Thematic report
29 May 2026

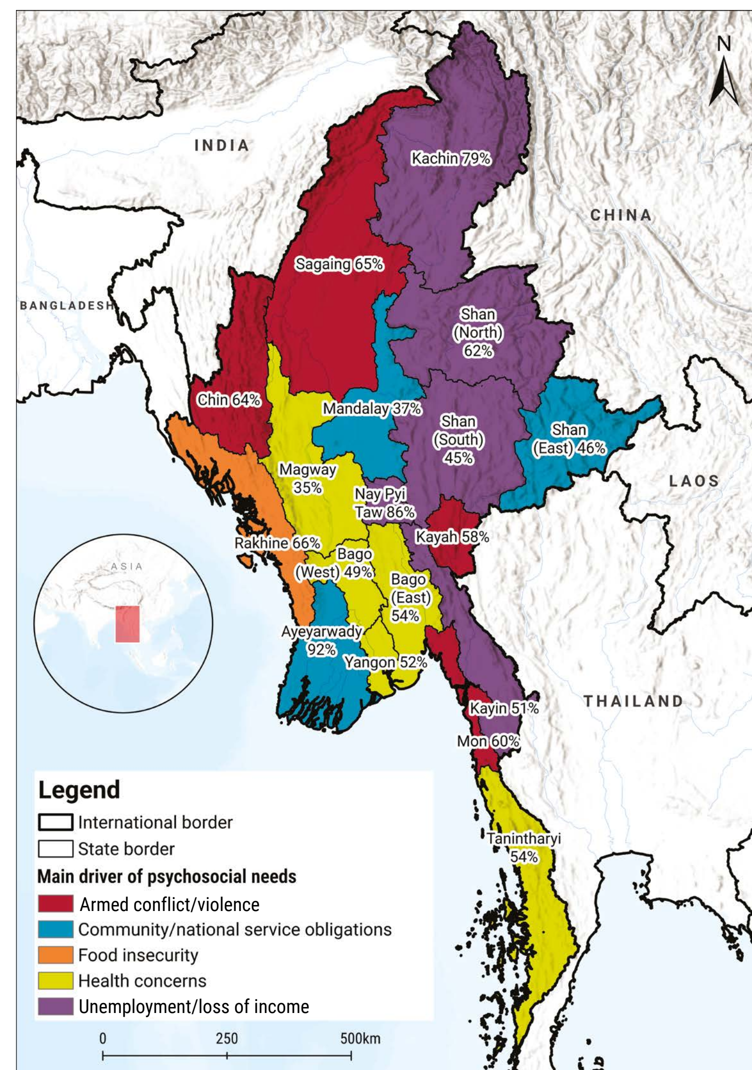
MYANMAR
Drivers influencing mental health and psychosocial needs

OVERVIEW OF MENTAL HEALTH AND PSYCHOSOCIAL NEEDS IN MYANMAR

The population of Myanmar is experiencing widespread and severe mental health and psychosocial support (MHPSS) needs driven by decades of conflict and political instability. Since the country's independence in 1948, recurrent displacement, economic deterioration, and climate hazards have exposed people to multiple, often prolonged psychosocial stressors (Lieber Institute 09/12/2025; OCHA 10/12/2025). Since the February 2021 military takeover, populations have been increasingly exposed to potential sources of trauma and distress across the country. By March 2026, an estimated 45% of the population was in need of humanitarian assistance, with around half the population estimated to be directly exposed to armed conflict, including widespread air strikes, armed violence, and other human rights abuses (WHO 09/03/2026; Fortify Rights 29/01/2026). Displacement – which affects nearly 3.7 million people (6% of the population) – is a major compounding driver of MHPSS needs, leaving IDPs at risk of anxiety, including fear of air strikes and other forms of violence, as well as uncertainty about their future (UNHCR accessed 28/05/2026). These factors collectively contribute to weakened psychosocial resilience at both household and community levels. The breakdown of health, education, and protection systems, particularly in conflict-affected areas, has reduced access to essential MHPSS structures, including informal community networks (OCHA 10/12/2025). At the same time, economic deterioration has limited households' coping capacities to meet basic needs, increasing reliance on potentially harmful coping strategies and aggravating psychological strain. Geophysical events, including the 2025 earthquake and its aftershocks, have introduced acute and longer-term effects of trauma and anxiety, further compounding existing stressors in conflict-affected areas (STC 28/03/2026; UNICEF 28/05/2025).

Despite significant mental health risks across the country, especially for communities affected by conflict or climate hazards, access to MHPSS services remains highly constrained and uneven.

Map 1. Drivers of MHPSS needs in Myanmar



Source: OCHA (10/12/2025)

The full spectrum of MHPSS services in Myanmar is historically under resourced, largely available only in urban areas, and poorly integrated into primary healthcare, leaving rural and conflict-affected populations with especially limited access (WHO accessed 24/04/2026). In many areas, service provision relies on community-based and informal support networks, with limited availability of specialised MHPSS care. While humanitarian organisations deliver MHPSS services, their response capacity is insufficient relative to the scale of needs, largely owing to access limitations resulting from armed conflict, particularly in high-needs-severity areas, such as Rakhine state and Sagaing region. As a result, many affected populations rely on informal coping mechanisms, including family and community support, which, while potentially helpful, do not offer the specialised support some individuals need (Tun et al. 19/12/2025; KII 23/04/2026).

Despite variations in context and severity across geographic and administrative areas, several factors consistently emerge as key drivers of MHPSS needs across Myanmar. These include, but are not limited to, the impacts of prolonged exposure to armed conflict, conscription-related anxiety among youth, limited MHPSS support targeting caregivers, the additional psychological burden created by the 2025 earthquake in conflict-affected areas, and longstanding limitations on state and civil society protection and health responders that constrain people's access to MHPSS services. While the severity of these stressors differs across locations, consultations with grassroots and international MHPSS responders indicate that affected populations are experiencing overlapping pressures that continue to erode communities' coping capacities.

Figure 1. Drivers influencing MHPSS needs

Source: ACAPS

ABOUT THIS REPORT

Methodology and limitations

ACAPS collected primary data for the analysis through key informant interviews (KIIs), which contributed to the identification and prioritisation of risk factors presented in this report. Discussions with humanitarian workers, MHPSS practitioners, and community-based responders across Myanmar informed the analysis, and the report used secondary data to design data collection tools and to triangulate and corroborate findings from primary data sources.

