

# Gender blind:

## Rebuilding Health Systems in Conflict-Affected States – Myanmar

### CONTEXT AND CONFLICT:

Myanmar has over 130 ethnicities clustered into eight main groups, with the Bamar being the largest (60% of the total population). Other groups include: Shan (8.5%), Kayin (6.2%), Rakhine (4.5%), Mon (2.4%), Chin (2.2%), Kachin (1.4%) and Kayah (0.4%).<sup>1</sup> The diverse setting has led, in part, to decades of internal conflict since its liberation from Great Britain in 1948. In the 1960's, a parliamentary democracy was replaced by a military regime that took the country by force and plunged its population into nearly 50 years of poverty and oppression. During this time, General Ne Win and his regime altered the social, political

and economic structure of the country, perpetuating the unequal role women played in society. Years of civilian uprisings and protests resulted in deadly backlash from the regime. Eventually, a civilian government was installed in 2011 and has slowly been gaining power- most recently, with the election of State Counsellor Aung San Suu Kyi and President Htin Kyaw in 2015 with the National League for Democracy (NLD). With the advent of a democratic path, rebuilding the country and its health system began.<sup>2</sup> However, there is a long road to go as 600,000 people are still displaced within the country and nearly a quarter of the population lives in poverty.<sup>3</sup>

Conflict is still ongoing in some regions, namely between the Rohingya Muslim minority and Rakhine Buddhists. The Rohingya have been "stateless" since the 1982 Burmese Citizenship Law, when the predominately Buddhist regime denied citizenship to the population, exposing them to systematic discrimination within the country. Today, there are between 800,000 and 1,100,000 Rohingya in Myanmar, with a poverty rate of 78% in the Rakhine state, where most live. Years of intense fighting between government forces and Rohingya insurgents, now the Arakan Rohingya Salvation Army (ARSA), have made peace nearly impossible with recent events raising tensions even more. As a result, the government is pursuing "clearance operations," which has consisted of mass killings, the razing of entire villages, and huge forced displacement.<sup>4</sup> As of August 2017, it is estimated that 688,000 Rohingya have fled across the border into Cox's Bazar, Bangladesh in fear of persecution.

**Gender equality:** Myanmar is ranked 145 out of 188 countries in the Human Development Index (HDI) for 2015, a 57.4% increase since 1990, placing it within a medium human development category. Within the newly created indicator, Gender Inequality Index (GDI), Myanmar is ranked 80 out of 159 countries, compared to Cambodia and Lao People's Democratic Republic rankings of 112 and 106, respectively. This indicator evaluates gender inequalities based on three factors: reproductive health, empowerment, and economic activity. While the GDI is lower than some surrounding countries, 27% of women, compared to 20% of men, completed at least a secondary level of education.<sup>5</sup> The issue of domestic violence is still taboo and rarely discussed openly, due to the need for an appearance of harmony and social acceptance of violence as a "family matter." Even now, there is **no national data** on intimate partner violence in Myanmar. One figure, from UNFPA, reports that 70% of women who visit their "Women and Girls Centres" across the country, experience domestic violence.<sup>6</sup>

### ROHINGYA FOCUS: CURRENT ISSUES

Within Myanmar, international humanitarian aid is not being permitted into the Rakhine state, despite urgent calls for access from MSF.<sup>12</sup> Every month, thousands of Rohingya refugees pour into the neighboring countries of Bangladesh and Malaysia, Thailand, and even Indonesia. Crowded and overburdened camps provide little support to those escaping ethnic cleansing in Myanmar.<sup>16</sup> These refugees live without adequate food, water, sanitation, and healthcare. Risk of disease is rampant for measles, tetanus, diphtheria, and acute jaundice syndrome. Children are especially at risk as many never received vaccinations due to the inability of families to access care within Myanmar. Further compounding disease and unsanitary conditions, 60% of the water supply is contaminated in the Cox's Bazar camp, hosting the largest number of refugees.

The human rights of the Rohingya have been violated at every turn as the international community struggles to coordinate a response to the ongoing crisis. Protests and sanctions attempt to pressure the Myanmar government to halt their campaign, to no avail. Meanwhile, governments in Southeast Asia lack established legal frameworks to protect refugee rights, while maintaining a "principle of noninterference" among their members. In Bangladesh and Malaysia, the Rohingya refugees have no legal status or right to work. Desperate and without aid, they face further exploitation.

In November 2017, Bangladesh and Myanmar signed a deal to repatriate the Rohingya refugees, though the deal has been postponed. Details remain vague about rights that would be granted, resettlement locations, and assurance from the government that this crisis would not be repeated.<sup>17</sup>

**Health Equity:** As of 2014, life expectancy at birth for women was 69.9 years, and 63.9 years for men. The leading causes of death are related to chronic disease, such as cerebrovascular and ischemic heart disease, which is increasing as deaths from infectious disease decrease.<sup>7</sup> Women have a lower probability of death by chronic disease, associated with tobacco and alcohol consumption. Yet, more women than men are reported overweight (23.4%, compared with 13.3% of men). There is little more disaggregated data available on the general health status of men and women in Myanmar.<sup>8</sup>

As of 2016, Myanmar has a low adult HIV prevalence of 0.8%, which has decreased by 51% since 2005. However, HIV-positive pregnant women are particularly discriminated against in hospitals, thus necessitating improved outreach and prevention to vulnerable women and girls essential. In 2016, the tuberculosis mortality rate was 53 per 100,000 people, which has decreased by 54% since 2005. The under-five mortality rate in 2016 was 27.7 per 1,000 live births and the maternal mortality ratio (MMR) was 236 per 100,000 live births (in 2016).<sup>9</sup> While progress is being made in many of the health indicator categories, there remains large differences between rural (70% of population) and urban communities.

