CASS

Community Analysis Support System

PERCEPTIONS OF HEALTHCARE IN RAKHINE STATE

| January 2021 |

UKaid from the British people

Powered by COAR

Contents

Introduction

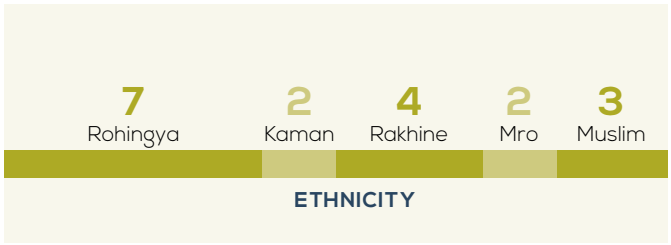
This brief snapshot was conducted in recognition of the healthcare and healthcare access challenges facing displaced communities in central Rakhine State amid the COVID-19 pandemic and related prevention measures. The objective of this snapshot is to provide humanitarian actors and donors with some understanding of how these communities perceive local healthcare services and their difficulties in accessing these services.

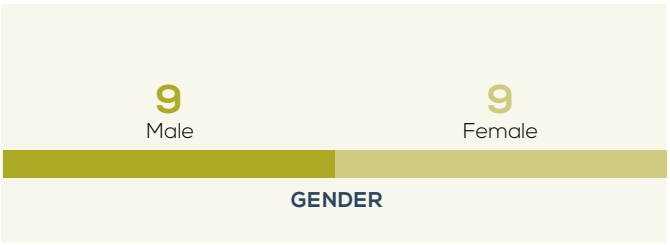
Data for this survey was collected between 25 November to 1 December 2020 in central Rakhine State, against a backdrop of restrictions imposed to prevent the spread of COVID-19. As this update is based on a small sample size of 18 respondents, the observations found here cannot be taken as representative. Rather, this snapshot is indicative, and the value of the qualitative approach can be found in its context-specific knowledge.

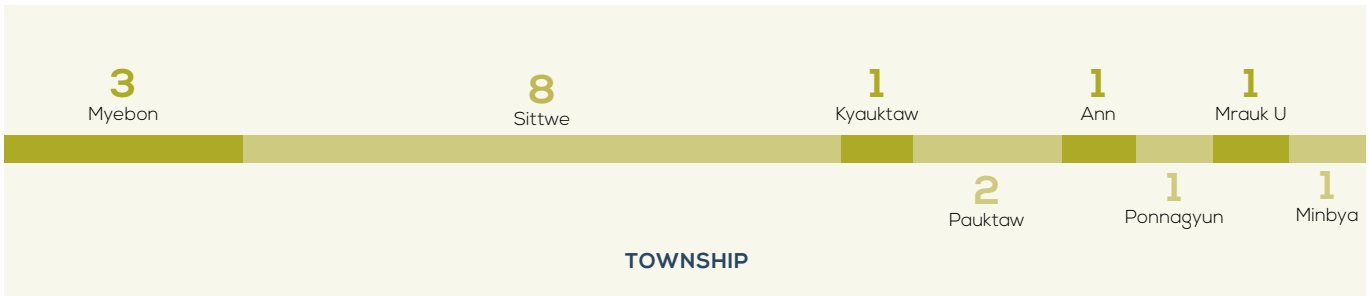
Respondents

Respondents were asked to comment on how they perceived:

- the availability of healthcare provision in their area and beyond
- how healthcare is accessed and barriers to access
- the quality of healthcare provision
- suggestions on what needs to change.