Significant data limitations remain, a result of Myanmar's security-sensitive context, which hampers information-sharing and limits access for assessments. These constraints affect the availability and representativeness of data.

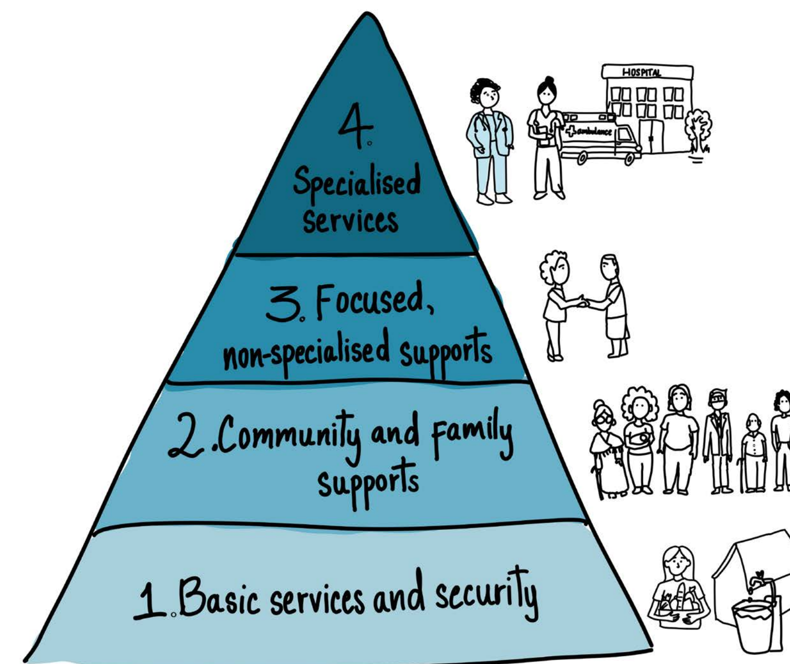
The risk factors presented in this report are not exhaustive but reflect those most consistently identified through KIIs and consultations with operational responders. While these factors are presented analytically as distinct categories, much of the population experiences them simultaneously, often in overlapping and reinforcing ways.

Available assessments – including multi-sector needs assessments (MSNAs) – indicate that in several regions, these stressors are not only associated with increased psychological distress but may also act as triggers for more severe mental health outcomes, including self-harm and suicide.

GAPS IN MENTAL HEALTH SERVICE PROVISION

Mental health service provision within the health system

Figure 2: Intervention pyramid for MHPSS in emergencies



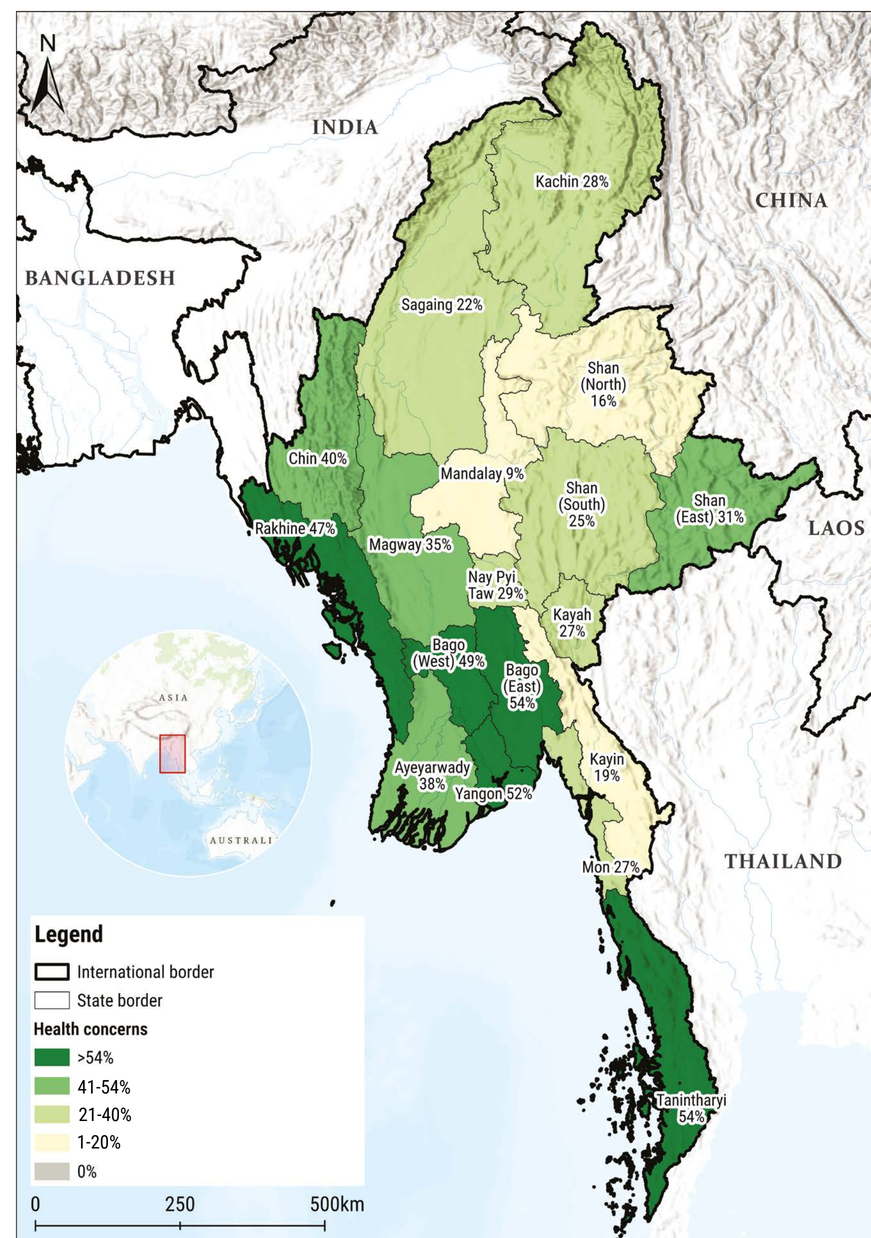
Source: IASC (01/06/2007)

