

Mental Health & Psychosocial Needs Assessment of Myanmar's LGBTQI Community

Wellbeing, everyday realities and service provision

May 2021

&PROUD



This report was commissioned and generously supported by UNFPA Myanmar.

The study was designed and conducted by &PROUD. The research team was comprised of Michael McGrath, Tout Tun Lin, Lilly Tin Tin Aung and Marlo Tin Zar Htay.

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Executive Summary

This report presents findings, analysis, and recommendations concerning the mental health and psychosocial status of LGBTQI people in Myanmar and opportunities for mental health and psychosocial (MHPSS) service provision. The study was designed and undertaken by &PROUD and commissioned by UNFPA Myanmar to determine how their programming can better meet the mental health and psychosocial needs of LGBTQI people across the country.

The study comprised of a self-completed online survey of LGBTQI people, a series of focus group discussions with youths of different sexual orientation and gender identities, and key informant interviews with community workers, service providers and underrepresented populations. The bulk of the fieldwork took place throughout January 2021 before being disrupted by the political turbulence beginning 1 February 2021. Several interviews were conducted in April 2021 when it was deemed safe to do so, although the original research plan had to be altered.

The findings herein describe a population in dire need of mental health and psychosocial support. Myanmar's LGBTQI community endures violence, abuse, harassment and social marginalisation across a wide-range of social settings – which have impacts on their relationships and outcomes pertaining to education, health and livelihoods. This has grave impacts on their mental and psychosocial wellbeing, as is evidenced by high levels of self-harm and suicidal ideation and action, and the manner in which LGBTQI people describe their everyday navigation of a hostile society.

The following pages outline key findings from the report, followed by a robust set of recommendations and considerations on how interventions and services can better meet the needs of LGBTQI people in Myanmar.

Key findings

1

Myanmar's LGBTQI community displays high rates of depressive symptoms and signs of anxiety.

51% of surveyed individuals had thought about self-harm and nearly 1-in-4 reported having self-harmed in the past, while nearly half of survey respondents had thought about suicide, with 15% having made an attempt to take their life. Anecdotes of self-harm and suicide abound, involving people as young as school-age students.

2

The poor mental health and psychosocial outcomes for LGBTQI people are directly attributable to widespread stigma and discrimination against LGBTQI that is embedded into Myanmar society.

Stigma and discrimination manifests in all manners of abuse (violent, sexual and verbal), discrimination within education, workplace and healthcare settings, and marginalisation from families, friends and other acquaintances. For many individuals, the family household is the setting for much of this abuse, while outside the household, perpetrators include well-respected community members such as teachers, doctors and police.

3

LGBTQI people internalise stigma and discrimination, resulting in the self-policing of their own behaviours and identities as a means of self-protection.

The internalisation of stigma results in the reinforcement of the negative stereotypes attributed to LGBTQI people, and manifests in homophobia and transphobia within the LGBTQI community itself. LGBTQI lives or often lived shrouded in secrecy and shame that is deeply damaging to their mental and psychosocial wellbeing.

4

Transgender women are particularly vulnerable to violence.

All identity groups could attest to a wide range of traumatic incidences and treatment, but transgender women appear to cop the brunt of deeply-entrenched patriarchal values that deny them of self-worth and dignity. Of all groups, their family relations were the most toxic and abusive, their livelihood opportunities the most limited and the everyday abuse encountered the most prolific and severe.

5

A widespread belief that LGBTQI people are ‘useless’ and unable to amount to anything plagues the community and instils a strong need to prove financial independence in order to gain trust and respect.

This stereotype evidently fails to take into account the structural discrimination and systemic disadvantages faced by LGBTQI people that drastically limits their education and livelihood options. Being able to provide financial support to families is often seen as a means through which acceptance and trust can be built with families, but this acceptance is usually fragile. Furthermore, employment for LGBTQI people is often precarious and the workplace a common site for discrimination, abuse and marginalisation.

6

Myanmar’s healthcare system fails to meet the needs of LGBTQI people – particularly transwomen and transmen.

Denial of service and mistreatment during service puts the physical health of LGBTQI people at significant risk, which in turn impacts their mental health outcomes. Lack of access and information around gender affirmation services denies transgender people of their bodily autonomy and drives many to seek services and products from medically-unsafe sources.

7

Romance and intimacy prove a major source of distress for LGBTQI people – with their relationships and desires facing scrutiny and rejection.

Relationships are often the cause of tension between LGBTQI people and their families, and as such, many are driven to keep their relationships secret. Due to the widespread rejection and invalidation of their relationships, they develop fatalistic views about their capacity and entitlement to engage in healthy and loving relationships. LGBTQI people also often place great emotional weight upon their significant others, given the lack of other social or professional outlets through which personal problems or challenges might be discussed. While lovers can be a solace from a hostile society, this dynamic can also instigate unrealistic pressures within relationships that burdens the mental and psychosocial well-being of LGBTQI people.

8

Covid-19 has severely exacerbated the pre-existing problems for LGBTQI people across all facets of their life.

Livelihood loss takes away not only critical financial lifelines but also the means through which LGBTQI people secured acceptance and trust from their families. Job loss and widespread restrictions on socialising means that many LGBTQI people have been trapped at home living in abusive or unsupportive household dynamics with limited social outlets for escape. Covid-19 has also caused challenges for transgender people using hormone replacement therapy or HIV-positive people using antiretroviral medication.

9

There is an overwhelming agreement that LGBTQI people are in desperate need of robust and sensitive MHPSS services.

Overall knowledge, exposure to and engagement with MHPSS services, however, is very low. There was demonstrable willingness amongst research participants to seek out MHPSS services should they be readily available, but three barriers emerged: i.) fear of association with LGBTQI and/or MHPSS services; ii.) scepticism about and general lack of exposure to MHPSS services and iii.) concerns around confidentiality and privacy.

10

There were mixed opinions on the most preferred platform through which to access MHPSS services – but Facebook Messenger was the most widely identified option.

Face-to-face was also an attractive option for many, but accessibility issues and fear loom as considerable impediments as compared to the relative anonymity of online options. Merits and drawbacks of different platforms should take into account the five following considerations: i.) privacy and confidentiality, ii.) accessibility and relevance (technology and language), iii.) level of human connection, iv.) locational exclusivity and v.) 1-on-1 VS group dynamics.

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1.

Introduction

1. Introduction

1.1 Study background

In Myanmar, LGBTQI people face human rights abuses and violence for the fact that they do not conform to expectations of gender norms and behaviours. They frequently suffer physical, sexual and emotional abuse at the hands of family and household members, and other community members such as police, neighbours, teachers and classmates. Such cases are rarely taken seriously by Myanmar's authorities or broader society, with the community's suffering typically attributed to their own inherent weakness or poor decisions.

Unsurprisingly, LGBTQI individuals face poorer outcomes in their physical and mental health, and often face economic marginalisation, disparaging representation in the media and are all but invisible in political spheres. With a vision to bolster the mental health and psychosocial of Myanmar's long-marginalized LGBTQI community, *Yin Phwint Yar* (YPY) was launched by &PROUD in mid-2018. Our first-of-a-kind programme in Myanmar provides isolated and vulnerable individuals with free, anonymous and non-judgmental counselling services to 'open their hearts'.

The ongoing socio-economic problems attributable to Covid-19 warrants even greater urgency to understand the mental health and psychosocial situation of Myanmar's LGBTQI population. Covid-19 has had profound impacts upon mental health worldwide, and has no doubt exacerbated the feelings of isolation and vulnerability of the country's already marginalized LGBTQI individuals. The shutting down of social spaces, job loss, limited access to sensitive medical care and the likelihood of being restricted in houses with potentially unsupportive family members are problems that can be expected to compound the minority stress experienced by young LGBTQI people.

1.2 Objectives

The objectives for this study were as follows:

1. To understand the mental health and psychosocial needs of the LGBTIQ community
2. To understand the extent to which Covid-19 has impacted the mental health and psychosocial condition of LGBTIQ individuals
3. To inform a best-practice guidelines for LGBTIQ mental health sensitivity for inclusive, youth-related programming (including referral pathways, M&E considerations etc)
4. To identify potential innovations for new services and referral networks

1.3 Methodology

This study was comprised of four components, each of which were designed to complement each other. The activities were as follows:

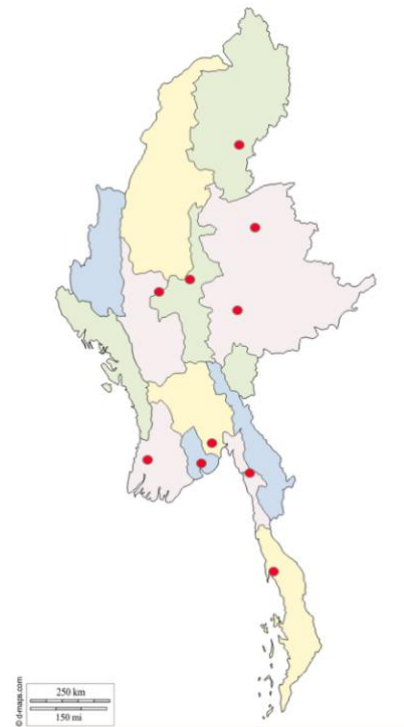
The needs assessment comprised of 4 components:

- A. An online survey assessing the mental health and psychosocial situation of LGBTQI individuals
- B. FGDs in 10 locations with LGBTQI youth (goal of 4 in each location; total 30-40)
- C. 25-30 KIIs with LGBTQI network leaders and other stakeholders (2 – 3 in each location)
- D. ~15 ad hoc interviews as appropriate for underrepresented key populations

For face-to-face fieldwork (i.e. components B, C and D) our proposed locations were as follows:

1. Bago
2. Dawei
3. Lashio
4. Mandalay
5. Mawlamyaing
6. Myitkyina
7. Pakkoku
8. Patheingyi
9. Taunggyi
10. Yangon

The reason for choosing these locations were to ensure a diverse spread of Myanmar’s demographic diversity and provide opportunity to unpack contextual differences across the country. From a practical standpoint, these were also locations where &PROUD and the LGBT Rights Network have strong community connections, so we had greater assurance for recruiting participants. For locations not featured on this list (i.e. places where our networks do not reach), we endeavoured to talk to stakeholders through online/phone platforms – including Rakhine State (Sittwe as focus, and elsewhere if possible), and Kayah State (Hpa-an and border areas in Myawaddy will be targeted).



A. Online survey

A short, self-complete survey uploaded on to Google Forms was disseminated through &PROUD’s Facebook channels and the LGBT Rights network. The questionnaire was designed to act as a ‘temperature check’ on the mental health and psychosocial situation of Myanmar’s LGBT community, and identify key issues, concerns, wants and needs.

B. FGDs with LGBT youth

Conducted parallel to the online survey, this component brought together groups of self-identifying LGBT youth to talk about the most pressing mental health and psychosocial issues they see facing their communities. Due to Covid-19 restrictions, all FGDs (apart from those in Yangon Region) were conducted over Zoom. For each location, &PROUD’s research team contacted relevant network leaders and put out the call for participation amongst their network. 4 FGDs were conducted in each location with 4-6 participants, with the following breakdown in each area:

1. G/B men/men who have sex with men
2. L/B women/women who have sex with women
3. Trans women, femme identifying people
4. Trans men, masc identifying people

The reason for splitting the groups was to allow for more natural discussion pertaining to specific issues experienced by each group. Breaking up participants as such means respondents will be speaking with people with similar experiences with gender identity and sexual orientation to themselves, meaning more specific issues could be unpacked in detail

FGDs were moderated by the research assistants, with another team member acting as a note-taker.

C. KIs with LGBT network leaders and other stakeholders

These interviews targeted LGBT network leaders from across the country representing a diverse range of different LGBT identities and experiences, as well as other stakeholders with strong knowledge of issues facing LGBT people (such as programming staff on gender, health and rights related projects). We aimed for 2-3 KIIs in each location, according to number of relevant people who could be reached in each location.

D. Ad hoc qualitative interviews

These interviews were used to identify the needs of harder-to-reach members of the community who might be missed or under-represented in Components 1-3. These interviews were tailored to elicit the specific experiences and needs of the individuals and the groups they represented, or the programmatic/community knowledge they have. Individuals included:

- People living in remote communities with few/no visible LGBT community groups (i.e. Rakhine and Kachin State)
- People who are living with HIV
- People who use drugs
- Male/female sex workers in major cities

Note on co-ordination:

To make the research as efficient and contextually-informed as possible, &PROUD relied on community counterparts in each location to assist in the coordination and recruitment of participants for the study. Depending on the location, 1-2 key logistical support organisations from the LGBT Rights Network were identified and served as the focal point for their respective region/state. To compensate for their time, communications costs and a logistical support fee were provided.

1.4 Fieldwork

Qualitative fieldwork commenced on 2 January 2021. The following tables detail the fieldwork components that have been completed at the time of writing this interim update, including location, date and time of research activity.

FGD's + KIIs (Locational specific)

Location	Activity	Completed	Date completed
Yangon	FGDs	4	2 – 3 Jan 2021
	KIIs 1. TGW outreach worker 2. HIV/PrEP doctor 3. PLHIV MSM	3	2, 6, 11 Jan 2021
Patheingyi	FGDs	4	4 – 5 Jan 2021
	KIIs 1. LGBT NGO leader 2. Health officer	2	5, 6 Jan 2021
Mandalay	FGDs	4	9 – 10 Jan
	KIIs 1. Lesbian NGO founder 2. LGBT legal worker	2	12, 13 Jan 2021
Mawlamyithar	FGDs	4	12 – 13 Jan 2021
	KIIs 1. Human rights activist 2. LGBTQI CSO Chair	2	12, 13 Jan 2021

<i>Pakkoku</i>	FGDs	4	16 – 17, 29 Jan 2021
	Kills 1. LGBT NGO Leader	1	
<i>Pyay</i>	FGDs	4	19 – 20 Jan 2021
	Kills 1. PLHIV NGO worker 2. TGM CSO Chairman	2	19, 20 Jan 2021
<i>Lashio</i>	FGDs	4	23 – 24 Jan 2021
	Kills 1. Tomboy/Lesbian CSO founder 2. CSO worker (PWID)	2	24, 25 Jan 2021
<i>Taunggyi</i>	FGDs (missing TGM)	3	27 – 28 Jan 2021
	Kills 1. TGW, Founder of LGBT CSO	1	19 April 2021
<i>Dawei</i>	Kills 1. HIV peer navigator 2. TGW CSO worker	2	19, 20 April 2021
<i>Myitkyina</i>	Kills 1. TGW CSO worker	1	21 April 2021

Ad hoc interviews (Completed 4 out of 12-15)

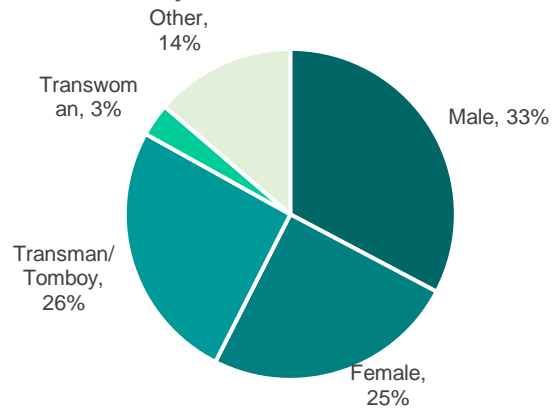
	Interviewee	Location
1	MSM PLHIV	Yangon
2	Sex worker	Mandalay
3	TGW CSO worker	Sittwe
4	TGM CSO worker	Sittwe

Online survey

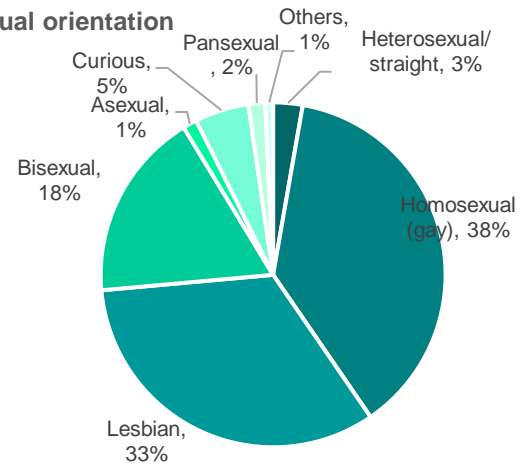
The online survey was launched 25 January 2021. Response rates far exceeded expectations and momentum picked up very fast, with the goal of n=300 being surpassed within the first 36 hours of the survey being live. At the time of closing the survey, n=1,524 people had completed the survey.