**Impact of conflict on gender roles:** During the militarization of the country, then known as Burma, traditional gender roles were perpetuated in both politics and the workforce, influencing career choices and aspirations of individuals. Ideal men were depicted as strong and ambitious, while ideal women were depicted as obedient and family-orientated. These stereotypes are still deeply entrenched within social institutions in Myanmar.<sup>10</sup>

Moving forward in time, during the civil war, men experienced the highest number of casualties in combat. However, women were victims of conflict, through sexual violence, and other human rights abuses. They also suffered from the indirect consequences of conflict, such as reduced access to clean water and health services. Women were not just victims of Myanmar's civil war; however, they have also played active roles in reconciliation and political change at the grassroots level, pushing for peace, community building, and reform. Despite their involvement at the community level, women were denied participation in initiatives towards peace at higher levels of government and their work in this area remains under acknowledged.<sup>11</sup> However, efforts are underway to increase women's participation in national and regional politics.

## INTERNATIONAL HEALTH ENGAGEMENT AND GENDER

**Humanitarian:** During the military regime in the 1990's, most foreign investment into the country, intended for health and education, was sequestered by the military to gain economic power. Moreover, humanitarian organizations are rarely allowed into the country for emergency aid. Since 2016, UNFPA has aided the health ministry in supplying low-income women in qualified hospitals with free contraceptive implants, which has been widely received across the country. To date, they have spent \$2.8 million on contraceptives and reproductive health medicine.<sup>10</sup>

## ROHINGYA FOCUS: GENDER CHALLENGES

UN Women estimates that 51% of the displaced Rohingya population in Cox's Bazar, Bangladesh are women and girls. They have experienced trauma and violence disproportionately, in addition to being a marginalized population. Sexual and gender-based violence are rampant, inflicted by both the Myanmar army and the Ethnic Rakhine population. While vastly underreported, "mass rape" is used as a weapon of war, with almost every female having witnessed or experienced this and other forms of systematic violence.<sup>18</sup> Furthermore, the cultural stigma of rape results in underreporting while post-rape care, through humanitarian assistance, is limited.

Once these refugees arrive in Bangladesh, the overcrowding and lack of access to services mean many do not receive treatment. Within the camp, most Rohingya women are without their burqa and thus, are forced to stay inside their small huts (around 4m<sup>2</sup>). Some cook food on wood-burning stoves to bring in extra income for the family. The closed huts and exhaust from cooking create a toxic environment, leading to respiratory and eye infections. Within the shared family living quarters, women build makeshift toilets and bathing areas, decreasing hygiene. Some aid organizations have developed "dignity kits" to provide women with necessities, such as soaps, clothes, scarves, menstrual hygiene products and flashlights. However, the immense demand from incoming refugees means there are not enough resources for all.

Outside their huts, the camp can be unsafe, especially at night. Many women and girls are at risk for more violence and exploitation. Women-only areas attempt to provide safe spaces, but more is needed.<sup>19</sup>

**Health System:** Decades of conflict and the economic effects of conflict and sanctions have left the health system in disarray and unable to support the population. The development project, "People Centered Development," is a government-backed programme that focuses on the average family's access to basic necessities, as well as health and education facilities. This project aims to strengthen democracy and contribute to sustainable development through health, research, and access to services. It has a focus on gender equity and ethnicity. In order to rebuild effective health services, a nationalized health information system is being developed through pilot testing at the university level. This research initiative has a special focus on women, particularly related to maternal and child mortality and morbidity.<sup>13</sup> Since 2004, there has also been a Strategic Plan for Reproductive Health supported by the United Nations Population Fund (UNFPA). As part of this plan, the government initiated a policy in 2014 to provide delivery at health care facility free of charge, to reduce maternal and infant mortality rates.<sup>1</sup>

**General gender programming:** A 2016 UN Women report, "Gender Equality and Women's Rights in Myanmar" suggested that the reform agenda of the new government does not specifically address gender equality and women's rights nor adequately respond to inequality. However, the Ministry of Social Welfare, Relief and Resettlement has adopted the National Strategic Plan for the Advancement of Women 2013–2022 based on the Beijing Platform for Action. The head of the Ministry, Win Myat Aye, has taken responsibility for implementing women's advancement and empowerment through the plan.<sup>8</sup>

## IS THE HEALTH SYSTEM IN MYANMAR GENDER EQUITABLE?

In order to review whether the health system is gender equitable, we assessed the country's progress against the framework of WHO's six health system building blocks:

