OLD WOUNDS

How ethnic tension is deepening a health crisis on Myanmar's border with Bangladesh

The legacy of war and a rising threat of drug-resistant infectious diseases in Rohingya refugee camps pose a serious challenge for Myanmar as it prepares for a historic election on November 8.

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Two speakers send the Islamic call to prayer sailing across Thet Kal Pyin, a refugee camp less than 100 km from Myanmar’s border with Bangladesh. The call wafts over several neat rows of large, low-slung buildings with blue roofs. Several families live in each structure, and the camp is home to around 5,000 people. Most, if not all, belong to the Rohingya ethnic group, a
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persecuted Muslim minority.

In response to the prayer call, bearded men in sandals emerge into the gathering dusk. They file into a thatched pavilion that serves as their makeshift mosque. At its entrance, they wash their hands and remove their shoes. Then, as darkness falls, they crouch on wicker mats to pray.

Three years ago, in 2012, the camp was created in the aftermath of deadly riots in the nearby port city of Sittwe. The violence resulted from a flare-up in long-running tensions between the Rohingya and the Rakhine, a Buddhist ethnic group. The Rakhine are an ethnic minority in Myanmar, where the Burmese are by far the dominant ethnic group. Yet they are dominant in Rakhine state, on Myanmar's western coast, and many of them resent the Rohingya as intruders.

Human rights groups say that for decades, the Myanmar government has effectively refused to grant citizenship to more than one million Rohingya; it refers to them as "Bengali" and has proposed citizenship rules that advocacy groups say have forced many Rohingya to leave the country. Rohingya suffered disproportionately in the violence of 2012, and about 140,000 of them were later relocated to the refugee camps (including Thet Kal Pyin) that now ring Sittwe’s rural outskirts.

Displaced Rohingya

This spring, Rohingya also accounted for many of the thousands of stateless refugees who sailed in rickety boats to Thailand, Malaysia and Indonesia in a desperate search for political asylum. Yet many displaced Rohingya in Myanmar have stayed put, and health is a pressing concern for those in the refugee camps. What is the best way, they wonder, of avoiding the malaria, tuberculosis, diarrhoea and other ailments lurking amid the camps’ dirt corridors, portable toilets and mosquito-prone drainage ditches? And if someone does contract one of those diseases, where can he or she find treatment?

“We overcame a lot of difficulties [in the chaos of 2012].” Abdul Rahim, a 43-year-old resident of Thet Kal Pyin, told me recently at the camp. “But our main concern became healthcare.”

In Myanmar, which lies at the junction between South-East Asia, China and the Indian subcontinent, healthcare and politics are inextricably linked. The repressive military junta that took power in the early 1960s choked off funding for health and other social services, and even though its ruling generals ceded power to a nominally civilian government in 2011, experts say the health system will take years – probably decades – to recover from half a century of neglect.
And Myanmar is still, in some respects, a country at war. International visitors see the former British colony, officially called Burma until 1989, as one of Asia’s last bastions of sleepy colonial charm. Yet conflicts simmer in the hinterlands between the Myanmar army and a slew of ethnic militias, some of which control vast swathes of autonomous territory. Since the political transition in 2011, there have also been outbreaks of deadly violence between Buddhists and Muslims in several cities and towns, including Sittwe. These conflicts have created further practical and ideological barriers to improving people’s health.

**Peace and problems**

The Myanmar government and many of its longtime rivals in the hinterlands are attempting to make peace, and this has led some health experts to talk optimistically about joint immunisation drives and other so-called "convergence" projects in which health workers from the central government collaborate with colleagues from rival autonomous regions. The experts see healthcare reform as a potential dividend of an ongoing peace process.

Yet health reform can also stoke tensions. Accusations fly from both sides. Health organisations in areas of eastern Myanmar, for example, complain that the central government has siphoned some of the international aid funding that they have long depended on to save people’s lives in minority communities. And the government has complained that the relief agency Médecins Sans Frontières or MSF has unfairly supported Muslims at the expense of Buddhists.

In February 2014, it ordered MSF to leave Rakhine State, where the group had been providing emergency medical care at Thet Kal Pyin and other refugee camps. MSF’s offence was declaring publicly that it believed it was treating victims of sectarian violence.

“‘Convergence’ is a sexy topic for aid and development people,” explained Bill Davis, former Myanmar project director for the New York-based advocacy group Physicians for Human Rights. “But it’s tough to put politics aside. There is a history of bad feelings.”