Historically, Myanmar's health system has been significantly under-resourced, with mental health receiving limited priority. Prior to 2022, the absence of an up-to-date mental health policy and implementation plan hindered service development and coordination, restricting access to mental healthcare as part of primary care (HelpAge 18/12/2019; WHO 06/09/2022). Until 2022, service provision remained highly centralised, limited, and largely concentrated in urban areas, with only two specialised mental health hospitals (in Yangon and Mandalay cities), two tertiary-level drug treatment hospitals, and 17 general hospitals equipped with mental health units at the secondary level. Community-based services were largely absent, with no rehabilitation centres

for substance abuse and no dedicated system for estimating or forecasting the supply of essential psychotropic medications (WHO 06/09/2022). After the 2021 coup, many health professionals, including the few available specialised MHPSS practitioners, walked out during the civil servants' Civil Disobedience Movement. Some refused to work under military authority, with many leaving the country (KII 23/04/2026; TNH 04/01/2022; PHR et al. 26/01/2022; Wootton et al. 18/09/2025).

Since 2021, at least 1,900 incidents of violence against the healthcare system have been reported across Myanmar, and the destruction of infrastructure and obstruction of services have significantly reduced healthcare access, including to MHPSS services (Insecurity Insight 24/04/2026). The depletion of health facilities not only reduces the availability of MHPSS services for individuals in need but also contributes directly to increased psychosocial distress. According to the 2025 MSNA, concerns about the destruction of the health system and limited access to healthcare and specialised services, particularly in Ayeyarwady region, Bago (West) region, Chin state, Kachin state, Magway region, Rakhine state, and Tanintharyi region, have become significant household stressors. In areas experiencing lower levels of active violence, anxiety over deteriorating health conditions and inadequate access to care has emerged as a primary driver of psychosocial distress (OCHA 10/12/2025).

Map 2. States reporting health concerns as a driver of MHPSS needs



Source: OCHA (10/12/2025)

Human resources

Myanmar has a severely limited mental health workforce, with shortages of key professional personnel, including psychiatrists, counsellors, mental health nurses, social workers, and psychiatric rehabilitation specialists. Psychology training is generally limited to a three-year bachelor's degree that provides foundational theoretical knowledge but does not fully equip graduates with the clinical competencies required to diagnose or treat mental health conditions. Other health professionals, including doctors and nurses, receive minimal exposure, with only a few hours of mental health training during their four-year undergraduate medical programmes (WHO 06/09/2022). The absence of postgraduate (master's level) training programmes contributes to a shortage of specialised personnel, resulting in significant gaps in diagnosis, referral of severe cases, and access to appropriate psychotropic medication (Health Cluster 08/12/2025; KII 01/05/2026). Despite an increase in the mental health workforce between 2014–2020, there remains less than one mental health worker per 100,000 people in Myanmar. This does not match the growing mental health needs in the country, hindering efforts to integrate mental health services into primary healthcare (WHO 06/09/2022).

In 2025, the WHO Mental Health Gap Action Programme was translated into Burmese. This is likely to strengthen the capacity of non-specialist health workers, support the integration of mental health into primary healthcare and humanitarian response settings, and help frontline providers identify, manage, and refer common mental health conditions for appropriate care (WHO 19/12/2025; KII 01/05/2026). Evidence from multiple countries shows that integrating the programme into health worker training improves the management of mental health disorders, particularly in low-resource settings with few mental health specialists (Chaulagain et al. 29/06/2020).

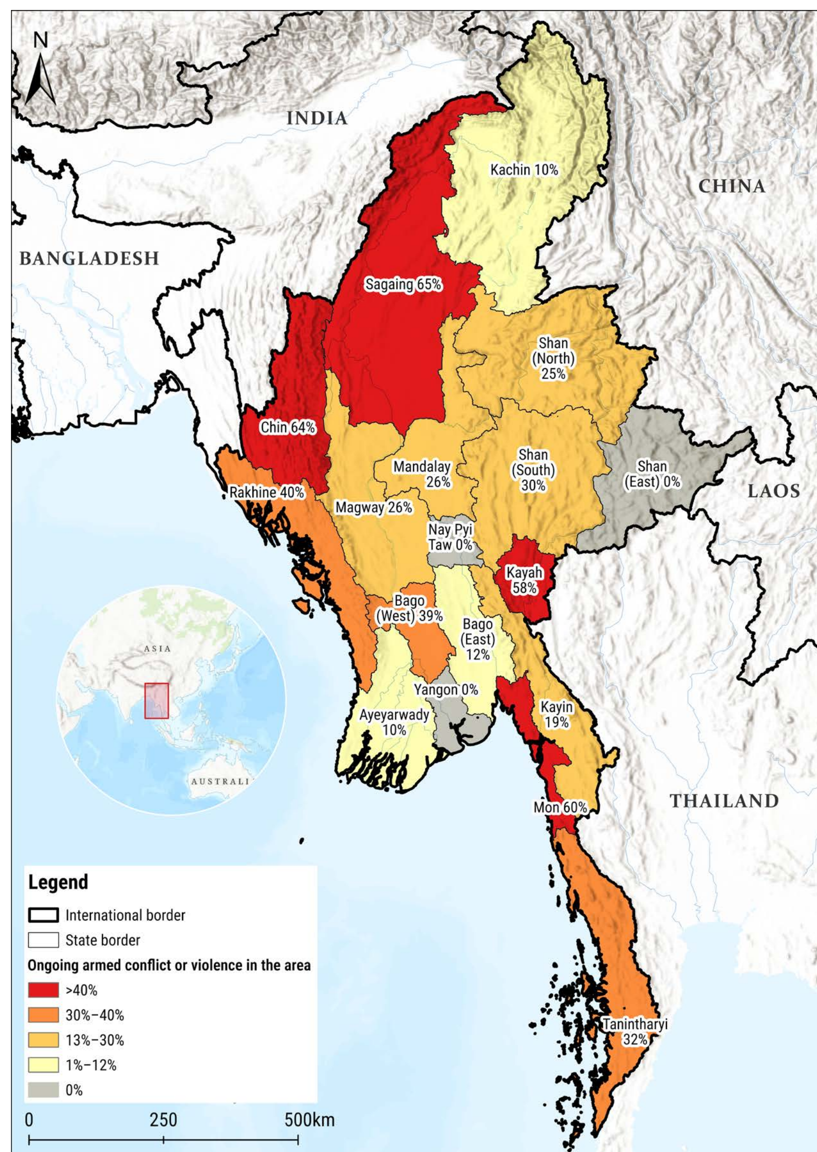
Operational challenges further affect service delivery. High levels of displacement and mobility, driven by conflict and economic pressures, contribute to service disruptions and require repeated investment in training new providers (MSF 10/10/2023). Private sector groups are also engaged in MHPSS provision, primarily through remote or online platforms (UNFPA Myanmar 28/06/2023). The heavy reliance on remote and online delivery, however, requires sustained trust-building and perceptions of confidentiality so individuals can engage effectively with services. The cost implications of the service, as well as limited internet connectivity, digital literacy barriers, and insecurity in conflict-affected areas, may limit access (KII 16/03/2026; UNFPA 14/06/2023).