### 1) Health service delivery

Overall, little is known surrounding the non-epidemiological gender dimensions that influence health outcomes in Myanmar. However, MMR and child mortality rates are important proxy indicators for measuring overall health outcomes, as many women require ongoing and repeated access to reproductive health services over their lifetime. The high MMR in Myanmar is indicative of difficulties in accessing services, both socio-economically and culturally, and is also influenced by high rates of unsafe abortion (abortion is illegal). Compounding this issue, 1.8 million women of reproductive age do not have access to modern contraceptive methods. Additionally, many women do not receive the needed pre- and post-natal care because they cannot afford it and services are geographically inaccessible and limited, especially in villages. Women are restricted in their ability to travel outside the village as public transport in rural areas is nonexistent or too expensive and requires most to travel long distances by foot. Even today, around 90% of women are reported to have births at home, yet around 84% are attended by skilled health personnel.<sup>9,10</sup> Overall, the weak health system affects women and girls more due to their caregiving roles in society.

Ethnicity also influences health outcomes in these remote regions, where all health indicators are the lowest among these communities compared to more urban provinces of Myanmar. Furthermore, slow-changing traditional ideas and conservative gender norms are still prevalent, further affecting ethnic minorities, who predominately reside in these rural communities. Women have limited ability to make their own decisions regarding their health and are seen as caregivers- the topic of reproductive health, even with a doctor, is taboo. Finally, many adolescent girls and unmarried women report difficulties in and reluctance to accessing family planning services due to social stigma related to ideas around women's sexuality.<sup>8</sup>

### 2) Health workforce

There is no Ministry of Health (MoH) central database for the health workforce; this is in process for medical doctors, but not for those from other medical professions. From 2006 to 2014, health workers (doctors, nurses, midwives) increased from 1.27 to 1.61 per 1000 population, with urban settings constituting the majority of this increase. While improving, the workforce to population ratio is still below the global standard of 2.28 per 1000. Related to reproductive health specifically, the number of births attended by health workers increased from 56% in 1997 to 78% in 2010.<sup>1,14</sup>

### 3) Health information systems (HIS)

Myanmar's HIS is composed of hospital, public health, human resources, and logistical information. It began with a Medical Records System, which collected information on morbidity and mortality in public hospitals. The system functions as a minimum essential data set to reduce the workload related to data management, which is still collected manually. While an electronic system has been proposed, logistical challenges related to electricity and Internet availability remain, as well as data sensitivity concerns. A 2006 health system assessment revealed that the current system is strong enough to report on indicators accurately. However, there remains a need for policy support and resources, as well as improved dissemination of information. Data which is disaggregated by sex, are available for public hospitals, but not in private facilities.<sup>1</sup> Within private hospitals, there is limited research and data collection available, making evidence-based policy change even more challenging.

### 4) Health system financing

Between 2001 and 2011, Myanmar invested just 2% of its GDP on health expenditure, the lowest among countries in the WHO South-East Asia and Western Pacific Regions. The MoH focused most of its allocated budget on tertiary care hospitals as opposed to primary healthcare. Currently, there is no state-subsidized universal health coverage in Myanmar. In the 1990's, health financing reform resulted in household out-of-pocket (OOP) payments being the dominant source of financing for healthcare costs. This continues to affect women's access to health care, as most have little control over the household finances. As of 2011, around 79% of health expenditure in Myanmar were OOP, having decreased from 90% since 2005. However, a Social Security System, put in place in 2012, has gradually been expanding to cover public- and private-sector employees. This care will include maternity leave, maternal care, and family assistance. Despite these advances, there is still no system in place for the poor or informal sector, affecting many women in rural areas.<sup>1</sup>

### 5) Medical products and technologies

Around 10% of the total national pharmaceutical expenditure is spent on purchases from the Myanmar Pharmaceutical Industry (MPI), which produces pharmaceutical products and medical devices in five national factories. Those medicines and products not available from the national system are purchased from private companies by the central medical store depot (CMSD). As a supplement to the government budget, UN agencies and international NGOs supply medicine and support the distribution process within the country. However, there is a need for more space in the CMSD's distribution warehouses for products, resulting from the 20-fold increase in the health budget in 2012. Another issue resulting from this budgetary increase is a lack of professional staff for efficient pharmaceutical management. Despite these challenges, people who can afford to, can generally access pharmaceutical products through private companies.

### 6) Leadership and governance:

Myanmar has ratified and endorsed the major international conventions and agreements on gender equality and women and children's rights. Yet, while the country's Constitution (2008) guarantees all people equal rights (Section 347) and does not discriminate based on sex (Section 348), there are still sections that use gender discriminatory language. It includes references

to women principally as mothers and makes the statement “nothing in this section shall prevent appointment of men to positions that are naturally suitable for men only,” regarding appointments to government posts.<sup>15</sup> This is reflected in UNDP’s Human Development Report on Myanmar, where just 13% of parliamentary seats are held by women.<sup>5</sup> Since the 2015 elections, a new Constitution has been put forward, which appears to promote women’s reproductive rights and gender equality more than before.

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