A Clinic on the Edge of Genocide

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In 1962, military leaders in Burma (now called Myanmar) devised laws that forbade granting citizenship to a minority group called the Rohingyas.[1] Despite historical records that suggest Rohingyas lived in Burma even in the early 1800s during British Colonial rule,[2] postcolonial governments, military juntas, and now even the proclaimed democratic state of Myanmar has refused to grant Rohingyas the right of citizenship. Too complicated to discuss in this article, the history of the Rohingyas is complex. Ibrahim[1] aptly describes the historical arguments for and against the existence of the Rohingyas as a minority group. He also makes it clear that by depriving the Rohingyas of citizenship, of education, of health care, and of basic services, the government in Myanmar has instigated genocide against the Rohingyas. The state-sponsored discrimination against the Rohingyas accelerated at a horrendous pace in August 2017. This pace, highlighted by mass rape; arson of villages; the slaughter of women, men, and children; withholding of citizenship; and prevention of marriage—all focused on one specific group of people—amounts to genocide.[3] Scholars, politicians, and this author share this opinion. As the genocidal acts against Jewish people in Europe, Armenians in Turkey, and Tutsis in Rwanda fell on deafened global ears, so too, the Rohingyas have faced a silent destruction. At the time of writing this article, the global community has asserted "ethnic cleansing" is occurring in Myanmar; however, no formal body has yet to call it "genocide." According to international law, by naming an act "genocide" would require an active response by the International Criminal Court.[4] This response would save lives.

(See Figs. 1–6.)

This article attempts to describe the current situation for Rohingyas who have escaped Myanmar, who have evaded capture and have been placed in the fishing slave trade by Thai fishing companies,[5] and who have survived the journey to neighboring Bangladesh. It will focus on health care delivery in a refugee camp for a group of people—many of whom have been deprived the right to health care for their entire lives—as it addresses the interpretation of "emergency" in this "acute--on-chronic" setting. Finally, I hope to elucidate a ray of hope for the survivors of this genocide while raising awareness among nursing communities in the United States and other resource-wealthy countries.

Acute-on-Chronic Setting

Similar to how authors Farmer et al[6] describe the catastrophic 2010 earthquake in Haiti as an "acute--on-chronic" phenomenon, in which an already-weakened state undergoes radical destruction from a single event, so too is the situation in Rohingya refugee camps in southern Bangladesh. The deprivation of access to basic health care alone[1] is enough to establish a chronic state of community-based illness with increased rates of morbidity and mortality. The diphtheria outbreak—which, as of early January 2018, saw more than 3,000 suspected cases and 30 reported deaths[7]—is a key example of acute-on-chronic. With regard to violence, the slaughter spurred by the Burmese government that has resulted in the forced migration of at least 650,000 people from August 2017, until December 2017[8] is another example of this phenomenon. As seen in contexts, like the Ebola outbreak that spanned from 2013 to 2016 in West Africa, communities affected by disaster that do not have an effective health care system in place immediately face dire circumstances.

Clinical Care

From late December 2017, until mid-January 2018, I volunteered with a nongovernmental organization (NGO) called MedGlobal. (It should be noted that my views expressed in this article are not representative of MedGlobal's organizational stance.) The clinic in which I worked was situated between the Myanmar border and a vast refugee camp in the Balukhali region of southern Bangladesh. NGOs in Bangladesh have struggled to bring supplies and adequate care to Rohingyas since the influx of refugees in August 2017. Bureaucratic "red tape" has been one of many factors limiting NGO access into the sprawling camps. Our clinic relied on the generosity of donors from resource wealthy countries such as Canada, the UK, and the

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FIGURE 1

One last standing tree at the edge of a Rohinga camp. Below this tree children play and fly kites. (Photo credit: Cunningham).

US. Volunteers, who generally joined the team for 1 week, brought with them oversized suitcases filled with medications and clinical supplies. Many volunteers also brought cash with which the team used to purchase medications locally: a sustainable model that also supports the local economy. The clinic, which was run by 2 nurse practitioners

FIGURE 2

Rohingya camp south of Cox's Bazar; estimated 800,000 people living there. (Photo credit: Dr. Aminul Islam).