Role of non-state groups in covering gaps

In many conflict-affected areas of Myanmar, particularly in Kayah state, Rakhine state, and Sagaing region, international and national NGOs, alongside community-based organisations, play a central role in delivering MHPSS services (WHO 09/03/2026; KII 23/04/2026). *Given the limited availability of specialised mental health professionals in Myanmar, current interventions are largely concentrated at levels two and three of the Interagency Standing Committee intervention pyramid, emphasising the strengthening of community and family support systems and providing focused, non-specialised psychosocial interventions for individuals or smaller groups experiencing heightened distress. As a result, organisations prioritise capacity-building initiatives targeting community members, teachers, frontline responders, and volunteers to deliver more basic psychosocial support and community-based care in areas where specialised services remain limited or inaccessible. While this model expands reach and aims to build individual and community psychosocial resilience, there are limitations in the scope of care. Non-specialist providers are typically trained to address specific conditions, such as mild to moderate anxiety, depression, and stress-related disorders, and require supervision and referral pathways for more complex cases. In practice, this can disrupt continuity of care, particularly when referral options are limited or geographically inaccessible* (KII 01/05/2026; WHO 24/06/2019).

ARMED CONFLICT AND VIOLENCE

Map 3. States reporting conflict as a driver of MHPSS needs



Source: OCHA (10/12/2025)

Armed conflict is a central driver of MHPSS needs in frontline areas of Myanmar. Conflict is associated with a range of mental health outcomes and risks, as not all affected populations develop mental health disorders. Impacts largely depend on individual and community coping capacities, including access to community networks and religious practices. In Myanmar, the protracted nature of the crisis, repeated exposure to violence and displacement, and declining access to social and economic support systems continue to erode coping capacities (Tun et al. 19/12/2025; OCHA 10/12/2025; HRW 16/01/2025; UN HRC 02/10/2024)

Conflict-related displacement conditions are also associated with a heightened risk of MHPSS needs. Increased exposure to insecurity – including fear of air strikes targeting displacement sites – and increased risk of forced eviction, gender-based violence (GBV), and livelihood loss contribute to these outcomes (AP 23/01/2026). By April 2026, an estimated 3.7 million people were internally displaced in Myanmar, many residing in informal settlements or displacement sites with limited access to basic services (UNHCR 07/04/2026). In 2024, a small qualitative study in Bago (East) region, Kayah state, and Kayin state found that even though some displacement sites were located away from active frontline areas, the persistent threat of air strikes diminished psychological security and led displaced communities to experience significant anxiety. Consulted IDPs also frequently reported emotional exhaustion, feelings of helplessness, and trauma effects, while humanitarian responders described experiencing anxiety and guilt over their inability to deliver sufficient assistance (Tun et al. 19/12/2025; KII 23/04/2026; KHRG 08/07/2022; KII 16/03/2026).

The war tactics deployed by the military, ethnic armed organisations (EAOs), People's Defence Forces, and local resistance groups formed in opposition to military rule further aggravate mental health risks.

- The military relies on **indiscriminate aerial bombardment of civilian areas** in Chin, Kayah, Mon, and Rakhine states, as well as Sagaing region, including the use of cluster munitions and air strikes on villages and displacement camps. These attacks usually take place at night and without warning, making it harder for civilians to flee or take shelter, sustaining fear among those who cannot predict or protect against attacks from above, and increasing the risk of chronic hypervigilance, sleep disturbances, and acute stress reactions (IISS 08/05/2025; KHRG 08/07/2022; UN HRC 27/04/2026; AJ 27/05/2024).

