

THE MSF SPEAKING OUT CASE STUDIES

MSF AND THE ROHINGYA

(1992-2014)

LAURENCE BINET



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IN THE COLLECTION, “MSF SPEAKING OUT”

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FOREWORD

This publication is part of the “Médecins Sans Frontières Speaking Out” case studies series prepared in response to the wish expressed in the 90s by the MSF International Council to provide the movement with literature on MSF *témoignage* (advocacy).

The idea was to create a reference document that would be straightforward and accessible to all and help volunteers understand and adopt the organisation’s culture of speaking out.

It was not to be an ideological manual or a set of guidelines. *Témoignage* cannot be reduced to a mechanical application of rules and procedures as it involves an understanding of the dilemmas inherent in every instance of humanitarian action.

The International Council assigned the project to a director of studies, who in turn works with an editorial committee composed of MSF representatives chosen by the International Board for their experience and expertise. They serve in their capacity as individuals and do not represent their national sections.

Faced with the difficulty of defining the term *témoignage*, the editorial committee focuses the series on case studies in which speaking out posed a dilemma for MSF and thus meant taking a risk.

Key information sources – MSF volunteers’ written and oral recollections – are reconstructed by highlighting documents from the period concerned and interviewing the main actors.

The individuals interviewed speak in the language they choose. They offer both their account of events and their assessment of MSF’s response. The interviews are recorded and transcribed.

Document searches are conducted in the sections’ archives and as far as possible, in media archives.

The research is constrained by practical and financial issues, including locating interviewees and securing their agreement and determining the existence, quality, and quantity of archived materials.

The main text exposes events in chronological order. It includes excerpts from documents and interviews, linked by brief introductions and transitional passages. We rely on document extracts to establish the facts as MSF described and perceived them at the time. When documentation is missing, interviews sometimes fill the gaps. These accounts also provide a human perspective on the events and insight into the key players’ analyses.

This methodology aims at establishing the facts and enables the debates and dilemmas encountered to be recounted without pre-judging the quality of the decisions made.

Preceding the main texts collected, the reader will find a map, a list of abbreviations and an introduction that lays out the context of MSF’s public statements and the key dilemmas they sought to address.

In addition, a detailed chronology reconstructs MSF’s actions and public statements in regional and international news reports of the period.

Each case study is available in English and in French.¹

These case studies are essentially designed as an educational tool. Some are now being used as the basis for podcasts and training modules. To reinforce this educational objective, access to all this material is available on the msf.org/speakingout website, and on Google books.

Enjoy your reading !

The SOCS Editorial Committee.
September 2023

1. Document excerpts and interviews have been translated into both languages

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PEOPLE INTERVIEWED AND THEIR POSITION AT THE TIME OF THE EVENTS

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MSF OCG, Head of Mission in Myanmar, January 2013-January 2015 (in English)

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MSF France, President, 1982-1994 (in French)

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MSF OCA, Operational Director [Programme Manager], 2004-2006; Director of Operations, 2006-2010; General Director, 2010-2017 (in English)

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MSF Holland, Bangladesh Programme Manager, 1993-1998 (in English)

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MSF OCA, Programme Coordinator for East Rakhine, January 2013-January 2014, Member of MSF Holland Association, MSF Nordic Association and Representative of MSF Nordic to IGA in 2015 (in English)

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MSF France, Head of Mission in Bangladesh, 1991-1992 (in French)

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MSF OCA /MSF OCG, Myanmar Communications Manager, April 2013-January 2015 (in English)

MSF France

Staff member in Myanmar, 2001-2006 (In English)

MSF OCA

Emergency Coordinator in Rakhine, Myanmar, November 2012-April 2013 and in June 2013; Operational Advisor for Myanmar from December 2014 (in English)

MSF OCA

Humanitarian Affairs Advisor, 2004-2007 (in English)

MSF OCA

Staff Member in Myanmar, 2003-2014 (in English)

P

MSF Holland, Logistician and Administrator in Bangladesh, 1992-1993 (in English)

R

MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (in English)

S

MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (translated from Rohingya in English)

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MSF OCA, Head of OSCAR (Operational Support in Communication Advocacy and Reflection) 2011-2016 (in English)

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MSF OCG, Project Coordinator in Rakhine State, December 2013-September 2014 (in English)

Dr Sidney Wong

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X.

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Y.

Former MSF staff member in Myanmar (In English)

Z.

MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (translated from Rohingya in English)

ABBREVIATIONS

ABC	Australian Broadcast Corporation
ACF	Action Contre la Faim (Action Against Hunger)
AFP	Agence France Presse
AI	Amnesty International
AMI	Aide Médicale Internationale
AP	Annual plan
AP	Associated Press
ARSA	Arakan Rohingya Salvation Army
ART/ARV	Anti-Retroviral Treatments
ASEAN	Association of South East Asian Nations
ASSK	Aung San Suu Kyi
AZG	Artsen Zonder Grenzen (Médecins Sans Frontières)
BBC	British Broadcast Corporation
BCN	Burma Centrum Nederland
BGD/BD	Bangladesh
BPRM	Bureau of Population, Refugees and Migration (USA)
BRANA	Burmese Rohingya Association of North America
CAME	MSF Access to Essential Medicines Campaign
CCSDPT	Coordination Committee for Displaced Persons in Thailand
CCTV	China Central Television
CERF	Central Emergency Response Fund (United Nations)
CHW	Community Health Worker
CIC	Camp-In-Charge
CM	Country Manager
CM	Chief Minister (Rakhine)
CMT	Coordination Management Team
CNN	Cable News Network
CXB	Cox's Bazar
DC	District Commissioner (Union of Myanmar)
DC	Washington District of Columbia
DCYT	Du Chee Yar Tan
DFID	Department for International Development (United Kingdom)

(DG) DEVCO	European Commission Directorate-General for International Cooperation and Development
DirOp	Director of Operations
DoS	Department of State (USA)
DVB	Democratic Voice Burma
ECC	Emergency Coordination Committee (Rakhine State)
ECHO	European Commission Humanitarian (Aid) Office
EEC	European Economic Community
EOP	Executive Office of the President (USA)
EPI	Expanded Program on Immunisation
ESD	Emergency Situation Desk
EU	European Union
EVI	Extremely Vulnerable Individual
Ex Com	Executive Committee
FAO	Food and Agriculture Organization (United Nations)
GAM	Global Acute Malnutrition
GD	General Director
GoB	Government of Bangladesh
GoUM/GoM	Government of Myanmar
HAA	Humanitarian Affairs Advisor
HAD	MSF Holland Humanitarian Affairs Department
HAO	Humanitarian Affairs Officer
HART	MSF International Humanitarian Advocacy and Representation Team
HE	Health Education
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrom
HK	Hong Kong
(D)HoM	(Deputy)Head of Mission
HPN	Humanitarian Practice Network
HQ	Headquarters
HR	Human Resources
HR	Human Rights
HRW	Human Rights Watch
IB	MSF International Board
ICG	International Crisis Group
ICRC	International Committee of the Red Cross

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ICVA	International Council of Voluntary Agencies
IDP	Internally Displaced Person
IHL	International Humanitarian Law
IIRO	International Islamic Relief Organisation
IMPD	Immigration and Manpower Department (Union of Myanmar)
IO	International organisation
IO	International Office (MSF)
IPD	In Patient Department
IRIN	Integrated Regional Information Networks
ISOC	Internal Security Operation Command (Thailand)
IVDU	Intravenous Drugs User
M&E	Monitoring and Evaluation
MCHC	Mother and Child Health Care
MD	Medical Doctor
MDMR	Ministry of Disaster Management and Relief (Bangladesh)
MedCo	Medical Coordinator
MGD	Maungdaw
MHAA	Myanmar Health Aid Association]
MM	Myanmar
MNHRC	Myanmar National Human Rights Commission
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoU	Memorandum of understanding
MP	Member of Parliament
MRC	Mekong River Commission
MSF	Médecins Sans Frontières
MSF CH	Médecins Sans Frontières Switzerland
MSF F	Médecins Sans Frontières France
MSF H/MSF NL	Médecins Sans Frontières Holland
MSF UK	Médecins Sans Frontières United Kingdom
MSF OCA	Médecins Sans Frontières Operational Centre Amsterdam
MSF OCB	Médecins Sans Frontières Operational Centre Brussels
MSF OCG	Médecins Sans Frontières Operational Centre Geneva
MSF OCP	Médecins Sans Frontières Operational Centre Paris
MSM	Men having Sex with Men
MUAC	Middle Upper Arm Circumference

NLD	National League for Democracy (Union of Myanmar)
(I)NGO	(International) Non Governmental Organisation
NPW	Naypyidaw
NS	National Staff
NY	New York
OD	Operations Department or Operational Director
ODI	Overseas Development Institute
OHCHR	Office of the High Commissioner for Human Rights (United Nations)
OIC	Organisation of Islamic Cooperation
OM	Operation Manager
OPLO	Operational Liaison Officer
OPSP	MSF Operational Platform
ORS	Oral Rehydration Solution
OSCAR	Operational Support Communications, Advocacy, Reflection
PC	Project Coordinator
PHC	Primary Health Care
PHD	Public Health Department
PHR	Physicians for Human Rights
PLWH/PHAS	People living with HIV/AIDS
PM	Prime Minister
PR	Press Release
PSP	Populations en Situation Précaire / Population in Precarious Situation (MSF training)
PSR	Press Scrutiny and Registration Division (Union of Myanmar)
RC/HC	Resident coordinator/Humanitarian coordinator (United Nations)
RFA	Radio Free Asia
RFI	Radio France International
RIO	Regional Information Officer
RNDP	Rakhine Nationalities Development Party
RRT	Rapid Response Team
(N/E)RS	(Northern/Eastern) Rakhine State
RSG	Rakhine State Government
RSO	Rohingya Solidarity Organisation
SAM	Severe Acute Malnutrition
SCF	Save the Children Fund
SGBV	Sexual and Gender Based Violence

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SGH	Sittwe General Hospital
SHD	State Health Department/Director (Union of Myanmar)
SLORC	State Law and Order Restoration Party (Union of Myanmar)
STI	Sexually Transmitted Infection
STW	Sittwe
TA	Township Administrator (Union of Myanmar)
TAs	Travel Authorisations
(MDR) TB	(Multi Drug Resistant) Tuberculosis
TBA	Traditional Birth Attendant
TFC	Therapeutic Feeding Centre
TMO	Township Medical Officer (Union of Myanmar)
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programm
UNFPA	United Nation Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USDA	Union Solidarity and Development Association
USDP	United Social Democratic Party (Union of Myanmar)
USG	Under Secretary General (United Nations)
VOA	Voice of America
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
WSJ	Wall Street Journal

INTRODUCTION

Please note: we are using 'Burma' and 'Burmese' until 1989 when the official names changed. From 1989 on, we are using 'Myanmar' and 'Myanmarese.'

The Rohingya people live in northern Rakhine state (formerly Arakan), located in western coastal Union of Myanmar (formerly Union of Burma) bordering Bangladesh to the north. The stateless Rohingya are predominately an Indo-Aryan Muslim¹ minority, in a majority-Buddhist country.

Their origins are controversial. Historians attest to Rohingya presence in Myanmar since the eighth century. Those who oppose Rohingya citizenship in the Myanmar nation consider that they migrated from East Bengal at the time of British colonisation. However, Rohingya citizenship has always been contested, often violently. These contestations come from both the ruling parties and the population, particularly from majority non-Rohingya neighbours in Rakhine state.

Since the late 70s, the Rohingya have fled persecution and violence to seek refuge in Bangladesh. Although population figures are unknown, an estimated 900,000 Rohingya currently reside in Bangladesh, leaving approximately 600,000 in Myanmar².

BANGLADESH 1990S

In 1992, a new wave of repression in Myanmar led to an exodus of more than 250,000 Rohingya to Bangladesh. Since then, the Dutch and French sections of MSF provided medical assistance to the Rohingya refugees in the Cox's Bazar camps in Bangladesh. In 1997, MSF France closed operations after repatriation of most of the refugees living in the camp where they worked. Only MSF Holland remained.

Throughout the 1990s, MSF worked mostly through diplomatic 'behind closed doors' channels, to advocate for the Rohingya refugees' plight with political stakeholders,

However, sometimes MSF spoke out publicly against various UNHCR, Bangladeshi, and Myanmarese agreements. These agreements led to waves of forced repatriation to Myanmar. The advocacy primarily targeted the UNHCR and its failure to comply with the mandate to protect refugees.

- **On 26 January 1993**, MSF France publicly released a report on the Rohingya's forced repatriation to Myanmar which described the UNHCR's impediments.
- **On 1 May 1995**, MSF France and MSF Holland publicly released a joint survey with a statement expressing repatriation concerns for the Rohingya refugees and the manner in which UNHCR was handling the crisis. MSF recommended that UNHCR cease repatriation activities until refugees could be provided with all available information on the situation in Myanmar upon their return. Additionally, MSF asked

1. There are Rohingya Christian and Hindu minorities.

2. Human Rights Watch Rohingya population estimates, <https://www.hrw.org/tag/rohingya>

UNHCR to ensure that repatriation was free from any constraints.

Nonetheless, once in Rakhine state, the Rohingya received no safeguards for their security and were not given an official status. Instead, the returning Rohingya were considered 'illegal foreigners.' To date, they maintain a 'non-citizen' status.

MYANMAR 1993 - 2006

In 1993, MSF Holland/AZG³ opened their first programme of basic healthcare in the Yangon townships. From 1994, under the leadership of the head of mission and medical coordinator, they opened and developed malaria programmes in Rakhine state. By October 1998, programmes were authorised for extension to the extreme north of Rakhine state, where the repatriated Rohingya refugees from Bangladesh were resettled. At the same time, MSF Holland/AZG began to implement HIV/AIDS awareness programmes in Yangon, and in Kachin and Rakhine states. MSF Holland/AZG began progressively providing patients with anti-retroviral treatments (ART) in several regions of Myanmar.

MSF Holland/AZG's operational research activities on malaria treatment failures and drug resistance were the subject of medical publications that encouraged changes in national treatment protocols. Data collection on transmission, prevention, and treatment of HIV/AIDS helped to revise the regime's denial of epidemic's existence and scale on national territory.

The MSF Holland/AZG teams in Rakhine collected incident data related to the persecution of Rohingya. These data were gathered in a database called "Club-Med" and were shared with human rights organisations. However, MSF never publicly released the "Club-Med" data to support any advocacy on the Rohingya crisis.

During this period, most advocacy activities were 'silent', meaning MSF Holland/AZG worked outside of the public or media's eye, advocating to foreign embassies and UN agencies in the region. While MSF Holland/AZG mostly aimed at securing increased access to extend medical activities, they also warned against consequences of the UNHCR's efforts to disengage from Rakhine.

MSF Holland/AZG's public silence was largely due to the head of mission's strident opposition to any public positioning in Myanmar for fear that the authorities would limit or eliminate access for the organisation. If MSF Holland/AZG's access were to be restricted, the ability to witness the Rohingya's plight would be lost. MSF Holland/AZG was often the only outside organisation working in Rakhine. The head of mission's position was not challenged by the MSF Holland/AZG headquarters, apart from the Humanitarian Affairs Department (HAD) in the early 2000s, which had little impact due to a concurrent hardening of the Myanmar regime toward the Rohingya from 2004. For internal memos on advocacy strategy, the utmost caution was applied to describe the persecution of the Rohingya. The words 'ethnic cleansing' or even 'stateless' were not allowed.

3. In Myanmar, MSF Holland was registered under the Dutch abbreviation 'AZG' (Artsen Zonder Grenzen) in order to avoid confusion with MSF France, whose support to the Karen refugees since the mid-1980s on the Thailand/Myanmar border, was unwelcomed by the Myanmar regime.

The programmes' scale, which made thousands of patients dependent on MSF Holland/AZG, placed limitations on the organisation's ability to speak out. MSF Holland/AZG's operations department questioned this predicament and the ongoing programme expansion. Efforts to impose a programme freeze were disregarded by the field.

Meanwhile, after an unsuccessful attempt to open programmes in Myanmar between 1994 and 1996, MSF France managed to open malaria programmes in the Mon and Kayah states in 2001. After five years, they publicly denounced "*unacceptable conditions imposed by the authorities on how to provide relief to people living in war-affected areas*" and left in March 2006.

MSF Switzerland continued to develop malaria and HIV/AIDS programmes opened in 2000 and remained in Myanmar.

BANGLADESH 2003 - 2012

By 2003, the Bangladeshi authorities forced MSF Holland to leave the Teknaf refugee camp where they assisted unregistered Rohingya refugees for several years. At the same time, MSF Holland challenged the UNHCR to uphold the protection mandate and fundamental respect for the rights of the refugees.

In 2006, the MSF OCA (Operational Centre Amsterdam), which now brought together the operational resources of MSF Holland, MSF Canada, MSF Germany and MSF United Kingdom, opened programmes for unregistered refugees in the Tal makeshift Camp.

In late 2006, in MSF OCA's headquarters, a new team was in charge of the Bangladesh and Myanmar programme management, now regrouped under the same portfolio. This team decided to circumvent the inherent advocacy difficulties inside Myanmar by publicly advocating for the Rohingya from Bangladesh.

In 2007, a series of MSF OCA press releases and website posts described the dire living conditions of the unregistered Rohingya refugees in the Tal makeshift camp. Eventually, in 2008, a provisional piece of land in Leda Bazar (Cox's Bazar) was allocated by the Bangladeshi government for tens of thousands of unregistered Rohingya to settle.

In 2009 and 2010, the unregistered Rohingya in the Kutupalong camps suffered several waves of crackdowns from local authorities and from the Bangladeshi population. These events led MSF OCA to publicly speak out. In February 2010, MSF OCA publicly released a report entitled, "*Violent crackdown fuels humanitarian crisis for unrecognised Rohingya refugees in Bangladesh.*" This report asked the international community to "*support the government of Bangladesh and UNHCR to adopt measures to guarantee the unregistered Rohingya's lasting dignity and well-being while they remain in Bangladesh.*" The report raised significant media interest and focused the international spotlight on the plight of the Rohingya. This effort resulted in decreasing arrests and violence towards the Rohingya in Bangladesh. However, the MSF OCA teams experienced increased government bureaucracy, monitoring, and investigation of their activities in Kutupalong camps. Further, the Bangladeshi government refused to grant MSF OCA official registration.

In July 2012, the Bangladeshi authorities ordered MSF OCA to cease 'unregistered' activities. Subsequently, a combination of cautious public and bilateral advocacy toward key international actors resulted in deescalating the situation.

MYANMAR 2007 - 2014

In 2007, MSF OCA decided to focus advocacy regarding Myanmar on support to two populations suffering the humanitarian consequences of state-sponsored discrimination, repression, and lack of access to healthcare: the Rohingya and people living with HIV/AIDS. For this purpose, systematic data collection and testimony gathering on discrimination and stigmatisation of those living with HIV/AIDS was launched. The "Club-Med" database, previously focused on Rakhine state alone, was reorganised and expanded to include abuses and violence related to healthcare access.

Advocacy activities regarding HIV/AIDS patients were essentially aimed at pushing the Myanmar Ministry of Health and international donors to scale up ART provision. The mid-term objective was to decrease MSF's importance in Myanmar's ART provision and therefore, reduce MSF's patient load. In late 2007, a briefing paper entitled, "*The ART of living in Myanmar*" was widely circulated to local and international stakeholders but was not publicly released.

In May 2008, Cyclone Nargis devastated western Myanmar. MSF operational centres intervened under MSF OCA coordination after an MSF campaign of diplomatic and public advocacy. The campaign was launched to convince the Myanmar regime to open the country to aid in the aftermath of the cyclone. Subsequently, a considerable influx of aid was permitted.

From 2010, the government's democratic political and economic reforms were praised by the international community, which triggered an explosion of media and social media. The population was unaccustomed to freedom of expression. The newly accessed social media facilitated the rise of community tensions, particularly between Muslims and Buddhists in Rakhine. Social media fuelled implementation of hate campaigns and disinformation towards international non-governmental organisations (INGO), particularly towards MSF, which was accused of Rohingya bias by Rakhine radicals. MSF procrastinated in responding.

Bilateral advocacy for the Rohingya was strengthened and diversified with the help of the MSF International humanitarian advocacy and representation team (HART). From late 2011, an MSF OCA briefing paper entitled "*Fatal policy: How the Rohingya suffer the consequences of statelessness*," was confidentially circulated. This paper was based on a nutritional survey in the Rohingya refugee camps in Bangladesh and on an in-depth survey on reproductive health among Rohingya in Rakhine state. It was recognised as unique, unparalleled, and useful in linking the Rohingya health status directly to their persecution.

In June 2012, inter-communal violence erupted in Rakhine, resulting in the displacement of thousands of people. For security reasons, MSF OCA drastically reduced activities. From September 2012, MSF teams could only work in direct collaboration with Myanmar Ministry of Health teams, including in camps and villages where Rohingya were confined and segregated. To prove its impartiality, MSF OCA opened clinics for the larger non-Rohingya Rakhine population. These clinics were separate from those for vulnerable Rohingya. A year later, in September 2013, MSF OCA opened a primary health care program in Rakhine, also with separate clinics, similar to MSF OCA's approach. MSF OCA teams were definitively evacuated in June 2014 following anti-INGO sentiment and direct attacks on organisations.

In 2012 and 2013, as waves of violence flashed regularly, most of MSF OCA's advocacy activities concentrated on regaining lost access due to insecurity. In addition to regular, bilateral advocacy, MSF OCA issued several press releases calling for the victims' access to healthcare with a focus on the humanitarian consequences on the population's health.

In late 2012, several brainstorming sessions on the Rohingya situation were organised to explore MSF OCA's positioning surrounding ethical dilemmas and advocacy strategies. A proposed strategy based on "red flags" emerged. In 2013, MSF OCA and OCG created a communications manager position in Myanmar to better coordinate communication and social media strategies. On 7 February 2013, MSF OCA held a press conference in Yangon, issuing a press release calling for "greater protection for vulnerable communities and threatened staff" in Rakhine. In late 2013, the MSF OCA Myanmar country management team was interviewed by the Myanmar national media. The team was direct about the problems for Muslims living in Rakhine and focused on denial of hospital access.

The September 2013 publication of an in depth-report entitled "*From bad to worse: humanitarian crisis in segregation in Rakhine state,*" was postponed due to issues linked to two MSF staff detained in Myanmar jails since June 2012. In all, six staff members were detained but four were previously released. On 3 January 2014, MSF OCA and MSF OCG held a press conference in Yangon to underscore the harassment of aid workers and insisted on MSF's impartiality in providing medical aid. Publication of the report was eventually cancelled in March 2014, after multiple revisions and internal wrangling.

On 13 January 2014, members of the Rohingya community were massacred in Du Chee Yar Tan village in Rakhine. MSF OCA was questioned by the authorities and the media about their efforts to treat the victims. These accounts unwittingly put the organisation in the spotlight of the international media, which in turn triggered further tensions with the Myanmar authorities. As a result, on 27 February 2014, MSF OCA was ordered to cease all activities in Myanmar. On 28 February, the order's scope was reduced to Rakhine state only. During these two days, while limiting their public advocacy to reactive communications and journalist briefings, MSF OCA and MSF International HART teams stepped up bilateral advocacy. The efforts resulted in increased pressure from international actors on the Myanmar authorities.

Following the 2014 official cessation orders, the MSF OCA management team rapidly took a "bottom line" decision to "try and protect a presence in other Myanmar projects, even if it was no longer possible to be present in Rakhine State." This decision was heavily discussed at-large and challenged for years within the MSF OCA executive and associative bodies. In 2014 and 2015, motions were voted on by MSF Holland's general assembly to push MSF OCA to question their Myanmar strategy and ask for a review of the overall strategy regarding the Rohingya for the five past years. Discussions lasted until the 2019 general assembly.

Throughout 2014, MSF OCA struggled to regain access to Rakhine, despite local hard-liner strong and often violent opposition. In early 2015, MSF OCA restarted Rakhine operations but were never able to obtain the pre-June 2012 access levels. Advocacy and negotiation activities were also hampered by concerns over the regime's detention of the remaining MSF OCA staff member, who was finally released in 2015, after three years in prison.

Throughout this period, the Rohingya increasingly risked their lives to flee Rakhine by boat in efforts to seek refuge in India, Thailand, or Malaysia. In 2012, MSF set up an intersectional, regional advocacy strategy to collectively address the Rohingya situation across international borders including those in Bangladesh, Myanmar, and in parti-

cular, for those in Thailand and Malaysia. In August 2014, after several exploratory missions, MSF OCA intervened in Malaysia to support unregistered Rohingya refugee healthcare and advocacy efforts that included a “cautious and strategic” approach.

In August 2017, an unprecedented wave of violence engulfed Rakhine which led to the massacre of thousands of Rohingya and the exodus of more than 700,000 people to Bangladesh. By December 2017, MSF publicly estimated that at least 6,700 Rohingya were killed during the attacks.

By November 2019, three separate international legal proceedings were filed against Myanmar for crimes against the Rohingya: in the UN International Court of Justice, by the UN International Criminal Court and under the “universal jurisdiction procedure” in Argentina.


MSF Dilemma & Questions

Throughout two decades of MSF assistance to the Rohingya people, the organisation was confronted with some major dilemmas and questions, including these:

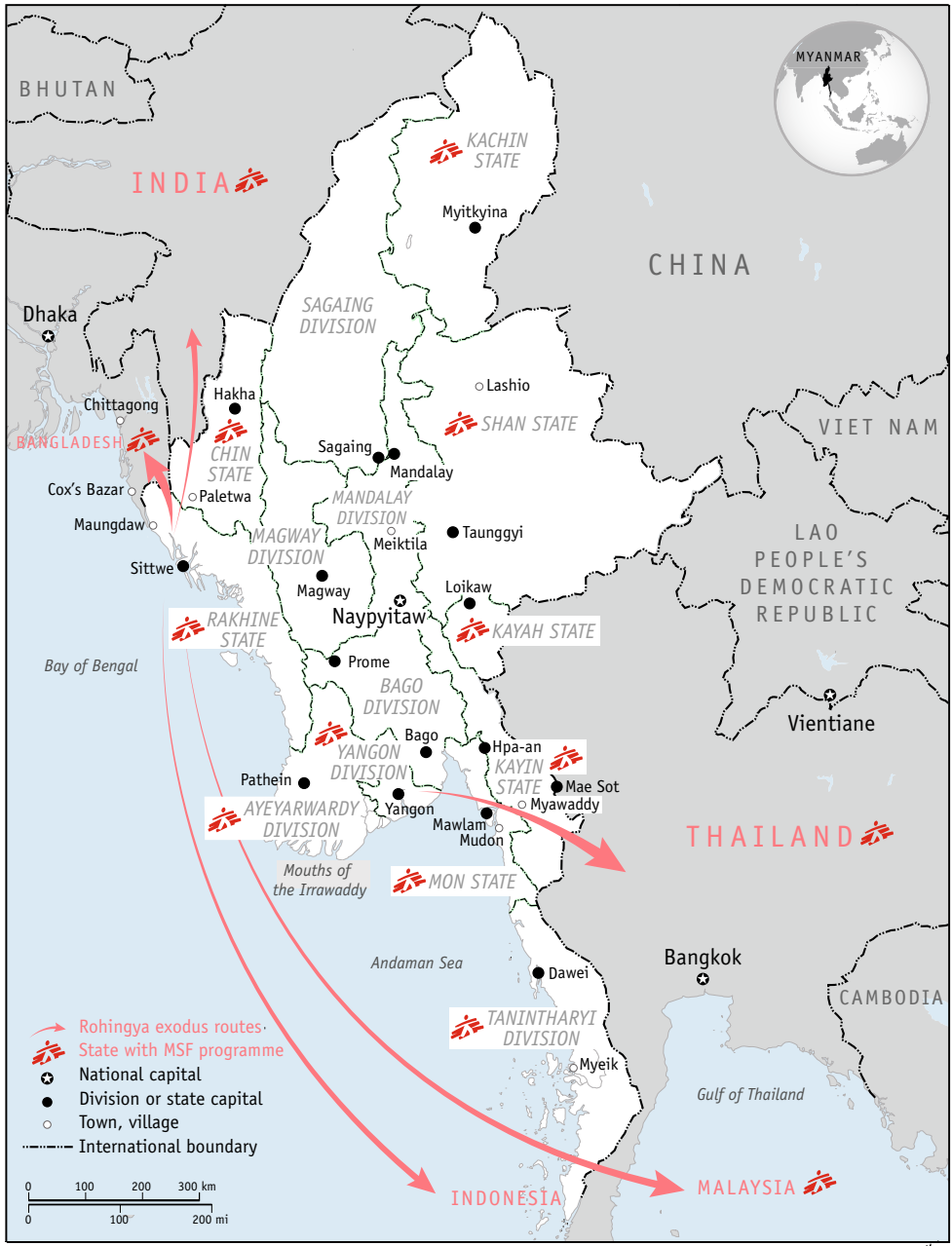
- ▶ Under an authoritarian regime, should MSF maintain a medical operational presence which enables information collection for potential public positioning, while imposing a communication silence for fear of losing access? Two apparent choices regarding public health and témoignage emerge:
 - Abandon patients whose life depends on MSF treatment, such as HIV/AIDS cohorts, to speak out against the persecution of a population such as the Rohingya.
 - Abandon a persecuted population through silence, or no public witness of their plight despite the maintenance of an operational presence and data collection which attests to the suffering.
- ▶ While substituting MSF public witnessing with second-hand witnessing (MSF gives data to human rights organisations, UN agencies, media, etc.) in order to maintain contact and medical activities for the Rohingya population in danger:
 - Is it possible for MSF to control these second-hand messages? What should MSF do when the message is altered or simply ignored?
 - What is the value in substituting MSF’s public voice with that of non-medical organisations?
 - What is the value in maintaining a presence when the substituted voices are not impacting the plight of the Rohingya?
- ▶ When purely medical data are not available or the data available do not directly link health status to persecution, should MSF denounce persecution on the basis of data which describes human rights violations? Does this risk the organisation’s credibility as medical and humanitarian? If so, should MSF remain publicly silent to maintain credibility and/or access? Are there cases where silence increases access over time? If MSF credibility is not at stake and no direct link between the health status and persecution can be established, what other circumstances could/can justify an MSF refrain from denouncing human rights violations?
- ▶ When MSF agrees to work concurrently in ‘ethnically exclusive’ clinics to prove its impartiality, such as those clinics for the vulnerable Rohingya separated from those for the larger Rakhine population, is MSF thereby complicit in segregation

policies? In so doing, does MSF reinforce the regime's policies of ethnic detention and 'encampment?'

- ▶ How far can MSF push negotiations for access with a regime that detains MSF staff members?

 ▶ [Click to access the video.](#)

Myanmar



Rakhine State and Cox's Bazar area



MSF AND THE ROHINGYA 1992-2014


Please note: we are using 'Burma' and 'Burmese' until 1989 when the official names changed. From 1989 on, we are using 'Myanmar' and 'Myanmarese.'

The Rohingya live in northern Rakhine a state located west Myanmar (formerly Burma) bordering Bangladesh. Rohingya are predominately Muslim¹, whereas most Myanmarese (formerly Burmese) are Buddhist.

Their origins are controversial. Historians attest to Rohingya presence in Burma/ Myanmar since the eighth century. However, those who oppose Rohingya citizenship in the Myanmar nation consider that they migrated from East Bengal at the time of British colonization.

Rohingya citizenship has always been contested, often violently. These contestations come from both the ruling parties and the population, particularly by non-Rohingya neighbors in Rakhine (formerly Arakan) state.

Among others, Burma independence fighters from Britain, including General Aung San² did not accept the Rohingya as Burmese. Conversely, the Rohingya were blamed for serving in the British army during the Anglo-Burmese wars (1824-26, 1852-53, 1885), the Second World War (1941-45), and aligning with the British during the decolonization period (declared January 4, 1948).

In 1962, after nationalist General Ne Win's military coup, persecution of the Rohingya was systematic and they were eventually stripped of their rights. In 1978, the military regime launched Operation Nagamin (Dragon King) to separate 'nationals' and 'non-nationals' prior to a census organised in Rakhine State. The national registration cards of the Rohingya were confiscated by authorities and never replaced. This triggered violence from the military and the Buddhist Rakhine against the Rohingya who were driven out from their villages and lands. They were replaced with Rakhine peasants by the Burmese authorities. Within a few weeks, 200,000 Rohingya crossed the Bangladeshi border en masse and settled in refugees camps close to Cox's Bazar. [V1](#) 

The Bangladeshi Red Crescent and the United Nations High Commission for Refugees (UNHCR) began assisting the Rohingya refugees and in May 1978, issued a call for additional support. Médecins Sans Frontières (MSF) France considered opening a medical and surgical emergency mission and sent two doctors to assess the needs in Cox's Bazar. MSF France concluded that the refugees

1. There are Rohingya Christian and Hindu minorities.

2. General Aung San, (1915-1947, widely considered the father of Myanmar), is the father of Aung San Suu Kyi, long-time opposition figure, Nobel Peace Prize winner in 1991, Foreign Minister, and State Counsellor (equivalent to Prime Minister) since 2016.

settled in open camps were quite well integrated within the local population, and sufficiently cared for by a number of medical staff. Therefore, they deemed MSF assistance was not needed.

The Bangladeshi authorities were not in favor of permanent settlement of the Rohingya refugees because of the economic and social burden of their presence in the local communities. The authorities hence, engaged in bilateral negotiations with Burma and simultaneously reduced the refugee food rations. As their living conditions in Bangladesh deteriorated, some of the Rohingya refugees resolved to return to Burma. Ultimately, the Bangladeshi authorities began forced repatriation to Burma, where there were little security safeguards in their hometowns. By early 1979, the Bangladeshi camps were empty. The Burmese regime was against this repatriation and considered the Rohingya as 'foreigners having illegally entered the country.'



'The Tragedy of Burma's Muslim Refugees,' *Le Monde*, France, 18 May 1978 (in French).

Extract:

One of the largest population exoduses in recent years is taking place at the Burma/Bangladesh border, in a difficult-to-access region. In one month, 143 Burmese Muslims fleeing General Ne Win's army have taken refuge inside Bangladeshi territory. After crossing the border, lacking resources and under attack by Burmese soldiers, these men, women, infants and elderly people crowd into makeshift camps set up by the Bangladesh Red Cross. The agency has sought international assistance. The refugees recount terrible stories of looting, rapes and killings. The Bangladeshi border guards had to open fire several times on Burmese soldiers, who were pursuing the refugees.

Just who are they? To the Bangladeshi government, they are Muslim Burmese citizens living in Rakhine State. Bangladesh filed a formal protest with Burma against their "expulsion" and the inhuman treatment and atrocities perpetrated against them "by the Burmese population and the country's army, perpetrated with the complicity of the authorities". Facing this "serious tension", the government of General Ziaur Rahman called for the refugees' immediate repatriation "in the interest of neighbourly relations and peace at the border".

The Burmese government considers the fugitives, which it estimates at 19,457, as "foreigners" - Bengalis who "entered illegally" and "violated the law", according to a 30 April Radio Rangoon radio broadcast, at the time the Ministry of the Interior and Religious Affairs launched Operation Dragon King on 15 February to screen illegal immigrants. The fugitives were driven "by unscrupulous people" and under no circumstances would they be readmitted into Burma.

The Burmese government also decided to re-examine the situation of every individual living in the county, "including newborns", "to classify them based on the law" because "some were registered by mistake and, mistakenly, received Burmese identity cards".

The refugees' assertion completely contradicts Rangoon's version. Some state that their Burmese identity cards were taken from them by force, while others brandish theirs as proof of their nationality. They all say that the intent of the government of General Ne Win, a Buddhist facing a multitude of separatist and communist insurrections, is to simply rid itself of the Muslim community of Rakhine. The fugitives fall into three main groups: the Rohingya, the largest of the three, who have lived in Rakhine State for several centuries; the Kamanchil, who claim that their ancestors arrived at the end of the 18th

century; and Bangladeshi farmers and fishers, who arrived during the British colonial period.

Since February, Burma's armed forces and Buddhist Rakhinese have driven them from their villages and their land. According to Bangladeshi radio, the Burmese authorities have already resettled peasants in their place.



'Minutes of the MSF France Board of Directors Meeting,' 15 June 1978 (in French).

Extract:

Bangladesh Claude Diaz and Jean-Marc Dumas travelled to Bangladesh, following a call from the Bangladesh Red Cross to all humanitarian organisations, to provide assistance to the refugees from Burma. The nine camps are located in the region of Cox's Bazar. On site, they found many doctors (more than 60) and paramedical workers, amounting to a total of 200 medical staff. In addition, the refugees are in open camps and are integrating fully into the local populations. Thus, there is no immediate need for an MSF presence.



When I left on my first MSF mission – so I was very tight – I heard about a mission that had left, or was about to leave, for Bangladesh but ultimately could not do anything because the refugees had been expelled from Bangladesh to Burma. This meant that the mission had been interrupted, along with everyone else, because there were historical actors – like Save the Children Fund and probably Oxfam – who were working with the Rohingya and had also packed up, including UNHCR. What this situation showed is that, at the time, everyone considered a decision taken by a political authority to be acceptable. If the government agreed to take in the refugees, then the organisations would work there. If it expelled them, we'd leave, but no one would object. This contrasts with what happened later, when we believed – on the contrary – that we were there to defend the right to asylum and that we had something to say on that subject. This opened up a range of supposed responsibilities on the part of humanitarian actors. That range had been quite narrow in the 1970s and was much broader in the 1990s; and according to the context each time. It was evident that we had nothing to say in the 1970s; it was equally evident that we did have something to say in the 1990s. So, what would that be? What form would it take? That remained to be discussed, but the era was changing, based on NGOs' [Non Governmental Organisation] perception – and MSF's perception, in particular – of their role.

Dr Rony Brauman, MSF France, President, 1982-1994 (in French).

In 1988, Burma pro-democracy demonstrations in Yangon (formerly Rangoon) were severely repressed resulting in thousands of deaths. This in turn, led to a coup d'état by a military regime. The new regime was structured under the State Law and Order Restoration Party (SLORC). On 18 June 1989, the new regime decided to change the country's name, from its colonial assignment of Burma, to the Republic of the Union of Myanmar.

These dramatic events of 1988 coupled with flight of persecuted minorities such as Rohingya to bordering countries, triggered MSF Holland to intervene. Because the

Myanmar's population was living under junta rule and was closed to foreigners, MSF Holland had the will to bring assistance. In 1991, MSF Holland managed to post a single expatriate in Yangon who began negotiations with authorities to open programs in Kachin and Karen states where civil wars were ongoing.



'Letter from the MSF France Head of Mission in Thailand to Luc Fréjacques, MSF France Programme Manager,' 19 September 1991 (in French).

Extract:

I'm writing to explain my point of view regarding opening an MSF Holland mission in Rangoon.

I knew that A [MSF Holland representative in Myanmar] was negotiating with the Burmese because we talked about it at length last year. So I had had a chance to explain my perspective and A [...] knew that I thought it was a mistake to officially open a mission right now.

In late August, I learnt, by accident, that things had moved forward because A [...] went to negotiate last June and the Burmese authorities turned out to be incredibly cooperative in terms of the conditions for setting up this project. A [...] himself was surprised.

I was shocked – not by the possible opening of a mission there – but because A[...] hadn't kept me informed on how the negotiations were going, even though he knew that opening an MSF programme in Burma could have adverse consequences on our programmes at the Burmese border. [...]

Based on what I understood, the project would be located in the townships where, before the May 1990 elections, entire Rangoon neighbourhoods had been displaced by force. And just coincidentally, these were neighbourhoods known to oppose the SLORC [Burma's military government]. [...]

Given the context, I was very sceptical about the SLORC's good faith and its 'guarantees.' I didn't see why, suddenly, they would agree to allow MSF to stick its nose – "with complete freedom" – into very 'touchy' areas that were typically officially off-limits to foreigners.

I was really worried that the real agenda was to use MSF to support the regime via major publicity stunts – which they were very good at doing – and polish their image, which had taken a big hit, particularly since the US and EEC (European Economic Community) embargo, the latest Amnesty International reports, the European Parliament awarding the Sakharov Prize to Aung San Suu Kyi, etc. It was increasingly obvious that they were trying to gain legitimacy in the face of national and international pressure. I listened especially closely to A[...] during our meeting. The arguments:

The needs are huge; we have guarantees that we can do what we want; we will have first-hand information and will be able to identify underground opposition networks; and, it's a small, low-profile project without a lot of attention. Given all that, it made sense to give it a try. I explained my fears to A[...], without being pushy. With a little distance, I'm sorry that I wasn't more forceful because I was deeply convinced that the SLORC was taking us for a ride and that this really wasn't the right time to go there.



'Burma (Myanmar) Evaluation of the MSF Holland Programmes: [...] **Report** by Egbert Sondorp, Commissioned by MSF Holland Evaluation Unit, December 1998 (in English).

Extract:

3.3 Reasons for intervention/strategy

The original impulse of wanting to work inside Burma was given by the student riots in 1988, and their bloody suppression. At the background, there was also the knowledge of the ongoing civil wars, in particular in Kachin and Karen. It took a year to get into the country and to prepare the arrival of permanent expat staff. The first expat was to assess options to work in the conflict areas. This proved impossible, for the time being, and a choice was made to become operational in two new townships near Yangon.



We went to Myanmar because of the Rohingya. That's what everybody says, but it's not true. We went there because it was the junta regime, because it was a closed country, an inaccessible country. We went there for a whole lot of issues, and then gradually got access to the different populations.

Marcel Langenbach, MSF OCA, Director of Operations, 2011-2019 (in English).

CHAPTER 1 - 1990S - ADVOCATING AGAINST ROHINGYA FORCED REPATRIATION FROM BANGLADESH TO MYANMAR

Between April and July 1991, the Myanmar Armed Forces' operations triggered a new Rohingya exodus from Northern Rakhine State (NRS) in Myanmar to Bangladesh. An even greater exodus occurred by the end of 1991 and continued in 1992. All in all, approximately 260,000 Rohingya refugees fled Myanmar in 1991 and 1992. They settled in twenty camps in the Cox's Bazar area once again. The Government of Bangladesh (GoB), the UNHCR, and other international organizations began to provide emergency relief. [V2](#)

In December 1991, MSF France asked Odile Marie-Cochetel, a former MSFer living in Bangladesh to conduct an exploratory mission among the Rohingya refugees. She found a population with dire needs, forced to seek refuge in a country poorer than the one they had left. Bangladeshi NGOs aligned with the government's position, of not wanting long-term refugees on their soil and thus not wanting large input of assistance were reluctant to help them.

However, some local organizations and local authorities, relying on the reputation and media visibility of MSF, were in favor of MSF highlighting the plight of the Rohingya, which would also help to publicize the situation in Myanmar. In early January 1992, MSF France decided to open a program to bring assistance to a group of refugees located in Dechua Palong, in Cox's Bazar.



'Burma's Tensions with Bangladesh Illustrate the Junta's Isolation,' *Le Monde*, France, 31 December 1991 (in French).

Extract:

Fleeing mistreatment by the Burmese army, 16,000 Rohingya – Muslims from Rakhine State – sought refuge in Bangladesh between April and July. The Bangladeshi government feared that this exodus would resume after the rainy season, which is what is taking place. However, this time there have been border incidents. On 21 December, an insurgent group, the Rohingya Solidarity Organisation (RSO), is reported to have killed 15 Burmese soldiers in an ambush near Maungdaw. Burmese government forces, which accuse the Rohingya who have taken refuge in Bangladesh of supporting the insurgents, are reported to have killed a Bangladeshi border guard and wounded three others in Rezapara. A bomb explosion at the same location left one person dead and five wounded. The Bangladeshi government immediately called for a meeting to calm the tension. When the Burmese failed to respond to the request and continued to build up their military presence on the border, Bangladesh placed its ground forces on alert there and evacuated 25,000 peasants in areas considered insecure. On Friday, the Bangladeshi air force and navy in the Bay of Bengal received the same instructions. During that time, the last Rohingya refugees who had arrived from Burma reported that hundreds of young Muslims had been arrested during police raids in Rakhine State.



'Report from the Exploratory Mission to Bangladesh, Odile Marie-Cochetel, MSF France,' 26 December 1991 (in French).

Extract:

Since March, people have been arriving gradually and continuously in small groups (families). The newspapers report their numbers at between 40,000 and 50,000, while local authorities place them at 20,000. In fact, no one knows as no census has been conducted. [...]

V. MSF project proposal

1. Reasons

A. Political

Burma does not get enough attention. Publicize the situation facing the Rohingya, who have taken refuge in a poorer, overpopulated country (setting aside the economic reasons). Opportunity to show that MSF works without religious discrimination among Burmese refugees: Christian Karens, Mons or Buddhist students, Muslim Rohingya. Why MSF? The NGOs in Bangladesh could handle this, but without any publicity: the Bangladeshi employees don't dare oppose the government's positions and extending the activities to the Rohingya population wouldn't offer them anything (no media attention).

B. Humanitarian

Essential needs are not being met. Shortages of food, clothing, shelter and medical assistance will increase with the rainy season. We have observed feelings of abandonment and despair among the Rohingya, particularly since the Burma/Bangladesh agreement.

C. Medical

Nutritional and medical emergency to be covered. Insufficient medical assistance in the sector.

2. Objectives

A: bring media attention to the Burmese problem. The other NGOs and local authorities support a certain level of publicity that MSF's recognition can provide. However, the

government could put pressure on to keep the aid from becoming known publicly (TBD when the authorisation request is submitted).

B: do not immobilise the refugees. Bangladesh is a poor, overpopulated country that cannot meet the refugees' needs. The Rohingya want to return to Rakhine as soon as possible, once security guarantees are provided. This refugee population is mobile and crosses the border in both directions.

C: ensure that basic needs for food, clothing, shelter, sanitation and medical assistance are met (minimal operations for emergency assistance).



'MSF France **Activity Report** in Bangladesh,' February 1992 (in English).

Extract:

On behalf of MSF France, Dr Odile Marie made a rapid survey about Rohingya refugees on 22 December 1991.

Following the report of this survey, MSF France headquarters decided beginning of January to open a programme of assistance for the first group of refugees located in Dechua Palong.



I was supposed to go to Bangladesh with my partner, who had a position as a lecturer in French at the University of Chittagong. Before leaving, François Jean³ said to me, 'Try to travel around in the southern part of the country.' He gave me a Thai newspaper clipping, which said, 'two or three thousand Rohingya are arriving in the region of Cox's Bazar.' I wasn't on mission for MSF and I didn't really feel like hanging around an apartment doing nothing. I went to see the French ambassador, who told me that he would be interested if I visited orphanages and places where France could fund reconstruction and other kinds of projects. I thought that at the same time I could confirm the situation of the Muslims who were coming from Burma. So, I made an appointment with the governor of Cox's Bazar, a conservative Muslim, a strong believer, honest and concerned, who thought that Muslims should take care of other Muslims. He told me, 'I'm going to show you what kind of condition these people are in.' He wanted someone to aid the Rohingya and he couldn't find anyone who would. We went in his car to see some 3,000 Rohingya – men, women and children – in tiny shelters, some 70 centimetres high, made of branches that you had to crawl under to enter. There was just one water point for 3,000 people. They had scabies and were infested with fleas. There were signs of significant malnutrition. Then the governor said, 'my problem is that I don't have government authorisation to assist them and you'll find out that the NGOs have been silenced.' I told him that if necessary, I would notify MSF. I went to Dhaka, the capital of Bangladesh, and visited the big NGOs. And there – surprise – Oxfam and company said, 'no, we won't get government authorisation. We can't do anything. But you, MSF, go ahead, request authorisation for MSF. You don't have any more programmes currently operating in Bangladesh. What are you afraid of? The worst is that they'll throw you out, but at least you will have tried.' I sent my exploratory mission report by fax and five days later, I got a phone call from headquarters. They said, 'you've got carte blanche.' That's MSF – 'you've got carte blanche.' In early January, a logistician, doctor and nurse we can't make a profit on the backs of poor people showed up, with money belts stuffed with dollars and money hidden in their clothes. That's how things were done in those days. We started to conduct studies and surveys.

3. François Jean was a Research Director for the MSF France Foundation until 1999.

Given the extent of the tragedy, I quickly got the go-ahead from the government. I still don't know how or why they made that decision.

*Odile Marie-Cochetel, MSF France, Head of Mission in Bangladesh, 1991-1992
(in French).*

ASSISTING ROHINGYA REFUGEES IN BANGLADESH

In February 1992, against the advice of the head of mission, the first MSF France chartered aircraft was organised, supplied, and sent to Bangladesh. It was briefly blocked by Bangladeshi authorities before its cargo was allowed to enter the country, a few days later.

On 14 February 1992, MSF France stated in a press release that it was “reinforcing its presence among the 40,000 Rohingya refugees in Bangladesh.”

The UNHCR also responded to the emergency and sent staff and supplies.



'Médecins Sans Frontières to Send a Supply Plane to the Rohingya Refugees in Bangladesh,' MSF France **Press Release**, 14 February 1992 (in English).

Extract:

In view of the critical situation, Médecins Sans Frontières is reinforcing its presence among the 40,000 Rohingya refugees in Bangladesh. A special cargo plane will leave Toulouse on Sunday for Chittagong (southern Bangladesh), carrying 38 tons of food for children, anti-measles serum, water processing and storage equipment, dispensary tents (with drugs and medical materials), plastic sheeting for shelters and various MSF modules designed for assistance to refugees. There will also be 10 volunteers (doctors, epidemiologists, nutritionists, nurses and logistics experts) on board the flight. An initial assessment of the nutritional state reveals that nearly 30% of the children under five are severely under-nourished with only 10% of the population's food needs being met by humanitarian aid. As soon as the plane arrives Médecins Sans Frontières will begin distributing food to all children under five and will treat cases of severe malnutrition in a centre for intensive renutrition. Reported cases of measles give rise to fears of an epidemic outbreak with possible severe consequences for children. Médecins Sans Frontières will thus simultaneously launch an anti-measles vaccination programme for all children under 12 and set up tent dispensaries for medical care. Médecins Sans Frontières will be reinforcing the 4-person team that has been on site since last January. They have been working with this refugee Burmese minority, living in extremely precarious conditions in makeshift camps. The refugees are Rohingya, a Muslim minority from the western provinces of Burma, who have fled a wave of violent repression by the authorities in Rangoon. The Bangladeshi government has launched an appeal for aid to the international community for help in bringing relief to this beleaguered population. This programme will be carried out with financial support from the Emergency Aid Fund of the EEC.



'UNHCR **Press Release**,' 14 February 1992 (in English).

The United Nations High Commissioner for Refugees is rushing an emergency team to Bangladesh to help more than 60,000 refugees pouring across the border from Myanmar. High Commissioner Sadako Ogata said she was deeply concerned about the tragic conditions in Myanmar that are forcing people to flee at the rate of 400 to 600 a day. The High Commissioner expressed her gratitude to Bangladesh for its generosity toward the refugees. Noting the increasing influx of refugees from Myanmar into other countries in the region, the High Commissioner urged that no one seeking asylum would be forcibly returned.

The Government of Bangladesh today requested UNHCR to provide immediate help to the refugees from Myanmar when the influx reached such proportion that the government's resources were stretched to the breaking point. The request followed an offer of emergency assistance from the High Commissioner during a meeting with the Prime Minister of Bangladesh at the OIC [Organization of Islamic Cooperation] summit in Dhaka last December.

The High Commissioner immediately allocated an initial \$100,000 from the Emergency Fund for urgently needed supplies for the refugees, most of whom are women and children.

UNHCR [United Nations Children Fund] is working closely with WFP [World Food Programme], UNICEF, Bangladesh Red Crescent/Red Cross and MSF to arrange for food, water, shelter, sanitation and health services in the border areas inundated by refugees.



'**The Mission** No. 62, MSF France Internal Satirical Newsletter,' 21 February 1992 (in French).

Extract:

The Bangladeshi local and national authorities tried to pick a fight with us. They even managed to infuriate Odile Marie, the mission's charming coordinator. After creating innumerable problems for us in terms of landing the plane, refusing the logisticians (what's a logistician good for anyway?), blocking our supplies and downgrading our projections for the anti-measles campaign, they simply confiscated the supplies in Cox's Bazar (the town closest to the Rohingya camps) and refused to provide written authorisations to work in the camps – all the while demanding that we pay the health workers. In short, the eight-person team that arrived after a complicated plane odyssey was slightly confined in its movements. In the meantime, two clinics and two feeding centres run by MSF are operating. We're trying to put pressure on all sides (EEC and the [UN]HCR, which is being feeble), before kicking up a fuss and getting ourselves thrown out.



Contrary to my advice, MSF France decided to send a plane stuffed with supplies, cars, and reporters (at least a dozen). The government was really annoyed. They thought that MSF assumed they were coming to the Sahel, sending material to a country where they were in short supply. There were cars and you could quickly assemble a nutrition survival kit for 10,000 people. When I went to the Chittagong market and said that I needed 5,000 spoons and 5,000 mugs for children, I got them in less than 24 hours – from a shop that measured 9 metres square! I specifically went to the market with people of different religions and the merchants offered me knock-down prices. I ended up paying five times less. They said, 'we

can't make a profit on the backs of poor people – particularly not Muslims! The plane circled for a long time. My partner and I negotiated with the government to grant it landing rights. It was first authorised to land in Chittagong, but forbidden from letting the passengers off. It took another 24 hours of negotiations to get them out. Then the government confiscated all of the supplies, which we recovered after two weeks. It was really nuts. I said to myself: "We've lost everything – we'll have to close it all down."

*Odile Marie-Cochetel, MSF France, Head of Mission in Bangladesh, 1991-1992
(in French).*

On 25 February 1992, MSF France announced in a press release that they were strengthening their programme and opening a second nutrition center. This was based on a nutritional survey conducted in Dechua Palong II camp which identified a high prevalence of child malnutrition.



'MSF France **Press Release**,' 25 February 1992 (in French).

The situation facing the 40,000 Rohingya in Bangladesh is serious. It may become catastrophic if massive, well-coordinated aid is not delivered to the camps quickly. Those are the initial conclusions of an epidemiological assessment of health conditions and mortality conducted by Médecins Sans Frontières in the camps in southern Bangladesh. The nutritional assessment conducted at Dechua Palong II, a camp housing 17,500 people, showed that 13.7% of the children are suffering from severe malnutrition (brachial perimeter less than 11.5 cm). In addition, 25% of the families have not received food rations for more than 12 days. The elevated mortality in the month preceding their arrival in Bangladesh proves that their health status is terrible. To prevent the situation from deteriorating quickly, general food distribution must be carried out and nutritional recovery centres must be built as soon as possible. MSF has thus opened a second centre for severely malnourished children.

While shelter remains inadequate (both in number and quality), the survey also identified another emergency: water and sanitary facilities. The refugees have access to less than five litres/day/person (compared to the 20 litres generally recommended) and there is one latrine for more than 500 refugees. It has been raining continuously for four days in the camps, where 500–1,000 new refugees arrive daily. Given these very crowded conditions, we are concerned about the risk of epidemics. The Bangladeshi authorities have thus undertaken a vaccination campaign, specifically for measles, using the supplies that MSF delivered.

Two weeks ago, MSF also expanded its four-person team, which has been working since January with the refugees, who belong to the Muslim Rohingya minority fleeing the eastern province of Burma, where they are subject to violent repression by the Rangoon authorities.

MSF's work is financed in large part by the Emergency Fund of the European Economic Community.

In March 1992, in a message sent to all sections of the MSF international movement, the MSF Holland leaders announced that, in response to a request for further assistance from the United Nations, they put a relief team on standby to respond to the alarming situation in Bangladesh. MSF Holland suggested discussing “a European set-up for this mission (multi-MSF section).” Finally, a program was opened under the sole responsibility of MSF Holland in the Balu Kali refugee camp.

On 28 April 1992, the governments of Bangladesh and Myanmar announced that they had concluded an agreement for the repatriation of 250,000 refugees by mid-May. However, the Myanmar government refused to allow UNHCR to supervise repatriation to its territory.

Then, in mid-May 1992, UNHCR announced that they would not participate in monitoring the repatriation of refugees, considering that the continuing influx of refugees in Bangladesh demonstrated that the conditions for a ‘voluntary and safe’ return to their country were not met. The start of repatriation operations was postponed again.



‘MSF Holland **Fax Message** to All MSF sections,’ 8 March 1992 (in English).

Extract:

In response to the alarming situation in Bangladesh and requests by the UN [United Nations] system for more assistance, MSF NL [MSF Holland] has put a relief team on standby which is due to leave Monday evening for Dacca. The purpose of the mission is: 1) exploration, 2) immediate assistance where needed. [...]

The team will be available to render assistance in close coordination with MSF F and also with UN agencies (UNHCR, UNICEF). I suggest we discuss a European set-up for this mission tomorrow, or today, if we manage to get in touch by telephone.



‘Bangladesh and Burma Agree on UNHCR Presence During Refugee Repatriation,’ **Agence France Presse (AFP)**, Dhaka, 7 May 1992 (in French).

A spokesperson for Bangladesh’s Ministry of Foreign Affairs announced in Dhaka that on Thursday, Bangladesh and Burma agreed to begin repatriating approximately 250,000 Muslim Burmese by 15 May. The operation will be supervised by the UN High Commissioner for Refugees (UNHCR). The same source reported that the two parties will allow HCR representatives to be present during repatriation to ensure security, responding to requests from refugees and human rights organisations, including Amnesty International. The Rohingya began their exodus from Burma around a year ago, fleeing atrocities committed by the Burmese army. The spokesperson outlined the major points of Thursday’s agreement and noted that the repatriation is scheduled to begin ‘no later than 15 May, in the presence of HCR representatives, and should be completed within six months.’ Five thousand refugees are expected to be repatriated every two days.



'HCR Will Not Supervise the Refugees' Repatriation, Given Current Conditions,' **AFP**, Dhaka, 13 May 1992 (in French).

Extract:

A spokesperson for the UN High Commission for Refugees (UNHCR) announced on Wednesday that, given current conditions, UNHCR will not participate in the repatriation of the approximately 250,000 Muslim Burmese who have sought refuge in Bangladesh. "We will continue our emergency operations in the camps, but we will not participate in monitoring Friday's refugee repatriation, given the current situation," she stated.

UNHCR's decision raises doubts regarding implementation of the plan to repatriate more than 250,000 Rohingya refugees. Under the terms of two agreements reached recently between Bangladesh and Burma, repatriation was scheduled to begin on Friday.

Approximately 2,000 Muslim Burmese arrive in Bangladesh every day, while the refugees already there have recently begun demonstrating in the camps. They oppose repatriation without adequate security guarantees.

[...], the UNHCR representative in Bangladesh recently noted that the continuing influx of refugees fleeing abuses by the Burmese army shows that conditions for a "voluntary and safe" return to their country have not been met.

He added that UNHCR would not be associated with the repatriation process if that safe, voluntary return is not guaranteed.

Bangladesh authorities stated on Tuesday that they will not force anyone to return to Burma, but that all preparations had been made to start the repatriation on Friday.

Meanwhile, two MSF Holland volunteers working in Balu Kali refugee camps witnessed violence against refugees from the Bangladeshi military police and the camp in-charge which led to at least one death. They reported confidentially to the UNHCR but no public accounts were given.



'**Fax** from Clemens Vlasich, MSF France Project Coordinator in Bangladesh to Olivier Rouleau, MSF France Programme Manager,' 15 May 1992 (in French).

Extract:

Hello Odile and Olivier,

14/5: first serious incident at Balu Kali 1. According to MSF France, 4 deaths; official information, 1 death. Dispute between the refugees and the camp administration, reason: repatriation. Apparently the refugees had to sign a document stating that they were returning voluntarily; the majis refused. The police fired on the refugees. No official statement yet from the government and UNHCR.



'**Sitrep** MSF Holland Bangladesh,' 25 May 1992 (in English), edited.

Extract:

General

The influx of refugee[s] recently dropped to 300–400 persons daily; despite the repatriation agreement between Bangladesh and Myanmar signed on April 1992. The

total refugee population amounts to approximately 260,000 people in 13 camps, of which some 85,000 refugees reside in temporary shelter outside the camps. [...] The repatriation of the Rohingya refugees to Rakhine in Myanmar, scheduled to start May 15, has been postponed several times. Unless there are clear guarantees for the safety of the returners no refugee will return voluntarily. The official Bangladeshi policy is not to force these refugees back into Myanmar.

Repatriation

[...] Tension is slightly rising in the camps. On the eve of the repatriation an incident occurred in Balukhali I in which at least 1 person was killed. [...] and [...], as the only foreign relief workers, witnessed the pre- and post-events. For the details I refer to the extensive report of [...] and [...]. MSF reported confidentially to UNHCR what it had witnessed. No public accounts have been given. UNHCR picked it up and is investigating the case through a legal advisor from Geneva who was due to come anyway. My personal feeling was that this incident might have been set up in order to put pressure on the refugee community.



It was in the early afternoon, all of a sudden there was an excited energy in the camp, all the men were coming down from the hills. They were all very angry and they said that I had to witness what was happening because the Bangladeshi people were torturing their majis, their leaders. So, I stood on the hill, but I told them that if I was standing there with my white face it would not be a very good thing for them, nor for me. So in the end they were hiding me behind their lungis and I was peeping through their lungis, squatting down, at what was happening. Suddenly, all the men started running to the office of the camp-in-charge and they literally ripped the whole place apart and came out carrying a man that was unconscious and beaten. They brought that man to me and we decided to carry him to the feeding centre, from there we put him in a van to drive him to the clinic of another camp where there was a doctor. At that moment, gunfire was heard and we all went down to the ditches. We waited for the gunfire to stop before crawling through the ditches to the entrance of the camp to try to locate my local staff. We saw bodies lying there. At that very moment the Camp In-Charge, and military-style police with rifles, came on jeeps leaving the camp. Police had shot five refugees. After that I went to Balu Kali II camp, where the doctor had managed to heal the leader. We brought him back and dropped him off at the edge of the camp because it was safer for the two of us not be seen together. That night the UNHCR protection officer arrived and asked me if I saw what happened. I said yes and when I get back to Cox's Bazar, I spent a night in the office writing a report based on facts and figures that I gave to the UNHCR. That night there was a party in MSF France. I went there, but I was not in the mood. I walked back to the office and sat there and the medical coordinator asked me why I was looking the way I was. I said: 'What do you think? I saw six people being killed today and I am wondering what I have to say the next morning when I see the officer in charge of this camp.' And she said: 'Nothing! The only thing that counts is that the medical programme continues and if you cannot live with that the next thing you should do is leave on your next mission with Amnesty International.' I said: 'Thanks, good night and fuck you all!' And of course, the next day, I saw the same person. I think in the end that having seen and documented this was maybe contributing in a negative way to our position, because it led to lessening the trust between us and the Bengali authorities who were intimidating us, stating that we were anti-Bengali and pro-Rohingya.

P, MSF Holland, Logistician and Administrator in Bangladesh, 1992-1993 (in English).

In late May 1992, the Bangladeshi government accused the UNHCR and MSF of convincing the refugees that the situation was not safe for them in Myanmar, and thus impeding the repatriation process. The government further threatened not to register MSF Holland's and MSF France's projects, which were operating under an authorisation granted by the Ministry of Relief. To calm the situation, MSF France and MSF Holland opened programs for the local communities, which were living in conditions even worse than in the refugee camps in Cox's Bazar town.

Concurrently, the living conditions for refugees deteriorated due to movement restrictions and an increase in police violence. On 18 August 1992, a nurse from MSF France witnessed Bangladeshi police firing on refugees, killing, and wounding several people.



'Letter from Olivier Rouleau, MSF France Programme Manager to UNHCR,' 29 May 1992 (in French).

Extract:

We have taken note of the full support that the UNHCR is prepared to provide our programme in Bangladesh. Over the last week, the MSF France and MSF Holland projects have been under threat as a result of a registration-related problem with the Bangladeshi government. The NGO Affairs Bureau is no longer willing to grant us permission to operate an emergency programme, even with authorisation from the Ministry of Relief. [...]

It appears now that the Ministry of Internal Affairs must issue its agreement and that we are required to work in cooperation with a local NGO. Given the current emergency context, we believe that the latter condition will be difficult to meet.

Support from your delegation in Dhaka would be very helpful to us in obtaining written, permanent authorisation quickly to work in these refugee camps, under HCR coordination.



'Letter from Clemens Vlasich, MSF France Project Coordinator in Bangladesh to Olivier Rouleau, MSF France Programme Manager,' 6 June 1992 (in French).

Extract:

Meeting today with the Chittagong Divisional Commissioner:

- We are prohibited from employing refugees, even if they are volunteers (as of 15/6)
- We have to provide a list of our staff + addresses
- The refugees no longer have the right to leave the camps
- No more markets in the camps
- Will not consider providing education programmes for the refugees.



'Letter from Odile Marie-Cochetel, MSF France Head of Mission in Bangladesh to Olivier Rouleau, MSF France Programme Coordinator,' 7 June 1992 (in French).

Extract:

Hello Olivier,

A short missive ... to let you know that the situation is very serious for the refugees here.

1. Harassment at every turn: prohibited from moving beyond a shrinking perimeter: some of the refugees no longer have access to health services and feeding centres! (Same as Haladia).

Refugees prohibited from trading with or purchasing food from locals (all markets are closed in the camps)

2. Violence, particularly at night: the police beat the refugees in all the camps with impunity.

3. Refugees and NGOs cut off: prohibited from employing even refugees who are 100% volunteers.

4. Authorities and “so-called” government doctors humiliate expat and MSF Bangladesh staff and lay down the law at certain feeding centres (Dechua Palong 2).

5. Most serious: preliminary results of the Helen Keller⁴ [NGO] survey shows 20–40% severe malnutrition (<75%), the highest rates are in Gundam and Damdamia. This week at Gundam: 54 new cases of kwashiorkor⁵!! [...]

The Divisional Commissioner has ordered the new Civil Surgeon to send all the NGOs packing. UNHCR is paralysed, warning messages sent to Geneva. The WFP is useless (they say they can't increase the food quotas) and Rome⁶ isn't responding. [...]

What do you think about all this? Isn't this information (or the info that Clemens has provided) enough to warn the EC, US, and put pressure on Geneva?



'AFP Dispatch,' 8 June 1992 (in French).

The independent daily newspaper, *Daily Star*, reported on Monday that Bangladesh has restricted the activities of certain humanitarian organisations in the camps housing Muslim Burmese refugees, after accusing the groups of blocking the repatriation programme.

Citing an “authorised source”, the newspaper noted that all these activities, conducted by some 20 organisations, including several religious groups, will be monitored and their employees' travel will be limited.

These measures follow a month of surveys conducted by Bangladesh authorities, who specifically accuse the UN High Commissioner for Refugees (UNHCR) and Médecins Sans Frontières (MSF) of trying to convince the Rohingya, the Muslim Burmese who fled abuses by the Burmese army and have taken refuge in Bangladesh, not to return to their home country.

“No organisation will be authorised to exceed the limits of its mandate,” the source specified. “Their activities have moved beyond humanitarian work and have become highly political.”

