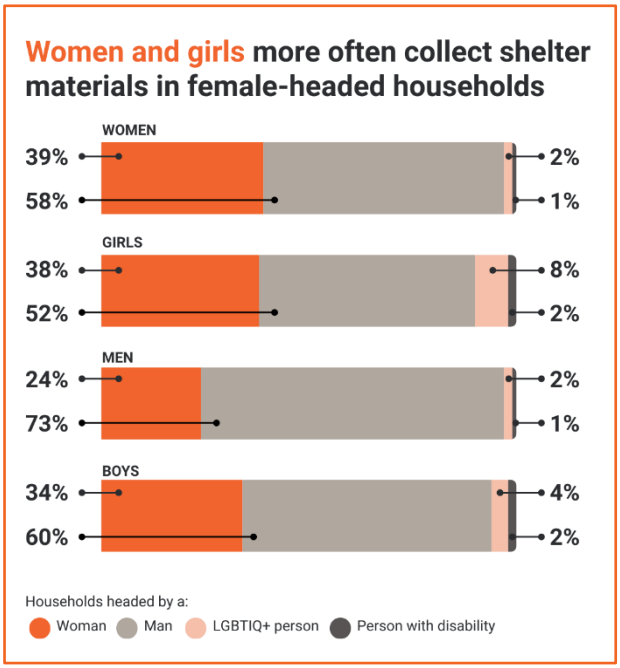


Figure 8. Household members responsible for collecting shelter materials by gender and age.

Recommendations: Shelter, safety and recovery

To reduce gendered risks and support inclusive recovery in shelter responses:

- Prioritize safe shelter and resettlement for households headed by women, LGBTIQ+ individuals, and persons with disabilities.
- Tailor cash and in-kind assistance to specific household needs, including older persons and unaccompanied minors.
- Design inclusive shelters with privacy, safety, lighting, secure locks and accessible facilities and sleeping areas.
- Expand inclusive cash-for-work and shelter repair programmes, empowering women, youth and persons with disabilities to participate in reconstruction.
- Address affordability and physical access barriers through safe community partnerships, safe market access and direct aid.
- Integrate GBV risk mitigation and referral systems into shelter planning and site management.
- Support women's leadership and meaningful engagement in shelter planning, site management and reconstruction efforts.

Water, sanitation, hygiene and menstrual health

Access to WASH services remains severely constrained across affected areas, with women, girls and persons with disabilities facing the most acute risks due to unsafe or inaccessible infrastructure. More than two thirds of respondents reported problems collecting water, most commonly due to long distances and lack of safe water availability (see Figure 9).

Water points were also reported as inaccessible for older persons or those with disabilities by 12% of respondents. Water collection is split quite evenly between women and men and, to a lesser extent, between boys and girls. Despite the shared burden, women and girls are often more exposed to the risks associated with water collection, including safety threats and loss of time for other responsibilities.

Although most respondents said their water points were "safe," more than one in ten said they were not, raising protection concerns. Households often cope by collecting water in same-sex or mixed-gender groups, or by reducing trips to limit risk exposure.

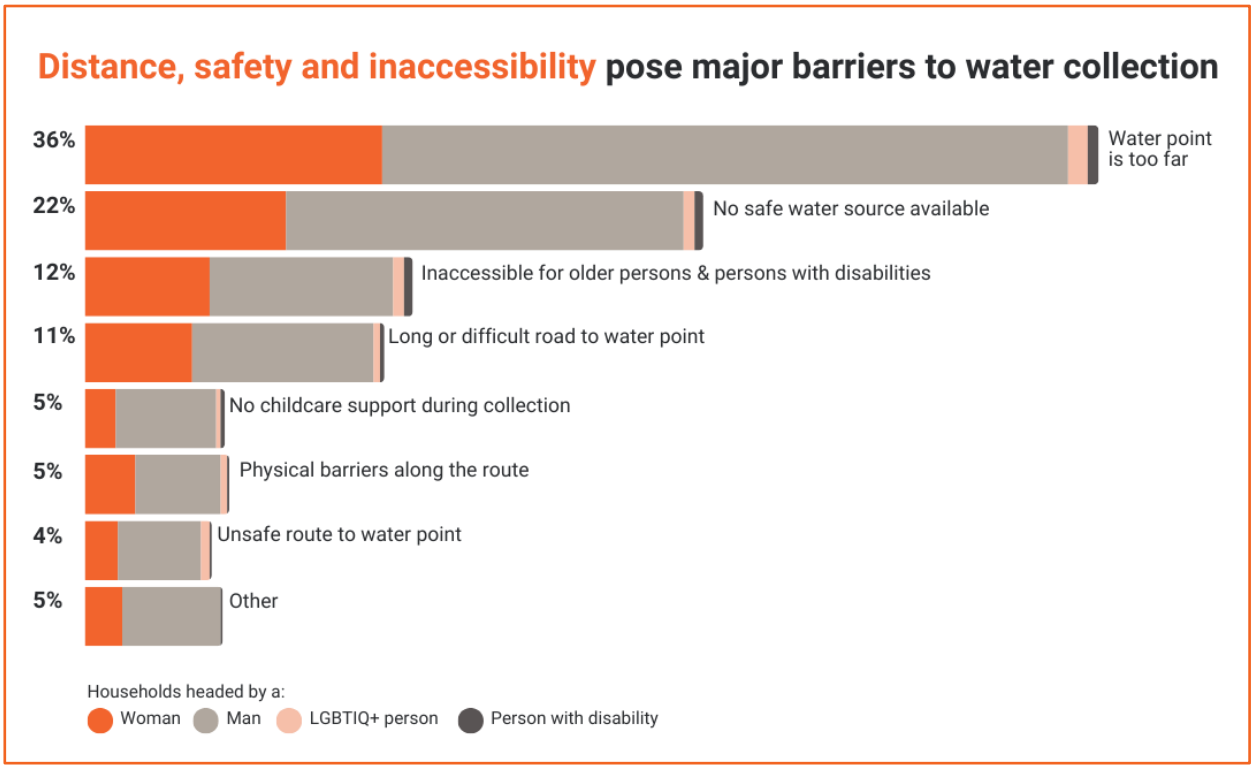


Figure 9. Reported barriers to water collection, by household type.