**A question of trust**

Last summer, a few months after MSF left Thet Kal Pyin, Myanmar’s ministry of health set up its own clinic about a kilometre down the road. The clinic is a concrete building with a fresh coat of yellow paint and several clean, sunny outpatient rooms
with concrete floors. When I visited this winter, health worker Naing Lin Oo told me the clinic had 15 beds and was equipped to deliver babies and to treat ailments such as common colds and diarrhoea. “If it’s serious, we send them to the hospital [in nearby Sittwe],” he said.

Back in the refugee camp, however, several Rohingya told me they were so emotionally bruised from the 2012 conflict, and so distrustful of Rakhine people and the Myanmar government in general, that they were reluctant to seek medical treatment anywhere but in the camp itself. It was technically possible to travel to Sittwe General Hospital in an emergency, explained one camp resident, adding, “But we’re afraid to go there because we’re afraid of being taken advantage of.” The resident and his neighbours said they missed MSF and wondered when the group would be allowed to return.

In January, MSF (which declined requests to comment for this article) announced that it had resumed some of its services in Rakhine State for “tens of thousands” of people in late 2014. But Matthew Smith, the executive director of Fortify Rights, a Thailand-based advocacy group that monitors conflicts and human rights crises in Myanmar, told me in January that MSF was “nowhere near as operational” in Rakhine State as it had been previously. The healthcare crisis among the displaced Rohingya in Rakhine State, he added, was among the country’s most severe and dramatic.

Health overview

Nearly half a million people die every year in Myanmar, a country of about 52 million. Child mortality rates and overall life expectancy – which is just 65.2 years, only slightly higher than Rwanda’s – did improve marginally under military rule, but many of the same problems that affect the world’s poorest countries are still common in Myanmar’s countryside, where about 70 per cent of the population lives. In some communities, mortality rates among children under five are close to Somalia’s.

Infectious diseases are a major threat in Myanmar; tuberculosis rates are three times the global average and among the highest in Asia, and drug-resistant TB was detected in 2007. A previous HIV epidemic seems to have been controlled, but government treatment still only covers about one in three HIV patients. And because roughly a fifth of Myanmar’s injecting drug users have HIV, according to a 2012/13 government survey, health experts worry that HIV infection rates could climb again if Myanmar’s long-standing heroin problem worsens.

It’s in Myanmar’s borderlands that some of the greatest threats to global health lurk. Tropical borderlands are often hotbeds for
the spread of malaria, which thrives in tropical climates and among poor, destitute populations. Myanmar’s yearly malaria infection rates have in fact been tapering in recent years, but they are still the highest in the Greater Mekong Subregion at about 91 infections per 10,000 people. And the strains found in the country’s borderlands appear to be increasingly resistant to life-saving drugs.

Clinical resistance to artemisinin, a widely used antimalarial agent, was first discovered nearly a decade ago in Cambodia. Resistance is now also found in the four other countries in the Greater Mekong Subregion: Myanmar, Vietnam, Laos and Thailand. Myanmar’s artemisinin resistance has long been confined to its eastern borderlands, but in February the Lancet reported “strong evidence” that resistance is now present across much of upper Myanmar, including northwest regions near the Indian border. The study added to long-standing fears that artemisinin resistance could spread west from Myanmar to India and then to Africa.

In Myanmar and beyond, “all the effort...in ten years in the control of malaria in many regions of the world, especially in Africa, could be totally jeopardised by the spread or the extension of artemisinin resistance,” says Philippe Guérin, director of the UK-based Worldwide Antimalarial Resistance Network. Newer drugs under development could eventually replace artemisinin in some places, he told me, but the process of negotiating with governments and training health workers to introduce those drugs on a large scale would be complicated, expensive and time consuming.

Political reform

Myanmar’s political reform process began in earnest five years ago, when Aung San Suu Kyi, the Nobel laureate who leads the National League for Democracy opposition party, was freed after serving more than two decades of house arrest. In parliamentary by-elections in 2012, Suu Kyi and members of her party won 43 of 45 seats in Myanmar’s parliament.

Since then, Western governments have lifted long-running trade sanctions against Myanmar, and investment by both Western and Asian companies has surged. Gross domestic product (GDP) growth for 2014/15 is expected to be around 8 per cent and international donors, once wary of supporting the military junta, are ramping up their aid commitments. A health fund called 3MDG, which is managed by the United Nations, plans to invest more than US$300 million by 2016 to reduce child mortality, improve maternal health and fight disease, among other things.
And the World Bank has pledged $200 million to help Myanmar achieve universal health coverage by 2030. Those 3MDG and World Bank initiatives alone are worth half a billion dollars, or nearly 1 per cent of Myanmar’s GDP for the fiscal year that ended in 2014.