Despite an agreement between the two countries reached in April, the repatriation of the Rohingya, planned initially for 15 May, has been blocked because the Burmese government has refused to allow UNHCR to supervise the repatriation inside the country. New discussions are expected to take place this month.

4. Helen Keller International is an NGO founded in 1915 and dedicated to eye health and nutrition.

5. Malnutrition produced by a severely inadequate amount of protein in the diet.

6. UN WFP's Headquarters is located in Rome.



'Report on Events by IB, Medical Coordinator in Bangladesh, MSF France,' 18 August 1992 (in English), edited.

Extract:

On arrival at the feeding centre in the morning around 7.30 am [...] already found refugees gathering, being unsettled at the camp, around the Camp In-Charge's office. During the next hours unrest among the refugees increased. Equally, many people were gathering around the feeding centre, children coming to seek protection there.

She was told that unrest among the refugees had come up subsequent to the Camp In-Charges decision to transfer one family from Haladia Palong to another refugee camp. Around 11 am policemen who had tried to calm the population, started to shoot with their guns, at first in the air [and] afterwards at the refugees. The nurse was told that one man had been shot dead behind the feeding centre. As fighting continued around the feeding centre the MSF nurse together with the Bangladeshi staff left the camp by foot. On the way out of the camp the team saw a male adult body lying on the floor behind the Camp In-Charges' office.

[MH] (MSF nurse from Dhoa Palong) and myself (Dr IB, MSF France Medical Coordinator) initially on the way to Ukhiya, stopped at the feeding centre/IPD [In Patient Department] in Maricha Palong at around 12 noon because we saw a crowd of wounded refugees who as they told us had been carried there by people from Haladia Palong

We saw:

- one male child with a destroyed shoulder who was dead
- one male adult with a shot wound on the head, semi-conscious
- one male adult with a shot wound on one arm
- one female adult with a shot wound in one leg.

We brought the three adult patients to Rabita hospital where they were admitted by the doctor doing the emergency consultations.

From there we returned in order to check whether any more wounded people needed assistance at first to Haladia Palong, where we were allowed to enter only on foot. The fence around the Camp In Charge's office was broken, he himself had been injured and instructed us to leave the camp for the time being. The situation at that time, around 1 pm, was quiet, we saw many armed policemen.

People at the camp entrance told us that there have been around 9–10 deaths caused by the shooting, one of them being a pregnant woman, two of them children.

We went back to Maricha Palong where people at that time had quietened down and as at that time there were no more wounded people we returned to Cox's Bazar to report the incidents to the UNHCR and the authorities.

At 4 pm the MSF France team in Ukhiya received information about more wounded people in Maricha Palong and went there to assist. As reported by the field coordinator [Nicolas Louis] they found four more wounded refugees

- one female adult with a frontal shot wound, conscious; seven months pregnant
- one male adult with abdominal shot wounds
- one male adult with a shot wound causing a fracture of the clavicle
- one male adult having been beaten with a fracture of the forearm

At this time, despite the permission of the camp-in-charge, the refugees refused transport to the hospital.



Things began to get complicated starting in May. There was a reversal ... The governor, who did not agree and did what he could, told me that there was a lot of pressure from the government, there were too many people, that there were many locals who

were homeless because of the cyclones that occurred every year, and that he couldn't agree that the refugees should have more than the local population. So we decided to open clinics in Cox's Bazar for the local population and diversify our activities a bit.

*Odile Marie-Cochetel, MSF France, Head of Mission in Bangladesh, 1991-1992
(in French).*



We were running six or seven big buses to bring our staff to the camps, passing through Ukiah market, and at certain moment students of the local university were blocking access to the camps saying that we were not employing enough people from their region. The Bengali government was also very much focusing on that we should serve the local population more. So it was tense but not hostile.

P, MSF Holland, Logistician and Administrator in Bangladesh, 1992-1993 (in English).



The camps were very basic, but it was like running a village in the sense of there being some schooling for the smaller children and there was proper decent food distribution and medical care. It was good enough for some of the Bengali living nearby to come to the camps to try to pretend to be Rohingya, just to be able to join in the food distribution and get the medical care. So it was all very basic, but in comparison to how some of the Bengali people live it was better than it was for them. It was also my first head of mission job. I was wondering if we could take care of the refugees only and leave out the local population when they are in quite a dire situation as well.

Rian Landman, MSF Holland, Head of Mission in Bangladesh, 1993-1995 (in English).

At the end of September 1992, the Government of Bangladesh requested a six-month extension of humanitarian aid because it was impossible to repatriate refugees in the short-term. Tension in the refugee camps remained high and MSF once again witnessed abuses committed by Bangladeshi forces. During September and October 1992, several dozen refugees were forcibly repatriated to Myanmar without UNHCR involvement.



'World Food Programme **Report**,' 21 September 1992 (in English), edited.

Extract:

WFP has been providing food assistance to Rohingya refugees in Bangladesh since April 1992. Food commodities under the ongoing Phase of the operation are being distributed to some 260,000 refugees housed in 17 camps in the Cox's Bazar area but will be exhausted by the end of September 1992. A request has been received from the govt of Bangladesh for an expansion of this assistance for a further period of six months.

The influx of refugees has now slowed considerably and numbers have stabilized at around 265,000. A repatriation agreement was signed between the two govts of Bangladesh and Myanmar in April 1992 but has not been implemented yet due to difficulties in guaranteeing a safe and voluntary return of the refugees. Prospects for an

early resolution of the repatriation issue appear extremely slim: conditions in Myanmar for a safe return of refugees remain uncertain and may require proof of a significant change in Myanmar govt policy to dispel existing fears regarding reception and treatment upon return.

Meanwhile conditions in camps remain precarious in spite of efforts by WFP, NGOs and the govt to improve health and nutritional status. A recent nutritional survey conducted by Helen Keller international revealed alarmingly high rates of malnutrition particularly among vulnerable groups.



'Rohingya: Forced or Voluntary? **Messages** No. 54, MSF France Internal Newsletter,' October 1992 (in French).

Extract:

5 am, 22 September, on the Bangladesh-Burmese border, 49 Rohingya refugees. The refugees, originally from Rakhine province (Burma), were escorted to the river that separates the two countries. A large police escort oversaw the repatriation, led by three Bangladesh officials from Chittagong province. The 49 men, women and children were from Ronchikali camp, which is under close military surveillance. MSF France and Holland were able to visit the camp by chance. Why by chance? Because this site, which the authorities refer to as a "transit camp", made them think more of a detention camp and access is officially prohibited to all NGOs, the UNHCR and the press. The UNHCR was not notified of the repatriation, although the bilateral agreement that the two countries signed last May clearly stipulated that UNHCR would be involved in future repatriation, at least on the Bangladeshi side. Was this repatriation forced or voluntary? The question is particularly complicated because the refugees received money from the authorities in exchange for their agreement. Some refused the offer and others jumped out of the boats carrying them back. Tension in the camps rose quickly, leading to confrontations that left several refugees dead or wounded. Several hundred were arrested. Logical.

The Bangladeshi government's policy was also logical: it sought to get rid of these problematic refugees as quickly as possible in response to pressure from the opposition, which accused the government of failing to manage the situation properly. UNHCR protested the repatriation process, from which it had been excluded. Despite the negative reactions from key embassies locally, the authorities made it clear that the repatriations would continue. And without guarantees of UN involvement. During that time, MSF France and Holland continued their programmes in the camps, where the health situation had improved and the refugees' living conditions were also "good" – and perhaps even better than those in local Bangladeshi communities. As a regular target of the national press, which accused it, via innuendo, of manipulating the refugees so that they would remain in Bangladesh, UNHCR kept a low profile. As for us, we are continuing our efforts in the programmes, keeping our eyes and ears open, and remaining because we know that our presence as expatriates plays an important role in calming the government's fervour. Until when? It's obvious that the government will not leave it at that – and everyone is waiting for the next rabbit that's pulled out of the magician's hat. In any event, it is time for the international community to really become aware and act for radical change in Burma. Evil is present there and the Rohingya are not the only minority to suffer from it. The Burmese authorities are clever – everyone knows that – but no one so much as raises a little finger to change things. We'll certainly be talking about the Rohingya again – whether in Bangladesh or in Burma. Let's hope that it won't be too late.



Note on Position with Respect to the Repatriation of 49 Rohingya on 22 September 1992,' UNHCR Bangladesh, 23 September 1992 (in English), edited.

Extract:

1. UNHCR is in favour of repatriation. However, international norms require that repatriation be voluntary and safe.
2. UNHCR has not been allowed by Myanmar to monitor the situation in Rakhine and hence cannot judge the safety aspect of the returnees. UNHCR has, however, noted the statements emanating from the bilateral GOB/GoUM [Government of Bangladesh/ Government of Union of Myanmar] talks, concerning improved conditions in Rakhine.
3. The repatriation of 49 refugees on 22 September 1992 took place without the knowledge, hence presence of UNHCR. We have been told by the GOB officials, of whom the office has sought clarification, that only those families which had volunteered to return had indeed been repatriated.
4. UNHCR has stated its position to the GOB interlocutors that, in its view, if UNHCR was able to ascertain independently the voluntary character of this repatriation, such action would have imparted to this repatriation the necessary transparency and international credibility. [...]
5. The UNHCR representative has requested the GOB authorities refrain from repatriation movements without UNHCR ascertaining the voluntary character of repatriation. The GOB officials were not in a position to provide such an assurance.
6. Within the context of the dialogue started between UNHCR and GOB (in the aftermath of the Haladia Palong incident of 18 August) UNHCR has made concrete proposals on a range of issues related to security, protection and repatriation of Rohingya. UNHCR has proposed a framework of cooperation and coordination between GOB, UNHCR and NGOs with the following objectives:
 - a. reducing tension and friction and hence violence within the camps.
 - b. reducing the tension and friction in the neighbouring Bangladeshi communities.
 - c. a limited UNHCR involvement in repatriation with a view to upholding the rights of and protecting the refugees who make a free choice to return on the basis of their own assessment of conditions in Rakhine or, alternatively, seek to obtain information about the situation through visiting Rakhine with the option to return.
7. While concrete proposal on the above points were submitted to GOB only on 22 September 1992, the policy line and object were verbally been communicated to GOB officials in Dhaka (Ministry of Home Affairs and Ministry of Foreign Affairs) on numerous occasions since 19 August 1992.
8. Following the discussions held on 23 August between the UNHCR representative and the Additional Secretary Home Affairs, and separately the Acting Foreign Secretary and his colleagues, it is understood that the GOB shall study and consult on UNHCR proposals and shall soon be in position to discuss the modalities of UNHCR' s involvement.
9. In the course of these discussions the UNHCR representative while slating the Office's reaction to the repatriation of 22 September 1992 (along the lines stated in this note), has agreed to be forward-looking and has welcomed the agreement of the GOB authorities to engage in a dialogue with the Office on the basis of the proposals submitted by UNHCR to the GOB on 22 September.



'Report on Events by Aymeric Péguillan, MSF France Head of Mission in Bangladesh,' 26 September 1992 (in English), edited.

Extract:

When we arrived in the camp, we could still hear a few shooting sounds and police presence was very important. A police officer was treated for small thumb injury by our doctor Dr [M]. He was accompanied by four armed policemen that we immediately asked to leave the premises, which they did. Our Logistics assistant who had been in the camp since early morning told us that the police force had been massively present since the morning. He mentioned that a meeting of about 150 majis was held during the morning at Dechua Palong 2 camp. Some of the majis attending this meeting were from Dhoa Palong camp. On their way back from Dechua Palong 2, they were questioned by the police and molested. Gathering of refugees armed with sticks started right after this. Police forces entered the sheds and started to beat the refugees and shooting at refugees also started.

He also told us that after our expatriate nurse left the camps, four policemen entered MSF France feeding centre and started to beat women refugees carrying children who gathered in the facility for biscuit distribution. They finally left the feeding centre after five minutes thanks to the intervention of both our logistics assistant and our doctor. He mentioned that he could count roughly 150 shots fired by police since 11:00 am. He added that he saw two wounded refugees who escaped to hide in the camp and that some other male refugees left the camp to find refuge in the bush outside of the camp. He also mentioned that he saw two lorries of refugees arrested by the police that were transferred to another location: in the direction of Teknaf. He estimated the number of refugees arrested to be around 70. When we arrived we could estimate that 120 police personnel were present in the camp. [...]

One of our cars with Mr B went to Moricha Palong to check that everything was OK and Dr B and myself returned to Dhoa Palong. On our way back we stopped where the lorries full of refugees were parked. We saw some refugees with blood on their faces but we could not approach them as a man who refused to identify himself told us that if we wanted more information we should talk to the Police Superintendent. [...]

The entrance gate was closed and no police force posted there. We therefore left the cars and walked in the camp to the CIC's [Camp-In-Charge] office. There we saw about 70 police and met with the CIC and the Assistant Police Superintendent. They confirmed to us that during the afternoon, shooting went on in the camp and we understood from the CIC that 72 refugees were arrested and transferred to an unknown location. Our staff in the IPD told us that heavy shooting went on in the afternoon and that some refugees were injured but none was admitted in the MSF France IPD. We then moved on with our local staff to Cox's. We left our IPD open with one nurse and one health worker as we had 15 patients present in the IPD. The CIC told us that the situation in the camp was under control. When we stopped in Dhoa Palong on our way back, the situation was calm and quiet but still we could notice important police forces present.



'Fax from Aymeric Péguillan, MSF France Head of Mission in Bangladesh, to Olivier Rouleau, MSF France Programme Manager,' 18 October 1992 (in French).

Extract:

Here is the latest news from Bangladesh, where the situation in the camps is calm, overall. Based on the information gathered from the embassies, UNHCR and the camps, the refugee population falls into three categories. The first group, which is a minority

(approximately 10,000 people) firmly intends to return to Myanmar. A second group, also a minority, which we could describe as hardliners, composed of the first refugees to arrive and those that follow them, is willing to return only if the UNHCR is present. If they do return, they will all go together. This means that the refugees who say that they want to leave now should pay close attention to them. They are probably the source of the inter-refugee confrontations last week at Balu Kali 2, where MSF Holland is working, that left eight people wounded (including two seriously). Last, a third group, the majority: they include all the others, who, it would be safe to say, overall do not want to go back but who are certainly starting to ask questions.

Given that, several additional points should be emphasised.

There are refugees in Ronchikali camp today who want to return to Burma but cannot because the Burmese don't want them, claiming that they are not Burmese. Unofficially, the Burmese have stated that only 50,000 of the 250,000 refugees here are truly Burmese. Thus, they are the only ones who can return to Burma for now. The others are considered illegal immigrants. The logical conclusion to draw from this is that, under these conditions, it is difficult to imagine how the Bangladeshis will be able to decide, at a given moment, to send back a large number of refugees without falling out with the Burmese.

Next, based on information gathered in Dhaka, the UNHCR, which participated in the last repatriation (the second) as an observer, is not likely to be involved in the process of selecting the refugees who are ready to leave.

ADVOCATING FOR “VOLUNTARY AND SAFE RETURN”

In November 1992, though negotiations were still under way between the Myanmar and Bangladeshi governments regarding a formal agreement, repatriation resumed on a low-scale and local basis thanks to a few clearances issued by Myanmar authorities. By 25 November 1992, at least one third of the 900 returnees was forced back.

The Bangladeshi authorities increased the pressure on the refugees, multiplying the frustrations and mistreatment. As a result, riots broke out in the camps, which fuelled the repression.

MSF France alerted the EEC (European Economic Community) countries about forced repatriations.



'Fax from Aymeric Péguillan, MSF France Head of Mission in Bangladesh, to Olivier Rouleau, MSF France Programme Manager,' 1 November 1992 (in French).

Extract:

Yesterday morning (31/10), 104 refugees, representing 23 families, were repatriated to Myanmar. This took place in the presence [of the] Divisional Commissioner and two expatriate UNHCR representatives. The families were originally from Shaila Derba (IIRO⁷), Balukhali I (MSF Holland) and Dhoa Palong (MSF France). It is interesting to note that the

7. International Islamic Relief Organisation.

104 included former Rakhine village chiefs. If their return goes well, this could lead to massive numbers of people volunteering to leave. To be continued.

Each refugee family left with enough rice and dal for one week, blankets, mosquito netting, clothing, a plastic jerrycan and a small first aid kit (ORS [oral rehydration solution], paracetamol and aspirin) and the equivalent of 2,000 takas (Burmese currency, equivalent to around 250 French francs [at the time about US\$47]).

I should note that during the last meeting (24/10) between the Burmese and the Bangladeshi, the Burmese agreed, bitterly, to the return of all the refugees. This was a significant decision and we hope that they can keep the promise.

No new date was set for another repatriation, but it is likely to happen slowly. No repatriation-related tensions to report in the camps. The NGOs that decided to expand their programmes to other recent camps (including MSF Holland) have not yet received authorisation from Dhaka. It appears that the NGO Office isn't the problem but, rather, the Ministry of the Interior. It thinks that the NGO Affairs Office has too much decision-making authority given the significance of the problem and looks askance at the expansion of the NGO programmes. Only the NGO Office falls directly under the Office of the Prime Minister. Also to be continued.

UNHCR is still talking with the authorities about being more involved in the repatriations, particularly with regard to selecting the refugees who are volunteering to leave.



'Fax from Aymeric Péguy, MSF France Head of Mission in Bangladesh, to Olivier Rouleau, MSF France Programme Coordinator,' 13 November 1992 (in French).

Extract:

Regarding the 9 November confrontations in the Dechua Palong 2 camp, we have a clearer handle on the events. First, one refugee expressed her desire to return to Burma. She was kidnapped by anti-repatriation refugees and ultimately killed in the confrontation between refugees and authorities. In addition, a list of refugees who had volunteered for repatriation was submitted to the Camp In-Charge. As on each such occasion, this led to a gathering because some challenged whether these lists could be trusted (some of the Camps' In-Charges were accused of paying refugees to give them lists of names of other refugees willing to be repatriated). [...]

Here is an update on the various players in the Rohingya refugee crisis.

Government of Bangladesh

Overall, the message has not changed: they want the repatriation to continue, if possible, at a faster pace, and discord in the camps is in their interest because it dissuades the refugees from staying longer.

Similarly, the way they negotiate with the Burmese has not changed: monthly meetings are held, alternatively, in Burma and Bangladesh, without UNHCR or the hypothetical refugee representatives. On this point, we note that between these monthly meetings, there is very little, if any, contact between the two governments; this leads us to conclude that the repatriation will not be able to move forward quickly.

They continue to submit lists of refugees' names to the Burmese to obtain their agreement. To date, they have provided approximately 150,000 and only some 20,000 have been "approved". [...]

NGO Affairs Bureau

They have recently made life difficult for us and the Dutch, as well as for several other local NGOs, which have been involved for a long time in development programs in the

country – and are discovering the joys of the permanent political nature of their work. We submitted our request for permanent registration ... in July 1992, as we were officially asked to do. Since then, we have had to wait while undergoing repeated investigations by the secret services (NSO) and local police into our operations, participating in the standard process. We have done this all willingly [...] Then we asked UNHCR and the new director-general of the NGO Office to personally call the Home Minister to tell him that it would be a “mistake” not to let us remain here. That worked because we expect to have our shiny new piece of paper tomorrow or the day after, signed by the director-general (who’s also charming). However, we were clearly informed that this does not mean that we will be able to launch just any kind of programme without detailed investigations, which leads us to think that we have a very special arrangement ... In short ... we are bothering them, which does not make us unhappy.

Government of Burma

Despite its recent promises that it would allow all the refugees to return home to Rakhine, things clearly haven’t changed much in Rangoon and there’s still a lot of reluctance. Similarly, the Burmese certainly understand UNHCR’s intentions – which are to force them to make concessions in managing the Rohingya crisis and then get them to do the same with the Karen. The outline is obviously a bit simplistic, but this is what has emerged from the discussions with UNHCR. And on that point ... the head of UNHCR’s Asia desk is here and will stay in Bangladesh until 17 November. I’m supposed to see him on the morning of the 15th. In any event, the Burmese are handing out authorisations for the refugees’ return in dribs and drabs, and that is likely to continue. Last, a senior Chinese official travelling through Dhaka last week let it be known that they (the Chinese) had encouraged the Burmese to accept “the repatriation of all refugees”.

UNHCR

It appears that UNHCR finally has a team here that will stay for a long time and that’s being expanded a little more each day. They returned during the second phase of negotiations with the government so that they could be more involved in the repatriation, particularly in selecting the refugee volunteers and their transfer to Ronchikali, which is still handled only by the government. However, their involvement in camp life remains limited, although they are quicker to respond in the event of a clash. Apparently they remain hopeful of travelling in Burma with the refugees, but I think that is premature on their part without huge international support, which does not seem likely. On the other hand, they too must deal with an internal conflict at the UN – with the WFP, which is making arrangements with the government to reduce the refugees’ basic rations. In the medium term, these agreements could cause new nutritional problems.



‘Fax from Max Glaser, MSF Holland Head of Mission in Bangladesh to Eelco Schoonderwoerd, Programme Manager,’ 26 November 1992 (in English), edited.

Extract:

- Repatriation of 25 November consisted of over 900 persons, at least 1/3 of whom were forced. Only 8 families in transit centre of about 42 had requested to stay. Many other families forced to change mind.
- Repression in camps is widespread with confiscated ration cards, arrests and beatings. Fear of return is very palpable.
- Local officials indicate that pace of repatriation will step up and they may not use transit centre. They are resisting private UNHCR interviews of repatriates.



'Fax from Aymeric Péguy, MSF France Head of Mission in Bangladesh, to Olivier Rouleau, MSF France Programme Manager,' 30 November 1992 (in French).

Extract:

Based on our information, there are currently 1,198 refugees in Ronchikali, who are supposed to leave with the next repatriation, which is apparently scheduled for 1 or 2 December. The coordination meeting with the authorities scheduled for next Thursday has been postponed for the third consecutive week.

[...] I spoke with the First Secretary of the US embassy this morning. He confirmed that they had begun high-level discussions with the government and that the Americans would not issue any public objections, so we shouldn't expect a major change. He also noted that, to his knowledge, other embassies were doing the same right now.



'Dossier sent to the French Ministry of Foreign Affairs by MSF France,' 30 November 1992 (in French).

Extract:

Following our telephone conversation, I am forwarding you a summary of the situation facing the Rohingya. This ethnic minority has taken refuge in Bangladesh after abuses inflicted by the Burmese army and are threatened with forced repatriation. The absence of international organisations in Rakhine (a Burmese province) leads us to fear the worst for these refugees.

France and the European Community have shown great interest since the start of this situation, financing many refugee assistance projects. We hope that through their influence, they will be able to help find a solution to this tragic situation.

We do not want to be referred to officially – keeping our authorisation to remain in the camps depends on that.

Forced Repatriations of Rohingya Refugees in Bangladesh/Situation Report 30/11/92

Since August 1992, the Rohingya have been under increasing pressure to return to Burma. Many uprisings have occurred in the camps. Over four months, some four to five refugees have been killed and several dozen wounded every month.

The latest occurred on 9 November 1992 at Dechua Palong 2 camp; four people died. This camp, like the 18 others, is under UNHCR protection.

On 25 November 1992, 932 refugees taken to the Ronchikali transit camp were repatriated to Burma. UNHCR confirmed that 754 of the repatriations were voluntary. The remaining refugees were fiercely opposed. When UNHCR left Ronchikali camp, the remaining 178 individuals were taken by force to Burma.

Since that time, this transit camp has filled again, with 1,198 refugees housed there. Another repatriation is planned for 1 or 2 December.

Many maji leaders and heads of family were arrested in the camps on 29/11/92.

The UNHCR no longer has access to all the camps. It is prohibited from entering two: Dechua Palong 2 and Nayapara 2. All NGOs are also prohibited from entering the second. Today it officially became a transit camp. The European Community is funding the medical assistance programme there, as it is in most of the other camps.

The lack of any international supervision in Rakhine province (Burma) suggests the worst for this Muslim ethnic minority, the Rohingya, who are persecuted by the current Burmese government.



Bangladeshi authorities were intimidating the refugees, they were listing people for voluntary repatriation saying to them that they had to return but the people listed didn't know that they were on a list. If they were not listening or resisting then torture was the next step. When there was a protest they would crack down on it, and put people in prison. There was a huge tension between refugees and the government

P, MSF Holland, Logistician and Administrator in Bangladesh, 1992-1993 (in English).

On 4 December 1992, Bangladeshi soldiers shot dead four Rohingya refugees in the camps.

On 7 December 1992, while forced repatriation continued and despite the risk of having its project hampered or halted by Bangladeshi authorities, MSF International issued a press release. MSF denounced the wounding and killing of fifty refugees from the Nayapara I camp, by Bangladeshi soldiers, as the refugees demonstrated against forced repatriation. They also denounced the expulsion of the MSF medical team and an UNHCR representative from the camp. Subsequently, MSF requested access for relief teams to the transit camps and for UNHCR to freely monitor repatriations.



'Minutes of MSF France Board of Directors Meeting,' 4 December 1992 (in French).

Extract:

Bangladesh – Brigitte Vasset [MSF France, Director of Operations]

For several months, the Rohingya refugees in Bangladesh, fleeing oppression in Burma, have been sent back regularly to their country. These returns intensified in late November, with 870 people who were gathered in a so-called transit camp expelled to Burma, including 178 against their will (UNHCR survey). In August, UNHCR had already declared publicly that it would not participate in forced repatriations. The question for MSF is whether to denounce the situation, given that such a stance could endanger our presence in the country. Marcel Roux [MSF France Board Member] believes that if repatriations are not carried out in dignified fashion, MSF must speak out. Antoine Crouan [MSF France Director of Communication] takes a similar position, noting that we should be firm, while taking the constraints of local diplomacy into account. Rony Brauman [MSF France President] proposes that Bernard Pécoul [MSF France General Director], who is leaving very soon for Asia, meet with the Bangladeshi authorities.



'Account of Events, MSF Holland Team in Bangladesh,' 6 December 1992 (in English), edited.

Extract:

Herewith the account of events in Nayapara 1 camp with MSF Holland on 4 and 5 December 1992.

As for today access to the camp was denied, and the camp official refused to talk to the Medical Coordinator of MSF Holland. We are refused by the Relief Commissioner also to go inside and inspect our medical facilities and our medicine stock in Nayapara 1.

According to reports our Field Hospital, which was forcibly evacuated yesterday and looted, was broken open by the camp officials. It is not yet known, and under the given conditions cannot be ascertained by us, whether medicines have been taken away or not. Some damage to our facilities is reported by local witnesses.

Also this morning, when our staff wished to enter Nayapara 1 camp they were surrounded by a large crowd of local inhabitants threatening the driver and medical staff, shouting it is MSF Holland's fault and responsibility for what has happened in the last 48 hours. They were very aggressive and were about to attack our car. The Medical Coordinator then decided to leave the scene. The military and camp authorities present at this event this morning did not do anything to prevent or protect our staff.



'MSF International **Press Release**,' 7 December 1992 (in English).

Extract:

Bangladeshi Soldiers Kill Rohingya Refugees Demonstrating Against Forced Repatriation to Burma.

MSF demands unhindered access to camps for relief teams and free UNHCR monitoring of repatriations.

On Saturday 5 December, Bangladeshi soldiers shot at refugees demonstrating against forced repatriation, killing four and wounding 50 of them in the Nayapara I camp. The medical team of Médecins Sans Frontières (MSF) working at the camp hospital was then expelled from the camp and a representative of the United Nations High Commissioner for Refugees (UNHCR) was denied access to the camp. The planned repatriation of 369 Rohingya refugees was carried out regardless.

This is the latest killing in a long series of violent incidents that have occurred in the Rohingya refugee camps in the south-east of the country since Bangladesh and Burma agreed to speed up the repatriation plan.

Since early November, conditions in the Bangladeshi camps have deteriorated dramatically as pressure mounted on refugees to accept repatriation. Bangladeshi authorities confiscated food ration cards and arrest and assault refugees at random. Access to the camps has been made increasingly difficult for humanitarian organisations. MSF teams have regularly witnessed the relocation of refugees in convoys from the camps of Dhoa Palong, Dechua Palong II, Gundam I, Balukhali I and II and Nayapara I to transit camps. In the process, UNHCR is often prevented from implementing its mandate to monitor whether repatriation is voluntary.

Rohingya refugees, Burma's minority Muslims have good reasons to fear repatriation to a country which has subjected them to military repression since 1978. The Burmese military junta refuses any independent monitoring of the human rights situation in the country.

At the end of December 1992, the refugee's situation had not changed, and the repatriation process was accelerating. MSF France planned to write letters to key stakeholders and to hold a press conference together with MSF Holland, simultaneously in London and Geneva.



'MSF France and MSF Holland **Joint Update** on Bangladesh,' 21 December 1992 (in English), edited.

Extract:

1. Repatriation

Since 12 December, 3,270 refugees have been repatriated to Burma. Daily transfers of refugees from our camps to the three transit camps continued and today there are reportedly 3,000 refugees in Jumma Para transit camp, and an unknown number in the other two transit camps (Nayapara 2 and Rongikhali). Clearly the process of repatriation has accelerated dramatically over the last month.

Since the repatriation of 25 November, UNHCR has not interviewed any refugees regarding repatriation.

Refugees continue to report beatings, confiscations of Family Books, and threats of arrest if they refuse to repatriate. On two occasions in two MSF Holland camps, refugees have had to be admitted to IPD following beatings by camp officials, allegedly because they refused to return to Burma.

Today in Balukhali 2 camp, while seven refugee families were being loaded onto trucks to go to transit camps, a group of refugees began throwing stones at camp officials. The assistant Camp In-Charge ordered the police to fire at refugees. Reports of between 1 and 3 refugees killed (1 confirmed), and 3 to 4 wounded have been received. We treated one child with a hand gunshot wound in our IPD before camp officials transferred the child to an MoH [Ministry of Health] facility.



'**Fax** from Olivier Rouleau, MSF France Programme Coordinator, to the MSF France team in Bangladesh,' 22 December 1992 (in French).

Hello, everyone,

Here are the conclusions of the discussion we have just had here with operations + Rony [Brauman, MSF France President] + Bernard [Pécoul, MSF France General Director] + communications.

Because the situation has reached an impasse, we don't think that responding with a press release sends a strong enough message and would certainly not create much interest.

Instead, we propose a press conference, held simultaneously in Geneva and London if the Dutch agree.

The holidays are just starting so this isn't the best time. Because of that, we've planned this press conference for early January. In the meantime, a letter will be written and sent to Boutros-Ghali [UN Secretary-General], Delors [President of the European Community], etc.

Similarly, a letter will be sent to Begum [Bangladesh Prime Minister].

Obviously, it's important to work on this letter with you and the Dutch. At the same time, the entire team should prepare a daily account of events in the camps (trucks, beatings, incidents, etc.), which will allow us to state real and recent facts.

The letter will focus on the following three areas:

- living conditions in Burma, reasons for fleeing, etc
- denunciation of the violence on the part of Bangladesh,
- statement of the minimum conditions necessary in Burma so that repatriations can be carried out.

On 23 December 1992, the UNHCR issued a press release appealing to the Prime Minister of Bangladesh, Begum Khaleda Zia, “to take all necessary measures, to ensure that refugees from Myanmar are not coerced into returning against their will to their country of origin.”

On 24 December 2012, the US Department of State issued a statement asking the Bangladeshi government to restrain from coercion and to let the UNHCR conduct operations unhindered.



'UNHCR Press Release,' 23 December 1992 (in English).

The United Nations High Commissioner for Refugees, Ms. S. Ogata, appealed today to the Prime Minister of Bangladesh, Begum Khaleda Zia, to take all necessary measures, to ensure that refugees from Myanmar are not coerced into returning against their will to their country of origin. While the Bangladesh Government, which has extended asylum to some 250,000 refugees from Myanmar, has given assurances to UNHCR of its strict adherence to the principle of voluntary repatriation, UNHCR has not been allowed to ascertain through private interviews the voluntary character of the return and has witnessed forced repatriation over the past weeks. Other independent sources confirm that forced repatriation is indeed taking place. Furthermore, UNHCR does not have the indispensable free and unhindered access to the refugee camps and is therefore not in a position to carry out its protection mandate nor can UNHCR effectively monitor the relief programme.

UNHCR has been holding intensive negotiations with senior Bangladesh Government officials to work out modalities whereby minimum international standards of protection are applied to enable UNHCR to discharge its mandate. However, so far, the Bangladesh Government has been unwilling to change the existing practices.

The High Commissioner is deeply concerned about the deterioration in security in refugee camps on the Bangladesh/Myanmar border, including instances of beatings, violence, demonstrations and shootings with resultant loss of life. The High Commissioner wishes to do all she can to promote voluntary repatriation and to protect and assist refugees, but will be forced to reassess her role if her mandate cannot be carried out satisfactorily

At the same time, the High Commissioner is continuing her efforts to obtain access to returnee areas in Myanmar. Such access would greatly help to provide greater confidence to those refugees who wish to return.



'Statement by Department of State of the USA Spokesman,' 24 December 1992 (in English).

The United States Government has received credible reports indicating that Bangladesh is coercing Rohingya refugees to return to Burma and that the Government of Bangladesh is denying UNHCR staff free access to the Rohingya refugee camps, thereby preventing the UNHCR from fulfilling its international mandate to protect refugees.

Over the past several months, we and UNHCR have repeatedly raised this problem with the Government of Bangladesh. The United States Government deplores the use of coercion by the Government of Bangladesh. The United States also deeply regrets that the Bangladesh Government and the UNHCR have not agreed on an effective role for

the UNHCR to protect the Rohingya both in the refugee camps in Bangladesh and during the repatriation process to Burma.

The United States Government calls upon the Government of Bangladesh to refrain from coerced repatriation and to negotiate with the UNHCR as soon as possible an effective protection role for UNHCR.

On 11 January 1993, MSF Holland declined the press conference proposal. MSF France decided to send a letter to the main institutional donors and key state stakeholders to express their concerns.

On 26 January 1993, MSF France publicly released a report on the Rohingya forced repatriation to Myanmar describing the UNHCR's impediments. This report failed to gain any media attention due to disinterest.



'Fax from Max Glaser, MSF Holland Head of Mission in Bangladesh to Eelco Schoonderwoerd, Programme Manager,' 20 December 1992 (in English).

Extract:

I hope you will be able to resist the French in making (at this stage useless and ineffective) press releases or conferences. I would rather stick to a "wait and see" policy and in case we do get obstructions and UNHCR pulls out, protest directly at the Government level.



'Letter sent by MSF France to Donors,' 11 January 1993 (in French).

Extract:

Dear Sir,

On 30 November 1992, we informed you of our serious concerns regarding the forced repatriation policy carried out by the Bangladeshi government against Rohingya refugees from Burma.** We are aware that the information we provided you has generated considerable interest within the community.

The situation has only worsened since that time. On 6 January 1993, 8,500 refugees were sent back to Rakhine province in Burma. Fifteen thousand refugees, isolated in three transit camps, await their repatriation. UNHCR remains powerless, unable to fulfil its protection mandate.

Médecins Sans Frontières' teams are daily witnesses to abuses committed against the refugees. Denied their ration cards, beaten and threatened, they have no choice but to be transferred to the transit camps, to which no organisation has access. The refugees' demonstrations against these forced repatriations have been put down harshly by law enforcement in Bangladesh. Since June 1992, 25 refugees have been killed, several dozen wounded and hundreds arrested.

This situation reminds us of the prior exodus of Rohingya in 1978; 12,000 of them died at that time. This episode in the history of the Rohingya ended with a forced repatriation under tragic conditions.

There is no question that the return of this population to Burma will result in new human tragedies, both individual and collective, because Burma has not changed its policy of repressing ethnic minorities and its opponents.

Only a strong reaction from the international community can halt this process. The violence used against the refugees by Bangladesh's police forces must stop. The UNHCR must be able to carry out its mandate and ensure that repatriations are voluntary.



'Rohingya: Refugees Repatriated by Force to Burma, **MSF France Report**,' 26 January 1993 (in French).

Forced repatriations without HCR supervision

The government of Bangladesh has deliberately removed UNHCR from the repatriation process. Consequences for UNHCR in the field: prohibited from accessing the transit camps; limited access, under surveillance, in the other camps (it is prohibited from entering Dechua Palong 2 and Nayapara 2 camps); not permitted to question refugees independently and privately. In summary, impossible to perform its mandate of refugee protection. In addition, the organisations' expatriate employees are no longer authorised to travel freely or speak to refugees in the camps and are prohibited from entering the transit camps.

UNHCR and MSF warned the international community twice, via press releases emphasising the importance of the voluntary nature of the repatriations, which must be confirmed by HCR under its mandate, as well as the essential need to ensure that international agencies have permanent access to the camps. Lobbying continues to focus actively on the diplomatic representations in Dhaka.

Humanitarian agencies, powerless witnesses to repatriation

In early December, UNHCR confronted the Bangladeshi government over the agency's inability to carry out its refugee protection mandate. The UN organisation denounced the abuses committed against the refugees by Bangladesh's armed forces. For now, the government continues to take a hard line, turning a deaf ear to criticism from donor countries and accusing UNHCR and non-governmental humanitarian organisations (MSF in particular) of 'anti-repatriation' activism.

Every day, MSF teams are powerless witnesses to massive, systematic transfers of refugees to transit camps. Each day brings a new convoy of trucks filled with silent, submissive refugees who are being taken to the three transit camps.

On 11 January 1993, 17,129 refugees were sent to Rakhine province and 16,000 more were waiting, in isolation, in the transit camps.



'Minutes of MSF France Communication Department Meeting,' 2 February 1993 (in French).

Extract:

Bangladesh: it's difficult to mobilise journalists right now. There's a complete lack of interest on the part of the press. We're waiting for UNHCR to follow up with the media.

AMBIGUITIES OF THE REFUGEE REPATRIATION AGREEMENT

In May 1993, the UNHCR High Commissioner, Sadako Ogata went to Dhaka to sign a Memorandum of understanding (MoU) with the Bangladeshi authorities. The UNHCR was supposed to be part of the repatriation process, provided they secured an agreement from the Myanmar authorities.

However, even after the MoU signatures, which allowed UNHCR presence in the camps between 10 am and 5 pm, the UNHCR workers were continually denied access to the camps in Bangladesh.



'MSF Holland Bangladesh **Update**,' 20 May 1993 (in English).

Extract:

The major 'events' in April and May thus far have been

- closure of our facilities in 2 camps for 4 days as a result of poor security conditions created by local communities,
- the visit of Ogata and signing of the MoU between UNHCR and GOB.
- a renewed request from UNHCR for MSF Holland to take over the health facilities in Nayapara 2 transit camp. [...]

THE MOU

The contents of the MoU seem quite diluted, and already a little 'dated' in terms of the problems being faced.

The main points of contention have been resolved as:

Unhindered, unescorted access for UNHCR to all camps between 10am and 5pm, "and other times as necessary". (A UNHCR office will supposedly be set up in each camp, with 2-3 camps supervised by a protection officer).

Independent interviews by UNHCR to determine voluntary nature of repatriation.

"Information sessions" will be held by GOB and UNHCR. Termed "motivation sessions" by the Bangladeshis, who seem to have different expectations of these sessions!

No interference from GOB or UNHCR to refugees 'wanting' to return.

UNHCR workers were denied access soon after the signing! A workshop is to be held by UNHCR in Cox's for CICs and other relevant local authorities, as well as UNHCR staff to introduce the practical application of the MoU. [...]

Probable scenario: Myanmar has approved a total of 98,865 of the 240,000 or so refugees to return in meetings with GOB. Around 23,400 have already been repatriated. Myanmar is likely to 'close the door' after a certain number of repatriations, leaving Bangladesh with the responsibility for those refugees who are not accepted. Thus, GOB wants to push the repatriations, in the hope that Myanmar will be forced to accept all the Rohingya refugees and will probably resort to their previous tactics in this regard, thus testing UNHCR's resolve in the MoU.



We kind of implicitly knew that there were discussions going on, but we did not have any detail. And, obviously we were worried because the international community had had enough, and Bangladesh had had enough of the refugees and Myanmar had no interest in having them back. So we were kind of puzzled and concerned about these talks.

Jeroen Jansen, MSF Holland, Bangladesh Programme Manager, 1993-1998 (in English).

On 5 November 1993, the remaining obstacles to the repatriation were lifted. The UNHCR signed a MoU with the Myanmar government. The Myanmar government agreed to issue identity documents to refugees in return for their

voluntary repatriation. The UNHCR would have access to repatriates in Rakhine state.

The repatriation began in January 1994, but as Myanmar authorities only cleared a small number of Rohingya for return, the process quickly stalled and the vast majority of refugees remained in Bangladeshi refugee camps.



'UNHCR **Press Release**,' 5 November 1993 (in English).

Extract:

Memorandum of Understanding between the Government of the Union of Myanmar and UNHCR was signed on 5 November 1993, in Yangon. [...]

The MoU stipulates the modalities of UNHCR's presence and programmes in the Rakhine State. It inter alia states that UNHCR will be given access to all returnees; that the returnees will be issued with the appropriate identification papers and that the returnees will enjoy the same freedom of movement as all other nationals.



'**Fax** from Isabel Tavitian, MSF France Head of Mission in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager,' 26 November 1993 (in French).

Extract:

Repatriation plan: [...]

Repatriation is scheduled to start in early January, after the UNHCR team arrives at five reception camps in Rakhine province. According to UNHCR, repatriation will proceed slowly during the first four months (so as not to rush the refugees) and will then reach 15,000 people per month???. We will not be able to follow. According to the government of Bangladesh, it would be preferable to carry out the repatriation quickly, starting in early January, before the rainy season. Slight contradiction. We don't know the order in which the camps will be closed, but if the government wants to kick us out, they'll first close the camps where we are working. Fortunately, we are responsible for the therapeutic feeding centres, where malnourished patients are referred after screening. The UNHCR representative suggested that if the government does close our camps, MSF could be transferred to others (as a sort of mobile team). This raises some basic questions about the involvement of MSF France and, even, Holland under this somewhat vague scenario. First of all, given the speed of the repatriation, what would our position be regarding a medical screening???. It's not unreasonable to fear UNHCR manipulation surrounding our involvement in this plan. We have expressed a lot of reservations because, apparently, no one seems to be concerned for now about reception capacity in Rakhine. It's difficult to support a repatriation about which you hardly know the ins, let alone the outs.

Currently, the transit camps are full of people without clearance from Myanmar. UNHCR would like to turn them back into normal camps with an NGO (Gonosasthaya Kendra) taking them. It seems that the government does not share that view. The MSF Holland manager, Jeroen Jansen, asked his team if MSF's two sections had already prepared policies on this issue. However, currently, given the lack of information, it seems like it would be difficult to come up with any strategy.



'Fax from the MSF France Team in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager,' 9 January 1994 (in French).

Extract:

Relative calm in the camps. The returnee figures have begun to decline (4,000/week in December). The pool of 'volunteers' cleared by the Burmese is no longer very large; according to UNHCR (reliable source), this will 'limit' the returns until March. They project 3,000/week from January to March. The Bangladeshis will be disappointed, "but they will get used to the idea" (also UNHCR).

The movements will slow now because the number of cases that the Burmese have rejected are building up. The initial pool is now 30,000. Because registration was presented to the refugees as [a simple] process of correcting their name and village, some were shrewd and provided false information! There are +/- 67,000 people who have been rejected for 'administrative' (incorrect name/village) or other reasons. As of 28 December, there were 130,360 returnees and 120,517 people still in the camps.

In April 1994, despite the MoU between the UNHCR, the Bangladeshi government, the Myanmar government, and a first flow of repatriation, the mass repatriation was still to commence. Over the following months, the Bangladeshi government put pressure on the UNHCR, threatening to not renew their MoU, if mass repatriation stalled or failed.

MSF was confronted with a dilemma, triggered by rumours, that if MSF went public about the mass repatriation, the Bangladeshi government would terminate their programs in the country.



'Fax from the MSF France Team in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager,' 5 April 1994 (in French).

Extract:

Discussion with the UNHCR representative, who insists that massive repatriations must and will start quickly – they can't wait any longer. I pointed out that communication between UNHCR Burma and UNHCR Bangladesh doesn't seem very good and that a six-month difference between the dates that each side is putting out is a bit much!

When I asked them to be more honest, he said that he was going to Geneva to resolve some differences in terms of their scheduling. Still, should we be worried?

And increasingly worried because:

- In the same way that the UNHCR 'bought' the MoU in Burma by leaving the government entirely in charge, it also allowed Burma to coordinate the repatriation, serving only as a bank at this point. [...]

Otherwise, rumours in the US and Dutch embassies confirmed by the UNHCR representative: the Ministry of Home Affairs reportedly suggested that if MSF opened its mouth during the massive repatriation, our activities in the camps could be shut down. The French ambassador hadn't heard anything. During his last discussion with the UNHCR representative, the only scenario mentioned was that the government could first close our camps to get us to leave sooner.

Regarding the camps.

Given that there are still refugees coming back from the bad guys and telling their cousins that the situation hasn't changed, and that Aung San Suu Kyi⁸ will remain under house arrest for another year, they don't seem to want to move. One of the problems the Bangladeshis face is that the government of Myanmar has still not accepted their priority list (people not registered by Burma). So the repatriations aren't moving very quickly at this point and our Moricha camp is not emptying out either.



'Fax from the MSF France Team in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager,' 27 April 1994 (in French).

Extract:

This month, the government (Ministry of Home Affairs) continued along the same path, informing UNHCR during a meeting in Dhaka and another in Cox's Bazar, that our dear refugees must be back home before the end of the year. They added that UNHCR interviews were no longer necessary (more voluntary repatriation) and that if the international NGOs had anything to say about how the repatriation is being carried out, they can say it at home – in other words, they'd throw us out.

Latest news – from a daily newspaper dated 26/4/94, a big headline and on the front page – the [Bangladeshi] Secretary of Foreign Affairs accuses UNHCR of spreading disinformation about the Rohingya. He mentioned the possibility that last May's MoU with Ogata might not be renewed. The pressure is mounting. I think it was done with the intention of poking UNHCR because of their lack of action regarding this repatriation, but it was done awkwardly, and the accusation was harshly criticized.



'Fax from Isabel Tavitian, MSF France Head of Mission in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager,' 19 June 1994 (in French).

Extract:

The reception centres will be almost ready for the end of the month (current capacity: 750/week, projected capacity: 3,400). Nothing to do with the UNHCR reintegration project in Burma has been put in place yet. We remain sceptical. [...] For now, there is very little movement and, despite stated intentions, the monsoons will probably slow things down.

In July-August 1994, arguing that the situation in Bangladesh and in Myanmar was conducive to the return, the UNHCR replaced pre-repatriation individual interviews with collective information sessions. Despite UNHCR claims about voluntary nature of repatriation, MSF staff in the camps witnessed refugee's refusal to return to Myanmar.

MSF was then confronted with a dilemma: could they support Rohingya refugees remaining in Bangladesh while knowing this could lead to de facto ethnic cleansing of their communities in Myanmar?

8. Aung San Suu Kyi, leader of the democratic opposition to the Burmese junta was placed under house arrest for 15 years between 1989 and 2010.



“Muslim Refugees from Myanmar Rakhine State in Bangladesh”, UNHCR **Situation Report** No. 43, July 1994 (in English).

Extract:

A mission to Bangladesh [...] conveyed a clear message from the High Commissioner to the GOB that UNHCR was convinced that the only durable solution for all Myanmar refugees in Bangladesh was their voluntary repatriation, and that this process should be completed in the shortest possible time. In the light of the positive environment for repatriation on both sides of the border, it was agreed with the GOB that UNHCR Bangladesh would implement a policy based on the view that conditions have been created to allow all refugees to return to Myanmar. Individual interviews were therefore replaced by repatriation promotion and registration sessions.



Fax from Isabel Tavitian, MSF France Head of Mission in Bangladesh to Jean-Hervé Bradol, MSF France Programme Manager, 27 July 1994 (in French).

Extract:

Negotiations between UNHCR Geneva+Dhaka and the government of Bangladesh were held on 23 and 24 July in Dhaka [...]. [UNHCR officials] came from Geneva to “negotiate”... the MoU... WHICH NO LONGER EXISTS AND NEITHER DO THE UNHCR INTERVIEWS.

The test of the interviews ended in Kutupalong, with an overall result of 23% “yes”. Same idea in a second camp in the north, but everything stopped on Sunday. There are no more UNHCR interviews.

Based on the information here, the decision came straight from Geneva, which believes that conditions have been met in Myanmar, allowing for their return.

In practical terms, there will be a systematic ‘registration’ of the refugees in each camp, which will be conducted by the government ... and one UNHCR staff person.

List finished for August 1994 (all 194,000!) and submitted to the Burmese. The Burmese approved five additional UNHCR expats, which makes 10 in total, but they are not ready and certainly not at full capacity yet. (The repatriations will be made directly from the camps of origin.) When the list is done, there’s still the agreement with Burma ... Inshallah.



Bangladesh Field Report, Jean-Hervé Bradol, MSF France Programme Manager, July 1994 (in French).

Extract:

3.1 The refugees [...]

The refugees don’t want to go back right away.

They are worried about several problems waiting for them on their return:

- being displaced from their land
- becoming victims of forced labour
- not having a Burmese identity card
- having to send young girls to a government training centre away from the family for three months. The only possible deciding factor might be the change to the situation in Rakhine. If the refugees get the impression that significant changes have occurred, they might rush back. This is less to do with UNHCR’s information campaigns and more to do with the information networks run by the refugees themselves. While they have been given just enough to get by, there is little chance of them postponing their return to Rakhine.

3.2 SLORC/ GOUM

The political opposition organisations in Rakhine [...] are not particularly concerned by the SLORC due to their relatively weak military capacities. [...] A successful repatriation could be an easy way for the SLORC to improve its image.

3.3 GOB

It [Government of Bangladesh] has declared that all refugees must return to Myanmar before the end of the year. [...] The return of refugees to Myanmar is certainly one of the GOB's objectives. Not opening itself up to criticism from the opposition by appearing incapable of resisting foreign pressure (international agencies/embassies) is probably the main motivation for the provocative declarations (refusal to do interviews, complete repatriation by late 1994) concerning the renewal of the memorandum of understanding between Bangladesh and the UNHCR. Independence from foreign powers is a strong sentiment among the country's elite. Fundamentalists have a lot of influence in the Cox's Bazar region. The region benefits economically from refugees there.

In Bangladesh, refugees are a domestic political issue. But this can work both ways. The opposition might criticise the GOUM for its lacklustre response to the question of repatriation one day, then the next criticise it for showing a lack of solidarity to Muslims in Myanmar.

3.4 The UNHCR

The UNHCR (Bangladesh and Geneva) has confirmed that it does not want to let go of the principles of voluntary repatriation, or surveillance on the return to Myanmar. The reality is slightly different due to numerous concessions:

- pressure/threats/abuse committed in the transit camps and the absence of international NGOs in these camps.
- the absence of any real monitoring in Myanmar. It has been unanimously agreed to organise the repatriation as soon as possible.
- the UNHCR for general political reasons, the GOUM because it hopes to present a positive report before the 1995 elections.
- and the GOUM in order to improve its international image. [...]

The international community

The US embassy is very firm on the voluntary nature of the repatriation, this is a crucial criterion.

4 Repatriation conditions

4.1 The refugees

For the time being, they don't want to go back. The observers are unanimous on this. One recent test was enlightening: the UNHCR carried out interviews in Kutupalong (not a transit camp) and only 13% of 200 families interviewed wanted to return to Myanmar.

4.2 The authorities

They are pushing the camp managers to transfer refugees to the transit camps. These transfers are sometimes done under coercion.

4.3 The transit camps

The refugees are interviewed in a climate of threats (ration books confiscated). In these conditions, 60-90% of refugees have said they want to return to Myanmar. [...]

4.4 Burmese authorisations

Around 55,000 have already returned since 1992. The list of returnees approved by the GOUM contains an additional 80,000 refugees. Some 115,000 have still not been recognised as qualified to return by the GOUM. [...] One slight hitch is that the UNHCR personnel in the two countries have not had proper authorisation to cross the border to meet and it seems that the two computer systems used for compiling the lists are not

compatible. This might change soon thanks to the decision to hold a regular tri-party meeting (GOB/UNHCR/GOUM).

4.5 Reception arrangements in Myanmar

Refugees receive two months of food rations, a few items of clothing and cash at the reception centres. They have to make their own way back to their villages after receiving a temporary permission to travel. This identity card, which is yellow, makes them third-class citizens. To our knowledge, the UNHCR's assistance programmes in the townships affected by the repatriation have not officially started. The UNHCR is not really in a position to keep track of families that have already returned to Myanmar. The MSF Holland programme (malaria 1 laboratory equipment) has just began and is not specifically aimed at returnees. The AICF's sanitation programme has obtained authorisation in Rangoon but has not yet started operations in the field. [...]

Conclusion

The major tactics are being prepared to encourage the refugees to return. We are neither for nor against: it's up to the refugees to decide if it's safe enough for them to return. The UNHCR can do all the propaganda it likes, it doesn't change the fact that the refugees are not sheep or children and are sufficiently close to their home region to make their own minds up. We just need to set the limits and keep an eye on them:

- no forcible repatriations
- assistance maintained at reasonable limits (i.e. those before the cyclone), which is not the case at the transit camps or the shelters across the camps.



in July 1994, UNHCR changed completely from one day to another, changed its policy and started to be involved in what MSF saw as forced repatriation. It was a very political decision, taken at the highest level in UNHCR. Impossible to change, in a way. Whatever MSF could have done or could have said, it would have had no effect because a decision was taken at the highest level by the High Commissioner herself.

Ed Schenkenberg, MSF Holland, Humanitarian Affairs Advisor 1992-1998 (in English).



At a certain moment the UNHCR declared that the situation on the other side was "conducive". That was the keyword used then to convince refugees or to start actively working on the repatriation. We questioned very much that "conduciveness" because we couldn't really see what had actually got better on the other side of the river to start the repatriation. I think it was rather due to refugee fatigue on the Bangladeshi side and also to UNHCR trying to push and make things move.

Rian Landman, MSF Holland, Head of Mission 1993-1995 (in English).

In 1993, MSF Holland was authorised to open programs in two Yangon townships, the capital of Myanmar. MSF Holland was registered under its Dutch abbreviation, AZG (Artsen Zonder Grenzen) in order to avoid being confused with MSF France, whose support to the Karen refugees since the mid-1980s on the Thailand/ Myanmar border was not welcomed by the Myanmar regime.

In early 1994, MSF Holland succeeded in opening a malaria treatment project based in Sittwe, Rakhine state.

In August 1994, MSF France and MSF Holland program managers conducted a joint visit to Rakhine State. Following the visit, MSF France was puzzled by the UNCHR reversal of positioning regarding the living and security conditions for refugees in Myanmar. MSF France concluded that the voluntary nature of the repatriation process was not being respected. For their part, MSF Holland/AZG believed that more time and analysis would be needed to find out what was really happening in the region but ruled out the existence of “*blatant genocide, widespread killings, or open conflict.*”



“Burma (Myanmar) Evaluation of the MSF Holland Programmes: “**Report** by Egbert Sondorp, commissioned by MSF Holland Evaluation Unit,’ December 1998 (in English), edited.

Extract:

MSF’s presence inside Burma started in 1992, with the posting of a single expatriate. This expatriate was to examine if MSF activities could be established, preferably in connection with the ongoing conflicts in Kachin and Karen states.

After quite a lengthy period of assessment and ensuring MSF’s very presence, MSF became operational in 1993, in two townships near Yangon, Hlaingtharyar and Shwepyitha. It proved impossible to enter the Karen area, while Kachin did not seem totally impossible, but nevertheless permission was not granted in those days.

In the meantime, MSF became interested in doing something with an alleged malaria epidemic in Rakhine State. This interest coincided with the quite sudden exodus, in 1991–92, of 250,000 Rohingya from northern Rakhine into Bangladesh.

Based on experiences gained in Pakistan, a malaria programme became operational in Rakhine State in 1993, with Sittwe as base.



‘**Fax** from Jean-Hervé Bradol, MSF France’s Programme Manager, to Jeroen Jansen, MSF Holland’s Bangladesh Programme Manager,’ 31 August 1994 (in English).

Extract:

Bangladesh: the registration has started and the UNHCR isn’t carrying out anymore interviews. The refugees are registered for repatriation by the Camp In-Charge. In some camps they have been told that everybody should register. There is a UNHCR person to register those who are not willing to go back immediately but it isn’t clear whether this possibility is real or not.

[...] All this ‘policy’ is based on the view that conditions have been created to allow all refugees to return to Myanmar (UNHCR monthly report, July 94, Bangladesh). According to UNHCR, Rakhine is today a kind of Disneyland, and they don’t understand why the refugees are not ready to go there to play the mouse. What is your opinion about the new UNHCR policy on repatriation? [...]

What should the MSF position be?



'Fax from Lex Winkler, MSF Holland's Burma Program Manager, to Jean-Hervé Bradol, MSF France Programme Manager,' 8 September 1994 (in English).

Extract:

As desk for Burma I can say the following on the situation in Rakhine. We, MSF, have now been operational for less than six months in Rakhine State [...]. Apart from one month, we have been able to travel to all townships, Buthidaung and Maungdaw included. Also, we have made trips to other areas. It is very difficult in an area like Rakhine State to get the facts on table. Little by little we start to know more about it. A fact for us is that the Islam community and the Buddhist (Burmese) community are a split society, with different social instruments and opportunities and possibilities.

I do not know the official position of UNHCR at this moment. I am wondering on what they base their assessment, as they have been present in Rakhine State just as long and will have the same difficulties as us. My experience over the past years in Burma is that it requires quite a bit of time to distinguish facts from rumours. There is no blatant genocide, widespread killings or open conflict going on. But to state that things are alright is absolutely ridiculous. For us to find out what is really going on requires more time and study. I can give you more details if you like but it will not help us now to make a decision today.



'Information Note on Burma Visit by MSF Holland and MSF France Teams in Bangladesh,' 15 September 1994 (in English), edited.

Extract:

Reception Centres: [...]

UNHCR presence in the reception centres is very limited: IMPD [Immigration and Manpower Department] is the one in charge, UNHCR field officers only do spot checks to see how the centres are running (source: UNHCR Senior Pr. Off.). [...]

Some personal opinions [...]

Dr [...], Health Consultant UNHCR:

Has decided to resign after three months with UNHCR: this was the first time and the last, no further comment.

Very difficult to work with the IMPD: the militaries decide about everything. There is nothing you can do without them.

Medically there is no way to take care of the refugees, especially the EVIs [Extremely Vulnerable Individuals]. Please do not send any TB [tuberculosis] patients. Some returnees arrive in unacceptable condition: highly pregnant (one delivery in reception centre, one stillborn baby) and several malnourished children.

UNHCR field officers in Maungdaw are very naive: they believe everything the military tells them. [...]

Our personal impression on the general situation

Rangoon city looks too beautiful to be true. And so, it is, as [N] showed us by taking us to one of the townships where MSF Holland is working; the other side of the coin. For sure if the government is behaving like this towards its 'own people' it is not difficult to imagine how it behaves towards the minorities.

[MSF Holland] stories about [their] trip to Maungdaw only confirmed this thought: forced labour is a daily phenomenon and redefined by its executers as "contribution to the

community, hospitality towards guests," etc. They probably believe it themselves and apparently so do the UNHCR field officers in Maungdaw.

Conclusion

Nothing really changed as the refugees already told us in the camps, except for the willingness of the Myanmar government to execute this 'repatriation exercise.' Of course, we can still give UNHCR the benefit of the doubt; although starting with a lot of compromises, they might try to slowly change the situation from the inside and gradually be able to reach their goals. Quite a challenge for sure. But maybe the timing is right. One thing became very clear: the word 'transparency' used by UNHCR on the Bengali side in the context of the repatriation, during all kind of recent meetings, surely has another meaning for UNHCR than for us.



We used the Dutch name, because MSF was also working on the Thai border with the Karen so MSF had a very bad name. I would say "we are not the same organisation. We are sister organisations" and I would compare this with the Myanmar Red Cross and the American Red Cross, which was of course not true. I was saving our skin. At that time, the only programmes we had were in Rangoon and in Rakhine State. I thought it would have been a pity if we had been kicked out.

X, Former MSF staff member in Myanmar (In English).



We visited reception centres in Rakhine State because we did question the whole repatriation thing. It was some kind of a gesture from the UNHCR to try and please us. From a logistical point, it was well organised. You enter and get your documents, then you had access to the next line and you get your stuff. There was nothing wrong with how it was set up, but also not much to see about what would happen to people after the reception.

Rian Landman, MSF Holland, Head of Mission 1993-1995 (in English).

MSF FRANCE'S GOES IT ALONE

In September 1994, the situation regarding forced repatriation deteriorated rapidly in the refugee camps in Bangladesh. Nonetheless, UNHCR upheld their decision not to perform individual interviews with refugees.

On 20 September 1994, MSF France proposed a joint advocacy plan to MSF Holland but received no answer. On 22 September 1994, two days later, MSF France released a dossier on forced repatriation. The dossier exposed that the agreed voluntary nature of the repatriation process for Rohingya refugees to Myanmar was not respected and that the living conditions and security situation in Rakhine State were not nearly as good as UNHCR claimed.

Over the following couple of months, MSF France distributed the dossier to key stakeholders. However, MSF Holland was not notified of this distribution. The dossier was criticised by various diplomatic stakeholders, including the European Union (EU), the UNHCR, the United Kingdom (UK), and other INGOS in Bangladesh.

They blamed MSF France for lack of consultation before bringing charges with potentially serious political implications.



'Minutes of the MSF France Operations Meeting,' 20 September 1994 (in French).

Extract:

Bangladesh: repatriation of refugees. The repatriation procedures established to respect the decision of refugees on whether or not to return to Myanmar have not been observed in recent weeks. Which means we are seeing more and more forced returns.

Decision: compile a testimonials report, go and see the UNHCR in Geneva. See if we take a stand against the UNHCR by criticising its breach of its mandate. We need to be prepared to go much further given the seriousness of the situation.



'Fax from Brigitte Vasset, MSF France Director of Operations, to Lex Winkler, MSF Holland Director of Operations,' 20 September 1994 (in English).

Extract:

This is to inform you that the situation in the camps is deteriorating seriously, concerning the repatriation process. Our team is daily witnessing forced repatriation. Refugees are writing letters to both MSF and UNHCR, refusing to go back to Burma. Some leaders have their cards taken away. Rumours are spreading about killings of new returnees inside Burma. UNHCR has decided not to perform any more individual interviews and has declared that the situation in Burma allows repatriation for all the refugees. Isabel, coordinator in Dacca is in Europe for the PSP⁹ course: we will try to have an appointment with [...], UNHCR director, Asia bureau, next week. We will also try to send her to Washington to meet US officials and lobby groups. Would you be interested to participate to this advocacy/lobby process??



'The Rohingyas: Forcibly Repatriated to Burma, MSF France **Dossier**,' 22 September 1994 (in English).

Extract:

The situation of the refugees has now taken a new turn since the start of systematic registration in the camps in July 1994 in view of mass repatriations to Burma. UNHCR recently secured a limited presence in Rakhine. There has however been no news of the 60,000 refugees already returned. The new UNHCR policy is based on their assessment that the situation in Rakhine allows all the refugees to go back. This view of the situation in Rakhine is shared neither by the refugees nor by international observers. The cancelling of UNHCR interviews makes it very difficult for the refugees to refuse an immediate repatriation. They are under the pressure of the Bangladeshi administration (Camp In-Charge), eager to speed up the repatriation process and to get rid of the refugees as soon as possible. The mass repatriations have recently started, and it is still time to act to guarantee the voluntariness of the repatriation process.

Recommendations

9. MSF training on assistance to Population in Precarious Situations (PSP: Population en Situation Précaire).

- Donor governments should express concern that the new UNHCR policy does not meet the requirements to ensure the voluntary nature of the repatriation.
 - Presence of UNHCR should be increased in order to guarantee protection of the refugees in the camps and to protect them from a non-voluntary repatriation.
 - UNHCR should be more present specifically when refugees leave the camps and at the departure points to Burma.
 - Emphasis on increased independence of UNHCR vis-à-vis the Governments of Bangladesh and Myanmar.
 - Require continuous external assessment of the situation in Rakhine and Burma.
 - Request the need for increased monitoring of refugees so far returned to Burma [...]
- Revised repatriation policy since July 1994

The revised UNHCR repatriation programme is based on:

- the view that the situation in Rakhine allows all the refugees to return to Burma;
- the set-up of a UNHCR monitoring programme in Rakhine;
- the voluntary movement from the camps to Rakhine.

Interviews are cancelled and replaced by mass registration in all the camps. The transit camps are being phased out. Refugees are repatriated directly from their camp of origin by the GOB, with UNHCR presence. [...]

Total population in the camps: 176,989 persons (September 1994).

Talks were held in Cox's Bazar (Bangladesh) between the GOUM and the GOB on 12.08.94 without the presence of the UNHCR. They agreed on a monthly figure of 20,000 repatriations whereas the figure of 13,400 had previously been set up by UNHCR and GOB. The total figure cleared by GOUM is now 150,000 out of which 72,606 have already returned.

The three main concerns:

- Has the situation changed enough in Rakhine to make it safe for all the refugees to return to their homeland?
- Is UNHCR in a position to efficiently monitor the repatriation in Rakhine?
- Everyone knows that an important part of the refugees is not willing to return to Burma right now; do they truly have the possibility to say they do not want to be repatriated? [...]

The situation in Rakhine in 1994

UNHCR describes the present situation in Rakhine as follows: "[...] It was agreed with the Government of Bangladesh that UNHCR Bangladesh would implement a policy based on the view that conditions have been created to allow all refugees to return to Burma." *UNHCR Bangladesh – situation report No. 43 – July 1994*

Since 1992, there has been no new major military offensive against the civilian population of Rakhine. According to the various agencies working in the Burmese context, no major evolution has taken place over the past year. Massive Human Rights violations are still reported, especially in the areas where the ethnic minorities live: arbitrary executions, torture, looting, forced recruitment, forced labour, arbitrary arrest and ransom [...]

Report from MSF field workers, August 21 "Various reports from Burma, include a Rohingya we spoke to who had just arrived on August 14, having crossed the Naf River from Buthidaung. M-H (34 yrs old) left shop and family after having been threatened and shot at by the Burmese military and fled to Bangladesh. He now lives illegally outside Moricha Palong camp. He also reports of the killing of 3 mollahi (religious mollahs) two weeks ago and burning with an iron rod of a Muslim suspected of RSO¹⁰ involvement (by the military). He saw UNHCR, says they are mainly in the urban areas and always accompanied by the Burmese, wherever they go. News filter back of refugees who were

10. Rohingya Solidarity Organisation.

repatriated and later beaten or killed by the army. We were given a list of twenty names, most repatriated by GOB 18 months ago with town/village of origin.”

To conclude:

The picture presented by UNHCR is not shared by the refugees or the Burmese nationals and foreigners having recently travelled through Rakhine. Through family and relatives, refugees have established their own network of information on the situation in Rakhine. It is clear they want to go home but not under the present conditions in Burma. If UNHCR is present, they will feel more confident but, as they remark: “If UNHCR says the situation has improved, how come the BBC [British Broadcast Corporation] does not?” “How long will UNHCR remain in Burma?” “When Aung San Suu Kyi is freed, it will be safe for us to return.” [...]