Barriers to sanitation facilities

To cope with these conditions, many rely on going to the latrine in either single-sex or mixed-gender groups for protection. While overall access is relatively high, a substantial minority still face protection and accessibility barriers, especially women, children and people with disabilities (see Figure 10).

A critical yet often overlooked concern is accessibility inside the facilities—many toilets and bathing areas lacked interior locks or locks that could be reached by children or people in wheelchairs. As a result, a small proportion of households resorted to open defecation.

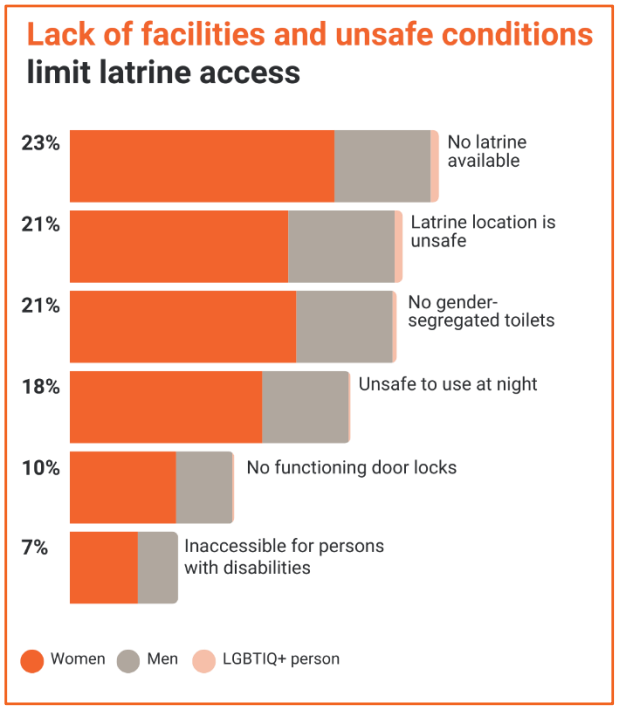


Figure 10. Reported barriers to latrine access, by gender identity.

Lack of safe bathing spaces

Bathing conditions were similarly inadequate. More than a quarter of all respondents reported having no safe place to bathe, with women and people with disabilities being the most disadvantaged. Safety, lack of gender separation and poor infrastructure (such as the absence of locks) were commonly cited as key barriers.

Without secure, private and physically accessible facilities, the risk of harassment or assault and gender-based violence increases—particularly for women, girls and persons with disabilities.

Inadequate water for daily use

While 90% of households had enough water for drinking, far fewer had enough for hygiene and cleaning. Female-headed households, large families and those living in displacement sites were especially vulnerable to water shortages.

Menstrual hygiene management

Menstrual hygiene access remains critically low. One in three women lacked access to menstrual hygiene products or services. Sanitary pads were the most requested item, followed by reusable cloths and access to safe, private washing and disposal facilities. Without access to appropriate menstrual hygiene materials and facilities, many women and girls are at risk of infection, isolation and reduced participation in daily activities (see Figure 11).

> **"Latrines are far from shelters and not reachable for the elderly."**
>
> *70-year-old woman in Mandalay*

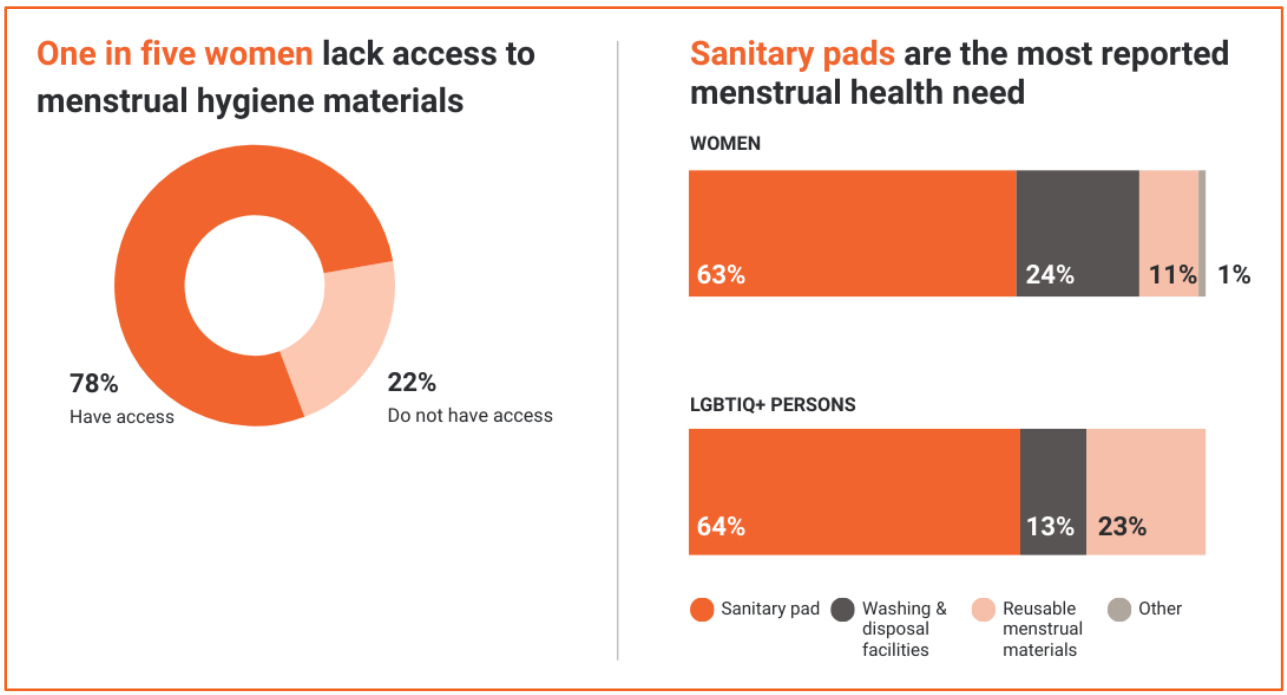


Figure 11. Access to menstrual hygiene among female respondents.