The government is also rolling out health reform programmes. In 2011, for example, a national HIV/AIDS plan set out an ambitious strategy for fighting the disease and preventing future infections. In 2013, parliament tweaked the national budget to allow more of Myanmar’s poorest patients to access free medicine. In the same year, Myanmar’s health minister at the time, Pe Thet Khin, said the goal of achieving universal health coverage in the country was “not impossible”.

Eye on voters

As Myanmar’s November election nears, government officials appear to realise that improving healthcare is a good way to win the public’s trust in a nascent democratic society. However, says one diplomat based in Yangon (Myanmar’s commercial capital), for all the talk of health reform, the national health system will be “a big ship to turn”.

Does Myanmar have the capacity and infrastructure to fix its broken healthcare system? The Ministry of Health is clearly taking more responsibility for fighting infectious diseases and other systemic problems than it did before 2010, says Saung Oo Zarni, who directs a network of 17 health outreach clinics in Myanmar for Population Services International, a non-profit organisation based in Washington DC. But the country’s health infrastructure is “not ready to absorb the aid”, he told me at his office in Yangon. As a result, he said, large influxes of international funding to address tuberculosis, HIV/AIDS and other diseases are still not reaching large swathes of vulnerable people.

Even in Yangon, it’s easy to see shortcomings in the national health infrastructure. At Yangon General Hospital, a colonial building with faded shutters, patients camp in the courtyard because there aren’t enough beds for them inside. And every night at dusk, a Yangon charity sends a fleet of five ambulances into the city’s congested streets. In theory the city’s public hospitals operate 24-hour ambulances, but in practice they are unreliable – especially after nightfall, says Zaw Sai, a volunteer on one of the charity’s ambulance crews.

One afternoon I paid a visit to a cluster of thatched huts on the city’s outskirts that serve as home for about 60 people, and their children, who live with HIV/AIDS. A man there told me that MSF was paying for him and his neighbours to receive life-
saving antiretroviral drug treatments. But they couldn’t afford to pay for the drugs themselves, he said, and they were “praying every night” that the funding would continue indefinitely.

Did he think, I asked, that healthcare had improved in general since Myanmar’s landmark 2011 political transition?

“A little,” he said. “Not much.”

Staff shortage

Even if Myanmar’s health bureaucracy were more efficient, the country would not have enough medical professionals. The number of doctors, nurses and midwives increased by a fifth between 2006 and 2011, boosting the total from 1.27 to 1.49 per 1,000 population. According to the WHO, however, that’s still “far below” the global standard of 2.28.

Many young doctors avoid the state sector entirely because the salaries are too low. Young doctors who join the state health service are immediately posted to rural areas for two to three years at an entry-level salary of just US$164 per month, according to Khaing Thandar Hnin, a 30-year-old graduate of a Yangon medical school. As a result, she told me, many are forced to open private clinics on the side – and work incredibly long hours – just to survive.

“I’m very sure I won’t join the government service because if I do, I will definitely be sent to remote areas,” Khaing Thandar Hnin said over lime sodas at a Yangon shopping mall. Fresh from her studies, she was applying for jobs with international non-profits that paid three to four times as much as the government does. But, she noted, at least she was working in Myanmar – a path that many of her classmates never considered because they saw medical school as a stepping stone to an overseas career.

Another problem is the drug supply chain. On a recent afternoon, I visited the centrepiece of the country’s US$495 million pharmaceutical industry: Yangon’s Mingalar Market. It sits on the upper floor of a ramshackle shopping plaza. After winding through a crowded fabric bazaar and climbing several flights of broken escalators, I saw a vast network of vending stalls, each stacked to the ceiling with wholesale medicines. Many of the product boxes were white; it was difficult to tell what use a given product served, much less whether it had been legally imported or not.
A vendor, Toe Oo, told me that until recently only about a third of the drugs he sold were registered. That is beginning to change as Myanmar’s Food and Drug Administration tightens its policies, he said, but unregistered drugs are still widespread, accounting for perhaps half of the market’s offerings.

Meanwhile, a handful of private hospitals have cropped up in Yangon in recent years to serve Myanmar’s urban middle class. But the quality of care in the private sector can be highly variable, says Naithy Cyriac from Solidiance, a Singapore consultancy that studies Myanmar’s pharmaceutical industry.

Those who can afford to go abroad for treatment usually do. According to Solidiance, patients from Myanmar spent US$150 million in 2012 on healthcare in Thailand, Malaysia and Singapore. Since 2013, several large hospitals from Singapore, Bangkok and India have opened representative offices in Yangon in an effort to tap a growing market.

“The wealthy are going overseas because there’s nothing here they can trust,” Cyriac says.