The new procedure of registration for repatriation

When there were fair interviews of the refugees done by UNHCR the outcome was clear: Kutupalong camp, July 1994, 13% of “yes” after 3 days, 23% at the end of the interviews (after 10 days). Following the test three majis were beaten by the Camp In-Charge because the turnout was too low. This would be another explanation for the final “Yes” rate now close to 90%.

Without prompting, this version was also reported to the MSF coordinator by refugees in Moricha Palong, 17 August. After this test was performed in a non-transit camp, Kutupalong, UNHCR decided to change its method of screening.



Letter from the European Commission to Jean-Hervé Bradol, MSF France Programme Manager, 30 November 1994 (in French).

Extract:

Our delegation in Dhaka and our services in Brussels were interested to read your report of 22 September 1994 on the forced repatriation of Rohingya refugees. This report has not received unanimous support, not from the UNHCR, the British representation or other NGOs in Bangladesh. It also breaches the fundamental principle of having at least some degree of dialogue between the various partners before making accusations with potentially serious political consequences. We are not denying MSF France’s technical expertise in the camps, and the EC [European Community]’s assistance to international NGOs is also designed to monitor the conditions refugees are living in and their repatriation, but any information needs to be carefully fact-checked before being widely distributed.

All things considered, we feel it is important that you come to Brussels as soon as you can for a joint meeting with ECHO [European Commission Humanitarian (Aid) Office] and the DG1 [EC General Direction for International Cooperation] to go over the impact of this report and re-examine the conditions of our cooperation.

MSF Holland found out about the MSF France report only in November 1994. Considering this report could potentially hamper their activities, they were disgruntled for not having been consulted beforehand.

MSF France pleaded that, given the urgency of the situation they couldn’t wait until MSF Holland clarified its position on repatriation. MSF France highlighted the document had not been publicly released but distributed manually instead. MSF

France claimed that the way MSF Holland was mentioned in the document would not implicate them in any 'highly political' manner.



'Fax from Jean-Hervé Bradol, MSF France Programme Manager, to Jeroen Jansen, MSF Holland Programme Manager,' 27 October 1994 (in English).

Extract:

Isabelle [MSF France Head of Mission] had a conversation with Rian [MSF Holland Head of Mission] yesterday and we still do not understand if you consider the present repatriation process as a voluntary one or not. For us it is clear the answer is no. Refugee International, US Committee for Refugees share the same position. Asia Watch recently met in NY [New York] and Washington do not wish to send a mission to Bangladesh only because they consider that the work has been done by 2 other organisations (RI & US committee). The UNHCR/GOB plan is to send back 20,000 refugees a month. 14,000 have been repatriated in September. It is obvious that it is a fast move. If we do not react nowadays it will be too late. It is exactly the meaning of lobbying: trying to get a decision before, not after. A joint mission (US, EEC, UK [United Kingdom]) will visit Cox's on Sunday. If Rian's position is "*we don't know, everything is normal in our camps*", I will consider that we don't share at all the same view on the situation. Of course, it is up to you but now it is time to make it clear.



'Fax from Jeroen Jansen, MSF Holland Programme Manager to Jean-Hervé Bradol, MSF France Programme Manager,' 2 November 1994 (in English).

Extract:

Yesterday I received, from Rian [...] in Bangladesh, your and Isabel's report on forced repatriation of 22 September 1994. I protest that you use MSF Hollands name for MSF France's highly political/advocacy standpoint(s):

- Without our explicit consent
- Without prior discussion or notification neither in the field nor on desk level (on September 26 we sat together at Mr Blatter's UNHCR desk and presented our concerns)
- Endangering MSF Hollands project implementation in Bangladesh.

Additionally, painful is the fact that Rian received this report through Stefano of the UNHCR in Cox's Bazar and not directly from Isabel! We know that this report has made its way through the US Embassy in Dhaka and other international and national channels. Rian has done her utmost to control the damage as our partners assumed wrongly that your report also reflected MSF Holland's stance. Neither lobbying nor, inter-sectional collaboration (which has always been good in the past) should follow these patterns... To continue our collaboration, I ask you to inform our partners that the presented report is solely yours and does not entirely represent MSF Holland's point of view. The question whether or not the repatriation is forced is indeed of another order. I would like to discuss this with you soon, as I think it is important MSF Holland + France operate jointly in Bangladesh. However, differences of opinion should not be excluded and thus be discussed openly among the first partners in operation and advocacy



'Fax from Jean-Hervé Bradol, MSF France Programme Coordinator to Jeroen Jansen, MSF Holland Programme Coordinator,' 4 November 1994 (in French).

Extract:


The fundamental problem is that MSF Holland has refused to spell out its position on repatriation and UNHCR's new registration procedure. [...] For the last two months, MSF Holland is still refusing to answer questions regarding the voluntary nature of the repatriation. This wouldn't be a problem if 80,000 refugees hadn't been repatriated since September '92 under conditions that did not give them the option to refuse their return to Myanmar. We therefore took the time we needed to observe the situation before forming an opinion. Due to the situation in Myanmar, the weak international presence in the country and the total absence of information on the situation of the 80,000 returnees, the conditions are such that it is not possible to secure automatic repatriation for all the refugees as was the case for the Khmer refugees in Thailand.

The fact that the UNHCR suppressed interviews to speed up the process and repatriation registration was delegated to the Bangladeshi authorities in conditions we have known about for two years (threats, physical abuse, confiscation of ration books to be used at canteens for returnees) requires us to share our opinions and our concerns with the UNHCR and the US authorities. We informed our American contacts (the list of which I already sent you) about our position (repatriations weren't voluntary, the refugees were forcibly repatriated to Burma and not subject to forced repatriation) in writing, on MSF Paris headed paper. This document was never made public but was hand-delivered. The only mention made in the text to MSF Holland, in the section presenting MSF's activity in the camps, indicated that MSF Holland worked in three camps: "The Dutch section (3 persons) is present further south in Balukhali 1 and 2 and Nayapara 1." Under no circumstances does this implicate MSF Holland in a "highly political" position. Not to mention that we still do not know MSF Holland's position. You told me that you didn't agree with the document that we handed over [to the UNHCR] during the joint meeting in Geneva.


The document handed over during the visit to the US was a copy of this document fleshed out with a long introduction (copied onto the document from '92) describing the past events and the new repatriation procedure. Furthermore, we intentionally didn't mention MSF Holland's work in Rakhine in our document to avoid potentially compromising your reports with the Burmese authorities despite that fact that MSF Holland is one of the few available sources of information and that Lex Winkler clearly told us, by fax, that he did not agree with the analysis of the situation carried out by the UNHCR on the developing situation in Rakhine. So, I don't know where the problem lies. Our position is clear: the repatriations are not voluntary (opinion shared by Asia Watch, Refugee International and [CR] report being written for the US Committee for Refugees); the refugees are being forcibly repatriated to Burma, and the refugees are not subject to forced repatriation. We have made our position known, although not publicly. This didn't surprise the State Department, which let us know that they had never understood how, after just a month, some 90% of refugees were suddenly voluntarily returning to Myanmar. I completely understand that you might not share this position. I do not know where you stand despite me asking repeatedly for the past seven months.

This does not prevent me from doing my work since we work in two, by all appearances, quite different associations. I think, as you do, that we can improve our collaboration. I am aware that we are currently jointly running a mission in Sri Lanka. I would be delighted if we could further improve our cooperation in our countries. Things would be easier if I knew your position on Bangladesh: are repatriations voluntary? If you feel that the matter could be cleared up by a meeting in Amsterdam, then I'd be more than happy to


come. This might also help me understand the work you do in Myanmar, about which I don't have any document either (Sitrep?).

 NGOs were worried about the repatriation process and the speed with which UNHCR was bringing people across. And especially about how that's happened. Now sometimes there were some rumours about violence on refugees, especially also from the Bengali camp directors who would beat up people or threatened them. MSF France decided to write a report about that, mainly based, I think on stories from people from the camps. So more like incidental stories, but not with much ground under it. There was a strong programme manager in MSF France who later kind of admitted to me that he was in a hurry to get the word out and to hit UNHCR with it, because of his own frustrations of the Rwanda crisis,¹¹ which happened not so long before that. But the worst about it was that it was not at all communicated to us. I had a meeting with the head of UNHCR who just put that report in front of me and said: "what have you been doing?" And I never saw the report before. So that was a pretty embarrassing situation, which gave quite a discussion between MSF France and MSF Holland. Unfortunately, the report was really not very good quality because it wasn't substantiated. It didn't go very far, and it was very easy for UNHCR to put it aside. So, it was quite a missed opportunity to really do something. It went too fast, too quick, not well done.

Rian Landman, MSF Holland, Head of Mission, 1993-1995 (in English).

 Our approach was obviously one of concern about the unwillingness of people being repatriated already and the remaining anxiety with refugees who came to us in the camps stating they were being asked or forced out that they didn't want to go. And I remember that we said, 'okay, we have these individual cases, but we want to have an approach of being well informed and do the advocacy with hard data.' MSF France would think that the Dutch are always late and that we wanted to have first big data. And then they spoke out and on the other side, it was all "here the politicians go again." So, this was a typical prejudice we both had. So, it started with a clash but it later developed into something more coordinated and also influencing each other's acting. I think it helped us to become more active. And for France it was the learning curve, to do it well-informed. So, I think there was probably a good mix there.

Jeroen Jansen, MSF Holland, Bangladesh Programme Manager, 1993-1998 (in English).

 There was something human in this report. The young Bangladeshi doctors we worked with had a political conscience of what was happening in their country. This political conscience urged them to keep an eye on the situation of the Rohingya refugees and they brought a great deal of information to us. They were deeply entrenched in the camps. So, we had an extremely broad and exceptionally reliable information network. Which is why we were quite confident about what we knew. The analysis from the MSF Holland's head of mission and their position was that the refugees were returning willingly. All the agencies shared this position. I can't remember any other exception. Lex and Jeroen did a field visit then came to Paris and that cleared up the situation. They criticised the first report we produced describing the situation, and they were right to do

11. See "Rwandan Refugee Camps in Zaire and Tanzania 1994-1995" MSF Speaking Out Case Study – Laurence Binet <https://www.msf.org/speakingout/rwandan-refugee-camps-zaire-and-tanzania-1994-1995>

so. However, the basic assessment in this report was fair, albeit incomplete, and there were some clumsy mistakes. It was for information only, not for public consumption.

Dr Jean-Hervé Bradol, MSF France, Programme Manager, 1993-1996 (in French).

MSF FRANCE AND MSF HOLLAND AGREE TO JOINT PUBLIC POSITIONING

On 3 February 1995, MSF Holland conducted their own survey in one Bangladeshi camp to assess refugees' awareness of their right to refuse to be repatriated. They found out that only 16% of them were aware. As a result, MSF Holland decided to give two weeks to the UNHCR to improve the procedures before starting to increase pressure.

The UNHCR disagreed with the proposal to issue letters informing the refugees about their rights or to conduct their own survey.

On 8 February 1995, despite the reluctance of the MSF Holland Humanitarian Affairs Department, the MSF Holland Head of Mission in Bangladesh shared MSF's concerns in a BBC interview. However, she did not give the results of their recent survey as she feared it could jeopardise MSF's negotiations with UNHCR. On 28 February, MSF Holland decided to go public with their findings in early April together with other INGOs.



'Fax from MSF Holland Humanitarian Affairs Department to Rian [Landman], MSF Holland Head of Mission in Bangladesh,' 7 February 1995 (in English).

Extract:

The general feeling here at HQ [Headquarters] is that refugees are not sufficiently informed about the option to stay nor about the human rights situation in Burma. Although the refugees are not physically forced to repatriate, it cannot be said that UNHCR has taken all steps to supply adequate information to the refugees to make a proper personal assessment about the safety of the repatriation. Therefore, the repatriation cannot be regarded as voluntary.

The question is to what extent MSF should contribute to the BBC programme at this stage, given the fact that MSF has given UNHCR two weeks to improve procedures before increasing pressure on UNHCR. Especially now UNHCR has shown willingness to consider our recommendations thoroughly. They might go through the roof when we make our concerns public through the BBC. While it seems reasonable that you supply the BBC with background information, and carefully express our concerns, at this stage MSF should probably not take a public position.

However, if you believe that by going public MSF would really achieve an improvement of the process of repatriation, you may consider using this opportunity.



'Fax from Rian [Landman], MSF Holland Head of Mission in Bangladesh, to the MSF Holland Humanitarian Affairs Department,' 8 February 1995 (in English).

Extract:

Talked to the UNHCR yesterday, to continue negotiations, using the survey results, told also that I would tell BBC our concerns, said I did not know yet whether I would use the survey figures.

Did the interview this morning. Did tell of the record that we did the survey but was not willing to give any results as it might harm our negotiations, only said the results underlined our concerns.

During the interview conveyed our concerns, we did put it on video ourselves, not bad.



'Fax from Theo Wijngaard, MSF Holland Humanitarian Affairs Department to Jean-Hervé Bradol, MSF France Programme Manager and Anne-Marie Huby, MSF UK Press Officer,' 10 February 1995 (in English).

Extract:

On Friday 3 February 1995, MSF Holland held a survey under the refugees (random sample of 313 refugees from one camp resulting in 311 valid forms) to see whether they were given adequate information with regard to their repatriation. In short, the results of the survey were as follows:

- 98% (305) of the refugees were registered by UNHCR (UNHCR numbers state the same percentage).
- 84% (311) of the interviewed refugees did not know they had a choice to say no against repatriation.
- 84% (305) of the registered refugees did not know they had a choice to say no against repatriation.
- 39% (118) of the registered refugees want to be repatriated [...]

Out of these figures, the MSF Holland team concluded that due to the lack of information, repatriation could not be regarded as entirely voluntary.

On Wednesday 8 February two BBC journalists were filming in the camps, trying to find out if the repatriation was voluntary or not. In an interview with the BBC reporters, MSF Holland told the BBC (off the record) that a survey had been carried out and that the results confirmed MSF Holland's concerns, stated above. The results, however, were not given to the BBC for this could jeopardise the negotiations with UNHCR a day later. During the negotiations the results of the survey were communicated to UNHCR together with the announcement that the concerns were told to the BBC and that MSF H[Holland] did not yet know whether it would use the results of that survey as well. Anyway, the return to Holland was delayed with one week. I do not yet know how the results of the negotiations with, nor the exact content of the interview with the BBC But I will let you now a.s.a.p.

Some days before the survey MSF Holland was informed that UNHCR responded positively to the recommendations on increasing the number of field staff (rec. 1) and an improvement of the interviews with refugees (rec. 2). Further, UNHCR agreed on the opportunity for NGOs to look into UNHCR's kitchen (rec. 3); according to MSF Holland the refugees were given sufficient privacy, the interviews held were of good quality and UNHCR treated the interviews very seriously. Moreover, UNHCR did not agree on the issuing of an information letter to the refugees (rec. 4) nor on holding a survey among the refugees (rec. 5). Thus, no 'hard evidence' will be made available to check MSF Holland concerns.



'Minutes of the Strategic Meeting on Repatriation from Bangladesh, MSF Holland,' 28 February 1995 (in English).

Extract:

Critical overview:

On Cox's Bazar- Dacca-, and Geneva level, MSF expressed concerns when the UNHCR changed their policy (in July 1994) from interviewing refugees to only registration of refugees. It seems that this policy of the UNHCR is a test case for a new and more bold kind of policy. MSF felt concerned about the lack of information given to the refugees, especially about the possibility to refuse repatriation. Furthermore, there is no system to be channelled out for refugees who want so. Based on a survey carried out by MSF, it became clear that a lot of people didn't know about the right to say no.

MSF France came with a report on coercion at the end of September 1994. However, coercion already ended in May and the report caused a lot of upheaval. It took MSF H a long time to re-establish relations with embassies, donors and create 'room' for its own advocacy activities etc.

MSF H chose to be more careful (silent diplomacy) as any action might endanger the whole repatriation. See earlier presented action plan (sitrep). Mobilisation of other NGOs also done. As there is no tripartite agreement between UNHCR, Burma and Bangladesh, the Government of Bangladesh might take over the whole repatriation process. MSF and other involved NGOs is pushing the UNHCR for better dissemination of information and decided to go public in the beginning of April together with a lot of other NGOs (if possible). HQ contacts European NGOs.

Taking a decision:

A decision should be taken on whether to go public or not and if yes, when to go public. Questions came up as: "Is it to the benefit of the refugees to go public" and "Why not going public now and demand a better information dissemination at this moment as already 2/3rd of the refugees has been repatriated" and "shouldn't MSF have gone public at the time when the results of their own research were there."

The conclusion: Action will be taken between two and four weeks from now. Rian [MSF Holland Head of Mission in Bangladesh] will go on lobbying on Cox's and Dacca level; all local NGOs will be involved, and Jeroen will do the same on European level.

A strong statement will be delivered in which the policy/procedure of the UNHCR (which is not taking care of a voluntary repatriation process which is not according to the UNHCR mandate) will be denounced. This is necessary as this kind of repatriation policy should not become the usual policy of the UNHCR. Concern about what will happen to the refugees in Burma once the UNHCR has left, will also have to be expressed. Precise formulations will have to be thought over. For this Ed [Schenkenberg, MSF Holland Humanitarian Affairs Department – HAD] will leave for Bangladesh and draw up public reaction and discuss further with whole team.



UNHCR did information campaigns in the camps, preparing refugees to go back, but no one told them that it was voluntarily, and that if they didn't want to go, they could choose to say no. They left that piece of information completely out. And that's exactly where the weak point was, what we put our finger on because we thought there was something wrong. So, when we got to this figure of 85% of the refugees, not knowing that they could say no we thought that we had a case. We talked with UNHCR, and the only thing they did was try to attack the epidemiological validity of our survey. And we said: 'we know you can attack us on the epidemiological validity if you want. But isn't the underlying message more important

ant? Even if the figure was 70% or even 50%, if the people don't know that they can say no, then there's something wrong with your information campaign and we would recommend you work on it.'

Rian Landman, MSF Holland, Head of Mission in Bangladesh 1993-1995 (in English).

In Early March 1995, MSF France and MSF Holland continued to deem that UNHCR was not guaranteeing a fair repatriation process, especially regarding the information given to the refugees. MSF decided to do a common survey with the help of Epicentre¹² in order to prove that the repatriation was not as voluntary as presented by the UNHCR and the Bangladeshi and Myanmar government.

Other NGOs acting in Bangladesh were sharing MSF concerns and analysis and were ready to help. The survey was ready by mid-March 1995. It confirmed that refugees were lured into registration without being properly informed about their right to refuse.



'Fax from MSF Holland team in Bangladesh to Jeroen Jansen, MSF Holland Programme Manager,' 6 March 1995 (in English), edited.

Extract:

In NGOs meeting of 22-2, it was clear that all NGOs are fed up with the slack attitude of UNHCR regarding info transparency, all agreed that an extra survey in all camps should be done within the coming week. Furthermore, all NGOs would start to put on paper the presence of UNHCR staff in the field, their willingness to handle problems and check on the re-verification system. Info put on paper since stories remain stories and are forgotten/twisted easily with time.

23-2 UNHCR repatriation meeting: In Dhaka UNHCR made a promise to Rian to improve re-verification system, it should become final re-interviewing system in which the refugee is informed of the possibility to say no: UNHCR was pretty annoyed when we brought up this point during the meeting: Do we have to talk about this over and over again. They had changed the last column of the re-verification form... And we were free to check the system in the field (but please, not all at once). According to them the system runs fine now... So, time to check.

Philip [Barboza, MSF France Representative in Bangladesh] of MSF France is willing to set up a new survey for all camps together with MSF Holland, based on the question/answers of our np [non-published] survey this time in all camps and achieve validity to have firm figures to be used as tool for final report and to put more pressure on UNHCR in coming months.

12. Epicentre is an MSF satellite association whose mission is to conduct field epidemiology activities, research projects, and training in support of MSF.



'Fax from MSF Holland team in Bangladesh to Jeroen Jansen, MSF Holland Bangladesh Programme Manager,' 10 March 1995 (in English).

Extract:

Survey Objectives

Official objective: Assess the level of awareness among the Rohingya refugees regarding the repatriation process, and especially the possibility to say no to repatriation.

Hidden objective: Document and/or prove the fact that the repatriation is not as voluntary as it is presented.



'"Awareness **Survey**, Rohingya Refugee camps, Cox's Bazar District" MSF France and Holland,' 15 March 1995 (in English).

Extract:

This survey is conducted on 15 March 1995 in eleven Rohingya Refugee Camps in Southern Bangladesh, in cooperation with the following Non-Governmental Organisations: Concern, International Islamic Relief Organisation (IIRO), Médecins Sans Frontières (MSF), Oxfam and Save the Children Fund (SCF). The report of this survey is produced by the MSF France and MSF Holland team in Bangladesh. MSF consequently takes full responsibility for this report.

Summary

- Awareness assessment survey, systematic sampling, performed in 11 Rohingya refugee camps in Cox's Bazar district Bangladesh. 412 families have been interviewed, on 15 March 1995.
 - 97% of the interviewed families went for registration.
 - 12 % of the surveyed refugees declared that they went for registration because they wanted to repatriate.
 - 79% stated that they went for registration because they were called by the UNHCR and/or by the Camp In-Charge.
- At the present stage of the process, 37% of the interviewees think that registration did not consequently mean volunteering for repatriation.
- 65% of the interviewed refugees are not aware of the possibility of saying NO to repatriation. [...]
- 37% of the interviewees want to be repatriated. Reasons given are the following:
 - 14%: Police or others threaten them if they want to stay and/or the camps are not safe anymore.
 - 33%: UNHCR and/or CIC told them to go.
 - 9% of the interviewees declare that they want to return because they consider Burma is safe now.
- For the group, which is not willing to repatriate, the reasons given are:
 - 80% mention that they do not want to be repatriated because Burma is not safe and/or the situation in Burma has not improved.
 - For 43% forced labour remains a major concern.
 - On the other hand, a large majority of the refugees, 75%, is definitely willing to return to Burma as soon as the political and/or safety situation will have improved.

Recommendations

- I. UNHCR should put the present repatriation on hold, until (a principal safeguard for voluntariness i.e.) a system for private interviewing is set up.
- II. UNHCR should ensure that the refugees are fully informed about their options, including the right to refuse repatriation.

- III. UNHCR should ensure that the refugees have full information available on the situation in Burma and that the repatriation is free from any constraint.
- IV. MSF believes that the level of information of the refugees on the right of saying no and information on the human rights situation in Burma may be facilitated by the issuing of a leaflet containing this information. Visits of refugees to Burma to inform themselves on the situation there – without such visits automatically involving loss of refugee status – could also be of assistance in this regard.
- V. The UN Special Rapporteur on the situation of human rights in Burma (Myanmar) should closely monitor what happens to the returned Rohingyas and report on their human rights situation.
- VI. The Executive Committee of UNHCR should review the present system for repatriation of the Rohingya refugees and determine whether this system is fully in accordance with the UNHCR mandate.



We were attacked on the validity of the first survey. So, we decided: 'let's do another survey, and let's do it better.' We had MSF France back on board by then and we also got all the other NGOs on board, which was quite something because we managed to do this completely secretly without UNHCR knowing anything. We did all the preparations and then we had one day where all the staff of all the NGOs went into all the camps and we did the biggest survey in 11 camps in one go. And we took UNHCR completely by surprise because they didn't see that one coming and they were in shock when they found out. We did a quick run through the results and interesting enough it was again, exactly 95% of people who didn't know they could say no.

Rian Landman, MSF Holland, Head of Mission in Bangladesh, 1993-1995 (in English).



As soon as the Dutch changed their position, people like Jeroen realised that the Rohingya were completely obstructed in a very hyper-aggressive manner. Diplomatic representations like those from the UK and Japan had to announce that Bangladesh, due to its own domestic politics, was in charge of the matter of refugees. The Cox's Bazar district was experiencing unrest with highly developed Islamic fundamentalism. These embassies all wanted Bangladesh to make political progress and bring the situation to an end. They really laid the pressure on. Few people at the UNHCR were happy about this. It was as if there were two UNHCRs: the one in Myanmar whose representatives were telling us they'd better not return, and the one in Bangladesh urging people to go back. We started working together and, since Jeroen and I got on well, we made a good team. It was he who came up with the idea to use the epidemiology investigation methodology. We were pleased that the investigation was done, and there was no more division, we managed to work together and come to the decision to put the information in the public domain.

Dr Jean-Hervé Bradol, MSF France, Myanmar Programme Manager, 1993-1996 (in French).



During my Bangladesh days we always had a very good collaboration with MSF France. We worked quite closely together. The two MSF worked in different camps. But I worked closely with the MSF France head of mission. We found common ground with Paris to

do strong advocacy behind closed doors with UNHCR, without any serious tension between Paris and Amsterdam on the message.

*Dick van der Tak, MSF Holland, Head of Mission in Bangladesh 1995-1996;
Humanitarian Affairs Advisor 2000-2003 (in English).*

MSF QUESTIONS UNHCR'S MANDATE INTERPRETATION

On 19 April 1995, MSF France and MSF Holland Program Managers met with the UNHCR in Geneva. They presented their survey results and discussed repatriation. They got the impression that UNHCR was stuck in a political situation where it would not be able nor willing to address MSF's concerns on repatriation.

Therefore, MSF decided to release the survey on 1 May 1995 with a statement sharing MSF's repatriation concerns for the Rohingya refugees and the manner in which UNHCR was handling the crisis. MSF recommended that UNHCR put the repatriation on hold until they could provide refugees with the full information available on the situation in Myanmar and to ensure that repatriation was free from any constraint. The UNHCR answered with a letter expressing their belief that repatriation operations should continue on current basis.



'MSF-UNHCR Meeting **Minutes** taken by Jeroen Jansen, MSF Holland Bangladesh Programme Manager,' 19 April 1995 (in English).

Extract:

Aims:

- present draft survey results
- discuss protection (mandate)
- understand each other's position
- present MSF standpoint + recommendation + give MSF options for advocacy
- ask for advice... [...]

Personal impression:

UNHCR is not going to change its actions. UNHCR has been incriminated by GOB. UNHCR is political. UNHCR is almost the only organisation which is so enthusiastic about situation in Rakhine: it admits that situation is not optimal. The feeling that UNHCR started to justify present repatriation only after McNamara became involved appears to be the case. If we go public it will not change their policy, it will only put them in a very defensive attitude which can be counterproductive to the cause (not with a capital letter). Issues raised by MSF are also (hotly?) debated within UNHCR HQ. MSF questions are legitimate ... and appreciated?

Plan of action:

To be confirmed after consultation MSF France/Holland Bangladesh + MSF Paris (Brigitte Vasset) and MSF Amsterdam (Lex).

In brief: statement without explicit international press release + presentation (summary) survey results.

24 April:

- Presentation of final statement + summary of results (possibly to give full survey report upon request) to meeting of 24th in Geneva.

- Idem officially to UNHCR Geneva + Dhaka + CXB [Cox's Bazar] with request to react before 1 May.

2 May:

- Statement + full survey (both adapted if necessary) to all international actors + GOB + press. Press contacts in form of briefing. Important to ask questions and not be trapped in journalist game. Press can quote from statement which will merely raise the questions/issues. Press can then make own investigation and articles.

Start of May:

- MSF France/Holland (Rian [Landman, MSF Holland Head of Mission in Bangladesh]?) presentation in Bangkok to e.g. CCSDPT (Coordination Committee for Displaced Persons in Thailand) [...].

May/June:

- Special visits by desks/HAD to e.g. EU, State Department (Jeroen [Jansen, MSF Holland Bangladesh Programme Manager] and Rian after codays?), UK and others (?).



'MSF's Concern on the Repatriation of Rohingya Refugees from Bangladesh to Burma, **Report** MSF Holland and MSF France,' 1 May 1995 (in English).

Extract:

SUMMARY

Médecins Sans Frontières (MSF) believes that the Rohingya refugee repatriation from Bangladesh to Burma is not voluntary. The Rohingyas are not well informed on their right of saying no to repatriation and access to full and proper information on the human rights situation in their place of origin Rakhine in Burma is limited. The situation in Rakhine has not changed fundamentally.

MSF understands the United Nations High Commissioner for Refugees' (UNHCR) dilemma to repatriate refugees to a country where the situation has not changed fundamentally. MSF wishes to raise awareness by questioning whether the new UNHCR policy of 'voluntary' repatriation of refugees to Burma is the future international standard answer to repatriation? The applied procedure of repatriation weakens the position of the refugees. Their protection is at stake.

MSF wishes to continue the dialogue with UNHCR and at the same time put the discussion with its fundamental question onto an international level. Does the new policy fit the UNHCR mandate?

MSF and other Non-Governmental Organisations conducted an awareness survey amongst the Rohingya refugees. The survey's outcome showed that many refugees were not aware of their right to refuse being repatriated. [...]

IV Conclusion and recommendations

MSF believes that the repatriation of Rohingyas is not voluntary and that the procedures set by the UNHCR do not guarantee that the refugees are able to take a decision out of free will. MSF is concerned that the UNHCR is trying out a new repatriation policy for countries where a fundamental change of circumstances has not taken place. MSF questions if this policy fits the statutory UNHCR mandate of voluntary repatriation. Therefore, MSF recommends the following:

- I. The UNHCR should put the present repatriation on hold, until (a principal safeguard for voluntariness i.e.) a system for private interviewing is set up.
- II. The UNHCR should ensure that the refugees are fully informed about their options, including the right to refuse repatriation.
- III. The UNHCR should ensure that the refugees have full information available on the situation in Burma and that the repatriation is free from any constraint. MSF believes

that the level of information of the refugees on the right of saying no and information on the human rights situation in Burma may be facilitated by the issuing of a leaflet containing this information. Visits of refugees to Burma to inform themselves on the situation there – without such visits automatically involving loss of refugee status – could also be of assistance in this regard.

- IV. The UN Special Rapporteur on the situation of human rights in (Myanmar) Burma should closely monitor what happens to the returned Rohingyas and report on their human rights situation.
- V. The Executive Committee of the UNHCR should review the present system for repatriation of the Rohingya refugees and determine whether this system is fully in accordance with the UNHCR mandate.



'Letter from UNHCR to MSF Holland,' 8 May 1995 (in English).

Extract:

Thank you for your letter of 1 May 1995 forwarding the MSF position paper "MSF Concerns on the repatriation Rohingya refugees from Bangladesh to Burma" for our comment.

I would like to reiterate in general terms our position with relation to the repatriation operation which I have recently explained in various meetings with representatives of MSF in Bangladesh and Geneva. UNHCR believes that the repatriation operation should continue on its present basis. UNHCR commenced promotion of repatriation in 1994 due to the fact that UNHCR had established a presence in Myanmar and could monitor the safety of returnees. Since the change of policy, UNHCR has monitored the return of an estimated number of 120,000 individuals who have returned under UNHCR auspices and have not experienced serious problems upon return. Any issues raised as a result of this monitoring have been promptly addressed with the Myanmar authorities who are actively cooperating with UNHCR to create conditions conducive to return in safety and dignity.

In relation to the issue of ensuring that refugees are fully informed of their options regarding repatriation UNHCR is satisfied that the safety nets which have been established ensure that anyone who chooses not to repatriate is able to indicate their position and that their wishes are respected. This is the case for an estimated number of 5 000 individuals who chose not to register for repatriation during the initial registration, together with a significant number who have subsequently indicated that they do not wish to return.



I can't remember that the whole issue was picked up massively by media. We did use it in front of media, we sent it to other NGOs, embassies and of course the UNHCR which we informed first. That was the trick. We first obviously informed them before we started sharing it with others because that will be the proper way to do it. We were also being funded by them. So, we didn't want to surprise them. In the end, I didn't think the report changed anything, but I know they were annoyed. They couldn't say anything else because it was a strong report, well done and well documented. In private UNHCR officers encouraged us to go ahead, but not officially of course.

Jeroen Jansen, MSF Holland Bangladesh Programme Manager, 1993-1998 (in English).

Over the next months, no major concrete improvement in the repatriation process occurred. UNHCR was internally divided on the best way to move forward and some staff in Bangladesh was supporting MSF's stance. While MSF Holland wanted to build on this momentum, MSF France shifted its strategy to a soft diplomacy approach so as to try and renew trust with UNHCR.



'Fax from Jeroen Jansen, MSF Holland Bangladesh Programme Manager to Martine Lochin, MSF France Deputy Bangladesh Programme Manager,' 17 August 1995 (in English), edited.

Extract:

Although talking to you on the phone I must say I am amazed to learn about your [passive] attitude towards the Rohingya refugee issue. JH [Jean-Hervé Bradol, MSF France Programme Manager]'s approach was slightly different as far as I remember. It's already some time ago [that] we discussed this. I am afraid at this stage I disagree with your wish to do nothing for the Rohingya issue. I think we still have to say a lot on the Rohingyas, see also Bernard Pécoul [MSF France General Director] and Jacques de Milliano [MSF Holland General Director]'s letter to Blatter [UNHCR General Director]. That the repatriation is on hold does not change the principle which we address and which we do not want that it is applied in future in other refugee crisis; a policy of involuntary repatriation dressed up as a voluntary repatriation! None of the recommendations have been seriously addressed, even not during this hold of repatriation: a perfect moment to improve things as we recommended! [...]

It must be noted that within the UNHCR there seems to be division over what the best strategy for the future repatriation is. In Bangladesh UNHCR staff already express personally that they support our actions so far and that the hope that we carry this thing through. This positive momentum cannot be more ideal and should not be lost. If we do not use this opportunity for which others are already prepared for, we throw away our alleged plight for the refugees.



'Fax from Martine Lochin, MSF France Programme Manager, to Jeroen Jansen, MSF Holland Programme Manager,' 18 August 1995 (in English), edited.

Extract:

So, what I think now, after speaking with Philippe [Biberson, MSF France President] and some others, I agree to continue "lobbying for the Rohingya refugees" but, perhaps in a more soft way ... because I think, MSF is discussing with UNHCR to build a new confidence

...

What I propose is:

- August is a holiday month, so I propose to do a statement for the beginning of September at European and Dhaka level.
- What to say in this statement
 - To repeat and confirm our position (analysis) about the repatriation = "non-voluntary" following the conclusions of MSF report (September 94) and the survey (March 1995)
 - To say that, for the moment, there is no more repatriation due to the absence of clearance from Myanmar, but it should start again after the rainy season, and 40,000–45,000 refugees still remain in the camps.
- What to ask UNHCR:

- To improve the information in order to ensure a real knowledge among the refugees. So, they will be able to say “no” or “yes” to the repatriation.
 - To have a real policy of voluntary repatriation.
 - To recognise that the repatriation for Rohingya refugees during 1994–1995 must not be repeated in other situations.
- How to conclude:
- MSF is very concerned by the future evolution and the modality of the repatriation. MSF wants to continue the dialogue with UNHCR about this situation during the meeting of 19/09/95.
- And MSF will continue to inform the other partners (Ex Com [Executive Committee of UNHCR], other NGOs) and give a time limit for reaction.
- What do you think about these proposals???



What I remember was that MSF France spoke out early and without details whereas the Dutch approach was to first collect sound data, which we did through the survey, and then speak out. After we did collect the data MSF France became more cautious. I do not know why, maybe they already spoke out and did not want to repeat themselves, or they wanted better relations with UNHCR.

Jeroen Jansen, MSF Holland, Bangladesh Programme Manager, 1993-1998 (in English).



At the time, the position of MSF's leadership towards UNHCR was 'critical but constructive engagement.' I remember having the same attitude towards Bernard Pécoul (MSF France General Director) as Jeroen (Jansen, MSF Holland Programme Manager) had towards Martine (Lochin MSF France Deputy Programme Manager). The question, 'how to react to the setbacks of UNHCR?' was the subject of a recurrent debate, concerning all the refugee camps on all continents. By the end of the Cold War, refugees had lost their political added value and the level of assistance and protection they were supposed to receive was being reduced.

Dr Jean-Hervé Bradol, MSF France Programme Manager, 1993-1996 (in French).

In September 1995, an UNHCR “note on international protection” suggested that repatriation of refugees could occur even if the conditions in their country of origin were not optimum. This was particularly concerning for the Rohingya refugees. MSF Holland and MSF France questioned the UNHCR Executive Committee on the UNHCR repatriation policy in general, using Bangladesh as a case study. The question was perceived as aggressive by the UNHCR, which at that time was internally divided on the interpretation of its mandate.

Regarding the Rohingya, UNHCR officials in Bangladesh began to highlight human rights violations in Rakhine State and advised Geneva headquarters to stop actively promoting repatriation. Contrarily, their UNHCR colleagues in Myanmar advocated for the resumption of repatriation.

MSF Holland decided to support the position of the Bangladesh office as much as possible.



'Note on International Protection, Executive Committee of the United Nations High Commissioner's Programme, UNHCR,' 1 September 1995 (in English).

Extract:

Related actions may include encouraging the facilitation of visits by refugees to countries of origin and, in the context of information campaigns promoting voluntary repatriation, of representatives of the country of origin to refugee camps. The process can be further strengthened through the provision of appropriate education in refugee camps and settlements. These actions are particularly important in the increasing number of situations where various factors, including the welfare of the refugee population, indicate that large-scale voluntary return must nevertheless be considered, despite the existence of less than optimum conditions in the country of origin. The safety and viability of such operations depends on a number of factors, including the commitments given by the country of origin, the effectiveness of international monitoring of returnees and proper provision for those who have valid reasons not to return home. It is likely that UNHCR will face an increasing number of such situations in coming years.



'Memo from Philippe Biberson, President of MSF France to the Members of the MSF International Council,' 16 October 1995 (in French).

Extract:

1) The question put to the Ex Com [of UNHCR] related to the change to UNHCR's repatriation policy and took the case of Bangladesh as an example.

It was a legitimate question since:

a) despite the many meetings and conversations with people at every level of UNHCR about the matter, we didn't have any other responses on the fundamentals other than the questions we were putting together ourselves [...],
b) regarding Bangladesh we only managed to agree to disagree, and
c) we had a concern regarding the preparatory note for the Ex Com meeting sent out to the other member states entitled 'Note on International Protection'. In paragraph 24 of the note, it assumed that, given the general situation, future repatriation operations might be instituted despite the far-from-optimal conditions in the home country.

2) The UNHCR was seriously annoyed by the question, and the way it was presented (an MSF note distributed to participants). S[ergio]. Vieira de Mello [Deputy to the United Nations High Commissioner for Refugees] and D[ennis]. McNamara [Director of UNHCR Division of International Protection] stormed out of the plenary session as a reaction to MSF.

My interpretation is that:

a) The question hurt because it was at the centre of an internal debate at UNHCR between those who supported a strong and restricted mandate and those who advocated for a broader, more politically ambitious role (peace building, etc.) and

b) the memo being sent around, which was perfectly written by the way, was taken as an act of aggression.

3) I think overall that because of these events, we managed to convey our message to the NGOs (our note will be included in the ICVA [International Council of Voluntary Agencies] [report to the Ex Com] and UNHCR. It's a concern that in high places UNHCR continues to have an uneasy even critical attitude towards MSF. Given the challenges

that lay ahead, Rwanda and the former Yugoslavia¹³, I feel it's legitimate to press on this matter. At the same time, Jean-Hervé Bradol [MSF France, former Programme Manager for Myanmar and Bangladesh, now Director of Communications] was meeting [...] to present MSF's position paper to him about the problem of a potential mass repatriation of Rwandan refugees and assure him of our collaboration. As for the states [?], it's up to each of us to try and position our message: UNHCR needs to be supported to have the resources to fulfil its mandate to provide refugees with help and protection. By expanding the mandate, UNHCR becomes a pawn in the realpolitik, and the refugees are at risk of becoming currency.



'Fax from MSF Holland Head of Mission in Bangladesh to Robert Mueller, MSF Representative in Geneva,' 21 January 1996 (in English), edited.

Extract:

Last Thursday (18 Jan.) I received some phone calls from disturbed UNHCR representatives in Bangladesh about a call made by you to UNHCR HQ Geneva. According to UNHCR Bangladesh you asked for the reasons behind stopping repatriation of Rohingya refugees to Burma. Since UNHCR did not stop repatriation, but the active promotion of repatriation, I thought you might need some additional info, to follow this cause properly:

- In Dec. 1995 UNHCR Bangladesh decided to recommend to UNHCR Geneva to stop the active promotion of repatriation because of ongoing and increasing reports of violation of Human Rights in Rakhine State.
- At the same time UNHCR stopped the active promotion in the camps.
- UNHCR Burma did not agree with this decision and wrote a firm message to Geneva, that UNHCR BGD [Bangladesh] 'overreacted' and that the situation in Rakhine was still improving.
- UNHCR Burma and Bangladesh have therefore totally different interpretations of the necessary policy in the field.
- UNHCR Geneva decided to side with UNHCR Burma and sent a message to Bangladesh that there is no need to stop active promotion of repatriation.
- At this moment UNHCR BGD is working on an answer to Geneva; although they do not agree with the Geneva decision, they will probably lose this internal battle.

As you can guess, this is all rather delicate. For the moment MSF decided to keep a low profile on advocacy. [...] For the time being we try to support the UNHCR Bangladesh as much as possible.



For the first time in UNHCR's policy, words could be found like 'return in less than optimal conditions' that is something between the class of voluntary return and enforced repatriation. They were trying to frame it now into new policies because the High Commissioner Sadako Ogata had put so much emphasis on repatriation as the preferred solution for refugees, on finding solutions compared to the protection. If one looks at the policy of Sadako Ogata she has put all the emphasis on assistance and completely forgotten about protection. The point is that there is a tension in UNHCR's mandate. It is two parts: it is to protect the refugees, but it is also to find durable solutions. And in this case, they have to protect refugees, but they know that states and the host country of Bangladesh, but also donor countries who are tired of funding protected refugee situations, can say to UNHCR, you have to work on

13. See MSF Speaking Out Case Studies – Laurence Binet 'Rwandan Refugee Camps in Zaire and Tanzania 1994-1995' <https://www.msf.org/speakingout/rwandan-refugee-camps-zaire-and-tanzania-1994-1995> and 'MSF and the war in the Former-Yugoslavia 1991-2003' <https://www.msf.org/speakingout/msf-and-war-former-yugoslavia-1991-2003>

a solution. And UNHCR's claim, of course, is yes, we have to work on a solution, and one cannot wait for years until the situation is completely at peace, the return of refugees should be part of the peace process. That is how they justified these less than optimal conditions.

Ed Schenkenberg, MSF Holland Humanitarian Affairs Advisor 1992-1998, (in English).



We criticised UNHCR for not being sufficiently present and active in defending the right of the Rohingya to seek asylum – which is why it exists.

Dr Rony Brauman, MSF France, President, 1982-1994, (in French).

In early 1996, due to impending scaling down of refugee camp interventions, MSF Holland and MSF France set up a single MSF representation office in Bangladesh that was coordinated by the MSF Holland's Head of Mission.

Toward the end of 1996, most refugees were repatriated to Myanmar, where according to the UNHCR and the Bangladeshi and Myanmarese governments, the situation was acceptable. However, MSF teams in Bangladesh continually witnessed numerous arrivals of refugees fleeing a situation considerably more difficult than described by authorities. The MSF teams obtained information in this regard, from UNHCR insiders who were quite aware and frustrated by their organisation's positioning.

Due to the Bangladeshi authorities' reluctance to an increase of refugee on their territory, the new refugee arrivals in Bangladesh no longer had access to official refugee camps, leaving them with no other option but to set up makeshift camps.

Both MSF France and MSF Holland planned to stay in the country and to open mid- and long-term programs for the population of Bangladesh. These programmes would be independent, while the MSF representation remained common.

By 1997, 20,000 refugees remained in Bangladeshi camps and the authorities asked NGOs to pull out of the country. In January 1997, the last camp where MSF France was working was closed. MSF Holland remained the only MSF section present alongside Rohingya refugees in Bangladesh.



'Bangladesh Visit Report, Marie-Pierre Allié, MSF France Programme Manager,' October 1996 (in French).

Extract:

[MSF International Structure](#)

Since the start of the year, the new structure was set up with the joint representative (MSF Holland coordinator) now based in Dhaka, in charge of representing MSF with the authorities, donors and other IOs and NGOs. With the end of the refugee programme approaching: the structure is to be formally established. Both sections plan to stay in Bangladesh and open medium- or long-term programmes aimed at the Bangladeshi population. The planned programmes will not require a large expat presence. The

proposal, therefore, is to keep on one joint representative, but to have two modular programmes independently coordinated.



During these 18 months that I was in Bangladesh, more and more people came to Bangladesh, to claim refugee status because they did not feel safe in Rakhine. New arrivals no longer had access to the camp because it was actually controlled by the government of Bangladesh. So, they ended up in illegal sites in the hills, camping, doing small jobs in the fishing industry, in the rice paddies, etc., etc. So, in my days, we tried to sort of set up a mobile clinic, to provide healthcare for those new arrivals who we felt were particularly vulnerable.

In 1995, 1996 we particularly felt that UNHCR, to put it strongly, failed its protection mandate and was very much communicating and supporting a communication line that was initiated by the government of Bangladesh and Myanmar, that the situation was conducive for return. UNHCR also took position that, because of their presence in Rakhine and to a certain extent the presence of some humanitarian actors in Rakhine, like MSF and ACF [Action Contre la Faim = Action against Hunger], they could monitor the humanitarian situation in northern Rakhine and that the situation was safe and conducive for people to agree to return.

Both based on our presence in Rakhine, but also from what we heard from refugees on the Bangladeshi side in Cox's Bazar on that security situation and on the opportunity to monitor that, we knew it was just not true and that people did not want to return. Despite that, there was this push for return to Rakhine and we started to see a trickle of new arrivals, as we called it at the time. We actually worked quite closely with UNHCR. We got some information from let's say friends within UNHCR about what was really happening. Some of the protection people in UNHCR were quite frustrated that they were not listened to and that there was this push from the higher ups and at political level to really paint this image of 'okay, it's time to repatriate. It's safe to return' where actually we knew that was not true. The fact that people started to arrive again confirmed that not all was as rosy as people wanted us to believe.

*Dick van der Tak, MSF Holland, Head of Mission in Bangladesh 1995-1996;
Humanitarian Affairs Advisor 2000-2003 (in English).*

In November 1997, MSF Holland produced a 'confidential' dossier on the plight of the Rohingya refugees in Bangladesh, calling upon UNHCR "to use all means to take up the plight of the Rohingya refugees and asylum seekers and to assist and protect them in accordance with the international standards." This report, which also described the plight of the Rohingya in Rakhine, was not publicly released. It was instead, circulated to stakeholders in the region, including the UNHCR.



"Better Off in Burma? The Plight of the Burmese Rohingyas," Report MSF Holland. Confidential – Not for Distribution,' November 1997 (in English).

Extract:

Summary

Forced labour, extrajudicial executions, arbitrary detention and other human rights abuses in Burma have led thousands to flee the country. It is estimated that there are currently at least 150,000 Burmese refugees in neighbouring Asian countries. In Bangladesh, a group of over 20,000 Rohingya refugees is the remnant of a refugee

population numbering 260,000 in the early 1990s. The Rohingyas are Muslims from the Burmese state of Rakhine, where they constitute a majority of the population. Not only the Rohingyas themselves, but numerous external observers have decried the treatment of the Rohingya population at the hands of the Burmese authorities. Despite increasing pressure to repatriate from both the Government of Bangladesh and the international agency for refugee protection, UNHCR, the remaining Rohingya refugees in Bangladesh have refused to return to Burma. In July 1997, the Government of Bangladesh used force to return 399 of these refugees.

Previous to and concurrent with the forcible repatriations, more than 25,000 Rohingya asylum seekers have entered Bangladesh since early 1996, some of them returnees after having been “voluntarily” repatriated. These so-called “new arrivals” are being denied any form of protection by the Government of Bangladesh and UNHCR. They may not enter the refugee camps, are officially denied any possibility of receiving humanitarian assistance from the humanitarian organisations including MSF, and face summary deportation to Burma if caught inside Bangladesh. Hundreds, possibly thousands, of other Rohingya asylum seekers are either prevented from fleeing Burma by the Burmese authorities or are turned back at the border by Bangladeshi authorities when they try to enter Bangladesh. The Government of Bangladesh attempts to justify their treatment of the Rohingyas by describing the new asylum seekers as “economic migrants”, a depiction that fails to give sufficient weight to the abuses reported by them. The latest wave of Rohingya asylum seekers have been denied any legal status both in their country of origin and in their country of supposed sanctuary.

The primary responsibility for the plight of the Rohingyas obviously lies with the Government of Burma, which continues to show scant regard for their human rights, and with the Government of Bangladesh which has failed to fully uphold its international obligations to protect the Rohingya refugees and asylum seekers. But UNHCR also has its share of blame. It accepted, albeit under pressure, to participate in a flawed “voluntary” repatriation programme, and its programme to monitor the safety of the returnees in Burma is creating a misleading impression of the human rights situation in Rakhine. Although the Rohingyas continue to suffer from human rights abuses in their home country, a senior UNHCR official stated that “the Rohingyas are better off in Burma”, as recently as 10 October 1997. The question is whether the Rohingyas who recently fled Rakhine agree with that statement. It seems that the existence of the “voluntary” repatriation process appears to have influenced UNHCR’s perspective and treatment of the latest Rohingya asylum seekers, effectively denying them just and individual consideration of their claims to refugee status. MSF understood from the UNHCR representatives in Bangladesh that they concurred with the Government’s statement labelling the asylum seekers as “economic migrants”; a description that was later denied by UNHCR in Geneva. Still, MSF has serious reason to believe that UNHCR is not fulfilling its mandate adequately. Therefore, MSF calls upon UNHCR to use all means to take up the plight of the Rohingya refugees and asylum seekers and to assist and protect them in accordance with the international standards.

IN RAKHINE, MSF HOLLAND/AZG EXPANDS WHILE MSF FRANCE IS BLOCKED

From 1994 to 1996, MSF France conducted a series of exploratory missions in Myanmar with the objective of opening projects. They submitted several

proposals but failed to have a proper Memorandum of Understanding signed by the Myanmarese authorities.

In March 1995, verbally encouraged by the Ministry of Health, a small MSF France team of 4 people set up an office in Myanmar. Despite efforts, their MoU proposal was rejected by the authorities. They were unofficially made to understand that MSF France's Thailand-Myanmar cross- border activities to support the Karen minorities were the main reason behind this refusal. However, the team's analysis revealed that the MoU refusal was likely due to the regime's desire to close the door to INGOs. The MSF France office in Yangon was closed in February 1996.



'Sitrep by MSF France in Myanmar, Virginie Raison, MSF France Representative in Myanmar],' 14 September 1995 (in French).

Excerpt:

Until [19]93, MSF F[rance] was reluctant to cooperate with the SLORC (Burmese military junta). There were no encouraging signs of entering into programme negotiations, plus they were making us vulnerable to possible political exploitation given that Myanmar had been isolated from international diplomacy. In '93, signs the country was opening up observed by the Thailand mission coordinator during their visit prompted us to send an exploratory mission there. This was carried out in two stages: the first in Feb-Mar '94 to make initial contact with the authorities, the second in Oct-Dec '94 for the exploratory mission. A programme and memorandum proposal were delivered to the Ministry of Health in late '94. Verbally encouraged in the field by our ministry contacts and after the health department technically approved our programmes, we decided to send in a first four-person team in March '95: two to the capital and two to the field. Despite our best efforts, we were unable to open a programme due to the extremely limited access to the field. The procedures for signing a contract with NGOs had actually changed in the meantime. So, we decided to withdraw the teams in late June, the coordinator staying on until late July to handle the negotiations alone. A meeting secured in late July, thanks to the Japanese embassy's intervention with the Deputy Minister of Health, gave us another cause for hope that we might achieve a positive outcome and a memo would be signed. In late August, we learnt from a phone call with our ministry contact that the SLORC committee had pushed back its decision to allow us into Myanmar, their refusal, it should be made clear, due to our activities on the Thai border.

Points to be discussed at operational HQ

- Pursue, hold fire or stop our operations in Myanmar?
- Critical analysis of our past strategy, assessment of the current situation.
- Define a new intervention strategy or not? If yes, set the operational, budget and negotiation terms.



'Email from Virginie Raison, MSF France Representative in Myanmar to MSF France,' 9 February 1996 (in English).

Extract:

MSF France (and not MSF) is closing its office in Burma because its MoU proposal was rejected at the final stage [...] The reason for this refusal as it was given to us (although not officially) was our activities on the Thai border; especially our cross-border operations. But we believe that this reason was an easy one to give [...] After having met representative

of various NGOs and looked at their proposals, MoUs, programmes, and after a two-year presence in Burma, our very strong feeling is that SLORC is clearly closing the door to NGOs now. [...] We believe that MoH is in a very weak position now inside the SLORC after having been reprimanded twice by the military authorities for letting in too many NGO people in the field. [...] Therefore, we take the opportunity of this departure to get the attention of donors on this situation, on behalf of humanitarian principles. The point is not to denounce our colleagues but to defend the “humanitarian space” as it is shrinking in Burma, and especially the access to Burmese people.



We went to see if there was any room for negotiation with the Burmese government. Virginie Raisson [MSF France Representative in Myanmar] and Hervé Isambert [MSF France Head of Mission in Thailand] believed there was. Personally, I didn't think there was much room given that we'd been the ones working with the ethnic minorities at the border since the mid-80s, which hadn't gone down well with the Burmese authorities. That was a major drawback. Plus, it was hell working in Myanmar. It was an attractive country in many ways but working with the Burmese government was a terrible ordeal at that time. It was impossible to go anywhere. To go five kilometres from the office you had to ask for authorisation. When we tried to contact the authorities and submitted a question, it could take months by the time the answer filtered back down. They were taking us for a ride. We'd just started getting something done, we'd think we were on the brink of being allowed to work, then all of a sudden, our efforts would go down the drain; red tape after more red tape.

Dr Jean-Hervé Bradol, MSF France, Programme Manager, 1993-1996 (in French).

Meanwhile, since 1994, the MSF Holland/AZG malaria programme in Rakhine gained momentum under the leadership of the Head of Mission, a medical doctor passionate and committed in malaria treatment. Hundreds of local staff, including many Muslims, who were denied jobs by the state health services, were trained by MSF in laboratory activities and over the years, diagnosed and treated tens of thousands of patients.

Four years since the MSF Holland/AZG's program start, in October 1998 programs were authorised to extend to the extreme north of Rakhine State, where Rohingya refugees repatriated from Bangladesh were resettled. A second base was opened in Maungdaw and primary health care activities were launched. This enabled local medical teams to be deployed in villages without health services, where administrative restrictions and police repression limited access to hospitals for Muslim populations.

At the same time, operational research activities carried out by MSF Holland/AZG teams on malaria treatment failures/resistance were the subject of medical publications that helped to change national treatment protocols.

Additionally, MSF Holland/AZG began to implement HIV/AIDS awareness programs in Yangon, and Kachin and Rakhine states. This launch was despite the regime's denial of the existence or scale of the epidemic on national territory. These activities enabled the teams to get information on the transmission, prevention, and treatment of this disease.



'Summary Sheet: Laboratory Project for Malaria Control in Rakhine, MSF Holland,' 15 October 1993 (in English).

Extract:

Project title: Laboratory project for malaria control in Rakhine, Myanmar

Submitting agency: MSF Holland

Duration: two years

Objectives: To reduce mortality and morbidity from malaria in Rakhine State, Myanmar, through the establishment of laboratory diagnostic services.

Activities:

1. Establishment of malaria laboratories in hospitals and rural health centres in up to eight townships of Rakhine.
2. Supervision of field laboratories from a central reference laboratory.
3. Promotion of appropriate treatment for malaria.
4. Evaluation of new preventive techniques. The inhabitants of the eight townships.



"Burma (Myanmar) Evaluation of the MSF Holland Programmes [...]", **Report** by Egbert Sondorp, Commissioned by MSF Holland Evaluation Unit,' December 1998 (in English), edited.

Extract:

Rakhine proved to be more seriously affected by malaria than other areas of Burma. The MSF efforts in the area, since 1994, were largely focused on getting malaria treatment based on appropriate laboratory diagnosis, to as many people as possible in this difficult-to-access part of the country [*There are hardly any roads in this part of the country, but the many waterways make extensive boat travel possible*] [...] Next to the treatment activities, some operational research is being done. A malaria drug sensitivity study was completed and published [*in an international medical journal: Transactions of the Royal Society of Tropical Medicine and Hygiene*] and a bed net feasibility study is ongoing.[...] Only in early 1998, extending the malaria programme, was access gained to northern Rakhine, with a second base in Maungdaw. [*Mobile presence, though, was achieved earlier, through two-weekly visits, every two months.*] [...] More recently a new initiative started in Maungdaw to try to improve Primary Healthcare services in northern Rakhine.



Very quickly, we had access to Rakhine. It was decided to focus on malaria. We treated more than 200,000 cases per year. And the government, they liked that and at the same time they did not like that. They didn't like it because the official number of malaria cases was going up. So, the minister called me, and he said: 'What are you doing? Since you were there, there has been a malaria outbreak!' There was this map with the red dots for the size of malaria and before we came there were very small dots on Rakhine State. Then MSF came and then the dots got bigger and then the dots got so big. Of course, that had nothing to do with us. It was because we did a lot of microscopy, we trained staff. We extended the programmes to a larger area, in the area where there were mainly Muslims and in the mixed areas, north and mid-Rakhine. In the north, particularly, we worked with Muslim volunteers that were not government staff. So, we had a whole network of Muslims who we trained to do microscopy and then we had a quality control programme. They tested many patients per month and they could treat thousands of patients. At a certain moment we had a peak in Rakhine, about 700,000 consultations per year (malaria and basic healthcare). That

year, MSF Holland in Myanmar conducted 10% of all patient consultations of all sections of MSF in the world.

The national treatment for malaria was Chloroquine and if that failed, it was Fansidar. I did two big studies which found that 80% of the treatments failed, and of children, 96% failed. Then we said: 'the national protocol doesn't work.' Then the minister called me. He was angry and said: 'You will never be allowed to do research anymore.' But in the end, we helped to change the national protocol twice.

X, Former MSF staff member in Myanmar (In English).

MSF Holland/AZG sometimes expressed itself publicly, through interviews with the Head of Mission, on the need to develop new and effective treatments for malaria and to address the HIV/AIDS epidemic. However, MSF Holland's advocacy against the repatriation of the Rohingya refugees returning from Bangladesh and for their protection from persecution once they return to Rakhine remained confidential, limited to what the organisation called "silent advocacy" and mainly with the UNHCR.

MSF Holland/AZG's activities in Rakhine, however, allowed its teams to get closer to the Rohingya populations and to obtain information about their plight, which fed into their "silent advocacy" activities with the UNHCR. A data collection system, called "club-med," for the sake of discretion, was set up and fed by MSF Holland/AZG teams with the help of Action Against Hunger (Action Contre la Faim). The medical data compiled in this database, however, was only indirectly related to the abuses committed by the regime. These data were shared with human rights organisations and some media, undercover of total anonymity for MSF Holland/AZG.

Caution was also exercised in the choice of vocabulary used to qualify situations. While the various memos on advocacy strategies from MSF Holland/AZG admitted that the situation of the Rohingya presented most of the factors indicating that their expulsion from their lands and villages was 'random to systematic,' they nevertheless refrained from using the term 'ethnic cleansing.' Nor did the team employ the term 'stateless' to describe the status of the Rohingya, on the grounds that this would be tantamount to a de facto recognition of the statelessness policies of the Myanmar regime.

For fear of being expelled from Myanmar, MSF Holland/AZG therefore, did not undertake any public advocacy on the situation of the Rohingya using the Club-Med database. Public speaking was only envisaged as a last resort because it could endanger the organisation's presence in the country and thus deprive the Rohingya of the rare witnesses to their plight. MSF Holland/AZG was locked in a contradictory injunction: try to preserve a presence in Myanmar in order to be able to collect information for a possible public position while imposing silence in order to avoid losing this access.



“Burma (Myanmar) Evaluation of the MSF Holland Programmes [...]”, **Report** by Egbert Sondorp, Commissioned by MSF Holland Evaluation Unit, December 1998 (in English).

Extract:

MSF International’s Chantilly document¹⁴, as well as a new MSF Holland vision document¹⁵ confirming ‘Chantilly’, places much more emphasis on the twin engines of medical work and advocacy. And activities in Burma would potentially fit within the realm of these policy documents. But the advocacy policy for Burma is still poorly developed, lacking good objectives. And the medical work and advocacy are insufficiently linked. This is partly due to the bulk of the medical activities being primarily geared towards medical issues that have a very indirect link with the regime’s abuse. [...]

Advocacy policy:

The MSF policy on advocacy will focus on observation and, if possible, backed up by medical data gathering. Information will be passed on through the international community, human rights organisations and the media, when guaranteed that the origin of these data cannot be traced back to our organisation. MSF should be extremely careful about information dissemination and advocacy activities as we will probably lose our presence immediately when the SLORC finds out. [...]

The new PHC [primary healthcare] project is much more directly related to the Rohingya problem. From the MSF perspective it is another tool to get into more close contact with the Rohingya in the smaller villages. Again, though, with no clear idea yet what to look for. Up to date, MSF did not retrieve a lot of “unique” information from this area but can confirm through direct contact some of the abuses reported by others. UNHCR may take up human rights issues, as reported to them directly or through other agencies, with the government, under “governance.” MSF occasionally uses this channel. A role that MSF plays is reporting to others about UNHCR’s role: its weaknesses, but also its strength as a protective force for the Rohingyas. The latter was leading to an appeal to the [UNHCR] Ex Com to extend UNHCR’s mandate in the area. [...]

The CM [Country Manager], summing up the advocacy activities over the past years, came up with these issues:

- Article on AIDS in Burma in the Economist, which raised awareness of the problem; Discussions with regional AIDS experts (WHO, UNAIDS) during visits in Burma and during two regional AIDS meetings (Chiang Mai 1996 and Manila 1998).
- Interviews with over 100 journalists. Often quoted in their articles afterwards.
- Discussions with various Diplomats – may have contributed to retainment of UNHCR in Rakhine.
- Attempts to attract attention for Rakhine and the health situation.
- Some relevant health data from Rakhine were collected, like two under 5 mortality surveys in Maungdaw/Buthidaung 1996, 1997. An assessment of the health services available in Buthidaung and Rethidaung in 1995 and 1996 in which it was clearly described that health services were clearly less [present] in these townships than in the rest of the country.
- This year we got nutrition data from the bed net survey.

14. Adopted by MSF sections in 1995, the Chantilly document defines the MSF community of culture and practice. It stated that “Témoignage”/Advocacy is “an integral complement” to the MSF medical action.

15. The MSF Holland’s ‘vision document’ proposed in 1998 by the management team was a basis for discussion on the strategic orientation of action.

- Member of Rakhine Planning Group, which prepares a 5-year plan for north-west Rakhine. MSF chairs the health sub-group and is a member of the “governance” sub-group.
- Establishment of working group of INGOs, which discusses appropriateness of aid in its various modes and provide information to newly arriving NGOs. A result seems to be that more donors and (thus?) more NGOs have become more critical and seek more distance from the government.
- Discussions with UNHCR.
- The AIDS activities as such.
- (Too) many contacts with human rights groups, providing them information, in particular regarding AIDS and about Rakhine. [...]

Annex 8 – Advocacy policy – Burma, autumn 1998 [written by Head of Mission] Strategy.

Low-profile diplomacy. Trying to inform and discuss with governments (embassies), international organisations, journalists and political groups. At some occasions an article could be written about a topic of special concern that does not get enough attention. We will not focus on topics that are already covered by many other players. We will not speak out in public under our name. [...]

General Human Rights information to a wide group of players.

An ongoing process of information gathering and distributing, taking into account all aspects of HR [Human Rights] issues. The level of information will not be new for all. Information might be derived from different sources, including other organisations, national and diplomatic individuals, articles, our own experiences, etc. The information will be used to have an informed opinion about the situation in the country which is needed during conversations with various policy makers (governments, EU, HR groups[...])

Specific topics:

Information gathering and distribution, including topics that MSF has access to due to the health projects.

1. Rakhine Muslims.

Objectives:

- a) Increased awareness of the situation of the Rohingya among the international community.
- b) Gathering of medical data to investigate the health situation.

Timeframe (past activities and future plans):

General information gathering and information of national and international players has been going on for the past 3 years, but on a limited scale due to access problems and due to the fact that other organisations were in a much better position for information gathering. Our position has improved since the beginning of the year and we will probably get better information.



'Advocacy in Rakhine State: Information Collection, Documentation, and Dissemination, Why and How, **Memo**, MSF Holland,' October 2000 (in English).

Extract:

Overall objective

To maintain attention of the international community to the situation of the Rakhine Muslims (and Hindus – non-citizens) so that ultimately the human rights abuses against

the population are reduced and that citizenship, and all the rights and privileges that come with it, are granted. [...]

• Why do we advocate for the Muslims (non-citizens) of Rakhine State?

- Medically, malaria is the number one cause of mortality and morbidity. Hence, the malaria programme. The authorities deny the severity of the HIV/AIDS situation/crisis in Myanmar, and therefore access to information about transmission, prevention, and care is limited. Hence, the HE programme. Health facilities in Northern Rakhine State are dysfunctional, and the Muslim population relies predominantly on traditional birth attendants and community health workers versus public health services. Both the traditional birth attendants and community health workers had been poorly trained and equipped. Hence, the Primary Health Care programme in southern Maungdaw.

- The general Muslim population in Rakhine State is a population in danger: the denial of citizenship subjects them to systematic discrimination and abuse. This abuse impacts, for our intents and purposes, their quality of health and access to healthcare. The repatriation of those who fled to Bangladesh in 1991/92 warrants the presence of the UNHCR, WFP, and other INGOs in North Rakhine State.

- The repatriation of the refugees to Myanmar, led first by the Bangladeshi government and then by the UNHCR, was not voluntary. Although the conditions they fled continue today, the UNHCR and government of Bangladesh still insist upon repatriating the remaining refugees, contending that the situation back home is stable due to the presence and activities of the international organisations.

- MSF recognises an inextricable link between medical humanitarian assistance and human rights, and the duty of *témoignage* (witnessing). The overriding benefit of our presence in Rakhine State is, in addition to our medical input, our ability to witness, report and advocate on behalf of our beneficiaries who continue to endure violations of their human rights, despite the pronouncements of the UNHCR. Ultimately, these abuses continue to impact this population's quality of health and their access to healthcare.

[...]

How are these human rights issues linked to good health and access to healthcare?

1. Restricted movement:

Cost and time to get authorisation, and curfew at 8, 9, or 10:00 p.m. impede access to care, especially in emergencies.

2. Health access and quality indicators:

Most healthcare providers are Buddhist, Rakhine, or Burman, and most Muslims cannot speak Burmese. Understaffed and under-equipped facilities, deficient medical knowledge, costs, and language barriers (though not great) impede willingness and ability to access care.

3. Forced/compulsory labour/portering:

Hard labour creates or exacerbates poor health; time away from own income-generating work reduces ability to pay for healthcare, transport, and travel permits.