Recommendations: water, sanitation and hygiene

To ensure safety, dignity and equitable access to WASH services, humanitarian actors should:

- Install accessible, gender-segregated WASH facilities with internal locks, lighting, and privacy features to support the safety of women, girls and persons with disabilities.
- Improve the proximity and safety of water collection points, including through mobile distribution or targeted support for households facing mobility or protection constraints.
- Ensure sufficient water availability for hygiene and domestic needs, not just drinking, particularly in displacement sites and female-headed households.
- Integrate menstrual hygiene management into all WASH programming, including distribution of sanitary materials, reusable options and safe disposal mechanisms.
- Address infrastructure barriers—such as latrine and bathing facility accessibility for older persons and persons with disabilities—through inclusive design and consultation.
- Engage women, girls and persons with disabilities in WASH response planning and monitoring to ensure relevance, safety and sustainability.
- Coordinate WASH activities with protection and GBV actors to mitigate risks linked to water access, latrine use, and bathing.

Freedom of movement

Freedom of movement is restricted for many, especially women, persons with disabilities and LGBTIQ+ individuals. Only 55% of women reported being able to access health centres without restriction, compared to 63% of men and 78% of LGBTIQ+ individuals. Similarly, just 60% of women are free to travel to local markets.

Travel to another region or state is more constrained for all, with only around a third able to do so without restriction: 41% of women and 34% of men say such travel is not possible.

Respondents identified cultural norms, security concerns, unaffordable transport costs and lack of accessible transportation as limiting factors.

Cultural norms affect women more than men, while LGBTIQ+ respondents cited physical constraints and lack of assistive devices.

These mobility gaps affect access to aid, protection, healthcare and participation, and they increase dependency. Services must be locally accessible and designed to account for gender and disability-related barriers.

Recommendations: Freedom of movement

To ensure safe, equitable mobility and access to services for all population groups, humanitarian actors should:

- Prioritize locally accessible services to reduce the need for long or unsafe travel, particularly for women, LGBTIQ+ individuals and persons with disabilities.
- Address mobility-related risks through gender- and disability-sensitive planning, including accessible transport options, assistive devices and safer routes.
- Expand transportation assistance, including subsidies or dedicated services, for those facing economic, physical or social barriers to movement.
- Engage communities in identifying mobility constraints, ensuring diverse perspectives inform access-related programming.
- Integrate protection and GBV risk mitigation into all movement-related services, including market access, healthcare and distribution sites.
- Promote inclusive infrastructure planning to reduce dependence and increase autonomy—particularly for women, older persons and individuals with disabilities.

> **"Women need permission from male relatives to go out."**
>
> *52-year-old woman, from Mandalay region.*

Security and risks of gender-based violence

In the aftermath of the earthquake, safety and protection concerns have intensified across affected communities in Myanmar, particularly for women, girls, persons with disabilities and LGBTIQ+ individuals.

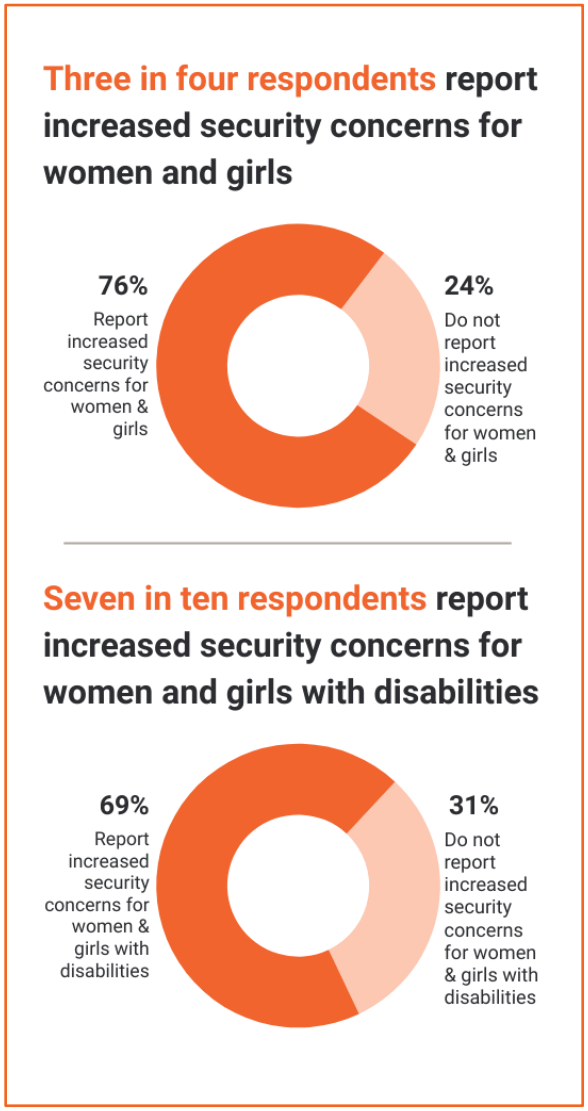


Figure 12. Security concerns for women and girls, including those with disabilities.

Nearly one third of respondents identified personal insecurity as a top concern, followed by gender-based violence, harassment and restricted mobility. These challenges are exacerbated among households headed by persons with disabilities and LGBTIQ+ individuals, highlighting their disproportionate exposure to insecurity, harassment and exclusion from formal protection systems (see Figure 12).