Key demographic factors comprising the collected sample are depicted in the following charts.

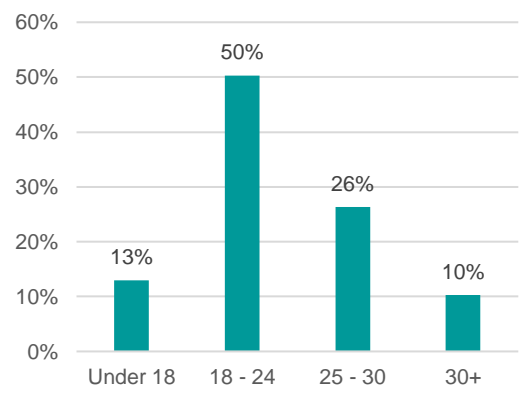
Gender identity



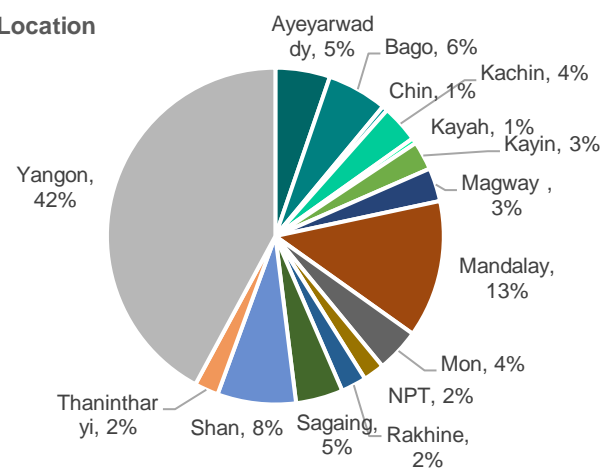
Sexual orientation



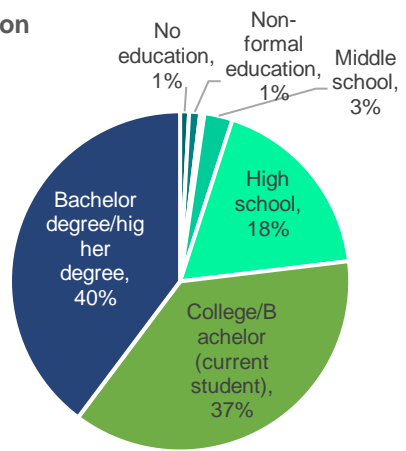
Age



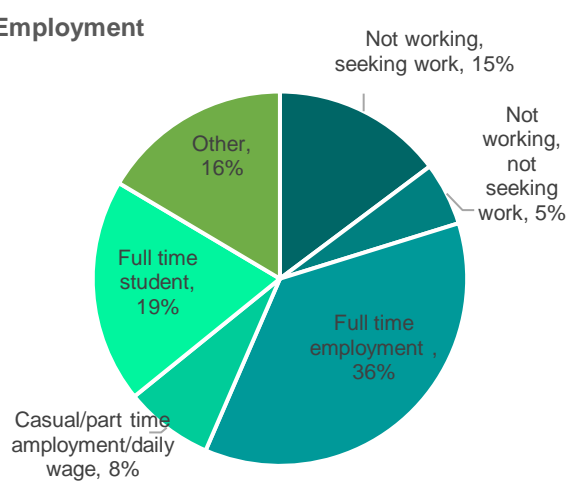
Location



Education



Employment



1.5 Limitations

Researching vulnerable minority communities inherently poses challenges and limitations upon a research team. To the best of our capacity, &PROUD sought to minimise and mitigate the risks of. Nevertheless, the following limitations should be taken into account when interpreting the findings and analyses presented in this report.

Covid-19 and methodology adaptation

The emergence of COVID-19 second wave in August 2020 and subsequent lockdowns changed our interview method from in-person to online. Apart from the Yangon FGDs, conducted at &PROUD's office in Sanchaung, all other interviews were conducted via Zoom video-conferencing app. This led to two identifiable limitations for our team.

Participants were limited to those who had access to the internet and had access to or know of someone who had access to Zoom. When combined with the fact that our recruiting relied heavily on NGO contacts in the location, our participants in FGDs skew towards people with connections to the LGBTQI NGO sector, whether as volunteers or service users. Participants of this sort will tend to have a greater understanding and/or knowledge of mental health, psychosocial and other health-related topics. They will also be more aware of resources that exist compared to participants who have no connection to these organizations, and by virtue of being connected with the wider LGBTQI community, are not necessarily going to represent the most vulnerable people.

Video interviews also limited our ability to ground our interview data within the geographical locations they occurred in. In-person visits to the participant site would have allowed for more ethnographic data on community engagement, cultural mores, and other insights based on participant observation. Due to the final online nature, we had to rely solely on the participants' narrative to get a sense of their respective communities.

Researching and sampling vulnerable minority groups

Since participation is voluntary, people who are doing well mentally, socially, and/or physically may be more likely to agree to an interview or take part in our online survey – which presents an element of 'survivorship bias'. As a result, the sample gathered in both qualitative and quantitative components may not represent the most vulnerable individuals. Highly vulnerable individuals may include those who have suffered extreme trauma, those who are isolated from the LGBTQI community and those who are closeted/unsure of their identity – all traits which might discourage individuals from participating in the survey, or disconnect them from the networks through which we recruited participants.

The effects of this may be especially pronounced in our self-harm/suicide data, where those who may have attempted or are attempting such acts will be less likely to fill participate. While we mitigate this effect through our FGDs by providing richer qualitative data on the topic, the reality is that the severity of mental health issues within the LGBTQI community may be higher than our data suggests.

Furthermore, the necessity of using purposive and snowballing sampling techniques means that our sample is not procedure was not randomised, and while it reflects a diverse population, it is not truly representative in terms of socio-economic data, geographical location, age or education status.

Disruption in February 2021]

While a majority of the fieldwork had been completed by February 2021, interviews and FGDs were disrupted in a number of locations (Dawei, Myitkyina and Taunggyi). &PROUD put fieldwork on pause through February and March as it was inappropriate given the instability and violent military crackdowns on peaceful protests and the widespread internet and communications shutdowns across the country. During April, we reached out to community partners in these locations and conducted several interviews with key informants, but it was ultimately deemed too difficult to hold FGDs for these locations, due to the community's unwillingness to participate and continued internet instability.

Representation of diverse identities

To the extent that was possible &PROUD strove to ensure inclusion of as diverse a range of voices within the LGBTQI community as possible. Representation for lesbian women, gay men, transgender women and transgender men is strong. Bisexual people are somewhat underrepresented given many are less likely to explicitly identify as bisexual. Notably, intersex people are unfortunately not represented within our sample, given the fact that intersex individuals in Myanmar are not well integrated within LGBTQI networks. &PROUD firmly believes greater work needs to be done to amplify the voices and experiences of these underrepresented individuals.

2.

LGBTQI MHPSS Wellbeing Status

2. LGBTQI MHPSS Wellbeing Status

This section provides an overview of the wellbeing of LGBTQI people in Myanmar in relation to their mental health and psychosocial condition. It presents quantitative statistics using two WHO approved measures that comprised part of the online survey – the General Anxiety Disorder 7 (GAD-7) and the Patient Health Questionnaire 9 (PHQ-9), as well as questions about self-harm and suicide. The data presented herein will be unpacked using findings from the qualitative components of the study, both within this section and in more detail pertaining to familial and social relations in the next section.

Key findings

- 12% of survey respondents displayed moderately severe or severe signs of depression.
- 19% of survey respondents displayed moderate anxiety symptoms or severe anxiety symptoms
- 51% of survey respondents had thought about self-harm, and nearly 1-in-4 respondents reported having self-harmed in the past.
- Nearly half of survey respondents had thought about killing themselves, and 15% had made a suicide attempt.

2.1 PHQ-9 (Patient Health Questionnaires-9)

Survey respondents were asked the full set of questions comprising the PHQ-9, which gives a measure of the extent to which respondents display symptoms of depression. The PHQ-9 comprises of 9 questions which ask respondents to indicate the frequency with which they experience a series of different traits that indicate poor mental health. Each answer category is allocated a score as follows: not at all (0), several days a week (1), more than half the days of a week (2) or nearly every day (3). Total scores are added together to gauge a respondent’s overall severity and susceptibility to depression or other conditions which are indicative of mental health challenges. The scenarios/experiences asked are as follows:

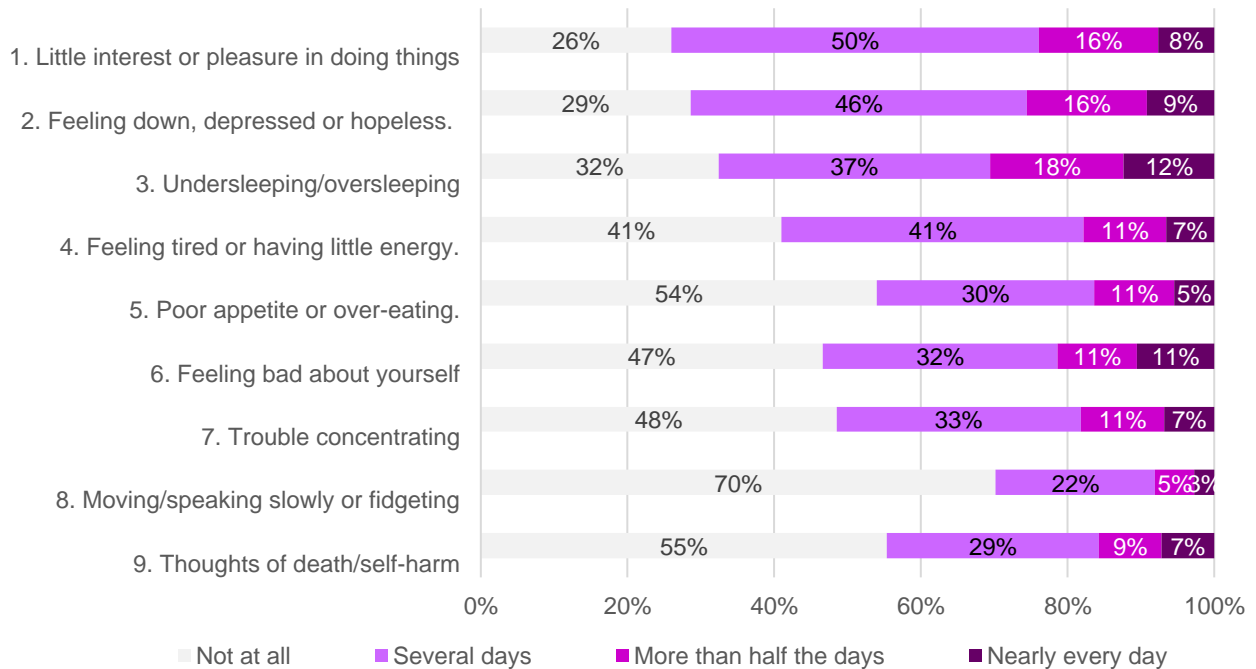
1. *Having little interest or pleasure in doing things*
2. *Feeling down, depressed or hopeless*
3. *Having trouble falling or staying asleep, or sleeping too much.*
4. *Feeling tired or having little energy.*
5. *Having a poor appetite or overeating.*
6. *Feeling bad about yourself (failure, letting self/family down etc.)*
7. *Having trouble concentrating on things, such as reading, watching tv etc*
8. *Moving or speaking so slowly that other people have noticed, or being so fidgety or restless that you have been moving around a lot more than usual.*
9. *Thoughts that you would be better off dead or hurting yourself in some way.*

Scoring categories are as follows:

0 to 4	Normal
5 to 9	Mild depressive symptoms
10 to 14	Moderate depressive symptoms
15 to 19	Moderately severe depressive symptoms
>20	Severe depressive symptoms

The chart below depicts the aggregated answers of respondents for each question. As can be seen, for most questions a reasonably consistent number of respondents (hovering around approximately 1-in-5 for the first 7 questions) fall within the top to boxes of experiencing symptoms either more than half the days of a week or nearly every day. Indeed, for all questions barring 5, 8 and 9, more than half of respondents experienced each symptom *at least* several days a week.

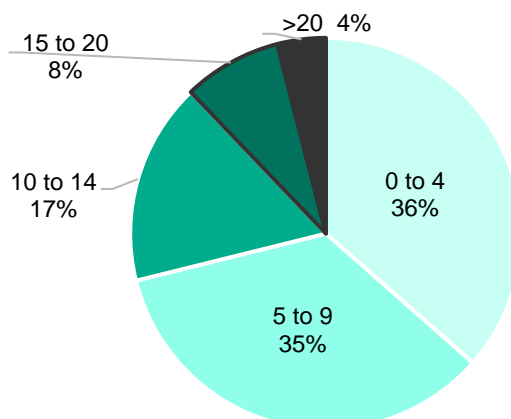
Figure 1: PHQ-9 by question



Accordingly, when individual scores are added up, 12% of respondents fall into the top two brackets of displaying moderately severe depressive symptoms (8%) or severe symptoms (4%). Approximately a third displayed no worrying depressive symptoms, and a half displayed mild to moderate symptoms.

12% of surveyed respondents displayed moderately severe to severe depressive symptoms.