Summary

1. In general, respondents perceive healthcare provision to be substandard, and access difficult. Among Rohingya and Muslim communities, reports of Sittwe General Hospital as inhospitable and dangerous persist. While some respondents commented that the healthcare provided by international agencies is of a good standard, it was also reported that the operating hours of such clinics are limited, that services offered are limited, or that getting referrals and permissions to travel to other healthcare centres (e.g. Sittwe General Hospital) consume a high financial cost in formal and informal fees.
2. Movement restrictions are a major barrier to healthcare access across all communities and have worsened with COVID-19. Movement restrictions for Rohingya and other Muslims in the 2012-established camps are well documented, but non-Muslim communities also report increasing COVID-19 restrictions and conflict-related restrictions on movement.
3. As a result of these difficulties, many people prefer to visit informal healthcare providers. Rohingya or Muslim people in particular report that their community relies on well-regarded traditional healers. All communities also reported relying on uncertified, self-trained, medical practitioners, who are less well-regarded.
4. Some Muslims from camp areas prefer to circumvent restrictions, if they have the means and connections. While tensions between communities are seen to have relaxed to a degree, there are significant barriers remaining. Participants note that government policies which restrict Muslims' access to urban areas discourages private clinics from serving the Muslim population.
5. Respondents want authorities to lift restrictions on freedom of movement, grant international agencies wider humanitarian access, and want government and international agencies to expand provision of healthcare services. Notably, two Rohingya women suggested international agencies collaborate with traditional healers, who have deep connections with the community and are trusted.

1. Current Situation

While respondents noted that their access to healthcare worsened after the serious onset of COVID-19 and measures to prevent its spread,[1] there have long been very limited healthcare options for all communities in Rakhine State. For Rohingya and other Muslim[2] communities in particular, the situation is particularly difficult and is well documented.[3]

> "Before the COVID-19, the clinic by [redacted] just used to open two days a week but it stopped about four months after the outbreak of COVID-19 in Sittwe. Now, it opens only one day a week due to COVID-19 restrictions."
>
> **- 50 year-old Muslim man, Sittwe Township**

Respondents report existing healthcare facilities to be inadequate, or even non-existent in some rural locations. Sittwe General Hospital is generally recognised as the best available healthcare in the area, despite difficulties with hygiene, experiences of abuse or discrimination (for Rohingya and Muslims in particular), and obtaining the necessary paperwork to get there.

[1] The COVID-19 situation worsened in Rakhine State from August onwards. On 25 August authorities announced a 'stay at home' order across all townships in the state. On 2 October, new restrictions were announced in Sittwe Township, requiring those travelling outside their homes to carry permission cards distributed by local ward officials.

[2] This paper uses the term 'Muslim' to refer to respondents who identified themselves variably as Rohingya, Kaman and Muslim, in reflection of the fact that camp-based Muslim communities face very similar challenges in accessing healthcare.

[3] Amnesty International 2017, "Caged Without a Roof": Apartheid in Myanmar's Rakhine State.

Healthcare access is particularly limited for Muslim camp-based communities in Pauktaw Township. According to a mobile clinic schedule, medical services in five Pauktaw camps (total population approx. 23,000) are far more limited than services available in camps in other townships. There, COVID-19 restrictions have made accessing healthcare even more difficult, illustrating the difficulties in balancing COVID-19 preventative measures and ensuring people can access basic services.

> "I am not happy with the current healthcare situation available in the camp, and the healthcare services turned into getting worse during the COVID-19 outbreak. We can not work and we don't have money to get treatment and [retracted] clinics also limit access. Many people lost their lives because of the restrictions and inadequate treatment."
>
> **- 40 year-old Kaman woman, Pauktaw Township**

> "The healthcare situation in the camp has changed because of COVID-19 restrictions. We can't go easily to the Sin Taw Maw village's rural health centre due to movement prevention by CMC and police checkpoints during the COVID-19 outbreak. Also right now, about 40 patients can access the [redacted] clinic on Thursday due to COVID-19 preventative measures."
>
> **- 50 year-old Rohingya man, Pauktaw Township**

In 2019, a new hospital was built at Thet Kae Pyin, which has helped to somewhat alleviate the situation for Rohingya IDPs and host communities in Sittwe Township. However, some respondents reported difficulties such as understaffing (particularly at night) and high costs. Capacities are also limited, and Thet Kae Pyin will refer patients to Sittwe General for emergencies or specific treatment. Although the presence of the hospital has improved healthcare access, challenges clearly remain regarding capacity and service delivery, as detailed by respondents:

> "Thet Kae Pyin village's hospital hosts 30 beds. But there is no operation room and not enough equipment. People who live in villages and have NRC cards can go to Sittwe downtown to see doctors in their private clinics."
>
> **- 38 year-old Rohingya woman, Sittwe Township**