A high proportion of respondents perceived increased risks to women and girls, including those with disabilities and LGBTIQ+ individuals, since the disaster. Key threats include the risk of attack during daily movement, sexual violence, the absence of safe community spaces and exploitation or harassment (see Figure 13). Movement restrictions imposed on women and girls by family members point to deeper gender norms and control. Adolescent girls also face pressure to marry, limited privacy and elevated risks when moving around their communities.

Over one-quarter of respondents reported a lack of safe places within communities. The second most common concern was the risk of exploitation and harassment. Women respondents also raised concerns about sexual violence and abuse, poor lighting, insecure housing and the absence of locks. Limited access to essential services and resources was also raised.

Women's shared concerns included the need to rebuild or repair housing and improve access to construction materials and rehabilitation support. They also highlighted accessibility and mobility challenges, particularly for maternal and reproductive healthcare. Narrative responses emphasized how women's safety is compromised by a combination of environmental insecurity, social restrictions and inadequate health services, especially during pregnancy and childbirth.

Despite these risks, help-seeking behaviour remains largely informal. People most often seek help from family members or community leaders, rather than police, NGOs or health providers. Only 10% had sought psychosocial or civil society support (see Figure 14).

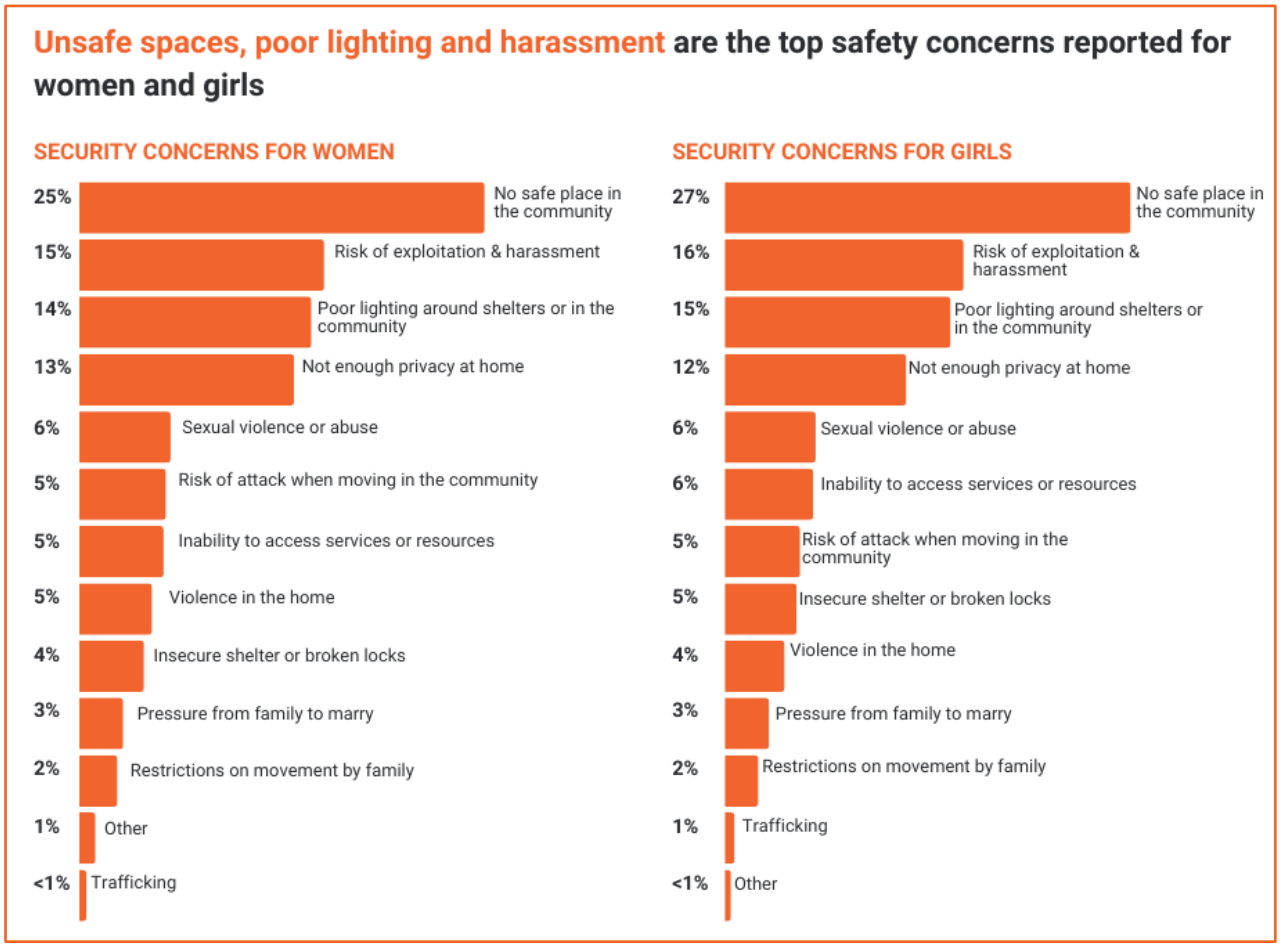


Figure 13. Distribution of reported security concerns for women and girls (% of total responses).

Coping strategies often involve walking in groups or turning to religious institutions for refuge.

Significant barriers exist to reporting gender-based violence. Many survivors are deterred by fear of retaliation, stigma or a lack of confidentiality—especially in displacement sites and in temporary shelters, where privacy is limited and community dynamics are complex.

Among households headed by persons with disabilities and LGBTIQ+ individuals, knowledge of, and trust in, formal reporting mechanisms was particularly low, emphasizing the urgent need for inclusive, survivor-centred, confidential, safe and accessible GBV services and support systems.