4. Confiscation of land:

Land is a source of income; without land, no income; without income, no money to pay for permits, transport, and care.

5. Forced relocation:

Relocation often involves land confiscation; the people are often displaced to remote areas where the nearest health facility is inaccessible; same for model villagers.

6. Arbitrary taxation/compulsory contributions:

The more money for taxes and contributions, the less for healthcare costs.

7. Acts of violence against individuals:

Self-explanatory. Also, threats to safety and security create a climate of fear and hesitance to travel beyond one's immediate surroundings to seek care.

8. Departures of families/individuals due to the human rights abuses:

All of the above are reasons behind fleeing Myanmar; many families who can afford it travel to Bangladesh for healthcare, due to easier accessibility, closer proximity, and better quality care. [...]

• Where does the information, especially from the Advocacy Reports, go?

1. Locally (Maungdaw):

Share certain facts with other INGOs, especially ACF, and maybe in inter-agency meetings; Report to UNHCR (in inter-agency meetings and per incident).

2. Capital level:

- a. Advocacy reports are sent to the Humanitarian Affairs Department Operations Department, and Context Unit in Amsterdam, and to MSF Holland team in Bangladesh (Dhaka and Cox's Bazar);
- b. Information from the advocacy reports is used in discussions with ambassadors from the region, especially ASEAN [Association of South East Asian Nations] countries (namely Japan [pro-constructive engagement], Indonesia [a Muslim country], Malaysia [a Muslim country]); North American/European donor countries in northern Rakhine State, especially donors of the UNHCR (USA, UK, Germany, France, Australia, etc.); and the Bangladeshi ambassador – to raise awareness, to pressure UNHCR to satisfactorily carry out its protection duties, and to effect some change in Myanmar policy;
- c. The information is also used in discussions with visiting journalists; other INGOs; UN organisations (especially those involved in the transition from assistance to development); other visiting UN figures and foreign diplomats; and multinational companies and other foreign business interests in Myanmar;
- d. Information is exchanged regularly with ACF, and often advocacy activities are joint. [...]

3. Regionally:

The representative of the European Union in Bangkok (the EU is a major donor of the UNHCR in both Burma and Bangladesh, and has sanctions imposed on Burma); Various ASEAN ministers (especially from Japan, Indonesia, and Malaysia); Policy makers from Bangladesh (and Pakistan? – a Muslim country, to which Myanmar has turned for military and economic support); Regional human rights organisations [...]

4. Internationally:

The HAD and OD [Operations Department] in Amsterdam and Country Manager and Humanitarian Affairs Officer in Yangon share information from the Advocacy Reports with international human rights organisations [...]; Burma-interest organisations [...]; various appropriate journalists and media; the Dutch and other European parliaments; the UNHCR in Geneva; the Special Rapporteur on Burma to the UN Human Rights Commission; the Special Envoy of the UN Secretary-General to Burma; the UN Special Rapporteur on the Freedom of Religion and Belief, etc.; Results from scientific studies (e.g. bed net study, drug sensitivity trials) could be published in scientific journals. [...]

The Strategy:

- Basically, in discussions with the various above-listed parties, the strategy is to describe the situation in Rakhine State to pressure UNHCR to fulfil its protection duties and to effect a change in Myanmar policy toward non-citizens in Rakhine State.

- With regard to the UNHCR in Maungdaw and Yangon, the tactic is to inform, and minimise confrontations and condemnation. Condemnation is an exercise in futility. We

should bear in mind its constraints and limitations, but always hold it accountable for its failure to do its job satisfactorily and to maintain proper allegiances (foremost to the beneficiaries and not the authorities). Work with the UNHCR proactively in protection and advocacy matters and monitor its activities, more so than criticising reactively its unfulfilled responsibilities. Turn to its donors to maintain pressure and influence.

- With regard to donors and diplomats, the idea again is to inform and encourage a change in policy, and to discourage (public) denunciation of the government of Myanmar. Denunciation is also an exercise in futility and will only backfire. The vengeful backlash of the hyper image conscious GOUM may result in obstruction of our activities and/or further entrenchment of the oppressive situation. Turn to its allies (using the language of political and economic interests) to maintain pressure and influence.

- With regard to the information we collect Yangon and Amsterdam refer to the information and data regularly for its ongoing face-to-face discussions with regional and international figures. Nevertheless, after being entered in the database, the data should be analysed periodically to determine (a change in) patterns and make comparisons. Ultimately (ideally), we should be able to conclude from the analyses and comparisons whether differences in healthcare access and quality are attributable to government policy, to Muslim/Hindu culture, and/or to other factors. It is important to always maintain the link between human rights and health when collecting, documenting, and disseminating information.

- The information disseminated, to stakeholders in Yangon and internationally, is always confidential: we insist on anonymity. "Going public" with information, which usually involves denunciation of an egregious government act and/or a serious compromise in our humanitarian principles and medical ethics, is a very last resort. Going public means eventual withdrawal (because the GOUM will not tolerate public reproach and will order our expulsion). Our absence means an end to witnessing; and end to witnessing means the end of advocacy for this population. Therefore, the situation warranting "going public" must be assessed carefully and thoroughly weighed against the pros and cons of withdrawal.



"Advocacy in Rakhine State, Information Collection, Documentation and Dissemination – Why and How" **Memo**, MSF Holland, June 2001 (in English), edited.

Extract:

MEASURING THE IMPACT OF OUR ADVOCACY EFFORTS

It is standard in MSF's *témoignage* strategies to include indicators by which we can measure the impact or efficacy of our advocacy activities. This is actually not an easy thing to do, especially in this context, in which seven years have gone by and the situation for the beneficiaries has hardly changed.

We can consider the continued presence of the UNHCR in NRS an achievement of our past advocacy efforts. We reached that objective. Now, we must evaluate whether we are reaching our *overall* objective of maintaining international attention to the situation in Rakhine so that the condition of the non-citizens improves. The bulk of that rests on the performance of the UNHCR and the responses of the international community to our appeals.

It is inevitable, given changing circumstances that our advocacy strategies and activities must change. Following are some areas that may need adapting in the future: [...]

Theory of ethnic cleansing:

The Muslims in Rakhine State are an unwanted people in Myanmar. [...] We have seen over the years the population being increasingly concentrated into smaller areas of northern Rakhine State, and the constraints on a productive, secure, healthy life increase. The push factors are numerous, enough to compel people to leave. Although we should avoid making claims of ethnic cleansing – as any milder claim may constitute a contradiction – we should be aware that most of the factors are present to indicate a random to systematic expulsion.

Statelessness

It has been argued that – because the Muslims/Rohingyas are descendants of India/Bangladesh, but citizens of neither – they are therefore “stateless”, or without national identity or connection to a country.

It is the position of the UNHCR, and AZG agrees, that the Muslims/Rohingyas are not stateless, but are de facto citizens of Myanmar. Hence, in our discussions with our target audience, we avoid the term statelessness, as that tacitly endorses the GOUM’s arguments that they don’t belong here and are not worthy of national protection.



Letter from MSF Holland and Action Contre la Faim Heads of Mission in Myanmar to Special Envoy of the UN Secretary-General to Myanmar, 16 May 2001 (in English).

Extract:

Re: The situation of non-citizens in Rakhine State


Dear Ambassador [...],

As representatives of international NGOs working in northern Rakhine State, Myanmar, we write to draw your attention to the situation of the non-citizen population in Rakhine State. The Muslim and Hindu population in Rakhine State is denied Myanmar citizenship, and this subjects them to systematic discrimination. In 1991–92, approximately 250,000 residents, mostly Muslim, fled to Bangladesh for protection from violence and harassment by the authorities. [...] We would like to go further and call special attention to the non-citizens in Sittwe, the capital of Rakhine State, in which Buddhists and Muslims clashed violently during the first week of February 2001. Many Muslim homes were destroyed, and several people killed. The security forces, in spite of their capacities, quelled the unrest only belatedly.


Our concern for the safety of the non-citizen population in Sittwe is compounded by the absence of permanently based representatives of the international community in Sittwe. Although UNHCR is present in the three townships of northern Rakhine State (Maungdaw, Buthidaung, Rathedaung), it is responsible for the reintegration and protection monitoring of repatriated refugees. As there are few repatriated refugees outside those three townships, the non-citizens in the rest of the State are outside the scope and protection mandate of UNHCR. There is great potential for their condition to remain unnoticed.

We consider the non-citizens in Rakhine State to be an extremely vulnerable population in Myanmar. This is illustrated by the fact that northern Rakhine has been the site of the largest international humanitarian operation in the country for seven years. Despite this, the same needs still remain. Citizenship, and the rights and privileges that go with it, are essential for the Rakhine Muslims and Hindus to pursue a productive, safer livelihood. We take note of recent political developments between the Government and the opposition toward reconciliation. It is clear that the issues that need to be resolved are

numerous. Nevertheless, we would like to take this opportunity to raise the issue of the non-citizen population in Rakhine State. We respectfully appeal to you to maintain priority attention to the situation of the Rakhine non-citizens, and to intervene where possible on their behalf.

 *When a team member went out to visit a village and they witness something or they heard somebody tell them a story, they would come back and just record it there. And that allowed us to build up some picture of the way that people were treated, essentially by government. So that included forced labour, land confiscations, denial of marriage or the very difficult process of being able to get married which had implications then on your ability to have children, the access to healthcare in emergency situations, experiences of Rohingya in the hospital system, in the official ministry hospital system. So, we were able to paint some picture, anecdotal, of what persecution meant for the Rohingya. We were able to use the database partly to feed our advocacy people and the other bilateral engagements that we were having. We also even shared parts of it, with Human Rights Watch and with Amnesty International encouraging them certainly not to out us but to take that data so that they could at least understand and use that as contextual background for their work. We had this relationship on and off with those two groups. It started before I arrived and by the time I left, it was still in existence but then the name had been dropped: it was just called a database or something.*

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).

 *If you sit in an office in Amsterdam, it is rationally quite logical to say we have to speak out. But if you see the impact of your activities, you also think maybe we want to keep on doing this. Because there's an enormous amount of suffering which you can do something about. So, in the end, we all have the same goal – I guess – to decrease the suffering of these people. Now, how can we do it best? There were reports and press conferences in Bangkok, but it was always about health. Because healthcare is something we can sell to the government, even though they don't like it. But for the Rohingya, it's a different story and I was always more reserved.*

X, Former MSF staff member in Myanmar (In English).

The presence of MSF in Myanmar was regularly challenged by other NGOs working in the neighbouring countries. It was perceived as too compromised with the Myanmar military regime. Many of them could not believe that MSF/AZG was able to do what they claimed they were doing.



“Burma (Myanmar) Evaluation of the MSF Holland Programmes [...]”, **Report** by Egbert Sondorp, Commissioned by MSF Holland Evaluation Unit, December 1998 (in English).

Extract:

When MSF entered Burma, it did so against mainstream thinking among quite a few, “respectable” NGO’s. The regime was “denounced” and it was stated that under this regime none of the conditions to improve human development were met. And that staying in the country would make them lackeys of the regime. Also, human rights groups as well as opposition groups abroad, were of the opinion that every presence in the country would only corroborate the regime and called for a boycott. The first few years, MSF’s main concern was to create a presence, and to create a presence in such a way as to minimise contacts with and benefits for the regime.



Every month there was this meeting in Bangkok for all the NGOs working on the border, the UN and the Thai government. Nobody from inside Myanmar dared to go. So, I went there once. The Burmese border consortium director, a leader of the Thai-based NGOs would say to me that I was helping the generals because I was working inside Burma. I didn’t think that way obviously. We started, we tried to work very independently, and we succeeded in that. I told him: ‘We are doing kind of the same job. We are also working for the Myanmar people. You can do only a very little cross border. But there are 50 million people in the country.’

Then I presented what we were doing, and people stood up and said: ‘You are a liar, it’s not true you cannot do that.’ They thought that we could not treat sex workers, treat HIV patients, work in Rakhine, Shan, and Kachin states. But we had our own clinics with the local people. And we had a community health worker programme where we just chose somebody in the village, and we trained them, and they would give the healthcare. But the Thailand-based organisations couldn’t believe it. They were so indoctrinated. I found it a bit strange because why would MSF go to help ‘the generals?’ Why would we do that? There’s nobody in MSF as far as I know who would have that in their mind. In the end of the presentation I showed a picture of Aung San Suu Kyi and me in one of our clinics she visited (during one of the short periods she was released from house arrest). She was very pleased with the work we did. That made some of the Thailand-based NGOs change their mind.

X, Former MSF staff member in Myanmar (In English).

2003: MSF HOLLAND’S FORCED DEPARTURE FROM TEKNAF CAMP IN BANGLADESH

In Bangladesh, for several years, MSF Holland had been working with the UNHCR under a Memorandum of Understanding in the Nakapala camps in the Teknaf area.

In 2001, a new MSF Holland Management Team took over and decided to change the advocacy strategy regarding the situation of the Rohingya refugees in Bangladesh. The objective was to disassociate MSF from UNHCR and their complicity and responsibility in the oppressive system targeting refugees.

The new strategy was to increasingly challenge the UNHCR to meet its mandate of protection and fundamental respect for the rights of the refugees. At the same time, the field team was getting closer to the refugees, who reported rising complaints and testimonies about the lack of protection. However, MSF Holland could only pass this data onto the UNHCR, which caused the refugees to misunderstand since they would expect MSF to directly report to the authorities.

In April 2002, MSF decided to use the 10th anniversary of the Rohingya exodus from Myanmar to Bangladesh to highlight the seriousness of their plight. MSF Holland held a press conference where a report entitled “10 years in Bangladesh for the Rohingya Refugees - Past, Present and Future,” was widely distributed. The report highlighted ten years of accounts of life in the Bangladeshi camps. It demonstrated that refugees benefited from very little protection and continued to live in emergency sanitary conditions well below standards.

UNHCR officials did not appreciate this report, which was perceived as an indictment and contributed to tarnishing their image.



‘Closure of the Bangladesh Teknaf Rohingya Programme – An **Evaluation** of MSF Holland’s Tumultuous Departure and Advocacy Activities – Confidential - For internal use only by Bart van der Linden, MSF Holland Humanitarian Affairs Department,’ March 2004 (in English), edited.

Extract:

MSF and the refugees

[...] the change in policy initiated by the management in 2001 definitely increased the interaction and the understanding of the problems facing the refugees. All the project expatriates were even made responsible to follow up on specific advocacy subjects related to their line of work in the camp. The management initiated the change of policy because it seemed to them that MSF was not clearly distinguishing itself from UNHCR and the camp authorities. “It seemed that MSF was part of the oppressive system targeting the refugees” was said in an interview by MSF staff. This view was undoubtedly altered as confirmed by the enormous increase in complaints and testimonies given by refugees to MSF instead of being given to UNHCR. The aim was to build natural contacts through our medical work. However, this change in policy became so successful that refugees were coming to MSF without medical reasons to testify or share concerns or problems with the MSF expatriates. [...] Some MSF staff said to me that a culture of complaining was created without clearly making the refugees understand that MSF could not solve their problems regarding a lack of protection but could only convey them to UNHCR.

MSF’s advocacy strategy [...]

With the new Operational Director and the new Head of Mission arriving in 2001, the advocacy strategy was also revised. MSF’s overall advocacy objective is redefined from “to ensure that humanitarian and human rights standards are recognised and upheld in discussions, plans and actions taken, that will impact upon the future of temporary and durable solutions of the Rohingya population in Bangladesh” to “MSF will challenge the UNHCR to meet its mandate of protection and fundamental respect for the rights of the refugees.”

The strategy to address witnessed incidents and testimonies by refugees is to first address them with the UNHCR Protection Officer and/or with the UNHCR Head of Sub-

Office in Cox's Bazar. The approach pursued towards UNHCR is cooperative and open to facilitate improvements. If the desired actions and/or feedback from UNHCR at Cox's Bazar level were disappointing, matters would be taken up by the Head of Mission with the UNHCR representative in Dhaka, in a rather confrontational manner. At the same time the international community of donors would be informed. If this strategy still did not yield any success, MSF Headquarters would be requested to contact UNHCR Geneva. [...]

10 years Conference

In 2001 it was also decided to mark the ten-year episode of the refugees in Nayapara camp by organising a conference on 10 years for the Rohingya Refugees in Bangladesh: Past, Present and Future, to be held on 1 April 2002.

The aim of the conference was to draw renewed attention to the plight of the Rohingya refugees in Bangladesh with the international and local communities. Specific objectives were:

1. To present the humanitarian and protection situation in the refugee camps, giving emphasis to the voice of the refugees;
2. To examine the situation in Myanmar/Rakhine State (with some attention to "new arrivals" in Bangladesh) and whether it is conducive to repatriation;
3. To explore permanent options in Bangladesh for the refugees;
4. To devise a realistic action plan for the Donor and International Community, Government of Bangladesh, Government of Myanmar, and UNHCR to improve the humanitarian, protection, and political situation of the Rohingya refugees.

The strategy chosen was to hold a conference, involve the media and to publish the 10-year report on the MSF website. MSF managed to involve some media and the international community showed renewed interest in the Rohingya. However, UNHCR dispatched only its legal officer to attend. [...]

In the minutes of a meeting between MSF and UNHCR and during my interview with the UNHCR representative, it is acknowledged that MSF's 10-year Rohingya conference held on 1 April 2002 contributed to a break in the relations between the two organisations. UNHCR explained that in conduct with UNHCR Geneva, it was agreed not to participate in the conference at a high level. That is why UNHCR only dispatched its Legal Officer. The reason given was that the conference contradicted UNHCR's programme direction, which was to reactivate the repatriation process, and therefore it was not the appropriate time for it (the conference was in part aimed at exploring durable solutions). The conference could have jeopardised UNHCR's efforts to revitalise repatriation. Furthermore, UNHCR claims that a summary of the conference was given to embassies but not shared with UNHCR and lastly, one organisation should not publicly expose negative information about the other. In regard to the latter, I think that UNHCR points at MSF's specific conference objective of "improving access to care and protection by encouraging the UNHCR and GOB to meet their obligations." This in itself is already a statement that UNHCR is failing to meet their obligations and tarnishing their image.



'10 years for the Rohingya Refugees in Bangladesh – Past, Present and Future, MSF Holland **Report**,' March 2002 (in English).

Extract:

The purpose of this report is to provide an understanding of the condition of the Rohingya refugees now and over the last decade. [...]

An Uncertain Future

10 years on and the Rohingyas still lack a remedy for their situation. The nearly 22,000 remaining refugees have come to be known collectively as “the residual caseload,” left over due to their reluctance to return to what caused them to flee in the first place, and due to a protracted clearance process by the Myanmar authorities. Although refugees have three possible solutions to their situation – repatriation, integration in the host country, and resettlement in a third country – the Rohingya refugees do not seem to have a choice. Repatriation has been promoted as the most optimal solution by UNHCR, and as the only solution by the Government of Bangladesh. As for the refugees, their eventual return in principle is not a point of contention. Many have expressed their desire to return; at issue is when. According to MSF’s January 2002 survey a large majority of the refugees said they wanted to go back when they were granted Myanmar citizenship, or when peace, freedom and/or democracy was achieved in Myanmar.

In late 2002, the UNHCR proposed a plan for ‘self-reliance’ for the Rohingya in Bangladesh including the handover of MSF Holland activities to the MoH of Bangladesh. However, no clear plan was proposed to streamline this handover despite MSF Holland’s multiple requests. In addition, the government of Bangladesh started to aggressively promote the repatriation of refugees to Myanmar with no reaction of the Bangladesh UNHCR. In mid-April 2003, the MSF Holland team was informed that they must handover activities in Nyapara camp in Teknaf area to the MoH before 1 July 2003.

The handover was hectic and frustrating as the MoH did not have the capacity to take over MSF activities in the camp and the refugees strongly expressed their refusal to allow MSF leave, which led to some violence. MSF Holland did a lot of bilateral advocacy, more specifically directly addressing the issue to UNHCR Geneva who eventually became more involved.

While MSF Holland officially ceased their activities on 14 August 2003, they waited until 17 September 2003 to issue a press release. This statement called upon the authorities and UNHCR to respect and protect the rights of the refugees. Many considered this was too late and too weak.

In 2004, MSF conducted an evaluation of the August 2003 departure which showed that UNHCR was disappointed by the MSF September 2003 press release and considered MSF as publicly critical without receiving any forewarning.



‘Thousands of Refugees Harassed to Return to Myanmar, MSF OCA **Press Release**, Dhaka/Amsterdam,’ 17 September 2002 (in English).

The Bangladesh government is subjecting thousands of Rohingya refugees to intimidation and harassment as part of a campaign to pressure them to return to Myanmar (Burma), says the international humanitarian organisation Médecins Sans Frontières (MSF). Many of them are afraid to go back but are now being left with no choice. On the eve of handing over its healthcare activities in the refugee camps to the Bangladesh Ministry of Health, MSF remains deeply concerned about the protection of the Rohingya refugees. MSF calls upon the Bangladesh government and UNHCR, the UN agency responsible for

refugee protection, to look after the refugee's basic rights and respect their free choice. Despite atrocious living conditions in the camps many of the refugees are not willing to return. The refugees live in overcrowded spaces with insufficient water and food. They are barred from growing food or working outside the camp. Last year 58% of the children suffered from chronic malnutrition.

In recent months, staff from MSF received over 550 complaints of coercion from the refugees. The complaints ranged from incidents of intimidation to outright threats of physical abuse to push people to repatriate. There are reports that some repatriated refugees have already come back to Bangladesh and are now taking shelter outside the camps. Meanwhile new refugees continue to arrive, fleeing the ongoing intimidation by the Myanmar authorities. Both repatriated refugees and new arrivals complain about the fact that they don't receive citizenship, food problems, arbitrary taxation, rising extortion and restriction of movement. Discrimination, violence, and forced labour practices by the Myanmar authorities triggered an exodus of more than 250,000 Rohingya Muslims between 1991 and 1992. Since 1992, approximately 230,000 refugees have returned. The voluntary character of this repatriation programme, supervised by UNHCR, has often been questioned. Today more than 19,000 Rohingya remain in two camps south of Cox's Bazar in Bangladesh.

Recently, the Bangladesh Ministry of Health took over the healthcare in both camps in coordination with UNHCR. MSF leaves the camp after having provided basic healthcare and nutritional programmes for 11 years. MSF urges the Government of Bangladesh and UNHCR to uphold their responsibility to provide protection and adequate healthcare to the refugees. Recent efforts by UNHCR to increase the protection of the refugees in the camps, came too late for many.

The refugees who are still in Bangladesh should be entitled to decide for themselves if it is safe to return home



“MSF's Withdrawal from Nyapara camp in Bangladesh – Handed Over” by Clea Kahn, MSF Holland Project Coordinator, Teknaf, Bangladesh - September 2002 to September 2003, **Ins & Out** (MSF Holland Internal Newspaper), December 2003 (in English).

Extract:

Refuse to leave?

MSF had to leave. It was impossible to work in the camp without a Memorandum of Understanding of some kind, and UNHCR was not willing to extend, despite intensive lobbying at all levels in Bangladesh and in Geneva. The government was unhappy with MSF and adamant that we should go. The only other option would be to refuse to leave. While this would make a strong statement, it would ultimately accomplish little and would mean that MSF would lose any hope of doing a good handover. The healthcare won out over the political statement, and MSF worked toward a handover. The first week was a mess. The hiring caused a national corruption scandal when it was discovered that a large percentage of the new employees came from outside of the district and had no health experience or local language skills. The locals were furious, and for several days roadblocks prevented senior MoH staff from getting access to the camp. In their absence, junior staff milled around in confusion. It was unclear whether they would even be able to keep their jobs. [...]

Heart-rending process

The entire process was frustrating and heart-rending for everyone involved and, in retrospect, much more could have been done. Opportunities to speak out were missed,

and MSF's advocacy approach was not as bold as it could – perhaps should – have been. On the other hand, there is no question that change occurred, and largely because MSF was there. From Geneva, UNHCR sent in additional consultants and protection officers, fearing that the situation in Bangladesh was about to blow up in their faces. When MSF left, the refugees were saying clearly that they thought that things were improving and that they were regaining trust in UNHCR. Repatriation numbers had decreased significantly and policies around repatriation had been changed. Unfortunately, this is a cycle that has repeated itself over and over for these refugees, and the next time the abuses occur, MSF will no longer be there to help.



'Closure of the Bangladesh Teknaf Rohingya Programme – An **Evaluation** of MSF Holland's Tumultuous Departure and Advocacy Activities – Confidential – For Internal Use Only – Bart van der Linden, Humanitarian Affairs Officer,' March 2004 (in English), edited.

Extract:

Streamlining process [...]

In August 2002, UNHCR announced that they would withdraw from relief assistance to the refugees in Nayapara camp in June 2003. In September they announced work had started on the implementation of a "self-sufficiency concept". In the self-sufficiency concept the following paragraph can be found: "In order to reduce dependency (of refugees on foreign assistance), and realistically implement self-sufficiency projects, a gradual reduction of the presence of international NGOs, WFP and UNHCR at the camp level shall be effected commencing mid-2003."

In November 2002 UNHCR announced it would start a "streamlining process", in which all the health activities in the camp would be brought under one umbrella (instead of with the three actors, MoH, MSF and Concern). UNHCR explained that in order to realise their withdrawal from relief assistance, their audit team recommended a complete takeover of the health activities by the MoH. In this scenario MSF would no longer be needed. In January 2003 UNHCR informed MSF that, regardless of the approval of the self-sufficiency concept by the GOB, UNHCR would go ahead with the streamlining of the health activities and MSF should be prepared for the handover by 1 July 2003. [...]

The GOB from their side kept MSF until June–July 2003 under the illusion that MSF could stay in Nayapara. When MSF first met with the MDMR [Ministry of Disaster Management and Relief] in April 2003 to get clarity about the proposed handover to the MoH, the minister explained that the GOB had not yet approved the self-sufficiency concept and that handing over to the MoH was a bad idea, because the MoH would not be able to deliver the same quality of healthcare as MSF.

In June the Government of Bangladesh gave approval to UNHCR to hand over MSF's medical activities to the Ministry of Health. In return UNHCR would fund the MoH in taking over the health and nutrition programmes by July 2003. And the UNHCR would remain involved in relief assistance and would facilitate repatriation until the end of 2003.

During the visit of the MSF interim Operational Director to Cox's Bazar in July, it was decided with the Country Management Team that MSF would stay as long as possible in Nayapara camp in order to facilitate a proper handover. When the OD [Operational Director] and Head of Mission visited the Minister of the Ministry for Disaster Management & Relief to explore the possibilities, the Minister and its Deputy Secretary explained that this was not up to the GOB. If MSF wanted to continue its presence in

Nayapara camp after June 2003, it would have to obtain an extension of its MoU with UNHCR (the MoU would expire at 30 June 2003).

The change in the GOB message between April and July 2003 can be attributed to the promised funding by UNHCR. As soon as the GOB realised it would get money to take over from MSF – an organisation which only blocked and frustrated the repatriation process – it agreed of course with the streamlining process and was suddenly in a hurry to take over from MSF to speed up the repatriation before the deadline of June 2003 given by Myanmar. It is also the time when the authorities turned tremendously hostile towards MSF, addressing MSF boldly in public meetings and starting to intimidate MSF national staff members. It was clear that MSF was leaving; it was only a matter of time – but the earlier the better for the GOB.

Departure and press release

After a couple of very tumultuous months in which MSF was treated in a very hostile manner by the GOB and UNHCR, the MSF team felt that it was impossible to continue its operations in the prevailing hostile environment. [...] On 6 August, MSF received a letter from the NGO Affairs Bureau informing MSF about the termination of its Rohingya programme and subsequent request to hand the programme over to the MoH by 30 September 2003. [...] Possibly the new information on the approved 3- to 4-month handover had not trickled down yet. During the streamline or handover meeting on 12 August with UNHCR and the authorities, MSF is requested to leave the meeting, based on the fact that “MSF had pulled out without giving any notice”. [...]

MSF went public with a press release on the departure only on 17 September 2003. This delay was caused by the many personnel changes and gaps at the Press Department, HAD and Operations. The content of the press statement has been criticised by many as being too weak. It called upon the authorities and UNHCR to respect and protect the rights of the refugees. The reason behind this “diluted” statement was that, after very intense lobbying by MSF towards UNHCR to uphold its protection mandate, it finally employed two extra expatriate protection officers in Nayapara camp in August 2003, who properly took up the protection role. As well, MSF had not been thrown out of the camp, but had left on its own timing. Without downplaying the hostilities exerted by UNHCR and authorities on MSF, MSF could have stayed in Nayapara for another 3 to 4 months. Then the handover could have been completed and MSF would have witnessed the results of its successful lobby for adequate protection.

CHAPTER 2 - 2000S - FROM “SILENT” ADVOCACY TO LESS “SILENT” ADVOCACY

Between 2001 and 2004, the MSF OCA (Operational Centre Amsterdam)¹⁶ medical activities in Myanmar grew significantly both in term of number of patients treated and geographical reach.

In 2001, MSF Holland/AZG began malaria, tuberculosis, and HIV/STI (Sexually Transmitted Infections) activities in Shan state.

16. In the mid-2000s, MSF Holland started to share operability with other MSF sections within the framework of MSF Operational Centre Amsterdam (MSF OCA). All operational sections adopted a similar setup, hence the shift from ‘MSF France’ to ‘OCP’ (Operational Centre Paris), ‘MSF Belgium’ to ‘OCB’ (Operational Centre Brussels), ‘MSF Spain’ to ‘OCBA’ (Operational Center Barcelona/Athens) and ‘MSF Switzerland’ to ‘OCG’ (Operational Center Geneva).

In late 2002 - early 2003, in addition to the HIV/AIDS education activities OCA implemented since 1998, they progressively began providing patients with anti-retroviral treatments (ART) in several regions of Myanmar. Like malaria programmes, these ART programmes extended both in geographical and cohort size terms, under the leadership of the Head of Mission, who was also the Medical Coordinator.

During this period, most of the advocacy activities were bilateral and 'behind closed doors' towards foreign embassies and UN agencies in the region. While they were mostly aiming at getting more access to extend medical activities, they also warned against consequences of the UNHCR's efforts to disengage from Rakhine.

There were few semi-public stands; primarily medical publications or cautious and balanced interviews of the Head of Mission.



'Burma **Trip Report**, Austen Davis, MSF Holland General Director,' 26 November to 5 December 2002 (in English), edited.

Extract:

The programme has excellent coverage – and sees A LOT of patients. The design and protocols have been based on current best practice and the collection of careful evidence. The programmes have allowed studies to be performed to demonstrate the efficacy of changes towards efficacious treatment – allowed as a 'pilot'. We have extremely good diagnostics – using both Para check and microscopy – with crosschecking of slides to maintain quality of diagnosis. The treatment protocol has been well established. The collection of good quality data has not just informed programme choices – but has been a powerful tool for lobby at the national level and for publishing results to force the pace of change internationally through the WHO. [...]

It is clear that the problem has been a major irritation to UNHCR for years. They have planned a major reduction in presence in Bangladesh and are trying to reduce presence on the Burmese side as well. UNHCR seems to accept 5,000 refugees in Bangladesh will never come home. So, they want to move 15,000 back next year and then have the others integrate and call the programme over. There is no indication that this is what the Bangladeshi authorities will accept – that the Burmese authorities will accept this – or most importantly that the Rakhine Muslims desire this. [...]

United Nations Development Program (UNDP) was due to come to the area to replace UNHCR – but this has not happened to date, and many NGO programmes are in crisis of funding. [...] UNDP has failed to negotiate access and failed to develop a programme to fill the vacuum left by a departing UNHCR. This could have serious consequences for the overall presence of the UN and NGOs in Rakhine and will make our continued presence all the more vital and unique. [...]

Recommendations: [...]

The question of témoignage – actually the team does A LOT. It does important bearing of witness to UNHCR, local authorities etc. It is immediate and reactive. It is important and will become more so as other agencies withdraw or reduce their presence.



'MSF Trip Report Humanitarian Affairs Advisor – Confidential – by Dick van der Tak, MSF Holland Humanitarian Affairs Advisor,' 1–15 March 2003 (in English).

Extract:

Advocacy is not separated from the medical project, but very much integrated in MSF's daily activities. It remains very difficult to negotiate access to remote areas; [...] Although this was my third trip to Maungdaw/Buthidaung and Sittwe, the humanitarian situation in the area continues to shock me. The Rakhine Muslims live in an open-air prison and are the victims of a vicious ethnic cleansing policy by the military regime. People are extremely vulnerable and seriously restricted in their freedom of movement, and confronted with excessive tax, neglect, denial, stigmatisation and forced labour. The Rakhine Muslims are not recognised as citizens with full rights but are only granted a secondary "white card." Some people refuse to accept the white card, as all other Burmese get a "red card," and they are left without any form of identification.

A relatively new issue, but frequently mentioned in my discussions with the staff, is the difficulty people face to get married. The Muslims have to apply a long time (up to 6 months) in advance to get the necessary paperwork done and have to pay a fee of up to 100,000 kyat. A daily labourer makes approx. 4,000 kyat per day. Effectively, this boils down to a vicious rule to control population growth as people cannot get married. It is illegal (and shameful) to have children if one is not married.

Being squeezed and squeezed and squeezed, people continue to leave for Bangladesh, although recently in low numbers. The Rakhine Muslims know that the situation in Bangladesh is at this moment not favourable to them and are trapped in NRS. People know they will be treated as unwanted, illegal immigrants in Bangladesh, and they know that the situation in the refugee camps is not good. Still, one person told how 6 families recently left for Bangladesh (Bandarban) because the male members of the family were called for forced labour by the army.

If anything, it is the hopelessness of the population that makes the context so sad. For the first time I heard two people talk about "an armed struggle", as only solution to end their misery. However, these persons were also realistic enough to say that 80% of the population will not fight, as their main day-to-day concern is to feed themselves and their children. Some hope that life will change if ASSK [Aung San Suu Kyi] gets into power.

In informal discussions with UNHCR staff it did not become clear what the "exit" plan of UNHCR from NRS is. MSF should continue to support an ongoing presence of UNHCR as the protection needs of the local population remain high.



At that time I felt MSF Holland should speak out more about the situation in Rakhine but I was always opposed a very strong sort of 'the forever argument: If we speak out, we will get kicked out of the country.' The Head of Mission, who was already there when I was Head of Mission in Bangladesh [in 1995–1996] and still there when I worked as humanitarian advisor was very protective of the Myanmar mission. Being in the Humanitarian Affairs Department (HAD), obviously I had a better grip on MSF positioning vis-à-vis the Rakhine situation. Actually, in HAD we were strongly pushing for more communication, either publicly or behind closed doors about the situation in Rakhine which we felt MSF Holland or OCA failed to do in the earlier years. Having visited also Maungdaw, and some of those camps between Sittwe and northern Rakhine where the situation was horrible, I felt frustrated that MSF did not do more. From a HAD perspective, a lot of our energy went into MSF taking a stronger position on the situation in Rakhine. It would be a mistake to say that MSF Holland didn't do anything. MSF Holland did do a lot behind closed doors in Myanmar. They talked about the

plight of the Rohingya with the embassies in Bangkok. But it was all very careful, very protective of the mission.

Dick van der Tak, MSF Holland, Head of Mission in Bangladesh 1995-1996; Humanitarian Affairs Advisor 2000-2003 (in English).



In 2003, it was my third day in the MSF Holland Humanitarian Affairs Department when Dick van der Tak returned from a visit to Bangladesh on where he had also been Head of Mission a few years earlier. He was not as knowledgeable as the Head of Mission in Myanmar but he was quite aware about the Rohingya situation. He started to tell me where he'd been, and I had never heard of this situation. In 2003, it was really unknown for people who weren't deeply engaged with that population. He started to explain the situation of the people in Teknaf camp in Cox's Bazar and what the situation was back in northern Rakhine State and about needing travel permission and having to register families and it being limited to two children. At that time, I was writing about international crimes and I was writing the bit about genocide. I had given practical examples of all the ways genocide is explained in the convention and the only one that I had no example of from a contemporary situation was preventing birth within a group. It caught my attention first of all because Dick had this very emotional response coming back from his mission, and secondly, because this sounded like a slow genocide and I thought: "How come I haven't heard of this situation?" So, throughout those four years in that capacity as IHL [International Humanitarian Law] advisor, I was quite closely involved with discussions around Myanmar.

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).



Regarding Rakhine, we always had the debate about what do we want from this speaking out? If you want a good outcome, don't strictly define the way to get that outcome. Find a way to reach that. That's how the head of mission saw things. The situation also was somehow stable in Rakhine at that time. We had malaria and PHCs and we could really provide PHC services in northern Maungdaw. We could provide a lot of treatment. We could travel a lot. Our Muslim staff too could travel with us to provide the services. Of course, there were abuses made in the area by individuals and authorities. It was worse there than in other places in the country.

MSF OCA, Staff Member in Myanmar, 2003-2014 (in English).

FIRST INTERNAL ATTEMPTS TO QUESTION THE "SILENT ADVOCACY" STRATEGY

In 2004, changes in the Operational Directors¹⁷ team in the headquarters led MSF Holland/OCA to start questioning the significant and - for some - incontrollable growth of the programs in Myanmar. A geographical expansion freeze was requested by Amsterdam, but was partly ignored by the field.

¹⁷ For the past few years, MSF Holland's operational team consisted of four Operational Directors who each managed a portfolio of programs. Since 2004, a single Operations Director supervised program managers in charge of these portfolios.

The new MSF OCA Operational Directors team also questioned the all-out “silent” advocacy championed by the Myanmar Head of Mission. Further, it was a moment in time when the entire MSF movement was asking questions about public positioning.

The MSF OCA Humanitarian Affairs Department was commissioned to explore possibilities of doing more public advocacy about the Rohingya together with the Rakhine team and the Head of Mission. Three arguments were put forward for a possible change of advocacy strategy: 1/ absence of improvement in light of the deterioration in the general situation for the Rohingya for the past ten years; 2/ impossibility to voice concerns towards Bangladesh since the 2003 departure of MSF in the Teknaf camps and 3/ the fact that such public advocacy strategies had never been tried by MSF or any other NGO in Myanmar.

In her trip report, the Humanitarian Affairs Advisor sent to Myanmar asked a series of questions that MSF should address including MSF’s possible contribution to violations of human rights and international humanitarian law through activities that would help normalise the ongoing situation of persecution in Myanmar.

However, her answers were *“based on [her] talks with international and national staff.”* She stated that while the regime was leveraging MSF’s and other INGOs presence to demonstrate their increasing openness, MSF continued to play an *“important and highly esteemed silent advocacy role. The problem is that there is not a (strong enough) political will or economic impulse for change, either from inside or from outside the Rohingya community.”* She concluded that it was, *“still morally justified for MSF to work in Burma in the same way as we have done during the past ten years.”*

This cautionary trend was reinforced by a hardening of the Myanmar regime from late 2004 onwards which led to increased restrictions and daily harassment against the Rohingya and additional constraints for INGOs in Rakhine.

In the subsequent years, the advocacy strategy documents of the MSF Holland humanitarian affairs department continually described the Rohingya situation in detail and recommended data collection sharing with human rights organisations. The conservative ‘silent diplomacy’ position of the Myanmar team was adhered to and thus, no public positioning to speak out in the name of MSF on behalf of the Rohingya was allowed.



MSF Trip Report Humanitarian Affairs Advisors in Rakhine (Burma), 8-16 March 2004 (in English).

Extract:

The Operational Director asked the HAD Advisor to look into the possibilities of more public advocacy with regard to the Rohingyas, together with the Rakhine team and the Country Management Team (CMT).

The reasons for this eventual change of advocacy tactics are threefold:

1. MSF Holland has been working in Rakhine for ten years, but the situation for the Rohingyas has not improved, rather deteriorated.

HAD: That is to say, the general human rights/political situation has not improved. There are considerable improvements in the health situation of the Rakhine Rohingyas because of MSF's work. And because of other INGOs and UN agencies.

2. Since August 2003 we no longer have the opportunity to voice our concerns about Burma via our work in the refugee camps in Bangladesh.

3. Neither MSF Holland nor other I(N)GOs have tried out such public advocacy.

To this purpose at first individual talks with team members were held, followed by extensive brainstorm-sessions with the team in Rakhine and the Assistant Head of Mission and Head of Mission in Yangon. The talks with several selected national staff members were very helpful to gain a more in-depth understanding of the feelings and insights of (some of) the population. [...]

What are the advocacy tactics used during the past ten years?

For years MSF has mainly used the following first two approaches:

1. 'Quiet' intervention/silent diplomacy:

Private meetings, raising concerns with relevant actors in a discreet way.

Examples: Plenty, both initiated by MSF and by others approaching us.

2. Intermediary action:

Passing on information on a confidential basis and in a way that MSF is not seen as the source. Asking others to follow up, to take their responsibility.

Examples: Also plenty. For years MSF has been "feeding" Amnesty International, Human Rights Watch, UNHCR, other UN representatives and Rapporteurs, embassy and government officials, INGO representatives, journalists).

But also, elements have been used of so-called

3. 'Semi-public' action:

That is to say, attaching our name to the information we provided, but providing it only to a small or select public.

Examples: The closed conference in Dhaka in March 2002, attended by UNHCR, the Government of Bangladesh, (I)NGOs and donors. As well some articles appeared in national newspapers in Bangladesh. As well MSF participated in many conferences and workshops on Burma organised by others. [...]

4. As well as sometimes public action:

Attaching our name to information provided to a wide audience, can be e.g. in the form of media statements (locally and internationally) or postings on MSF websites.

Examples: Head of Mission giving an interview to a HK [Hong Kong] newspaper, and to a Burmese one (mainly on HIV/AIDS, never on Rohingyas) And his interview to MSF Austria, to be used by other sections.

Many more examples; British, Japanese, Austrian, Swedish television over the last 2 years, plus at least 30 newspapers. This all on AIDS or general humanitarian assistance.

Why do we discuss AIDS in public, with our name attached, and not Rakhine Muslims?

AIDS is a very sensitive topic, but it is still a medical topic and therefore not totally unacceptable for a medical organisation (in the eyes of the authorities). In addition, when we talk openly about the AIDS problem in Myanmar, we always try to use a way that does not attack the government too blatantly i.e. focusing on the region as opposed to Myanmar alone, or focusing on the future possible nasty scenarios instead of the situation now. I believe it still clearly gives the message but not too direct.

The Rakhine Muslim situation is a more difficult topic for us to bring up publicly. In the eyes of the authorities it is purely political, and therefore off limits. It would also be very difficult not to accuse the authorities directly.

Guiding questions to ask ourselves now:

1. With regard to the decision to yes/no going public in the near future:

- a. Is what we achieve very minor in light of the bigger overall situation?
- b. Are people happy with the healthcare provided, against the background of the ongoing violations? Or do they tell us that they'd rather have us acting in a different way?
- c. Do we contribute to the violations of HR/IHL going on?
- d. Is the regime using our presence for their own p.[public] r. [relations]?
- e. Moreover, do we make the situation worse in the sense that our presence prevents others to intervene? ("MSF Holland and other INGOs are allowed to work there, so the human rights situation can't be that bad")

So, summarising the above: Are we so complicit that it is no longer morally justified to work?

Opinion HAD Advisor, based on talks with international and national staff members:

Ad 1 a. What we achieve is definitely not as much as we would like, however it is quite impressive and not minor in the light of the ongoing human rights abuses: We provide healthcare to the Rohingyas (which the government did not do in the past and will not do in the future, even in case MSF Holland would stop), we give attention and solidarity to the population we work with and we play an important and highly esteemed silent advocacy role.

Ad 1 b. People are very appreciative of what we do and do not ask us to do more, even not when explicitly questioned. They just ask us to "pass this information to your boss, to others".

Ad 1 c. We do mitigate the consequences of the violations of HR/IHL. However, not in the sense that we would so to say, "prevent a popular uprising". Because nothing is to be expected in that regard. The Rohingyas in Burma have quite a low level of self-organisation. They lack leadership, probably partly because there are relatively few educated people amongst them. The average uneducated Rohingya just tries to comply with the many obligations to ask permission and to pay, only some of the more educated persons try to negotiate with the authorities for lesser taxes and the like.

So far, we have not come across an impulse for change from within the Rohingya community.

Our staff tells us that the population is "waiting till this regime collapses, and then we will take up weapons. Because they are killing us now, so then we will kill them". There is no Rohingya army, or an armed group of any importance. People don't have weapons now, however it must be easy to smuggle weapons via the porous borders with Bangladesh and India.

Ad 1 d. Yes, like with all the other I(N)GOs working in Burma, the regime uses our presence to show off their increasing openness.

I am not convinced of this at all. I have not seen that the government uses the presence of INGOs much. In fact, I am surprised by the lack of it. In 10 years, I have not seen us in the media.

The only people who use INGO presence to show increasing openness of the authorities are the UN organisations, in particular in the reports of the Special Rapporteur of human rights and in the reports of the special representative of Kofi Annan.

Ad 1 e. Our presence does not prevent others to intervene. The problem is not that the rest of the world is not or badly informed about the plight of the Rohingyas. Well-documented reports of AI [Amnesty International], HRW [Human Rights Watch] and others are placed on internet and there is a relatively small but quite active lobby-movement which is constantly keeping the general Burmese and the specific Rohingya problem on the agenda.

The problem is that there is not a (strong enough) political will or economic impulse for change, neither from inside (see under 1 c.) nor from outside the Rohingya community: [...]

None of [...] outside actors is putting (sufficient) pressure on the present regime to change the plight of the Rohingyas. Taking into account that this regime is known as extremely immune for outside pressure.

Summarising: It is still morally justified for MSF to work in Burma in the way as we have done during the past ten years.



Trip Report Myanmar, Michiel Hofman, MSF Holland Director of Operations in charge of Myanmar programmes 20–23 December 2005 (in English).

Extract:

Rakhine

Specific issues Rakhine:

- Increase of malnutrition noticed in Malaria clinics.
- Further restrictions on citizenship/travel, like stop of registration of new-born children, further restrictions for marriage licenses.
- Lack of possibilities for follow-up of patients referred for treatment cross-border in Bangladesh. [...]

Context Analysis:

- Over the past year internal power struggles and changes in the top structure has led to a significant hardening/tightening of control on all levels by the regime. Partly through inaction as lower level authorities have become less willing to take responsibility/decisions waiting for the dust to settle on the new power balance, partly rules/regulations for international NGOs have been (re)introduced/added as the more “NGO friendly” authorities have been removed from power.
- This is visible on all levels: longer and more unpredictable visa and travel permit procedures.
- Tightening of rules around registration of clinics/staff.
- Difficulties to access certain areas, specifically the mining areas.
- Tightening of importation rules and practice.
- Expectation is the regime lacks the capacity to maintain these levels of control, but a prolonged period of difficult access and erratic implementation of all sort of rules still lies ahead, before the situation relaxes.
- A rise of influence of USDA [Union Solidarity and Development Association] – described as “fresh young patriots” – political movement starting to harass the population.
- In the international arena Burma gets even more isolated; no chairmanship of ASEAN anymore, change/hardening of US policy towards Burma, withdrawal of Global Fund (no financial impact, but political). Upcoming key-event referendum/elections in 2007. [...]
- Rakhine State: On most issues the situation has worsened for the population; travel restrictions, citizenship issues, harassment by authorities.

Advocacy:

General advocacy around HIV/AIDS, both in terms of medical advocacy to make the appropriate diagnosis/treatment available as well as stigma and discrimination, an improvement is seen over the past few years. Some restrictions on testing, treatment etc. have been removed, but many restrictions remain. Also, discrimination/stigma of both government and population has decreased.

Specific advocacy for the Rakhine population has not yielded any visible positive results on any of the restrictions imposed on this group, or daily practice of harassment by authorities. General feeling was that, however, without the NGO presence and lobby the situation would have been worse, as the presence of the international organisations is the only small protection this population has. [...]

Main conclusions/Recommendations:

1. There has not been any significant change of context in since the start of the mission in 1993; same oppressive regime is in place, and likely in place in the foreseeable future, nor has the regime significantly changed their ways. Specifically, the most vulnerable group in Burma, the Rakhine Muslims, have not seen any improvement of their plight, rather a steady decline since 1993.

As the context and therefore the reasons for intervention have not changed, the planning horizon for the mission “open”; which means MSF Holland will be in Burma for years to come, any discussion on end-dates will come at a change of context.

Either in the negative sense – restrictions on NGOs reach such unacceptable levels we judge there is insufficient “humanitarian space” to operate; identified for the MSF Holland mission as “interference from the government to the level of choice of beneficiaries/patients”; meaning that if we are no longer able to determine ourselves whom we are or are not allowed to treat, we would consider withdrawal. Other restrictions are a nuisance, not a principle, so can lead to changes in intervention strategies/volume of programme etc.

A change in context in the positive sense of course would also be the start of an exit discussion, but is seen as less likely for now.

2. The geographical expansion of the mission has been “frozen” last year (no more new clinics); this has only frozen the patient numbers for malaria in Rakhine (roughly the same in 2005 as in 2004). Admissions for other components have not been frozen so are projected to increase in 2006. Especially for HIV/AIDS a further doubling of number of patients under care is planned for (e.g. patients on ARV from 2,000 at the end of 2005 to 4,000 at the end of 2006) – this extends of course to patients under care, as well as increase of number of TB patients (co-infected) etc., etc.

Although not decided yet – this process is likely to be “frozen” as well by the end of 2006 as both the level of resources MSF Holland is willing/able to put into one mission will reach its limits, also what is regarded as a manageable volume for one mission will reach its limit. Both criteria are of course highly subjective but nevertheless will come to a conclusion of “freeze” at a certain point in the future, and by nature will be arbitrary as the level of needs of the identified target groups is bigger than MSF Holland alone can cover – and no meaningful impartiality criteria can be applied to rationalise one area in Burma over another other than the ones already applied.

3. The HIV/AIDS components of the mission, which have started with a large focus on prevention, followed by treatment where applicable, this focus has to shift in thinking, programming and even language used for the whole mission to treatment, with prevention where applicable. The project purpose for this reason for the 3 projects Yangon, Shan and Kachin therefore needs to be rewritten, for starters to state as our objective “treatment, care and prevention of transmission for HIV/AIDS” (to be formulated by the mission) rather than the current “prevention, care and treatment” – not as a bureaucratic exercise, but to make sure that on all levels (CMT, PC [Project Coordinator], Teams, Amsterdam, etc.) its deeply understood we are there to first and foremost TREAT patients, care for patients and then of course from that position CONTRIBUTE to prevention measures – to ensure that in our day-to-day logic on making choices/priorities we do not lose focus of what we are there for – which is NOT primarily to prevent the

spread of the HIV virus (although of course we hope to make a contribution to that as well), but to CARE for people that are already infected. [...]

4. As the MSF H mission is now, and will remain, the single biggest HIV/AIDS treatment programme in 2006 in Burma (something like 90% of all patients on ARV in Burma are under care with MSF H) the mission runs the risk of becoming the de facto referral for all other actors for ARV treatment. Now that significant funds will become available in 2006 (with a year or more delay due to Global Fund withdrawal and subsequent re-routing the same funds through this new "3 disease fund") it's essential to concentrate our lobby efforts to ensure that new actors applying for those funds to start HIV activities include treatment, including ARVs, in their plans, in significant numbers. [...]

Some other recommendations:

Advocacy Rakhine: no change in our objective (ensure proper access to healthcare as MSF Holland direct advocacy, all other advocacy through other channels so as to safeguard our presence) there are specific new issues to address (further restrictions on citizenship: registration new-borns, marriage licences, cancellation of red-cards); as well as addressing stigma/discrimination of HIV/AIDS now that this component has been added to the Rakhine project, as well as opportunities to explore, notably the re-engagement of MSF in Teknaf/Cox's Bazar areas in Bangladesh.



I froze the number of malaria clinics all over the Rakhine state at 26. But actually, the main preoccupation was HIV projects in Yangon itself, but also in Shan and Kachin provinces, in the mining areas and in cross-border areas. That was continuous expansion and opening more sites and more clinics specifically for HIV and specific target groups like sex workers. In terms of volume, it was unsustainable. Also, in terms of the mandate of MSF, it was diverting towards systems building and it was all about coverage.

Everybody thought that the whole Myanmar programme was becoming unmanageable and out-of-control in terms of the volume of projects and that the head of mission was out of control. Initially they gave me the brief that I had to replace him long-term. Something had to be done. The main issue at that time was an internal one where he had made all kinds of important initiatives for HIV and malaria treatments. He was the one who introduced artemisinin combination malaria treatment that all of MSF was boasting about. So, I did not want to drop him like a hot potato just because he carved out quite an autonomy... I also agreed that obviously there is an expiry date for heads of missions. This also applies to positions of general director or operations director. But I thought it was to be discussed with and negotiated with him on how to ease out of it and not say, 'you are a bad guy and this and that.' You can't just disown somebody just because they don't suit you anymore at that stage. You have to find a way, progressively.

Myanmar is one of the rare places through the course of those years, that I went twice for extended periods to actually work with [the Head of Mission] before imposing limits on the volume and scope of the projects and to help him create an exit strategy. He did not agree with my idea that MSF should not behave like an organisation mandated to build Ministries of Health, and that coverage and assistance building could be a side project but shouldn't be the objective of humanitarian projects. In the end, he accepted that certain limits on continuous growth were needed. So, I essentially froze the volume of projects and we started discussing his exit strategy.

Michiel Hofman, MSF OCA, Operational Director, in charge of Myanmar, September 2003-February 2007 (in English).



Every new Operational Director, I had to convince about Myanmar. We had to discuss how we are going to do this balance of advocacy and healthcare. Of course, everybody knew that that was a difficult thing. If you talk too much, then there is no access and if you don't talk enough then well that's not what MSF has in mind in general. That was not only in Myanmar, but surely in Myanmar that was an enormous dilemma. My idea was to have access and we had created that really well, I think. We could travel freely all over these areas and we could provide healthcare, which they didn't have. We could discuss regularly with other people what was happening there. So, at the local level, we could do things, but speaking out, that is what I always advised against. And I guess it was agreed by the headquarters because when they challenged me, I pushed back and then in the end, we usually agreed. I think they realised that it's this or it's nothing. We also did work with HAD. And there was always the same tension. Regarding HIV, they were more like, 'let's go' and I was more like, 'be careful.' In the end, we agreed, maybe begrudgingly sometimes.

X, Former MSF staff member in Myanmar (In English).



I wasn't involved, but my sense is that in those early years I am sure that the head of mission and those who were there understood the Rohingya situation but it was much more about the medical impact that we could have and about getting the access into a place that was important. The mission in general was very much about 'changing protocols,' changing the medical system for the benefit of the people that we were reaching out to assist. They only considered public speaking as a mode of advocacy only on issues related to changing treatment protocols for malaria and HIV. It wasn't about témoignage at all. Témoignage just wasn't in the whole philosophy of the mission, it was outside of it. What was unique to Myanmar was the continuity of the head of mission, who had a very clear vision and philosophy about what MSF was supposed to do in that context. That whole approach had a lot of integrity. What it lacked was the piece about public speaking out because it didn't fit. I had lots of conversations with many Myanmar nationals and others who felt so strongly about the risks... of speaking out in that context from individual staff members' security and detention-related risks to increasing administrative hurdles that would be put in place if you were seen to be uncooperative and ultimately, to potentially being kicked out. And, those risks were deemed and felt to be very high amongst a certain portion of the people working in the mission, both nationals and internationals. If you add that to an authoritarian regime, it was the mix of those two things that made it very immovable.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



The Rohingya issue was a big focus of HAD [Humanitarian Affairs Department] the whole eight years I was there. Within HAD, Dick, the advisor, was frustrated with the head of mission. In 2004, when Dick left, his replacement worked on the Rohingya situation very intensively. She really did a lot of detailed research and analysis and it was a constant effort to keep us speaking about what to do with this situation. I remember her at a 9.30 am presentation to the office we used to have every morning, explaining the whole history of the Rohingya. There was the 'Club Med' [confidential database], all this documentation that was going on and was being used in confidential meetings at embassies and so on. There was a constant conversation about whether we were part of the problem or part of the solution in northern Rakhine State because the medical impact was not a massive one. Of course, we were a witness but the act of bearing witness was very limited. So, we were wondering whether

the fact of our presence was somehow legitimising all that was happening there. The advisor worked very seriously on that.

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).



Gradually that mission built up and became more important. There was a question of whether we would put in jeopardy all those tens of thousands of people we were supporting on ARVs and with the malaria and the malaria study, for the Rohingya, which was an intractable frustrating issue, where we haven't made any gains over years and nobody had made any gains.

Everybody thought: 'The Head of Mission is doing such good revolutionary work.' But nobody thought to say: 'Well, actually is it an MSF mission? Is it really balancing the values and the interests and the ideals of MSF as a both a medical and a humanitarian organisation?' At that time, MSF was going through various 'Are we medical? Are we humanitarian?' debates. But for Myanmar nobody dared or wanted to challenge and to upset the boat because the Head of Mission was doing this great medical work. At one point the operational advisor even refused to let me have contact with the mission because I was being a thorn in everybody's side.

MSF OCA, Humanitarian Affairs Advisor, 2004-2007 (in English).

MSF FRANCE'S DEPARTURE FROM MYANMAR

In November 2005, faced with the impossibility of working independently using international staff, MSF France decided to close the malaria program they were running since 2001 in the Mon and Kayah states. They actually left on 26 March 2006 and on 30 March 2006, they issued a press release stating that they were leaving, "because of unacceptable conditions imposed by the authorities on how to provide relief to people living in war-affected areas."

MSF France also mentioned that the Dutch and Swiss MSF sections were continuing their programs in the country for the time being since, "they feel they can remain in the country and provide quality care to their patients without making unacceptable compromises with the authorities." MSF Holland prepared a Q&A document to answer journalists who would question why MSF Holland was not leaving. It mostly focused on MSF's indispensable medical activities for Myanmar's most vulnerable populations.

A few months later, asked about the impact of MSF France's public communication at departure from Myanmar, the MSF France president explained to the board members that the decision to leave was a practical one, requested by the field team who had been unable to work for months due to lack of travel authorisations. According to him, the public communication was implemented "out of honest concerns" to expose the blockages.



'Minutes of the MSF France Operations Meeting,' 29 November 2005 (in English).

Extract:

Myanmar: Hervé [Isambert, Programme Manager] and Asis [Das, Head of Mission] The dictatorial regime became radicalised in late 2004. That year, our medical intervention for border populations was seriously impeded on several occasions. MSF was the only international NGO that had access to these people. In a very tense political context that restricted our capacity to not only independently carry out our medical intervention, but also speak out, was the impact of our presence on the living conditions of populations handed over without witnesses to nothing but arbitrary laws enough to ensure our programme was relevant? Was there a humanitarian space in Myanmar that would allow us to consider alternative operational approaches?

Decision:

We had spent enough time in Myanmar to make such an assessment. We set ourselves the target of closing the programme within three months, unless there was a radical political change that would allow us to prepare new operational strategies.



“Q & A on MSF Holland’s Work in Myanmar;” **Draft for Review** with Comments from Head of Mission,’ 6 March 2006 (in English).

Extract:

Why is MSF France leaving and other sections are staying?

MSF France was running a malaria project in Mon and Kayah states. This section has decided to close their project because they have limited access to patients. Which patients in what sense? The section has also been denied permission to work in XXX state. Based on these factors, the section has decided to withdraw from the country. We'll probably get the question: 'Is this something that suddenly changed or has it always been like this (so on what basis did they make that decision)?'

Because they were working in another part (different target area, different target group) of the country than MSF Holland and MSF Switzerland, there is no reason why their decision to close their project would necessitate the close of the rest of MSF's projects in the country. At present, we still have access to the people we identified to be very much in need of assistance. We are treating thousands of patients in need of care for life-threatening illnesses including HIV/AIDS, tuberculosis, malaria and other sexually transmitted infections. Because of the lack of other available care, MSF believes it is offering crucial medical treatment to some of the country's most vulnerable inhabitants. Many of whom would otherwise lack needed medical care.



'Prevented from working, the French Section of MSF leaves Myanmar (Burma),' Médecins Sans Frontières [France] **Press Release**, Paris, 30 March 2006 (in English, in French).

After four years in Myanmar (Burma), the French section of Médecins Sans Frontières (MSF) has closed its medical programmes and left the country. The programmes were situated in the Mon and Karen states, a region bordering Thailand, and caught in an armed conflict between the Burmese military government and rebel groups. MSF has left because of unacceptable conditions imposed by the authorities on how to provide

relief to people living in war-affected areas. The French section of MSF ended its presence in Myanmar on 26 March when the head of mission departed from the country. [...]

“The Myanmar regime wants absolute control over any humanitarian actor present in these politically-sensitive regions,” explains Dr Hervé Isambert, Programme Manager for the French section of MSF in Myanmar. “If we accept the restrictions imposed on us today, we would become nothing more than a technical service provider subject to the political priorities of the junta. It appears that the Myanmar authorities do not want anyone to witness the abuses they are committing against their own population.” Faced with this deadlock, the French section of MSF has decided to close its programmes and leave the country.

The Dutch and Swiss sections of MSF continue to work in Myanmar. Although they too are facing serious access problems in the regions where they work and are concerned about the future of their projects, for the time being they feel they can remain in the country and provide quality care to their patients without making unacceptable compromises with the authorities.



'Minutes of MSF France Board of Directors Meeting,' May 2006 (in French).

Extract:

Franck [member of MSF France association]: have we measured the impact of our exit from Myanmar? In other words, did it serve any purpose... ?

Jean-Hervé Bradol [MSF France President]: [...] I remind you that this exit was a practical decision because the team simply told us that they could no longer work without travel authorisations, after long months of near inactivity. We were aware that our departure would not change the course of events in Myanmar. The discussion focused on the public communication of our departure and it seemed more honest to us to talk about the existence of these blockages.

Dr Asis [Das, MSF France Head of Mission in Myanmar]: there are still two MSF sections in Burma and our contribution there was very modest compared to the other sections, but if all the sections left, I think the effect would be the same.



'MSF in Myanmar Doubts and Certitudes, Draft Critical Review February–March 2008, Dan Sermand, Dr Jean-Clément Cabrol,' June 2008 (in English), edited.

Extract:

2.3 MSF France

After an unsuccessful attempt to start operations in MM [Myanmar] in 1995, MSF France took the opportunity of a change in the GOUM attitude and behaviour towards international NGOs early 2000 to propose (as the other MSF started with) a malaria control programme in Mudon, Mon State (multi-drug-resistant malaria was prevalent and reported as the main cause of mortality and morbidity in the area at that time). First MoU with MoH was signed in July 2001 (for 2 years) for malaria control activities in various locations in Mon State (4 malaria units). [...] Quickly in 2005, the French team realised that all activities planned and approved in their MoU would not be allowed that easily by the GOUM. Only 3 units in total have been allowed to be run in Kayin of all those planned and, over the year, access to remote areas remained extremely difficult. Malaria treatments were never provided with means. No fixed activity was developed in Myawaddy, partly due to difficulty in access, partly to uncertainty from MSF France. Only

a few mobile clinics were carried out. It was in September 2005 that the GOUM requested the withdrawal of all MSF international staff from Kayin State and their presence in Mon was also restricted. Consequently, activities were further reduced, and as part of national staff as well. November 2005, MSF Francerance decided in its annual planning meeting to stop the activities considering the ongoing difficulties of implementation, lack of access to the population, and failure to obtain acceptable level of results. The mission was completely closed in March 2006. [...]

2. Relevance and impact

The main point about the relevance of MSF France action in the country focuses on the closure of the mission rather than its opening. [...] Unlike the other sections, no “stable” projects were performed/envisaged. The sole priority was access to the locations of interests. But once agreements were obtained, the project did not develop enough in terms of activities and catchments areas (as it could have, through alternative approaches: CHW [Community Health Workers] for example). At a later stage, when the government again hardened its position/policies against international NGOs and regarding access to many areas, MSF France found itself quickly cornered: little access, no authorisations for expatriate presence and no other project “active” and justifying a “lay low and await ameliorations of the situation” strategy. The decision to leave the country “based on MSF principles” no access, free movement, independence ... was quickly on the table. [...]

B- Advocacy

1. Description

The advocacy strategy of MSF France was built to reach four main objectives via national or international channels.

- First to document and disseminate the humanitarian status of victimised population, victim of a chronic conflict (displacement, forced labour, recruitment, torture, rape...) and its consequences (restriction of movements, taxation, poverty, lack of access to basic services, ...).
- Second, via medical data collection targeting international actors (such as governments, UN agencies, other INGOs and Human Rights organisations) to advocate on lack of access to healthcare as well as specific vulnerability imposed by different factions in conflict (including treatment of most common diseases such as malaria, EPI [Expanded Program on Immunisation¹⁸], etc...).
- To be informed and to remain vigilant on the condition and appropriateness of preparedness for the potential repatriation of Karen refugees from Thailand.
- And finally, to stay informed about the populations in danger in Myanmar, the country's health needs, the general human rights situation, and the political process.

2. Analysis [...]

Analysing the strategy of the French section already prior to departure, it is obvious that due to the fact that its programmes and activities had already been reduced to very few (in 2005), advocacy activities were weak then. In parallel, MSF Holland and MSF Switzerland were reluctant to speak out about the humanitarian situation in Myanmar the way the French wanted, fearing to see their operations affected afterwards (traditional consensus in between section to find). As well, and according to interviews, it seems that the desk (decentralised in Japan) was a bit alone due to the fact that Paris HQ was not really interested in MSF France's operations in Myanmar. Almost all communication around the departure of MSF Francerance of Myanmar, previously decided to be supervised (and partly done) by Paris, has been done by the MSF Japan desk and Communication Department. Communication related to the departure has

18. The Expanded Program on Immunisation was launched by WHO in 1974 with the objective of universal access to all relevant vaccines for all at risk.

been qualified as “soft”, internally as much as externally by other actors, as with the letter to the MoH (reasons of MSF leaving the country) written at the same period.

Also, during the annual plan discussions in Paris HQ in November 2005 the team felt almost “neglected” and a “non-priority” (perception), while the future of MSF France was at stake. Nationally, it seems that the departure of the French has been very little prepared in terms of process, not really announced in humanitarian circles and not really discussed with others apart from MSF. The impact has been described as unanimously flat without any benefit for anyone (beneficiaries, other actors, etc...) and has gone almost unnoticed according to quite a few of other actors. A strong communication would have been the first about Myanmar and his population since years, the first about the voluntary departure of an INGO. Other actors were not expecting more trouble than the already existed at this time.

The only positive impact as mentioned by others could be the withdrawal of the new national guide for the INGO with more constraints, controls to work in the country. Internally in MSF France, it has been a pile of frustrations around the entire advocacy which could have been done following the decision, and leaving a bitter taste around it characterised by a feeling of waste: five years waiting for access, five months of real operation and another year waiting for results in terms of advocacy ...