> "My mother suffered from heart disease and she became worse, so we went to Thet Kae Pyin hospital because it was Sunday and there was no doctor. At night one doctor arrived and he asked my mother to take oxygen. To take oxygen we need a generator because there is no electricity. We have to pay for diesel to run the generator but at 4 am they stop the generator and the oxygen is not working because there is no electricity. When we asked the nurse they said there is no more diesel. My mother died at 5 am because of the lack of oxygen. After my mother passed away, I no longer go to the Thet Kae Pyin hospital."
>
> **- 36 year-old Kaman woman, Sittwe Township**

Displacement among non-Muslim communities as a result of armed clashes between the Tatmadaw and Arakan Army has presented new healthcare challenges. One displaced Rakhine respondent in Myebon Township spoke of a lack of facilities in the camp:

> "People in this area feel bad about the quality of healthcare because they do not get access to healthcare at the IDP camp. So, we only have one option to go to other places such as Ann, Kan Htaung Kyi, and Myebon towns when we face serious health problems or in an emergency."
>
> **- 51 year-old Rakhine man, Myebon Township**

2. Access and Barriers

All respondents indicated that they experience difficulty accessing healthcare. Clinics are seen as suitable for only minor ailments, and all respondents indicated several barriers to accessing hospitals for treatment beyond the basic. Overwhelmingly, the difficulties related to movement restrictions and to formal and informal costs, especially related to permissions, medicine, treatment costs, and the hire of private vehicles for transport to hospital, illustrating the large amount of red tape that people must tackle. While there are some ambulances available for Muslim camp-based communities, this is not always the case, and the service is considered unreliable.

2.1 Movement Restrictions and Approvals

Restrictions on movement are a major barrier, particularly for people in camp or displacement site settings.

> "We are not happy because we face movement restrictions to access better healthcare services in Myebon and Sittwe towns. We face good healthcare services at the [redacted] clinic in the camp for normal health problems, and we can access good healthcare services at the urban hospital for an emergency as well. The only one we face is freedom of movement for good healthcare services."
>
> **- 30 year-old Muslim woman, Myebon Township**

Rohingya or Muslim respondents reported a range of documents needed for medical referrals and travel, and a range of sources for these documents. These included Citizenship Scrutiny Cards,[4] medical referral letters and letters from authorities available variously from the Myanmar Red Cross Society, Camp Management Committees, police, village leaders, Thet Kae Pyin Hospital, or international agencies. The cost of these documents, however, can be insurmountable. The temporary closure of international agency-run clinics during COVID-19 in the camp areas also made accessing these documents difficult.

[4] Commonly referred to as 'NRC'.

"Some Rohingya hire cars to go to Sittwe hospital at night but most of the time they are arrested by the police because they come illegally without referral and without security guards. The taxi helps to call security police but it costs around 20,000-50,000 MMK for them."

- 38 year-old Rohingya woman, Sittwe Township

"The security guards in the hospital take corruption (we need to pay money) when we need to ask them to buy food and medicines as we are not allowed to bring mobile phones and not allowed to go outside of the hospital. If we ask the security police to buy food or medicine they charge double the price."

- 40 year-old Kaman woman, Pauktaw Township

Movement restrictions are not limited to Rohingya, or camp-based, communities. Non-Muslim respondents are also facing numerous restrictions on freedom of movement which limit their access to healthcare. This includes both persons displaced by armed conflict, and villagers in conflict zones with a high military presence.

"We face many healthcare problems in our village or Dar Lat Chang area because of movement restrictions on people and blocking both road and waterway by the Tatmadaw meaning that we cannot go freely to get access to healthcare... We can't go outside of this area without permission from the Tatmadaw -- that makes it very hard to reach Ann urban hospital."

- 49 year-old Rakhine man, Ann Township

2.2 Language

Language was also highlighted as a barrier for those not fluent in Burmese or Rakhine, and it was reported that good translators are difficult to find. The language barrier was linked to perceptions of discrimination, with some reporting abuse.

"The language barrier is another challenge to communicate with nurses and doctors in Sittwe hospital. Because we can't speak in Burmese and Rakhine, so the doctors and nurses shout at us when they don't understand. They act very angrily even when we hire the translator. Most translators are also uneducated and unfamiliar with healthcare terms; they often don't understand what the doctor or nurse says about the disease."