Less than a quarter of women surveyed reported that survivors could access GBV services or confidential spaces in their communities. Among women, more than half did not know how or where to report. Awareness among men and LGBTIQ+ respondents was even lower. Fewer than one in four respondents felt it was safe to report violence when the perpetrator lived in the same household—suggesting widespread fear, impunity and lack of protective options.

Fear of violence and harassment significantly restricts participation in community life (see Figure 15). Half of all female respondents and nearly one-third of male respondents reported avoiding travelling alone at night and even visiting essential locations, such as latrines, water points and markets. These avoidance behaviours signal real and perceived risks of displacement-related hardship.

These findings reveal a high-risk environment in which formal protection systems are largely inaccessible or unknown, leaving marginalized groups—especially women, girls, persons with disabilities and LGBTIQ+ individuals—particularly vulnerable. Immediate action is needed to strengthen survivor-centred GBV referral pathways, expand inclusive safe spaces, train local actors in protection response and raise public awareness of available services. This requires addressing the underlying reasons for under-reporting—including fear, stigma and lack of confidentiality—and addressing harmful social and gender norms that reinforce power imbalances and impunity.

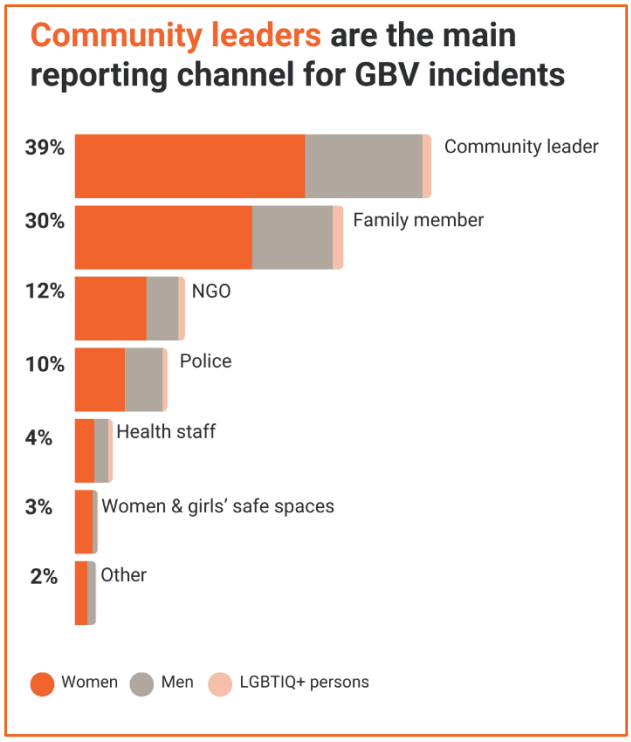


Figure 14. Reported channels for reporting GBV incidents, by population group (distribution %).

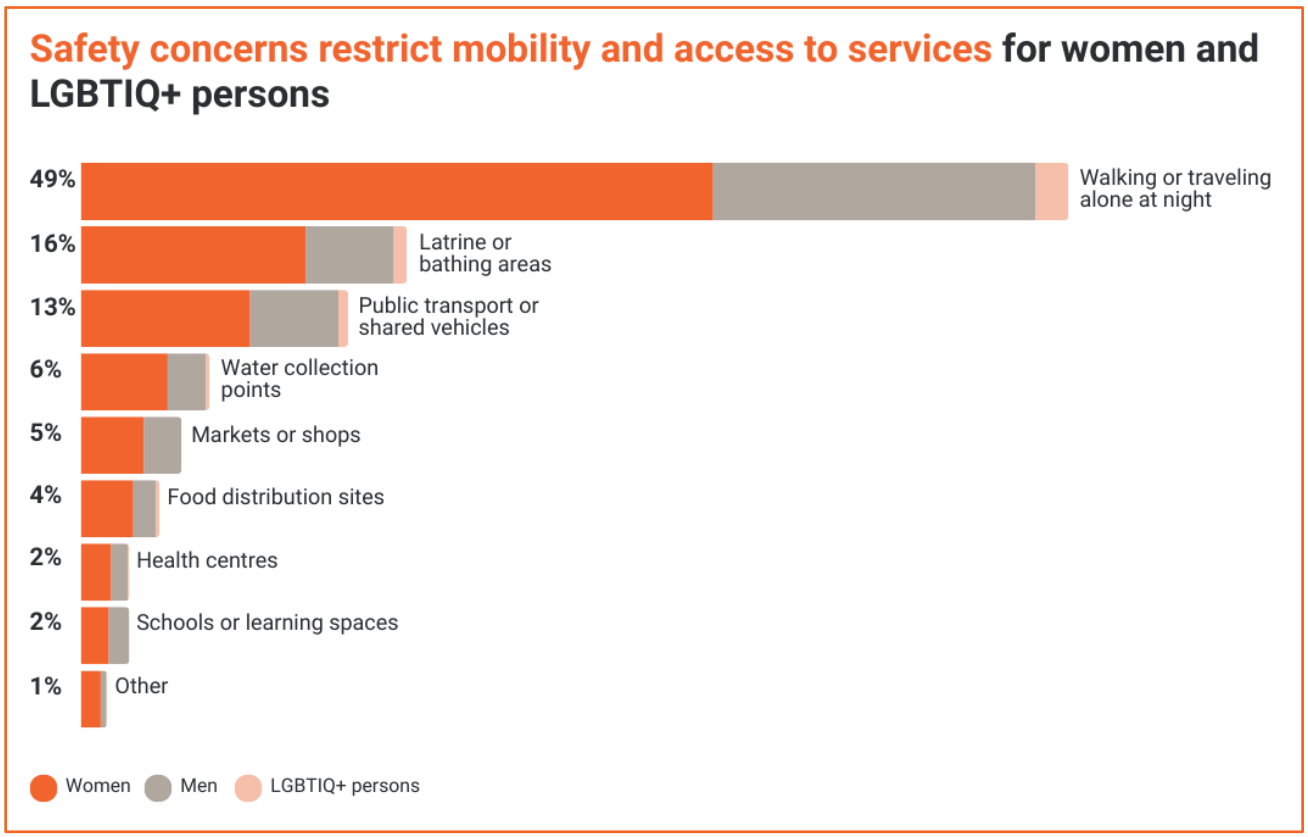


Figure 15. Distribution of areas and activities avoided due to GBV-related safety concerns, by population group.