Figure 3. Mental health and psychosocial risks caused by conflict

Source: ACAPS

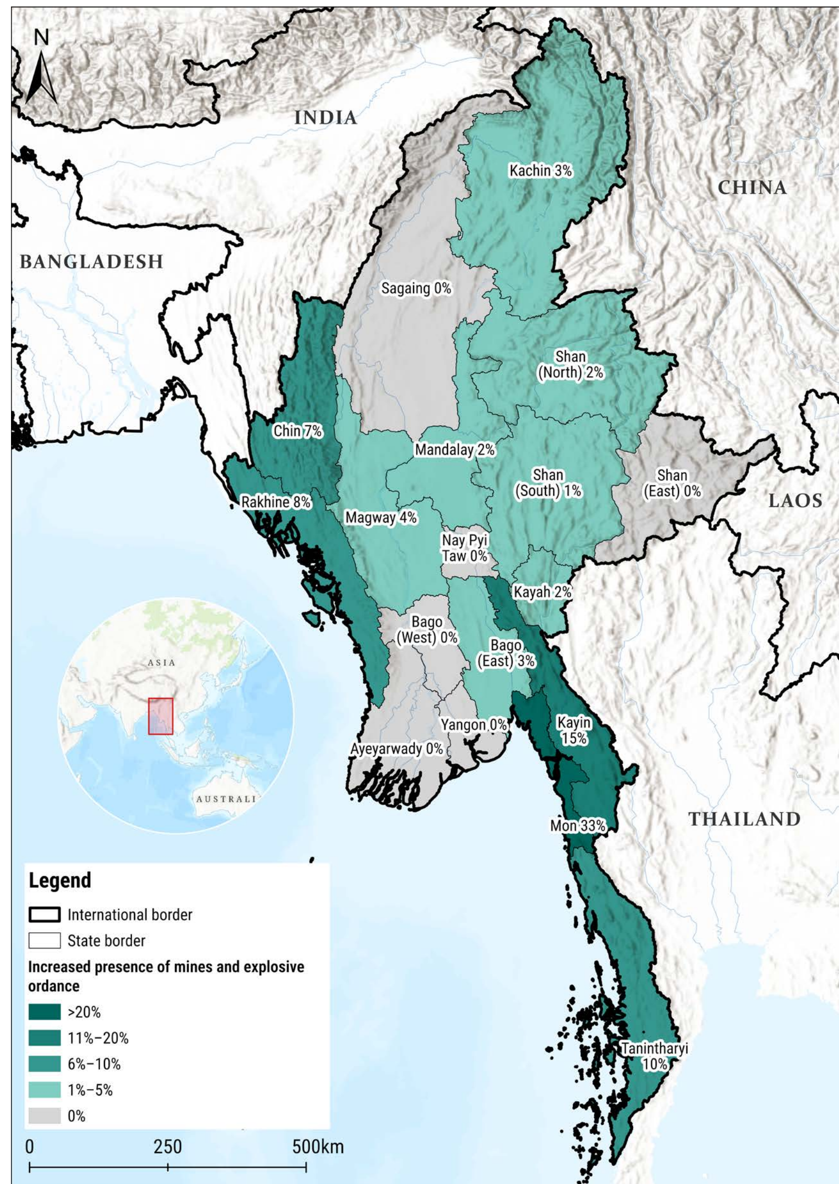
- **The military has deployed extensive, systematic arson attacks on villages in opposition strongholds** in Chin state, Magway region, Mandalay city, Rakhine state, Sagaing region, and Tanintharyi region, destroying more than 100,000 homes since 2021 (UN HRC 27/04/2026; Mizzima 22/02/2026; PV 08/03/2025). Several key informants observed that the deliberate nature of the arson attacks and their recurrence across affected areas have contributed to sustained perceptions of insecurity and unpredictability, elevating anxiety among affected communities (KII 30/04/2026; KII 16/03/2026).
- The military's and EAOs' **extensive use of antipersonnel landmines,** combined with reports of both groups forcing civilians to act as 'human minesweepers' or engage in mine-clearing activities, has significantly heightened MHPSS risks in Chin, Kayin, Mon, and Rakhine states, as well as Tanintharyi region, which are among the areas most heavily contaminated by landmines. In 2025, the country recorded 2,029 landmine casualties – the highest number reported globally (ECHO 04/12/2025; UNICEF 10/10/2025; KII 28/04/2026). Many survivors sustain life-changing injuries, including amputations, which may increase the risk of acute and longer-term mental health disorders, including depression, as individuals readjust to living with their injuries (ICRC 11/03/2022). Amputees may face additional mental health risks because of harassment and suspicion of affiliation with armed groups, reinforcing isolation and stigma (UN HRC 22/11/2024).

"Amputees are being forced into hiding to avoid harassment and arrest, as a missing limb has become a source of suspicion that they are part of the resistance." (UN HRC 22/11/2024)

Conflict has also significantly **heightened GBV risks,** particularly for women and girls affected by conflict, insecurity, and repeated displacement (Protection Cluster 13/12/2024). Although underreporting means that prevalence data is unlikely to reflect the scale of GBV in emergency settings, reports indicate rising incidents of sexual violence, intimate partner violence, exploitation, forced marriage, and trafficking, especially in areas affected by conflict and other access constraints, which limit protection services (OHCHR 03/07/2024; UN Women 27/02/2024). All these forms of violence can have acute and longer-term detrimental impacts on survivors' mental health and wellbeing. Movement restrictions, overcrowded displacement sites, the collapse of community protection mechanisms, and reduced access to healthcare and legal support also further heighten women's and girls' vulnerabilities to GBV and impede survivors' access to services that can help support their recovery. At the same time, insecurity, fear of stigma, and the limited availability of specialised GBV services continue to constrain reporting and access to survivor-centred support (including for MHPSS), increasing the risk of long-term physical and psychosocial harm among affected populations (Protection Cluster 20/02/2025; UN HRC 01/07/2024; Linn et al. 18/08/2025).

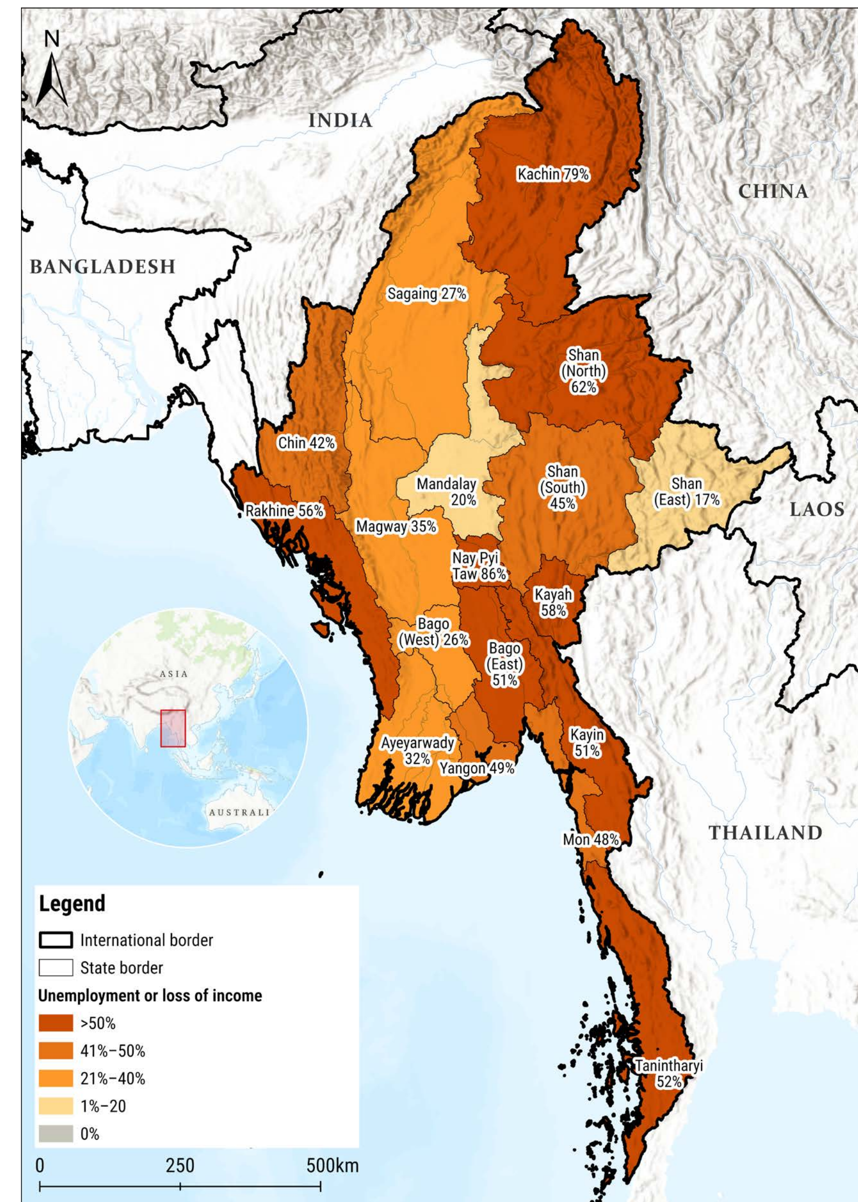
The **disruption of education** has significantly increased MHPSS risks, particularly among children in frontline areas. The closure and destruction of schools in states such as Rakhine deprive children of safe and structured environments that provide stability, social interaction, and emotional support, exposing many to MHPSS risks (UNICEF 28/08/2025; FCA 20/11/2025; EiE Hub accessed 24/05/2026; Cesvi 23/01/2026). Children have been observed playing unsupervised in known ordnance-contaminated areas and other unsafe areas, engaging in child labour, and, for adolescents, engaging in substance abuse (KII 23/04/2026; Ballard Brief 24/03/2022; Huh et al. 01/03/2022).