I worked for the MSF France malaria and primary healthcare project in the southern part of the country for four and a half years. And then the mission closed. There was a press release at international level but nothing in the country. At that time there were no proper media in Myanmar. The MSF Holland head of mission complained to MSF France head of mission saying: 'If you submit anything you need my permission. I am the one in charge. I am the one responsible. I am in contact with authorities on the ground.' But, we would not have done anything without permission because we were aware that there could be consequences for MSF Swiss or MSF Holland. The government did not ask MSF France to close. MSF France closed down by choice. MSF Belgium was doing cross-border and helping this Burmese Karen from Thailand. MSF Belgium was to leave and MSF France wanted to reach that region and help these population from inside Myanmar. But they did not get permission to bring international staff. The authorities said that national staff only could go. So, every month, as long as we followed our approved movement plan, we national staff, could go and run our activity anywhere. I was working on the front line, close to the Thai-Burmese border with mobile clinics, and it worked well. But MSF France made a choice to leave because international staff couldn't reach there. The field team, including the Head of Mission, did not want to close down the mission. He asked me some data and he went to Paris for some meeting and he fought not to close. But the headquarters in Paris made the decision to close.

MSF France National Staff Member in Myanmar 2001-2006 (in English).

In late 2006, MSF Switzerland/OCG which was working in the Tanintharyi (southwest region) and in Kayah state (eastern region and on the border with Thailand) since 2000 was also faced with restrictions and reviewed the relevance of their presence in Myanmar.

In late 2007, they eventually decided to develop a two-fold advocacy strategy: passive communication activities would focus on website publications including patient's testimonies, articles on specific medical issues, and narrative texts on obstacles to independent humanitarian action; and active communication activities would gather this information in a report to be circulated to key stakeholders. Regarding advocacy on medical issues, MSF Switzerland/OCG would strive to complement and echo MSF OCA's advocacy work.



'Myanmar Visit Marine Buissonnière MSF International [...] **Observations** for MSF Switzerland,' 23 October 2006 (in English), edited.'

Extract:

Observations for MSF Switzerland

[...] for as limited as my input can be, and with all due reservations (including my limited knowledge of the area and even more limited knowledge of the MSF CH [Switzerland] programmes), here are a few suggestions:

- Review reasons for presence in the country in view of the political reality of the regime's choices. Opt for a more confrontational operational strategy.
- Do not expand medical programmes targeted at the general population (Myeik, Dawei). Consolidate and start developing scenarios for handing over of activities.
- Invest resources to develop activities for the most vulnerable in the most critical areas (Kayah State, others?), confronting authorities as necessary. Document systematically.
- Set oneself limits in terms of objectives, activities to be developed and timeframe. State clearly where your limits are and stick to them: meaning be ready to consider moving out if needed, and build your programmes accordingly.
- Do not internalise constraints and, by all means, keep confronting and putting pressure on officials. Do not self-censor yourself, let the regime censor you.
- Be crystal clear on what you believe is not acceptable, breaches principles (impartiality and independence certainly being the two most at stakes in this situation), be explicit and stick to it. [...] the government will exploit any perceived weakness in the outsider's position (wavering arguments, words not followed up) and you can count on it that they will if they perceive that MSF is anchored on shaky principles.
- Use all leverages available when confronting authorities including:
 - Programmes in Tanintharyi division with authorities (do they value the programme? Do they use it in terms of image?)
 - MSF F departure: remind that reasons for MSF France departure include hindrance of access to vulnerable populations, and that any further hindrance would make it impossible for MSF CH as well to pursue its humanitarian assistance endeavour.
- Impose a system of regular and systematic review on the context developments having a direct or indirect impact on humanitarian space.
- Further reflect on how NGOs in general and MSF in particular is being blocked/instrumentalised by the system, and contributes – if at all – to the exclusion of certain groups from assistance.
- Develop briefings/advocacy strategies with key actors to describe degradation of the situation and obstacles confronting aid actors: ASEAN Secretariat & Chair, most confrontational countries in the region (Malaysia, Singapore), countries with public images at stake (Thailand), regional observers (Japan, Australia), large donor countries including replacement of global funds donors (see infra). [...]

On MSF Communication

- Talking with national staff and asking the analysis of sections about potential consequences of communication on national staff, they all seemed rather confident that the impact would be limited. For MSF France staff, some mentioned that the best guarantee was for them to have found other employment in an international NGO.
- Asking various actors on the ground, they all said that communication is likely to have no impact whatsoever on the government, but that it would certainly be a mistake not to speak out and explain the reasons for MSF departure, letting the government get away with it silently and not being explicit about the limitations imposed.
- Need to develop an institutional explanation of WHY the French section left. Could serve as a basis for discussions with other sections and other external actors.
- The direct impact of the communication is unlikely but indirectly may come in resonance with:
 - Renewed request/confrontation by MSF Switzerland to gain access to certain areas
 - Steps taken in a coordinated manner inside by international NGOs to reaffirm principles without which humanitarian assistance is no longer possible
 - UNDP expression in writing to the ministries of their worries on the guideline content and possible consequences
 - It may in turn impact on donors' questions on the consequences of hindrance placed on NGOs, their operational partners on the ground.



'MSF in Myanmar Doubts and Certitudes, **Draft Critical Review** February–March 2008, Dan Sermand, Dr Jean-Clément Cabrol,' June 2008 (in English).

Extract:

2. Relevance and impact MSF Switzerland/OCG [Operational Centre Geneva]] [...]

2.1 Relevance [...]

The discussion and debates following this evaluation can be again about “should I stay or should I go” if the compromises are too high. It seems with the existing information, that even if we have access to the black zone in the heart of the conflict.....

B- Advocacy

1. Description [...]

In terms of advocacy MSF Switzerland in the field, strives to be active towards counterparts and authorities at local and national level, aiming to preserve humanitarian space without being compromised and raise the main health issues. As well, from a headquarters perspective, the Swiss section implemented since last year a twofold perspective in its advocacy strategy: Passive and Active communication. The first focuses on patient's testimonies, analytic articles on specific medical issues and narrative texts on hindrances to independent humanitarian action. The second, via the gathering of all the pieces of the first, will be dedicated to produce and edit report to be dispatch to a targeted audience (donors, UN agencies, other INGO's and MM authorities). [...]

As well MSF Switzerland wants to maintain a high level of awareness (among government representatives, donors, INGOs, the media) about the hardships faced by patients [...], especially for those forcefully relocated and advocate, with all possible and adopted means, for an improvement of their situation. Towards the GOUM and other health actors in the country (as with the Dutch section) MSF CH advocates also for the availability and the use of efficient drugs and adequate treatments/medical protocols. Gap of funding to institutional donors (and the need for the supervision of the donors and their direct implication/responsibility in the follow-up of the programmes in certain areas) and more especially on the programmes for treatment of the 3 diseases [...] and increase of

the national health budget to the MoH are also strategically developed by MSF Switzerland in its advocacy.

Finally, maintaining and increasing the pressure for physical access to identified target populations in restricted access regions, relocated villages, and to those in hiding areas remain high in the agenda of the Swiss section.

JUNE 2007 - "TAL MAKESHIFT CAMP: NO ONE SHOULD HAVE TO LIVE LIKE THIS - THE ROHINGYA PEOPLE FROM MYANMAR SEEKING REFUGE IN BANGLADESH" (RELEASED PUBLICLY)

Since the early 2000s in Bangladesh, MSF Holland teams had been silently advocating in vain for unregistered Rohingya refugees who settled in makeshift camps after being expelled several times by the authorities, from other locations.

In May and July 2006, MSF Holland successively opened the Damdamia outpatient clinic and a therapeutic feeding centre (TFC) in the Teknaf area of Cox's Bazar to take care of both the local population and of thousands of unregistered Rohingya refugees.

In September 2006, MSF OCA opened a clinic in Shamlapur Union (also in Cox's Bazar) for another group of people living on a beach. MSF OCA was the only international actor actively and directly engaged with the Rohingya outside the official refugee camps.



"Tal Makeshift Camp: No One Should Have to Live Like This – The Rohingya People from Myanmar Seeking Refuge in Bangladesh – An MSF Briefing Paper" MSF OCA **Briefing Paper**, May 2007. **Posted on MSF Website**, 19 June 2007 (in English).

Extract:

In November 2002, in an attempt to curb criminality and restore order in the country, the military-led 'Operation Clean Heart' was carried out countrywide by the Government of Bangladesh. In the Teknaf area this led to many (semi-) integrated Rohingyas getting expelled from their homes and losing their livelihoods. As a result of this operation, a group of approximately 4,500 people ended up in a makeshift camp on a piece of privately-owned land in Teknaf town. This was the first 'Tal Camp.'

At the end of 2004 the owner claimed his land back and forced the group to move. While on the move, the group was stopped by the district authorities and forced to settle on the banks of the Naf River, 7 kilometres north of Teknaf town. Since then, over 3,000 additional people have moved into the makeshift camp, either because they were facing hostility from villagers, were evicted from their homes or were unable to make a living to pay rent elsewhere. In August–September 2005, MSF visited the Tal makeshift camp and – shocked by the appalling living conditions – concluded that an intervention was necessary. In March 2006, the first team arrived in Teknaf and made a rapid health assessment of the camp. The results indicated high mortality and malnutrition levels. In addition, the majority of people who reported recent illness appeared to be unable to get treatment since they had no money to pay for consultations or medicines. These findings indicated a need for free basic health services and a nutritional intervention.

In May 2006 MSF opened the (free-of-charge) Damdamia outpatient clinic in Teknaf and in July 2006 a therapeutic feeding centre. Despite the diverse and complex needs, no other international organisation aside from MSF is currently active, nor has had a consistent presence in the camp. During an assessment of other areas known to house Rohingyas in August–October 2006, the MSF team found a population of approximately 2,250 Rohingyas occupying the beach area in the Shamlapur Union, approximately 35 km from Teknaf. MSF decided to also set up a clinic in Shamlapur Union. This free-of-charge clinic is run on a mobile basis and it is open one day a week to anyone living in the surrounding area.



All these new arrivals were literally living in mud on this very low land close to the river. So, horrible sanitary conditions. Initially, of course both the government of Bangladesh and UNHCR took the line that, 'new arrivals it's not so serious, it's just a trickle. It's nothing that we should be concerned about. Let's not be too noisy about it.' But the next year, it had grown in size so that it was impossible to ignore how sanitary and living conditions were even more desperate than before.

There was a push probably also to move these people to a better environment, a better place inside the camps so that first of all, they had better access to services and secondly, that they would be moved from that very dangerous low-lying land in particular in light of the rainy season in Bangladesh and the area being flooded or potential risk of being affected by cyclones etc. It was an extremely vulnerable population. We had discussions in particular with government of Bangladesh who sort of refused to give MSF any access to these people. We really fought, debated, and had discussions and lobby activities on all different levels in Bangladesh to get access.

*Dick van der Tak, MSF Holland, Head of Mission in Bangladesh 1995-1996;
Humanitarian Affairs Advisor 2000-2003 (in English).*

In the second half of 2006, as a result of a reorganisation of the MSF OCA operational department in Amsterdam, the Myanmar and Bangladesh programmes¹⁹ were regrouped in the same portfolio and managed by the same team at headquarters. This team had a fresh approach.

Together with the Humanitarian Affairs Department, who had been striving to refocus advocacy on Rohingya for several years, they pushed for a larger agenda than strictly medical, to include a more humanitarian approach for Myanmar and to remain in Bangladesh to advocate for the Rohingya.

The MSF OCA teams in Rakhine, with the exception of those based in the north of the state who witnessed persecution on a daily basis, remained focused on their medical activities. They did not closely follow incidents related to the persecution suffered by the Rohingya that impacted healthcare and access. In order to fill this gap, the humanitarian affairs department suggested positioning humanitarian affairs officers in the field and organising debates and discussions with the teams on this subject.

19. MSF OCA Bangladesh programs were managed by MSF Germany for a couple of years.

In late 2006, a new advocacy strategy proposed to conduct advocacy on the plight of the Rohingya from Bangladesh in order to circumvent the difficulties inherent in any advocacy work inside Myanmar. The advocacy objective remained the same: to “expose the situation internationally, advocate for recognition of the protection needs to the authorities (UNHCR included), address the inhumane living conditions and assistance shortages, and through it all to call attention to the situation in Myanmar.”



Position Paper: MSF Holland's role with the Rohingya in Bangladesh [for 2007], 2006 (in English).

Extract:

Summary of position

The Rohingya in Myanmar comprise one of the most oppressed populations in the world. They flee persecution to Bangladesh, yet cannot find refuge. Their situation is the result of a cycle of forced displacement, failed asylum, neglect, abuse and discrimination. Given the ongoing terrible situation in north Rakhine State and our important presence there, responding in Bangladesh remains key to addressing the Rohingya question in a coherent and coordinated fashion. There are identifiable health needs yet no identifiable political solution. Their plight requires MSF's unique intervention capacity, both medically and in terms of témoignage. [...]

MSF's Role on the Bangladesh Side of the Situation

According to the Strategic Plan for 2007–2010, OCA chooses to intervene to assist populations in situations characterised by violence, neglect and deliberate abuse, including situations of severe repression creating medical need and reducing life to mere survival without dignity or choice – and to situations where normal mechanisms of protection fail. The oppression of the Rohingya in both Myanmar and Bangladesh provides a classic justification for MSF intervention. This is core business. The lack of willingness and/or capacity (depending on the case) of other actors to intervene simply reinforces the real and concrete need for the OCA to be meaningfully present in Teknaf. Hence the need to focus on Rohingya across the borders for 2007.

[...]

Témoignage and Advocacy

“Nobody should be allowed to live like this.” [Head of Mission Bangladesh]

Due to the targeted discrimination and well-established systems of exploitation, the Rohingya remain an abused and neglected population in their country of ‘refuge’. MSF is the only international actor actively and directly engaged with the Rohingya outside the official refugee camps. Our proximate medical activities provide an opportunity to expose their plight.

Perhaps more importantly, our intervention with the Rohingya in Bangladesh should be viewed complementary to the programming in Myanmar. There, MSF teams bear witness to the oppression of the Rohingya but are severely restricted in their capacity to address the situation through advocacy. The witnessing priorities for MSF Bangladesh should expose the situation internationally, advocate for recognition of the protection needs by the authorities (UNHCR included), address the inhumane living conditions and assistance shortages, and through it all to call attention to the situation in Myanmar.

The Bangladesh mission will seek to expose the abuse and persecution of the Rohingya in Myanmar through inclusion of evidence collected in Bangladesh. The témoignage efforts by MSF in Burma will be used to contribute to any future international advocacy efforts by sharing data collected in Bangladesh. We do great medical work in Burma, but we are not able to do the other part so vital to MSF, specifically for these people.

Nobody claims that the Rohingya's medical needs in Bangladesh present a compelling crisis (nor should they be discounted). Though valuable in their own right, delivering assistance to the Rohingya in Bangladesh must not be judged solely in terms of medical aid and witnessing. Amid their persecution in Myanmar and their suffering in Bangladesh MSF must stand shoulder to shoulder with the Rohingya, demonstrating and providing the comfort of our solidarity.

We need to maintain and reinforce the MSF interpretation of humanitarianism and the importance of proximity and solidarity with populations in distress (OCA Strategic Plan).



“Humanitarian Affairs **Handover Document** - Burma” – MSF Holland Humanitarian Affairs Advisor, 15 November 2006 (in English), edited.

Extract:

• Work done in the past year (advocacy, lobby, witnessing, analysis, HAO [Humanitarian Affairs Officer] status)

[...] We feel that it is more important to be present and undertake indirect advocacy - on a confidential level, without MSF directly and publicly signing off on anything, because of the benefit to the population.

- The baseline for NRS has been an updated database (delineating type of abuse, location, numbers of people affected, MSF follow-up and consequences), an adapted version of which has been shared with key contacts. At points, an adapted version of the Humanitarian Affairs report (done by the Assistant Head of Mission) is also shared with the same persons at key moments;
- Discussions have been held with UNHCR in Geneva (over the phone and in person) around their position and role in NRS;
- Discussions have been held with Refugees International about the situation in Burma (and the link to Bangladesh); [...]
- Meetings at BCN [Burma Centrum Nederland] have been attended (relatively regularly) and non-confidential information and analysis of the situation shared; a conference hosted by the European Institute for Asian Studies was attended in Brussels mid-2006, where lobbying of UNDP, UNHCR, the British Ambassador to Burma, ICRC, ECHO and others took place around specific issues [...].

In the past, MSF also participated in sharing information (anonymously) with the consultants who wrote the 2004 Report for Amnesty International. However, this report was disappointing in that it only treated civil-political abuses and not the socio-economic abuses that are so prevalent and so key to understanding the suffering of the population.

• Work planned/Ongoing, which needs follow-up from new HAD advisor

It's been quite difficult to do much in Burma due to human resource specificities and mission priorities. Normally, work on humanitarian affairs is undertaken by the Assistant Head of Mission, although currently this position is vacant and it seems now more appropriate, given the weight of work of the Assistant Head of Mission around non-humanitarian affairs, to look at deploying HAOs (where it was possible to agree) to get any substantial work undertaken.

- A low level of awareness of humanitarian affairs and engagement among all teams exists, particularly outside of NRS. To my knowledge, teams do not monitor systematically or follow up issues of concern and often feel that (unless directly related to patients), they are not important: e.g.: forced labour in front of the office. Greater sensitisation and bimonthly or quarterly CMT meetings with the involvement of the PCs from each of the project sites, would no doubt enhance debate and sharing of ideas around issues and the role (if any, direct/indirect) of MSF.

- Within NRS, teams generally tend to be more aware (the abuses are much more well known, so briefings can be more focused, and systems are in place to deal with them). However, they need encouragement to regularly document issues of concern in the incident database shared with ACF and to ensure timely follow-up. [...]
- Of particular concern to MSF is data collection/analysis (within the existing database and incident reporting format) around the causes behind health needs and access to healthcare, with restrictions on movement inhibiting referrals and timely, appropriate and effective treatment for many MSF patients. However, this is generally not systematically documented. Were it to be, this would be the one point on which MSF could undertake direct lobbying (respecting the principle of local level advocacy and when this is frustrated, moving up the hierarchy).



The new programme manager fell sick at the very moment of handover and I was asked to do an interim management. That meant that I had an interaction with a mission that was by then seen as very stable and not so very communicative with the HQ. But it also meant that I had interaction with what was called the Humanitarian Affairs Department where people were quite committed and passionate to the situation of the Rohingya. At the same moment of rotating desks and missions, Bangladesh which was until then under MSF Germany came back to Amsterdam and Bangladesh and Myanmar which so far were not in the same portfolio were back in the same portfolio. I got it handed over by MSF Germany with a remark that 'by the way this mission should be closed'. The project was the precursor to Kutupalong, a small camp of Rohingya, so far not sent back to Myanmar. With the HAD and some other people we were rediscovering OCA's involvement in Myanmar and Bangladesh purely because we were new people while the people in mission were like 'you knew this from a long time.' The mission didn't share an awful lot of paper and there were a lot of concerns as to programme continuity and institutional questions of 'Should we stay in Bangladesh?' We were involved quite passionately about defending the stay of OCA in Bangladesh for the sake of the Rohingya and we started pushing for a more humanitarian-oriented outlook on Myanmar rather than what was the dominant speech, 'malaria and HIV, this is what the mission is about.'

The head of mission for twelve years, honestly all of us admired him. When I took over, my predecessor told me: 'he [the Head of Mission] knows his job, so don't touch it. And what about the Rohingya? Ah, the Rohingya ... hmm.' Missions always begin copying the culture in which they function. I don't think Myanmar was a context where individuals had a lot of opinions and I don't think missions in Myanmar had a lot of space for individuals and international staff. We start mimicking the same culture.

Vincent Hoedt, MSF OCA, Emergency Manager, interim Myanmar and Bangladesh Programme Manager in 2007 (in English).

On 7 March 2007, thousands of Rohingya refugees were ordered by the Bangladeshi authorities to leave the Tal makeshift camps without being given any alternative place to go.

On 12 March 2007, MSF OCA issued a press release calling on the Bangladeshi authorities to work together with members of the international community to find and offer alternatives for these refugees.

In May 2007, MSF OCA circulated and posted on their website, a briefing paper to raise awareness on the Rohingya refugees' dire living conditions in the Teknaf area with a particular focus on the Tal makeshift camp. Once again, MSF called upon the various international stakeholders "to work together in support of the Government of Bangladesh to find a durable solution" for the Rohingya refugees.

In the following months a series of updates on the situation of the Rohingya in Bangladesh were posted on the MSF Holland website.

Eventually, in mid- 2008 the Government of Bangladesh allocated a makeshift piece of land in Leda Bazar (Cox's Bazar) for tens of thousands of unregistered Rohingya to settle down.



"Myanmar Refugees in Bangladesh: Stuck with Nowhere to Go", MSF Press Release,' 12 March 2007 (in English, in French).

Extract:

Having fled persecution in Myanmar and lived in appalling conditions for many years in Bangladesh, hundreds of refugee families are now requested by the Bangladeshi authorities to evacuate and leave without being provided with an alternative place to go. This is the situation facing hundreds of families based in a makeshift camp near Teknaf since Wednesday 7 March. "Tal" camp, as it is commonly referred to, consists of small, ramshackle shelters situated in an area between the river Naf and the highway leading to the city of Cox's Bazar. More than 6,000 men, women and children have sought refuge on a stretch of land 800 metres long and 30 metres wide, where food and potable water is scarce and access to healthcare limited.

The Muslim refugees, who are ethnically referred to as 'Rohingya', have been fleeing Myanmar's northern Rakhine State for many years from which, they say, they were subject to severe abuses such as forced labour, restrictions on movement and land confiscation. For many years they have lived in extremely vulnerable conditions, stateless within their own country and denied refugee status in Bangladesh. "Going back is like drowning in the sea," says a woman from Tal Camp. "We had lots of sufferings there (Myanmar). If we ate once, we couldn't eat the next seven times."

In April 2006 Médecins Sans Frontières (MSF) carried out an assessment and found worrying health indicators among the makeshift camp population as a result of the squalid living conditions: shelters are built extremely close together leaving no room for gardens to grow crops; during the rainy season 79% of the shelters are flooded and during the rest of the year 10% of the shelters are affected by water that comes in at high tide. These conditions cause diarrhoea, respiratory infections and malnutrition, among other health consequences. Soon after, MSF opened a clinic and a therapeutic feeding centre near the makeshift camp. Both facilities are open to everyone in the camp as well as those living in the surrounding area. However, malnutrition and disease disproportionately affect the people living in the camp. Over 100 consultations are done on a daily basis, while the TFC feeds an average of more than 40 children a day.

In an effort to clear roadsides nationwide, the government of Bangladesh is demanding that part of the makeshift camp, located next to the main road, be cleared as well. Moreover, authorities are making certain families that do not appear on their residents' list leave as well. After being displaced, forcefully relocated or having sought refuge for the better part of the last 15 years, a significant number of the camp's occupants will have to move again. "While it is still unclear what is going to happen to the people that

are being driven out of Tal Camp,” said Frido Herinckx, Head of Mission for MSF OCA, “it is time for the Bangladeshi authorities to work together with members of the international community to deal with a problem that has already been there for 15 years and is not going to disappear just by sending people away. Alternatives have to be offered or negotiated; they have to go somewhere. Nobody should be allowed to live like this.” If no durable solutions are found to improve their living conditions and access to services, thousands of Rohingya people are likely to continue to be exposed to disease and malnutrition, after having suffered displacement, exploitation and abuse throughout their lives, both in Bangladesh and Myanmar.



“Tal Makeshift Camp: No One Should Have To Live Like This: The Rohingya People from Myanmar Seeking Refuge in Bangladesh – An MSF Briefing Paper” MSF OCA **Briefing Paper**, May 2007 posted on MSF Website, 19 June 2007 (in English).

Extract:

Tal Makeshift Camp

Your nose is constantly assaulted by the foul smells of the mud at low tide, latrines, and various other waste that comes from people living in such crowded, unhygienic conditions. When you enter a two-by-three-metre shelter and ask how many people sleep there, it seems impossible that a family of five has the space to live. People survive in these conditions every day with no privacy, no peace and no dignity. (Jane, MSF nurse, Teknaf).

[...]

Health problems resulting from the poor living conditions

The Damdamia clinic near Tal provides healthcare for both camp inhabitants and local Bangladeshi residents. The most common health problem suffered by Tal Camp inhabitants attending the clinic is respiratory tract infection (40.4% of cases). This is likely to be linked to the overcrowded situation and exposure to cold and damp.

A higher percentage of diarrhoea and worms is seen in patients from Tal Camp (7.1% and 2.3%) compared to the local host community (3.9% and 1.0%). This is probably due to the extremely poor sanitary and hygienic conditions in the camp.

Moreover, nineteen patients from Tal Camp were treated at MSF’s clinic during the last three months for road accidents, many of them children. We consider the proximity of the camp to the Teknaf–Cox’s Bazar’s road as a major factor in the incidence of trauma wounds reported and underscores how the camp is an inappropriate living space.

Food and nutrition [...]

The Rohingyas’ lack of food and livelihoods is a real concern. Since space in the camp is extremely limited there is no more land available to grow food or raise animals, so it is very hard for them to be self-sufficient. Apart from the therapeutic food supplied by MSF, no general food distribution is done by any other NGO or UN agency. Occasionally, Islamic organisations or mosques distribute meat, rice and dhal.

Female-headed households are the most vulnerable [...]

A recent MSF count showed that 31% of households from Tal are female-headed. These women are extremely economically insecure and vulnerable to exploitation.

Mental well-being

The population of Tal Camp is mostly illiterate, dependent on outside resources for their survival and exposed to all forms of abuse, corruption and neglect.

MSF has found that anxiety, depression, fear and lethargy are pervasive amongst this population, and particularly affect women. The cycle of abuse, violence and deprivation suffered in Myanmar seems to replicate and cumulate in Bangladesh to the point of

exhaustion, hampering people's ability to take care of themselves and their families. MSF is currently setting up a mental health intervention to respond to the mental health needs of this population.

Limited access to health care [...]

The stateless Rohingyas living in Tal are not recognised as refugees and are therefore not receiving the same assistance as those living in the official UNHCR camps. At present, MSF is the only health provider offering them direct free access to medical care. [...]

Even when they are able to pay, the Rohingyas seem to still be victims of discriminatory treatment. People have told MSF that medical staff in Ministry of Health facilities often see Rohingya people only after Bangladeshi people have been attended to.

Meanwhile, in August, September, and October 2007, a series of economic and political protests led by students, political activists, and Buddhist monks were triggered in Myanmar, by the removal of subsidies on fuel prices. These protests were prominent in the international media and were labelled as the "saffron revolution" in reference to the saffron colour of the Monk's clothes.

The protests were severely repressed by the Myanmar police. On 7 October 2007, the MSF OCA Myanmar Head of Mission gave a defensive and – for some – too cautious interview to a CNN [Cable News Network] journalist about MSF's possible role in taking care of wounded protestors.



'CNN – MSF quote – Myanmar – **Interview** with MSF Head of Mission,' 7 October 2007 (in English).

Extract:

HARRIS: The medical community is also taking action to help the people of Myanmar. Doctors without borders is on the ground there, fighting a critical battle against AIDS, malaria and other deadly diseases. Joining us now by phone from Yangon, Dr [...]. Doctor, good to talk to you.

[Head of Mission], DOCTORS WITHOUT BORDERS (on the phone): Good morning.

HARRIS: Doctor, if you would, [...] how would you describe your working relationship with the military regime in Myanmar?

[Head of Mission]: Actually, the relationship is sometimes difficult but in general it's quite good.

HARRIS: Has the relationship been strained by the recent unrest, the demonstrations and the suppression techniques from the government?

[Head of Mission]: No, actually there has been no influence on the work that we are doing in the field.

HARRIS: Has your organisation been able to help the people injured, we're taking a look at some video now, of the military beating protestors? Has your organisation been able to help the people injured in this military crackdown?

[Head of Mission]: Actually, Doctors without Borders has five clinics in Rangoon and overall something like 25 clinics. But the demonstrations were quite localized. And we have not seen any injured in the places where we were.

HARRIS: Well, then perhaps this is the question, [...] has the organization asked to be allowed to help?

[Head of Mission]: Well, you must see this is actually quite a small scale and locally. It's a very big town, Rangoon, and we work on the outskirts while demonstrations were on the in skirts [closer to town]. And today we had an ambulance driving around but even they have not come across any injured people. I believe that the injured people were taken away quickly and quietly.

HARRIS: But [...] you've seen the pictures and you know that there are 'injured people who have been hurt by the crackdown?

[Head of Mission]: Sure. And I think these people have been taken to private places where they've been treated.

HARRIS: Does your organisation have a moral obligation to demand access to the injured? The detained?

[Head of Mission]: I think that the injured sure they need [...] medical help. And if they come to us or if we know where they are, we will treat them like anybody else.

HARRIS: But you don't feel an obligation to move forward, to reach out to the government to in any way demand that you have access to the detained and the injured?

[Head of Mission]: Well, you see we have a very large program. We have treated last year more than one million patients, for malaria, AIDS. These program activities are still going on. We are working for deadly diseases. So, it is very important for us to continue the treatment of these patients and this is actually where our staff is busy in these clinics serving these more than a million people.

HARRIS: So, you want to protect that relationship with the government to do the work you are doing on the ground?

[Head of Mission]: Well, I want to continue these activities. However, if injured people are coming to our clinics. That is not the main reason why we have been set up there but if people come to the clinics, we will definitely help them.

NOVEMBER 2007 - "THE ART²⁰ OF LIVING IN MYANMAR"

In late 2007, MSF OCA's headquarters Myanmar programme team focused advocacy strategies on two categories of vulnerable people: those whose vulnerability is linked to their humanitarian situation; and those for whom it is linked to their medical situation. Two populations who suffered the humanitarian consequences of state-sponsored discrimination and repression and lack of access to healthcare were MSF advocacy targets: the Rohingya and people living with HIV/AIDS, deemed particularly at-risk groups.

A systematic collection of data and testimonies on the discrimination and stigmatisation of those living with HIV/AIDS was launched, while the "Club-Med" database, dedicated to Rakhine, was reorganised to focus on abuses/violence data related to access to health.

The MSF International humanitarian advocacy and representation team²¹ (HART) began supporting both the headquarters and to reach key international stakeholders. MSF OCG, who was running ART (antiretroviral) treatment programs in Myanmar was also included.

20. Play on words with the acronym ART which also means antiretroviral treatment.

21. The MSF International Humanitarian Advocacy and Representation Team (HART) is in charge of representing MSF to international institutions and state stakeholders.

These advocacy activities were essentially aiming at pushing the Myanmar Ministry of Health and the donors to scale up ART provision. The mid-term objective was to decrease the importance of MSF's role in ART provision in Myanmar and therefore to reduce the MSF's patient load.

During the same period, a briefing paper titled "The ART of living in Myanmar" was widely circulated to the main stakeholders at national and international level but not publicly released.



"Myanmar Advocacy", **Message** from Fabien Dubuet MSF International Representative to UN in NYC to Joe Belliveau, MSF OCA Myanmar Operations Manager and Elena Torta, MSF OCA Communication Advisor, 2 November 2007 (in English), edited.

Extract:

Our feeling is that we are ready to support you but that it is difficult to organise an advocacy initiative/humanitarian diplomacy on Myanmar focused only on access to ARVs and on the need to mobilise mere financial resources on that issue. We should also talk about the general humanitarian situation/other humanitarian issues and the lack of humanitarian space (= the difficulty in working, obstacles to our work, problems of access to some areas/regions). This is particularly important for us as it will be our first major advocacy initiative on Myanmar. Although it is probably a good idea to use the momentum on Myanmar created by the recent political developments to highlight the humanitarian situation, we should also make sure that our initiative is not seen as a political gesture and reaffirm the independence of humanitarian action from the political agenda.

Lastly, there has been incoherence and/or contradiction in our public communication during the recent demonstrations, between the statements of [the Head of Mission] on CNN and those of [...] MSF Switzerland mentioning the fact that MSF France withdrew from the country last year, after denouncing the lack of humanitarian space/the control of the government over assistance. We need to build a more coherent message on Myanmar if we want to remain credible vis-à-vis external interlocutors (donors, UN officials, journalists, diplomats). In case we set up meetings here, we would like to make sure MSF Switzerland's concerns are also raised and part of our agenda.

In terms of meetings, we think it could be relevant to associate the ASEAN (its current President -- Singapore -- and its key members like Indonesia, which is also a Security Council member) key regional players (China, Japan, India), but also the main donors of humanitarian assistance to Myanmar (Norway, UK, Switzerland; Germany, EU and OCHA [(UN) Office for the Coordination of Humanitarian Affairs] -- through the CERF [Central Emergency Response Fund]). We should also see the Myanmar mission to the UN here. The ASEAN will hold its annual summit at the end of November in Singapore (18–22 November) and Myanmar will be one of the main points on its agenda, so we should also use this opportunity/timing for possible advocacy plans. Would it be possible to advance our advocacy plans to meet this deadline?



“The ART of Living in Myanmar” MSF **Briefing Paper**, Yangon, November 2007 (in English).

Extract:

Much of Myanmar’s population lives in precarious circumstances, faced with difficulties that range from economic hardship to discrimination, repression and violence. Many are also vulnerable to disease and have few options for seeking medical care. For the past 14 years, Médecins Sans Frontières (MSF) has helped address some of the needs left unmet by a poorly functioning and under-resourced medical system. In recent years, HIV/AIDS has emerged as one of the main killers. MSF has developed one of its largest programmes in response but it falls far short of what is needed. MSF calls upon the government of Myanmar, international agencies and the donors who support them to urgently scale up the provision of ART in Myanmar.



“**Notes** on Myanmar Meetings – NYC” **Message** from Fabien Dubuet, MSF International Representative to UN in NYC to Joe Belliveau, MSF OCA Myanmar Operations Manager and Frank Doerner, MSF OCG Myanmar Programme Manager, 4 December 2007 (in English).

Extract:

Dear all,

Here are some notes on the Myanmar meetings we organised for Joe’s visit in NYC. MSF key messages were in line with our previous discussions and the agreement between desks [...]. Access issues and our willingness to reinforce our assistance efforts in the centre and south of the country were clearly raised with all contacts, especially South Korea, Japan, Singapore (ASEAN President) and China.

Overall, most of our contacts (except China) seemed sincerely surprised about the scale of the HIV/AIDS crisis and more aware of the difficulties to work/lack of humanitarian space in some areas in Burma. The meetings with UNICEF and Singapore were probably the most constructive, though it is difficult to evaluate the impact of other meetings at this stage. We were unable to arrange meetings with the Burmese mission (they said clearly, they had no time to meet with us ...) and India (always a pain in the ... to see them). Interestingly, we were told by several contacts that humanitarian issues are part of Gambari’s agenda and China also informed us they sent an envoy mid-November to advocate for a more open position from Burma on humanitarian action and the ICRC role.



‘Myanmar Mission Strategy, **Memo** by Joe Belliveau, MSF OCA Myanmar Operations Manager, 19 December 2007 (in English).

Extract:

Pattern of vulnerability – there are two broad categories of vulnerability:

1. Vulnerability due to *humanitarian situation*: groups most directly and acutely affected by the regime and its policies, and those groups that are either wilfully neglected or actively repressed. Includes Rakhine Muslims, other groups caught in conflict zones such as the Karen, Karreni, those in ‘brown/black’ zones, areas that the GOUM deliberately neglects more than others [...], also includes groups discriminated against due to HIV status, sex workers, IVDUs [Intravenous Drugs Users], MSMs [Men having Sex with Men] [...]

2. Vulnerability due to *medical situation*: combination of high prevalence of certain diseases and lack of access to adequate care and treatment. Some groups – including sex workers, IVDUs, minors, and MSMs – are more vulnerable to certain diseases like STIs, TB and HIV/AIDS. And service provision for some diseases such as malaria, HIV/AIDS, MDR-TB [multi-drug-resistant tuberculosis], cholera and measles is extremely inadequate

Prevailing strategy

Within these categories of vulnerability MSF OCA has identified two populations in Myanmar that suffer from the humanitarian consequences of state-endorsed discrimination and repression and lack access to healthcare:

The Rakhine Muslims fall under both categories, suffering extreme forms of repression (as outlined above), vulnerable to diseases (malaria is chief among them) and malnutrition, and lacking access to basic healthcare

People living with HIV/AIDS (especially high-risk groups) also, to some extent, fall under both categories. [...]

With these groups identified, the underlying mission logic has been one of *coverage*, i.e. trying to reach and treat as many people as possible (limited only by budget and HQ) from amongst these groups. [...] *In Rakhine* – the severe repression of the Rakhine Muslims has been the underlying justification for the programme. [...]

Advocacy – advocacy efforts have been restricted based on the assumption that any outspokenness that can be interpreted as critical toward the GOUM is likely to have significant negative repercussions for our programme (in terms of visas/Letters of invitation, travel permission, imports, access to new and current operating areas, and possibly to our programmes themselves). Nonetheless, significant advocacy particularly on medical issues through bilateral and multilateral channels has taken place over the years. The current advocacy strategy includes three themes:

- Effects of repression on civilian populations (Rakhine Muslims and People Living with HIV/AIDS)
- Humanitarian space – access to parts of the country difficult/impossible; ability to respond to emergencies (disease and/or violence) restricted
- Very low input into health system (low ODI [Overseas Direct Investment], low GOUM investment in health, few operational organisations) with specific focus on HIV/AIDS and access to ART.

In order to advocate on these themes, the mission will use a mix of methods including closed-door bilateral meetings, delivery through multilateral channels and public outspokenness through media, reports etc balancing of course the imperative to and benefits of speaking out with the associated risks. [...]

Vision

To reduce number of patients in the ART programme (by seeking competent handover partners)[...]

To maintain the Rakhine project due to the severe repression to which the population is subjected

Actions [...]

- In order to decrease the relative importance of MSF's role in ART provision and reduce MSF's patient load:
 - Advocate and support MoH and donors/NGOs to scale up ART provision [Rounds of advocacy have been undertaken in Bangkok, Yangon, London, Geneva, Auckland, Sydney, New York, Washington and Toronto]. There has been some response, but it is unlikely that the results will lead to a direct takeover of MSF activities

- Seek to hand over one (or part of one) project to another MSF section or another INGO



'MSF in Myanmar Doubts and Certitudes, **Draft Critical Review** February–March 2008, Dan Sermand, Dr Jean-Clément Cabrol,' June 2008 (in English).

Extracts:

In its strategic objective to be able to measure the vulnerability of the HIV patient, MSF Holland is working to implement (before June this year) a systematic data collection and testimonies of the discrimination and stigmatisation of the patient by the HE [Health Educators] or the counsellors.

MSF Holland expressed clearly that it's today easier to do advocacy work on HIV/AIDS in a country where the government is today much more active on the topic than 15 years ago and allowing INGO to talk a bit more freely for this specific issue.

Second focus is access to healthcare for a specific minority: Rakhine Muslim community leaving in an 'open sky jail' in the NRS. Here, MSF Holland implemented together with ACF a database called Club Med collecting information and testimonies on human right violations (patient referral authorisation, travel restrictions; travel authorisations for Muslim staff; marriage permits (delays and high costs); registration and denial of citizenship; forced labour; confiscation of land; taxation, etc...). This data collection used to be based on simple descriptive, non-analytic registration of 'incident', which has been changed in 2007 in order to be more relevant and efficient (focusing on fewer types of abuses/violence and more related to access to health).

As for HIV/AIDS, advocacy activities on access to healthcare for the Rohingya have an international and national dimension. The collection of this information compiled in reports is transferred to MSF Holland and ACF headquarters to be cleaned up and sent to relevant Human Rights organisations, UN special envoys, etc... knowing that it will be impossible (suicidal) to use in situ this information for the 'security' of MSF Holland programmes and personnel in the area and in the country. An internal MSF Briefing paper on Access to healthcare in Rakhine is foreseen. This document should be a tool for low-profile lobbying towards donors, governments and other NGOs (probably share with UNHCR, other INGOs and Human Rights organisations).



After a period of silence pure and simple, when I became an Operational Director, that modus operandi was questioned, generally, for MSF Holland programmes, but also specifically for Myanmar.

Jo Belliveau became desk at the time, and he invested a lot in finding ways in which to communicate and advocate on the situation in Myanmar. He did it in particular with regard to the situation of the HIV-positive population, which was a marginalised and discriminated population. That responsibility towards these patients is now seen as an obstacle towards speaking out on Rakhine. But at that time, it was about investing in a very discriminated minority within the country, that was being left to die and to rot. So, he invested in particular to talk about both the population in Rakhine and about HIV within Myanmar. In fact, he managed, with the head of mission, which was no mean feat, to actually have some quite structured and strategic public advocacy and communication, on Myanmar in that period. There was some sort of commitment to gather essentially human rights information to relay that to other human rights organisations. It was a way to reconcile the silence externally with

the commitment to nonetheless gather information about the situation in Rakhine, which is essentially a human rights crisis and to relay that to other actors that could actually do something.

Arjan Hehenkamp, MSF OCA, Operational Director [Programme Manager] from 2004 to 2006; Director of Operations, 2006-2010; General Director, 2010 to 2017 (in English).



There'd been years and years and years, maybe even decades of a kind of a struggle around this issue of speaking out about the Rohingya. As an organisation, it is only over the years that we gradually understood more and more what persecution looked like for the Rohingya. When I came in 2007 and started to understand the mission more, and in particular to understand what persecution looked like for the Rohingya, I felt increasingly uncomfortable with the entire mission philosophy and approach that just left a public, vocal denunciation and rejection of that system out of the whole mission approach. It's one of the core dilemmas of témoignage that you rarely can draw a straight line between your voice and positive change. But I felt that not enough of the world and the influential political actors knew and understood what was happening in that context. They were either not aware of the situation enough or did not have enough pressure from their constituents to do something about it. And so, I felt very strongly that we had to use our voice much more even if not necessarily sending press releases all over the place.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



OCA asked for our help and we said, 'OK – but we can't talk only about ARVs. There is an ASEAN meeting in November in Singapore. Myanmar will be on the agenda and we'll also use this opportunity to talk about advocacy plans, and so forth.' In 2007, Emmanuel [Tronc, MSF International Policy and Advocacy Coordinator] and I were already convinced that MSF had to diversify its discussion channels and reach out to actors and governments with which we hadn't really talked previously. That was when we were building a dialogue with ASEAN and other Asian powers, such as China, India and Japan. They were all very influential in terms of Myanmar. They held some of the keys to opening up that space and resolving the access issues. We also thought that these countries had a responsibility toward the Rohingya. We didn't think there should be any taboos about that. We shouldn't prohibit ourselves from talking about the Rohingya with these countries. We put everything on the table.

Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020 (in French).

Over January and February 2008, ahead of a government referendum planned for May 2008, the Myanmar regime tightened its control over INGOS, reinforcing constraints that were already strong.



'Situation Report Myanmar: January-February 2008 MSF OCA Myanmar' (in English).

Extract:


Stricter rules and more control for NGOs

In the past months the GOUM has tried to increase its control over International Organisations working in the country. Leading up to the referendum in May '08, the hard line of the new Secretary 1²² (in office since November) is being passed down to all levels. State media accuses NGOs of supporting the opposition and telling the population not to go to the referendum. Our counterparts at the Ministries are being put under increasing pressure to collect information, implement rules and exercise control over the foreign NGOs. [...] From now until May it will be increasingly difficult to apply for permits for any kind of access, or new initiatives. There are rumours that travel will be restricted and expats will be asked to stay in the cities during the referendum. We have no confirmation of these rumours yet. [...]

Also, in Rakhine we see the more control by the authorities.

2008: NARGIS CYCLONE TIPPING POINT

On 2 May 2008, Cyclone Nargis devastated the Irrawaddy Delta in Myanmar and left an estimated 130,000 people missing or dead. V3 

It took some time to MSF operational centres to set up operations, due to the Myanmar regime's strong willingness to control and distribute all international aid. Therefore, INGOS were not allowed to bring international staff into the devastated area. V4 

Each MSF operational centre tried to intervene alone. OCP faced specific difficulties, likely due to a mix of Myanmar authorities' memories of MSF France's 2006 departure and a reaction to recent strong stances from the French Minister of Foreign Affairs, Bernard Kouchner²³. Eventually, a coordination team was set up, based on MSF OCA's registration in the country and its ability to rely on its numerous and experienced national staff to conduct operations.

Extensive advocacy was carried out directly toward the government of Myanmar and its ambassadors to the UN, and by informing other organisations who denounced the regime's abuses in this significant crisis. MSF advocated at all levels to get unhindered access to the affected population.

On 16 May 2008, in a press release, the MSF International Movement called on the Government of Myanmar "to allow for an immediate scale-up of the relief effort and free and unhindered access of international humanitarian staff to the affected areas."

22. Secretary 1 was the 5th member in protocol order of the State Peace and Development Council, the governing body of the then ruling military junta.

23. Facing the Myanmar government's refusal of independent international humanitarian aid, French Minister of Foreign Affairs Bernard Kouchner, proposed to invoke the "responsibility to protect" to the United Nations Security Council. It would have forced access to the country through a military-humanitarian operation. Bernard Kouchner was one of the founders of Médecins Sans Frontières in 1971 and left the organisation in 1979.



“Cyclone in Myanmar (Burma): MSF Teams Intensify Emergency Response, As First Relief Plane Lands in Yangon,” MSF International **Press Release**, Geneva/ Yangon, 9 May 2008 (in English).

As the first MSF relief plane receives permission to land in Yangon tomorrow, Saturday, MSF has already intensified its emergency programme. As MSF scales up, there is a need for more technical experts and further supplies in the coming days. MSF has staff in various countries awaiting visas, and several other planes of cargo ready to leave in the coming days, though these still need permission from the authorities to land.

The first cargo plane, containing 40 metric tons of water and sanitation equipment, relief stocks, medicines, and therapeutic food, will leave Europe this afternoon. Landing clearance has been given, and our teams will be there to receive the material and immediately distribute it to some of the most affected. MSF teams, already based in Myanmar, responded immediately after the cyclone hit, providing food, basic relief items, medical care, and improved access to clean water. MSF teams are using two boats to reach the most affected areas in the south-west tip of the Irrawady Delta, mainly in Haigyí, Tongwa, and Pyinsalu, where 95 percent of shelters are destroyed. So far, nine truckloads of supplies have gone to Bassein, including 14,000 pieces of plastic sheeting, 62 tons of rice, as well as oil, fish and therapeutic food. The teams have done several hundred consultations since Wednesday, about half of which were for cyclone-related injuries while the remainder were for diarrhoea, fever and respiratory infections.

Other MSF teams are carrying out assessments by truck between Yangon and Labutta, including heavily hit Bogaley. In every affected location the teams simultaneously assess the needs, distribute food and provide medical care to the people. Following the assessments, trucks with additional relief items and food will follow shortly. The food being distributed comes from existing MSF stocks and from the World Food Programme. However, more food and safe drinking water are urgently needed as our teams await the arrival of Saturday’s plane. “Additional teams and key materials should arrive soon to help us scale up our relief effort”, says Hugues Robert, Head of MSF emergency operations in Geneva. “We’ve had very constructive discussions with the authorities and the fact that they have given a green light for the first cargo plane to land on Saturday is a positive sign. We’ve seen the scale of the destruction and the suffering is huge. But we will not be able to address these urgent needs without the necessary additional supplies and the arrival of more experienced emergency staff, particularly experts in water and sanitation.”

As MSF scales up and begins to see the extent and severity of the damage, the number of casualties, and people vulnerable to exposure, hunger and disease, it is clear that a much greater response is urgently needed.



“Myanmar” **Email** from Fabien Dubuet, MSF International Representative to the UN to MSF Directors of Operation, 6 May 2008 (in English).

Extract:

So far, after talking with Joe [Belliveau, MSF OCA Operations Manager] and Hugues [Robert, MSF OCG Programme Manager], we have decided to open channels of communication with the Burmese ambassador to the UN in NYC, in addition to the meeting Hugues had with the ambassador to the UN in Geneva. [...]

The main messages I will pass are:

- MSF has been working in Burma for the last 16 years and we are confident that this long working relationship will facilitate our response to the current emergency.

- MSF counts on the GOUM to facilitate its medical mission/response (issuance of visas, imports of emergency material, movements within the country, etc.) in line with their call for international assistance and we are willing to reinforce the dialogue with them at all levels to address all the practicalities.

- MSF is a strictly humanitarian and impartial organisation and we maintain our independence towards the political developments in Burma.

I will only make additional contacts with the ASEAN presidency and members, key regional players like China, Indonesia, India and Japan and the UN, if we face obstacles and problems while trying to scale up our assistance. Additionally, please note we are having meetings this week with several ASEAN members



'Re: Burma: Donor States Must Monitor Aid, **Message** from Fabien Dubuet, MSF International Representative to the UN in NYC to Human Rights Watch,' 15 May 2008 (in English).

Extract:

We have three main concerns:

- the need to send more international staff, especially experts on water and sanitation, thus, to be granted more visas. There has been some opening from the authorities since last Friday for us (we have been given dozens of visas), but it's not enough in light of the needs. And according to one of our emergency directors, whom I spoke with yesterday evening, several organisations (UN and NGOs) have seen their international staff expelled from the Delta yesterday. Waiting for more info on that point.
- the freedom of movement of those staff, once arrived in Myanmar, especially the possibility to go to the Delta to continue assessments and the provision of assistance.
- the level of assistance is clearly not enough in light of the needs. We can't say our aid is diverted (we have been able to unload all our full charters and to keep the control over the distribution of our assistance, except in two locations in the Delta) but I think keeping the pressure on the necessary monitoring of it/control over the distribution of assistance remains useful and necessary.
- we can't say there is discrimination in the way aid is distributed but I would personally be careful on that point as we have a limited number of international staff on the ground (around 50 now), so we are not able to have a comprehensive view.



"MSF Teams Delivering Aid to the Delta Call for Immediate and Unobstructed Escalation of Relief Operations," MSF International **Press Release**, Yangon/ Geneva, 16 May 2008 (in English).

14 days after Cyclone Nargis hit Myanmar (Burma), needs remain immense in the Irrawaddy Delta. Médecins Sans Frontières (MSF) teams are directly delivering medical assistance and relief supplies to tens of thousands of people. However, MSF urges for an immediate scaling up of the overall relief operation, which until now has been deployed far too slowly and is largely insufficient.

Hundreds of thousands of people have lost their homes, and many are gathered in makeshift camps. They are in urgent need of drinking water, food and other basic necessities. Elsewhere, survivors are living among the remains of their shelter, surrounded by floodwater and dead bodies.

MSF already had medical projects in Myanmar before Cyclone Nargis hit. This has enabled MSF to immediately respond to the catastrophe in the Delta bringing relief

directly to the populations. Teams now work in over 20 different locations and are managing to push further into the outlying areas. They treat several hundred patients each day. In addition to wounds, the main health problems are respiratory infections, fever and diarrhoea. So far, 140 tons of relief material were flown into the country. More than 275 tons of food has been distributed since the beginning of operations.

“Although MSF is able to provide a certain level of direct assistance, the overall relief effort is clearly inadequate. Thousands of people affected by the cyclone are in a critical state and are in urgent need of relief. The aid effort is hampered by the government-imposed restriction on international staff working in the Delta region. For example: despite the fact that some MSF water and sanitation specialists have been granted visas to enter Myanmar, they have not been permitted to travel into the disaster area, where their expertise is desperately needed. An effective emergency operation of this magnitude requires coordinators and technical staff experienced in large-scale emergency response,” explains Bruno Jochum, Director of Operations of MSF in Geneva. MSF calls on the Government of Myanmar to allow for an immediate scale-up of the relief effort and free and unhindered access of international humanitarian staff to the affected areas.



Myanmar, **Message** from Fabien Dubuet, MSF International Representative to the UN in NYC to Nicolas de Torrente, MSF USA General Director, 19 May 2008 (in French).

Extract:

Here is the latest news about Myanmar, after the Ops teleconference this morning, in which I took part [...]


- MSF France is apparently frowned upon by the authorities. Is this linked to Kouchner, to the tension over the French military boat waiting in the area (a dispute between the French and Myanmar ambassador in NYC during the UN General Assembly), and to the departure of MSF France with public communication a few years ago? The only concrete possibility seems to be the integration of MSF France expats under a Holland or Switzerland umbrella. [...]
- Lobby and Communications: we must continue to maintain pressure on the lack of international staff, thus visas and freedom of movement to the Delta and the insufficient level of assistance/needs with the authorities in Myanmar, ASEAN members and countries such as China, Thailand, Indonesia and Vietnam. The Office for the Coordination of Humanitarian Affairs and the office of Ban [Ki Moon, UN Secretary General] need to be informed of our activities and blockages. We also need to highlight progress and signs of openness alongside the difficulties. I would like Christophe [Fournier, President of MSF International] to make a phone call to the Secretary General and the ASEAN presidency, to Holmes [UN Under-Secretary -General for Humanitarian Affairs and Emergency Relief Coordinator] or Ban and to various ambassadors from countries like China, Indonesia, Thailand, Viet Nam who are in frequent contact with the junta. We're going to work on this and see if it can have an added value with Operations.



Everything changed with Cyclone Nargis. This was a natural disaster that created an opening in the humanitarian space. Some embassies and some mediators understood this was an opportunity to use the humanitarian situation as a way to enter into a

dialogue with the junta. And that worked. There was no reason for MSF not to ride that wave, too. This political process and these diplomatic efforts created a greater opening.

*Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).*

Between June and November 2008, while handing over the Nargis programs to the MoH and to other NGOs, all MSF Operational Centres continued to publicly describe the seriousness of the situation and to call for increased aid to be deployed for the population hit by this crisis. V5 



“One month after Cyclone Nargis: Hope and Despair”, MSF International **Website Project Update**, 4 June 2008 (in English).

Extract:

Operations scope [...]

“We sincerely hope that the UN and other international NGOs will now be able to quickly scale-up their presence and dramatically increase the level of food and relief assistance provided. There is a pressing need to send a lifeline to tens of thousands of people, especially those living in remote areas in the southern part of the Delta,” said Arjan Hehenkamp, MSF Director of Operations, who came to Myanmar at the end of May to assess the situation on the ground.



“MSF Handing Over Cyclone Projects in Myanmar, but will Remain for Greater Health Needs Throughout the Country” MSF International **Website Project Update**, 27 October 2008 (in English).

Extract:

Six months have passed since Cyclone Nargis devastated Myanmar’s Irrawaddy Delta, leaving an estimated 130,000 people dead or missing and altering the region immeasurably. An unprecedented number of international non-governmental organisations (INGOs), working alongside the state authorities, have done much to stabilise the situation and continue to provide essential support for people’s ongoing recovery. As such, Médecins Sans Frontières (MSF) is now able to hand over many of its programmes to other actors. In distinct contrast, elsewhere in the country MSF staff continue to battle against chronic and urgent health needs, compounded by a lack of investment by both the government and the international community alike. These countrywide needs, not least in the areas of HIV/AIDS, tuberculosis and malaria, to mention a few, continue to cost the lives of thousands of people year upon year, yet fail to get the attention of the media.

EXIT OF LONG-SERVING HEAD OF MISSION

In mid-2008, following a series of disagreements between the head of mission and the MSF operational centres' operations directors, OCA decided that their Myanmar head of mission of almost 14 years would step down and handover to a new head of mission by May 2009. The disagreements stemmed from a revision process commissioned by the operational centres to planned reductions in programme activities through advocacy strategies.



'MSF in Myanmar Doubts and Certitudes, **Critical Review** February-March 2008, Dan Sermand, Dr Jean-Clément Cabrol, **Draft** Submitted to MSF OCA Myanmar Management Team (Comments in CAPITAL LETTERS),' June 2008 (in English) edited.

Extract:

2. MSF in Myanmar

2.1 MSF Holland (OCA) [...]

B- Advocacy [...]

2. Relevance/Impact

Regarding advocacy, the Rakhine project's relevance with respect to the context and the targeted population, was clearly well defined at the start of the intervention in 1993 and remains valid. Its objectives in terms of advocacy are still relevant today. However, in practice, the implementation (tools, mechanisms) of this advocacy strategy for this particular project, could have been done differently in order to obtain better pertinence and impact, and it seems that MSF Holland had understood it already and is working to reshape these tools and mechanisms. In 2007, MSF Holland decided to focus more on fewer violence-related aspects (in terms of indicators in the data base) and more related to the work of MSF in NRS: access to healthcare for the Muslims minority directly or indirectly affected by violence. FYI: WE DID A SIMILAR EXERCISE IN 1996, COMPARING HEALTH SERVICES AND PATIENTS VISITING HEALTH FACILITIES COMPARED TO THE REST OF THE COUNTRY. A new set-up has been designed and implemented in the field since early October 2007. A briefing paper on the actual situation in NRS should be ready for March 2008 to be shared internally in MSF and externally with UNHCR, INGOs and Human Right organisations.

As for now, this mine of information, that MSF Holland collects, is still too little used at the field level and feeds more human rights organisations documents internationally than MSF's pure advocacy reports or press releases (at the international level) on témoignage of what our teams witness in their daily work. If the strategy remains, it is questionable how this activity fulfils MSF Holland's advocacy/témoignage objectives in NRS as mentioned in its mission statement, annual action plan and country policy paper. It would be interesting to follow on the foreseen March's briefing paper and analyse eventually the impact nationally of such advocacy (towards UN, INGO and donors) than afterwards, to be able to analyse also the pertinence of doing advocacy to actors which are present in the same region (or fully aware of the situation due to their presence in the country) which might not be that relevant anymore if nothing has changed. IF 'SOMETHING CHANGED' IS THE INDICATOR OF SUCCESS THEN I AM QUITE PESSIMISTIC. IF 'BRINGING BACK' THE VULNERABLE POPULATION IN THIS REGION IS A MERIT [BELOW], THEN I AM MORE OPTIMISTIC AND I THINK THAT WE HAVE HAD SEVERAL SUCCESSES

WITH THIS. IN PARTICULAR FIGHTING UNHCR'S PREVIOUS PLAN OF WITHDRAWAL AND HANDING OVER TO UNDP TO START DEVELOPMENT (A VERY LARGE PLAN WHICH AFTER > 1-YEAR PLANNING WAS SHELVED). AND KEEPING THE DONORS INTERESTED IN NRS.

However, even if everyone knows that direct advocacy towards the GOUM will be most probably 'useless' still today and will bring more administrative troubles and affect directly the MSF project in Rakhine more than anything else, this specific advocacy strategy towards other actors ('diverted' target) will have the merit to bring back the vulnerable population of this region at the forefront of the discussion even if the impact of it will remain uncertain.

Looking at the latest vision/strategic document of MSF H, it's clear that advocacy efforts have been restricted, based on the assumption that speaking out on other issues or differently to what MSF Holland has done so far, will have significant negative impact and side-effects on its programme. However, without thinking about a wild or standard MSF communication/advocacy as MSF traditionally do the legitimacy and credibility of MSF Holland in the country should not be underestimated and used to at least try to tackle and advocate on humanitarian issues in NRS more directly/openly (still with a certain amount of precaution obviously) if meaningful changes MSF wants to provoke vis-à-vis the extreme vulnerability the Rakhine Muslim community is still facing without real improvement for decades. REGARDLESS THE LEGITIMACY AND CREDIBILITY, THE EVALUATORS PROBABLY AGREE THAT CHANGE IS EXTREMELY UNLIKELY TO BE THE RESULT. THERE HAS BEEN QUITE A LOT OF INTL PRESSURE ON THIS GOVERNMENT AND CHANGE HAS NOT BEEN THE RESULT. THAT DOESN'T MEAN THAT WE SHOULDN'T TRY IT. THE QUESTION REMAINING IS HOW? TO BE MORE DIRECT/OPEN IS UNLIKELY TO HAVE THE WANTED EFFECT. [...]

3. Conclusions [...]

MSF is present today in locations strongly affected by the governmental oppression (Rakhine and Kayah states). The difficulties in operating freely are real; Burma/Myanmar is an extreme example of administrative headache and nightmare, limited authorisations and, more often, recurrent refusals. The success of having achieved a presence could be used differently, better if one keeps the population at the heart of the rationale:

- In the case of Rakhine not only performing a system (health centre) or addressing a disease (malaria), but adding specific activities like the offer of safe abortion or an adequate nutritional support in response to problems arising from governmental policy against the population. This may also open new perspectives regarding advocacy, to witness and even to try to change some issues, or at least to push/provoke other actors involved (like UNHCR) to act. WE DON'T PERFORM SYSTEMS. WE TREAT PEOPLE. AND WE FEED THE MALNOURISHED. [...]

The example of HIV/AIDS has demonstrated it is possible to achieve changes at the level of the government. The GOUM is far from being able to (or even willing to) tackling this problem alone. MSF treats more than 90% of the patients under ARV in the country and is hostage of the weight of its number of patients and everything that volume involves (cost, responsibility, management, etc). It is even more difficult to envisage confronting the authorities on other issues for fear to not be able to continue to treat the HIV/AIDS patients under MSF responsibility. WE ARE QUITE SURE THAT WHEN YOU ASK AROUND WHICH ORGANISATION SPEAKS OUT MOST FRANKLY TOWARDS THE AUTHORITIES, YOU WOULD GET MOSTLY "MSFH" AS AN ANSWER. AND SURE, THERE IS ALWAYS A FEAR WHEN YOU CONFRONT AUTHORITIES THAT YOU CAN'T TREAT THE POPULATION YOU WANT. THEREFORE, YOU MAKE A STRATEGY DEPENDING ON THE SITUATION. ON THE

OTHER HAND, YOU COULD ALSO CONSIDER THAT THE FACT THAT WE ARE TREATING 90% OF THE ARV PATIENTS MAKES IT VERY DIFFICULT FOR THEM TO KICK US OUT. At the same time – the weight presented by the numbers of patients – has prompted MSF Holland to stop including new patients already last year. [...]

It needs also not to be forgotten that the population in Burma/Myanmar is hostage of a twofold situation: on one side from its own government and on the other side from the international community, which puts the country under embargo (economic sanctions) with, since 1993, no effects on the military junta ruling the country for the last four decades.

The evaluators believe it is relevant to operate in such a country/context and to seek provision of assistance to people in Burma/Myanmar; keeping in mind that compromising our principles, one is never far from becoming accomplice to a given situation. The aspect of time and how compromise over time changes the equation is important. Equally important is the commitment to people and to challenging ones established acceptance in order to move beyond the achieved, to seek better assistance and assistance to new population.

We should never forget that in this kind of setting, MSF can be seen trapped exactly like the population is. MSF cannot cover (and it is not its role neither) the entire population and its needs.

OUR CONCLUSION:

THE EVALUATORS SEEM TO HAVE THE IMPRESSION THAT MSF H ADDRESSES ONLY DISEASES (MALARIA,... PUBLIC HEALTH,... COVERAGE...) AND NOT ADDRESSING/FORGETTING THE POPULATION (MENTIONING IT 30 TIMES?). WE ABSOLUTELY DISAGREE WITH THIS IMPRESSION. SURE, WE ARE WORKING LARGE SCALE, BUT IN SMALL UNITS AND WE KEEP THE POPULATION AND THE INDIVIDUAL AT THE CENTRE OF THE ACTIVITY. IN ADDITION, THEY STATE REPETITIVELY THAT WE DO NOT REACT TO EMERGENCIES. THAT IS FACTUALLY INCORRECT. [...]

WHAT I UNDERSTOOD WITH THESE STATEMENTS WAS THAT TREATING PATIENTS IS A PRIMARY RESPONSIBILITY AND A MAJOR PART OF MSF ADVOCACY IS TO ENSURE THAT POPULATION IN DISTRESS SHOULD HAVE ACCESS TO HEALTHCARE. BY READING THIS REPORT I HAD A GENERAL FEELING THAT VIRTUALLY NO VALUE WAS PUT ON THE FACT THAT MSF H PROJECTS IN MYANMAR TAKE CARE OF THE SICKEST OF THE SICK, MOST VULNERABLE OF VULNERABLE AND COULD ADD A BIT OF DIGNITY TO THOSE PEOPLE'S LIFE.

I CANNOT SCIENTIFICALLY PROVE WHAT IS WRONG IN THIS REPORT BUT AS AN MSF I FIND THIS REPORT SHOCKING AND INSULTING TO ALL THE PEOPLE WHO ENDEAVOURED TO OFFER TREATMENT TO THESE PEOPLE.



Every time there's a new Operational Director, they were a little bit restless. That was okay for six operational directors, but it always goes wrong one time... And the seventh, Arjan, said: 'We have to speak out ourselves.' And, they had written for me a speech that I should deliver during a press conference in Bangkok. I don't like it when people write things for me. We can discuss, they can let me write it and then they can make edits. It was ready-made without any discussion. I looked at this speech and I said: 'Alright, shall I first close the project or shall I close afterwards? If I close it now, we can do it much more orderly!' So we had a big fight about it. I said: 'I'm not going to do that. That is really stupid. We provide lifesaving healthcare to people and after that we will not be able to do it anymore. I can guarantee that.' I was 100% sure. But I thought 'maybe I'm too narrow-minded. After so many years, maybe I don't see any more the trees for the forest.' Then I showed this text – without asking permission of course – to a number of people from ICRC, Human Rights Watch, Amnesty

International, some Burma experts etc. And I said: 'I have been asked by my headquarters to say this, what do you think?' And all of them, Amnesty, Human Rights Watch, all of them, they said: 'Well, the text is sort of okay, but you're not going and say that as MSF, please don't, don't do that. That will be such a bad thing for the population in Rakhine.' That was already my conclusion that they confirmed.

With Joe Beliveau, the desk manager, we were friendly, we could drink beer together, but we disagreed. He wanted also to decrease the programme. It started with these silly rules, like 'you're not allowed to treat more than 150,000 malaria cases per year.' 'Okay. Well we treated 150,000 patients in October. What shall we do with the patients in November? And in December when the real peak season is occurring?' Then there was this report, a big evaluation of MSF in Myanmar, written for the International Council by two guys, Jean-Clément [Cabrol] and Dan [Sermand]. So, these guys had planned their trip to Burma. And I said: 'Okay, that's nice, let's talk.' And then they changed that trip and I said: 'Okay, that's fine.' And then it changed again. And then it was my holiday (with a group of other people). So, it was impossible to change. I said: 'that's a pity because you arrive exactly on the day that I leave. But I will stay one day longer and fly later to my friends so that we can meet.' Unfortunately, one of the two guys came later, so I did not meet him. I only met JC the evening he arrived, but he was mainly talking about himself. Not a single question about MSF in Myanmar. I think he knew already what he wanted to write.

Their report was completely wrong. I didn't feel attacked or something like that. It was just factually incorrect. And it came out after Nargis, the big storm and we were working 20 hours a day, to the level of craziness. There was so much misery. I got the report which was completely full of mistakes and they said they were going to have an international meeting, probably an IC, let's say on a Monday. We were working, working, working, working on Nargis and I got the report the Friday before and I had no time. Still, it was a 30-page report and I wrote 30 pages of comments in there. I might exaggerate, I don't remember it anymore, but I wrote a lot. The problem was the meeting was a Monday, it was now Saturday and I was working on until Sunday. I thought I'd better send it directly to everybody. And, of course that was not according to the hierarchical system. Arjan, our Director of Operations was furious because he had said: 'This is for you and if you have some comments, please give it back to me.' I had to send it to him, not to all these people. Then I thought: 'What is that? Is that a kind of censorship? I just gave my answers because there were a lot of facts wrong. Actually, not even my opinion. And why do I have to send it to you and then what are you going to do?' So I sent my comments and cc-ed it to everybody involved. Arjan was furious and I was called to come back to Amsterdam and Arjan said: 'It is not if you ARE right, it is if you GET it right.' I don't agree with that at all. I think if I see something which is incorrect, then I try to correct it. If they then choose to believe me or not... that, everybody can decide for themselves. That is not up to me. I completely disagreed with Arjan and that is why then I knew already the end was coming. That's probably another reason why they had to 'release me from duty' because I was a little bit difficult to handle. One of my friends, a former director of MSF Holland said: 'You're on your way out.' Really? I did not consider leaving. But he was right.