- 40 year-old Kaman woman, Pauktaw Township

2.3 Social Cohesion & Coping Mechanisms

Some Muslims from camp areas prefer to circumvent restrictions, if they have the means and connections.

> "Some Muslim people lie and pretend like Rakhine people to go to the Sittwe and take the treatment at the Sittwe hospital. If it is an emergency, Rakhine taxi drivers help sometimes but mostly they not want to help -- it is too risky for them if police know."
>
> **- 40 year-old Rohingya woman, Sittwe Township**

Since approximately 2018, Muslims have increasingly accessed private healthcare clinics in downtown Sittwe, reflecting an increased acceptance of Muslims' movement through Sittwe among the Rakhine population, even as they violate restrictions on freedom of movement. One respondent noted that a privately-owned ethnic Rakhine-run clinic has even opened a 'sub-clinic' in the camp complex, from which they refer Muslim patients to their downtown clinic — if they have the money to pay for the service.

> "There is a private clinic... near the Thea Chaung village where they just transfer the patients who can afford the money to its Sittwe private clinic... But, this service is not for poor people."
>
> **- 50 year-old Rohingya man, Sittwe Township**

However, while tensions between the communities may have relaxed to a degree, there are evident barriers remaining. In particular, government policies restricting Muslims' movement to the urban area discourages private clinics from serving the Muslim population, as explained by this respondent:

> "In Sittwe, there is one eye specialist doctor but he does not accept Muslims. Last year I went to his clinic and he asked my ethnicity, then I lied to him and I answered that I am Kaman and I only speak the Rakhine language. A few minutes later he told me don't lie about my ethnicity. I beg him to check my eyes as it becomes worse and I can't see clearly. He accepted and checked my eyes and told me not to come back again. He told me he can not take a risk for 'Kalar'. Healthcare access is becoming worse for us nowadays."
>
> **- 40 year-old Rohingya woman, Sittwe Township**

The same respondent noted: The government needs to do plan for social cohesion among us to build trust with Rakhine and Muslim community. It will help the Muslim community to go to the Rakhine villages to access the healthcare facility.

Many respondents linked their lack of income to limited access to healthcare provision, reflecting the unaffordability of good healthcare for most people. According to other recent community consultations, medical costs are among the most common causes of indebtedness among communities in Rakhine State. While treatment is ostensibly without charge at INGO-run clinics and at government hospitals, costs (formal and informal) for transportation, medicine and permissions can be overwhelming.

> "I think access to healthcare has become worse than the COVID-19. Now the Thet Kae Pyin's hospital only accepts emergency patients and they don't have enough doctors and nurses and medicines. Many poor people pawn their home and their ration book to take treatment and to buy medicine."
>
> **- 40 year-old Rohingya woman, Sittwe Township**

The challenges to accessing good healthcare means many people from all communities resort to attending informal healthcare providers. Rohingya or Muslim people report relying on well-regarded traditional healers, while all communities also rely on uncertified, self-trained, medical practitioners, who are less well-regarded and often derogatively referred to as 'quacks'.

> "The transportation, security threats to go outside of the camp or to go to the city and financial difficulties push people to take inappropriate treatment from quacks."
>
> **- 38 year-old Rohingya woman, Sittwe Township**

3. Quality of Healthcare

With few exceptions, respondents felt that the quality of healthcare available to them was substandard. The discrimination reported by Rohingya communities at Sittwe General Hospital is well documented,[5] and respondents for this update noted name calling, segregated conditions, substandard treatment from staff, security concerns, and additional informal costs for food or basic services at the hospital. One respondent conveyed a vivid description of inadequacy, discrimination and concerns for safety at Sittwe General Hospital.

> "They separate Rakhine and Muslim patients in a different room at Sittwe General Hospital. The Muslim patient stays in a very small, the smell is so bad and dirty room. It is very crowded and they allocated all the patients in the room and there is a hall type room. So, women patients face a lot of difficulties to stay in the hall type room. The room is very close to the hospital public toilet and most are allocated near the toilet and the platform on the way to the toilet.

[5] See for example, Amnesty International 2017, "Caged Without a Roof": Apartheid in Myanmar's Rakhine State.