Map 4. States reporting the presence of mines and explosive ordnance as a driver of MHPSS needs



Source: OCHA 10/12/2025

Map 5. States reporting livelihood loss as a driver of MHPSS needs



Source: OCHA 10/12/2025

The destruction of livelihoods, income loss, and worsening economic insecurity also heighten stress, uncertainty, and feelings of hopelessness across the country. In areas experiencing active conflict, communities further face movement restrictions that disrupt access to markets, trade, and income-generating activities, undermining household resilience and aggravating mental health and psychosocial risks (UNDP 10/10/2025; OGR 16/04/2026; WB 06/12/2025).

CONSCRIPTION AND FORCED RECRUITMENT

Conscription and forced recruitment by both the military and EAOs have emerged as major drivers of declining mental health among young men and ethnic minority communities (UNDP 10/10/2025; MOHR 28/04/2025; KHRG 31/03/2025). In 2024, the Government activated a 2010 conscription law requiring compulsory military service for men ages 18–35 and women ages 18–27. Introduced amid mounting military casualties and defections following the 2021 coup, the law has heightened fears of forced enlistment, particularly among young men who face increased targeting and enforcement measures despite the law applying to both men and women (OHCHR 21/02/2024; BBC 27/02/2024; The Diplomat 03/01/2024). Reports suggest that anxiety and deterioration in mental health and wellbeing – often presenting as social withdrawal and hypervigilance, particularly among youth – have intensified. This is likely a result of the threat of arbitrary arrests, night raids, and the military's and EAO's coercive recruitment practices, which include abductions, forced portering, and the recruitment of child soldiers by armed groups in areas such as Kachin, Karen, and Shan states (The Diplomat 03/01/2024; GCHR 27/02/2025; UNDP 10/10/2025; MOHR 28/04/2025; SAJ 13/06/2024).

Across Myanmar, conscripted soldiers, many of whom are reportedly untrained, are being deployed to conflict-affected areas with limited support and high exposure to violence and insecurity. At the same time, families often receive little or no information regarding their whereabouts, safety, or condition, creating prolonged uncertainty, fear, and emotional distress. The absence of communication, combined with concerns over injury, death, detention, or forced recruitment, is likely to increase MHPSS needs among family members (BBC 11/11/2024). In 2025, young men reported heightened concerns about personal safety as a result of perceived conscription risks irrespective of the recruiting group. A UNDP report found that feelings of insecurity increased after dark, with over 40% of youth reporting feeling 'unsafe' or 'very unsafe' when walking alone at night, more than double pre-2021 levels, likely caused in part by the reenactment of the conscription law (UNDP 10/10/2025).

Map 6. States reporting conscription as a driver of MHPSS needs

Source: OCHA (10/12/2025)

In 2024, because of conscription, young men reported slightly higher levels of perceived safety concerns (16.7%) than young women (13.4%), diverging from broader global patterns where women typically report greater safety concerns (UNDP 10/10/2025).

Fear of recruitment has prompted many men to restrict their movement or flee their communities. As male family members flee, hide, or are forcibly recruited, many women face increased caregiving responsibilities and economic pressure, contributing to heightened household MHPSS needs (ISP 26/07/2024; RFA 26/06/2024; The Diplomat 07/07/2024). Youth of conscription age who limit their movements to avoid being identified can experience exclusion from urban centres and constrained access to employment, while the detention or loss of primary earners further weakens household coping capacity. Some families also incur additional financial burdens when bribed to avoid conscription, compounding economic strain and associated psychological stress (KHRG 31/03/2025). At the same time, growing mistrust within communities, as people fear being reported as eligible for conscription, has eroded social networks critical to collective wellbeing and psychosocial resilience (HBS 15/09/2025; The Diplomat 03/01/2024).

MARCH 2025 EARTHQUAKE

The magnitude-7.7 earthquake on 28 March 2025 killed people and livestock, damaged housing and infrastructure, and disrupted livelihoods and services, exposing the people in Magway region, Mandalay city, and Sagaing region to potentially heightened mental health risks in contexts where broader national instability had already strained coping mechanisms (WHO 09/03/2026; MSF 11/06/2025 and 10/04/2025). Six months after the earthquake, communities reported heightened anxiety regarding their immediate future, including concerns related to accessing basic services (MSF 12/06/2025).