It was quite friendly because they asked me to stay for another eight months. So, it was not a very nasty firing, but I was fired.

X, Former MSF staff member in Myanmar (In English).



The expulsion of MSF from Sudan²⁴ in particular, but also Niger, emphasised the fact that if you want to communicate a position as an organisation, you needed to do that in a transparent and explicit manner, and not do that through the back door, through other organisations. And then, the question was what actually was happening to that information? You assume some sort of responsibility by gathering that information, but you could not ensure or guarantee anything would happen with it. One consideration that was almost an ethical one was: 'Don't gather information if you don't have a particular purpose for it.' And the other one was a more political consideration: 'If you want to speak on a situation, then do it in your own name, with your own convictions and your own analysis, in a transparent and honest manner, rather than doing it through the back door.'

Arjan Hehenkamp, MSF OCA Operational Director [Programme Manager], 2004 to 2006; Director of Operations, 2006-2010; General Director, 2010 to 2017 (in English).



I really enjoyed working with him and I really valued incredibly what he had built in that mission. What had happened though, after 16 years or so of him being in that position, was that there was no room for conversation about change or evolution. It was pure static status quo on every single topic and even though [the Head of Mission] had a great vision and huge integrity for what that was, from his perspective, it was immovable. And from a distance, there was little that I could do or headquarters could do to influence that or change that... and so I asked him to step down. It's that simple.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



The Head of Mission was definitely against speaking out. On the other hand, he was also the person who understood Myanmar better than anybody else in the organisation. So, it was always hard to know whether he had lost sight of the mission somehow or whether he just knew a lot more than everyone else. And he's a smart guy who gave us the direction as the most knowledgeable person about the situation in Myanmar. It was difficult. I think there was a general feeling of frustration – I don't know how general it was actually – always with this slight question whether he was actually right.

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).

In September 2008, a new MSF OCA memo on advocacy strategies for Myanmar was published with the same objectives as the previous ones: to advocate for the HIV/AIDS patients' needs and the Rohingya. This memo highlighted that fact that any briefing paper, even confidential documents, would presumably end up in the hands of the Myanmar government and eventually in the media.

24. In July 2008, the Government of Niger decided to end MSF France's activities in the country after MSF criticised the poor management of malnutrition. MSF OCA and MSF OCP were both expelled from Sudan in April 2009, shortly after the International Criminal Court issued an arrest warrant for Sudanese President Omar Al Bashir. Authorities wrongly accused MSF of cooperating with the Court.

In October 2008, MSF OCA submitted an op-ed (opposite the editorial page) describing the situation of the Rohingya in Rakhine to Overseas Development Institute's magazine, 3 Humanitarian Practice Network (HPN) 3. This op-ed raised a 'hot' debate between MSF OCA and the Myanmar field teams about the pertinence of MSF's public positioning and risking the programmes in Rakhine. Eventually, the article was not published in HPN but, was postponed until 2009, when MSF *"will take certain operational risks and speak out on the humanitarian situation for Rakhine Muslims."*

In the meantime, the team started to collect data on Rohingya reproductive health and more specifically on the consequences of unsafe abortions within the population in Rakhine.

On 22 December 2008, MSF USA published their annual list of the "top ten most underreported humanitarian crisis,"²⁵ a report distributed by the whole movement. The Nargis and the HIV/AIDS crises in Myanmar made the list, however the Rohingya's plight was not mentioned.



"Advocacy strategies for MSF Myanmar" **Draft**, 2 September 2008 (in English).

Extract:

In the humanitarian/protection issues, MSF Myanmar has been working on collecting data regarding three topics: a) PLWH [People living with HIV], b) the specific problems of accessibility of the health services for Rohingya population, and c) general situation of Rohingya population. [...]It should be assumed, as in any advocacy strategy that a briefing paper handed out by us to whoever (including internal MSF) will end up with the GOUM authorities and possibly the media.

Specific Objectives (one per each area mentioned above)

- 1) Increase the number of HIV programmes providers and fight against the discrimination of PLWH
- 2) Raise awareness among key organisations about the problems of accessibility of the healthcare for the Rohingya population
- 3) Raise awareness of the living conditions of the refugees



"Even the Walls of the Hospital Ask for Money": Restrictions on Access to Healthcare in Northern Rakhine State,' **Draft**, MSF OCA **Op-ed** Proposed to Humanitarian Practice Network in October 2008, not published (in English).

Extract:

Rakhine State, formerly known as Arakan, lies along the Bay of Bengal, borders Bangladesh, and is the westernmost state in Myanmar. The state capital is Sittwe. The population is estimated at 3 million, 60% of whom are Arakanese, a Buddhist ethnic Burmese group, and 40% of whom are Muslims not considered to be Burmese citizens, and who are therefore stateless. The largest group of Rakhine Muslims are also known

25. Created in 1998 after a famine in Sudan went completely unnoticed in the media, this yearly publication listed the 10 most serious though less mediatised crises in which MSF intervened over the past year. The objective was to build awareness on their magnitude in the absence of sufficient media coverage. <https://www.doctorswithoutborders.org/what-we-do/news-stories/news/top-ten-humanitarian-crises-reveal-growing-insecurity-neglected-health>

as the Rohingya. Most of the Rohingya live in northern Rakhine State, where they make up over 80% of the population: an estimated 750,000 people. This article seeks to highlight the particular obstacles faced by the Rohingya in seeking and receiving effective healthcare.

The healthcare system in northern Rakhine State faces many challenges. Government health staff at all levels are poorly paid, and many resort to running private practices to supplement their income, leaving public health facilities understaffed or closed. Health providers are rotated every two to three years around the country to cover the public health structures, but many positions in Rakhine, as in other remote border areas, remain vacant. Extremely limited services in secondary healthcare are available only in three township hospitals: Maungdaw, Rathedaung and Buthidaung. Rathedaung has just one medical doctor with limited capabilities, there are three doctors in Buthidaung, and in Maungdaw there are six including a paediatrician and an obstetrician/gynaecologist. All more demanding cases needing specialist care must be referred to the State hospital in Sittwe.

Health needs in the area are high. While malaria is the leading cause of illness and death in Myanmar, the MSF project areas in Rakhine show a malaria incidence rate of 250/1000, over 20 times higher than the official national rate. A recent survey in NRS indicated an infant mortality rate of 200/1000 live births, three times higher than the national average of 76/1000 live births. And in the last months, MSF witnessed a measles outbreak (to which the government reacted), as well as neo-natal tetanus and the reappearance of polio within the Rohingya population. All three of these diseases are vaccine preventable. There have been some positive developments on the part of the government. Since the mass outflux of Rohingya refugees to Bangladesh in the early 90s, international organisations have been allowed to operate in NRS. UNHCR, FAO [Food and Agriculture Organization] and WFP are also present, along with some half dozen other NGOs. MSF started programmes in 1993, and is currently running five primary healthcare clinics in northern Rakhine State and the Sittwe area, which provide treatment for malaria, reproductive health services, nutrition programmes and referral services. Three STI clinics focus on treatment and reduced transmission of HIV and STIs, as well as specialised response to sexual violence. Malaria treatment is further delivered through 29 field sites and three mobile medical teams, treating approximately 200,000 malaria patients in northern Rakhine State and the Sittwe area. We do deliver health services at scale, independently and through Department of Health clinics, showing that it is possible to provide healthcare in cooperation with the Myanmar authorities. However, the delivery of healthcare to the Rohingya population in particular is impeded by the financial and administrative obstacles they face.

Travel Restrictions

One of the key barriers facing a Rohingya person in need of medical care is the Travel Authorisation. Unlike non-Muslim Rakhine people, the Muslim population are required to get an official Travel Authorisation whenever they cross township lines, and sometimes even between villages. There is no exception for cases of medical need, even in emergencies. In order to get clearance, a recommendation letter from the village chairman is needed. This involves a fee, generally around 200 kyat or a sixth of a daily labourer's daily income, depending on the chairman. This letter then needs to be submitted to the local authorities who provide the Travel Authorisation upon payment of another fee. The official fee for the Travel Authorisation is 25 kyats, but in practice it amounts to whatever the officials demand. The more urgent the request and the further the travel distance is, the more expensive the authorisation becomes. People who wish

or need to stay overnight outside their place of residence must report to the village chairman and pay another fee per person per night. Staying overnight without permission can result in imprisonment and a fine of hundreds of thousands of kyats to get released. Travel Authorisations have to be shown at the many checkpoints along the journey, where the traveller is subject to further arbitrary taxes and charges according to the whim of the officer in charge. The average paid by a random sample of MSF patients over the last year ranged from 1500–2000 kyat, or 1–2 days' income. [...]

Between November 2007 and March 2008 MSF referred 231 seriously ill patients to township or district hospitals in northern Rakhine State. All Muslim patients travelling across township borders needed a Travel Authorisation. Though the majority of Travel Authorisation requests for travel within northern Rakhine State were granted within 2–4 hours, there were three exceptions taking 1 day, 2 days and 1 week. And the referral of Muslim patients from NRS to the better-equipped state hospital in Sittwe (central Rakhine State) or to more specialised hospitals in Yangon, has proved to be very difficult or impossible. Travel Authorisations for these journeys are extremely expensive, with no guarantees of clearance. In the past seven months all Travel Authorisations to either Sittwe or Yangon took several weeks to be granted or were refused outright. As a result, some cases needing specialist care were left without treatment. [...]

Muslim MSF National Staff have also frequently been denied travel permits, preventing them from running mobile clinics and providing lifesaving medical services to the population. Between May 2007 and January 2008, 114 Travel Authorisation applications for Rohingya MSF staff, needed to do mobile clinics in another township, were denied. Rohingya staff have also been denied travel permits for training necessary to maintain the quality of the services provided.

Economic barriers

Fees for travel permits which may or may not be granted are only the first financial barrier to healthcare in NRS. As the Rakhine Muslim saying goes: “even the walls of the hospital ask for money”. This impacts particularly hard on the Muslim population as many Muslim households are landless and depend on daily work. The average daily wage is 1,200 kyat (approximately 1 US dollar). Among the 231 patients referred to township or district hospitals by MSF between November 2007 and March 2008, the average cost of a short stay in the hospital (less than 5 days) was 25,000 kyat, although in some of cases the costs amounted to some hundreds of thousands kyat. 16% of the patients reported that they had to pay 50,000 kyat or more for their treatment, drugs representing the biggest proportion of expenses. Among these 231 cases were patients needing lifesaving treatments: 17 patients died in hospital.

Other Administrative Barriers: marriage and registration of children

Muslim couples in Rakhine are only allowed to marry if they have an official licence and, in NRS, upon payment of a substantial amount of money (from 50,000 kyat in Maungdaw downtown to over 1,000,000 kyat in other areas). If couples apply for a marriage permit, they have to sign a paper stating that they will not have more than two children. Couples also have to pay to register the birth of a child with the authorities. If an unmarried or illegally married woman becomes pregnant the family may be subject to large fines and possibly jail. This significantly discourages women in this situation from seeking medical help. Simply put, many Rohingya cannot ‘afford’ to have children the official way, which results in resort to illegal abortion as well as inhibiting access to reproductive healthcare more generally. [...]

In Rakhine State 31% of women with children under 5 years old reported having had either a miscarriage or an abortion. In the MSF Primary Healthcare facilities in Maungdaw South women regularly present with vaginal infections, sepsis and haemorrhage related to (self) induced abortions. From January to April 2008 MSF saw 26 abortion cases (some women admit to having had an induced abortion and some do not.) This number is very low, because cases of abortion do not present to the clinics unless there is a serious complication, and women are very scared to admit to an attempted abortion. Attempting to provide effective healthcare to this population is a challenging experience. It is clear that the desperate situation of the Rakhine Muslims impacts on their health, while attempts to respond medically are hampered by the restrictions described in this paper. MSF teams are involved in lobbying for improved access, in particular to tertiary care in the state capital Sittwe, but efforts are frequently in vain. Our field teams are therefore confronted with the practical and sometimes deadly consequences of the obstacles facing Rakhine Muslims in need of medical treatment.



“Beyond the International Spotlight Critical Health Needs in Myanmar Remain Unmet” MSF Top Ten Humanitarian Crisis 2008, MSF International **Website Post**, 22 December 2008 (in English).

Extract:

On May 2, 2008, Cyclone Nargis, in all its horror, threw Myanmar back into the international spotlight, devastating the Irrawaddy Delta and leaving an estimated 130,000 people missing or dead. Governed by a military regime since 1962 and enduring low-intensity conflict in certain areas, the disaster was the latest blow to a people largely forgotten by the outside world. Meanwhile, chronic and urgent health needs remain unmet throughout the country, compounded by a lack of investment by both the government and the international community. State health expenditure was 0.70 USD per person in 2007, just 0.3 percent of the country's gross domestic product. The level of international humanitarian aid was around 3 USD per person, the lowest rate worldwide. The selective blindness to countrywide needs, not least in the areas of HIV/AIDS, tuberculosis and malaria, continues to cost the lives of thousands of people year upon year and demands attention.

Nargis prompted an international outpouring of aid, as news of the extent of the disaster trickled out of the country. Within 48 hours of the cyclone hitting, MSF teams began providing emergency assistance to people in the worst affected parts of the largest city, Yangon, and the Delta. Since then, around 750 (rotating) staff have assisted more than half a million people in responding to their emergency needs; providing food, shelter, water, healthcare, psychosocial support, and relief supplies. The majority of this aid was delivered thanks to the tireless efforts of MSF's national staff, as the regime refused to grant visas for additional expatriate emergency staff for several weeks after the disaster. As the situation stabilised and the number of NGOs present in the Delta significantly increased, MSF was able to hand over many programmes. However, adequate assistance remains limited in some harder to reach areas, particularly in the southern parts of Bogale Township, where MSF continues to work. MSF continues to monitor the nutritional situation in the delta. Sadly, the struggle to get an appropriate level of assistance for Myanmar's most vulnerable people is one that extends throughout the country.

In distinct contrast to the efforts made on behalf of the victims of Cyclone Nargis, the government of Myanmar and the international community have all but ignored HIV/AIDS treatment, a disease that claimed 25,000 lives in 2007 alone. An estimated 75,000 people urgently need antiretroviral therapy but less than 20 per cent of them can access

treatment. As it stands, MSF provides around 80 per cent of all freely available ARV treatment in the country (to more than 11,000 people), an untenable and unacceptable situation. Thus, MSF has had to make the difficult decision to severely restrict admissions to its HIV/AIDS programme, while advocating strongly that the government of Myanmar and the international community urgently and rapidly scale up ARV treatment. HIV is just one of a number of treatable epidemics that causes Myanmar to have some of the worst health statistics in South-east Asia. Malaria remains the number one killer, with deaths in the country equalling more than half of those in South-east Asia as a whole. Further, more than 80,000 new tuberculosis cases are detected each year, among the highest rates worldwide, and multidrug-resistant TB is on the rise.

The people of Myanmar cannot wait until the next big disaster for their critical health needs to be recognised; both the government of Myanmar and the international community urgently need to act in order prevent thousands of unnecessary deaths.



'Situation Report Myanmar Oct–Dec 2008, 20 January 2009, Luke Arend, MSF OCA Myanmar Deputy Head of Mission' (in English).

Extract:

Rakhine

- Extensive 'hot' debate surrounding if MSF should speak publicly in MSF name on Rakhine. Existing policy not to speak in MSF name has been changed. The catalyst for change was the discussion surrounding the submission of an article in HPN magazine in October (later withdrawn). In 2009 MSF will take some operational risk (see risk analysis) and speak out on the humanitarian situation for Rakhine Muslims. The Head of Mission and others in the mission believe this is a bad decision as it threatens the Rakhine programme.
- MSF has been successful in advocating for immediate referrals of patients from NRS to Sittwe for tertiary care. Previously this took 4–5 weeks to receive authorisation. This will save lives and a great success.
- Advocacy plan proposed for Amsterdam with 5 medical objectives (see plan). The mission is proposing July for public communications to enable time for the advocacy campaign. This advocacy will not be successful if we make public statements before lobbying the authorities on these issues.
- Began collection of data on abortions and outcomes.



'Annual Plan 2009: MYANMAR – Mission Overview,' December 2008 (in English).

Extract:

Mission statement

To support the population in Myanmar which is suffering under a repressive and violent military regime. To be present in areas where the population is most effected by the humanitarian and medical crisis and where there are insufficient or no other medical actors. To alleviate suffering and save lives by providing medical care to the most neglected, repressed and vulnerable groups and to express solidarity with the populations at risk. To witness and expose the humanitarian condition of our target populations and advocate for change to improve their situation.

Mission Strategic Vision 2009

- The mission will use its considerable credibility and unique access to communicate and advocate more, including publicly, about the humanitarian condition of its target populations (see new communications/advocacy policy in Country Policy)
- The mission maintains a focus on the Rakhine Muslim population

NOVEMBER 2008 - "A PREVENTABLE FATE: THE FAILURE OF ART SCALE-UP IN MYANMAR" (RELEASED PUBLICLY)

On 25 November 2008, MSF OCA and OCG issued a press release and a report to denounce the failure of the ART treatment scale up strategy in Myanmar. These communiques were launched during a Bangkok press conference and published on all movement-wide MSF websites.



"A Preventable Fate: The Failure of ART Scale-up in Myanmar" MSF OCA, MSF OCG **Press Release**, Geneva, Amsterdam, Yangon, 25 November 2008 (in English).

Thousands of people are needlessly dying due to a severe lack of lifesaving HIV/AIDS treatment in Myanmar, says international humanitarian organisation Médecins Sans Frontières (MSF) in a report released today. Unable to continue shouldering the primary responsibility for responding to one of Asia's worst HIV crises, MSF insists that the Government of Myanmar and international organisations urgently and rapidly scale up ART provision.

An estimated 240,000 people are thought to have HIV/AIDS in Myanmar. Of these people, 76,000 are in urgent need of antiretroviral treatment, yet less than 20 per cent of them are currently able to access it. "Last year, around 25,000 people died of AIDS-related illnesses. A similar number of people could suffer the same fate in 2008 unless there is a significant increase in accessible antiretroviral treatment," declares MSF Operations Manager Joe Belliveau.

As it stands, the majority of ART available throughout the country is provided by MSF (to more than 11,000 people), with the Government of Myanmar and other non-governmental organisations providing relatively little. "It is unacceptable that a single NGO is treating the vast majority of HIV patients in a crisis of this magnitude. It is unacceptable because it is wholly inadequate. We cannot meet the needs, and we therefore call upon those who can to take up this responsibility," states Mr. Belliveau. Pushed to its limit, MSF has recently been forced to make the painful decision to drastically reduce the number of new patients it can treat. With so few other actors providing ART, there is little option to refer new patients for treatment elsewhere. "With so many needs still unmet, we strongly urge all actors, led by the Government, to scale up the provision of ART," continues Mr. Belliveau.

The urgent need for increased treatment is evident, yet investment from both inside and outside of the country remains grossly insufficient. In 2007, the Government of Myanmar spent just 0.7 USD per person on healthcare, with a paltry 200,000 USD allocated for HIV/AIDS in 2008. This sum is hugely disproportionate when compared to the extent of the needs and availability of resources. The government of Myanmar has proven its ability to treat HIV/AIDS patients in the public sector, but must commit the necessary resources to scale up.

Likewise, the level of international humanitarian aid is strikingly low, around 3 USD per person, one of the lowest rates worldwide. This is significantly less than the far greater amounts received by nearby countries facing similar epidemics. Few of the big international donors provide resources out of concern over the appropriate and effective use of aid in the country, yet it is the people of Myanmar who suffer as a result. A 29-year-old male ART patient in Myanmar best explains why more should be done, "It is everyone's responsibility to fight against this disease. All people must have a spirit of humanity in helping HIV patients regardless of nation, organisation and government".

MSF's work has shown that even though working in Myanmar can be challenging, providing lifesaving HIV/AIDS care and treatment directly to patients is possible. It is long overdue that the Government of Myanmar and other international organisations step up their efforts and make ART rapidly and widely available. It is crucial that they act now, in order to prevent the suffering and needless death of thousands of people.



'Situation Report Myanmar Oct-Dec 2008, Luke Arend, MSF OCA Myanmar Deputy Head of Mission,' 20 January 2009 (in English).

Extract:

3. Humanitarian issues (incl Public Communications)

Mission

- Public report 'A Preventable Fate: The Failure of ART Scale-up in Myanmar' published in Nov 2008 as collaboration between OCA & OCG. Press conference launch in Bangkok. Report put on OCA/OCG and International website. Report sent to Asian embassies, UN, donors, NGOs. Photographer Greg Constantine used for the photos for the report. Victor/Naomi – did the report get distributed to the 'rest of the world' as planned?
- Slideshow connected to the ART report above produced by Greg Constantine and issued on the MSF website.

Short film related to lack of ART in Myanmar commissioned by MSF.

FEBRUARY 2009 - "A LIFE OF FEAR WITH NO REFUGE: THE ROHINGYA'S STRUGGLE FOR SURVIVAL AND DIGNITY" (RELEASED PUBLICLY)

In February 2009, on the MSF Holland and MSF International websites, an article was published that was initially intended as a proposed editorial to certain newspapers. Building on the unpublished October 2008 article drafted for HPN, entitled "*A Life of Fear with No Refuge: the Rohingya's Struggle for Survival and Dignity,*" it described the medical consequences of the Rohingya's plight, "*witnessed first-hand in Myanmar, Bangladesh and Thailand.*" The article stated that, "*without a fundamental solution for the Rohingya, not only in countries where they seek asylum but also in their home country, there is no apparent end to this humanitarian crisis.*" MSF OCA teams in Bangladesh and Myanmar and MSF OCB teams in Thailand contributed to the report, which was considered a first step toward more public advocacy on the Rohingya. However, it was perceived as "*pretty scary*" by the OCA coordination team in Myanmar, including the head of mission who was approaching the end of mission. These fears regarded the eventual impact on the security of MSF national staff in North East Rakhine.

At the same period, during a discussion on the risks and benefits of advocacy and public communication, the MSF OCA national staff in Rakhine State spoke clearly in favour of MSF speaking out publicly. International staff felt that the national staff might not realise that public communication could lead to MSF's expulsion from the country and thus increase the isolation of the Rohingya.



“Rohingya Op-ed, Along the Lines of ... for Discuss ...” **Email Exchange** between Naomi Pardington, MSF OCA Communication Advisor, Joe Belliveau MSF OCA Operations Manager, MSF OCA Myanmar Head of Mission and Luke Arend MSF OCA Myanmar Deputy Head of Mission, 9 February 2009 (in English) edited.

Extract:

I like the concept very much to use all 3 countries where we can ‘follow’ the Rohingya back to their Rakhine where they are being forced out from. I see that information from Rakhine will give this piece more influence, and with the public debate now is the opportune time to make this public statement. Personally, I would love that we can include the Rakhine stuff in this article. However, on this one I have to agree with [Head of Mission]. To have testimonies of MSF staff in NRS puts all MSF (Muslim) staff at risk of violence and intimidation. In this respect it is far riskier than the previous HPN article. I have spoken to a few expats here this morning including the PC and all think that any mention of MSF staff could impact any of them (with the Rohingya being the most vulnerable to abuse).

Bangladesh testimonies can give all the horrible detail about abuse in Rakhine and the medical situation. What we could do is say a ‘greyish’ quote, something like this: “MSF has been working in Rakhine state for the last 16 years. The Rohingya are the main recipients of the medical support MSF provides in Rakhine as they are the most vulnerable group in the state. This vulnerability is due to the level of impoverishment, discrimination, restrictions on movement and access to education which all contribute to the Rohingya’s poor health status.”

I think we can risk the word discrimination as it doesn’t say by whom (state or local population).

Regarding maternal mortality we don’t have any decent data to back up any statement (we have recently started collected stuff relating to abortions). The UNHCR data that we discussed before they don’t want to publish because: 1) they don’t have confidence in the data 2) fear of impact of disclosing it. I don’t know the deadlines we set ourselves but on Wednesday PM, in NRS, PC, team and Amsterdam guests will discuss coms and the associated risks with some trusted local staff so we will have a better understanding of possible repercussions for staff after that. I think it would be prudent to wait until then if we can.

Luke

Hi Joe and Luke,
Pretty scary stuff.

I think it is a bad idea to get a staff member and a person in Rakhine to give their opinion. That clearly confirms that we are ‘spies.’

Try to keep it in Thailand and Bgd. The Rohingyas there can speak very well about the situation in Rakhine state, because that is the place and the reason they just fled. If the medical situation is bad in NRS, THEY can say that from their experience. At most we can say that MSF’s experience in Rakhine State confirms that the medical needs in Rakhine State are serious. This will get the message out and limit the risk.

Having said that, the medical situation is surely not good, but it is also clear that the medical situation in NRS is not worse [I think better] than elsewhere in MM, because of the intervention of the intl community. MSF alone brought in 10 national Medical Doctors (MDs) and 3 international MDs. On top of that there are AMI [Aide Médicale Internationale] and Malteser [International] with medical staff.

I think that Kate and Victor have the same opinion, but better ask them yourself, in case I am misinterpreting their text. That seems to be quite common.....

Cheers, [Head of Mission].

From: Joe Belliveau

To: *[the Head of Mission] and Luke Arend, Deputy Head of Mission*

Subject: FW: Rohingya Op-ed, along the lines of.... for discuss...

Hi guys,

This is very slowly taking shape. Below is still extremely rough, but better that we have some back and forth on it at an early stage. Any comments so far? We'll be working on some sort of draft in the next 24-48 hours.

Cheers,

Joe

Original Message

From: Naomi PARDINGTON

Sent: Sunday, 08-02-09 10:50 PM

To: Joe Belliveau [MSF OCA Myanmar Operations Manager]

Subject: Rohingya op-ed, along the lines of.... for discuss...

The human cost of statelessness [work in progress... Hate titles!!!!]

Inter-sectional: OCA (lead), OCB and OCG

What: An op-ed (MSF editorial), shared with key media - specifically in Bangkok, New York,

UK and South Africa.

Objective: To put 'publicly' on the record the medical impact of the plight of the Rakhine Muslims, as witnessed by MSF in Myanmar, Bangladesh and Thailand

Content: A tri-part editorial, reflecting the personal experience of three MSF staff members in working to assist the Rohingya, in Thailand, Bangladesh and Myanmar... mapping the medical consequences of the issue and emphasising:

a) what people are willing to undergo to escape Myanmar (thus inferring how bad the situation is there),

b) the core of the problem lies within Myanmar,

c) the longevity of the issue (endless suffering and to date no resolution),

d) both the GOUM and the international community are responsible for finding a solution. The voices of MSF staff will be interspersed with testimonies/short personal stories taken from Rakhine Muslims in each location.

Note* This style of narrative enables us to add a strong human touch to the core medical information - enhancing readability and impact. If three different voices becomes too disjointed can super-impose a single MSF voice

Key points in each section:

Thailand:

“One man described his relief at making it to shore alive. At sea, he witnessed another boat also carrying around 80 people sink in front of his eyes. He believes that everyone on board died”, MSF Head of Mission - Thailand.

- MSF has some access to detained Rohingya, although limited
- On arrival overriding medical concerns include dehydration, weaknesses and stress
- Varying conditions of detainment
- MSF wish to continue to work together with authorities to ensure adequate health response

Bangladesh: [...]

- MSF long history of working with the Rohingya... most recently Tal camp
- Reflection on Tal – atrocious living conditions and impact on health
- Fear associated with returning to Myanmar – personal stories
- Problem far from resolved ... large numbers, questionable conditions (??)

Myanmar:[...]

- Rakhine Muslims especially impoverished
- Nutrition
- Travel authorisations
- High maternal mortality



“A Life of Fear with No Refuge: The Rohingya’s Struggle for Survival and Dignity”
MSF **Web Article**, 23 February 2009 (in English).

Extract:

Weak, dehydrated and traumatised, the Rohingya people stepping off the boats that make it to Thailand’s shores tell an alarming story. This is a story that begins across the Andaman Sea that the Rohingya risk their lives to cross, in the western State of Myanmar. Here, the Rohingya, a minority Muslim ethnic group, have suffered decades of restriction and indignity that has led countless people to flee across the border to neighbouring Bangladesh and further afield. Those who make the often risky and dangerous journey abroad find their suffering far from over, facing detention, deportation or life in overcrowded and unsanitary refugee camps. International medical humanitarian organisation Médecins Sans Frontières (MSF) has witnessed first-hand the medical consequences of this group’s plight from its projects in Myanmar, Bangladesh and Thailand. Contrary to claims that the Rohingya are solely economic migrants or opportunists, MSF’s experience exposes the situation for what it really is – a chronic humanitarian crisis. [...]

MSF has been granted access to groups of Rohingya detained by the Thai authorities on a number of occasions during recent years. “On arrival their medical condition speaks volumes about the experience that they have undergone at sea. We generally treat people for dehydration, skin disease and bruising, varying in severity – depending on the length of their journey,” explains MSF Head of Mission, Thailand – Richard Veerman, “Last year we found out that one immigration detention centre was holding six hundred Rohingya, many had been detained for around three months and were showing signs of stress. Some appeared to be suffering from severe psychological trauma.” Over the past two years, the number of Rohingya arriving in Thailand has reached an all-time high. “This is a clear indication that more needs to be done, not only to ensure adequate assistance on the spot, but to address the root cause of the problem back in Myanmar,” concludes Richard. [...]

Cox's Bazar, on the eastern shores of Bangladesh has seen countless Rohingya come and go over the years; those who have fled from Myanmar and those who pile into overcrowded boats headed for Thailand and beyond. For those who stay, living can be extremely tough. MSF began providing health services for the Rohingya in Bangladesh in 1998²⁶, most recently assisting about 7,500 people who struggled to survive, otherwise unaided, in atrocious living conditions in Tal Makeshift Camp. "The overcrowded, unhygienic living conditions were a breeding ground for respiratory tract infections and skin diseases; diarrhoea was rife and many of the children were malnourished. Mental health problems added to the burden, and an MSF programme was started to support those struggling with the psychological impact of life in the camp," tells MSF Medical Coordinator, Bangladesh, [...].

"Over the years I have heard many reasons why people fled from Myanmar. A woman and her three children left following her husband's arrest, in fear for her family. Another couple left, the woman some months pregnant, out of fear of the repercussions they would face for being unable to afford the official marriage licence, not to mention the childbirth licence," [...] continues. The Rohingya living in northern Rakhine State Myanmar, are legally obliged to purchase expensive marriage permits, unlike the rest of the population. Children being born outside marriage often results in high informal fines or imprisonment and a two child only policy applies. [...]

Despite the daily hardships people face in Bangladesh, returning to Myanmar is an option few Rohingya seem willing to consider. At the root of their reluctance lies fear. "People fear that they will be punished for marrying without permission, for having children without permission, for travelling without permission, for having left without permission, for doing anything without permission, and permission costs money, something that the Rohingya have little of – partly due to the numerous other discriminatory measures imposed upon them," concludes Gabi.

MSF has worked in Rakhine State for the last sixteen years, and encounters the fragile health status of the Muslim population on a regular basis. An estimated one million Muslims – known as Rohingya only outside of Myanmar - live here and the fact that they require authorisation for so many things, including travel outside their villages, affects their access to healthcare – especially in emergencies – and increases their vulnerability. In 2007, during MSF's last major nutrition intervention, 90% of the malnourished children treated were Rakhine Muslim, even though they constitute only 45% of the population in the affected area. MSF has been providing medical assistance to the Rohingya for years and is witness to their ongoing suffering both inside and outside of Myanmar. "Without a fundamental solution for the Rohingya not only in countries where they seek asylum but at their origin, there is no apparent end to this humanitarian crisis," says Hans Van de Weerd, MSF General Director.



Situation Report Myanmar Jan–Mar 2009, Luke Arend, MSF OCA Myanmar Deputy Head of Mission,' 20 April 2009 (in English).

Extract:

Summary

[Outgoing Head of Mission] will leave MSF at the end of May, Dep Head of Mission Luke to cover until begin of Sep when [new Head of Mission] arrives [...]

- Consequent to the Thai army sending, and the Rakhine staff supporting public coms in MSFs name, MSF wrote a web article with the aim to link the Thai story back to the route

26. 'Date correction: MSF first opened Bangladeshi programmes in 1992.

cause, the brutal repression in Rakhine state. It had input from MSF Belgium in Thailand, MSF OCA in Bangladesh and us in Burma. It was intended as an op-ed but because we had to water down the message it ended up on the website. However, this was the first public coms relating to the Rohingya and a first step. [...]

- Meeting held in Feb in Maungdaw to discuss with senior national staff about advocacy and public communications and the associated risks and benefits of doing so. The response was unexpected and dramatic. Staff were enormously keen that MSF speaks out. People are aware there are risks to them and MSF for doing so but “want the world to know....as in 20 years we probably won’t be here anymore”. It was very emotionally charged with tears and a regret that NGOs in Rakhine have been quiet. Staff said they are willing to risk losing their jobs and risk imprisonment themselves to tell the story. MSF was busy managing expectations that what we say most likely won’t have any obvious impact but staffs were clear on what they wanted. This response surprised [the Head of Mission] as a few years ago he asked them and they didn’t want MSF to speak out.



I went to North Rakhine State with the question about what the Rohingya want from us. They were unequivocal and unanimous – both privately and in group meetings: they wanted us to speak out, to carry the message about their plight to the world, even if that meant that we would not be present any more providing healthcare. Emotions were high and that should be taken into account: it may be easier to call for outcry over healthcare in the heat of the moment.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



We were in this constant dilemma about how to communicate about the issue. So, we decided to go and meet with the Rohingya staff, among other things. We tried to explain to them the situation and what we understood the stakes to be and we asked them what they wanted us to do. I remember that meeting extremely clearly because it was very upsetting. Middle-aged men just broke down in tears. We said to them: ‘We could go more public about this situation, but you realise that we’re very likely to be expelled, operations would be shut down. So not only will you lose your job, but there’ll be no medical provision, etc.’ And they really said: ‘We’ve got nothing to lose, in 20 years we’re not going to exist anymore anyway.’ They really felt: ‘just go for it.’ At the same time, we thought that they probably had an unrealistic idea of what the impact would be, what would happen if we spoke out about their situation. They were so isolated. Maybe they thought we would have more impact than we would. But it was certainly an important factor to take into account.

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).

In May 2009, the MSF OCA Myanmar head of mission left office for good, after fifteen years in office, after delivering a controversial last statement to the New York Times. The deputy head of mission took over as interim for a few months. Subsequently, he was summoned to the Myanmar Ministry of Health, where

MSF was blamed for the November 2008 published report, “A Preventable Fate: the Failure of ART Scale-up in Myanmar.” The disgruntled MoH also presented him with several press statements made by the outgoing head of mission.



“NYT” Myanmar MSF” **Message** from Fabien Dubuet, MSF International Representative to the UN in NYC to Joe Belliveau, MSF OCA Myanmar Operations Manager, Arjan Hehenkamp, MSF OCA Operational Director, Emmanuel Tronc MSF International HART Humanitarian Advocacy and Representation Team (HART) Coordinator’, 1 May 2009 (in English).

Extract:

These are unbelievable statements ... Is [the outgoing Head of Mission] on ecstasy?
Cheers Fabien

A Year After Storm, Subtle Changes in Myanmar by *The New York Times*, 30 April 2009 [...] *“You can work here very well, and to say that you can’t is a lie,”* said [the Head of Mission], a physician and the long-time country director for Médecins Sans Frontières. *“Look, the human rights record is shaky, yes, and it’s politically nice to beat up Burma, but the military has actually been quite helpful to us.”* [the Head of Mission] said the delta had recovered well enough – and that enough other agencies were working there – that he had deployed his staffers to poorer, needier parts of the country.

Diplomats suggest that Washington might start by upgrading Myanmar to full diplomatic status with the appointment of a U.S. ambassador. [...] *“I hope they have the guts to do it,”* [the Head of Mission] said. *“The U.S. could reduce the isolation of a country that has already isolated itself.”*



‘Situation Report Myanmar April 2009, Luke Arend, MSF OCA Myanmar Deputy Head of Mission,’ 12 May 2009 (in English).

Extract:

[...] [The Head of Mission] will leave end of May not end of June as previously planned



‘Situation Report Myanmar May 2009, Luke Arend, MSF OCA Myanmar Deputy Head of Mission,’ 10 June 2009 (in English).

Extract:

Summary

Situation for Rakhine Muslims is deteriorating [...]

[The Head of Mission] left MSF.



‘Situation Report Myanmar June 2009, Luke Arend, MSF OCA Myanmar Head of Mission,’ 14 July 2009 (in English), edited.

Extract:

[Interim] Head of Mission got summoned to the capital to meet the DG for Health, Deputy DG, few others and a major from the Ministry of Information. Everyone had a copy of the ‘preventable fate’ report so I knew this would be a difficult meeting! (7 months

after the report was published and the press conference held). The major from MoH proceeded to inform me that 'my predecessors report' has caused insult, doesn't bode well for our upcoming MoU extension and they don't expect this from one of their partner INGOs. He also had a 1 cm thick pile of quotes from mainly [the former Head of Mission] (highlighted in yellow), which they were upset about (the irony!). They were pissed about the comments about the allocation of budget to healthcare, but they were especially pissed about the reference to constraints working in the country. He informed me that "*people above Secretary One had discussed this report*". My defence was that the article was aimed at a Western audience to attempt to bring in more funds into Myanmar for ART and to ignore the reality of restrictions, which is well known internationally, would make the report seem bias and less credible. Also, that the overriding message was that despite restrictions good quality medical programming is very possible in Myanmar. Dr K [...], who was with me, perceives this as purely a 'slapped wrist' and a warning shot not to do it again and won't affect the MoU being extended in Sept. However, it will be remembered when it comes to Rakhine advocacy. Dr K [...] is sure that although we didn't get feedback for 7 months; they would have picked it up at the time of writing.

FEBRUARY 2010 - 'MSF WILL NOT BE HELD HOSTAGE OF ITS ART COHORT'

In June 2009, the local Bangladeshi authorities used violence to force thousands of unregistered Rohingya refugees to leave the Kutupalong makeshift camps where, since March 2009, MSF OCA teams were providing health care, improving water sources and waste facilities, and treating thousands of severely malnourished children. After the violence, MSF OCA teams treated numerous wounded, mostly women and children.

On 18 June 2009, MSF OCA issued a press release raising awareness about this situation.



"Long-suffering Rohingya Face Unacceptable Abuse – Forced Displacement, Intimidation and Abuse in Kutupalong Makeshift Camp, Bangladesh" MSF OCA Press Release,' 18 June 2009 (in English).

Extract:

Thousands of un-registered Rohingya refugees living in Kutupalong Makeshift Camp, Bangladesh, are being forcibly displaced from their homes, in an act of intimidation and abuse by the local authorities. International medical organization Médecins Sans Frontières (MSF) has treated numerous people for injuries, of which the majority were women and children. Further, the organization has witnessed countless destroyed homes and heard many reports of people being warned to remove their own shelters or face the consequences.

"I was working. When I went back to my shelter, I found it totally destroyed. An inspector was there with nine or ten people, I asked why they destroyed my house. They showed me a fish-cutter and said if you say anything, I'll cut you," told a camp resident. To date, an estimated 25,000 people have flocked to Kutupalong Makeshift Camp hoping for recognition and assistance. Instead of finding help, they have been told that they cannot

live next to the official camp, supported by the Bangladeshi Government and the United Nations High Commission for Refugees. Nor can they legally live on adjacent Forestry Department land. They have nowhere to go and no way to meet their basic needs. "I cannot move. If we go to collect wood we will be arrested, if we collect water we will be beaten, if we move our house where should we go," explains another camp resident.

In March 2009, MSF was alerted to rapidly rising numbers in the makeshift camp and conducted an assessment. 20,000 people were living in dire humanitarian conditions, with global acute malnutrition rates above the emergency threshold, 90% food insecurity, poor water and sanitation, and no assistance. "To forcibly displace this group when they are already so vulnerable is outrageous," says Gemma Davies, Project Coordinator, Kutupalong Makeshift Camp. MSF responded immediately by treating the severely malnourished children, offering basic healthcare and improving water sources and waste facilities.

"Within four weeks of opening we had almost 1,000 children in our feeding programme. The rainy season has begun and the appalling water and sanitation situation is further deteriorating increasing the risk of communicable diseases. These people have little to no access to even the most basic of services and they are being forced to flee in fear, with nowhere to turn. The situation is deplorable," continues Gemma.

Sadly, such a desperate situation is nothing new to the Rohingya, a Muslim ethnic minority originating from Myanmar, where they are denied citizenship and suffer persecution and discrimination. Over the past two decades, hundreds of thousands of people have fled their homes to seek refuge abroad. However, few have been granted refugee status. The majority struggle to survive unrecognised and unassisted in countries like Bangladesh and Thailand. A fundamental solution for the Rohingya, not only in countries where they seek asylum but at their origin, is crucial to restoring the health and dignity of these long-suffering people.



"Mounting Desperation for Rohingya in Bangladesh" Project Update, MSF **Web Article**, 24 June 2009 (in English).

Extract:

Now, increasing violence and intimidation are forcing the Rohingya to flee once again. Médecins Sans Frontières (MSF) reports on the appalling living conditions and maltreatment refugees are enduring at the hands of local authorities in Kutupalong Makeshift Camp, Cox's Bazar, Bangladesh. [...] "It's some of the worst poverty I've ever seen," said Gemma Davies, MSF Project Coordinator in Kutupalong makeshift camp. "People are living in makeshift shelters built out of bits of plastic and wood or whatever they can find. They don't even have basic things to cook with. And the sanitation is appalling."

In the last weeks, the situation has spiralled out of control, according to the MSF team members who have recently set up an emergency health intervention in the camp. "This highly vulnerable population is facing imminent expulsion by the local authorities who are using unacceptable methods to uproot them from their homes," continued Davies. "We hear people were dragged out of their shelters if they refused to move. There was one four-year-old girl who arrived at our clinic with knife injuries and another five-day-old baby that had been thrown onto the ground. It is totally unacceptable." [...]

On 20 June, MSF was informed by unregistered refugees living outside the camp that they had, once again, been told by the local authorities to leave. The order followed days of forced displacement, as people were ousted from land surrounding the UNHCR camp and then again off the adjacent Government Forestry land. The MSF clinic at the

makeshift camp, originally intended to deliver basic health care to children under 5 years old and to treat the high levels of global acute malnutrition in the camp, has become a haven for those exhausted by what is happening.

"They come to us for solutions which we can't offer them," said Davies. The team of MSF medics and Bangladeshi staff feel totally helpless in a situation that is swiftly becoming out of control. "One day, we had more than 50 people turn up to our clinic, saying that they had nowhere to go. They didn't know what to do. They'd been moved three times in the last week. And we can't do anything to change their situation. They're tired. People are threatening suicide now."

Desperation and a feeling of resignation are mounting among the refugees. [...] Amid the unrest, MSF continues to offer medical care to those in need of assistance, both camp residents and the host community alike. [...] "We don't have the solution for these people. It's frustrating, but what we can do is provide whatever medical support we can, be there with them and bear witness to what's happening."



'Trip Notes – Bangladesh 24 June to 2 July 2009, Joe Belliveau, MSF OCA Operations Manager' (in English).

Extract:

Advocacy. The end point of our mission, as above, is when a durable political solution is achieved that results in recognition and respect for the Rohingya's dignity and basic rights (e.g. access to employment, education, healthcare...). Therefore, our advocacy strategy needs to be built around achieving this end point. Next steps:

- Clarify advocacy strategy (through common log frame with Burma mission)
- Survey to find out where the makeshift camp dwellers have come from
- Briefing paper to be circulated to GOB, diplos, UN and journos
- Position paper (for internal use)
- Description of 'typical' Rohingya family in Kutu makeshift camp (for website)
- Meeting in Bangkok end Aug on Rohingya advocacy.



We agreed to step up public advocacy re the Rohingya using a strategy in which Bangladesh was the launch pad for comms in order to reduce the government of Myanmar's backlash. In 2009 and early 2010, we produced 5 public pieces in this way.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).

In mid-July 2009, an article was posted on MSF websites denouncing the increased displacement and abuse of Rohingya refugees in the Kutupalong camp in Bangladesh. A briefing paper, titled "Nowhere to Go: a Never Ending Cycle of Displacement and Suffering for the Rohingya in Bangladesh" was also posted that raised awareness on the situation in Kutupalong as a basis for addressing the plight of Rohingya in general, including in Myanmar's Rakhine State and in Thailand, where MSF OCB teams were visiting imprisoned Rohingya refugees.

On August 27, 2009, MSF OCA headquarters and field representatives in charge of the Myanmar and Bangladesh programmes met in Bangkok to discuss the

Rohingya advocacy strategy, based on a memo written in July. According to the memo's annex on risk analysis, despite all the fears, there was no negative impact of the February 2009 website post entitled, "A Life of Fear with No Refuge: the Rohingya Struggle for Survival and Dignity." This highlighted that the risk would be more related to data collection and to "defining the border between the public advocacy topics and the confidential ones."



"Update of the Advocacy Strategy for Rohingya people" MSF OCA, July 2009 (in English).

Extract:

Inter-sectional, inter-mission approach

Rohingya issue is a regional problem which should be analysed by MSF in the same way. The proposal is basic but essential, to set up a regional space for discussing MSF role.



"Nowhere to Go: A Never-Ending Cycle of Displacement and Suffering for the Rohingya in Bangladesh" MSF **Briefing Paper**, July 2009 (in English).

Extract:

MSF is witnessing history repeat itself at Kutupalong in Bangladesh, where thousands of Rohingya desperately seeking refuge have gathered to form yet another makeshift camp. With nowhere else to go, these people are now struggling to survive in crammed and unsanitary living conditions which pose a significant risk to their health. Sadly, the plight of these people is symptomatic of the wider issues faced by all unregistered Rohingya in Bangladesh. This briefing paper seeks to highlight the situation at Kutupalong and in doing so raise awareness of the wider issues.

In December 2008, a "makeshift squatter settlement of 4,000 Rohingya" was recorded as building up around the edges of the United Nations High Commissioner for Refugees (UNHCR) camp for official refugees in Kutupalong. In February 2009, MSF received reports that a growing number of unregistered Rohingya refugees were settling in the area and living in appalling conditions without any assistance. When MSF made its first exploratory assessment in early March 2009, it found over 20,000 people, 90% of which were severely food insecure. Malnutrition and mortality rates were past emergency thresholds, and people had little access to safe drinking water, sanitation or medical care. Since then, the numbers of people in the makeshift camp have continued to grow to an estimated 25,000 people as of July 2009.

In response to the evident needs, MSF immediately initiated an emergency humanitarian action, treating severely malnourished children, offering basic healthcare and improving water sources and waste facilities. Within one month, MSF had enrolled over one thousand malnourished children in its therapeutic feeding programme, and treated around 4,000 under five-year-old children in its out-patients department.

Throughout this time MSF has witnessed the continued abuse, manipulation and discrimination of people living in Kutupalong makeshift camp. From 7 to 15 June the unofficial refugee population was threatened, arrested, beaten and had their homes destroyed by local authorities. Events culminated on 15, when MSF treated 27 people who presented at the clinic with violence-related injuries, the youngest being a five-day-old child who had been thrown to the ground. People were told that they cannot live next to the official UNHCR camp, nor can they legally live on adjacent Forestry Department land. Yet, for now they have nowhere else to go and no way to meet their basic needs,

so most of them remain crammed into the shrunken space that remains in the makeshift camp.



“‘Inter-sectional/Inter-mission Approach” MSF OCA **Memo**,’ July 2009 (in English), edited.

Extract:

The Rohingya issue goes beyond Burma and, then, should be understood as a regional one. MSF Holland in Burma, MSF Holland in Bangladesh, and MSF Belgium in Thailand, may develop some kind of regional approach. (The split up of the Rohingya into two MSF Holland portfolios is a pity). Rohingya issue is a regional problem which should be analysed by MSF in the same way. The proposal is concrete:

a) To have an MSF internal meeting in Bangkok with the participation of MSF missions in Bangladesh, Burma, and Thailand, and key persons from the different sections involved in the Rohingya issue. Based on the position paper [...] to clarify the position and scope of MSF related to Rohingya crisis. Then, and only then, to specify the programmatic discussion related to MSF intervention (first day).

b) Once we have a common position it would be possible to develop a second confidential meeting with the participation of RI, [Refugee International] and ACF, among others. It makes sense to invite regional researchers of Amnesty International and/or HRW (second day). The objective is to talk about general view of the Rohingya issue and a potential mechanism for cooperation and sharing information.

c) The sparring-partners role. Once we have the first draft of our report (maybe at the end of 2009) the proposal is to present it confidentially to a select group of sparring partners, to make much stronger and clearer our position. [...]

d) A key actor which deserves special comment is UNHCR. International Refugee has already pointed out the lack of commitment of UNHCR. MSF has faced an ambivalent UNCHR position. The interviews collected by MSF in Bangladesh (2008) give us a bad impression of the UNHCR role or, at least, of the perception that people have about them (including taking part in forced repatriation practices and lack of respect for the official refugees and even more for the non-official one). I think part of this regional, inter-agencies approach should include a specific point related to how to deal with UNHCR and push them closer to their real mandate.

e) We had a relevant meeting with Mr Quintana in Geneva, in March 2009 (the Special Rapporteur on human rights for Myanmar). I consider we have to meet them once we have a strategy and/or even just preliminary information to share. The Special Rapporteur can be the vehicle to speak out, especially if MSF considers, for security reasons, not to speak out publicly as MSF. [...]

f) There is another inter-agency proposal: a closed-door meeting with European Union in Brussels. The idea is to select some key persons of the European Union and conduct a confidential meeting. Even this meeting could be convoked by ECHO to review ‘the humanitarian situation of the Rohingya people’. This meeting would have three moments: a general overview (by Arakan Project), nutritional and food issues (ACF) health conditions (MSF). It could be also a moment to distribute some hard copies of briefing papers by humanitarian organisations. It should include Thai, Burma, Bangladesh desks and Asian Department of the European Union.



'Advocacy Risk Analysis/Some Considerations for Burma, MSF OCA **Memo**,' 9 July 2009 (in English).

Extract:

We agree that the risk analysis would be done by the Project Coordinator/Head of Mission. However, I would like to include some considerations for the risk analysis:

1) The meetings with the Arakan Project [...] and ACF [...] showed that the risk is not as high as MSF considers. Anyway, there is not a single scenario where the speaking out does not include some kind of risk.

2) In our own experience, there is no evidence of negative repercussion due to the website article published by MSF in February 2009 ('A life of fear with no refuge: the Rohingya's struggle for survival and dignity') despite all the fears expressed in that moment.

3) The risk in the Rohingya case is not only related to the distribution of the final report, but also the data collection process. Then, it is necessary to underline that not all the information will be collected in the same way. Some should be collected based on medical data, other through interviews, and also through testimonies of our local staff. It is duty of the PC/Head of Mission to precise the most adequate for each question.

5) It is necessary to define the border between the public advocacy topics and the confidential ones.

6) It is necessary also to be aware of the level of accessibility and its variables before the data collection, after the data collection, and after the confidential and public statements. Doing that, we can compare if the advocacy activities produce (or not) a real impact in our access to the victims (including Letter of invitation, visas, etc.) [...]

8) It is recommendable to distinguish between personal risk (expats and local staff) and programme risk. In the case of Burma, besides the risk of the programme, it is extremely necessary to evaluate the risk of the local staff

9) Part of the analysis should include the "red line" of the Burma government (the issue that I know/suspect the government will never accept by MSF) as well as MSF's red line: the issues that we will never accept. This kind of analysis (worst possible scenarios) would allow us to anticipate not only the risk but also our position, based on our principles. In other words, what is the price that MSF is ready to pay, (in the case that MSF is ready to pay). It should include the impact on the population if MSF withdraws from the country (rather than the impact on MSF itself)

10) It is also to review (via desk) the risk analysis made by other MSF sections in Burma, for security reasons as well as for advocacy activities

11) We discussed extensively with Gina [Bark, Operation Liaison Officer] and [MSF Myanmar Head of Mission] about the way to justify the data collection. We agreed that it should be presented as an MSF study/review "to evaluate our own programmes" from a public health perspective. It allows us to interview people outside the clinic and/or to ask other issues to our patients in the MSF health facilities.

To summarise, a risk analysis for an advocacy agenda, should also see MSF principles, security issues, operational priorities, perception and acceptability, potential operational consequences, etc.

On 17 February 2010, during a meeting in Bangkok, the MSF OCA HQ and field managers for Myanmar and Bangladesh defined an advocacy objective to ensure that if the situation changed in Myanmar and opened up, the Rohingya would be on the agenda. They stated that, "MSF will not be held hostage to its ART cohort,

so will be willing to risk the loss of access if the right circumstances to prevail.
The meeting included: operation manager and advisor, heads of mission and communication advisor, the head of humanitarian affairs department, and the regional information officer (RIO).

These managers also decided to address the shortcomings of the Rohingya dossier being split again between two OCA desks, to the OCA director of operations. They deemed that working between two desks and negotiating between two teams created the same problems as working between two MSF sections. To no avail, the split remained in the following years.

In August 2009, a new position was created and filled with the former project coordinator in Rakhine, Gina Bark. She was recruited to the Bangkok position of Operational Liaison Officer/Humanitarian Affairs Officer in charge of Advocacy for the Rohingya dossier in the whole region. From April 2010, she started to develop an MSF network of stakeholders and experts on the Rohingya issue in the region, so as to feed the mission and headquarters with a better understanding of the regional context.



'Minutes of Bangladesh & Myanmar Communications & Advocacy Meeting, Bangkok,' 17 February 2010 (in English), edited.

Extract:

Present: MSF OCA Myanmar Head of Mission, Deputy Head of Mission, Operations Manager; MSF OCA Bangladesh Head of Mission, Operations Manager ; MSF OCA Humanitarian Affairs Department Advisor, Communication Advisor, MSF International Regional Information Officer)

III. Sensitivities

- The Myanmar mission has been self-censoring due to fears of losing access to the ART cohort. The CMT is willing to make this sacrifice in the future if the time is there. This is also partly possible also due to new actors come in. MSF will never leave Myanmar by choice, but will have to be kicked out. MSF OCG will need to be kept in the loop to be able to gauge their response.
- While there are no public comms for Rakhine at present, if MSF cannot operate in Rakhine, then we will need to speak out and push the agenda. It is good to prepare a rough strategy in advance for response, including the range of limitations.
- It is acknowledged by all present that even when only speaking about the Rohingya in Bangladesh, journalists may follow up on the broader issue and speak about conditions in Myanmar. MSF may be quoted with or linked to statements of others. The Myanmar mission acknowledges this and can be defended as long as the Bangladesh mission sticks to the current comms agreements. With the Rohingya issues in Bangladesh at current, the Myanmar government is likely to see this as a Bangladeshi issue, so not much backlash is expected.
- Two Desks! Having the Rohingya split between 2 operational managers has shortcomings and sometimes feels like negotiating between 2 Sections. It is difficult to get strong engagement or ownership on many issues. The pressure is felt greatest at the level of field and advisors who have to spend more time and energy on getting people involved. Advisors feel a greater sense of responsibility. It is not always clear who to go to and things may get missed. There is a risk of Ops not having a full Rohingya overview and

key issues being missed, leading to security implications or less support for the Rohingya. We are no longer looking at what is best for the population.

- MSF will not be held hostage to its ART cohort, so will be willing to risk the loss of access if the right circumstances prevail.
- OM [Operational Manager]s to address the concerns about the split of the Rohingya with director of operations and feedback to field and advisors.

HAO

- Gina has been recruited and is expected to start in Bangkok in April. This is a 2-year post.
- MSF wants to improve its advocacy regarding the Rohingya and to have better networks in the region. It will allow for someone to join the ASEAN summits or UNHCR meetings to monitor and report. With a better regional understanding, better advice is anticipated. Longer more strategic and proactive advocacy should be possible.
- This position allows someone linked to the Bangladesh and Myanmar missions to liaise and represent MSF, although, key representation will still need to be done by the Head of Missions who remain the official spokespersons.
- It allows for more support to the Myanmar mission, without taking up one of the 19 expat posts and for networking to be done with the diasporas, not just for the Rohingya but also broader Burmese.



'OM Bangladesh **Trip Report** – July 2011,' Chris Lockyear, MSF OCA Bangladesh Operations Manager (in English).

Extract:

- The management of Bangladesh and Myanmar missions by separate OMs at HQ gives advantages:
 - Continuity of management at a time of portfolio reshuffling
 - Ensures Bangladesh mission is not reprioritised in relation to the much larger Myanmar mission [...]
- The management of Bangladesh and Myanmar missions by separate OMs at HQ gives disadvantages:
 - Complicated approval procedure (comms and advocacy).
 - Complex management set up of operational liaison officer.
 - Disconnect within contextual understanding at HQ level.



We were stuck in this conversation about public, not public, operations, témoignage blah, blah. Like a vicious circle, so we thought this has got to get more sophisticated.

We wanted to be a lot more granular than what we'd done before. We'd really tried to hammer out a smart strategy, to take this thing to another level. First of all, we came up with an objective. We were aware that the goal of getting people to do something about the Rohingya now and hoping that the Myanmar authorities are going to do anything now was just ridiculous. It wasn't motivating for anyone. Therefore, we decided that what we had to do as an objective was to make sure that when the situation changed in Myanmar and opened up, the Rohingya would be on the agenda.

We thought it was a realistic goal. At that point it was nowhere near the agenda for Myanmar. The change in Myanmar then happened two years later, but of course we had no idea that was going to happen. We thought it could be another 10 years or 20.

So, we decided that would be the strategy and that Gina would really work to find, not who were the influential states, but who were the influential individuals in which position, maybe

within ASEAN or within embassies in Bangkok or whatever who could actually help us achieve this goal. At that point we changed gear and it started to be more productive. We kind of got out of this circular, desperate situation of people feeling impotent in the face of what was happening to Rohingya.

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).



We decided to hire the OPLO, the Operational Liaison Officer which was a name purely for visa reasons... because we couldn't call it humanitarian affairs or whatever... This position was in a way placed there to correct what went wrong in Amsterdam and to connect again Bangladesh and Myanmar, especially when it came to advocacy related matters.

Former MSF OCA Staff Member in Myanmar (in English).



I pleaded for a Rohingya strategy. Of which having it under the same desk would be a potential mechanism to do that. I thought it was important to see Cox's Bazar and Rakhine as a unique context in itself because the situations were so clearly linked. When I came in, there had been that policy to Rohingya advocacy from Bangladesh because there was an assumption that Bangladesh was a lower risk country to be able to speak out in. It was one of my key arguments for why both missions should be under the same desk. But it never happened. However, in a way it was good having the two desks because it meant that Bangladesh had a champion. Within OCA, Bangladesh was always the poor brother of Myanmar, because Myanmar was the massive and prestigious mission.

Chris Lockyear, MSF OCA Bangladesh Operations Manager late 2010 to July 2014 (in English).



The position in Bangkok was really focused on the Rohingya, that's why it was created, there was no other objective. But there wasn't a lot of thought process going into "how does this position function? what are the lines?". So, my line was basically to Joe [Belliveau] for Myanmar and Chris [Lockyear] for Bangladesh at the time. But when Kate was still there, humanitarian affairs played quite a strong functional role. I also had a link with the deputy head of mission in Myanmar who was responsible for advocacy and also a lot of contact with the head of mission in Bangladesh and with the PCs in Cox's Bazar. I spent a lot of time in Bangladesh.

I started to set up a network, just trying to find out who's in Bangkok, who's connected to who, how, what, how does it function? At that time majority of NGOs, UN agencies, working for Myanmar were based in Bangkok because they couldn't be based in Yangon. I knew clearly that people weren't willing to say much publicly. I had to be very inconspicuous to make sure that there was never anything that I would say or do that we could put anybody at any risk on anything. And then of course there was the HART playing their role and I would coordinate with them.

I was looking at Bangladesh and Myanmar and I also was looking at what was happening with the Rohingya in other areas. There was a bit going on in Thailand and people moving to India.

There were a number of different sort of exoduses of Rohingya over periods of time with routes

which changed over time, depending on what was happening. There was a constant movement of Rohingya by boats. I was trying to just get a bigger picture and found out who were the players. When I first started, people knew it was an issue, but there wasn't a massive awareness.

Gina Bark, MSF OCA, Project Coordinator in Rakhine, 2009-2010; Operational Liaison Officer in Bangkok, 2010-2012; OSCAR Humanitarian Affairs Advisor, 2012-2017 (in English).

FEBRUARY 2010 - "STATELESS ROHINGYA VICTIMS OF VIOLENT CRACKDOWN IN BANGLADESH" (RELEASED PUBLICLY)

On 18 February 2010, MSF OCA held a press conference in Bangkok and issued a press release denouncing both the authorities and the local population of Cox Bazar for violent crackdown on thousands of unregistered Rohingya refugees, forcing them to flee their home and to seek refuge in Kutupalong makeshift camp. They also denounced the constant pressure from the authorities forcing Rohingya refugees to return to Myanmar.

MSF OCA published a report on the same day entitled, "Violent Crackdown Fuels Humanitarian Crisis for Unrecognised Rohingya refugees in Bangladesh." This built on their briefing paper drafted in July 2009 which asked the international community to "support the Government of Bangladesh and UNHCR to adopt measures to guarantee the unregistered Rohingya's lasting dignity and well-being while they remain in Bangladesh."

This public communication raised significant media interest and put the plight of the Rohingya in the international spotlight. In the days following the conference the Bangladeshi government reduced arrests and violence towards the unregistered refugee population.

However, for several months, MSF OCA operations in Kutupalong experienced an increase in bureaucracy, monitoring, and investigation of their activities. Once again, MSF was refused the official FD-6 registration they requested. However, this did not prevent them from providing continual healthcare and assistance including to non-registered refugees, though under more difficult conditions.



"Stateless Rohingya Victims of Violent Crackdown in Bangladesh", MSF OCA Press Release, 18 February 2010 (in English).

A violent crackdown against stateless Rohingya in Bangladesh is forcing thousands of people to flee in fear. Driven from their homes throughout Cox's Bazar district by local authorities and citizens, many have sought refuge at Kutupalong makeshift camp. Here, medical organisation Médecins Sans Frontières (MSF) is treating victims of beatings and harassment, including people the Bangladeshi Border Force has attempted to forcibly repatriate to Myanmar. As camp numbers continue to swell, conditions pose a significant risk to people's health.

In a report released today, 18 February 2010, MSF calls for an immediate end to the violence, along with urgent measures by the Government of Bangladesh and United Nations High Commission for Refugees (UNHCR) to increase protection to Rohingya seeking asylum in the country. "More than 6,000 people have arrived at the makeshift camp since October, 2,000 of those in January alone," explained MSF Head of Mission for Bangladesh Paul Critchley. "People are crowding into a cramped and unsanitary patch of ground with no infrastructure to support them. Prevented from working to support themselves, nor are they permitted food aid. As the numbers swell and resources become increasingly scarce, we are extremely concerned about the deepening crisis." For decades, thousands of Rohingya, an ethnic and religious minority from Myanmar, have sought refuge in Bangladesh. However, a mere 28,000 are recognised as prima facie refugees by the government, and live in official camps under the supervision of UNHCR. In sharp contrast, more than 200,000 people struggle to survive unrecognised and largely unassisted. In a densely populated country in which strong competition over work, living space and resources is inevitable at a local level, the stateless Rohingya are left highly vulnerable.

"It is imperative that the Government of Bangladesh act immediately to stop the violence and provide these people with the protection to which they are entitled," Mr Critchley concluded. "The UNHCR also needs to take greater steps toward developing a clear policy to tackle the issue, and must not let the terms of its agreement with the government undermine its role as international protector of those who have lost the protection of their state, or who have no state to turn to."

As the Thai boat crisis of 2009 made clear, regional solutions are needed to the situation of the stateless Rohingya. The international community must support the government of Bangladesh and UNHCR to adopt measures to guarantee the unregistered Rohingya's lasting dignity and well-being in Bangladesh.



'Burmese Refugees Persecuted in Bangladesh' by Seth Mydans, *The New York Times*, 19 March 2010 (in English).

Extract:

Stateless refugees from Myanmar are suffering beatings and deportation in Bangladesh, according to aid workers and rights groups who say thousands are crowding into a squalid camp where they face a "humanitarian crisis" of starvation and disease, "Over the last few months we have treated victims of violence, people who claim to have been beaten by the police, claim to have been beaten by members of the host population, by people they've been living next to for many years," said Paul Critchley, "who runs the Bangladesh program for the aid group Médecins Sans Frontières".



"'Rohingya 'Crackdown' in Bangladesh", *Al Jazeera Central Asia*, 19 February 2010 (in English).

Extract:

The aid organisation Médecins Sans Frontières has said that ethnic Rohingya refugees from Myanmar are suffering an increasingly violent crackdown in Bangladesh. An MSF report released on Thursday said the stateless group are being driven from their homes in the Cox's Bazar district of Bangladesh by local authorities and residents. The report also accused the country's military of trying to forcibly repatriate some Rohingya back to Myanmar.



'MSF OCA "Lessons Learnt" Bangladesh Communications, February 2010 **Report**, February 2011 (in English).

Extract:

From June 2009, the Bangladesh mission protested privately and publicly about violence against the Rohingya population in Bangladesh. The most visible element of this was a press conference in February 2010, although bilateral and off the record briefings continued throughout the first half of the year. There have been many developments around the situation of the Rohingya in this period, not least that MSF operations in Kutupalong camp are now under threat. [...]

1. Advocacy and Communication Chronology

In February MSF decides to make a public statement and contacts the EU mission and informs them of MSF's intent to time the press release to coincide with the upcoming members of European Parliament visit to Bangladesh. This follows MSF's unsuccessful efforts to gain access to contacts within the Bangladeshi administration that seemed unwilling to discuss the crackdown. [...]

2. Impact

Both the conference and the press release created a huge amount of interest and action from journalists, academic groups, human rights organisations, media, diplomats and aid agencies. The overwhelming response and significant increase in attention given to the Rohingya situation were a great success. The conference was attended by over 20 journalists and interviews were given to Al Jazeera, BBC World Today, with TV reports running on the BBC and the Asian TV news programme Asia Today. The Bangladeshi Head of Mission was interviewed on AFP, APTV and AP [Associated Press], Reuters, Reuters Alertnet, VOA [Voice of America], Herald Tribune, New York Times, some freelance journalists and RFI [Radio France Internationale]. The story was picked up by numerous online networks and created a wide range of reports in English, Arabic and French. The *New York Times* article that was written captured the interest of US policy makers. It has contributed to the full engagement of the US Embassy in Dhaka on the Rohingya issue in accordance with instructions from Washington.