Figure 2: PHQ-9 scores (aggregation)



2.2 GAD-7 (General Anxiety Disorder-7)

Survey respondents were also asked the full set of questions comprising the GAD-7, which gives a measure of the extent to which respondents display symptoms of anxiety. The GAD-7 comprises of 7 questions which ask respondents to indicate the frequency with which they experience a series of different traits that indicate poor mental health pertaining to anxiety. Each answer category is allocated a score as follows: not at all (0), several days a week (1), more than half the days of a week (2) or nearly every day (3). Total scores are added together to gauge a respondent’s overall severity and susceptibility to anxiety or other conditions which are indicative of mental health challenges. The scenarios/experiences asked are as follows:

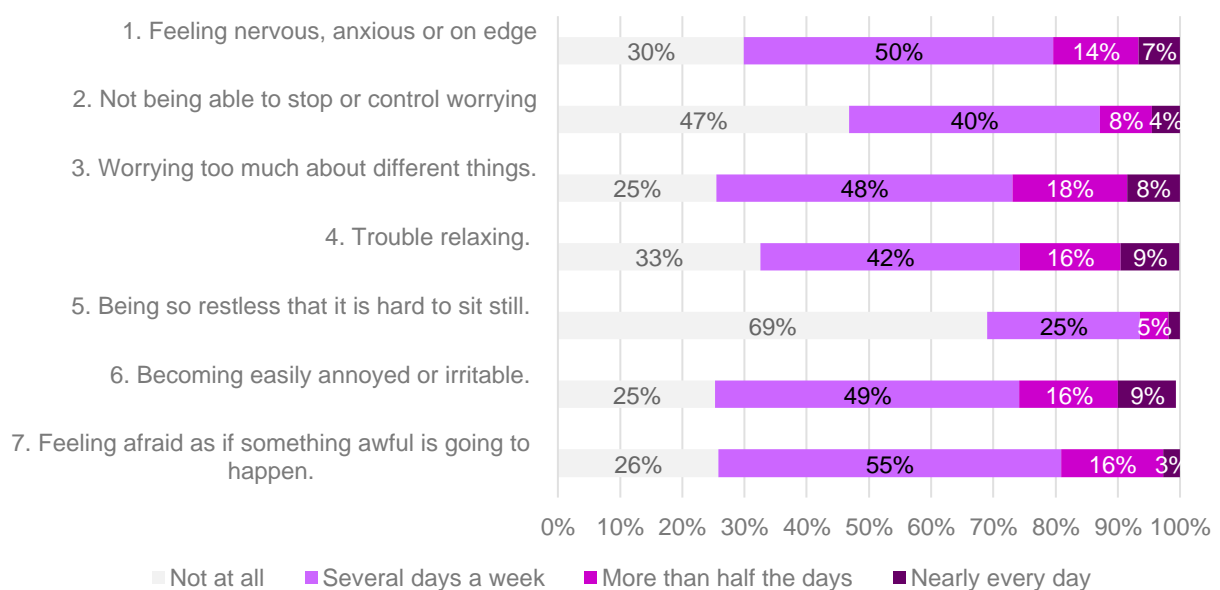
1. Feeling nervous, anxious or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Having trouble relaxing
5. Being so restless that it is hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful is going to happen

Scoring categories are as follows:

0 to 5	Normal
6 to 10	Mild anxiety symptoms
11 to 15	Moderate anxiety symptoms
>16	Severe anxiety symptoms

The chart below depicts the aggregated answers of respondents for each question. As can be seen, there is significantly more variance across the questions than was present in the PHQ-9, and indeed for most questions, respondents appeared more likely to demonstrate experiencing each anxiety symptom at least several days a week. Across the question set, an average of 19% of respondents fell into the top-2 categories.

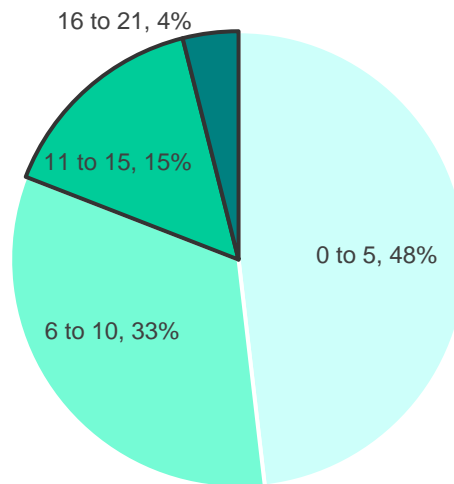
Figure 3: GAD-7 by question



When individual scores were added up, 19% of respondents fell within the top two brackets of displaying moderate anxiety symptoms (15%) or severe anxiety symptoms (4%). Nearly half of the respondents displayed no noteworthy symptoms of anxiety, while 1-in-3 displayed mild symptoms.

19% of surveyed individuals displayed moderate or severe anxiety symptoms.

Figure 4: GAD-7 scores (aggregation)



2.3 Self-harm and suicide

In both quantitative and qualitative components, respondents were asked a series of questions pertaining to their experiences of both self-harm and suicide – in terms of both thoughts and actions. The findings demonstrated some alarmingly high results for ideation and action for both self-harm and suicide attempts, and a significant proportion of people had direct stories regarding themselves or people they knew.

In the survey, those who answered that they had considered harming themselves or attempting suicide were prompted with a follow-up question as to whether or not they had ever followed through on this idea (action for self-harm, attempt for suicide). As the charts below demonstrate, there are alarmingly high rates for both thoughts and actions across both self-harm and suicide.

Regarding self-harm, more than half of respondents (51%) answered that they had thought about self-harm before, with 42% answering that they had not, and 6% preferring not to answer. Of those who answered that they had thought about self-harm (n=882), 42% of them had followed through on this thought and committed an act of self-harm – representing 24% of the total sample.

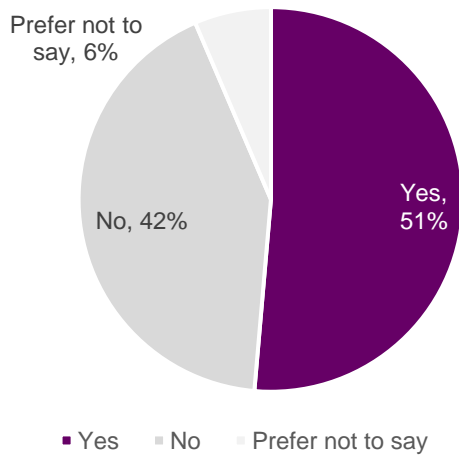
“I’ve tried to kill myself 3 times before... I told myself if I don’t exist, everything will be okay again.”

R2, LB Woman, Pyay.

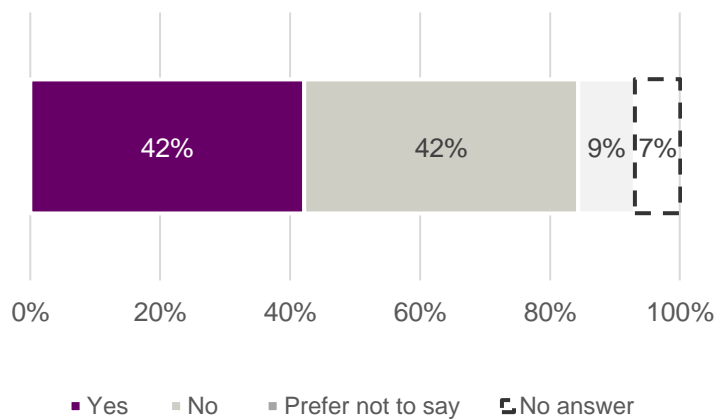
Nearly 1-in-4 participants admitted to having engaged in self-harming activity.

Figure 5: Self-harm - ideation and action

Self-harm: ideation (n=1,524)



Self-harm: action (n=882)

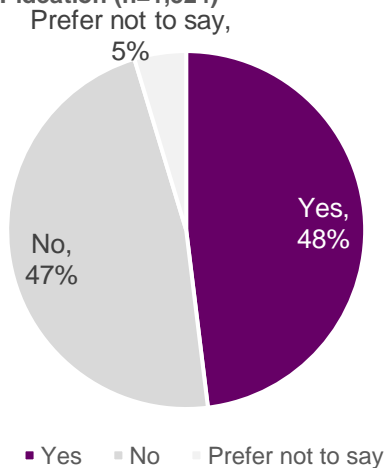


Meanwhile, nearly half of respondents had considered taking their own life (48%), with 47% answering that they had never done so, and 5% preferring not to answer. Of the respondents who had thought about suicide (n=797), 29% answered that they had made an attempt on their life, representing 15% of the entire sample.

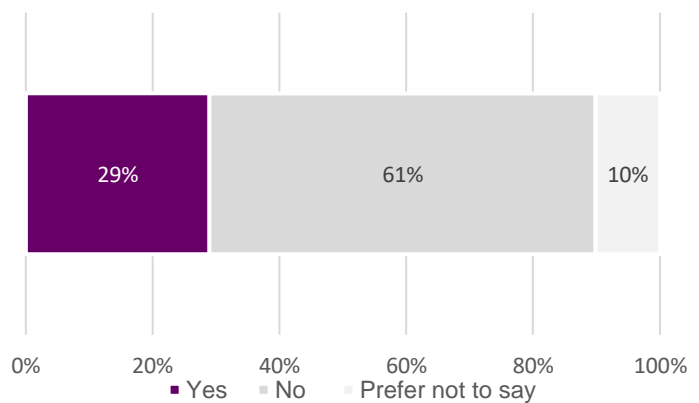
15% of surveyed individuals had made a suicide attempt.

Figure 6: Suicide - ideation and attempt

Suicide: ideation (n=1,524)



Suicide: attempt action (n=797)



Indeed, in qualitative components, some respondents opened up about incidences of self-harm and suicide, both in terms of ideation and previous actions. These were usually associated with reference to trauma, anxiety or depression around experiences of stigma, discrimination or self-loathing. Some individuals had personal stories to share, while others mentioned examples involving friends or acquaintances.

“I’ve tried to kill myself 3 times before... all three times people found me just in time. I was depressed when I realized I liked women... I couldn’t handle society’s views, and my friends and parents’ comments and attitudes. I told myself ‘if I don’t exist, everything will be okay again” **R2, LB Women, Pyay.**

“When my ex broke up with me, I wanted to give up on life because I don’t want to live without him. I took poison. All of my colleagues and headmistress were there for me though... it still hurts when I see my ex with others. I smash or punch the wall” **R2, GB Men, Mawlamyaing.**

“I tried to commit suicide 3 times. I drank methylated spirits , put a knife into my chest and ran at the wall, and overdosed on medicine” **R2, GB Men, Lashio.**

“Sometimes I think ‘if a motorcycle hits me and I die, that will solve everything”, **R2, TG man, Pathein.**

“My closeted friend never opened up, and at the same time, he didn’t even accept himself, so there were a lot of bottled-up emotions. Finally, he hung himself. I feel regret because I could not help him”, **R1, GB Men, Pyay.**

“One of my friends cut herself and took 50 pills” **R1, TG woman, Pathein.**

“He [former lover and transman] would cut his wrists and thighs and told me he had tried to commit suicide. He said there was no other escape, and when he cuts himself, he feels better. When we were together, we both thought of killing ourselves together – to drown, cut our veins, be strangled. I was scared of dying so I asked if he would do it to me” **R1, LB Women, Mawlamyaing.**

The above quotes are but a few examples of stories shared in FGDs throughout the study. Self-harm and suicide are clearly commonplace amongst Myanmar’s LGBTQI community, regardless of location, sexual orientation or gender identity. The following section situates the statistics and stories depicted above in the broader societal context and life experiences of LGBTQI people. By exploring relationship and social dynamics of LGBTQI lives – which are profoundly characterised by experiences of stigma and discrimination – a deeper understanding can be acquired to make sense of the high rates of anxiety, depression, self-harm, and suicide that is endemic amongst Myanmar’s LGBTQI community.

3.

LGBTQI Mental & Psychosocial Health in Context

3. LGBTQI mental and psychosocial health in context

This chapter puts the findings of the previous pages into the context of LGBTQI peoples' everyday lives. It begins by exploring how LGBTQI people conceptualise mental health, before introducing the key themes that emerged when discussing stigma and discrimination against LGBTQI people. It then comprehensively unpacks the challenges faced by LGBTQI people across a range of different settings – including the family, education, employment, healthcare, and romantic and intimate lives. The chapter concludes with an overview of challenges faced by LGBTQI people during Covid-19.

Key findings

1. LGBTQI people associate good mental health with agency, contentedness and positive social relationships, while bad mental health is associated with trauma, discontent and marginalization from society.
2. There is a broad understanding that LGBTQI people are more vulnerable to experiencing poor mental health. While broader society and some LGBTQI people attribute this to an inherent weakness of LGBTQI people, there is generally consensus amongst LGBTQI people that their poorer mental health status is the result of severe stigma and discrimination.
3. LGBTQI people internalize stigma – resulting in the self-policing of behaviours and identities as a form of protection. This internalization of stigmas can manifest in harmful homophobia and transphobia within the LGBTQI community itself.
4. LGBTQI people frequently endure violence, harassment and marginalization within their own households. Transgender women are particularly vulnerable to violent abuse from parents and siblings.
5. Being able to provide financial support to families is often seen as a mechanism for building acceptance from families, as it debunks a widely held assumption that LGBTQI people cannot amount to being productive members of society.
6. Schools and university are also common sites for abuse, bullying and marginalization, with teachers being common perpetrators. This results in many LGBTQI people leaving school early, which limits their livelihood opportunities.
7. LGBTQI people face serious challenges in gaining employment. Stereotypes are reinforced within their working environments and results in their marginalization from peers and a lack of opportunities to be promoted. Livelihood options are also severely limited due to a lack of willingness on the part of employers to hire LGBTQI people.
8. Myanmar's healthcare system fails to meet the needs of LGBTQI people – particularly for transwomen and transmen. Denial of service and mistreatment during service puts the physical health of LGBTQI people at significant risk, which in turn impacts their mental health outcomes. Lack of access and information around gender affirmation services denies transgender people of their bodily autonomy and drives many to seek services and products from medically-unsafe sources.

3.1 LGBTQI conceptualisations of mental health

FGD participants were requested to provide an overview of how they defined and understood mental health as a concept. Responses varied considerably, and a majority of participants admitted that they did not particularly understand or know how to define mental health. Most in this camp tended to think about mental health solely in terms of insanity and did not have an understanding of good and bad mental health until they were asked more specific questions differentiating mental health experiences. Furthermore, connecting poor mental health experiences with trauma and abuse was not an automatic assumption for many participants, and recognising this correlation largely only emerged with probing from the moderator. Nevertheless, a few participants had a strong conceptual grasp of mental health concepts and could describe how both good and poor mental health manifested. As one respondent concisely framed the issue:

“Physical and mental health should not be thought of as separate. People can be in poor physical health and need to be treated, so the same approach should be applied to mental health. MH is closely linked to physical, social and occupational [factors]” **R2, TG man, Yangon.**

Good mental health was most consistently associated with agency, contentedness and positive social relationships. As one respondent described: “Good mental health is when I can do what I want” (*R2, TG woman, Pathein*). Another noted: “When everything is fine, when you can stand on your own two feet, you have good mental health” (*R5, LB woman, Pyay*). Other answers demonstrated the value of being in a position to be able to contribute to society, for example: “When your business is doing well and things are going well generally, mental health is good. You can do charity and feel happy... but if not, you feel sad and cannot help others” (*R1, TG woman, Pyay*).

Meanwhile, bad mental health was associated with trauma, discontent and negative social relationships. A consistent theme that emerged in these conversations was the heightened vulnerability of LGBTQI people to experiencing poor mental health. Some respondents described this as an inherent condition of LGBTQI people – for example, as one respondent answered: “LGBT people are more fragile and sensitive with their feelings” (*R2, TG woman, Mawlamyaing*). Notably, this was not just a belief restricted to younger participants, with one peer navigator interviewed reporting: “LGBT minds are more fragile...they might fight but will cry later in a corner” (*KII5, gay HIV peer navigator, Yangon.*)

With further probing however, many participants were able to ascribe LGBTQI people’s poorer mental health outcomes as the consequence of the external influences of discrimination and stigma that they face across a wide range of social contexts in their lives.