In Mandalay and parts of Magway – areas comparatively less exposed to sustained armed conflict since the 2021 coup – the earthquake introduced a new and acute natural hazard stressor. Many urban and peri-urban households in the affected areas had previously maintained relative stability. In these contexts, the earthquake introduced an acute and potentially longer-term stressor that contributed to heightened anxiety, fear, and uncertainty. In more heavily conflict-affected areas, the earthquake likely compounded pre-existing stress and trauma, further straining already weakened coping capacities and increasing vulnerability to psychosocial distress (KII 01/05/2026; OCHA 10/12/2025; MSF 11/06/2025; WHO 09/03/2026). Immediately after the earthquake, affected communities faced not only acute stressors associated with the earthquake but also additional conflict-related MHPSS risks as the military carried out air strikes in opposition strongholds (IISS 08/05/2025; HRW 27/03/2026).

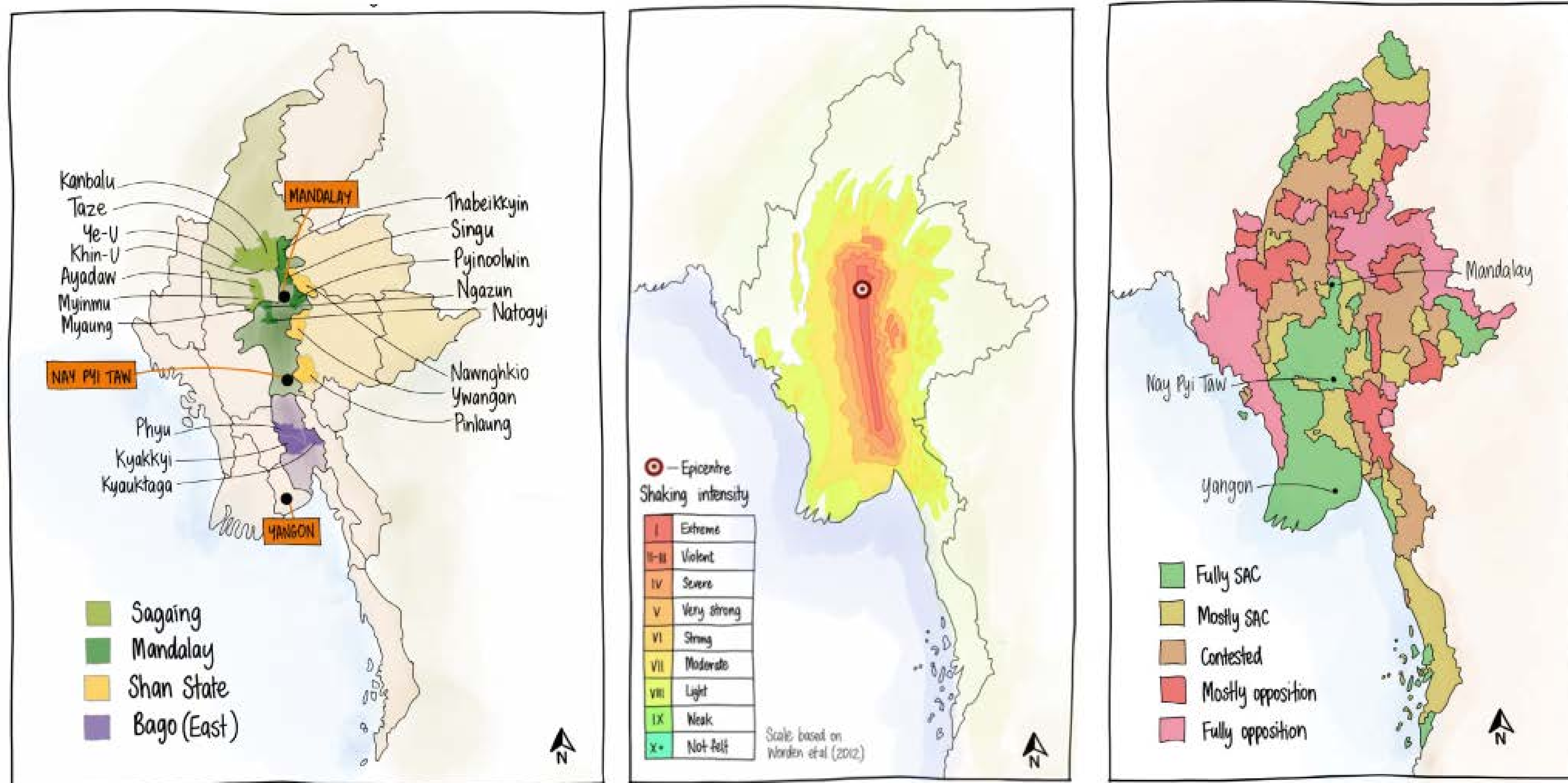
In contrast, the earthquake-affected communities in Sagaing region had already endured years of intense conflict, displacement, and loss. In an assessment conducted after the earthquake, 67% reported anxiety associated with both the earthquake and the conflict (UN 24/06/2025). The convergence of conflict-related trauma and hazard-related shocks increases affected communities' risk of MHPSS needs (UNICEF 18/02/2026; WHO 30/05/2025).

Aftershocks have emerged as recurring stressors, particularly for populations still recovering from initial losses. More than 140 aftershocks, including some reaching a magnitude of 5.9, were recorded in the weeks following the earthquake (USGS accessed 04/05/2026; UN 18/04/2025). Continued seismic activity has prolonged fear of further earthquakes and destruction, reinforcing a state of heightened alert and psychological strain, with many households continuing to sleep outdoors because of concerns about the further collapse of or damage to their homes (KII 30/04/2026; MSF 12/06/2025; UN 18/04/2025).

The earthquake's mental health impacts appear to vary across population groups, with certain groups facing heightened risks because of pre-existing vulnerabilities or specific exposure patterns. Rapid needs assessments after the earthquake confirmed rising mental health challenges among women and girls, as overcrowded displacement sites with limited privacy and inadequate security increased exposure to GBV, a known contributor to poor mental health (GiHA WG 08/2025; UN 03/04/2025). Even after six months, children continued to report persistent fear and anxiety, with reported behavioural changes including increased dependency on caregivers, sleep disturbances, and heightened startle responses (STC 26/09/2025; HelpAge 09/05/2025).