Following the conference, the Bangladeshi government did reduce its arrests and violence towards the unregistered refugee population. While many factors may have contributed to this outcome it is believed by the Rohingya community themselves, as well as MSF staff and other agencies working in the area, that the MSF conference and press statement played a key role in bringing the issue to light and helping to abate the acute crisis. Subsequently the international community in Bangladesh is no longer divided when addressing the issue of the Rohingya with the government.

However, the communications have led to a more difficult working relationship with the Bangladeshi authorities. Limited pre-warning to Bangladeshi officials due to lack of access and the pressing nature of the events unfolding, resulted in strong criticism of MSF's actions by the government of Bangladesh. Following this both ACF and MSF have had issues with the approval of their FD-6 (official application for implementation of programmes with the GOB), as have Solidarités [Solidarités International] and Handicap International. The denial of the FD-6 and the ongoing complications of maintaining access in Kutupalong are complicated and cannot be solely attributed to MSF's public communications, however they did certainly anger the government and ensure a less cooperative attitude from officials at some levels.

a) MSF Operations

MSF operations following the February public communications were affected in four main areas:

- Temporary reduced service provision at MSF Kutupalong Clinic

- Objection and rejection of MSF FD-6 for the Kutupalong Project
 - Increased bureaucracy, monitoring and investigation of MSF's activities in Kutupalong
- Rebukes, criticism and reluctance to cooperate with MSF team at project and capital level resulting in MSF being ignored and not invited to NGO coordination meetings.

Most of these issues have been short-lived and at the project level relationships with the officials have been well mended and a good cooperation again exists. [...]

The FD-6 has since been rejected and, although MSF remains operational and activities continue, our presence is illegal and the future of the project uncertain. The denial of the FD-6 relates to political and policy shifts and is not solely an MSF issue. Both Handicap International and Solidarities' have had FD-6s rejected for their work in Cox's Bazar and the United Nations Joint Initiative was also rejected by the GOB. Essentially the GOB do not want organisations to work officially with the unregistered refugees. [...]

Following the release of the communications the GOB began to look into MSF activities in Kutupalong. The PC was shown an intelligence office report in March mentioning MSF activities. In the following months MSF received visits from various officials to the Kutupalong Clinic questioning the legitimacy of MSF's programmes and the status of their FD-6. In April the Camp In Charge came to the clinic asking questions and in August the Civil Surgeon made an unexpected visit asking why MSF had resumed complete services, questioning expats about their medical credentials and complaining that MSF was working covertly. [...]

MSF also received heavy criticism from government officials from the local to the international level. In several meetings with high-level officials in Geneva, NY and Dhaka, as well as local authorities in Cox's Bazar district MSF was rebuked for its actions. The officials were not satisfied with MSF's approach and did not understand why they had not been consulted in order to internally deal with the issues before public communication action was taken. [...]

Despite the ongoing complications MSF remain in Kutupalong and continue to provide healthcare and assistance to the unregistered refugee population. No direct action has thus far been taken to expel or close down MSF operations. The FD-6 issue remains on the agenda but has a far wider scope than the public communications released by MSF in February. While the future is uncertain MSF currently maintains its presence with full operations. [...]

Conclusion

This press release along with the press conference, were carried out on the basis of a strong strategic decision across the Bangladesh and Myanmar missions to give priority to advocacy initiatives for the Rohingya issue. While the communications were a last step in an acute situation, the commitment of the Bangladeshi mission and continued awareness and interest of those contacted will benefit any future closed door or bilateral briefings.

Through our bilateral meetings, briefings, media interviews and press conference MSF established a legitimate voice on the Rohingya subject and gave a strong message to diplomatic, donor and UNHCR community, as well as to the Bangladeshi government.

Despite the effect on our ability to operate in Cox's Bazar district in relation to our FD-6 rejection and the unhappiness and continued questioning of actions by the authorities, MSF now continues to work and maintain all its programmes in the area. There is also fundamental and coherent agreement amongst most stakeholders and actors involved in the issue that the communications in February were successful and a positive contribution towards future advocacy initiatives.



When I came in, there had been that policy to Rohingya advocacy from Bangladesh because there was an assumption that Bangladesh was a lower risk country to be able to speak out in. Before I started there had been a press release, which essentially condemned the government of Bangladesh's management of the camps, particularly the Kutupalong Camp. Be it linked to it or not, the first couple of years I was in charge of Bangladesh, in 2011 and 2012 after this press release, it was arguably harder to speak out in Bangladesh than in Myanmar. Shortly after this press release, there was a renewal required of the FD-6, the registration to be able to work in a district of Bangladesh. We spent many years trying to get this registration. At my time it never happened. And so, we were living in Cox's Bazar without an FD-6.

*Christopher Lockyear, MSF OCA, Bangladesh Operations Manager late, 2010-July 2014
(in English).*



This public communication about the Rohingya, which was based on aid operations in Bangladesh because it was undoubtedly easier to do, was very forceful, but it was good. It included information that really fell within the humanitarian and medical context, as well as certain information that some would think of more as human rights related.

*Fabien Dubuet, MSF International HART,
Representative to the UN, 2005-2020 (in French).*

After this episode, MSF OCA continued international bilateral advocacy activities while maintaining a low profile in Bangladesh. The MSF OCA Operations Manager and the MSF International HART conducted rounds of advocacy meetings with a diverse group of people in New York, Brussels and Geneva. Various other meetings were held to discuss the FD-6 issue.



'Message from Kate Mackintosh, MSF OCA Head of Humanitarian Affairs Department to Emmanuel Tronc and Fabien Dubuet, MSF International HART,' 31 March 2010 (in English).

Extract:

Dear Emmanuel and Fabien, [...]

In brief, there are 3 main issues with regard to this population (apologies to those of you already very familiar with this situation):

1. The Government of Bangladesh. On the local level, the authorities are instigating or at the very least tolerating violence against this vulnerable group. More fundamentally, the Government refuses to consider all but a small minority of the Rohingya as refugees (Bangladesh is not a party to the Refugee Convention), and in extreme cases has even tried to force them back to Burma.

2. UNHCR: UNHCR's position is weakened by the fact that Bangladesh is a non-state party. However, they have for years, at least as far as we can tell, given up on the larger Rohingya population, and no longer make any visible effort to protect them or to assert their right to non-refoulement, individual status determination etc., etc. – even though they do acknowledge them as a 'population of concern' on their website.

3. The government of Myanmar. This is of course the source of the problem and one we cannot speak about publicly, at least at the moment. However, it is also one of which we are operationally aware, as we have massive healthcare programmes in northern Rakhine state where the Rohingya originate.

The question to you is which actors in New York, Brussels and Geneva have influence on any of the three issues above, and so which would it be worth a follow-up meeting with. [...] Your collective thoughts much appreciated,



“Rohingya Next Steps”, **Message** from Kate Mackintosh, MSF OCA Head of Humanitarian Affairs Department to Emmanuel Tronc and Fabien Dubuet, MSF International HART, 12 April 2010 (in English).

Extract:

Hello again both of you, [...]

We are facing serious problems over the renewal of our permission to work. It was unclear for a while whether lobby meetings in this were wanted or not, but Vanessa is now clear that she would like to meet anyone who might be sympathetic and of course have any influence asap. The situation has deteriorated [...] She is available for the next few weeks and is willing to jump on a plane asap. [...] Fabien, by the way, I heard [...] that Bangladesh has asked China to put pressure on Burma to improve treatment of the Rohingya (to stop them going to Bangladesh)! Wonder if you think it is worth visiting your contacts at Chinese representation? And Japan maybe, following your mail, and given their long-standing funding of HCR in the Teknaf area?

Your thoughts gratefully received,



“Rohingya Advocacy – New York & Washington”, **Message** from Fabien Dubuet, MSF International Representative to the UN, 10 May 2010 (in English).

Extract:

Dear all,

Please find below the notes of the meetings on Bangladesh on 4 and 5 May in Washington. [...]

This round of meetings was the first one done on Bangladesh. The main topic of the discussions was the Rohingya situation and the concerns and challenges we face in the field, especially in Kutupalong Camp. It was the first time to talk about Bangladesh, but not the first time about the Rohingya. The last time was in December 2009, during a round of meetings on Myanmar.

Keep in mind that the discussions were most of the times regional, going from Bangladesh to Myanmar and vice-versa.

The main messages were:

1. The need for more assistance/support to the GOB to provide good services to the population
 2. UNHCR should exercise its mandate and take greater steps in the protection of the unregistered Rohingya living in Bangladesh
 3. MSF wants to continue working in Bangladesh and specifically in Kutupalong Camp, waiting to have the FD-6 authorised
- The messages, depending on who we were meeting, were fine-tuned according to the role of the person and the different interests.

- Everybody received in advance or during the meeting the MSF report released in February.
- Vanessa updated everybody on MSF activities in the country.

In June 2010, the MSF OCA Myanmar Coordination Team issued an advocacy and communication strategy for Myanmar. The strategy document stated that, “external advocacy will remain mostly ‘silent’ to limit the risks to both the mission’s programming and the security of its national staff.” It also explained that “speaking out is still considered an option for the mission, particularly on big issues such as the situation for the Rohingya.” Further, “a direct and aggressive confrontation with the government” was rejected in the report which also mentioned that “volume of medical programming plays a role in shielding the mission from major repercussions.”

This strategy was reviewed in January 2011 and re-discussed by managers in a regional multi-mission meeting in Bangkok in April 2011. In July 2011, an evaluation of operational risks in Bangladesh was carried out. Eventually, it was acknowledged that the assumption that speaking out from Bangladesh (and not Myanmar) was less risky was false and that any strategy based on this assumption, did not address the breadth of the problem.

Throughout the following year, intensive bilateral advocacy was conducted throughout the region on behalf of the Rohingya, with support of the operational liaison officer in Bangkok and the MSF International HART.

In January 2012, ahead of the official visit of the British Foreign Secretary to Myanmar, MSF UK organised a series of briefings on the Rohingya situation in collaboration with the UK Department for International Development (DFID).



‘Advocacy and Communications Strategy – MSF OCA Myanmar **Memo**, 30 June 2010 (Review January 2011)’ (in English).

Extract:

1. Lobbying and Advocacy

2.1 General

MSF is one of the few international organisations with significant and permanent expatriate field presence in Myanmar. As a result, MSF is in a unique position to speak out on the basis of witnessing reports and medical data obtained from its extensive medical programme. Many issues MSF is confronted with are concealed and not easily noted by outside observers. As a consequence, and in keeping with the Chantilly document, MSF has an obligation to provide information about the government’s deliberate neglect of medical needs and persecution, especially of minorities, in Myanmar. [...] MSF will aim in its advocacy and lobbying to address primarily (technical) medical issues (internally in Myanmar and externally) where we aim for concrete changes of existing government policies. Other specific issues relating to deliberate neglect and persecution are difficult to address with the regime as the consequences of speaking out on these issues in Myanmar may result in loss of operational space, losing access to our patients and may jeopardise our presence. Considering MSF’s delicate position in

Myanmar confronting the government directly and aggressively may in addition pose significant risks to our national staff. However, the size of the medical programme may also shield the mission against major repercussions. Subsequently risks and benefits will need to be carefully weighed against each other. [...]

External advocacy will overall address the following concerns:

- Situation of specific marginalised, persecuted and vulnerable groups with the ultimate aim to improve their access to healthcare and to advocate for change of repressive policies (i.e. the Rohingyas)
- Expose policies of deliberate neglect, exploitation, abuse and violence (i.e. specific Human Rights violations and barriers to care)
- Advocate for particular issues to be taken up by external actors mainly in conjunction within country lobbying efforts (insufficient provision of care or misallocation of funds, etc.)
- Communication on technical medical issues will mainly focus on particular actors (e.g., Global Fund, WHO, donor governments providing funding for healthcare) while more general awareness building and information about human rights violations will be addressed to other actors (e.g., western governments, HRW, ICG [International Crisis Group], academic institutions, media) [...]
- MSF will, through the regional HAO, aim to establish and maintain contact with opposition groups and Other (Armed) Groups to open additional channels for lobbying and advocacy
- Internal issues and constraints resulting from official restrictions will also be communicated to external actors who may have some (although likely only little) leverage to support our own lobbying. There is some scope to also publicly communicate specific issues; however, communication will need to remain balanced to safeguard operations and staff security
- Subsequently any aggressive communication which would result in the GOUM losing face and where information can be traced back to the mission requires a specific risk assessment and creative solutions
- External advocacy will therefore remain mostly 'silent' to limit both the risks to the mission's programming and the security of its national staff. *[There is a popular misconception in MSF that advocacy is limited to and worthwhile only when it entails public communication denouncing the government. However, public communication is often and in particular in repressive contexts an inadequate tool to influence decision makers.]* Silent advocacy will usually take the form of direct bilateral meetings and off the record briefings – only in exceptional cases (and after approval Head of Mission) briefing papers will be provided
- It has to be kept in mind that the large operational volume of MSF in Myanmar does not necessarily just create risks but may also shield the mission against repercussions from the regime. In addition, speaking out is considered still an option for the mission, particularly on big issues such as the situation of the Rohingyas. Risks of advocacy may be offset by benefits both of which will need to be carefully assessed.



'Rohingya Advocacy USA **Message** from Hilary Bower, MSF USA Operational Advocacy Advisor to Hernan del Valle, MSF OCA Head of OSCAR [Operational Support Communications Advocacy Reflexion], Cc: Fabien Dubuet, MSF International Representative to the UN, Emmanuel Tronc, MSF International HART Coordinator,' 14 June 2011 (in English).

Extract:

Dear Hernan,

Thanks very much for running this by Fabien and myself. Thoughts from our side: The meetings that Fabien [Dubuet], Emmanuel [Tronc] or Andrea [Pontirolli], [MSF HART] have had over the last few years with the diplomatic community, the UN system and regional organizations (Thailand, Bangladesh, Myanmar, Indonesia, the ASEAN Secretariat, the OIC, Ban Ki-moon's²⁷ executive office) suggest that the issue continues to be very sensitive. The main advice is to keep advocacy/engagement at a bilateral level and to increase dialogue at a regional level and not to be seen as too associated with the UN which is perceived in a very negative light not only by the Burmese themselves but also by the neighbouring countries and implicated multilateral groups. With that in mind, we don't feel it is a good idea to associate meetings with diplomats and others with a UNHCR-sponsored exhibition.

From my side, though as you know I am new in this post, I think a better approach in Washington would be bilateral rather than a group meeting, not directly connected with the UN, and focusing on the diplomatic representatives of the influential countries. I'll look out the notes/contacts from Luke Arend's meetings in 2009.

Ideally, we suggest that relevant desks [...], yourself, Gina [Bark, MSF OCA Operational Liaison Officer in Bangkok], Emmanuel, the upcoming international position in East Asia, Fabien and I meet (in person or by video conference) to take stock of where we are after 5 years of efforts and to flesh out a strategy for this side of the world for both Myanmar and Bangladesh – so that we move ahead more strategically and regionally on both public communication and humanitarian diplomacy/advocacy. Given the difficulty of MSF's position in Bangladesh as well, we need to be very sure of our messaging, and to make sure that we have a stronger and more humanitarian-oriented documentation to back up what we're saying, particularly with regard to medical data – which we believe was a weak point in the last round.



'Operational Liaison Officer, Bangkok, **Monthly Report**,' April/May/June 2011 (in English).

Extract:

Opportunities/Constraints:

- China Trip with Head of Mission, Medco [Medical Coordinator] Myanmar and OPLO facilitated by MSF HK went very well. Several different Chinese academics were briefed on the situation in Kachin, Shan and Rakhine. Meetings were also held with organisations working on the border with Myanmar in Yunnan Province. Through this trip we were able to establish the beginnings of a good network for further cooperation and also gain a better understanding of the border situation and the Chinese response and thought process on the Rohingya issue. An assessment Terms of Reference has been written for an explo to find out more about the situation of HIV/AIDS and TB in the

27. Secretary-General of the United Nations from January 2007 to December 2016.

border areas and possibilities to reach areas and groups inaccessible from the Myanmar side.

- London meetings held with various stakeholders about the Rohingya issue. Several interesting meetings and opportunities for ongoing cooperation.



'Bangladesh Operational **Risk Evaluation**,' July 2011, Andrew Cunningham, MSF OCA Operation Department,' 3 October 2011 (in English).

Extract:

Recommendations:

Advocacy, communications and representation:

Advocacy and communication activities are the biggest risk: Other aspects of operations are manageable. Unless political decision is made to close down INGOs, operations are safe if managed well.

- A long-term (3-5 year?) country specific and regional advocacy and communications strategy is needed as the Rohingya situation will not change anytime soon. This should be a comprehensive strategy inclusive of advocacy in the Mid-east, Asia and the West.
- The advocacy/communications risk analysis needs updating.
- A new 'Bangkok' meeting should take place with the two OMs, the two Head of Missions, the RIO, the Liaison Officer, a HAD representative and the CA. What about a medical representative? Would it also be good to have the DirOps there for decision-making? It may be best to have someone external chair the meeting. [...]
- How much to talk about Burma programme in Bangladesh? This can strengthen our position as it shows we are attending to the situation in Myanmar, but we don't want to be seen as an actor trying to pave the way for repatriation from Bangladesh. We should also always stress that we are not a political actor and are not doing development work in Myanmar with the aim to facilitate the return of the 'economic migrants.'
- Protection issues: How to approach this issue from advocacy/communications perspective? Talking about negative consequences of (lack of) status is ok. Challenging Bangladesh on legal issues not ok (threatened sovereignty). Status discussions may have effect of forcing Bangladesh to push them back [...]
- On an international level: Is 'Muslim solidarity' a channel? Can there be more advocacy in the Gulf states/OIC? Work done by Antoine a good start.
- Our policy/strategy concerning how to advocate with regional states needs further fleshing out.
- But what happens if another egregious situation arises? We should have contingency plans for this.
- Deeper and more consistent HQ engagement needed [...]
- In a certain way the threat of our public communications may be protective for us as the authorities may think twice about limiting our operations or kicking us out in fear of the public consequences.




MSF OCA **Operational Bulletin**, 11 January 2012 (in English).

Extract:

Myanmar: British Foreign Secretary William Hague just made an official visit to Myanmar and it seems that he discussed the plight of the Rohingya and was able to frame the issues in a very articulate and well informed manner.

Our UK team didn't have an opportunity to speak directly with Hague about the Rohingya before he left for Myanmar; however, they have facilitated advocacy rounds with DFID earlier, so it seems their efforts have paid off and are having an influence.


 *I didn't agree with the risk analysis that it was easier to speak out in Bangladesh. In 2011, I asked Andrew Cunningham from Humanitarian Affairs Department to go to Bangladesh to look into this in more detail. I had suspicion that we couldn't make this judgment that Bangladesh was easier than the Myanmar. And I think his conclusion was the same, if I remember correctly.*

I also thought that this strategy was not rational. It didn't seem comprehensive enough. It didn't seem Rohingya enough. It was just using "the Rohingya in Bangladesh" as your case study, which doesn't then address the root cause of the issue. It seems like the risk analysis wasn't accurate from what I was seeing in Bangladesh.


And then there was a Rohingya workshop in Bangkok [April 2011], basically to try and put all these things together. That was a good meeting which helped to frame an advocacy strategy centred around the Rohingya which we then tried to implement. It was a bit tricky because the context kept changing and the buy in from doing it, centring it around the Rohingya or centring it around Bangladesh or Myanmar was always a challenge. The question was also: "do we do public positioning for the Rohingya?"

And it was at that time, that it was accepted that Bangladesh may be as difficult, if not more difficult than Myanmar to speak out. So, then things were being a bit aligned in terms of risk, but it still wasn't framed brilliantly in terms of Rohingya. However, that notion was coming that with the big travel of people away from Bangladesh and Myanmar we were missing that third dimension to the problem.

*Chris Lockyear, MSF OCA, Bangladesh Operations Manager late 2010-July 2014
(in English).*

 *"It was, of course, all bilateral or in meetings, nothing was public. So we did a lot in New York, in Washington. We did a ten day tour in China even, which was very interesting where we used as an entry point the HIV and then we put the Rohingyas on the table ... Gina [Bark, MSF OCA Operational Liaison Officer in Bangkok] set up quite a few of these things, so that was a very useful...but that had no impact on our operations.*

Y, Former MSF staff member in Myanmar (In English).

 *The new Myanmar Head of Mission was my Operational Assistant in Amsterdam before taking up that post so he was well aware of the issues and also of my position, and of the need and our efforts to try to do more on the témoignage side. He brought that into the mission but it didn't significantly change the dynamic in terms of how we were speaking out.*

*Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland,
Board Member, 2013-2016 (in English).*



It happened a bit more after I left, so I didn't see that – but I definitely heard that there was some disappointment from Amsterdam. People would say: “Oh my God. It's like [the first Head of Mission] all over again!” Did that mean that [the first Head of Mission] was right and his successor only got it when he got there?

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English).



It wasn't a lack of public communication on the part of MSF that had buried the Rohingya dossier. Rather, my sense is that the opposite happened. The issue was increasingly visible. This was the result of – among other actions – very intense advocacy on our part, up until 2012. MSF is one of the humanitarian organisations that really exposed and cast light on the fate of the Rohingya with the embassies, in the broad sense of the term. At the start, this was just in New York and Geneva, but once the team was set up, the activity became more intense. We brought these issues to the attention of the EU and European countries, as well as to OIC countries. From that time, there was a certain momentum built with countries like Turkey and Saudi Arabia, where they monitored the Rohingya issue at a very high level.

Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020 (in French).

OCTOBER 2011 - “FATAL POLICY: HOW THE ROHINGYA SUFFER THE CONSEQUENCES OF STATELESSNESS”

In October 2011, MSF OCA produced a report/briefing paper entitled, “Fatal Policy: How the Rohingya Suffer the Consequences of Statelessness” that would be circulated for several years to regional governments, donors, and UN agency heads. Based on a nutritional survey in the Rohingya refugee camps in Bangladesh and on an in-depth quantitative and qualitative survey on reproductive health among Rohingya living in Rakhine state, this paper was recognised as being unique, unparalleled, and useful in linking the Rohingya health status directly to their persecution.



“Fatal Policy: How the Rohingya Suffer the Consequences of Statelessness” MSF OCA Briefing Paper, October 2011 (in English).

Extract:

This paper is based upon two surveys conducted in northern Rakhine State, Myanmar and Kutupalong Makeshift Camp, Bangladesh, between July and October 2011. The Rohingya people of Rakhine State are considered outsiders and have been persecuted by the government of Myanmar for decades. Denied citizenship, they are essentially stripped of any rights, making them easy targets for systematic discrimination and abuse, which severely impact on their health and quality of life. They are susceptible to extortion and humiliation and targeted by prejudiced policies which restrict movement, religious practice, marriage, land access and ownership and access to education and jobs.

In particular, marriage restrictions and their implications have a severe impact. They are one of the main reasons people flee Myanmar and the reason why so many women have unsafe and illegal abortions. The results of a recent reproductive health survey show that an alarming number of women, fearing the repercussions of unauthorised childbirth, resort to illegal abortions using highly risky techniques.

As refugees in Bangladesh they are often unwelcome and face further abuse and exploitation. Regarded as 'illegal migrants' they remain unregistered and unprotected, and are subject to high levels of exploitation, extortion and harassment. Malnutrition, an indicator of general vulnerability, is a particular concern in Kutupalong makeshift camp, where thousands of Rohingya desperately seek refuge. The results of a recent survey show above emergency thresholds for malnutrition primarily affecting children, a trend that has not changed significantly in the past year.

MYANMAR

[Marriage Restrictions: The Direct Consequences \[...\]](#)

[Induced Abortion \[...\]](#)

[Unregistered Children \[...\]](#)

[Travel Restrictions: Deadly Delays \[...\]](#)

BANGLADESH

[Unregistered and Unrecognised: The Health Consequences \[...\]](#)

Conclusions

The surveys conducted in Myanmar and Bangladesh directly link restrictions placed on, and abuses directed toward the Rohingya people with an impact on their health status. Marriage and travel restrictions in Myanmar have severe consequences. They produce harmful and fatal outcomes, particularly related to unsafe abortions, and are often the driving factor behind why many flee to Bangladesh. Marriage restrictions and their relentless social, economic and health effects on the community must be addressed. The policy of restricting marriages and limiting the number of pregnancies of Muslim women in northern Rakhine State must be abolished. The critical nutrition situation in Kutupalong makeshift camp indicates the neglect and abuse faced by the unregistered refugees. The refusal of the Bangladesh government to officially recognise this population traps them in a cycle of injustice and suffering. The Rohingya must be ensured a healthy and dignified life and if, due to a well-founded fear of persecution, they choose to leave their homeland then they should be afforded refuge and assistance in accordance with humanitarian standards and international law.



'Notes from Myanmar Round in London – 13 December 2011 from Sandrine Tiller, MSF UK Humanitarian Advisor,' 15 December 2011 (in English).

Extract:

[UK Visit: Myanmar Round](#)

Joe Belliveau, Operations Manager, Amsterdam

Gina Bark, Operational Liaison Officer, Bangkok

Sandrine Tiller, Programmes Advisor – Humanitarian Issues, UK

13 December 2011

Objective & approach

- If the aim of the visit was to highlight the plight of the Rohingya people following two recent surveys of Rohingyas in Myanmar and in Bangladesh. The conclusions of the survey are summarised in the briefing paper 'Fatal Policy'.
- To revisit and develop new contacts with UK-based NGOs working on Myanmar/ Bangladesh, and refugee issue in order to continue influencing key stakeholders on the issue.
- Our approach was to present the information in the report (and hand out hard copies selectively) but also get some insight on how to influence the UK government and see if there was interest in a roundtable on Myanmar in UK next year.



We had been doing on a yearly basis nutritional surveys in the makeshift camp in Bangladesh for quite a period of time. We had been discussing for a long time and the big pusher was in Myanmar. We wanted to do a reproductive health survey and we wanted to do this survey in northern Rakhine and HQ was supportive. We started out wanting to do it with both communities. We had discussions and discussions on "What is a feasible thing to do?". And then the deputy HoM at the time assembled a team, there was a door opened and they ran with it. From the headquarters there was a massive support. Someone was hired to coordinate the survey, analyse the results and write a report. Teams were sent to different areas in northern Rakhine to interview Rohingya to do a quantitative survey on reproductive health and they got an incredible amount of information. The quantitative information from that came out, was analysed and started to be put together for the Myanmar side.

Then I went back into northern Rakhine. I got a group of five women together, trained them, put together questionnaires and went to some of the same areas where we had done the quantitative survey to do more semi-structured and longer interviews and to try to correlate the quantitative information with a bit more substance. So, we went for around 15 days and we interviewed people. We did focus groups as well with similar questioning, both with women and with men, and with the staff working in the clinics. I put all that information together and then looked at that in relation to the quantitative information that we had from the reproductive health survey.

And there were a lot of things that came out of that. One of the big parts of it was the rate of abortion, which was incredibly high. We knew there was an issue with abortion. We were seeing it. We knew there was an issue with movement. And that movement is an issue for everybody. But you can show it when somebody's baby doesn't survive because they weren't able to get to the hospital in time or denied a travel authorisation. So, because I saw that in a quantitative analysis, I wondered: "Why? What's actually happening?" So, we've got more information on what people are doing, how they're doing and why they're doing it. We got quite a bit of information on movements, on registration of the child, marriage restrictions and things that came out of these focus groups.

The Myanmar part was about reproductive health and the Bangladesh part was based on the nutritional survey. I put that together and we got the 'Fatal Policy' report. Then I had a document that had been at least approved not for public distribution, but as something that I could use. There was a debate on whether we could put MSF logo on it or not. We had at least one version with one for sure. But it was not used. It took a good six months to put together. I think it was issued in October 2011. I went to my whole network and made it available where I could. I did several different distributions of that paper just to give people a baseline which everyone said to me they found super interesting and very helpful. They would constantly say "this is what we need. With this, we can have a conversation". Of course, it was never distributed to the government. It was never made public. And it was very quietly spoken about for a long

period of time. Outside of MSF, it was a bit more known by people who are working on Rohingya. And nobody knew where it came from.

And a lot of people weren't aware of it. It wasn't known within MSF, even within OCA. Bigger issue was the field. As everybody in Myanmar – myself included when I was there – the field can be paranoid. It becomes this Myanmar syndrome of paranoia where one person just lulls the next and next and next. And when you actually tried to find out: “well, what are you afraid of or what's the actual risk?”. Nobody could tell you because nobody actually really knows. The big thing is always saying: “oh, we'll get chucked out.” And yes, they make our lives difficult. I'm not denying that in any way. But I think there are a lot of things that we didn't really know what we were afraid of actually. That we never really properly analysed. It was kind of fear building fear and then there's paranoia.

Gina Bark, MSF OCA, Project Coordinator in Rakhine, 2009-2010; Operational Liaison Officer in Bangkok, 2010-2012; Humanitarian Affairs Advisor in Amsterdam, 2012-2017 (in English).



Because of the marriage problem and the access to health problem and the limitations on people having children, and abortion being illegal ... women who were getting pregnant knew that if they were giving birth, their children would be illegitimate, they themselves would be at risk of going to jail. So, they were having abortions and very unsafe abortions. And we basically were able to collect data that described that situation. So, it was a direct link to government policy and humanitarian outcomes. It was a bit of a breakthrough in that sense because up to that time we had all kinds of anecdotal, people telling stories and things but this one was a sort of evidence-based link between policy and consequence. We used that report more forcefully than we had used the first report. Not public per se but semi-public, like making it really available and really trying to use it... We knew for sure the government was seeing the press releases, we knew that and so in a way 'Fatal Policy' was a way for us to test the waters a little bit like how far we can go before they really do something drastic...

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



We used 'Fatal Policy' quite extensively but we didn't publish it. We obviously considered putting it public, but the argument put forward for not doing so was access. I would have liked for it to have been public.

Christopher Lockyear, MSF OCA, Bangladesh Operations Manager, late 2010-July 2014 (in English).

Throughout 2011, tensions between Muslim and Buddhist populations in Rakhine persisted. This was despite continued implementation of democratic reforms in Myanmar, which were praised by the international community.



'Sitrep: May 2011 Sittwe Project, Myanmar Mission' (in English), edited.

Extract:

1. General Situation Context

- There seems to be growing disappointment among the Rakhine population regarding promises that are not fulfilled as stated during elections. Most of the requests from RNDP [Rakhine Nationalities Development Party] are just not approved by the new State Governor (who belongs to the USDP [United Social Democratic Party]). The Rakhine population is known to be very opposed to the new government.



'Burma: Eight Months of Spectacular Political Reform (CHRONOLOGY) AFP, Yangon,' 29 November 2011 (in French).

Extract:

The US Secretary of State Hillary Clinton arrives in Burma on Wednesday for a historic visit, following an astonishing series of reforms by the 'civilian' regime in place in Naypyidaw since March.

30 March: Former general Thein Sein, Prime Minister, becomes president of Burma. The junta is dissolved and Generalissimo Than Shwe, in power since 1992, steps down. The West calls the reform a façade.

6 July: Hundreds of Burmese gather in the centre of Bagan in support of the opposition figure Aung San Suu Kyi following her first sortie, in a private trip, from Yangon after being freed from detention in November 2010.[...]

15 August: The US 'encouraged' by the exchanges between opposition leader and the regime.

19 August: Historic meeting between Suu Kyi and Thein Sein.

6 Sept: Setting up of a national human rights Commission following a request from the United Nations Head of Mission.

9 Sept: Derek Mitchell, the first US envoy appointed to undertake talks with Burma, arrives in Naypyidaw.

18 Sept: Agence France Presse exclusive: Suu Kyi deems the reforms to be "positive" but remains cautious as to the authorities' capacity to adhere to them.

29 Sept: leading diplomat Wanna Maung Lwin meets Derek Mitchell in Washington.

30 Sept: Naypyidaw suspends a controversial China-financed dam project in Kachin State (north). The West approves.

8 Oct: the chief censor believes that the media should be free.

12 Oct: 200 political prisoners including the comedian Zarganar are freed.[...]

17 Nov: the Association of Southeast Asian Nations to entrust Burma with the presidency of the regional bloc in 2014.

18 Nov: Barack Obama announces that US secretary of state Hillary Clinton is to visit Burma. Suu Kyi's national league for democracy votes for its return by legal means and through participation in the forthcoming partial elections.

19 Nov: peace discussions between the Burmese government and armed ethnic minority groups at an unknown location.

25 Nov: former general Shwe Mann, president of the lower chamber of Parliament and one of the regime's most powerful men, declares that Burma wants "normal relations" with Washington.



'**Situation Report** ERS [East Rakhine State] Project, Myanmar 2011,' 5 January 2012 (in English).

Extract:

2. SECURITY

The tension between the Muslim and Rakhine population seems to rise and fall in constant waves. Between Min San and Shwe Pyaar Quarters many issues are going on. Rakhine Buddhists regularly blackmail Muslims and take money or goods from them. If they cannot pay, they beat them and/or verbally abuse them. The Muslim population avoids being on the street in the evening. Despite a huge Muslim population of around 1,400 ppl (in Shwe Pyaar Qtr) they stay quiet and succumb to their fate as the police is not interfering either.

From late January 2012 onward, MSF OCA strengthened its bilateral advocacy campaign concerning the consequences of the November 2011 cancellation of the 11th Global Fund cycle. This cancelled round was intended to allocate funding for treatment of patients with HIV/AIDS, malaria and tuberculosis patients.

During advocacy rounds on the cancelled Global Fund with ECHO and the European Commission and ahead of their planned meetings on Myanmar, MSF representatives again warned about the plight of the Rohingya. In these bilateral meetings, MSF again drew upon the briefing paper "Fatal Policy" initially circulated in 2011. Under the seal of confidentiality, MSF described the link between restrictive marriage policies and the health of Rohingya women. However, MSF interlocutors were requested not to link this information to MSF so as to avoid endangering their programmes in Myanmar.



'MSF OCA **Ops Bulletin**,' 25 November 2011 (in English).

Extract:

Myanmar where the cancellation of [Global Fund] Round 11 means that the best case forecast for HIV/AIDS treatment is that less than half of people in need of Antiretrovirals will be receiving them by the end of 2015. The decision does not affect our immediate programming – as Round 9 is now starting to kick in – but is a big blow to longer-term planning and hence our advocacy efforts will have to be redoubled.



'MSF OCA **Operational Bulletin**,' 20 January 2012 (in English)

Myanmar & Bangladesh – Rohingya Advocacy Initiative Operational Advisor, Jan-Peter Stellema, was in Brussels yesterday doing advocacy rounds with ECHO and European Commission officials to continue to raise awareness for the plight of the Rohingya, a marginalised Muslim minority that is heavily discriminated. He presented and discussed the main findings highlighted in the Fatal Policy briefing paper, which focuses on the link between restrictive marriage policies for Rohingya in Myanmar and their impact on the health of women: induced abortion rates are high due to fear of fines or imprisonment

if children are born out of wedlock, while the process to get a marriage permit is a lengthy, humiliating and costly one. The Paper also covers the continuation of unacceptable high malnutrition rates – above emergency thresholds – amongst the non-recognised Rohingya refugees in Kutupalong in neighbouring Bangladesh. The information was well received by the various officials and the presentation was timely since the EC will have its Ministers meeting next Monday where Myanmar is on the agenda.



“Myanmar (Rohingya) Advocacy Round in Brussels”, **Notes** from Andrea Pontiroli, MSF Representative to EU, 23 January 2012 (in English).

Extract:

1/ Everybody recognised the pertinence and good timing of this paper/analysis, since today and tomorrow EU Foreign Ministers will meet to discuss Myanmar, including a probable easing of sanctions.

s3/ On a slightly more optimistic side, there is a small opening for the EU not only investing in reproductive healthcare, but also pushing for a geographical allocation of such funds in the Rakhine State (RS), to ensure that the 3 townships there are included amongst the 40 that will receive the funds.

4/ Again on the optimistic side, the two Commissioners may be pushing for concrete steps to ease marriage restrictions.



“Myanmar Round Washington DC: 1–2 February 2012”, **Notes** from Hilary Bower, Operational Advocacy Advisor MSF USA, 2 February 2012 (in English).

Extract:

MSF participants: Head of Mission MSF OCA Myanmar; Medical Coordinator MSF OCA Myanmar ; operational advocacy advisor MSF USA.

MSF talking points [...]

Rohingya

Fatal Policy briefing paper: given to all interlocutors with request not to link with MSF to avoid consequences on programmes. Request for Rohingya situation to be raised as a talking point with GoUM.

Concern that Rohingya will be overlooked in new situation because of complexity of problem, focus on other ethnic issues which GoUM has willingness to move on, and labelling of Rohingya situation as “not an ethnic conflict”. Reframe perception of NRS as situation of extreme physical and psychological ethnic violence, one large political prison. [...]

Summary of main points

Most people were unaware of the plight of the Rohingya and its seriousness. Those who do know, agree that unless efforts are made, they likely to get overlooked. Most were open to do what they could to avert that, and/or to help put the issue in front of those in the US who might have influence, but some felt it was too sensitive at this moment. There is significant and acknowledged lack of knowledge about Myanmar, the health situation and what’s needed. But also, clear scaling up by USG [Under Secretary General] and others in terms of preparation for assessments and planning.



'MSF OCA **Operational Bulletin**,' 10 February 2012 (in English).

Extract:

Myanmar: The mission is heavily engaged in advocacy and communications initiatives about the cancellation of Global Fund (GF) Round 11 and the plight of the Rohingya. The cancellation of Round 11 has major implications for HIV/AIDS, malaria and TB patients around the world and MSF programming. We are concerned that treatment gaps will continue to increase in Myanmar and any gains that have made in the last few years will be eroded due to the cancellation of this funding stream. So, the OCA mission issued a joint letter together with other INGOs operational in Myanmar to draw attention to these issues. The letter has been sent to all MSF sections and it will then be directed by the General Director's to the respective governments in their Head of Mission countries, but also to the Board members of the Global Fund.

The Head of Mission and Medco were just in New York and Washington where they participated in 28 meetings with US government agencies and UN bodies to discuss funding issues and the plight of the Rohingya. Operations Advisor, Jan-Peter Stellema was also doing advocacy rounds in Brussels this Wednesday. He met with the Myanmar ambassador to discuss the same issues and offered MSF assistance to the Myanmar government to apply for transitional funding to cover gaps created by the cancellation of Round 11.

FEBRUARY 2012 - "LIVES IN THE BALANCE: THE NEED FOR ART AND TUBERCULOSIS TREATMENTS IN MYANMAR" (RELEASED PUBLICLY)

On 22 February 2012, at a press conference in Bangkok, MSF OCA together with the MSF Access to Essential Medicines Campaign²⁸ released a report entitled, "*Lives in the Balance: The need for ART and Tuberculosis treatments in Myanmar,*" which was a follow-up to the end 2008 report, "*A Preventable Fate: the Failure of ART Scale-up in Myanmar.*"

A press release was issued that outlined the situation for people affected by HIV and TB in Myanmar. MSF called for the Global Fund and its donors to help Myanmar ensure a "*rapid scaling up in HIV and TB treatment to prevent further transmission and save both lives and money.*"

On 11 May 2012, the Global Fund announced it would free up 1.7 billion dollars of which two-thirds would be attributed to needy countries. Myanmar was considered, as in the past, to have a good chance to make this list.

28. Launched in 1998, the MSF Access Campaign aimed to support research and development for tropical diseases and related areas; make new drugs and vaccines affordable for disadvantaged populations; ensure the production and commercialisation of targeted orphan drugs; and humanise the World Trade Organisation (WTO) and the trade-related aspects of intellectual property rights, which was an agreement between all the members of the WTO.



MSF OCA Ops Platform Meeting **Minutes**, 22 February 2012 (in English).

Extract:

Myanmar: Today, MSF released a new report, *Lives in the Balance*, which is a follow-up to the 2008 report, *A Preventable Fate: The Failure of ART Scale-Up in Myanmar*. [...]. Today, we held a press conference in Bangkok and followed up with a press release and a web-based slide show to raise additional awareness for the message we have brought forth in *Lives in the Balance*. Overall, the story has been well received and picked up by various media outlets, including BBC and Reuters.



MSF calls for urgent action to save lives in Myanmar MSF OCA **Press Release**, Bangkok, Thailand, 22 February 2012 (in English).

Extract:

In a report released today Médecins Sans Frontières (MSF), the largest provider of HIV treatment in Myanmar (1), highlights the critical need for increased HIV and Tuberculosis, including multidrug-resistant tuberculosis, treatment in the country. According to the report, 85,000 people in urgent need of lifesaving anti-retroviral therapy in Myanmar are today unable to access it. Of an estimated 9,300 people newly infected with MDR-TB each year, so far just over 300 have been receiving treatment. *Lives in the Balance* shows the devastating effect that the cancellation of an entire round of funding from the Global Fund to Fight AIDS, TB and Malaria, will have on the struggle to provide HIV and TB treatment in Myanmar. The cancellation of Round 11 means that there will be no foreseen funding to expand treatment for HIV or TB and its drug-resistant forms until 2014.

“Yet again, donors have turned their backs on people living with HIV and TB in Myanmar” said [...], Head of Mission, MSF Myanmar. “Every day we at MSF are confronted with the tragic consequences of these decisions: desperately sick people and unnecessary deaths.” Between 15,000 and 20,000 people living with HIV die every year in Myanmar because of lack of access to lifesaving anti-retroviral therapy. TB prevalence in Myanmar is more than three times the global average and Myanmar is among the 27 countries with the highest MDR-TB rates in the world. MDR-TB has the same airborne transmission as non-resistant TB, but it is far more complex and lengthy to treat (2). As with non-resistant TB, perfectly healthy people can easily be infected with MDR-TB.

“Without increased availability of treatment, HIV and TB will continue to spread unchecked in many areas. The time to treat is now,” said MSF’s Dr K [...], “There is a real opportunity here; HIV prevalence rates in Myanmar are relatively low. It is lack of access to treatment that makes it one of the most serious epidemics in Asia.” Myanmar, the least developed country in Southeast Asia, is one of the lowest recipients of Official Development Aid in the world. With political reform being reciprocated by greater engagement from the international community, there is a real opportunity to put access to treatment for people living with HIV and TB at the top of donor priority lists. Myanmar suffers from an underfunded state healthcare system. While there are promising efforts to increase the health budget, which MSF encourages to continue, it will be years before the country has a fully comprehensive healthcare system. [...]

“The maths is simple. Rapidly scaling up HIV and TB treatment now will prevent further transmission and save both lives and money. Less people infected means fewer lives lost, and less people in need of treatment,” concluded (the Head of Mission). “It is critical

that donors help Myanmar ensure more patients across the country can receive treatment for HIV and MDR-TB.”



“Lives in the Balance: The Need for Urgent HIV and TB Treatment in Myanmar”
MSF OCA/MSF Access Campaign **Report**, 22 February 2012 (in English).

Extract:

Recommendations:

International donors must help ensure that the planned scale-up of HIV, TB and MDR-TB treatment goes ahead. They can do this by:

Increasing funding, both bilateral and multilateral, for HIV and TB programmes in Myanmar.

Providing additional funding for the Global Fund in 2012, and actively encouraging other donors to do the same.

Supporting the Government of Myanmar in taking the necessary steps to facilitate the planned scale up of HIV and TB treatment.

The Global Fund must ensure adequate funding allocations for Myanmar.

International NGOs must play their part, and increase support for HIV and TB treatment in Myanmar. MSF is encouraged by the recent efforts by the Government of Myanmar to increase the health budget and hopes this will continue. The Ministry of Health needs the resources to provide necessary health care to the population, inclusive of HIV and TB treatment.

MSF asks the Government of Myanmar to continue to support the process of decentralising lifesaving ART and MDR-TB treatment by facilitating increased geographic access, and through simplifying operational constraints such as importation procedures.



MSF OCA **Operational Bulletin**, 14 May 2012 (in English).

Extract:

Myanmar Since the cancellation of Global Fund Round 11 last November there has been little hope for the scale up of ART and (MDR) TB care in Myanmar. However, late last week the Global Fund announced that it can free up 1.7 billion dollars between now and 2014 owing to internal cuts, the decision not to fund mid-developed countries such as China and Brazil, and the attraction of new donors plus increased pledges from existing donors. With this fund no extra round will be revived, but about 2/3 of the money will be available for ad hoc funding to needy countries, and Myanmar has a good chance of featuring high on the list.

CHAPTER 3 - 2012-2013 - COMMUNAL VIOLENCE AND ACCESS ISSUES IN RAKHINE

In early April 2012, the Myanmar opposition party NLD [National League for Democracy] won the legislative elections in Myanmar. While the restrictive bureaucratic environment for INGOs persisted, some intervention conditions were significantly improved. For example, the expatriates’ travel authorisation’ renewal periods were extended to every three months from monthly renewals.

In late April 2012, the European Union suspended all political and economic sanctions on Myanmar for one year, with the exception of the arms embargo. However, they warned that they could reconsider their decision at any time.

While Ban Ki-Moon, the UN Secretary General called for further lifting of sanctions, the USA ruled out lifting key sanctions in order to keep pressure on the Myanmar regime.



'MSF OCA **Operational Bulletin**,' 4 April 2012 (in English).

Extract:

Myanmar Against the historic backdrop of NLD parliamentary election wins over the weekend, the bureaucratic environment in Myanmar remains highly restrictive. Nevertheless, one small step forward was recently achieved. Expat travel authorisation renewals have been changed from monthly (in person) to three-monthly. This essentially allows field expats to spend significantly more of their time doing their jobs rather than dealing with bureaucratic hurdles. The mission is still under the imposed 19 expat rule, a rule that makes management of such a large mission a huge challenge.



“Ban urges further easing of sanctions in Myanmar” by Daniel Rook, **AFP**, 30 April 2012 (in French).

Extract:

On Monday, the UN's Secretary-General called on the West to go further with its easing of sanctions against the Burmese regime, support that has the backing of the current leadership, while leader of the opposition Aung San Suu Kyi concluded her first trial of strength since she was a member of parliament. The EU recently suspended sanctions for a year, and the United States ruled out lifting them for now. Ban Ki-moon has, however, demanded further action from the West during the first speech from a foreign figure to the Burmese government. “I commend the measures taken to date by the international community, but it has to do more,” declared Ban, in Myanmar since Sunday, calling on it “to go further with the lifting, suspension or easing of trade restrictions and other sanctions”.

JUNE 2012 - “MSF - VICTIMS OF RECENT MYANMAR CLASHES MUST HAVE ACCESS TO HEALTHCARE” (RELEASED PUBLICLY)

On 28 May 2012 in Rakhine State, a Buddhist woman was raped and murdered, allegedly by a group of Muslim men. On 4 June 2012, a mob of people attacked a bus in Taungok, mistakenly believing that some of the passengers were responsible for Buddhist woman's murder. Ten Muslims were killed in the attacks.

On 8 June 2012, interethnic violence erupted in Maungdaw and spread to Sittwe. Hundreds of houses were burned down, which led to 75,000 displaced people from both communities. MSF OCA began mobile clinics to treat the victims of violence in displaced camps.

On 10 June 2012, the President of Myanmar, Thein Sein addressed the nation in an effort to calm the situation down. The next day, a curfew and a state of emergency were declared in Rakhine state. As a result, the UN evacuated non-essential staff. Faced with escalating violence and threats against INGOs, MSF OCA suspended its activities in Rakhine state.

Harassment and intimidation of national staff increased, particularly for the Rohingya. The international and senior national senior staff were unprepared to cope with security issues in such an emergency context and were evacuated.



'Burma Violence: Tension High in Rakhine State, **BBC News**,' 11 June 2012 (in English).

Extract:

Tension is high in Burma's western Rakhine state after President Thein Sein imposed a state of emergency.

A spate of violence involving Buddhists and Muslims in the past week has left seven people dead and hundreds of properties damaged in the area. [...] Trouble flared after the murder of a Buddhist woman last month, followed by an attack on a bus carrying Muslims. According to a Reuters report, the violence over the weekend began on Friday in the Rakhine State town of Maungdaw, spreading to the capital Sittwe and neighbouring villages. Rival Buddhists and Muslim groups were witnessed setting houses on fire, reports said. "We have now ordered troops to protect the airport and the Rakhine villages under attack in Sittwe," Zaw Htay, director of the President's office was quoted as saying by Reuters. [...] The clashes began on 4 June when a mob attacked a bus in Taungup, Rakhine province, apparently mistakenly believing some of the passengers were responsible for the earlier rape and murder of a Buddhist woman.



'MSF OCA **Operational Bulletin**,' 13 June 2012 (in English).

Extract:

Myanmar Since 3 June there has been a lot of unrest in Rakhine, leading to houses being burnt, people killed and mobs in the streets that are fighting each other. There are reports of the police going from house to house and arresting people. At the same time the Bangladeshi army is securing the border. The ministry of defence stated that they are trying to keep refugees out. It is a critical situation, also for MSF because anti-NGO sentiments in Rakhine are running high and NGOs are accused of supporting only Muslims. In this climate of violence, threats and rumours, many of our staff have felt threatened. Most of our senior staff have now been relocated back to Yangon, while the tensions between various population groups affect the remaining national staff teams. It is extremely difficult for us to respond under these circumstances to new needs, but also to continue with our regular clinics and many have actually closed down. For the longer term we fear that the authorities might deny us access when we try to return and put bureaucratic obstacles in place.



A Rakhine woman was killed by three of Rohingya allegedly, reportedly. Then the Rakhine hung three Rohingya men. Then some Rohingya also burnt the Rakhine's houses. Then 12 persons of Tablighi Jamaat²⁹ were killed by Rakhine people. The situation got worse and worse and worse. We had so many restrictions, so many violations by Myanmar authorities. For example, no one could marry without permission, no one could go from urban area to Maungdaw or other cities without permission of the chairman of the authority. We had almost 16 checkpoints, and at every checkpoint we had to pay 200 Myanmar kyat. It was very difficult for us. In Maungdaw, people were threatened by the authorities. It was not actually physical or violent threat but they were pressurising so that they cannot get out from the office, they cannot run their activities. The security was so tight that MSF closed their clinic for five to six months. The services were closed. We were told to stay at home, not to go out, not to work. MSF closed the operations but they didn't leave. They were in the office, negotiating with the government...

S, MSF OCA, Myanmar Staff, fled to Bangladesh in August 2017 (translated from Rohingya into English).



I came back home on Thursday. Then on Friday, no one was going out as usual. Everyone was waiting there in their houses. It was raining heavily. I was outside and I saw that some 20 young people had taken shelter in some other houses. Then I noticed that a military vehicle was coming from the other side of the village. They came and found those 20 people including five children under ten years old. They beat all of them. So, the local Rohingya community went out of the home and said: "if we can't speak to the military who will settle this issue? Please can someone speak to them?" Then together with a friend I went to talk to the military and asked: "Why are you doing that?" The military asked me: "Can you tell us who the educated people in your community are? Where do you work?" He asked a lot of questions. I didn't tell him that I was working for MSF. I told him I was a teacher because that was my previous position. He asked me: "Do you have a bicycle." I said yes. He said: "go and bring the bicycle." Then I brought the bicycle with me and the military took it. They went house to house looking for people who were educated. They came back with 20 people wrapped in plastic tarpaulin/sheets. I just asked them why they were doing that to those people. They weren't educated people. They worked in the fields, with the cattle. I was talking to them in a polite way so that the situation doesn't get worse. They did not say anything. They took them to Maungdaw and then they jailed them for ten years; without any reason, any offense, any crime.

Z, MSF OCA, Myanmar staff, flew to Bangladesh in August 2017 (translated from Rohingya into English).



In June 2012, the team was not prepared for an emergency response situation like that and they were not prepared to manage security in a way that became necessary at that moment. So, part of the reason for the evacuation was that we didn't have the right personnel on the ground.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).

29. Created in 1926, the Tablighi Jamaat (Society of preachers) is a Sunni Islamic revival movement from the Indian sub-continent.

On 12 June 2012, MSF OCA issued a reactive statement highlighting the consequences of forced suspension and disruption of life-saving primary healthcare services, particularly the provision of anti-retroviral treatment to HIV patients. This reactive-only statement was not intended for general and active distribution. However, the media quickly relayed the message, despite lack of precise information on the violence.



Message from Jo Kuper MSF OCA Communication Advisor to MSF Communication Advisors, 12 June 2012 (in English).

Extract:

Hi all, please find below a reactive statement on the situation in Rakhine. You are welcome to put this on your websites, and to share with journalists. If you are asked/or have any specific questions please direct them to me.[...]

[MSF statement on situation in Rakhine state, Myanmar.](#)

Tuesday 12 June 2012.

MSF has temporarily suspended activities and reduced staff in Rakhine state. Suspension of activities means the disruption of lifesaving primary healthcare, including the provision of urgent antiretroviral treatment to HIV-positive patients. MSF is concerned about the safety of all its patients and staff, and hopes to resume medical activities as soon as possible in order to avoid unnecessary lives being lost.

MSF has worked in Rakhine state since 1992, its medical activities focus on primary healthcare, with a specific emphasis on reproductive health, malaria, HIV and TB. In 2011, MSF conducted more than 487,000 consultations. Of these, nearly 75,000 were for malaria treatment, and nearly 24,000 were related to maternal health. MSF also provided lifesaving ART treatment to over 600 patients.

Dear all,

A clarification on the Rakhine statement that was issued earlier. Apologies for any confusion, it is a reactive statement, developed in response to increasing journalist questions – from people that already know the situation on the ground. You are not expected to proactively push this but are welcome to share it if you get questions and, if you want to, to feature it on websites.

I have added the following line to the beginning of the statement – “Following escalating violence in Rakhine state...” We are quite deliberately not as MSF going into details about what is happening on the ground.



“Myanmar: MSF Suspends Its Activities in Rakhine State” AFP (Bangkok), 12 June 2012 (in French).

Extract:

The organisation Médecins Sans Frontières (MSF) has temporarily suspended its activities in Rakhine State, in western Myanmar, which is ravaged by bloody sectarian violence, a spokesperson for the group announced Tuesday. The suspension related to “basic healthcare, including the provision of antiretroviral treatments for HIV patients”, informed MSF in a statement received by the AFP. The NGO, one of the few international organisations working in the region “is concerned for the safety of its patients and staff

and hopes to resume its medical activities as soon as possible to avoid preventable loss of life”.

In Rakhine State, MSF teams were no longer running activities, except for eight malaria treatment centres. This treatment interruption put HIV/AIDS patients particularly at risk

The remaining MSF OCA Rakhine team engaged in a networking campaign with local leaders to rebuild confidence and access to vulnerable populations.



‘MSF OCA **Operational Bulletin**,’ 15 June 2012 (in English).

Extract:

Myanmar: The situation around the unrest in Rakhine remains hard to analyse. There are rumours about displaced populations, both Buddhist and Muslim in and around Sittwe. [...] Joe Belliveau, [Operations Manager], has arrived in Myanmar and will support the team. It is hoped that some of our access can be regained via external comms, targeting the local population; more news on this next week. Only 8 of our malaria field sites are still running; the rest of activities have come to a full or partial halt. Because of this, around 600 patients might face discontinuation of ARV treatment.



The military government was so on top of the situation, controlling and authoritarian, that before 2011, the idea of violence was just out of the question. It just wouldn't have taken place. As a result, MSF had got quite complacent in relation to who we needed to be talking to. We had contacts in governments, but our community level contacts were very poor. So, after the violence in June 2012 we went on a massive sort of networking campaign. The project coordinator really spent a huge amount of time trying to build relations with leaders amongst communities, trying to do a very balanced approach, but with a big focus on the Rakhine community

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission for Rakhine and advocacy, May 2011-May 2014, Acting Head of Mission in February 2014 (in English).

In mid-May 2012, with several high-level visits in Bangladesh, including the US Secretary of State Hillary Clinton, the international interest in the Rohingya refugee plight increased.

The MSF OCA team received information from a contact within the Bangladeshi government, that they would never receive official accreditation for their activities with the non-registered Rohingya refugees in Kutupalong, but these activities would be tolerated.

However, one week later, MSF received a letter from the camp administrative authorities demanding the suspension of activities of several INGOS, including MSF.



'MSF OCA **Operational Bulletin**,' 11 May 2012 (in English).

Extract:

Bangladesh Paul (Head of Mission) and Lisbeth (PC Kutupalong) just returned from Bangladesh. [...] At national level, the Kutupalong project has still not received accreditation. Contacts we have within the government tell us that we'll never get the official permission, at the same time our activities will be tolerated. So, there is constant tension within high levels of government. Things might improve as there is a lot of international interest recently in the Rohingya issue and in Bangladesh in general (Hillary Clinton visited last week, the head of ECHO is coming to visit this year), which puts a lot of international pressure on the government.



'MSF OCA Operational Platform **Minutes**,' 23 May 2012 (in English)

Extract:

2.) Strategic threats and opportunities [...]

Bangladesh: Yesterday we received a copy of a letter that had been given to Muslim Aid which cited another letter to the local district commissioner which listed four NGOs working in the area, including MSF. It was from the district commissioner saying that they must stop us from working in Kutupalong and that there would be disciplinary action taken. We have not directly received either of these letters yet. At the same time there had been a meeting in Dhaka where the authorities had been sympathetic to us and our work. The teams went to the clinic today as normal. In the meantime, we are working out a comms package and intend to keep going for as long as possible.

BANGLADESH STILL REFUSING TO OPEN BORDERS

The MSF OCA Bangladesh team started to work on a communication strategy in the event that MSF was expelled from Kutupalong camp.

Eventually, in late May 2012, thanks to the unprecedented engagement of several ambassadors in Dhaka, the situation calmed down. It appeared that the threat had been created by a "hardliner" anti-NGO advisor to the authorities.



'MSF OCA Operational Platform **Minutes**,' 30 May 2012 (in English).

Extract:

Bangladesh: After last week's update on Bangladesh, the situation has deteriorated. Muslim Aid and Solidarity were told that their bank manager should not process any of

their transactions. At that point the situation looked quite concerning. Since then there have been positive reactions from some ambassadors who are actively engaging in Myanmar, specifically from the EU, Australian, British, and American Ambassadors. At the moment the information we are getting from one of the advisors to the Prime Minister is that the situation will be ok. It looks like the threat originated from another advisor who is a bit more hard-line. This advisor will be approached through the Australian Ambassador to see if there is anything we can do to mitigate. At the same time the Australian Ambassador is planning to visit our camp. Though not visibly, we are facilitating this visit.

In Bangladesh, the authorities did not heed international calls to open the border and let the refugees fleeing the violence in Myanmar to cross their border. Refugees attempting to reach Bangladesh by boat on the Naf river were sent back to Myanmar.

On 20 June 2012, the Bangladeshi authorities demanded for proof of MSF OCA operational legality and proof of expatriates' work visas. Accused of exacerbating tensions by inviting people to cross the border from Myanmar, MSF OCA cancelled an assessment in the border area.



“Bangladesh Still Refusing to Open Its Borders to Rohingya Refugees” **AFP** (Dhaka), 14 June 2012 (in French).

Extract:

Bangladesh on Thursday again refused to open its borders to Rohingya Muslims attempting to flee the inter-religious violence in Myanmar, despite calls to do so from the United States and human rights organisations. This deprived country in South-east Asia, where around 300,000 Rohingya refugees are currently settled, has pushed away boats of new arrivals of migrants seeking refuge. At least 17 vessels transporting nearly 700 Rohingyas on the Naf River separating the two countries have been told to turn back since Monday. “Our position on the issue of Burmese refugees has not changed,” declared Masud Mahmood, spokesman for the Ministry of Foreign Affairs, to the AFP. On Wednesday, the US urged Bangladesh to allow entry to the Rohingya, which the UN considers one of the most persecuted minorities in the world. [...] The UN High Commissioner for Refugees and the organisation Human Rights Watch have also called on Dhaka to open its borders.



‘MSF OCA Operational Platform **Minutes**,’ 20 June 2012 (in English).

Extract:

Bangladesh. Operations in Cox’s Bazar have become threatened in recent days with demands from the district commissioner and the local police for proof of our operational legality and international staff work visas. We are stalling on providing proof of visas. Accusations were also made by the Commissioner that we are exacerbating local tensions by inviting people to cross the border from Myanmar. In response we cancelled

an assessment in the border area and verified instead with another actor. Our lobbying at capital level continues.

Meanwhile, in Kuala Lumpur, thousands of Rohingya settled in Malaysia demonstrated to demand the end to violence against their community in Rakhine, which they labelled as “genocide.” Some even asked for a United Nations intervention of peacekeepers.

Questioned on this subject during a trip to Europe, Aung San Suu Kyi, leader of the opposition, simply referred to the importance of the rule of law.



“Malaysia: Thousands of Burmese Muslims Denounce Violence”, **AFP** (Kuala Lumpur), 15 June 2012 (in French).

Extract:

Thousands of Burmese Muslims in Malaysia took to the streets in Kuala Lumpur on Friday to call for an end to the violence being waged against their community in western Myanmar, reported a journalist for the AFP. Over three thousand people protesting on behalf of the stateless Rohingya minority marched from a mosque in the Malaysian capital to the Burmese embassy, holding up banners reading “Stop the genocide” and “Stop the religious violence”.

“We demand urgent international intervention to bring the massacre and violence against the Rohingya community to an end,” stated the Myanmar Ethnic Rohingya Human Rights Organisation in Malaysia (Merhrom) in a press release. “Even if the military junta says that the situation has improved, the information we have leads us to believe it has, in fact, worsened and the violence increased,” the release added. The organisation demands the UN sends in its peacekeeping forces and also calls for humanitarian aid.



“Communal Violence in Burma: Aung San Suu Kyi on a Knife Edge” by Aidan Jones, **AFP** (Bangkok), 15 June 2012 (in French).

Extract:

The Burmese opposition leader Aung San Suu Kyi has been urged to speak out against the deadly riots targeting the Rohingya Muslim minority in recent days. But it is a volatile subject in a country plagued by sectarian division. The Nobel Peace Prize winner, taking an historic tour of Europe, addressed the repeated questions from journalists on the clashes between Rohingya Muslims and Buddhists that have left scores dead and displaced over 30,000 people in Rakhine State (western Myanmar). But the MP [Member of Parliament], an astute politician, above all insisted on the importance of the rule of law, without which “such communal strife will only continue”. But she was careful not to offer any real support to the 800,000 Rohingya Muslims confined in this part of the country. Stateless and regarded by the UN as one of the most persecuted minorities in the world, the Rohingya Muslims are not recognised as Burmese by the government. And many Burmese make no secret of their hostility to those whom they consider illegal foreign immigrants from Bangladesh. “We are calling out to the United Nations, foreign nations, the Burmese government and Suu Kyi in particular,” declared to the AFP on Thursday Mohammad Islam, representative of Rohingya refugees in a camp in the border city of Tena, in Bangladesh. “Aung San Suu Kyi has said and done nothing for us,

while the Rohingya Muslims, including my parents, campaigned for her in the 1990 elections.” But it’s a thorny issue for the opposition leader who is trying to emerge as a unifying figure for the country’s ethnic minorities.

On 18 June 2012, MSF OCA issued an international press statement calling for access to healthcare for the victims of clashes in Myanmar. The statement implored Bangladesh to open their borders while highlighting that MSF’s regular programme resumption was critical to the long-term health and well-being of all communities throughout Rakhine state.

This public stance was complemented by advocacy efforts towards non-medical Bangkok-based organisations working in Rakhine that risk could speaking out, having no medical activities to endanger.

In the field, the remaining MSF OCA staff in Rakhine heard reports about looting, burglaries, arrests, and population displacements.



“Press Release Just Gone Out: MSF – Victims of Recent Myanmar Clashes Must Have Access to Healthcare”, **Message** from Jo Kuper, MSF OCA Communication Advisor to MSF Communication Advisors, 18 June 2012 (in English).

Extract:

Hi all,

Please find below, and attached, a more public press release on the situation in Myanmar and Bangladesh that has just been released to international and regional media from Bangkok. It would be great if you could share this with interested journalists, and put the release on your websites. [...]

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Why

We are putting out this press release to state as MSF our concern that victims of the recent clashes in Myanmar are unable to access healthcare.

Objective

Leverage and visibility – to state our concerns for all victims of the clashes and our desire to both provide emergency response and treat our patients. To support calls for the Bangladesh border to be opened and to state our readiness and willingness to treat people in need of medical care.

To whom?

- International media
- MSF public audiences [...]

MSF International Press Statement: MSF – Victims of recent Myanmar clashes must have access to healthcare

Monday 18 June 2012 – Yangon, Myanmar. With continued tension and unrest in Rakhine Sate, Myanmar, Médecins Sans Frontières (MSF) is seriously concerned that those people most affected by violence and deep communal divisions, are unable to receive medical treatment.

MSF was forced to suspend most of its medical activities in Rakhine State on 9 June when violence erupted, which put its clinics and staff in danger. “MSF is extremely worried that

victims of the clashes are not receiving emergency care, and about the ongoing healthcare needs of our patients,” said Joe Belliveau, MSF Operations Manager. “Our immediate concerns are to provide emergency medical services, get food and supplies to people, and get our HIV patients their lifesaving treatment.” In their effort to find a safe haven, people are trying to flee to southern Bangladesh. MSF is disturbed by reports that the Bangladesh government is denying access to people attempting to flee the violence and seek healthcare across the border. MSF also provides medical services in Bangladesh, and is ready to treat anyone in need of assistance, regardless of their origins.

“People seeking refuge and in need of food, water and medical care should be allowed to cross the border,” continued Belliveau. “In both Myanmar and Bangladesh, MSF is trying to reach those affected by the violence, but they should also be allowed to reach us.” In Rakhine, MSF has been providing medical services for 20 years, focusing on maternal health and infectious diseases such as malaria, diarrhoea, HIV/AIDS and TB. In 2011, MSF conducted more than 487,000 consultations, and has over 600 patients on antiretroviral treatment for HIV/AIDS. In addition to meeting immediate emergency needs, getting MSF’s regular programmes back on track is critical to the longer-term health and well-being of people from all communities throughout the state.

In all of its activities worldwide, MSF’s sole aim is to ensure that the most vulnerable people – regardless of ethnicity, origin or religion – receive the medical humanitarian assistance they require. MSF’s medical programme in Myanmar is one of its largest anywhere in the world. MSF is the country’s main AIDS treatment provider and has been at the forefront of the fight against malaria.



‘MSF OCA **Operational Bulletin**,’ 18 June 2012 (in English), edited.

Extract:

Myanmar/Bangladesh: We have released a press release today on the situation in Myanmar and Bangladesh. In quite strong wording it urges the Bangladeshi authorities to open the border for refugees that are fleeing violence and are seeking healthcare, security and food across the border. At the same time MSF seeks to improve its access in Myanmar to treat victims of the recent violence while also trying to bring urgent needed healthcare to existing patients. In the past weeks we have been contacting a lot of organisations in Bangkok who can speak out in stronger terms on the issue since they don’t have (medical) activities on the ground and many organisations have expressed their concern at the ongoing violence in Rakhine. In the meantime, we are hearing about looting, robberies, etc. and about displacement and arrests. Only having received previous permission can Rohingya travel outside of their townships; if found sheltering at other people’s houses without such permission, they risk arrest.