“LGBT are more fragile with their mental state, and it’s easy for them to get depression because of bullying and discrimination. Society discriminates them, they feel pressured and vulnerable, they react badly and then society takes them as rude people” **R4, TG woman, Mawlamyaing.**

“I think LGBT people are more prone to mental health illnesses because of the external problems If parents and relatives can support LGBT people, that will do wonders for us. Others are good too, but parents are the most essential” **R4, LB woman, Pyay.**

“For LGBT people, none are in a good mental health situation because every LGBT person has experienced some kind of trauma in their lives” **R1, GB man, Mawlamyaing.**

“Compared to non-LGBT, LGBT probably have more mental health issues due to external issues” **R1, LB woman, Pyay.**

“Someone with good mental health doesn’t have to feel the pressure or discrimination of society” **R5, LB woman, Taunggyi.**

“

3.2 Understanding LGBTQI stigma and discrimination

Indeed, almost all discrimination and stigma experienced by LGBTQI people in Myanmar hinges upon the perception that their identities, relationships, behaviours and desires defy strongly held notions of gender. For a majority of LGBTQI people in Myanmar, this stigma and discrimination is either an everyday reality or a fear that impacts most or all facets of their lives.

“I act appropriately in public so that I will not be an eye sore... so that I don’t get discriminated.”

R4, GB man, Mandalay.

“I try to be well behaved because I don’t want other LGBT people to get insulted because of me”

R2, GB woman, Mandalay.

When discussing stigma and discrimination, two intersecting forces recurrently emerge. The first of these, is the **external pressure** experienced by LGBTQI people for not being seen to comply with societal norms and expectations, resulting in their social marginalisation. Compounding this external pressure, is the **internal pressure** experienced by LGBTQI people, whereby they self-police their behaviours to ostensibly abide to the social norms and expectations that are pushed upon them. Acknowledging how these two forces are consistently at play in governing the lives and wellbeing of LGBTQI people is critical to understanding their experiences of mental health.

In Myanmar language, the word “*sin-chin*” was frequently used by research participants when discussing societal pressures.¹ *Sin-chin* describes the self-policing of behaviour that might upset others or invite discrimination, stigma or ridicule (i.e. a *sin-chin* individual is one who ostensibly “fits in” and follows social norms). In such a way, to behave in a *sin-chin* manner acts as a protective mechanism from being associated with the myriad negative stereotypes about LGBTQI people that are deeply embedded and enforced by society – such as promiscuity, emotional fragility, having a poor work ethic, being rude or having poor relations with their community. In this interpretation, a gay man might try to hide sexual or romantic partners and avoid acting effeminately in order to embody the masculine traits expected of him. For a

transwoman, being *sin-chin* might mean striving to be as feminine as possible, while a transman might feel the need to appear hyper-masculine – as doing so demonstrates their commitment to upholding social gender norms (even if they might be perceived to have already transgressed these norms by virtue of being transgender).

Many respondents discussed their struggles with trying to mask their identity, or else described scenarios that revealed their own internalisation of derogatory attitudes towards LGBTQI people. This self-policing can be simultaneously inflicted upon themselves, and also turned outwards towards LGBTQI people who are not *sin-chin*. Indeed for some, those seen to not be *sin-chin* are believed to be at fault for the mistreatment they encounter by virtue of their ‘decision’ to act in a way that is socially unpalatable. Elsewhere, those who are not *sin-chin* were framed as being personally guilty of reinforcing negative stereotypes against the LGBTQI community, which manifests in pressure to not only protect themselves, but also other LGBTQI people.

¹ Note that this term is not solely used in reference to the LGBTQI community and has broader application.

“I try not to drink, chew betel, smoke... because I don’t want people to say that’s what transmen do” **R2, TG man, Mandalay.**

“I think stigma and discrimination depends on the person. If particular gay people wear make-up while dressing up as a man, people will judge them. As for me, I live an ‘ordinary’ life” **R5, GB Man, Yangon.**

“As a transman, it feels like I have to be one step better than others so that others can accept me. I try to be dependable and good just so others will accept me” **R4, TG man, Mandalay.**

“My parents told me not to disgrace the family image... So I don’t dare make my identity obvious” **R4, GB Man, Yangon.**

“My partner is a government official, so we need to be careful not to drag his image down... and also we don’t want to give reasons to bring the LGBT image down.” **R1, GB Man, Yangon.**

Notably, several conversations with LGBTQI community leaders and stakeholders echoed the need for self-policing within the LGBTQI community – but this was often presented in a manner that implied LGBTQI people as being complicit in their mistreatment due to their own behaviour. Numerous community workers or prominent activists openly accused the LGBTQI community of marginalising themselves from society and inviting discrimination and abuse vis-à-vis publicly unpalatable behaviour. While there may be some truth in these accusations, the fact that these comments were rarely balanced with a perspective that aggressive or unsavoury behaviour was reactionary or a form of self-protection protective against years of abuse and harassment is a somewhat concerning stance for senior LGBTQI leaders to express. Accusing LGBTQI people of inciting their own mistreatment is tantamount to victim-blaming and will do little to foster empathy towards the LGBTQI community. It places the burden of change upon marginalised and vulnerable individuals as opposed to dismantling the norms and systems under which LGBTQI people are oppressed and abused.

“[Transwomen and gay men] abuse the word human rights’ and are rude to society. They have no respect. If someone says a few rude words to them, they reply back with many swear words and fights happen.” **KII2, Gay NGO worker, Patheingyi.**

“LGBT people who do not behave appropriately in the community are more prone to stigma and discrimination – they should act with dignity.” **KII13, gay peer educator, Dawei.**

There were also some notable differences in views amongst community leaders and other stakeholders as to the severity of discrimination and abuse against LGBTQI people. Specifically, those based in Yangon tended to have a more optimistic view about the situation for LGBTQI people and reported that the situation had significantly improved. This contrasted experiences and perceptions elsewhere, where stories of stigma and discrimination were abundant. Overall, it was widely agreed upon that the situation for LGBTQI people was significantly worse in rural areas, and others highlighted the particular struggles faced by LGBTQI people belonging to ethnic minority groups.

“Discrimination in Yangon seems more okay, the focus needs to be on rural areas... if the family is supportive, the general environment doesn’t matter as much” **KII1, Gay healthcare worker, Yangon.**

“Stigma towards LGBTs seems to be decreasing in big cities like Yangon and becoming more acceptable in recent years - yet many parents struggle to adjust after learning their children are LGBT.” **KII 4, Gay healthcare worker, Yangon.**

“No more harsh reactions from parents anymore but from older brothers mostly” **KII5, gay HIV peer navigator, Yangon.**

“Problems are worse in rural areas. People cannot come out properly especially Tainyingtha nationalities...Pa-O, Kayin and Mon traditions are very strong” **KII6, Gay LGBTQIA NGO Worker, Mawlamyaing.**

“Being LGBT is still unacceptable, mostly in rural areas. Religious-based discrimination is common in Mawlamyaing and Kyaiktio. There is no legal protection for LGBT people...society teases and makes a joke of them...they face unwanted touching and grabbing of their body parts - they are treated as jesters just to be laughed at” *Kil8, female human rights worker, Mawlamyaing.*

Another theme that emerged in conversations was that perpetrators of violence and abuse believed that their actions would compel LGBTQI people to change – revealing an underlying assumption that being LGBTQI is simply a behaviour or choice that an individual can stop. These attitudes are most commonly held amongst figures of authority during the upbringing of LGBTQI young people – whereby acts of violence in the family household or pressure to marry someone of the opposite sex, or the tolerance or perpetration of bullying and abuse by teachers in school environments, are conceived of as ways to alter the behaviour and ‘choices’ of LGBTQI people to steer them on the ‘right’ track.

As the following pages illustrate in explicit detail, the continuous reinforcement of negative assumptions about LGBTQI people through abusive and marginalising behaviour is a reality across all social settings, and the collective mental and psychosocial wellbeing of Myanmar’s LGBTQI community suffers considerably as a result.

3.3 Stigma and discrimination in social settings

3.3.1 Family

By far the most prominent conversation regarding social relationship pertained to family. Overwhelmingly, respondents discussed stories of rejection or fear of rejection on the basis of their sexual orientation or gender identity. This rejection was experienced in a multitude of ways by participants – ranging from wilful ignorance and subtle undermining from family members in milder cases, to much more serious instances of violence, harassment and home eviction. The prevalence of stories that emerged where respondents described themselves or others enduring painful and fearful relationships with not just parents, but also siblings and other family members, cannot be underestimated as a potent factor contributing to the poor mental health outcomes suffered by LGBTQI people.

“I ran away from home because of all the harassment and abuse. I lived on the street like a stray dog.”

R1, TG woman, Taunggyi.

Only **12%** of survey respondents were **officially ‘out’ to their parents**, and **21%** were **‘out’ to their siblings**.

In focus group discussions, transgender woman by far reported suffering more violence than any other group. Largely such violence in the household was attributed to fathers, for whom the violence was justified on the grounds of their children’s noncompliance with traditionally masculine traits or pursuits, and which was believed to be a way of making them ‘straight’. For others, abuse or marginalization came in subtler forms – which reveal underlying associations of transgender women with HIV/AIDS or other illnesses.

“I was the only son of the family. My father would tie me to a tree in the garden, stripped my clothes off and beat me... I ran away from home because of all the harassment and abuse. I lived on the street like a stray dog...” **R1, TG woman, Taunggyi.**

“When I came out as trans, my mother cried hard and slapped me, punched me in the genitals. My whole family swore at me... None of my relatives greet me if I bump into them, I can’t convince my family to accept me no matter how well I behave.” **R2, TG woman, Taunggyi.**

“I was beaten by my father because I was girly, and forced to do hard labour, ploughing, farming, which might display strength, power and competitiveness... because that’s what he thought would make me a real man. I felt suffocated.” **R5, TG woman, Yangon.**

“I remember when my dad kicked me when he first found me wearing women’s clothes. But the physical abuse made me more determined to express myself.” **R1, TG woman, Patheingyi.**

“My experience was okay, but that’s not true for everyone. I know someone whose dad would hit her until her back was bleeding” **R2, TG woman, Mandalay.**

“When I was young, my father and sisters did not like me being ‘gay’. So when they’d see me hang out with my gay friends, my sisters would swear at me and my father would hit me with a bamboo stick. He’d say ‘My son is gay because he hangs out with other gays!’ and would smash up my make-up boxes...” **R2, TG woman, Pyaw Bwe.**

“My little brother won’t even wear my old clothes because he’s scared of AIDS” **R3, TG woman, Pakkoku.**

“My parents would not even drink the same water as me” **R1, TG woman, Pakkoku.**

Explanations for the much higher prevalence of family violence experienced by transwomen are complex and overlapping. One important aspect is the vulnerability to which transwomen are exposed when they begin outwardly expressing their gender identity – a problem not faced by cis-normative lesbians, gay men or bisexual people whose sexual orientation can be a more hidden or compartmentalized part of their identity. Another aspect to take into account is the prevalence of patriarchal social norms that more harshly punish a male transgressing gender boundaries, due to a perceived abandonment of the prestige that is associated with being male. In Myanmar culture, where to be masculine means to be in charge and honourable, transwomen are seen to be wilfully giving up the honour of being a man. These ideas provide preliminary explanations for why transwomen report higher levels of violence than transmen.

Nevertheless, other identity groups experienced abuse, sometimes violent, at the hands of their family members. In non-violent situations, respondents described being ignored, marginalised or bullied within their home environment. Wilful dismissal of LGBT identities appeared common, with some participants reporting that their parents would pretend not to know about their identity even if they had been told, and in some cases people faced pressure to marry from parents who were either unaware of their child’s identity, or else trying to rectify an identity that they saw as problematic or shameful. It must be noted that even when there is an absence of violence in the household, long-term subjection to neglect, harassment or the disapproval or denial of an identity can have profoundly negative impacts on

“...my mother didn’t talk to me for 2 weeks. Even living in the same house as my family, it felt like nobody was there... like I was isolated.”

R4, GB Man, Mawlamyaing.

psychosocial health of individuals. The high rates of self-harm and suicidal thoughts and actions and the experiences of depression and anxiety described by participants attest to this notion.

“It was terrible when I came out to my parents. My mum didn’t talk to me for 2 weeks... even living in the same house as my family I felt like there was nobody there, like I was isolated...” *R4, GB man, Mawlamyaing.*

“My parents know I’m bisexual. I’m not super close to home or my parents... they don’t really say much about my identity” *R1, GB woman, Pathein.*

“My family know about my identity, but they never talk about it in the open. There is some pressure by my family to marry” *R4, GB man, Yangon.*

“I was engaged to a man when I was 17, but I cancelled because I couldn’t follow through with it. I had to leave my

family afterwards” *R2, LB woman, Pathein.*

I know of someone whose parents forced her to marry a man, because they believed it would ‘fix’ their daughter” *R4, LB woman, Pyay.*

“No matter how well I behave, my family does not accept me and pretends they don’t know” *R2, GB man, Lashio.*

“When we go to weddings of my female friends, my mum always nags me about when I am going to get married to a man” *R3, TG man, Lashio.*

“My mum doesn’t say anything to me about it – but that doesn’t mean she’s accepting. She still keeps calling me her daughter at home” *R5, TG man, Mandalay.*

The stories above and many others revealed numerous underlying assumptions and stereotypes against which LGBTQI people must battle. Indeed, for many, abuse and marginalisation within the household hinged on an assumption that LGBT people were “useless” – that their ‘chosen’ identity meant they would never amount to anything and they could therefore not provide for their family. Respondents often talked about the importance of demonstrating their independence and a capacity to support their family as a means of securing greater acceptance. Striving to do well in both school and livelihoods in spite of stigma and discrimination was a defining theme of many stories.

“My parents said things like ‘gays are useless and will never be able to accomplish anything’. Because of those words, I tried hard on my own and got a bachelors degree... Now I’m no longer treated badly as I am capable of leading my own life” *R3, GB Man, Mandalay.*

“The more financially independent I became, the more my family came to accept me” *R4, TG man, Pathein.*

“They would put me down, I was beaten and looked down upon... It’s not common for LGBT people to live with their family. They support their family so they can be accepted, little by little” *R4, GB Man, Pathein.*

“Some family members tell me I’ll become an animal in the next life, or that I’ll get struck by lightning” *R3, GB Woman, Pathein.*

“I’ve got many scars from beatings, the most amongst my siblings...but later my family accepted me as I was the only one to pass 10th grade” *R4, GB man, Lashio*

3.3.2 School and university

Regarding school environments, numerous stories emerged whereby participants endured discrimination, harassment and abuse at the hands of both classmates and teachers alike. While these experiences are not only profoundly harrowing in their own right during such formative years of life, many respondents also reported feeling compelled to leave school, and thus faced longer-term ramifications in terms of further education and prospective livelihood opportunities. The complicity of teachers within the stories of mistreatment and abuse is particularly striking, and points to the deep entrenchment of discriminatory attitudes towards LGBTQI people in Myanmar society – even amongst those who are the supposed caretakers of young people.

Negative experiences varied from verbal harassment to physical violence, and many reported that they felt they were actively denied equal opportunities or treatment in school or workplace settings. Complaints around bullying were generally ignored by teachers, given that in many cases the teachers were perpetrators themselves, or they simply believed the bullying would stop if the victim would behave differently.

Some respondents described masking their LGBTQI identities to avoid mistreatment, but for others, this was more challenging. Transwomen once again appeared to suffer the most physically brutal treatment by virtue of their identity, but gay men also reported high rates of marginalisation and bullying on account of having effeminate characteristics. Transwomen and men reported facing difficulties in regard to uniforms – whereby uniform codes were strictly enforced by teachers, or else they were simply bullied for defying clothing norms.

“...the lecturer pointed to me and used me as an example for the expression ‘not everything is clear as black and white’. She humiliated me in front of the class saying that she couldn’t tell if I was a female or male...”

