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Letter to Editor

Calling Upon the International Community to Rise against the Atrocities in Myanmar by the Myanmar Military Janta

Mamun Al Mahtab[1]*, Kamrul Hasan Khan[2], A B M Faroque[3], Sitesh Chandra Bachar[4], Nuzhat Choudhury[5], Md. Abdur Rahim[6], Mohammad Helal Uddin[7], Sheikh Mohammad Noor-E-Alam[1], Musarrat Mahtab[8] and Sheikh Mohammad Fazle Akbar[9]

[1]*Department of Hepatology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh*

[2]*Department of Pathology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh*

[3]*Biomedical Research Centre, University of Dhaka, Dhaka, Bangladesh*

[4]*Department of Pharmacy, University of Dhaka, Dhaka, Bangladesh*

[5]*Department of Ophthalmology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh*

[6]*Department of Hepatology, Abdul Malek Ukil Medical College, Noakhali, Bangladesh*

[7]*Forum for the Study of the Liver, Dhaka, Bangladesh*

[8]*Department of Biochemistry and Biotechnology, North South University, Dhaka, Bangladesh*

[9]*Department of Gastroenterology and Metabology, Ehime University Graduate School of Medicine, Ehime, Japan*

***Corresponding Author:** Mamun Al Mahtab, Department of Hepatology, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh.

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Around 146 BC, the Battle of Carthage [1] (The Third Punic War) reminds us the documented event of ethnic cleansing campaigns of the Roman Empire. More than 2000 years have passed after the Battle of Carthage. However, the trend and tendency of the so-called supremacy of majority class over the minority regarding ethnic cleansing are still going on. Although political, economic, religious grouping and demand of racial superiority have always influenced the concept of this inhumane mentality, the impact of this on health care delivery system has poorly been addressed.

During the last several years, Myanmar has stepped to the path of ethnic cleansing by killing, torturing, raping and forcibly displacing millions of the Rakhine population from Myanmar to Bangladesh [2]. There remain two significant concerns prevailing in these situations. In 21st century, usually, a small bulk of autocratic population take the lead to accomplish ethnic cleansing, whereas, rest of the people usually remains inert at the hand of military or rouge politicians.

The International Court of Justice (ICJ) in The Hague, Netherlands, has found the Myanmar military regime guilty of crimes against humanity against the ethnic Rohingyas in recent years [3]. On the other hand, on March 10, 2021, the United Nations Security Council has unanimously condemned the recent inhuman atrocities committed by the military of Myanmar against the peace-loving, democratic people of the country [4].

Most of the people of Myanmar recently fell victim to another unique autocracy by their establishments. And this is unfolding at a time when Myanmar is also affected by COVID-19. As citizens and

physicians of South Asia, we stand and write in solidarity with our fellow physicians and citizens of our neighboring Myanmar, across their race, religion and political belief. We have closely watched the developments in the recent days and over the years in this once-prosperous country with great pain and concern.

Such brutal acts had widespread implications, including on the healthcare delivery system of the country. United Nations Resolution 2286 protects all healthcare workers serving humanity in conflict zones [5]. The recent acts by the Myanmar forces are a clear violation to this resolution by the world body. We have learned from the media and personal communication with our colleagues in Myanmar that they are under constant threat and oppression, which obstructs the access of Myanmar citizens to their fundamental right to 'health for all'.

Earlier, we have seen more than a million minority Rohingya citizens of Myanmar being displaced from their homeland in the Rakhine state of Myanmar and forced to seek refuge across the international border in Bangladesh. Some of us witness the atrocities committed against the Rohingya people through our direct interactions with these displaced citizens of Myanmar at their refugee camps in Kutupalong and Balukhali in Cox's Bazar district of Bangladesh [6]. The Rohingyas have been denied basic healthcare for a long time, and this, combined with their recent forced relocation, has had devastating health consequences. As shown by the fact that they are now highly vulnerable in terms of health and have one of the largest hepatitis C virus burdens of any population on the planet [7].

We join our colleagues [8] in calling upon the international community to denounce the Myanmar junta and refrain them from committing further criminal offenses against humanity, including that against innocent healthcare providers.

It is natural to ask why we, the doctors and allied health professionals of Bangladesh, would be vocal at this moment as the brutality of Myanmar has been recognized by the UN and the ICC, and all are moving forward to resolve these issues. We are keenly following these events as history taught something about health concerns in situations prevailing in Myanmar.

We have lessons to learn from the SMALLPOX eradication program. Smallpox was an infectious disease caused by one of two virus variants, Variola major and Variola minor [9]. The risk of death after contracting the disease was about 30%, with higher rates among babies [10]. In the early 1950s, an estimated 50 million cases of smallpox occurred in the world each year. By the end of 1975, smallpox persisted only in the Horn of Africa. Conditions were challenging in Ethiopia and Somalia, where there were few roads. Civil war, famine, and refugees made the task even more difficult. Intensive surveillance, containment and vaccination program were undertaken in these countries in early and mid-1977, under Australian microbiologist Frank Fenner.

Between January 1, 1972, and December 31, 1975, 225,000 smallpox cases and 45,000 smallpox deaths occurred. The last naturally occurring case of the more deadly *Variola major* had been detected in October 1975 in a three-year-old Bangladeshi girl, Rahima Banu [11,12]. However, unnecessary death and thousands of cases due to smallpox could be contained in Bangladesh. The genocide and ethnic cleansing by the Pakistani army were not taken place in occupied Bangladesh in 1971 [13].

It is mandatory to actively interfere with the activities of Army Janta of Myanmar, also from public health point of view. The international community must act immediately and new resolutions should be sponsored at the UN for active intervention against COVID-19 and hepatitis C with other infectious diseases [14]. Bangladesh has also a legal right to demand this as we have been harboring about 1 million Rohingya refuges for years and decades and encountering hepatitis C virus infection, human immune-deficiency virus infection and COVID patients.

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