Recommendations: Gender-based violence and security response

To reduce risks and strengthen safety and dignity for survivors and at-risk groups in the aftermath of crisis, humanitarian actors must:

- Expand inclusive, confidential safe spaces for women, girls, persons with disabilities and LGBTIQ+ individuals, ensuring physical accessibility and trust.
- Establish and publicize survivor-centred GBV referral pathways, including training for service providers in inclusive, confidential, and trauma-informed care.
- Strengthen awareness of available GBV services and reporting mechanisms, especially in displacement sites and remote communities.
- Integrate GBV risk mitigation measures across all sectors, including lighting, locks, privacy features and safe movement to water, sanitation, health and shelter facilities.
- Address harmful social norms and gendered power dynamics through community engagement, education, and behaviour change strategies.
- Support collective coping and community-based protection initiatives that reflect gender equality, reduce stigma and uphold survivor dignity.

> **"As an older woman living alone, I'm terrified of thieves and armed robbers."**
>
> *63-year-old woman in Sagaing*

> **"Travelling by shared transport is now seen as unsafe, especially for girls."**
>
> *55-year-old man in Sagaing*

> **"When we go to toilets and bathing spaces, we go together with friends and relatives."**
>
> *27-year-old woman in Sagaing*

CONCLUSION

This GIHA Working Group Gender Analysis demonstrates that the impacts of the 2025 Myanmar earthquake are deeply gendered. They intersect with age, disability and identity to shape how individuals and households experience crisis and recovery. Women, girls, persons with disabilities, older persons and LGBTIQ+ individuals face disproportionate barriers to accessing aid, health care, safe shelter, water and sanitation, and meaningful participation in community decision-making.

Across all sectors—protection, food security, health, shelter and WASH—marginalized groups were not only more vulnerable but also less likely to be consulted, informed or supported by humanitarian services. Most households preferred cash assistance, yet access was limited for those headed by women and persons with disabilities. Emotional distress was widespread, particularly among women and gender-diverse persons, yet formal psychosocial support remained virtually absent in many locations.

Despite their exclusion, women, girls and LGBTIQ+ individuals demonstrated considerable resilience and agency. They were actively involved in shelter repair, food distribution and caregiving, often under conditions of insecurity and deprivation. However, this resilience must not be mistaken for adequate support. It is essential that humanitarian actors recognize and respond to both the burdens and capacities of affected populations.

To ensure no one is left behind, all sectors must prioritize gender- and disability-inclusive approaches, directly consult affected communities and reinforce local women-led and community-based initiatives.

These findings demand a shift in resources and practices—including increased funding for women-led organizations, disability-accessible services, support for organizations working with LGBTIQ+ individuals, and investment in long-term, inclusive protection systems.

Doing so is not only a matter of rights and dignity—it is a prerequisite for effective and equitable humanitarian response.

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APPENDICES

Appendix 1: Comparative analysis of humanitarian assessments

This appendix compares findings across four post-earthquake humanitarian assessments, highlighting consistencies, gaps and unique insights to guide an inclusive response.

Thematic area	GiHA Gender Analysis	MIRA (UN-led)[6]	GiE Gender RGA[7]	COAR Rapid Assessment[8]	Alignment of findings
Shelter & overcrowding	High overcrowding, shared shelters, poor privacy, locks missing	Many informal/makeshift shelters, especially IDPs	Emphasis on gender-inappropriate shelter design; overcrowding risks for GBV	>50,000 affected; widespread home collapse, 29–33% say homes unsafe	✅ **Consistent**
WASH (toilets, privacy, menstrual needs)	Unsafe or inaccessible WASH, especially for PWD/women	Poor water access, no mention of gender-specific hygiene	Unsafe toilets, lack of lighting, menstrual health unmet	Access poor: 28% report unsafe drinking water in Mandalay; 33% lack safe toilets in Sagaing	✅ **Consistent**
Health access & SRH	Some sites lack services or knowledge; SRH not detailed	Some visible malnutrition; distribution limited	Pre-existing collapse of SRH care; urgent maternal needs; no transport	Up to 20% healthcare facilities not functioning; Mandalay/Sagaing access fragile	✅ **Consistent**
GBV & protection risks	Limited awareness of GBV services; response gaps; safety issues for women at night	Data not disaggregated or detailed	GBV risk extremely high: early marriage, IPV, exploitation; services barely exist	GBV and trafficking flagged indirectly; security blocks worsen access for survivors	✅ **Consistent**, GiHA GA adds detail
Accountability & information access	Many don't know where to report or get help	Community info sources listed (radio, social)	Women not represented in camp/site planning or decision-making	<6% sought assistance from gov; most rely on friends/monasteries	⚠️ **Divergent** – GiHA Gender Analysis highlights info gaps
Food & markets	Food needs widespread, esp. women-led HHs	Access strained; food items unaffordable	Women bear food responsibility but lack control over finances	Prices rising; 48% report low availability; damage to markets in Mandalay	✅ **Consistent**