> One time when I was in Sittwe hospital the security police do sexual harassment and he shouted at me bitch 'Kalar ma.' I was really scared and most women are afraid to complain and stay silent. There are rumours about the Sittwe hospital and many Muslim women believe that if they go to Sittwe hospital to deliver the child both will die so we don't want to go to the hospital. Many women deliver children at home and only emergency women go to Thet Kae Pyin Hospital and if she needs to do the operation the doctors deliver her to the Sittwe General Hospital again."
>
> **- 40 year-old Rohingya woman, Sittwe Township**

The quality of healthcare at clinics run by international agencies was generally perceived to be good, if limited. As reported above, respondents report that only limited healthcare services are available in the clinics, and that clinics have limited operating hours — a problem exacerbated by COVID-19 restrictions.

4. What Needs to be Improved?

Respondents suggested various measures for how international agencies and government could improve healthcare and access to it.

4.1 INGO Intervention

Reflecting the limitations detailed above, many respondents simply suggested they would like an INGO to set up a clinic or healthcare facility in their camp or village. This was true for both Rohingya/Muslim and non-Muslim communities, but was particularly heard in the armed conflict-generated IDP sites which have been established since 2018, where international agency-run clinics are rare.

> "We want not only health workers or staff from the Department of Health but also other international organizations to come to provide health care at the IDP camp. The government should manage to deliver adequate medicine, staff, and clinics, and allow some international organizations to provide healthcare for IDPs in the camp."
>
> **- 30 year-old Mro woman, Kyauktaw Township**

Other respondents went into more detail around issues such as awareness-raising, transport, and how to improve services.

> "We would like to suggest that international organizations should provide more healthcare education while they are giving medical services including adequate transportation and facilities for patients. For instance, providing enough and comfortable waiting spaces for patients and giving more training to volunteers to respect beneficiaries or to follow humanitarian principles."
>
> **- 30 year-old Rohingya woman, Sittwe Township**

Two Rohingya women respondents suggested there were opportunities for international agencies to work with traditional healers, who are well-connected and trusted in the community. While international agencies may not wish to provide healthcare through traditional healers, there may be opportunities to work with traditional healers in raising awareness of COVID-19 or in spreading other health-related messages. Additionally, previous research also suggests that midwives are also very well connected, and trusted, among all communities in Rakhine State.[6] One respondent suggested international agencies should strengthen the skills of midwives in the villages.

> "The international agencies should support and raise the awareness of traditional healers. They are very close with the community and the community already trusts them."
>
> **- 40 year-old Rohingya woman, Sittwe Township**

4.2 Government Intervention

Among Rohingya and other Muslim respondents, respondents overwhelmingly requested the government to lift restrictions on freedom of movement, to improve access to healthcare. Citing discrimination and the unavailability of healthcare during certain hours, some Muslim respondents also wished the government would train Muslim healthcare workers in the camps or to support a 24-hour healthcare centre in the camp.

> "The government should lift movement restrictions on people to access healthcare services in urban areas and need to allow INGOs to set up healthcare services freely for us. As for [redacted], they should appoint experienced health workers in the village to provide healthcare services every day."
>
> **- 50 year-old Muslim man, Sittwe Township**

Some responses were common across all communities, Rohingya/Muslim and non-Muslim. Given the lack of quality healthcare available to all communities, it is not surprising that many respondents wished to see the government expand healthcare provision. Additionally, there is a clear desire among all communities for the government to allow international agencies access to displacement sites and rural areas to provide healthcare services.

> "The government and the Tatmadaw need to allow humanitarian assistance to this area and provide healthcare services for people."
>
> **- 51 year-old Rakhine man, Myebon Township**

[6] McKay, M 2019, 'The Religious Landscape in Myanmar's Rakhine State', Peaceworks, No. 149, United States Institute of Peace.

This material has been funded by UK aid from the UK government; however the views expressed do not necessarily reflect the UK government's official policies.

COAR is an independent social enterprise that supports the international community to navigate and adapt policy, programs, and projects to emerging and progressively complex, fragile, and high-risk environments. Based on knowledge of affected populations and a deep understanding of their respective political, economic, social, security, and environmental systems and stakeholders, COAR builds a blueprint for humanitarian, stabilization, early recovery, social-cohesion, resilience and development-focused interventions.