R1, TG man, Lashio.

“In my final year, the lecturer pointed to me and used me as an example for the expression ‘not everything is clear as black and white’. She humiliated me in front of the class saying that she couldn’t say if I was a female or male... I was so ashamed, I skipped classes for a week.”

R1, TG man, Lashio.

“I’d get into arguments with my classmates when they’d tease me. The teacher would blame me because I didn’t live as a man. I was sexually abused first in 7th grade, and eventually I ran away from school and home because of all the harassment and abuse.”

R1, TG woman, Taunggyi.

“There was so much bullying from teachers and classmates. I couldn’t finish school because of all the harassment and discrimination. So I don’t have much choice for a career...”

R4, TG woman, Mawlamyaing.

“I had no friends at school. People didn’t want to sit with me and the teachers never favoured me so I got terrible grades and dropped out. Now I’m a disabled, transwoman with HIV... I feel so ill-fated”

R4, TG woman, Pakkoku.

“I used to play badminton and *chinlone* with boys. There were times when some boys would say they won’t play anymore because I was joining. When I told the teacher, they just said ‘it’s because you act *this way!*’” [referring to gender expression] **R3, TG man, Mawlamyaing.**

“I was teased by other students because I was girly and my voice was so soft. My 9th grade teacher once asked me if I was gay in front of the whole class, I was so embarrassed... Then I was sexually abused in my 2nd year university. I was traumatised and thought about suicide and even had to seek counselling” **R4, GB Man, Pyay**

“They had a dress code for tuition. They’d force me to wear a skirt; it made me so uncomfortable” **R1, TG man, Mandalay.**

“Last year, at [local school], the headmistress summoned the transmen and tomboys and asked them to fill in a questionnaire, asking questions like: ‘do you want just mother or father or both a mother and a father?’” **R2, GB Woman, Mandalay.**

3.3.3 Work and employment

“When I apply for jobs, I hate the stares. If I apply for a female position, people stare. When I apply for a male job, people stare. I don’t know what job to apply for!”

R1, TG man, Pakkoku.

“My colleagues feel like they can’t change clothes or wash themselves in front of me. They don’t trust travelling with me. They say they don’t trust my desires.”

R2, LB Woman, Pathein.

Meanwhile, in the workplace, LGBTQI people encounter similar incidences of discrimination, harassment and stigma. While in these settings, incidences of violence are less common, feeling marginalised and disadvantaged in the workplace was an everyday lived reality for a number of participants.

As discussed in the section on family relations, LGBTQI people are compelled to strive towards financial independence either because they do not want to or cannot rely on their family for support, or else they want to support their families in order to gain acceptance and fight off stereotypes that LGTBQI people are ‘useless’.

Many LGBTQI people advance into livelihoods where they feel they will be safe and respected; for example, it is common for transwomen and gay men turn to make-up artistry or hairstyling. For some, choosing a profession that reinforces their LGBTQI identity feels empowering, such as a transwoman who enters the beauty industry and feels her femininity is amplified, or a transman or tomboy who chooses manual labour work that would normally be deemed ‘masculine’.

However, while many respondents certainly reported taking pride in these professions, the situation is frequently described as involving little choice – insofar as they are forced to pick these industries because they either have not had the education to pursue other livelihoods, or else feel other livelihoods are inaccessible by virtue of their identity. Stories pertaining to the sheer lack of choice of livelihood options on the grounds of appearance and identity were particularly prevalent amongst transwomen, for example:

“I don’t have much choice for a career... I can’t pursue any professional career when I’m dressed as a woman. Only make-up, selling flowers, *nat kadaw*” **R4, TG woman, Mawlamyaing.**

“My mum wanted me to be like my cousins, who are doctors, lieutenants, engineer... I wanted to be a lawyer, but that wasn’t possible. Who wants a lawyer who is a transwoman?” **R2, TG woman, Taunggyi.**

“During Covid-19 there were groups of vendors that were hiring, and I wanted to join. When I met the organiser, they told me I had to dress and look like a man in order to sell... People can’t do work because of their looks – banks will say you can’t have long hair or wear certain clothing” **R4, TG woman, Patheingyi.**

Others too, faced discriminatory attitudes and behaviours regarding work and employment opportunities in direct reference to their identity. Strongly ingrained attitudes around the categorisation of different kinds of work in regards to gender identity emerged as a significant issue. Transmen in particular reported having their adequacy for typically ‘male’ jobs dismissed or questioned. Amongst those who gained employment, they reported additional ongoing pressures to prove their worth to employers in ways that non-LGBTQI peers did not have to endure. For some, success in this regard served as a positive reinforcement of their gender identity and a sign that they were accepted for who they are. For others, rigid notions of male and female work were a force of frustration and confusion.

“At the workplace I can work just like the men – I get equal treatment like riding a motorbike. As long as I dress like a man and can do tough work like them, I don’t get ridiculed” **R5, TG man, Lashio.**

“When I apply for jobs, I hate the stares. If I apply for a female position, people stare. When I apply for a male job, people stare. I don’t know what job to apply for!” **R1, TG man, Pakkoku.**

“I’m not promoted because I’m a transman. Once one employer admitted that if the company has to pick from LGBT and non-LGBTs, then they’d hire non-LGBT because they don’t have to consider uniform or hotel accommodation.” **R1, TG man, Lashio.**

“Factories don’t want to hire tomboys. They’d ask me to wear a *tamein* (female attire) when I come in for an interview. Once an interviewer accused my NRC of being fake. Another said they liked me but that they couldn’t offer me a job because I’m a tomboy.” **R2, TG man, Patheingyi.**

The biggest issue faced by lesbians, gay men, and bisexuals were stigmas around their character. Numerous stories emerged in which respondents had faced harassment or marginalisation in the workplace because of perceptions amongst colleagues, employers or customers that they were sexually perverted, inappropriate or shameful. This became particularly problematic in regards to sharing intimate space with colleagues, a common scenario in jobs that require travel or the sharing of accommodation. Meanwhile, one story from a gay man illustrated the extent to which these negative perceptions are internalised and perpetuated by gay men themselves, who seek to hide their identity. This results in the self-policing of so-called “gay” behaviour, and active separation from openly gay men, who are understood to be inappropriate and vulgar, and who may pose a risk to exposing their identity and bringing shame upon them in the workplace. The reinforcement of these stigmas by LGBTQI people themselves reveals the extent to which harmful stereotypes about LGBTQI people are entrenched in Myanmar society.

“When I was a seamstress, the majority of my customers were female and they usually joked about not letting me measure their body, or their boyfriends would say not to get close to me because I’m obsessed with sex.” **R3, LB woman, Mandalay.**

“My colleagues feel like they can’t change clothes or wash themselves in front of me. They don’t trust travelling with me. They say they don’t trust my desires.” **R2, LB woman, Patheingyi.**

“I used to work for the government, but because of my colleagues’ discrimination and mocking I left the job” **R4, LB woman, Taunggyi.**

“When ‘hidden gays’ reach management levels, they don’t approve of opportunities for ‘open gays’ and try to sabotage them because they know that those gays will try to bring shame to them... the obvious gays are so bad, management don’t want to give them any places” **R2, GB man, Mandalay.**

3.3.4 Healthcare

“Some doctors don’t want to treat us. They are scared of disease.”

R4, TG woman, Patheingyi.

“I’m afraid to go to hospitals and clinics because I can’t bear people’s assumptions and judgements. They assume I’ve got HIV just because of who I am.”

R1, TG woman, Yangon

Experiences of stigma and discrimination in the healthcare setting was almost exclusively discussed by transgender participants – indicating the much starker gaps in healthcare provision faced by transgender individuals as compared to cisgender lesbians, gay men and bisexual people. Privacy, trust, and comfort are critical components of equal and accessible healthcare provision, and conversations with transgender research participants indicate that in their experience, this is sorely lacking in Myanmar. A healthcare system that is hostile to transgender people not only places them at risk by discouraging them from engaging with healthcare services for general health problems, but also denies them therapies and services that help affirm their gender identity. Global research has shown that both physical and mental health outcomes for transgender people are significantly higher when healthcare services holistically respect their identities and serve their needs. Improving healthcare services for transgender people in Myanmar will thus be a critical component in improving their mental health situation.

Two key themes emerged in discussions around healthcare: i.) experiences of abuse, harassment or misunderstanding from healthcare providers and ii.) a lack of information and services that meet their needs. Both of these issues ultimately put transgender people at significant risk of harm, given that it discourages them from accessing healthcare providers and can prompt them to seek dangerous alternatives in unsupervised and unregulated settings.

Abuse, harassment and misunderstanding ranged from general ignorance by care healthcare providers, to more serious cases of blatant mistreatment and denial of service. Conversations with respondents revealed once again the pervasiveness of negative assumptions and stereotypes about LGBTQI people endemic within the healthcare setting. Fears and misunderstandings around HIV/AIDS were particularly common, as was a general assumption of contagious sickness and disease – which appears to prompt many healthcare providers from serving transgender people. These stories were mostly common amongst transgender women.

Meanwhile, many respondents noted being blatantly mocked and mistreated by healthcare providers. Once again, such experiences were more common amongst transgender women, although some transmen noted instances of humiliation or discomfort when being triaged when their ID does not match their gender expression. Clear issues exist around triaging transgender patients, and there appears to be common unwillingness to serve people according to their gender identity. This can vary from humiliating encounters to an outright lack of cooperation to respect transgender identities.

“I had an accident and was admitted to the men’s ward. The nurses were laughing at me and asking between themselves if I was a girl or a boy... at a different healthcare centre, they arranged for me to be admitted to a girl’s ward but requested me to ‘act appropriate and not be so noisy” **R2, TG woman, Mawlamyaing.**

“In 2019 I was in a motorcycle accident... I got sent to hospital and the doctors and nurses asked if I should go in a female or male ward. They probably didn’t mean to humiliate me intentionally, but it really hurt.” **R2, TG woman, Pakkoku.**

“I’ve heard it’s worse in rural areas... that some doctors physically harass us, touching and grabbing breasts.” **R5, TG woman, Yangon.**

“I feel embarrassed to go to healthcare services because of my features... I’ve got breasts despite being a ‘man’...” **R3, TG woman, Yangon.**

“Sometimes I get mocked or sarcastic looks at the clinic or hospital because I don’t look like a girl even though it says ‘Ma’ on my ID” **R2, TG man, Pyay.**

There also appeared to be a view amongst healthcare workers focussing on HIV that stigma and fears were decreasing towards gay men and transwomen. Notably, however, both service providers were based in Yangon – and our anecdotes depict clear scenarios of stigma and discrimination running rife in the healthcare system. Healthcare programming needs to take locational context into account and be cognisant of the experiences of more hidden and unreached LGBTQI communities outside of urban centres.

“HIV status disclosure and stigma depends on ones’ living standards, class and education level.... But there’s less stigma to PLHIV as well because there has been a decade of HIV/STI projects. Public awareness is improving gradually” **KII4, Gay healthcare worker, Yangon.**

“In the past, HIV patients got burned alive outside of villages in some rural areas, but there is no discrimination and stigma from society anymore in present days” **KII5, gay HIV peer navigator, Yangon.**

Regarding healthcare needs specific to transgender people – it is clear that while there is a demand for gender affirmation information and services, the healthcare system is ill-equipped to deliver. More specifically, this was most commonly a problem for people wanting to access hormone therapies, and to a lesser extent, gender affirmation surgery. Numerous participants reported a willingness to access hormone treatment and information but said this was impossible in their location. Another concerning reality is transgender people’s reliance on informal networks through which they access hormone therapy, in lieu of medically supervised and regulated options. Ensuring that transgender people can

access critical hormone therapy in settings that are understanding of their needs will be critical to improving physical and mental health outcomes for transgender communities.

“It’s a big problem that there are no services about hormones for transgender healthcare... trans people are left behind more than anyone in the population.”

R4, TG woman, Pathein.

“It’s a big problem that there are no services about hormones for transgender healthcare. For gays and lesbians, they don’t have problems in their everyday life, because their gender expression is ‘normal’. But trans people are left behind more than anyone in the population.” ***R5, TG man, Pyay.***

“There needs to be specific healthcare centres for transmen. They will have issues with ‘women-related’ diseases - but they won’t dare go to clinics or hospitals. They also need safe places to get hormones - I’m worried for the ones who are injecting themselves!” ***K1110, female community healthcare and social worker, Pyay.***

“It’s a little scary getting hormones without a doctor’s consultation... but this is what I want so I have to do it... there needs to be a place that helps and assures transmen that the hormones they are taking are safe.” ***R4, TG man, Pakkoku.***

“There aren’t any dedicated resources for transmen about hormone information or services” ***R1, TG man, Pathein.***

“I want to do hormones and things like that but I’m scared of the side effects.” ***R2, TG woman, Pathein.***

Healthcare systems must cater to the needs of all people, regardless of sexual orientation or gender identity. Given the disproportionate barriers and mistreatment faced by transgender people, serious attention must be paid to transforming and innovating services that promote dignity, respect and bodily autonomy for transwomen and transmen. The links between bodily autonomy and physical and mental health cannot be ignored. Ensuring that LGBTQI people not only have equal access to healthcare providers, but that they have services that cater specifically to their needs and facilitate their ability to make informed decisions about their bodies – such as hormone therapy treatment – will drastically improve their mental health outcomes.

3.3.5 Romance and intimacy

A theme that was consistently talked about by participants were problems encountered around romance and intimacy. While for many, romantic relationships provided comfort and validation in what might otherwise be a world filled with marginalisation and discrimination, respondents discussed numerous anxieties and concerns in their romantic and intimate lives. Findings from this study, as well as &PROUD’s discoveries through *Yin Phwint Yar*, reveal that these problems particularly occupy the minds of young people, and there is a clear need for intervention in this space.

Three overlapping themes emerged through conversations with participants:

Invalidation or rejection of their relationships by others

Unrequited feelings and fatalistic views of inevitable loneliness

Toxic relationships

Certainly, all groups had experienced the invalidation or rejection of their relationship by others. This was often in the family setting, but also extended to friendships, the workplace and general society. As a result of social stigma, many LGBTQI people keep their relationships a secret to avoid abuse and harassment. Reasons for the invalidation of LGBTQI relationships were varied and included a perception that the relationship brought shame to the household or associated individuals, that the relationship was invalid because the couple could not reproduce or that the relationship was physically dangerous due to misplaced fears around HIV/AIDS. There were also many stories of people being forced to marry by their parents, or else people marrying to hide their attraction to someone deemed off-limits.

Stories of unrequited feelings or attractions for others, or a perception that LGBTQI people would inevitably be condemned to living without love, intimacy or relationships were also exceedingly common, and no doubt informed by the previously discussed invalidation and stigmatisation of LGBTQI relationships. Concerns around an inability to reproduce or raise a family were offered as explanations as to why LGBTQI relationships could not be long lasting. In other cases, the inherent promiscuity of LGBTQI people was also frequently given as a reason – a perception that demonstrates the internalisation and reinforcement of stereotypes about LGBTQI people by LGBTQI people themselves. Without shaming sexual freedom, consensual open relationships, and polyamory, it is useful to consider the fact that LGBTQI people may seem to be or indeed may be more promiscuous because the concept of having an ongoing, stable relationship with another LGBTQI individual is inconceivable given the widespread societal rejection of such relationships.