The earthquake also heavily affected religious monuments and temples, which often serve as important sources of informal and non-specialised MHPSS services through community gatherings, spiritual counselling, collective mourning, and social connection. It destroyed almost 10,000 religious sites across affected areas (RFA 14/04/2025). The loss of these spaces has not only further reduced already-limited mental health service capacity in affected townships but also weakened the community-based support systems that populations rely on for emotional support, increasing psychosocial risks (Health Cluster 08/12/2025; UNDP 30/09/2025; KII 01/05/2026).

Map 7. Earthquake-affected areas control status in 2025



Sources: USGS (accessed 06/06/2025); COAR (accessed 09/04/2026); Worden et al. (2012)

Notes:All hand-drawn maps are indicative.

LIMITED MHPSS SERVICES TARGETING CAREGIVERS

Layered stressors associated with conflict – including displacement, trauma exposure, financial strain, and prolonged insecurity – combined with limited access to psychosocial support, may undermine caregivers' ability to provide consistent care, emotional support, and protection. These pressures can heighten the risk of family stress (Pearson et al. 24/10/2025).

In contexts where caregivers face unaddressed stress, anxiety, or trauma, they may have reduced capacity to provide stable emotional support and consistent care to children, older people, people with health issues, and people with disabilities. This is particularly significant in displacement settings and conflict-affected areas, where overcrowding, poverty, and repeated exposure to violence have weakened traditional family and community coping mechanisms. A 2024 study indicated that violence against children had increased since 2021, with at least 80% of respondents reporting experiences of caregiver psychological violence between 2023–2024 (Pearson et al. 24/10/2025).

Caregivers in conflict-affected areas face elevated mental health risks and extremely limited mental health services. As a result, those facing stress or anxiety may aggravate children's pre-existing mental health risks (KII 23/04/2026; PATH 15/01/2026; Bendavid et al. 13/01/2022; Ferrara et al. 12/2025).

In many cases, caregivers themselves do not know how to identify signs of MHPSS needs in children or respond to trauma-related behaviours, limiting early support and referral pathways (Ferrara et al. 12/2025; Tun et al. 19/12/2025; KII 21/04/2026). The absence of adequate caregiver-focused MHPSS interventions may contribute to longer-term psychosocial risks for children (KII 05/01/2026; WHO 06/09/2022). Humanitarian responders in Myanmar highlight how caregivers' weakened mental health conditions place a growing emotional burden on children, while access to specialised mental health services remains limited, particularly in areas experiencing access constraints (Rizkalla et al. 12/11/2020; Bendavid et al. 06/02/2021). Disruptions to education are likely to compound these MHPSS risks, as school closures and interrupted learning reduce children's access to structured environments, peer support networks, and school-based psychosocial services that can help mitigate distress and identify children in need of protection services (De Lille et al. 24/06/2025; UNICEF 31/07/2024).

Role of community networks

Given the limited availability of formal MHPSS services across much of Myanmar, communities continue to rely heavily on informal support networks, including family structures, community groups, religious leaders, monasteries, and community-based organisations. These networks play an important role in providing emotional support, strengthening social connectedness, and offering practical assistance that can help mitigate psychosocial stress during periods of crisis and displacement. For displaced populations, peer and family support systems, religious practices, and shared expectations of future political change are reported to help affected people cope with insecurity (KII 23/04/2026; KII 16/03/2026; Tun et al. 19/12/2025).

Community-based organisations, religious groups, and grassroots NGOs also play an important role in providing non-specialised psychosocial support and identifying individuals in need of referral to more specialised MHPSS services, where available. Humanitarian interventions such as psychological first aid – an approach that provides humane, supportive, and practical assistance to individuals experiencing distress – as well as self-care interventions aimed at helping individuals and caregivers manage stress, maintain emotional wellbeing, and strengthen coping strategies – contribute to reinforcing community-level coping mechanisms and mutual support structures (KII 23/04/2026; KII 01/05/2026). *While these informal support networks do not replace specialised mental health services, they provide an important protective function by facilitating referrals where available, helping sustain social cohesion, reducing isolation, and partially mitigating MHPSS risks in contexts characterised by conflict, displacement, and limited access to formal care.*

"When community groups and organizations started showing up and providing support, I slowly began to regain some hope. The next step is to think ahead."
(MSF 12/06/2025)

Role of the internet in aggravating mental health risks

Since 2021, social media platforms have become central sources of information, particularly in conflict-affected areas where access to traditional media and services is constrained (K4DM 04/07/2025). *While these platforms provide an important lifeline for communities seeking information, they are also associated with increased mental health risks. Continuous exposure to political developments, graphic conflict-related content, misinformation, and reports of violence contributes to heightened MHPSS needs among users. The rapid circulation of distressing images and rumours, often without verification, also reinforces perceptions of insecurity and uncertainty* (Thomas 08/2024).

In Myanmar, technology-facilitated GBV functions as a systematic state weapon deployed by the military and affiliated groups to silence women's participation in political activities and enforce authoritarian control. By the end of 2022, politically motivated online abuse targeting politically vocal women had increased at least fivefold since immediately after the coup, with incidence rates up to 500 times higher than international benchmarks, according to an analysis of 1.6 million social media posts (HRM 05/11/2025; APC 21/04/2026). *A primary tactic is doxxing, which involves the malicious release of women's private information, including addresses, phone numbers, and photographs. This enables cascading offline consequences, including targeted arrest, sexual violence threats, family harassment, and physical attacks when published information allows perpetrators to locate survivors of technology-facilitated GBV* (APC 21/04/2026).

The military's AI-powered Person Scrutinization and Monitoring System is also understood to systematically profile individuals from conflict zones and ethnic minority areas as resistance supporters, triggering their arbitrary arrest, detention, and torture (PV 20/07/2025; Fulcrum 30/01/2026). *Women from ethnic minorities in conflict-affected states, including Chin, Kachin, Kayah, and northern Shan, face compounded risks as both their gender and ethnicity trigger algorithmic targeting. This convergence of AI surveillance with gendered violence has created persistent fear and hypervigilance, forcing self-censorship that eliminates women from political discourse, heightens MHPSS risks linked to family safety following doxxing, and causes social isolation as women withdraw from online and physical spaces to avoid targeting* (Human Rights Myanmar 20/11/2025).

Figure 4. Role of the internet in aggravating mental health risks