[6] UN OCHA. *Myanmar Earthquake Multi-Cluster Initial Rapid Assessment Findings*, 30 April 2025. Available at: https://reliefweb.int
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Thematic area	GiHA Gender Analysis	MIRA (UN-led)[6]	GiE Gender RGA[7]	COAR Rapid Assessment[8]	Alignment of findings
Cash and livelihoods	Limited income, esp. for widows and women-led HHs	Mentioned, not detailed	Women depend on unpaid labor; denied land, HLP rights	71% households have <1 week of savings; cash most reported need	✅ **Consistent**
Displacement & site conditions	Pre-quake displacement already high; insecurity, lack of safety, lack of access and tailored services for priority groups	Most IDPs live outside camps; aid very limited	Informal, mixed-type sites (monasteries, religious sites, wards); limited services	IDP numbers rising; sites in forests or damaged urban spaces	✅ **Consistent**
Disability inclusion	Toilets often not accessible; no specific SRH/WASH for PWDs	Some mention of visible malnutrition in PLWs	Intellectual disabilities high-risk; PWD girls doubly vulnerable	Poor access to water and medical care also affects PWDs, esp. in Magway	✅ **Consistent**
Aid & coordination	Unclear who provides services; local CSOs mentioned in Q25	CSO role acknowledged but little detail	Strong emphasis on feminist/local actor role; CSOs frontline	56% received help from friends/family; <6% from govt	✅ **Consistent**
Security & access constraints	Not measured	Not analysed	Cited as a major barrier to SRH/GBV response	Lack of access to and assistance for people in need	➕ **Additional detail from COAR**

✅ Consistent findings across all reports	⚠️ Divergences	➕ Unique contributions from the GIHA Gender Analysis
• Severe overcrowding especially impacts safety and security of women and girls. • Toilets are inaccessible, unsafe, and lack gender segregation. • GBV risks and SRH access are low, especially for displaced and female-headed households. • Women have limited access to resources, aid information, and decision-making. • PWDs and elderly face mobility and service barriers. • Reliance on friends/family for aid; lack of trust in formal systems.	• GIHA Gender Analysis data emphasizes response awareness and service access gaps more clearly than others (e.g. GBV referral knowledge, actor mapping). • The COAR report uniquely focuses on conflict constraints, including direct military interference in aid delivery and rescue.	• Rich site-level insights, including safety details (e.g., whether toilets have locks, mixed-use sites). • Inclusive gender-disaggregated data, drawn from household interviews that intentionally include and reflect the experiences of people of diverse sexual orientations, gender identities and expressions and sex characteristics (SOGIESC). • Mapping of service actors (Q25) and analysis of how different community members—especially marginalized groups—engage with and access support systems.

Appendix 2: Summary of functional difficulties

This appendix presents findings from the Washington Group Short Set of questions on disability, highlighting patterns of functional difficulty across gender and age groups.

Gender differences in reported functional difficulties

Across all functional domains, women reported higher rates of difficulty than men:

- **Communication:** 6% of women versus 3% of men reported some or significant difficulty
- **Hearing:** 10% of women versus 9% of men reported some difficulty.
- **Mobility (walking):** 21% of women reported difficulty compared to 14% of men—the largest observed gender gap.

Gender-diverse respondents also reported notably high levels of difficulty:

- 22% experience difficulty walking
- 25% reported difficulty seeing

However, small sample sizes among gender-diverse respondents limit interpretation.

Age-related trends in functional difficulties

Functional difficulties increased for those aged 60 and above:

- **Walking:** 22% reported difficulty (compared to 9% of those aged 18–29)
- **Self-care:** 18% reported difficulty (versus 3% aged 18–29)
- **Vision and memory issues** were most prevalent in this group, affecting 28% and 22% respectively.

Recommendations

The results highlight the compounding vulnerabilities faced by older individuals, reinforcing the need for:

- **Age- and gender-sensitive** humanitarian programming, including health, mobility, and psychosocial support interventions
- **Inclusive communication strategies** that ensure accessibility for persons with visual, auditory, or cognitive limitations.

Incorporating these considerations into response design and implementation is critical to upholding the rights and dignity of all affected populations.

Appendix 3: Inclusion of LGBTIQ+ individuals

Based on data collected from 2,136 household interviews and 298 site observations, the following findings provide insight into the experiences, needs and preferences of individuals with diverse sexual orientations, gender identities and expressions following the earthquake in Myanmar.

Data on sexual orientation, gender identity and expression in humanitarian response

A total of 56 respondents (3%) self-identified as LGBTIQ+ or non-binary. Additionally, 2% of household heads were reported as identifying similarly. This level of self-identification is notable for a post-emergency survey and presents a critical opportunity to better understand the needs of a population that often lacks visibility in humanitarian data and programming.

Please note: This appendix uses *LGBTIQ+* to refer to people, while referring to *SOGIESC* (Sexual Orientation, Gender Identity and Expression, and Sex Characteristics) when discussing data dimensions or inclusivity frameworks.

Shelter-related needs of LGBTIQ+ individuals

A total of 405 respondents (17%) identified LGBTIQ+ individuals as needing additional support with shelter reconstruction or securing housing. This placed them alongside other high-priority groups such as older persons, people with disabilities, and single caregivers, indicating their heightened vulnerability in the post-earthquake context.

Limited visibility and risk of marginalization

Despite these known vulnerabilities, LGBTIQ+ individuals were rarely observed in community-level activities. Fewer than half of site observations reported seeing visibly LGBTIQ+ or non-binary individuals participating in communal settings. Additionally, 65 survey respondents (3%) explicitly noted their absence—suggesting exclusion, self-isolation, or barriers to accessing services.

Limited Reporting of Security Risks and the Potential for Underreporting

Although the dataset included a question about increased security risks for LGBTIQ+ individuals post-earthquake, no affirmative responses were recorded. This absence does not necessarily indicate a lack of risk. Rather, it may reflect underreporting due to stigma, fear of disclosure, or limitations in how the question was asked or understood. In conflict-affected and conservative settings, fear of discrimination or outing may discourage individuals from disclosing their identity to enumerators or aid workers.

Risk of exclusion from humanitarian response

There appears to be a gap between identified needs and the visibility or inclusion of LGBTIQ+ people in programming. While 17% of respondents indicated this group required shelter support, only 5.8% of sites visibly included them—suggesting potential service gaps or accessibility barriers.