There were also some examples of toxic relationships in which individuals were trapped within harmful relationship dynamics with partners. This is particularly concerning for LGBTQI people given the secrecy under which so many of the relationships take place and the lack of social or professional outlets through which they might seek help or talk about problems. In worst case scenarios, toxic relationships may escalate to domestic violence and abuse – which LGBTQI people would be unlikely to report or seek help from given their mistreatment by general society and the fact that opening up about problems in their relationship may ultimately put them at more risk.

While these three themes were discussed broadly in all focus groups, the nuances of experiences across identity groups varied and are worthy of deeper exploration.

Transwomen had particular grievances with their male partners feeling ashamed about being in a relationship with them, or that their partners were bullied by their family and friends who saw their relationship with a transwoman as being invalid or shameful. Not being a “real” woman was also an issue raised by many, usually in terms of not being able to conceive and provide a family for their partners. These dynamics compound to create a situation in which transwoman see themselves as being frequently sexually objectified, whereby men might pursue transwomen for fun with no consideration for their expectations, needs or desires. This is often reflected back upon transwoman through a stereotype that transwoman themselves are *exclusively* interested in sex and that they are highly promiscuous. Not only do these dynamics instil significant fatalism in many transwomen about

their right or ability to access intimacy and romance, but it also exposes them to toxic or harmful situations in which they might be vulnerable to violent abuse or exploitation for money.

“It’s hard for men to show their transwoman partner in public because they will also get criticized. So, they don’t take them as a serious partner... They only take us for fun because there is no pregnancy issue. Boys treat us like a ladder for pleasure” **R4, TG woman, Mawlamyaing.**

“My boyfriend struggles a lot too. He’s teased by his friends and his parents don’t do his laundry for him because they think LGBT people are born with AIDS” **R3, TG woman, Pakkoku.**

“Due to the media’s representation, transwomen are always portrayed as those who can’t take their eyes off any guy and offer money for sex. Due to this sort of propaganda, 75% of men who are interested just use us for our money” **R5, TG woman, Yangon.**

“We always feel inferior to ‘real’ women because we can’t get pregnant. According to Myanmar culture, not being able to be a dad makes men feel like less of a man. We aren’t capable of fulfilling this wish, so they can’t love us with all their heart” **R5, TG woman, Yangon.**

“If it’s a relationship between a man and a woman there are legal structures in place to support their marriage... But if it’s two LGBT people, society doesn’t take them seriously. If I get hit by my partner, where can I go? Society will laugh at me and the police will too” **R3, TG woman, Pyay.**

“At the end of the day, transwomen are destined to be forever alone. We are not able to give a normal family life to our partners, so who wants to have a serious relationship with us? ... it’s better to not expect too much from a relationship”

R3, TG woman, Pakkoku.

Transmen raised similar concerns relating to the extent that they are considered ‘real’ men in romantic and intimate relationships. Participants spoke about a concern that their partners (usually women) would leave them to partner with or marry a ‘real’ man, whether it be due to their own preferences or by force from their family. Indeed, there were numerous anecdotes about parents actively intervening in relationships between transmen and their partners, which were mired in accusations that transmen were leading their daughters astray and setting them up for failure. For some, this leads them to conduct relationships in secret, while for others it simply generates a sense of fatalism about the pointlessness of pursuing intimacy.

“My girlfriend’s family is really conservative... when they found out that their daughter was dating me, they beat her. So we have to hang out secretly.”

R3, TG man, Pyay.

“One of my ex’s mothers told me to stop being with her daughter and that I should leave her daughter’s life. Then my girlfriend’s friends started calling me names.” *R5, TG man, Mandalay.*

“My parents said, ‘this lifestyle is not conducive to Myanmar society – go abroad if you want to have this kind of love’”, *R2, TG man, Mandalay.*

“Last year there was a huge argument. My girlfriend’s mum came to my home and said if I didn’t break up with her daughter, she would report me to the police” *R4, TG man, Pyay.*

“I’ve had bad past experiences, I don’t believe in love anymore... they’ll leave me sooner or later and get married to a real man” *R1, TG man, Yangon.*

“I know my partner can’t be with me my whole life because I’m not fully a man, and I can’t compete with a real man” *R1, TG man, Pathein.*

Lesbians, gay men and bisexual people had grievances in common with their transgender peers, though in many ways to a less extreme extent. While this does not at all indicate that their romantic and intimate lives are less challenging, it is likely a product of the fact that as someone cisgender, they do not need to navigate all of the other challenges faced by transgender people that have been explored thus far in the report in *addition* to issues in their romantic lives.

Secrecy and self-policing are similarly common themes for lesbian, gay and bisexual relationships, as are pressures to marry someone of the opposite sex and start a family. Stereotypes about the sex drives and promiscuous nature of LGBTQI people were also frequently discussed, and for many people, particularly gay men, assumptions about promiscuity appear to be internalised. This once again drives people towards a fatalistic view about entering relationships in general.

“My ex-husband knew I was bisexual. He accepted it for a while, but then started to mock me. I couldn’t bare the sarcasm anymore or his stereotypes that LGBT people have uncontrollable sexual desires.”

R2, LB woman, Mandalay.

“I want a family of my own but it’s impossible, so I don’t even dream of it.” *R3, GB Man, Pathein.*

“It’s been 3 years and 4 months since I’ve been living with my girlfriend. Her family still disapproves of our relationship... also I don’t dare to take a stroll with her in public. In Mandalay most people give a shocked look” *R4, GB Woman, Mandalay.*

“If a gay man wants a faithful partner, he is considered an egocentric person” *R6, GB Man, Yangon.*

“Many guys get married to women at the end of the day... most LGBTs are not in serious relationships, there’s a lot of reasons behind it. Maybe their parents are too conservative, or they are not committed” *R3, GB Man, Pakkoku.*

3.4 Spotlight on Covid-19

LGBTQI people appeared to suffer acute mental health and psychosocial problems during Covid-19. Whilst it is true that many of the experiences mentioned by participants are quite universal and not necessarily in relation to their LGBTQI identity, in understanding the relative toll on mental health for LGBTQI people we must take into account that their benchmark for mental health and psychosocial outcomes is already comparatively lower. Thus, the problems that emerged during the onset of Covid-19 compound previously existing anxieties and concerns and deteriorate their psychosocial well-being to even lower standards than their non-LGBTQI peers.

Three key areas came up in discussions that were the topics of greatest concern: social and family relations, livelihoods and health.

3.4.1 Social and family relations

As the previous pages have clearly depicted, LGBTQI people endure serious challenges in their relationships with families and broader society – in which they encounter significant discrimination and stigma in their everyday life. The pressure of the ‘new normal’ during 2020, in which socialising options were reduced, people were forced to stay in their households and livelihoods were lost all contribute to exacerbating the social and family difficulties encountered by LGBTQI people.

Loneliness and feeling depressed were major issues for most participants in this respect. The ability to socialise with other LGBTQI peers and relax in supportive and affirming environments is essential to the psychosocial wellbeing of LGBTQI people – a facet that was largely unavailable as Covid-19 restrictions rolled out across the country. This report has extensively detailed the immense struggles that countless LGBTQI people face in their family households. In a period of time where there was little choice but to remain at home means that thousands of LGBTQI people were restricted to unsupportive and abusive home environments with no social outlets. Meanwhile, job loss instilled added difficulties for LGBTQI people who gain trust and respect from their families only if they can financially support them, meaning many who lost their jobs and struggled to find employment felt that they were fulfilling the commonly held stereotype that LGBTQI people are ‘useless’. Separation from partners was also a problem due to cross-country travel restrictions.

“I can’t find words to describe how difficult life is, I’m downhearted and worried about what tomorrow will bring. I just want to be able to support my family to gain their trust.”

R3, TG woman, Pakkoku.

“I’m so depressed. I have to live at the office the past 3-4 months [despite no work]. I’ve had no contact with anyone... no one will even know if anything happened to me” *R3, LB woman, Yangon.*

“For all the worries we face during the day, we would relax at night by meeting our friends. Now we can’t because of Covid-19 rules” *R4, TG woman, Pathein.*

“My family didn’t accept me in the first place, now they seem even more disapproving. I have trouble sleeping as I’m thinking about tomorrow.” *R4, TG woman, Pakkoku.*

“My boyfriend is from Yangon. Because of travel restrictions, we couldn’t meet each other” *R4, GB man, Mawlamyaing.*

3.4.2 Livelihoods

“With school closed, I’m feeling so hopeless for my future... I’m not skilled enough, I don’t feel ready for the new year.”

R4, GB man, Pyay.

Loss of livelihoods and lack of opportunities to find new work also plagued the LGBTQI community – amplifying the troubles they face with employment pre-pandemic. As stated, having an income and being able to support their family is critical to trust and acceptance-building with most LGBTQI people and their families, and loss of incomes at this time put significant strain on familial relations. The precariousness of employment faced by some LGBTQI people was also revealed, especially for transwomen and gay men who work in beauty and events industries. Cancellations and bans on events meant that crucial income was sorely lacking, and stigma and discrimination made it difficult for them to find employment elsewhere.

Meanwhile students also voiced frustration at the closure of classes and expressed fears for their future employment prospects. Given the difficulties LGBTQI people face in getting employed in normal circumstances, additional concern in these unprecedented times is easy to understand.

“I can’t support my parents like before. If I were a man, I could work in construction, so I resent it (being TG) sometimes...instead I had to borrow money from others at a high interest rate, so my family isn’t happy.” *R5, TG woman, Yangon.*

“I’m not financially stable. Before, I could do 3-4 jobs, but now just 1 job is not enough for my family” *R4, GB man, Patheingyi.*

“...for LGBT it’s worse because we have to stand on our own for our living.” *R4, TG woman, Mawlamyithar.*

“Because make-up jobs are dependent on weddings and events, my income has been pretty much nothing” *R3, TG woman, Pyaw.*

3.4.3 Health

Finally, some respondents, particularly transwomen and transmen, expressed health concerns in relation to Covid-19. Once again, many of these concerns echo general grievances they endure when navigating unsupportive healthcare systems as explored previously. Anxieties around triaging, formal identification and their gender identities were significant for many transgender participants. While this may seem a trivial or superficial matter for some, the blunt reality is that concerns around being misgendered or having to use identification that does not match their gender identity is strong enough to deter people from accessing healthcare services – which is a deeply worrying circumstance in normal times, but especially so during the pandemic.

Meanwhile, others expressed grief and frustration at the added difficulty the present situation posed to the accessibility of hormone therapies, and one HIV-positive participant described how it made her access to life-saving anti-retroviral medication much harder.

“I’m anxious about getting a positive Covid-19 test and the workers call my ‘real’ name on the ID card outloud. I wouldn’t dare go into a clinic thinking about this. I can’t figure out who to consult; instead, I just take extra good care of my health” *R5, TG man, Pyaw.*

“I’ve not been in good health during Covid-19 and had to go to the clinic often and needed chest X-rays. I needed to take off my shirt... it’s okay if it’s the family doctor...” *R1, TG man, Pyaw.*

“I can’t find words to describe how difficult life is... This affects me getting on ART.” *R3, TG woman, Pakkoku.*

4.

Support services:
exposure, perceptions & needs

4. MHPSS services: exposure, perceptions and needs

This section maps out exposure, perceptions and needs regarding potential options for mental health and psychosocial support (MHPSS) services. It measures willingness to engage with services and analyses the merits and drawbacks of different platforms that may be utilised in future interventions.

Key findings

There is overwhelming agreement that LGBTQI people are in desperate need of robust and sensitive mental health services. Overall knowledge, exposure to and engagement with mental health services, however, is very low.

From a demand side, there was demonstrable willingness amongst research participants to seek out mental health services should they be readily available, but three barriers emerged: i.) fear of association with LGBTQI and/or mental health services; ii.) scepticism about and general lack of exposure to mental health services and iii.) concerns around confidentiality and privacy

There were mixed opinions on the most preferred platform through which to access mental health services – but Facebook Messenger was the most widely identified option. Face-to-face was also an attractive option for many, but accessibility issues and fear loom as considerable impediments as compared to the relative anonymity of online options.

Merits and drawbacks of different platforms should take into account the five following considerations: i.) privacy and confidentiality, ii.) accessibility and relevance (technology and language), iii.) level of human connection, iv.) locational exclusivity and v.) 1-on-1 VS group dynamics

4.1 Exposure and Perceptions

Our FGD data suggests that there is a significant lack of exposure to and understanding of mental health resources within the LGBTQI community. Different identities have different understanding of what mental health counselling looks like. When asked to identify mental health resources they know of, transwoman and gay/bisexual men frequently cited HIV and sexual health clinics as places that offered counselling services, while transmen and gay/bisexual women frequently cited advocacy groups and community centres.

This discrepancy may reflect a broader difference in services that are provided for each demographic. Frequently mentioned groups such as TOP Centre and Pyigy Khin typically target gay/bisexual men and transwomen for HIV prevention and treatment (and other sexual health issues). For many gay/bisexual men and transwomen, this may be the closest link to counselling that they have encountered.

On the other hand, gay/bisexual women and transmen were more inclined to mention mental health counselling programs such as YPY and Mee Pya Tike. Those interviewed from Yangon, Mandalay and

“What LGBT people need most is mental health services. A lot of people have interviewed me about this, but nothing actually happens.”

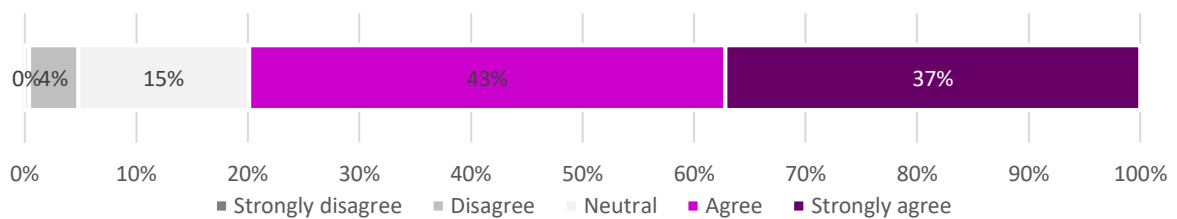
KI17, lesbian NGO founder, Mandalay.

Pathein area either know of YPY or have previously reached out, while those from other locations mentioned organizations that host community building activities in their areas.

Regardless of slight differences in understanding, the majority of our FGD participants agree that more mental health and psychosocial support are needed for the LGBTQI community. This matches our survey data which shows that 80% of our respondents either agree or strongly agree that LGBTQI people need more dedicated mental health services in our communities.

The need for mental health services was also strongly championed amongst the LGBTQI activists and community leaders interviewed.