**Ethnic tension**

In Myanmar’s restive hinterlands, where the government has been fighting armed ethnic insurgencies for decades, lack of trust is also a central problem.

Some see healthcare funding decisions as drivers of inequality. Eh Kalu, director of the Health and Welfare Department of the Karen National Union (KNU) – a major healthcare provider in eastern Myanmar – says the department has suffered financially as a result of Myanmar’s political transition. International donors have tapered funding for his department, he explains, and redirected the money to projects controlled by the Myanmar government – funds that the KNU cannot always access.

“The international NGOs and donors need to support both sides,” he told me, at least until political dialogue and peace negotiations begin in earnest. In the meantime, he oversees 1,500 health workers who serve a population of about 200,000. A lack of adequate training and capacity building are a constant problem, he says, and he struggles to pay the salaries of his doctors and community health workers.

Others say healthcare itself is used as a weapon. Matthew Smith of Fortify Rights, for example, argues that the government...
prevents international aid workers from travelling to certain areas outside its control as a “tactic of war” against armed ethnic
groups. “If there is a displaced population that is in a particular need, the government realises that those people will draw on
resources of non-state armies,” he told me. “You can imagine the consequences on the ground.”

The links between conflict and healthcare funding are not “black and white”, says Tom Kramer, a political consultant who has
worked on several United Nations projects in Myanmar. The ethnic groups often have a point about the dangers of reducing
their aid budgets too quickly, he adds. However, in the longer term, it’s inevitable that the Myanmar government will assume a
greater role in healthcare delivery in restive border regions – particularly if ceasefire agreements are reached with rebel groups
like the Karen National Union.

**Tensions persist**

The challenge is figuring out how to integrate government and autonomous healthcare systems with the least friction possible.
If health officials push too quickly for convergence between the government and its former enemies, says Kramer, “that can
also create problems for the peace process”. Spokespeople for two international charities with operations in restive Myanmar
states declined to comment when I reached them by telephone, saying that healthcare was such a politicised issue that they
couldn’t afford to speak publicly about their own work.

Peace has technically come to Sittwe, the city in western Myanmar that was wracked by rioting and arson in 2012. But
according to a 2014 report by the International Crisis Group, the “political temperature” there has remained high. Furthermore,
the report says, the persistence of ethnic tensions poses a “significant threat” to the Myanmar government’s reputation and the
overall success of its political reform process.

When I visited Sittwe this winter, I didn’t witness any violence, and the downtown areas felt safe. But reminders of violence
and tension were everywhere. On the road from the airport into town, for example, I saw a turquoise mosque that had been
burned in 2012; all that was left were some walls and broken arches. And on the road from the city to some refugee camps, I
passed a military checkpoint ringed with barbed wire.

A few miles away in Thet Kal Pyin refugee camp, street life looked and felt as it does in many villages in South-east Asia.
Groups of children played football in parched grass as women cooked meals or washed dishes. Some people sold produce out
of the front of their homes. Others simply sat around, shooting the breeze.

But when I spoke to the camp’s residents, they sounded bitter. Many regretted the loss of their homes and businesses, and they desperately wanted their old lives back. “A lot of people here are jobless,” said Faizul Anwar, an unemployed teacher, as he walked past some frolicking kids. “I’m crying inside, but I don’t want the children to see.”

The people of Thet Kal Pyin were afraid to travel to Sittwe because they feared for their safety. Some told me that they assumed they would be arrested if they tried to enter the city through those barbed wire-ringed checkpoints. Even in a medical emergency? Perhaps not then, they said, but they still wouldn’t trust a Rakhine or even a Burmese doctor to treat them with respect. One man even suggested that a Rakhine doctor might kill him on the operating table.

Back in Sittwe, I mentioned the Rohingya people’s concerns to Daw Tin Win, a healthcare worker with the Myanmar Health Assistant Association, a non-profit professional organisation. She has worked in six of the 14 refugee camps outside Sittwe. She told me she understood why some Rohingya might be fearful, but she says that their fears of being mistreated were unfounded.

**Fear factor**

The main problem in some camps, she added, was that a fear of receiving care at Sittwe General Hospital was preventing many Rohingya from going there at all – even if they had medical emergencies.

In one example, a Rohingya boy in one of the camps was bitten by what looked like a rabid dog. Daw Tin Win urged his parents to send him to Sittwe General Hospital, she recalled. No luck; they were simply not going to a place like that, they said, because they did not trust the people there.

She urged them again, with the same result. Eventually – and only after being convinced by a Rohingya nurse – the parents relented, and the boy survived the bite.

“We don’t discriminate,” said Daw Tin Win. “Our main goal is to save lives.”