Recommendations

Conduct targeted, safe outreach to LGBTIQ+ individuals through trusted intermediaries, such as local organizations or trained protection actors.

- Ensure humanitarian programming addresses the unique vulnerabilities faced by LGBTIQ+ individuals in post-disaster contexts—including harassment, exclusion, and threats to physical safety.
- Improve data collection mechanisms to more accurately capture SOGIESC-related information while ensuring safety, confidentiality, and informed consent.
- Ensure LGBTIQ+ people are explicitly included in all age, gender, and diversity frameworks and sectoral assessments, alongside women, girls, and people with disabilities.

Appendix 4: Single-adult households with children

This appendix provides detailed analysis of the specific vulnerabilities and support needs of single-adult households with children, which face compounded risks during crises.

Analysis of vulnerabilities and support needs

Among the surveyed population, 144 households included children under the age of 18 and had only one adult (aged over 18 years) present in the home. These households are of particular concern due to their heightened vulnerability, stemming from limited caregiving capacity, income-generation constraints, and reduced resilience during crises.

Findings

Single-adult female households with children

A total of 108 households (75%) were identified as having only one adult female and at least one child under the age of 18.

- **66 households (61%)** are classified as *female-headed*, indicating the woman is recognized as the primary decision-maker or responsible adult.
- **39 households (36%)** are listed as *male-headed*, possibly reflecting inconsistencies in reporting or entrenched social norms that presume male headship, even in the absence of a male adult.
- **1 household** is headed by an *LGBTIQ+ individual*, and **2 households** provided no response on headship.

The high proportion of female-headed households highlights the gendered nature of caregiving responsibilities. These families may face compounded barriers to accessing assistance, especially if the adult female is also managing young children alone.

Single-adult male households with children

A total of 36 households (25%) were found with one adult male and children under the age of 18:

- **22 households (61%)** are categorized as *male-headed*.
- **12 households (33%)** are reported as *female-headed*, which may again suggest inconsistencies in recording or household dynamics that are not aligned with formal roles.
- The remaining **2 households** are headed by an LGBTIQ+ individual and a person with disability.

While fewer in number, male caregivers may be overlooked by services that traditionally assume women are the primary caregivers. They may also be less likely to seek or access psychosocial or gender-focused support.

Interpretation and implications

The presence of single-adult households—led by both women and men—caring for children signals a need for targeted protection and assistance strategies.

Key vulnerabilities include:

- **Economic stress:** With only one income-generating adult, these households may have limited livelihood opportunities and face greater financial insecurity.
- **Childcare burdens:** The absence of shared caregiving may lead to insufficient supervision or support for children, particularly when school access is disrupted.

- **Barriers to assistance:** Single women may face mobility restrictions, protection risks, or exclusion from aid processes that favour male engagement or documentation.
- **Social norms and data consistency:** The mismatch between household composition and reported household headship suggests possible misclassification or entrenched norms about male authority, even in absentia.

Table 1. One woman + children

Household head	No. of households
Woman	66
Man	39
No Answer	2
LGBTIQ+ individual	1

Table 2. One man + children

Household head	No. of households
Man	22
Woman	12
LGBTIQ+ individual	1
Person with disability	1

Recommendations

- **Tailor outreach and registration** procedures to recognize and validate diverse household structures. Avoid use of “male-headed” and “female-headed” categories, which may misrepresent actual caregiving roles. Instead, consider terms such as, “One-adult (female)” and “One-adult (male)” for clarity.
- **Prioritize support to single-adult households**, particularly female-headed households with young children.
- **Monitor household caregiving dynamic** in follow-up assessments to better understand shifting needs and address emerging vulnerabilities.
- **Provide safe, accessible, and dignified support** for single caregivers, including cash-based assistance, psychosocial care and child-friendly spaces.

Appendix 5: Child-related findings by gender

This appendix presents findings related to children's access to services, living conditions and participation in recovery efforts.

Access to child-friendly spaces

A significant gender gap was observed in awareness of and access to child-friendly spaces:

- 65% of female respondents reported that child-friendly spaces were available in their community
- In contrast, only 23% of male respondents and less than 3% of LGBTIQ+ individuals reported the same.

These differences may reflect both real gaps in access and gendered differences in caregiving roles. Women, as primary caregivers, may be more likely to seek out and use such services, while men and gender-diverse caregivers may be under-informed or excluded due to limited outreach or assumptions about caregiving roles.

Children's participation in shelter and reconstruction

When asked about children's involvement in shelter construction before and after the earthquake:

- Girls were mentioned in 3.5% of responses by women and 1.2% of responses by men.
- Boys were noted slightly more often, with 3.5% of women and 1.2% of men indicating their participation.
- Across all respondent genders, about 60–65% did not identify any involvement of children (girls or boys) in shelter construction.

While this could reflect appropriate protection of children from labour, it may also suggest a lack of child-inclusive recovery activities, even for older adolescents who may want or need to participate in rebuilding efforts (e.g., for family cohesion or psychosocial recovery).

Health conditions in children

Reports of child illness varied slightly by gender of the respondent:

- Diarrhoea was reported in 10% of female-led households, compared to 4% in male-led households.
- Respiratory diseases affected children in 8% of female-led households and 3% of male-led households.
- Skin infections were noted in 7% for female-led households and 3% of those led by men.

This may reflect differences in reporting—women may be more attuned to child health issues due to caregiving roles—or could point to greater vulnerability in female-led households, linked to poor shelter conditions, overcrowding, or limited access to safe water.

Water, sanitation and hygiene: Toilet accessibility for children

Respondents were asked whether toilet locks were accessible to both children and wheelchair users:

- 53% of female respondents said "Yes," compared to 31% of male respondents.
- Only 1–2% across all genders reported that locks were not accessible
- Around 13% gave no clear response or did not observe.

FOR MORE INFORMATION

Contact the GiHA Working Group

Email: gihawg@unwomen.org

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