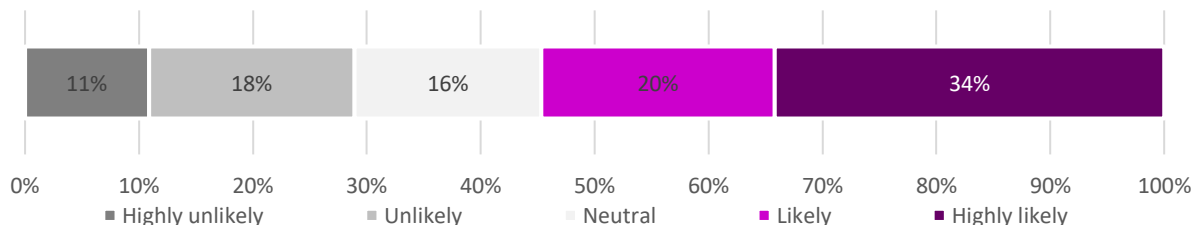
Figure 7: Perception on whether or not there needs to be more mental health services for LGBTQI people



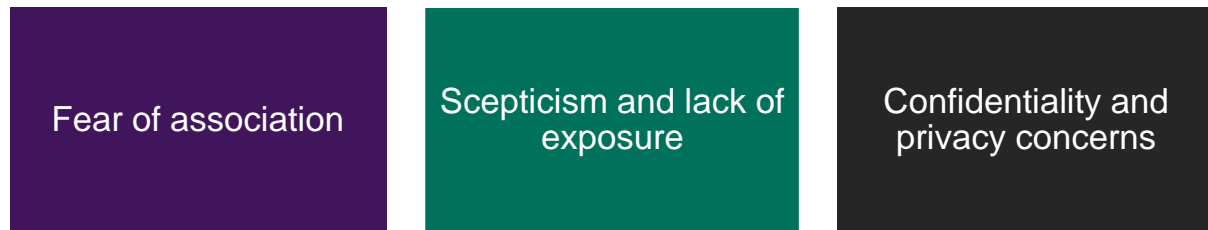
4.2 Accessibility and Barriers

Survey respondents were also asked whether they would access mental health service if it were readily available. 55% of the respondents responded they likely will seek out services while 55% were neutral or unlikely to seek out services. For those who responded unlikely, we asked them why they were unwilling.

Figure 8: Likelihood to seek services if they were readily available



3 main barriers for LGBTQI people to seek out mental health services in their communities emerged from the study:



The first barrier is specifically related to in-person service. Many participants expressed discomfort at being seen entering a centre that is known to provide mental health service and/or a service that specifically helps LGBTQI people. Potential clients seeking out LGBTQI-centric mental health centres face the dual risk of being outed by the community and the negative stereotypes associated with mental health. As one respondent puts it:

“When we go to a HIV clinic, people always look at us funny. So, if I enter a counselling center, it would probably be the same.” **R2, GB Man, Mawlamyaing.**

The second barrier is scepticism around whether or not seeking help is actually beneficial. Many feel uncomfortable sharing their personal stories, while others view mental health as a private problem that can only be solved by themselves. Some respondents question how a stranger with no knowledge of their life can help them with such personal issues. What must be taken into consideration here, however, is the currently very limited number of mental health services available to LGBTQI people. A sheer lack of exposure and unfamiliarity with accessing more formal means of counselling or peer-to-peer help will contribute to people’s wariness or dismissiveness of the services themselves – pointing to a need for targeted marketing to entice stronger demand for services by LGBTQI individuals, and endorsement and promotion of services by influential LGBTQI community leaders.

“They solve problems alone because they know that they have to be independent... I haven’t heard of someone needing to go to counselling - but it might be because they don’t know counselling services exist.” **KII5, gay healthcare worker, Yangon.**

“I’ll never seek outside help even if I need it because I don’t want to bother strangers with my troubles. If I have to receive a stranger’s help then I need to do something for them beforehand, I never want to get something for free” **KII12, founder of TG man group, Sittwe.**

“Even if there was an organisation providing a service, I’d be worried that I’d be discriminated against still... so I wouldn’t try to get help” **R3, LB woman, Taunggyi.**

The third barrier, perhaps the most mentioned, speaks to the perceived lack of confidentiality among LGBTQI community organizations. Respondents were wary that their conversations with providers will stay confidential, with some citing previous experiences at sexual health clinics where their statuses were disclosed without their consent. Other cite the small nature of the LGBTQI community (where most know of each other) as a deterrent to seeking help, fearing that providers will spread their private information to those in their circle.

“I’m not sure if my privacy would be respected, or if the other person will laugh at me or mock me behind my back” **R3, TG man, Mawlamyaing.**

“I doubt that they wouldn’t laugh at LGBT people behind our backs and tattle on us” **R2, LB woman, Pakkoku.**

“I don’t want to be vulnerable with a stranger. Or if it’s anonymous, I’d still be scared that the other person is someone that I’d know” **R1, TG man, Mawlamyaing**

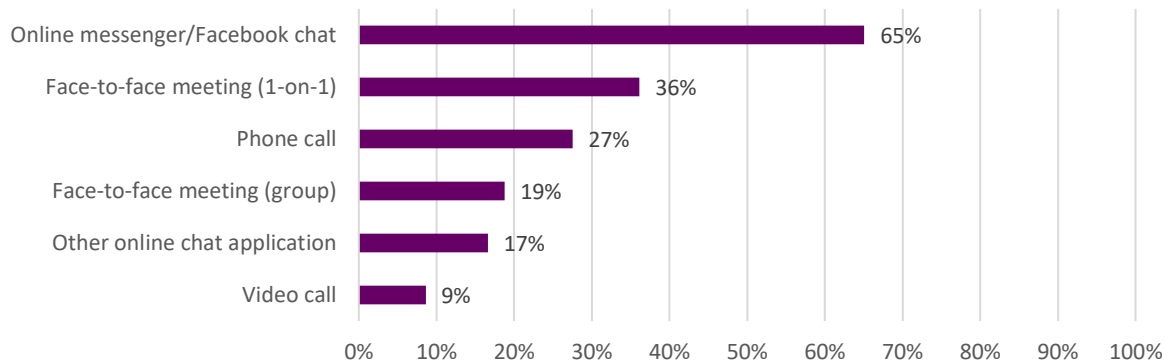
“I’d have to check the background first... is the counsellor trustworthy for LGBT people? Who is the counsellor? What kind of person are they?” **R4, GB man, Mandalay.**

These barriers, whether real or perceived, pose a great impediment to accessing mental health services and will need to be addressed in any current and subsequent mental health projects. Once again, this will require ensuring strong buy-in and promotion from existing community leaders and convincing and targeted marketing of services.

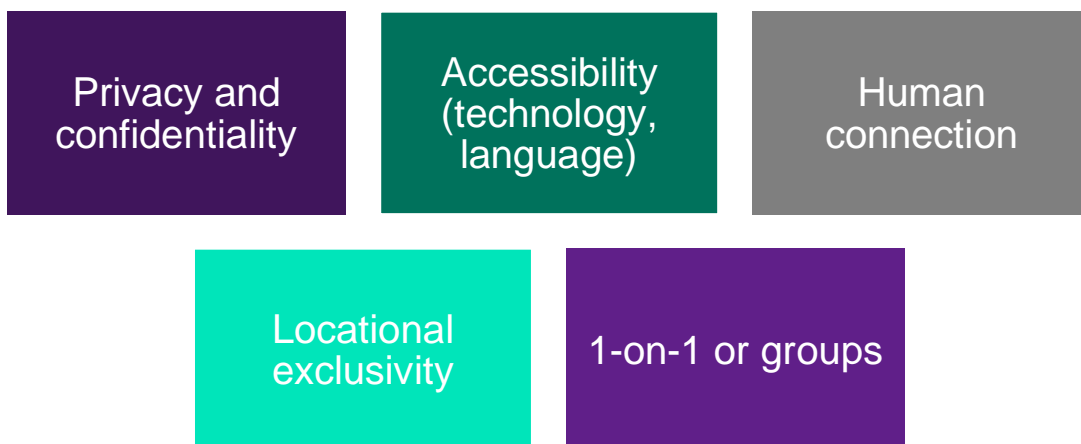
4.3 Platforms: Needs and preferences

Survey respondents were asked to identify the platforms they would be most willing to use to access mental health services. They had the ability to pick more than one answer. 65% of the respondents chose Facebook Messenger as one of their preferred methods, with 82% picking a type of online chatting platform. The next popular method was individual face to face meetings at 36%, almost half as popular as Facebook Messenger. The third most voted on method was phone call at 27%.

Figure 9: Preferred communication channel for seeking support (multiple answer possible)



Qualitative conversations helped to unearth the perceived pros and cons of each different platform. When discussing different means for accessing MHPSS services, five key considerations emerged when discussing the pros and cons of each kind of platform:



Facebook Messenger is the most widespread online platform in Myanmar and has the ability to reach people far from city centers where most resources are located. It is the most convenient of the three mediums, and especially useful for those who cannot travel or safely talk on the phone. It provides a degree of anonymity for the users, since they are able to utilize a fake account for the services. However, while Messenger excels in convenience, it is less successful in providing depth of response. Providers and clients are not able to judge each other's tone and emotions based on texts, and a lot of context can be lost as feelings are translated into words.

"Maybe because I am *taingyintha*, but I don't feel like my speech fully reflects my emotions. I have to write out my thoughts so I prefer texting on Messenger, but I do see the merits of face-to-face." **R3, LB woman, Lashio.**

"If I'm completely broken down, I don't think messages or phone will work. I just need someone who I can cry to and will tell her encouraging words. For small things though, I think messages is fine." **R3 LB woman, Mawlamyine.**

"Online messaging applications might be the best option because most parents won't check their children's phone.... We need to respect the individual's privacy" **KII8, female human rights activist, Mawlamyaing.**

Phone calls occupy a space that is neither as anonymous as Messenger nor as personal as individual FTF counselling. A hotline can be accessed by people who cannot travel to centers and provides a greater degree of personal interaction than Facebook Messenger. However, within our FGDs it was often cast aside as a medium, with those that prefer Messenger saying it was a little too close to comfort, and those that prefer individual FTF saying it wasn't personal enough.

"I think face-to-face is impactful, but I don't know I can say what I want in front of another person. Talking on the phone would work but I fear that the other person may not pay as much attention." **R2, TG man, Pakokku.**

"Because I live at home, I don't feel comfortable talking over the phone, especially family members around so texting would work best for me" **R1, GB man, Mawlamyine.**

Individual FTF counselling provides the greatest degree of personalized care for clients. They are able to meet someone in person and feel like their problems are being listened to and prioritized. However, access is one of the biggest issues with this method. Most respondents living in rural areas argue they wouldn't be able to travel to urban centers where such resources typically exist. Participants are wary of the judgement from the community as stated in the previous section.

Face-to-face has transportation barriers, time constraints of opening hours and people's availabilities" **KII5, gay healthcare worker, Yangon.**

"I prefer Messenger because it feels more private and convenient. However, I cannot hear or speak, so it does feel a little distant. I think face-to-face is the best option but it would not work for me if the service is only in the city" **R1, TG man, Patheingyi.**

"Face-to-face services will build trust, empathy and friendliness." **KII13, gay peer educator, Dawei.**

Regardless of the platform, our service providers have to be able to contextualize a client's experience within the geographical and cultural landscape in which they live. With such varying demographics in Myanmar, service providers will need to be well versed in the various intersection of identities that exist

within the country and be able to cater responses to those specific needs. Without the context, clients may feel a disconnect between their problems and the responses from the provider. Another important consideration raised was the need to ensure services were relevant and differentiated for different identity groups. There was some concern noted that certain identity groups may have trouble relating with each other or did not have particularly good social dynamics (this was particularly noted as being the case between transwomen and gay men). Separating groups according to identity will also have the added bonus of clients being able to directly relate to each other’s experiences, and is more likely to be conducive to fostering open conversation.

“Someone in Yangon cannot know the experience of someone in Pakokku. Where do I even begin to talk about my experience?” **R2, TG man, Pakokku.**

“It would also be best to offer separate groups for transwomen, transmen, lesbians, gay men, bisexuals...” **K113, gay peer educator, Dawei.**


“Some transwomen and gay men do not get along with each other.” **R5, TG woman, Yangon.**





Another critical point, regardless of platform, was the need for *strong* buy-in from key community leaders so that services would be promoted, and demand could be driven. This requires robust referral networks and ensuring close-knit relations at the grassroots level. These considerations will be particularly important if service provision models intend to roll out face-to-face services across the country, which will necessitate constant communication with implementers at the grassroots level in order to ensure a commitment to cohesive services across the country.

“There needs to be strong referral networks where groups and individuals share [information and services] with each other. I’ve noticed that most services are only for urban areas and there isn’t much outreach elsewhere” **R4, TG man, Mandalay**

“There needs to be good advocacy and community-level mobilisation” **R1, TG man, Mandalay.**

Figure 10: Pros and cons of different service provision platforms

Platform	Pros	Cons
 <p>Online messenger and chat</p>	<ul style="list-style-type: none"> ● Relative anonymity and privacy for user ● Gives user time to collect thoughts and respond as they please ● Accessible across the country (dependent on internet connection and mobile ownership) ● Can access within their own household without arousing suspicion ● Familiar user platform (no need to download anything new) ● Easy to schedule shifts for counsellors ● Cheap and sustainable to fund 	<ul style="list-style-type: none"> ● Less human connection possible ● Rhythm of conversation can be lost if respondent pauses/takes time between answers ● Difficult to guarantee same counsellor every time, so may not be familiar with the client’s issue ● Current difficulties with social media platform restrictions

 <p>Hotline (phone calls)</p>	<ul style="list-style-type: none"> • Higher level of human connection • Instant response guaranteed (dependent on opening hours) • Relatively simple to staff • Lower burden on staff 	<ul style="list-style-type: none"> • Family/roommates can overhear • Dependent on mobile reception (more challenging in rural areas) • Need to have limited opening hours • Not a hugely popular or well used platform in Myanmar • Can be more costly unless (challenging for organisation to foot the bill of phone calls)
 <p>Face-to-face (1 on 1)</p>	<ul style="list-style-type: none"> • Very high level of human connection • Allows staff to visually assess the wellbeing of user • Easier to connect them to peers and other services 	<ul style="list-style-type: none"> • Accessibility issues (rural vs urban disparity) • Requires a physical meeting location (safety, cost, visibility issues) • More serious demand on staff, requires higher skill level • Limited time • Confidentiality concerns
 <p>Face-to-face (group)</p>	<ul style="list-style-type: none"> • Very high level of human connection • Peer-learning possible (a group member might ask questions or voice concerns that are shared by others) • Can easily schedule identity-based group meetings 	<ul style="list-style-type: none"> • Accessibility issues (rural vs urban disparity) • Requires a physical meeting location (safety, cost, visibility issues) • Potentially intimidating • Less confidentiality • More serious demand on staff, requires higher skill level
 <p>Group chat (online)</p>	<ul style="list-style-type: none"> • Accessible and increasing familiarity with video/online calls • Easy for first-timers to try out • Peer-learning possible (a group member might ask questions or voice concerns that are shared by others) • Benefits of group session but higher level of anonymity possible • Relatively easy for staff to facilitate • Cheap and sustainable (does not require fixed location) 	<ul style="list-style-type: none"> • Potential accessibility issues (unreliable internet) • More serious demand on staff to moderate conversations – potential for lots of silence so will need to fill the space

5.

Recommendations

5. Recommendations

This report concludes with a series of recommendations for future programming around the mental health and psychosocial support of LGBTQI people. Recommendations have been separated into four different categories: i.) general programming; ii.) the operations of LGBTQI specific MHPSS services; iii.) demand generation and accessibility of LGBTQI-specific MHPSS services and iv.) other community-focussed initiatives.

Each recommendation is followed by a series of specific action points and considerations.

I. General programming

- 1. LGBTQI specific mental health and psychosocial support services need to be rapidly upscaled and rolled out across Myanmar.** The prevalence and severity of mental health and psychosocial challenges amongst the LGBTQI community evidenced by this report should serve as a clarion call for immediate action to better meet the needs of LGBTQI individuals. Covid-19 appears to have exacerbated problems of stigma, discrimination and marginalisation endured by LGBTQI people, and the political turmoil as of 01 February 2021 will no doubt further intensify anxiety and depression. The upscaling of services will not only involve the development of robust service provision models that can cater towards diverse individuals in a variety of contexts but will also require efficient and broad-reaching marketing given the very limited exposure that LGBTQI people have with mental health and psychosocial support services.

Action points and considerations

- a. Organisations with the capacity to intervene in mental health and psychosocial support service provision need to allocate resources to pivot current services to accommodate an LGBTQI-specific focus, or else develop new models of service.
 - b. Service provision models will need to take into account the overlapping contexts of the Covid-19 pandemic and the current political turbulence when developing service models
 - c. Organisations that are not mental health service providers should still include psychological first aid training and basic emotional support within their service provision, and LGBTQI-focused organisations and donors should mainstream MHPSS activities into programming.
- 2. Service provision needs to recognise the systemic nature of LGBTQI stigma and discrimination and commit to promoting LGBTQI agency.** While there is a clear need for the upscaling of mental health services for LGTBQI people, any intervention in this space must be done in tandem with activities that focus on reducing the pervasiveness of LGBTQI stigma and discrimination, rather than solely focusing on damage control. Work in this space must also proactively debunk the widely held myth amongst the general population and the LGBTQI community itself that LGBTQI people are inherently emotionally fragile – and instead adopt the mentality that LGBTQI people suffer poorer mental health outcomes as a direct result of societal marginalisation. Ultimately, service providers themselves must promote the idea that societal values and attitudes towards LGBTQI people need to change, and that an intervention in this space is not simply a matter of making LGBTQI people stronger so they can withstand mistreatment.

Action points and considerations

- a. Organisations should adopt internal policies, rhetoric and models that centre LGBTQI people as victims of systemic discrimination, rather than as people who require assistance due to an innate emotional weakness and capacity-building and awareness-raising around LGBTQI issues should be mandatory.
- b. Wherever possible, service providers and programming should ensure inclusion and partnership with other LGBTQI service providers and advocacy groups to keep an overarching mission to reduce stigma and discrimination as a key priority to supporting better mental health and psychosocial outcomes for LGBTQI people.
- c. UN agencies, development actors, other service providers and community partners should engage in mandatory LGBTQI sensitisation training and undertake a review of how best to mainstream LGBTQI inclusion and sensitivity within their own programming.

- 3. Referral mechanisms for LGBTQI MHPSS services should be embedded throughout all community service provision models regardless of whether the service focuses directly on MHPSS.** This will involve mainstreaming LGBTQI sensitivity across all community-facing programming so that service providers and community outreach workers are equipped with the knowledge to recognise and cater towards the needs of LGBTQI people and to recommend other services where appropriate. Indeed, there are currently very limited LGBTQI-specific MHPSS services, so initially developing a referral mechanism will be more akin to a marketing strategy for activities under *Recommendation 1*.

Action points and considerations

- a. Basic trainings regarding sensitivity to sexual orientation and gender diversity, as well as discrimination and stigma, should be rolled out to service providers across different arms of programming.
- b. Strengthening community networks between LGBTQI community groups and other MHPSS service providers to enhance co-operation and engagement will be essential to developing a functional referral mechanism.

II. LGBTQI MHPSS services: Operations

- 4. Staff for MHPSS services (lay-counsellors, community outreach workers etc) should themselves be LGBTQI individuals or demonstrate knowledge of and connection to the LGBTQI community.** Myanmar's LGBTQI community is tight-knit, and due to the widespread marginalisation they suffer, communities can be wary or cynical of the intentions or capacities of newcomers. Furthermore, the inclusion of LGBTQI people as the core service providers will not only enhance perceptions of trust and relatability from the side of the service user, but also boost the overall status and sense of worth among LGBTQI people themselves by giving opportunities for employment, upskilling and the chance to give back to their community.

Action points and considerations

- a. Staff providing MHPSS services (lay-counsellors, community outreach workers etc) should be guided through basic training pertaining to sexual orientation and gender identity to ensure the team has a cohesive understanding of different LGBTQI identities and their varying needs.

- b. Staff should also be provided with basic MHPSS training covering basic skills such as active listening, empathy, psychological first aid, basic emotional support and self-care.
- c. Hiring practices should entail guidance through and commitment to the overarching mission of the intervention service model that incorporates the approach described in *Recommendation 2.*]
- d. Recruitment processes should not be explicit that they are not discriminatory based on gender identity or sexual orientation.

5. Given the high rates of self-harm and suicide amongst the LGBTQI community, it will be essential to equip staff with crisis de-escalation skills. This will involve teaching staff advanced communication skills to detect warning signs, to delicately probe when they are not certain and the knowledge of what resources they can and should offer if someone reaches out to them in an obvious moment of crisis.

Action points and considerations

- a. Staff should undergo training regarding self-harm, suicidality and crisis de-escalation.
- b. Staff must be provided with a clear action plan for crisis de-escalation in the case of emergencies.
- c. Further research into the efficacy of suicide hotlines or other platforms in Southeast Asia should be undertaken.

6. Ensuring the confidentiality and privacy of MHPSS service users will be critical to their willingness to engage with services. The decisions made around confidentiality and privacy will depend upon the chosen service provision model. Ensuring confidentiality is obviously more challenging if a face-to-face group model is selected. It is thus advisable for services to be provided across a range of different platforms so that those unwilling to identify themselves can still access mental health and psychosocial support (i.e. through online or phone options where they do not have to identify themselves). Furthermore, while data collection will be critical to monitoring and evaluating efforts to measure the impact of programming, approaches will need to take into account the appropriateness of collecting certain information from respondents (see *Recommendation 8*).

Action points and considerations

- a. MHPSS services should always have an option for engagement that does not require users to identify themselves (online/mobile option), whether it is for engaging with services themselves or simply to find out more information.
- b. Confidentiality and privacy should be at the centre of all activities. Clients will need to agree to respecting the confidentiality of fellow users both during and outside of group settings.
- c. Staff must agree to strict confidentiality policies concerning MHPSS service users.
- d. Any data collected about MHPSS service users must be kept secure and private – accessible only to those deemed necessary.

7. Simple and adaptive monitoring and evaluation tools should be developed to measure and assess the impact of the intervention. The development of such tools should look to best-practice examples in other mental health and clinical settings, but as a bare minimum should measure outreach efforts, number of engagements and retention levels (if applicable to the service model). Entry and exit surveys for people using these services could also be considered, but these should be as concise and non-invasive as possible so that they are not seen as a burden by users.

Action points and considerations

- a. Develop simple monitoring and evaluation mechanisms based on best-practice approaches in other mental health and clinical settings including ongoing knowledge and attitude assessment for all capacity building trainings and SOGIE awareness raising trainings.
- b. Consider feedback mechanisms and entry/exit surveys for clients to make suggestions for improvement to services and to measure satisfaction rates.

- 8. Service models that use a group (or peer-to-peer) approach to MHPSS service provision should offer separate groups according to identities – i.e. separate groups for transwomen, transmen, lesbians/bisexual women and gay/bisexual men.** Separating these identity groups will be more conducive to comfortable conversations and will allow respondents to relate to one another's issues more easily. It also dissipates the extent to which in-fighting between LGBTQI groups (most specifically transwomen and gay men) will be an issue. To the extent that is possible, the facilitator for these group sessions should belong to the specific identity group, or at the very least be well aware of the specific needs and different experiences of these groups. For example, a facilitator dealing with transgender groups should be aware of the health concerns that are common amongst those wanting to undergo gender affirming therapies or surgeries.

Action points and considerations

- a. Provide separate group sessions according to different identities.
- b. Align lay-counsellors/facilitators with the same identity group (i.e. a lesbian/bisexual woman should run the bisexual group sessions).

III. LGBTQI MHPSS services: Demand generation and accessibility

- 9. MHPSS services should be provided across a range of different platforms to be as accessible as possible – but should prioritise online and face-to-face options.** A single engagement option will never meet the needs of all members of the LGBTQI community, and therefore diversifying service provision platforms will enable the greatest level of reach. Online chat options (particularly Facebook Messenger) are the most preferred and accessible option for engagement given their convenience, user familiarity, accessibility across the country and relative confidentiality. The biggest problem attributed to online chat platforms is that it limits the extent to which users can feel genuine human interaction – and for this reason, online group sessions are a useful consideration worth exploring. This might entail setting up weekly or monthly conference-style sessions for different groups, where users can be guided through a group conversation by a trained moderator/counsellor. Face-to-face sessions in urban hubs are appealing to many LGBTQI people and where possible should be pursued – but will be challenging and unsafe to roll out in the current context of Covid-19 and the 2021 political turbulence (which has seen restricting access to Facebook and mobile data across the country). Hotlines currently have limited efficacy and appeal.

Action points and considerations

- a. Prioritise scaling-up online chat platforms.
- b. Develop online platform equipped with resources for LGBTQI issues
- c. Explore online, peer-to-peer group sessions.

10. Being conscious of the different needs of LGBTQI people in rural areas, and those who belong to ethnic or religious minorities, will be essential to ensuring inclusive MHPSS service provision. The needs of LGBTQI individuals vary according to their personal contexts and the intersectionalities of their identity. Ensuring that MHPSS services are not exclusive, and that MHPSS service providers are sensitive to the different needs of people living in hard-to-reach locations or from diverse, minority backgrounds will involve service provider trainings and careful, considered expansion approaches once service provision models are functioning.

Action points and considerations

- a. Ensure the MHPSS service provision model caters towards people who cannot visit a physical area due to living in an isolated area or transportation costs (i.e. have online options).
- b. Consider providing MHPSS services in some ethnic minority languages.
- c. Roll-out services and awareness trainings within IDP camps.
- d. Ensure staff are aware of intersecting identities and how it might contribute to an individual's experiences (e.g. how might an LGBTQI person from a religious and ethnic minority have a different experience to a Bamar Buddhist?).

11. Engaging and mobilising grassroots community groups within the MHPSS service provision model will be critical to demand generation and community buy-in. Myanmar's LGBTQI community boasts many strong grassroots civil society organisations across the country. Tapping into this network will not only be essential to spreading the word about services and ensuring the maintenance of referral mechanisms but could in itself be a central part of the service provision model. Distrust, cynicism, and unfamiliarity with MHPSS services can also be better overcome if leaders within the LGBTQI community advocate and endorse such services within their spheres of influence. A roll-out model that involves formally training members of community groups across the LGBTQI network to act as service providers in their areas and become ambassadors for LGBTQI mental health could prove an extremely effective way to ensure much wider face-to-face outreach options across the country, but will require careful monitoring, maintenance and excellent relationships with community leaders.

Action points and considerations

- a. Scale-up engagement with LGBTQI community groups across the country through mental health awareness training.
- b. Map LGBTQI community groups across the country and identify potential partnership with local offices.
- c. Mobilise LGBTQI leaders across the country to help generate demand for LGBTQI MHPSS services and promote community buy-in.
- d. Consider MHPSS services provision model that actively uses existing LGBTQI groups and members (particularly for hard-to-reach areas, but also in urban areas such as Mandalay where strong community hubs exist).

12. Given the nascency of MHPSS services provision in Myanmar, programming should be prepared to take an adaptative trial-and-error approach that allows for lesson learning, adjustment and growth. Currently there is extremely low exposure to and engagement with MHPSS services. Simply put, it is difficult for LGBTQI people to articulate their needs around mental health and psychosocial support if they do not have the experience or

language to articulate what sort of services would be useful for them. Furthermore, unfamiliar platforms, such as online group calls, may feel unappealing, but it could indeed be a matter of getting used to a new mode of engagement – a circumstance that will benefit greatly if there is buy-in and support from community leaders (*Recommendation 12*).

Action points and considerations

- a. Encourage flexible funding-models and scale-up approaches that accommodate innovation, risk-taking and alterations.

IV. Other community-focused initiatives

13. LGBTQI awareness-raising and service sensitisation in healthcare settings – especially regarding transgender people – will be essential to improving mental health outcomes for LGBTQI people. In particular, staff should be made aware of how current stigma and discrimination in the healthcare sector impacts the health-seeking behaviours of LGBTQI people and tangible actions should be made to improve service provision – in terms of both providing new services that meet the needs of transgender people (such as hormone therapy and affirmative surgeries) as well as reducing hostility and insensitivity in general medical practices. Education around hormone replacement therapies, and the dangers of a system in which transgender people are motivated to take matter into their own hands and use hormones in unsupervised and unregulated settings, will be essential, and attention should be paid towards normalising the provision of such services in medical facilities across the country.

Action points and considerations

- a. Develop and roll-out trainings for healthcare providers around LGBTQI sensitivity, particularly focussing on equal treatment of transgender people.
- b. Develop and roll-out trainings to normalise the provision of gender affirmative treatments in general healthcare settings (rather than pigeonholing transgender people to only access niche services)
- c. Engage in lobbying activities and collaboration with institutions working towards better healthcare services for LGBTQI people, specifically health issues for transgender communities (UNAIDS, FHI360, PSI etc).

14. Workplace LGBTQI sensitivity sessions regarding support and acceptance of LGBTQI people will help make workplaces safer and more inclusive places. General content for employees should include basic awareness-raising sessions and orientation through organisational policy that outlines a zero-tolerance approach to stigma and discrimination based upon sexual orientation and/or gender identity. Trainings targeting more senior leaders within workplaces could focus on developing anti-discrimination policies within HR and leadership frameworks, as well as guiding management teams in how to better support LGBTQI employees.

Action points and considerations

- a. Develop and roll-out trainings for offices and workplaces around LGBTQI support and acceptance and encourage conversations around how workplaces can be made to be more inclusive places.
- b. Undertake workshops with business and workplace leaders around developing LGBTQI-inclusive anti-discrimination policies.

- c. Ensure organisational policies have zero tolerance approaches for stigma and discrimination clearly outlined, and guide new employees through this during their orientation.

15. Awareness-raising sessions or other community outreach activities should consider targeting schools and families to ensure a more holistic approach in reducing stigma and discrimination against LGBTQI people. This study has documented the severe trauma endured by countless LGBTQI people at the hands of people who are supposed to protect them and have their best interests at heart – their families and educators. Ensuring better mental health outcomes for LGBTQI people will necessitate engaging with perpetrators of abuse and marginalisation. Countries around the world have developed models and services that support families and schools to better meet the needs of LGBTQI young people. While it may be some time before robust support mechanisms like this can be implemented in Myanmar, service providers would do well to consider how families and schools can be better engaged with to ensure the safety and wellbeing of LGBTQI young people.

Action points and considerations

- a. Consider outreach options, messaging and content that is tailored towards family members and encouraging acceptance of LGBTQI children.
- b. Consider outreach options, messaging and content that is tailored towards schools and universities around fostering inclusive education spaces with zero-tolerance for LGBTQI discrimination.
- c. Mainstream sexuality education programming with a youth focus (i.e. peer education programs, youth groups and outreach sessions) should be LGBTQI sensitive, so that young LGBTQI people are not only reached through LGBTQI-specific programming (such as the UNFPA-led out of school CSE program).

16. Activities and messaging content need to address the romantic and intimate lives of LGBTQI young people – as this is a major area of distress for many queer youth. While this is likely to be a core area of conversation in counselling sessions, service providers should consider developing innovative content (vlogs, podcasts etc) that tackle romance and intimacy related matters given that LGBTQI people have such limited sources to receive information and ask questions on these topics. Content could cover topics such as healthy VS toxic relationships, conversations around consent, communication skills for successful relationships, sexual health information and positive examples of community and family acceptance.

Action points and considerations

- a. Consider innovative outreach options, messaging and content that focuses on relationship and intimacy issues faced by LGBTQI young people.
- b. Current programming focussing on healthy relationships and sexuality education should have LGBTQI sensitivity mainstreamed into content and activities.



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