On 19 June 2012, two men were sentenced to death for the rape and the murder of the Buddhist woman on 28 May, which had triggered the wave of violence.

According to the State media, more than 30,000 people of all communities had fled their houses, which were burnt and destroyed during these riots.

According to the UN World Food Programme, they distributed emergency food aid to 66,000 displaced people in Sittwe, Maungdaw, Buthidang, and Rathedaung. They

reported that 90,000 displaced people were in need of assistance. The Myanmar government asked for assistance to manage the forty temporary displaced camps, put in place in six Rakhine towns.

In Bangladesh, despite dire reports from Rakhine refugees received by the UNHCR, the authorities continued to repel refugees from their borders.



“Unrest in Western Myanmar: Two Men Sentenced to Death”, **AFP** (Yangon), 19 June 2012 (in French).

Extract:

Two men have been sentenced to death in Myanmar for the rape and murder of a woman, a case that provoked a series of bloody communal riots in the west of the country, reported a government official on Tuesday. “The court informed them that they could appeal to the Supreme Court within seven days,” specified the source, according to which the two men were judged guilty of “murder, rape and theft.” [...] According to the state press, over 30,000 people – Buddhists from the Rakhine ethnic group and Muslims from the stateless Rohingya minority – have fled their homes, torched and destroyed during the riots. Some 50 people have been killed and the same number injured in two weeks, according to official figures. Rohingya officials say that the figures are much higher, but the AFP has been unable to confirm these allegations.



“The UN is Mobilising to Support Burmese Refugees”, **AFP** (Geneva), 19 June 2012 (in French).

Extract:

The UN is mobilising resources to bring support to the tens of thousands of Burmese refugees fleeing the regions where communal riots are flaring in the northern state of Rakhine in Myanmar.

“The UN’s World Food Programme distributed emergency food assistance to 66,000 displaced people last week, mainly rice and beans,” declared the WFP spokesperson on Tuesday in Geneva. The WFP distributed aid in the towns and cities of Sittwe, Maungdaw, Buthidaung and Rathedaung. The WHP [World Health Partners] is in the process of developing a three-month food assistance plan that will require a new appeal for funding from donor countries. [...] About 1,600 homes have been destroyed by the unrest.

An inter-agency team, including UNHCR, is set to visit Sittwe on Tuesday to carry out a needs assessment. The Burmese government is currently managing over 40 temporary accommodation camps in six towns in Rakhine State, and has asked for humanitarian aid. The UNHCR is also monitoring what is happening in Bangladesh, on the other side of the Myanmar border. Over the weekend, seven boats carrying 128 people from Myanmar, arrived in Bangladesh. Despite the interviews conducted by UNHCR, Bangladesh stood by its decision to keep the borders closed. Some 139 people were turned back on Monday by the Bangladeshi authorities at the borders.

On 20 June 2012, inter-ethnic and religious violence resumed north of Sittwe. Increasing administrative constraints prohibited MSF OCA from augmenting the expatriate team size, a move that could have improved perceptions around

impartiality. Subsequently, MSF OCA even considered “composing teams along religious and ethnic lines and deploying them in corresponding ethnic areas.”



“Communal Violence in Myanmar: Further Riots, Three Dead”, **AFP** (Yangon), 20 June 2012 (in French).

Extract:

The communal violence claimed another three lives when further riots erupted in the west of Myanmar, despite the state of emergency declared for the past 10 days, a governmental official told the AFP on Wednesday. The same source also said that three members of the Rakhine ethnic minority, mostly Buddhist, were killed on Tuesday in the village of Yathedaung, 60 kilometres north of Sittwe, the capital of Rakhine State (otherwise known as Arakan).

“The actual figure could be much greater,” he added, assuring us nevertheless that the situation “was under control in most of Rakhine State.”



‘MSF OCA Operational Platform **Minutes**,’ 20 June 2012 (in English).

Extract:

Myanmar. In Rakhine state, following recent unrest leading to disruption of our programmes, the community remains divided along religious and ethnic lines. We are now looking into composing teams along the same lines and deploying them in corresponding areas. More expatriates are needed on the ground to increase perceived impartiality, but the state appears to be opposing this, the first expat travel permits already denied. Also, a new editor at the *Lancet* (an ex-Access Campaign person) expressed interest in us providing information for a series of articles. We should be proactive and consider our message.

Myanmar/Bangladesh. Following PR [Press Release] of Monday ongoing monitoring of events and analysis whether any new comms is required.

JUNE 2012 - MSF NATIONAL STAFF IMPRISONED AND DETERIORATED ACCESS

In late June 2012, a dozen relief workers, half of which were working with the UN and the other half for MSF OCA, were arrested and jailed by the Rakhine authorities.

On 29 June 2012, MSF OCA issued a reactive communication confirming that several of its staff were detained and expressed concerns about the safety of all patients as well as the MSF staff. They said MSF hoped to resume medical activities as soon as possible.

On 6 July 2012, one Buddhist MSF staff member was released from jail without any charge. However, there was no access to the remaining five detainees. An updated, reactive communication was issued.

Later in July 2012, another MSF OCA staff member, 'R,' was sentenced to ten years in prison. Since the beginning of the detentions, MSF OCA provided all possible support and attempts to obtain their release.



"Myanmar Holds Relief Workers After Outbreak of Violence", *International Herald Tribune*, 29 June 2012 (in English).

Extract:

About a dozen relief workers have been detained in Myanmar in the past two weeks after an eruption of sectarian violence that resulted in dozens of deaths and drove tens of thousands from their homes, officials said Thursday. The workers, half with United Nations agencies and the rest with Médecins Sans Frontières, were detained by the police and the military intelligence at different dates and locations.



"Reactive Line Re: Detained Staff Myanmar," **Message** from Jo Kuper, MSF OCA Communication Advisor, 29 June 2012 11:09 (in English).

Extract:

Hi all,

You may have seen some reports about NGO staff, including MSF staff, being detained in Myanmar. The International Herald Tribune article is attached, and some further reporting is here.

A reactive line you can use is below this message.

Reactive line

MSF can confirm that some of its staff members have been detained. We are in touch with the authorities to try to confirm their wellbeing. MSF has temporarily suspended activities and reduced staff in its Rakhine state projects. MSF is obviously concerned about all of our staff in this uncertain situation. We are in contact with staff wherever possible. Suspension of activities means the disruption of life-saving primary healthcare that MSF has provided to all communities in Rakhine State for the past two decades, including the provision of urgent anti-retroviral treatment to HIV positive patients. MSF is concerned about the safety of all its patients and staff, and hopes to resume medical activities as soon as possible, in order to avoid unnecessary lives being lost.



"Myanmar detainment" **Message** from Jo Kuper, MSF OCA Communication Adviser, 07 June 2012 12:52 (in English).

Extract:

Hi all, from the back of the AFP article that went out this morning [...] there has been renewed interest in the MSF staff detained in Myanmar. To let you all know that we heard this morning that one of the staff members has been released without charge. The general reactive line remains the same just updated with the new information. If you get further queries please direct them to me or Vero [...]

Reactive line: MSF can confirm that some of its staff members have been detained. One staff member has been released, and five staff members are still detained. We are in touch with the authorities to try to confirm their wellbeing. MSF has temporarily suspended activities and reduced staff in its Rakhine state projects. MSF is obviously

concerned about all of our staff in this uncertain situation. We are in contact with staff wherever possible.

Over the following months, MSF OCA's operational restart in Rakhine was partly hampered by the authorities' denial of access and partly by lack of national staff. Threats against INGOS and particularly MSF, which was accused of being biased and not neutral continued to deter staff to join the organisation.

On 12 July 2012, the President of Myanmar Thein Sein declared to the United Nations that the only solution would be to expel the Rohingya to other countries or to resettle them in camps overseen by UNHCR.



'MSF OCA **Operational Bulletin**,' 29 June 2012 (in English)

Extract:

Myanmar: The situation in Rakhine State is slightly calmer but the process of restarting operations is extremely difficult due to a lack of access of key outside staff, partly due to personal fears and partly due to denied access. The problem is particularly acute in Sittwe where communal divisions are so deep and emotions so high that MSF local staff are not comfortable to restart activities, even toward their own respective communities. The situation is exacerbated by the publicised detention of MSF staff and the vitriolic (social) media activity that has described MSF and other agencies as biased and not neutral. It will take time, especially in the Sittwe area, to address the deep rift and find a way to restart activities in a safe way. One plan is to start a dialogue with the different communities through community/ religious/ business leaders. Luckily some other relief agencies have not had the type of publicity that MSF has had and are in a better position than we are to start some health and nutrition activities. We are also looking at different ways to ensure ART resupply for HIV patients.



“Re: Fw: Myanmar Humanitarian Meeting”, **Message** from Maria Guevara, MSF OCA Medical Coordinator in Myanmar to Fabien Dubuet, MSF Representative to the UN in NYC, 16 July 2012 (in English), edited.

Extract:

Situation remains tense in general between the communities but no outright violence at the moment. The hatred between these two communities runs so deep that no one can begin to resolve this with a flick of the wand. The only hope was that the govt would remain neutral and try to solve this democratically and fairly. Unfortunately, things do not look good after the statement that Thein Sein made the other day about Resettlement of the Rohingya to a third country and that they are not legal in Myanmar. The perception on the part of the Rakhine community of INGOS and UN is really bad. The social media has been the worst propagator of unfounded rumours that all believe to be true. The community is new to this media and if it is published then it must be true. The culture is not there to triangulate and seek verification of info. We therefore become the butt of the joke. They are using different means of threats and accusations, intimidation factors through letters for examples. Different influential groups are

involved, especially the monks sadly enough. Because of this we struggle to gain access to the population, Rakhine or Rohingya. We are making little headway though. [...]

3) Through the MoH and some hard negotiations and advocacy with the Medical association Red Cross, etc. we will soon be sending some MDs (tomorrow) under the MoH Bag to work in the Rakhine camps to begin with. We are hoping to secure a consultation space at either the MoH facilities or Medical Association office for HIV patients as well (still in negotiation). With the help of PHAS (Persons living with HIV/AIDS) (self-help groups) and our HIV pts and some MSF Staff, we have been able to reach over 60% of our HIV cohort (we have around 670 pts +/- in all of Rakhine State on ART) but unfortunately at least over 100 have already had drug interruptions. Unless we secure proper consultation and constant drug supply, we cannot restart them due to risk of complications/side-effects from restarting and higher risk of development of resistance if there is stop and go type management. Malaria is worrisome, esp. in this peak season. We are trying to work with the National programme to resupply malaria field sites and they are assisting us with this. For NRS though, our malaria field sites remain closed. We have however been able to keep one of our clinics open for dispensing of ARV drugs only a couple of hours a day. We are also working with the Township Medical Officer there in providing medical aid in the camps around MGD [Maungdaw] town only. Access to the other population remains nil at the moment, not cleared by the community.

4) The malnutrition situation is very critical according to ACF and Save's [Save the Children] recent nutrition assessment with a quoted SAM [Severe Acute Malnutrition] of 7.5% and GAM [Global Acute Malnutrition] of 23% across the board (obviously the situation is worse in the other camps). Apparently, this is fast becoming a sensitive matter and just recently, WFP has also been receiving threats about providing assistance in these camps. (They had been the only ones able to access them with light armed protection.)

5) In-country, we have been pushing on a step by step approach with keeping a solid and unified voice about neutrality and the criticalness of the situation but medically speaking time is ticking and the clinical concerns will only get bigger (in probably a very unbalanced way considering the poor baseline of the populations to start with). Reality is that the only hope of access we see is through providing care first to the camps (where of course aid is needed anyway) and improve our visibility that way. Is this selling ourselves short? Perhaps it can be seen as such but if we bulldoze our way through to get to the other side, we will end up kissing any hopes of ever working in the area on a long-term basis goodbye. And at the end, there will most likely be more deaths as a result. When is or will enough be enough? We are in deep discussions on the different scenarios now as we speak and will be brainstorming together with the HQ (hopefully to come and join us here in person) on the way forward for MSF.

6) For the detainees, still no word about those remaining (5 still). Of note, normally the process is that they have 30 days to bring detainees to court to state official charges or not, so we do expect staff to come up on trial soon. We are still trying to obtain contact and see how best to assist them if needed. At the moment the stance is, of course, any charges that has been placed on them due to their association with MSF we will help with. Outside of that, no. But since we are not sure of the charges made, we cannot even make that call at this time.

7) Now what is UN doing about all this. I can tell you at field level the usual disaster of coordination under them exists but then again, what can we really expect. On a larger scale, what do they have to say about the President's statement? Where are they in all this? Many here, INGO-wise, are ready to push the UN even harder or at least would like to shout at them. It is hard to be caught between a rock and a hard place. There is unfortunately no right or wrong answer but definitely there should be a response

somewhere. It is not easy for any of us but they should step up to the plate, one would think. [...]

Maria

Me again.

Forgot to add – we understand and are clear about our purpose to be in Rakhine (internally) but indeed we do have to acknowledge our own mishandling of communications and perceptions about MSF in the area (rather slow in responding – many plans to do so but not fast enough in the implementation) even amongst our staff. Here as much as anywhere else, or perhaps even more critical here, is the need to be seen as fair and balanced. The Rakhine are poor themselves with many needs as well. (Rakhine being the second poorest state in the country, second only to Chin.) They are second-rate citizens according to the general Myanmar population and suffer from the middle child syndrome (I think). Kind of like the little brother picks on the even littler brother because he is taking out his aggressions from being picked on by the big brother in the first place. (Perhaps that is oversimplifying it a bit but close enough.)

They do have a point of needing assistance themselves. A bit hard to swallow fairness when all they see these past 20 years is aid going to one side. I can imagine that they would see it another way. This does not of course justify their treatment of the Rohingya but just trying to understand their point of view. In any case, our access now is through medical advocacy (as it always has been for this country) but we need to be balanced or perceived to be so in our way of providing it. [...]

Maria



On Friday, every mobile team would come from the field. The Buddhists would beat members from the Muslim community, so sometimes we had to say: “It is a medical team, we are MSF. If you target us you are not targeting Muslims, you are targeting MSF.” Some people understood and some others still tried to attack, and people ran. Once, one of our driver colleagues signed for entering the camp but forgot to sign out. Like many of us, he was out of his mind. Then he was on the road, going back to the office with the team. A few days later he was arrested. They said they did know where he was ... MSF brought all the people that were in the car with him as witnesses to try and release him.

R, MSF Myanmar Staff, fled to Bangladesh in 2017 (in English).

MSF OCA continued to implement a mix of communication via “reactive lines” and regular advocacy activities in the form of confidential meetings with the main actors, led by the heads of missions and Operations managers with support of the MSF International HART:

- **On 16 July, the MSF International Representative to the UN met informally a representative of the Burmese Rohingya Association of North America (BRANA) at a UN meeting.**
- **On 17 July 2012, the MSF representative met with the Special Adviser on Myanmar to the UN Secretary General who recommended MSF to privilege “descriptive” public communication focusing on the medical and humanitarian consequences of the discrimination policy against the Rohingya.**

- **On 20 July 2012, the MSF OCA Operational Coordinators for Bangladesh and Myanmar attended a closed-door meeting on the Rohingya crisis in London with other organisations and representatives of the British government.**



'Message from Fabien Dubuet, MSF Representative to the UN in NYC to MSF OCA and MSF OCA Operations Managers and advisors,' 19 July 2012 (in English).

Extract:

Informal Meeting with [...] [Chairman of the Burmese Rohingya Association on North America [Press Release]] 16 July 2012 [...]

- Note this was the first meeting organised by the UN with a Rohingya representative at the HQ level. Even though the gathering was informal, [Professor] said this was quite a step for him and wished this could be the beginning of a more consistent dialogue.
- [...] even though his narrative and presentation [...] contained some tough language ("ethnic cleansing", "crimes against humanity" or "carnage"), he was nuanced in his remarks, flagged there was some intense debate within the Rohingya groups on how to qualify this violence and insisted on the need for a peaceful solution through dialogue with the Government of Myanmar. He also advocated for a multi-confessional and multi-ethnic Myanmar with communities living in harmony with each other and excluded any claim of autonomy or independence for the Rohingyas that would not respect the territorial integrity of Myanmar.
- He admitted that the Rohingya representation and diaspora were still fragmented and that this was the move towards more unity was "a work in progress" but also a request formulated by the Secretary-General of the OIC. [Professor] also said the Rohingyas did not benefit from a lot of support from the other communities inside Myanmar, "except the Christians maybe" (Karens and Kachins).
- He also admitted that contacts between his advocacy groups and Rohingyas in Myanmar (including with the 3 Rohingya members of Parliament) were "very limited", mostly because "there was a lot of fear" from them.
- [Chairman] considers that "it is the best time" to push the envelope on the Rohingya situation because of the political transition in Myanmar and said he was actually disappointed about the recent decisions of the US Government.

Bilateral Meeting with Vijay Nambiar [Special Advisor on Myanmar to the UN Secretary-General] 17 July 2012

- While we have maintained a continuous dialogue with his office and his team, this was our first meeting with the Special Advisor himself. [...]
- Nambiar was very familiar with MSF's activities in Myanmar, in terms of scope and nature. He understood the need to balance our involvement and advocacy towards the Rohingya with our broader medical activities in the country. Warm and positive about MSF in general. As expected, he enquired about the whereabouts of our detained staff members (but did not offer to help/note it was decided with the operations not to ask for such support). [...]
- Regarding the use of public communication on the situation of the Rohingyas, Nambiar said he did not think there was more space on that front because of the political transition and the ongoing reforms. [...] He also said "descriptive" public communication about the situation of the Rohingya would be fine. He agreed that our best card was our medical and operational identity and that the challenge for us was to keep this angle and ensure our statements be perceived as focusing on the medical and humanitarian consequences of the discrimination policy.



'Rohingyas Roundtable – London, **Message** from Sandrine Tiller, MSF UK Programmes and Humanitarian Affairs Advisor to MSF OCA and MSF OCG Programme Coordinators and Advisors on Myanmar and Bangladesh,' 19 July 2012 (in English).

Extract:

The main objective of the meeting was to brief others on the ongoing situation of the Rohingyas as well as the current crisis, but to look also at what potential openings there were to influence change in Myanmar in particular and possibly in Bangladesh. It was essentially, a meeting to mobilise others.

Key points made by the panellists (MSF, ACF and the International Observatory of Statelessness): Myanmar

- There is an opportunity now to link the opening of the country with ethnic reconciliation.
- MSF is witnessing the health consequences of state policies which target and discriminate against the Rohingyas.
- Segregation is a worry – it's happening already. Camps are being built. Reconciliation and integration are key elements of a future solution.
- Social media is inciting hatred, and there are false accusations against NGOs and the UN leading to a climate of fear and suspicion.
- Malnutrition rates are over the emergency threshold.

It's important not to get overwhelmed by the regional dimension; the problem originates in Myanmar. The solution should be found there.

Bangladesh

- How to put pressure on the Bangladesh government? Which donors might have influence? It's not easy, there is just a lot of resistance to even discuss the subject in Bangladesh.
- Community reconciliation and understanding are also vital in Bangladesh, this has to be part of finding a solution.
- UNHCR is very much hampered by the Government's refugee policies (they have not signed the convention) and they do not recognise Rohingyas as legitimate refugees.

General

- Is this a matter for the Security Council? It should be taken up higher, this will help UNHCR and others get more traction.
- We should also call upon regional bodies OIC and ASEAN to support finding a solution to the Rohingyas issue.
- Rohingyas should be supported to build their capacity for advocacy and have representatives that work together.
- It's also important to engage journalists and issue public condemnations. Public attention can avert atrocities.
- Trade sanctions on Myanmar shouldn't be lifted yet – this is an important pressure point for the Government.
- International business should be lobbied – there is an aspect of corporate social responsibility that can be pushed. [...]


MSF reflection and follow-up

I think this kind of roundtable provides a good opportunity to mobilise our peers from the sector (including Human Rights, campaigning, multi-mandate and peace building NGOs) as well as academics and researchers. [...] MSF should continue its global approach to lobbying for the Rohingyas. OIC and ASEAN could be targeted, but also it would be worth considering undertaking roundtable discussions with academics and NGOs from

the Muslim world; it seems the Rohingyas are not quite yet on their radar and they could be quite influential.

JULY 2012 - ULTIMATUM FROM BANGLADESHI AUTHORITIES

On 24 July 2012, MSF OCA received a letter from the Bangladeshi Humanitarian Affairs Bureau ordering that MSF Holland cease “unregistered” activities in Kutupalong camps. The letter stated that *“The Rohingya citizens of Myanmar are encouraged to come to this country because this organisation is providing rations, financial support, overseas travel, as well as other attractive benefits to Rohingya.”* It accused MSF of *“spreading negative information through international news agencies that harms the image of Bangladesh.”*

Despite MSF OCA's ongoing application to register “unregistered” activities, they decided to continue operations and take the advocacy actions to the next level. On 3 August 2012, MSF OCA received notification from the Bangladeshi government that they had three days to close their programme in Kutupalong. ACF and Muslim Aid received similar letters. [V6](#) 

Meanwhile, Human Rights Watch published a report which held the Myanmar government responsible for the June 2012 clashes in Rakhine state. This triggered an increase in media requests toward MSF OCA teams.

MSF OCA wanting to keep a low profile, issued cautious reactive lines on both situations in Myanmar and Bangladesh. However, in the proceeding days, they decided to be more proactive, giving interviews on the situation in Kutupalong as a result of heightened media requests from leading organisations.

Several international actors, including the UNHCR and the US State Department also went public to support MSF.



“Regarding To Close All The Unapproved Activities of Voluntary Organisation ‘MSF Holland’ in Cox’s Bazar District”, **Letter** from The People’s Republic of Bangladesh NGO Affairs Bureau to MSF Holland Head of Mission, 24 July 2020 (in English).

Extract:

It is to notify in the proper subject, there is no project approval of voluntary organisation “MSF Holland” issued from NGO Affairs Bureau to conduct any activities in Cox’s Bazar. In this circumstance, evidence became true through Bureau’s investigation that this organisation is providing medical healthcare services as well as other services to the illegal shelters Myanmar citizens in Cox’s Bazar district.

02. The organisation is spreading negative information to disregard the image of Bangladesh through international news agencies.

03. The Rohingya citizens of Myanmar are encouraged to come to this country because this organisation is providing ration, financial support, overseas travel as well as other attractive benefits to Rohingya.

Above-mentioned activities of this organisation are unacceptable. Under this circumstance, it is instructed as well as requested that the organisation shut down its all prevailing unapproved activities in Cox's Bazar district immediately and to inform to NGO Affairs Bureau, therefore.



MSF OCA Ops Platform Meeting **Minutes**, 1 August 2012 (in English).

Extract:

2. Strategic Threats and Opportunities

Bangladesh. The government has issued us with a letter ordering that “unregistered” operations be ceased in Kutupalong, Cox's Bazar. We have an application in process, but stalled by the government. Other agencies received similar instructions. Muslim Aid plans to close operations and ACF is reducing services with the plan to renegotiate access at a later date. We plan to continue operations and lobby for high-level meetings.



'Dhaka Bans NGOs from Helping Rohingya,' **Al Jazeera** (Doha), 3 August 2012 (in English).

Extract:

Bangladesh has ordered three international charities to stop providing aid to Rohingya refugees crossing the border from Myanmar where they have fled persecution and violence. Local administrator Joynul Bari said on Thursday that France's Doctors without Borders (MSF), Action Against Hunger (ACF) and Britain's Muslim Aid UK have been told to suspend their services in the Cox's Bazar district bordering Myanmar. “The charities have been providing aid to tens of thousands of undocumented Rohingya refugees illegally. We asked them to stop all their projects in Cox's Bazar following directive from the NGO Affairs Bureau,” Bari told the AFP news agency.

Bari said the charities “were encouraging an influx of Rohingya refugees” from across the border in Myanmar's Rakhine state in the wake of recent sectarian violence that left at least 80 people killed. The charities have provided healthcare, training, emergency food and drinking water to the refugees living in Cox's Bazar since the early 1990s. MSF runs a clinic near one of the Rohingya camps which provides services to 100,000 people.



“The Government Could Have Stopped This:” Sectarian Violence and Ensuing Abuses in Burma's Arakan State,' Human Rights Watch **Report**, August 2012 (in English). https://www.hrw.org/sites/default/files/reports/burma0812webwcover_0.pdf

Extract:

Drawing on 57 interviews conducted in Burma and Bangladesh with Arakan, Rohingya, and others, this report describes the initial events, the acts of violence that followed by both Arakan and Rohingya, and the role of state security forces in both failing to intervene to stop sectarian violence and directly participating in abuses. It examines the discriminatory forced relocations of Rohingya by the Burmese government from an Arakan population that feels long ignored.



'Reactive Lines on the Rohingya Situation in Myanmar (OCA) **Message** from Diderik van Halsema, MSF OCA Communication Advisor to MSF Communication Advisors,' 3 August 2012 (in English).

Extract:

Dear all

As you might have heard/read there was significant attention for the Rohingya issue in Myanmar following the release of a report by Human Rights Watch[...] As a result, there were a number of media inquiries and therefore we have come up with a reactive line (see attachment) on the current situation in Myanmar with regards to MSF's programme in Rakhine State. Pretty much at the same time AFP released a story on the situation in Bangladesh where the government ordered 3 INGOs to stop their assistance to the Rohingyas in Cox's Bazar district (Kutupalong) including MSF. It was picked up by a number of media in the UK, US, SA and Sweden as well as by BBC and Al Jazeera.

<http://www.aljazeera.com/news/asia-pacific/2012/08/2012827524058965.html> <http://dawn.com/2012/08/02/bangladesh-bans-foreign-charities-helping-rohingya/>

As a result, we released a reactive line as well on this particular situation which you find attached too. For both stories: we are trying to keep a very low profile on this. Mainly because of operational reasons. That might be frustrating as in some cases the media pressure is quite intense but at this stage, we are not willing/able to say more than the attached reactive lines.

Myanmar reactive line – 3 August 2012

MSF was forced to suspend most of its medical activities in Rakhine State on June 9 when violence erupted, which put its clinics and staff in danger. Since then, MSF has been able to resume only part of its activities including the provision of lifesaving HIV/AIDS drugs to some of our patients. However, despite our efforts, we have not been able to restart our services in our clinics in Maungdaw Township (4 in total) and Sittwe Township (2 in total), that remain closed. Continued suspension of these services means the disruption of lifesaving primary healthcare, including the provision of urgent antiretroviral treatment to HIV-positive patients and TB treatment.

Until today we have not been able to assess the needs of the population, displaced or not, that have developed during the current crisis. In the meantime, MSF remains concerned about the safety and well-being of all its patients and staff, and hopes to step up its medical activities as soon as possible in order to avoid unnecessary lives being lost.



“Reactive lines on the Rohingya situation in Bangladesh (OCA)” **Message** from Diderik van Halsema, MSF OCA Communication Advisor to MSF Communication Advisors,' 3 August 2012 (in English).

Extract:

Bangladesh reactive line – 3 August 2012

There have been some media reports on the ban of international NGOs working in Bangladesh assisting the Rohingyas

<http://www.aljazeera.com/news/asia-pacific/2012/08/2012827524058965.html>

<http://dawn.com/2012/08/02/bangladesh-bans-foreign-charities-helping-rohingya/>

This led to some additional inquiries from various media asking for a response from MSF. Please find below the reactive line that you can use in case you get follow-up questions “MSF does confirm we have received a letter from the Bangladeshi authorities requesting us to stop our activities in MSF's project in Cox's Bazar district. As we are currently

discussing this matter with the Bangladeshi authorities we refrain from further comment on this issue.”

Internal only

We have received a letter requesting us to stop our activities; but the order hasn't been implemented so far. Our activities continue unhindered for the moment and we seek ways to ensure that we can continue to do so and we don't want to jeopardise the current fragile balance for the sake of an external soundbite putting additional pressure on the teams on the ground. If this changes in the coming days we will reassess our public response.



“Update on Bangladesh/Rohingya project”, **Message** from Diderik van Halsema, MSF OCA Communication Advisor to MSF Communication Advisors, 8 August 2012 (in English).

Extract:

As communicated by us previously, last week MSF received notice to end activities in Kutupalong from the Government of Bangladesh. While we initially chose not to comment, over the weekend we changed tack to respond to a number of interview requests with leading media (AFP; BBC; Aljaz-Eng) to emphasise the need to stay based on the ongoing high medical humanitarian needs (objective: plea to stay and rally international support). Since then, a number of other international actors have followed with public statements, notably UNHCR <http://www.unhcr.org/5020ed329.html> and the US State Department [...]

With these now taking a strong public position, operations once again wish to resume a low-key presence publicly in order to protect what little space is left for negotiation. We are trying to strike a difficult balance between raising the alarm and generating international support, while not closing down any last chances for negotiation with the Government, who are highly sensitive to international reporting. Therefore, for the time being we ask that press officers maintain a REACTIVE position on this issue. If asked, you can refer journalists to the information below, also posted on the MSF international site (open for use on all MSF websites) and back dated to last Saturday when we gave the interviews.[...]

Feel free to also share the public statements by UNHCR and US Gov. However, please be clear that for now MSF has no new information to share, and therefore for the time being is not able to respond to new media requests as we await to see how the situation develops.

Internal information:

For the time being we continue to work in Kutupalong, and to push bilaterally through MSF's strong advocacy network to try and turn this situation around. [...]

MSF website text:

MSF urgently seeks ways to continue medical assistance in Bangladesh

Around 100,000 people risk losing access to medical aid, as Médecins Sans Frontières (MSF) is given notice to end activities in Cox's Bazar, Bangladesh. MSF is deeply worried by the announcement and the impartial medical organisation is urgently seeking means to stay in order to continue to provide lifesaving healthcare. MSF continues to seek dialogue at the highest level with the Government of Bangladesh to understand what can be done to turn the situation around.

MSF's health centre, located in Kutupalong, provides comprehensive medical assistance to an average of 5,000 people every month – just under half of whom are children under five. Each month MSF provides around 1,300 antenatal consultations, 250 postnatal consultations, and performs 50 deliveries, as well as treating 200 people in the inpatient department – half of whom are children suffering from severe malnutrition. Other activities include mental healthcare, therapeutic feeding for malnourished children, emergency obstetric care; and referrals.

MSF has provided assistance to people in the Cox's Bazar area since 1992, and has run its clinic in Kutupalong for several years. During this time MSF has witnessed an unchanging need for humanitarian medical aid among the Bangladesh host community, and large number of Rohingya refugees (registered and unregistered) in the area, equal numbers of whom access the free medical services. MSF requests all stake holders, Governments and the international community, to recognise the urgent need for ongoing lifesaving medical care for these highly vulnerable people.

US State Department text:

7 August 2012

Statement by [...] acting deputy spokesperson:

Humanitarian Access for Rohingya in Bangladesh

The United States is deeply concerned by the Government of Bangladesh's stated intent to shut down non-governmental organizations that have been providing critical humanitarian aid to Rohingya residing in Bangladesh. We urge the Government of Bangladesh to permit these NGOs to continue providing humanitarian assistance to the Rohingya, other vulnerable individuals fleeing the violence in Burma's Rakhine State, and the local Bangladeshi population in the Bangladesh-Burma border region.

We are continuing to monitor ethnic and sectarian tensions in Burma's Rakhine State and continue to call for restraint, an end to violence, and the upholding of principles of non-discrimination, tolerance, and religious freedom. We have consistently urged the Burmese government to reach a peaceful resolution as soon as possible and to bring those responsible for the violence to justice in a timely manner and in accordance with due process.



If anybody ever went to visit our programmes in Kutupalong, they always came back – myself included – saying this is a really important project. But we were always having discussions about how high profile should we be. Then there was a big drama with ACF, Muslim Aid and us where we received a letter basically telling us to leave Kutupalong and Teknaf because we were working without authorisation, which we really were. It was complicated. There were some rumours of corruption by Muslim Aid team in Teknaf. So, we were concerned about how closely to align ourselves with them. We were very close with ACF anyway because we rented land on which there was our clinic and their feeding centres that we shared. I did some media then. There was a BBC web piece basically pointing out the consequences of NGOs having to leave Bangladesh or the Cox's Bazar. I did also a round of meetings in London in particular because the Foreign Office and DFID were very engaged. ECHO [European Community Humanitarian Office] was also very engaged at the time. We had some ECHO funding and they were very supportive of us and incredibly interested in the project staying. And so, they mobilised EU ambassadors to speak to the government of Bangladesh, though EU ambassadors also had a difficult time getting to the high levels of the government of Bangladesh. We didn't leave, but it was quite high risk. That letter was an important one. That was quite a pivotal moment, because it was then very clear to people that our presence

in Bangladesh wasn't guaranteed in the way that people thought that it was, when they were doing this Myanmar/ Bangladesh comparison.

*Christopher Lockyear, MSF OCA, Bangladesh Operations Manager, late 2010-July 2014
(in English).*

In August 2012, the government of Myanmar considered placing tens of thousands of displaced Rohingya in detention camps. MSF OCA teams reflected on how to respond to this scenario. The MSF OCA Emergency Team was sent to Rakhine to support the Myanmar team in organising emergency operations in these particularly difficult conditions.

The MSF OCA operations department tasked OSCAR, the OCA department in charge of operational support for communications, advocacy, and representation to draft a reflection paper analysing the main dilemmas posed by this situation. Questions included were how to bring assistance to the Rohingya without being seen as complicit in the segregation policy of the Myanmar government? And, how to bring assistance to the Rohingya when the Rakhine population in general viewed MSF as biased in the favour of the Rohingya?

Everybody agreed on the need to improve communications with the Rakhine Buddhist community in order to communicate MSF's impartial approach.



'MSF OCA Ops Platform Meeting **Minutes**,' 1 August 2012 (in English).

Extract:

Myanmar / Bangladesh: potential scenarios, risks, strategies

- Purpose. A discussion of the current situation is required to draw attention to our current difficulties in restarting operations in Rakhine state, the likelihood of 'detention' camps for the Rohingya in Myanmar, and the difficult question of whether to provide aid to these camps.
- Myanmar. The government is discussing housing around 60,000 Muslim Rohingya in camps in Sittwe. A group of NGOs put together a proposal for providing services to these camps. We gave input to the proposal, but intentionally sat out discussions to keep space for future decision-making. Camps exist and services are in place, but we do not know to what level. The mission is struggling with how to respond to the camp scenario and how to restart operations in Sittwe. Anti-INGO sentiment is still strong and we have only 2 expats on the ground in Rakhine and 2 in Sittwe, plus some NS [National Staff] doctors seconded to the MoH. New MSF Canada GD [General Director] Steve Cornish will be on ground next week to participate in discussions with the team as to next steps.
- Discussion.
 - Proposed prioritising lobbying high-level Buddhists at a capital and international level.
 - Suggested assessing camps unmarked, negotiate access at the gate.
 - It is frustrating that after 20 years we don't have enough high-level contacts, or staff willing and able to intervene, to gain any more access than other INGOs. On the flipside, as at least in the current situation we have little to lose in terms of actual

operations we need not be overly cautious in our approach. At a minimum an assessment of the camps is needed to understand fully the needs.



“The Rohingya in Myanmar & Forced Encampment” OSCAR **Reflections**, August 2012 (in English).

Extract:

Object: In light of explicit recent declarations for the opening of camps to deal (in part) with the displacement of Rohingya populations [...] a review of policy implications for advising on an OCA positioning has been requested by the Operations Department. [...] Encampment of (displaced) populations – what meaning for Rohingya IDPs [internally displaced persons]? If the policy were to be enacted by the Burmese government, it could emerge as a stepping-stone in the declared goals of deportation and/or segregation. Here below, a rough sketch of possible scenarios.

- Camp populations are maintained in ‘survival mode’ through aid providers – serious implications on MSF decision-making/perception (whether to accept working in such camps, under what conditions and with what level of local acceptance)
- Reinforcement of existing restrictions to further reduce livelihood opportunities (goal: full deprivation to force exile under international protection) – slow, gradual elimination of Rohingya populations in Myanmar
- Await opportunity to ‘clear’ camps (potential mass killings or organised expulsions) under security justifications and with the probable use of proxy forces to not directly implicate Burmese security forces
- Increased ability to pressure international community by using Rohingya as a bargaining chip in line with facilitation of new economic opportunities in Myanmar and overall reduction of isolation/sanctions
- Any combination of the above.

Critically, the current dilemmas linked to whether MSF would consider working in such camps comes at a time of increased stress on field operations in Rakhine: international staff have been evacuated at the beginning of the unrest while national staff has been arrested in conjunction with their activities. Publicly, MSF and other aid actors have come to bear a social media campaign accusing them of partiality in their activities, specifically catering to Muslim populations.

It is expected that the redeployment of field medical teams in Rakhine will be seriously challenged in the short term (national staff unwilling to return to work for fear of direct targeting/international staff unable to obtain required work permits and travel authorisations) – this situation is having grave consequences for the cohort of HIV/TB patients treated in Rakhine while diminishing the ability of an already vulnerable population to access both basic (primary level) and more specialised (ex: RH referrals) healthcare. At this juncture, the humanitarian situation is expected to further deteriorate in the mid-term even if the levels of violence seem to have subsided between the Muslim and Buddhist communities over the last few weeks.

In a setting of extreme polarisation where Burmese authorities are clearly a part to the conflict (reports have appeared accusing local security forces of participating in the campaign against the Rohingya through direct acts of violence targeting Muslim communities: destruction/burning of villages, arbitrary arrests and killings, impunity afforded to Buddhist groups engaged in violence), sustained efforts at examining advocacy/communications (and their impact on access, ability to operate and security risks) are required. The Myanmar context currently boasts a number of Red Flag situations calling for an increase in the level of MSF *témoignage* activities both locally

(inside Myanmar where it is believed that the key to regaining acceptance lies), at regional levels (main players: India, China, ASEAN, OIC) and internationally (UN/NGO aid system, US/UK governments, EU). It is recommended that an OCA positioning be adopted in relation to the potential Rohingya encampment policy internally and that an accompanying external strategy (silent/public advocacy, high-profile media and diplomatic campaign) be developed to support our ability to safeguard our working space in Rakhine under acceptable conditions.

Forced Encampment & MSF principles

IMPARTIALITY – Forced encampment implies that populations restricted in their freedoms have needs but questions the logic of impartiality by choosing which ethnic group would access MSF care, ensuring that specific populations are targeted for who they are, while others would not receive the aid they might need as much as Rohingya Muslims. In Myanmar, it is easy to see how camps would be used to maintain high levels of pressure on Rohingya Muslims until a more appropriate solution fitting with the Burmese government avowed policy (segregation or deportation) is available – MSF would then become a caution for the survival of the Rohingya.

INDEPENDENCE – The opening of an IDP [Internally Displaced Person] camp imposes a geographical area for humanitarian actors to work in and, potentially, the type of activities to be implemented on behalf of IDPs, fixating them to a restricted setting in which assistance can be rendered (negating operational decision-making independence). In the case of Myanmar, this could mean that MSF would become instrumental in the ethically problematic and legally questionable policy developed by Burmese authorities to further discriminate and ultimately eliminate the Rohingya populations from Myanmar.

NEUTRALITY – Camp-based assistance in the context of Myanmar would significantly alter the notion of neutrality by aligning MSF to the dominant side of the conflict (the government of Myanmar, itself responsible for the desperate situation of the Rohingyas, condemned to be stateless and treated as sub-human ‘Bengali migrants’) and restricting its ability to publicly question the policy as well as its expected consequences on the (physical and mental) health of affected populations.

Implication of Policy Decision on Encampment – Early Recommendations

Clearly, there would be a humanitarian imperative to support Rohingya communities forced into camps but this would also lead to increased pressure inside Myanmar in line with the large-scale social media campaign questioning MSF’s impartiality over its work in Rakhine. In return, this might necessitate operational adjustments following targeted assessments seeking to respond to needs of Buddhist communities affected by the June 2012 violence. While the field situation remains tense, the choices made in the coming weeks/months might alter MSF acceptance in Rakhine in the long-term – opportunities to reverse hostile perceptions over OCA impartiality should be sought.

Further, specific communications/advocacy initiatives should be developed at local and national levels inside Myanmar to try and offset some of the more problematic claims made against MSF. More visibly quantifiable products could be developed in order to leverage our presence in-country (in terms of patient volumes, including if possible, a breakdown in the ethnic composition of our patients, and essential nature of MSF projects in the Myanmar health setting). Such targeted efforts at fostering our acceptance should be coupled with an international effort meant to increase pressure on the Myanmar government over the way it plans to manage the Rohingya issue. The balancing out of local/national initiatives and the international push will be most delicate and would require dedicated resources to assess risks both in-country and with support from Amsterdam HQ over the adopted strategy.

Looking at developments across the border in Bangladesh where pressure is increasing on MSF to stop its activities in/around Kutupalong, there could also be opportunities to approach the Rohingya question in a concerted regional way. While the Rohingya issue has literally blown up in social media in the Arab-Muslim world over the last month, there are clear risks involved in being overtly seen as supporters of the Rohingya, which would then impact on Myanmar dynamics. More than previously, there is a need to rationalise work done around this theme both internally and at higher MSF levels (including the HART network efforts for ex).



I was emergency manager in Amsterdam. A few weeks after that first lot of extreme violence that had led to the displacement of people, I was asked to go to Rakhine and give some support to the mission in how to respond. At that time the team still wasn't able to live in their house. They did have some international staff back in a field and a few Myanmar national staff from outside of Rakhine, but they had only a couple of staff within Rakhine.

I went for a few weeks, and I worked with the head of mission and the coordination team and the team that was on the ground in Sittwe. It was actually incredibly difficult to work, not just because of the limitations from the government but also because of not having your usual group of national staff.

120,000 people were displaced out of Sittwe town, but also out of multiple smaller villages as well. People were displaced from their homes and many of their homes had been destroyed, burnt to the ground, and they were living in very makeshift camps in and around Sittwe and quite poor situations. It's a high rain country with rice paddies. So, drainage and water and sanitation were issues, accommodation were issues, highly overcrowded. There appeared to be a reasonable amount of freedom of movement within those different displaced population settlements, but there was sort of a cut off to be able to come back into Sittwe town so people were not allowed into the town. That obviously had quite significant implications on their access to wells, to markets, to livelihoods, to healthcare, everything. There were quite some limitations in what people were able to do or permitted to do by the government. No one, MSF included, was able to respond in a way that you would usually respond to that type of large population displacement.

After a few weeks, I came back to Amsterdam for not very long. Then things were not really going very well with the mission. It sort of collapsed a little bit just because of the extreme difficulties of working in that environment where there were large segments of the community who didn't want us to be there. And the government, who certainly within Rakhine and Sittwe itself clearly didn't want us to be there either. So, then I went back again, I think for about six weeks and then handed over to a longer-term emergency coordinator.

Dr Lauren Cooney, MSF OCA, Emergency Manager until 2012; Myanmar Operations Manager, January 2013-January 2017 (in English).

INTERSECTIONAL REGIONAL ADVOCACY APPROACHES

In mid-August 2012, three of the detained MSF OCA staff members were released, after two months of detention. Two others remained in prison. MSF OCA teams wanted to see these releases as "signalling a subtle shift in attitudes in Northern Rakhine, coinciding with an increased willingness amongst national staff to again be associated with MSF."

They perceived other 'signals' that showed an improvement in the Buddhist community's perception of MSF: better access with six expats on the ground, an MSF visit to the largest displaced camp near Sittwe, the drug resupply of malaria and HIV-AIDS programmes and the fact that some MSF staff could work in collaboration with the Ministry of Health teams. However, the MSF activity level was far below the level of the pre-June 2012 clashes, particularly in Northern Rakhine, which remained inaccessible. Further, a strategy to counter the government's desire to fully segregate the displaced into 800 isolated barracks, currently under construction, was urgently needed.

On 15 August 2012, during the OCA headquarters' weekly update meeting, the outgoing medical coordinator for Myanmar questioned whether MSF OCA should complement its diplomatic negotiation approach to advocacy with stronger public positioning and calls for unhindered access?

However, on 17 August 2012 MSF OCA issued only a reactive line once again, highlighting concerns about the lack of access to healthcare for many people caused by the ongoing violence. They also highlighted the fact that two staff members remained in detention.



MSF OCA **Operational Bulletin**, 15 August 2012 (in English).

Extract:

Myanmar: [...] Medco in Myanmar for the past three years gave an update of the challenges we face in Rakhine State. [...] The main dilemma for the team is whether our diplomatic negotiation approach that we have followed so far and which has led to small steps forward, should be complemented by a more robust positioning and call for unhindered access, even if that could feed the current hostile position of the non-Muslim population towards MSF. For sure a push is needed to improve our visibility and our acceptance to the community and develop better contacts with this part of the population.



"Myanmar Detainees – Some Good News, Update and Reactive." **Message** from Jo Kuper, MSF OCA Communication Advisor to MSF Communication Advisors,' 17 August 2012 (in English).

Extract:

Hi all,

Some good news from Rakhine State – we can confirm that 4 of our 6 staff members have been released. We are of course still very concerned about the remaining two. We are not going to say anything proactively for the moment, but if you get any questions you can send out the reactive line below. Also, we are also not releasing any names, but if journalists come to you knowing names already, you can contact me for confirmation – you can also give journalists my contacts directly. [...]

Reactive use only

MSF is greatly relieved to confirm that 4 of its 6 staff members detained in Rakhine State, Myanmar, have been released; but remains concerned about the two staff members

that remain in detention. MSF continues to be worried about all people affected by the ongoing violence that are still unable to access healthcare.



'MSF OCA **Operational Bulletin**,' 20 August 2012 (in English).

Extract:

Myanmar: Since June, seven of our national staff have been arrested in northern Rakhine, one Buddhist and six Muslims. Our Buddhist colleague was quickly released, but our Muslim colleagues have been held longer, their detention likely fuelled by a climate of anti-Muslim and anti-INGO sentiment and suspicion. Thankfully, four were freed last week, their release signalling a subtle shift in attitudes in northern Rakhine, coinciding with an increased willingness amongst national staff to again be associated with MSF. Also, we continue to gain traction with Buddhist community groups who are starting to recognise that MSF's activities have been more balanced toward both communities than they had thought. We now have six expats on the ground, three in Maungdaw, northern Rakhine and three in Sittwe. Steve Cornish, MSF Canada GD, along with Vickie (Deputy Head of Mission) were able to visit the largest IDP camp near Sittwe (where MSF had one of its largest and longest running clinics prior to the events), also a positive sign in terms of regaining access. Operationally, progress is still slow but these developments are very positive indicators that things are shifting in a way that will lead to increased operations. In the meantime, seconded MSF staff are working with the MoH, malaria field sites have been resupplied in most areas, and the bulk of ART patients have been resupplied with consultations restarting in one location. We are still operating at a fraction of the prevalence volume but the signals are more positive than they have been since the beginning of the crisis.

On 3 September 2012, an MSF meeting was held to brainstorm and create an intersectional, regional advocacy strategy including both contexts, for the coming weeks. The session included MSF OCA and MSF OCG operational managers in charge of Myanmar and Bangladesh and MSF International team members responsible for advocacy and humanitarian affairs. The brainstorming included a subsequent meeting with MSF field teams in Bangkok.

- **In Bangladesh, where MSF continued working in Kutupalong camp despite orders from the authorities to cease activities, the main objective of the advocacy strategy was to secure a high-level meeting with the government and explain that MSF's departure would have a public health and political cost.**
- **In Myanmar, the primary objective was to regain lost access to Rakhine after the June 2012 violence and to address the medico-humanitarian impact of discrimination against Rohingya.**

In both cases, this strategy's planned implementation was through bi-lateral meetings with stakeholders, whose support was considered crucial: UN, EU, USA, ASEAN, as well as diplomatic missions of selected countries in South East Asia. A window of opportunity opened to push through the messages about the Rohingya because of the international interest triggered by the June 2012 violence,

the ongoing democratic transition, and the upcoming Myanmar chairmanship of ASEAN (in 2014).

The Organisation of Islamic Cooperation was recognized as a specific contact to reach out to as they were already supportive of MSF in other contexts such as Somalia, that could help with the Bangladeshi government.

Regarding Rakhine, the MSF OCA Myanmar Deputy Head of Mission, Vickie Hawkins set up a medium-term strategic framework for advocacy activities. She acknowledged that ‘acceptance’ of MSF by the Rakhine community was too ambitious. She recommended to strengthen networking and public communication towards the Rakhine community and to provide them useful and valued services. In case all local and diplomatic efforts failed, MSF OCA should be prepared to speak out publicly. Vicki also highlighted the risk of contributing to segregationist policies of the government, particularly in the camps.



“‘Rohingya Brainstorming’ **Notes**,’ 3 September 2012, Geneva (in English).

Extract:

Present: Joe Belliveau (OCA), Coline Beytout (IO), Antoine Bieler (IO), Fabien Dubuet (IO), Kenneth Lavelle (OCG), Chris Lockyear (OCA), Andrea Pontiroli (IO), Andres Romero (MSF USA), Sandrine Tiller (MSF UK), Emmanuel Tronc (IO).

Note this brainstorming was aimed at feeding the upcoming meeting in Bangkok with field teams.

[...] Bangladesh (Chris): [...]

Advocacy strategy:

- To secure a high-level meeting in Dhaka with the Government of Bangladesh (MFA [Ministry of Foreign Affairs], PM [Prime Minister], advisor on administrative affairs); Note that a request for a meeting with the GOB has already been submitted in Dhaka (MFA, PM, advisor on administrative affairs)
- Meet with selected Bangladeshi ambassadors for advices and support to get the meeting in Dhaka
- Brief Ban Ki-moon’s executive office before the visit of the Bangladeshi delegation to the UN General Assembly.

Key messages:

Essential to provide a humanitarian and medical assistance, meaning secure our presence and ideally to get an FD-6 (Other programmes (kala azar) are going well and have received an FD-6; they can be used as a counterbalance). MSF doesn’t want to end its programme there and privileges the dialogue with the authorities before any public initiative and additional diplomatic pressure. If the MSF project is closed there will be an increase of malnutrition rates, communicable diseases, and maternal deaths. Kicking out MSF will have a public health and political cost. The first objective is to pass the message to the government directly or through other channels that MSF is requesting a meeting in Dhaka and seeking dialogue and a quiet resolution of the problem. The ultimate objective is to reiterate our willingness to continue providing support to the Bangladeshi government in addressing the humanitarian and medical needs of the Rohingya (public health issue too). Our highest cards can be played now even if we still have de facto access. From a humanitarian point of view there’s a divide between the

two countries, so the messages will be different. From a political point of view the 2 contexts can be linked depending on the interlocutor. It's a humanitarian crisis but a humanitarian solution is not a response, a political solution is needed. There will be 2 steps: first within 2-3 weeks to secure contacts and a meeting in Dhaka through Bangladeshi ambassadors; second, to involve other relevant stakeholders. Marcel [Langenbach, MSF OCA Director of Operations], Chris [Lockyear, MSF OCA Bangladesh Operations Manager], Arjan [Hehenkamp, MSF OCA General Director] and Unni [Karunakara, MSF International President] are on standby for any high-level meetings.

The targeted interlocutors are Yemen, Pakistan, Saudi Arabia, India, China should also be targeted for advocacy in addition to traditional western countries. Muslim organisations and countries should be more included in advocacy rounds. For the second stage, at EU level: while we already have the support of ECHO (see statement by Commissioner Georgieva), we now need to target both EU Member States (who never really cared for the R issue in Bangladesh, always privileging EU-B [EU-Bangladesh] trade relations) and EU Institutions beyond ECHO (External Action Service...). USAID is also an important leverage. It should be decided when scaling up advocacy from humanitarian pressure to political pressure. OIC should also be approached to encourage them to have a more comprehensive response to the Rohingya file, not just limited to Myanmar.

[...] Myanmar (Joe):

Advocacy strategy:

In general, our analysis is that there is a unique window of opportunity to push our messages on the Rohingyas due to the current crisis in Rakhine, the political transition in Myanmar, the upcoming departure of the Secretary General of the ASEAN (who is a Muslim and could exploit the diplomatic space linked to the end of his tenure) and the upcoming chairmanship of the ASEAN by Myanmar (in 2014). Greater access to respond to the needs in particular in NRS, including for international staff.

Myanmar key messages:

3 months after the beginning of the crisis, there is still a serious humanitarian situation in Rakhine;

We should insist on the medical/humanitarian consequences of our absence;

Access is needed asap to assess and respond to needs;

The discrimination policy against Rohingyas has serious medical and humanitarian consequences with a regional dimension.

There will be two phases:

- The first phase is immediate and will focus on asking for a better access to Rakhine State. Targeted interlocutors are the ASEAN Secretariat in Jakarta as well as selected diplomatic missions to the ASEAN (Indonesia, Thailand, Cambodia-current 2012 chair of the ASEAN). In NYC: India, Thailand, OIC, UN Special envoy, OCHA, Myanmar ambassador, China, Indonesia and Japan. In Geneva, it will be Myanmar, WHO and UNHCR. In Brussels, Myanmar Embassy, External Action Service Desk, ECHO, DEVCO [European Commission Directorate-General for International Cooperation and Development] and Georgieva and Piebalg's³⁰ offices will be targeted. In [Washington] DC, the DoS [Department of State], EOP [Executive Office of the President] and USAID will be targeted. In the Middle East, the OIC HQ as well as the Turkish government (which is closely following this file and is taking a less Muslims vs. Buddhists stance) should be contacted for advocacy purposes.

30. Kristalina Georgieva, European Commissioner for Crisis Management, 2010-2014; Andros Piebalgs, European Commissioner for Development, 2010-2014.

- In the second phase, a broader round of meetings in several capitals should be organised to highlight the medical and humanitarian consequences of the discrimination policy towards the Rohingya communities. This will require a document with solid medical data and field-based information and a specific effort at a regional level in East Asia (ASEAN Secretariat and the diplomatic community posted in Jakarta).

In London, it will be the Myanmar embassy, DFID, and the Foreign Office. In DC, it will be State Department, BPRM [Bureau of Population, Refugees and Migration], USAID, EOP and Congress. In the Middle East, the OIC and the Arakan Union will be contacted.

Aung San Suu Kyi could also be targeted but it is very unlikely that she will advocate for the Rohingya.

In Brussels, in addition to the interlocutors already targeted in the first phase, we would also meet selected EU Member States (revision of sanctions in May 2013). Meetings would also be held in Geneva, NYC and Tokyo with the UN system and the international diplomatic community (OIC, Indonesia, Japan, Thailand, Myanmar, etc.).



“Myanmar, Bangladesh and the OIC – Meeting with the Assistant Secretary-General for Humanitarian Affairs + Some Questions”, **Message** from Antoine Bieler, MSF International HART Representative in Middle East to MSF OCA Deputy Head of mission in Myanmar, MSF OCA Head of mission in Bangladesh, MSF OCA Operations Manager and Operational Advisor for Bangladesh and Myanmar, MSF International HART’ 14 September 2012 (in English).

Extract:

Reasons for nurturing the MSF- OIC relation:

- The OIC will most likely have a direct access to the highest level of the authorities, so we can also pass indirectly through them the messages we do as well pass to the authorities we have access to
- The OIC (as well as its partners) will be arriving in a country they know nothing about. As the OIC has a lot of respect for MSF we should not hesitate to tell them about the identified gaps and where we feel support should be provided. They are looking for this type of info and might help them avoid some traps
- About the position they might take (i.e. being pro-Muslim), there is nothing we can do about it as they will certainly not change their rhetoric for us or because we suggest them to. However, we can warn them by telling them what happened to us and by explaining that it is not only all about Muslims vs. Buddhists. Still, imagine their reaction when as newcomers in the country, they will see the difference between the IDP camps of each community...
- At a more global level, the OIC is playing an increasing role on the political and humanitarian scene (again, don't understand me wrong: it has very limited capacity to deliver but huge influence and access to the top). We have the chance to be very well positioned with this institution (long-term relationship, trust, open discussions, collaboration). Thus, I feel we need to maintain this ongoing and developing relation as much as we can
- And more concretely, we do share a hospital in Yemen, we collaborated in Somalia and the idea is to continue this trend on ad hoc basis (obviously not in Myanmar, but for me Myanmar is part of this global engagement).



'Medium – Term **Strategy Paper**, Rakhine State August-December 2012, Vickie Hawkins, MSF OCA Myanmar Deputy Head of Mission,' 24 September 2012 (in English).

Extract:

MSF OCA Myanmar – August – December 2012 [...]

This paper pulls together the threads of the strategy as it has so far been developed and provides a framework for activities for the remainder of the year.

Objective: respond to the immediate, medical, humanitarian need experienced by violence-affected communities (inter-ethnic, state security forces) and recover priority long-term programming, namely HIV, TB and malaria activities.

1. Provision of primary healthcare services for displaced communities (...) ensuring services target both communities and is appropriate to level of need. [...]
2. Respond to the primary healthcare needs of violence-affected, non-displaced communities (Maungdaw, Buthidaung, Kyauktaw and as new needs develop). [...]
3. Provision of support for emergency obstetric cases in Maungdaw and Sittwe [...]
4. Recovery of HIV/TB cohort in Sittwe, Buthidaung and Maungdaw.[...]
5. Maintain existing malaria field sites which are situated in areas of high prevalence and pilot peak-season service. [...]
6. Outbreak response [...]

In order to achieve the objective and implement medical activities as planned, the following obstacles have been envisaged and efforts to overcome them are ongoing:

1. Access

- We need to enlarge/redefine the definition of 'affected population'.
 - Now the official definition is IDPs and as a result response to immediate, humanitarian need is allowed only for this group. [...]
- Our access to the camps in ERS has so far only been achieved through a direct secondment of staff to the MoH. [...]
 - Key to improving quality and scale of what we do, is negotiating a more independent way of working but this is also contingent on there being other actors in health to provide a greater coverage.
- Physically challenging the access restrictions in NRS without official permission is not a viable option. [...]
 - We must negotiate and apply pressure at all levels, Maungdaw, Sittwe and Nay Pi Taw, and with all ministries involved, most notably Border Affairs and the MoH.
 - Pressure should come not only from MSF but from donor govts and UN agencies. [...]
 - In the case of those advocacy efforts not succeeding, ultimately, we have to be prepared to speak out, with the consequences that will bring for perceptions and the image of MSF elsewhere in Myanmar and most notably in Sittwe.
- In order to apply this pressure, we need to get a better understanding of the decision-making process between the union government and the state authorities. The state of emergency is also influencing access. How? By who?

2. MSF staff capacity

- Currently national staff capacity represents a major constraint in what we are able to achieve. In Sittwe, many of our Muslim staff are simply unable to return to work as they cannot travel into Sittwe town, due to the risk it presents to their physical safety. Our Rakhine staff remain fearful of what association with MSF and its perceived biases, means for them and their family. In Maungdaw, again many of our staff from outside of town are unable to travel to work. [...]

- Staff from outside of the area are reluctant to go to Rakhine out of fear or pressure experienced from family and friends. We have to attract emergency minded staff, who have higher tolerance levels to intimidation and pressure. We also have to continue and invest in team building processes for those local staff that are willing to return to work.
- Increased expat staff capacity is extremely important not only for technical knowledge due to constraints in finding skilled medical staff but also for reasons of independence, neutrality, proximity and monitoring of humanitarian situation. [...]
- Recruiting/mobilising support staff is a priority, no scale-up is possible without support staff.

3. External recruitment for emergency personnel has started. (...)

Tolerance of MSF

- In the current climate, acceptance of MSF and its activities is too high an ambition. Instead we aim for tolerance, based on providing a useful and valued service to the Rakhine community (extent of which is to be discussed) improved networking and public communication. It is most important to generate this tolerance in Sittwe, which as the state capital and therefore the political centre, is pivotal for our ability to work at all in Rakhine. [...]
- Increased links with civil society in Rakhine (religious leaders of both faiths, political parties, local NGOs/social welfare groups, state government and security forces, ward administrators).
- Building more links with civil society in Yangon (religious leaders of both faiths, civil society associations, political parties, think tanks).
- See who might have any influence, knowledge on the radical Rakhine groups.
- Tolerance will also be built through doing – importance of maintaining a certain level of activities that benefit Rakhine community (HIV, TB, malaria and PHC). How far do we go??
- Proactive comms:
 - Interviews so far done with 7 days news, Eleven Media Group, RFA [Radio Free Asia], Myanmar Times (which ended up on DVB [Democratic Voice Burma]).
 - Editorial to be produced for Myanmar Times (both languages) on role of humanitarian principles and how MSF works in Myanmar.
 - Possibility of an MRTV4 interview (Hard Talk style) with HoM [Head of Mission] being investigated.
 - Potential press briefing for week 40, to focus on Kachin as well as Rakhine.
 - Information being circulated to the community of Sittwe includes what MSF did in Rakhine in 2011 and the MSF in Myanmar leaflet. Some other draft materials have been developed and will be finalised if useful for the project.
 - Other issues to improve MSF profile: HIV (Thaketa construction, launch Myanmar version Lives in the Balance, HIV/TB Symposium), malaria with focus on Rakhine?

4. Longer-term issues

- The risk of contributing to a permanent process of segregation of the two communities, particularly through a presence in the camps in Sittwe, is a very real one. The government's future vision of Sittwe is as a town of two halves, inhabited by two communities that essentially live separately but are economically interdependent. In Myanmar, the CMT and projects have spent much time debating the dilemma presented by responding to immediate needs in the camps now vs the prospects of contributing to a long-term segregation policy, documented in Deputy Head of Mission trip report from June, CMT minutes of July and Sept and minutes from the advocacy meeting in Bangkok of Sept.



We started the relationship with the OIC in New York, where we had the good fortune to have an ambassador who really listened. We also thought that inviting the OIC to get involved in this issue would encourage ASEAN to do more. The OIC put pressure on and created momentum within the UN General Assembly. Links and strategic alliances between the OIC and the EU on Myanmar and the US were set up at that time. There were a lot of diplomatic initiatives. It was pretty intense.

*Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).*

OCTOBER 2012 - RESUMPTION OF VIOLENCE AND BATTLE FOR ACCESS IN RAKHINE

On 18 October 2012, the official reopening of the MSF OCA clinic in a Buddhist area, intended to be a gauge of MSF's impartiality, was derailed by Rakhine extremist protesters. MSF OCA's presence in this clinic was key to the process of re-gaining access, including in Muslim areas. However, threats against MSF staff and contractors such as local clinic landlords and hotel owners continued.

From 23 October 2012, violence flared again in several Rakhine towns where dozens of people were killed and houses were burnt, resulting in continued displacement of thousands of people.



'MSF OCA **Operational Bulletin**,' 19 October 2012 (in English).

Extract:

Myanmar: Yesterday's official reopening of our Sittwe clinic (in a new location) was derailed by a small group of protesters, about 30, who posted anti-MSF signs linking us with OIC and demonstrated against the clinic opening. Despite the team's tremendous efforts to reach out to all levels of Rakhine Buddhist society, there continue to be a few spoilers within that community. The clinic had already been open for some days with 87 patients treated, some former HIV/AIDS patients and others seeking Primary Health Care, but is not temporarily suspended. This clinic is in a predominantly Buddhist area of town and is a key step toward increasing medical activities throughout Rakhine including in predominantly Muslim areas. Yesterday's events caused fear amongst our staff – 4 doctors have at least temporarily left Sittwe – as well as others associated with MSF (such as the owner of the hotel from where expats were again asked to leave, and the clinic landlord). Nevertheless, we hope to get back on track shortly with this clinic and general expansion of activities. As part of that process we are calling on the Government of Myanmar to continue and step up its support for MSF's activities.



'MSF OCA **Operational Bulletin**,' 26 October 2012 (in English).

Extract:

Myanmar: In Rakhine State, violence again erupted in 5 townships east and south of Sittwe since last Sunday. Reports mention 56 deaths, 1,000–2,000 houses burnt and around 6,000 people displaced so far. It is the biggest outbreak of violence since June. Government forces apparently stepped into separate communities, but we did hear of at least one Muslim village that did get overrun. Many of the displaced are on boats, reports suggest 50 or 60 of them with an average of 100 per boat, trying to get to Sittwe or further. We heard that 6,000 displaced would be directed toward a village in Maungdaw South. We sent a medical team there, but the displaced did not come. We don't know if the violence is still ongoing at the moment. This follows the incident last week when the opening of our clinic in Sittwe got derailed by protests and intimidations. Our ability to respond to the displaced who might reach Sittwe is therefore highly limited. There was some good news from Sittwe. We have been supplying our HIV/AIDS patients with drugs and medicine since June, but we hadn't been able to give consultations. 2 days ago, we found room in a building used by Utopia, a group of people living with HIV/AIDS, and have been giving consultations to patients there.

On 2 November 2012, MSF OCA prepared a communications reactive line calling for unhindered access in Rakhine and for local communities to accept the provision of medical care for all who needed it. MSF OCA insisted that an urgent scale-up of medical care provision was needed and that they were ready to do more. For national media, MSF stressed that they apply principles of impartiality, neutrality, independence, transparency in recruitment. They furthered that the choice of interventions are based purely on medical and humanitarian needs.

On 5 November 2012, a stronger and more proactive press release was issued stating that MSF was “prevented from reaching the majority of communities affected by the violence.” The MSF teams at headquarters and in the field gave numerous national and international press interviews based on the proactive press release that were widely and accurately reported.



“**Public Reactive Line** on Rakhine” MSF OCA Communication,' 5 November 2012 (in English).

Extract:

As MSF medical teams work to reach communities affected by the most recent spate of violence in Rakhine State, and respond to the needs generated by the violence in June, they face ongoing antagonism generated by the deep ethnic divide. The antagonism also impacts longer-term programmes focused on malaria, reproductive health, TB and HIV/AIDS, from which hundreds of thousands of patients were benefitting annually. In Rakhine State, MSF has been running one of its largest medical programmes worldwide since 1994. In 2011, MSF conducted nearly half a million medical consultations, and since 2005, MSF has treated more than a million people for malaria as well as providing primary healthcare, TB and HIV treatment, and maternal health services to many others.

MSF's patients hail from all ethnic and religious groups in Rakhine. But since the outbreak of violence in June the organisation is operating at a mere fraction of its capacity due to access limitations and, more importantly, threats and intimidation aimed at staff members for simply acting in accordance with Universal Medical Ethics and the principle of impartiality, which demands that people in need of medical care are treated regardless of who they are. That MSF is prevented from acting, at this time of exacerbated humanitarian need for all the communities in Rakhine, is shocking and is leaving tens of thousands without the medical care they need.

In the past few days MSF teams working in conjunction with the Government and other international and national humanitarian organisations, have assessed some pockets of people around Sittwe, displaced mainly in the last 10 days. The Government has provided some assistance to these groups and medical needs are so far not urgent amongst those the organisation has seen, but without homes and resources they are extremely vulnerable and their health status could deteriorate quickly. Health provision for those from the Rakhine and Muslim communities already gathered in camps from earlier violence continues to be limited and the antagonism displayed to MSF makes it increasingly difficult to support Ministry of Health run clinics, which are already overstretched.

In addition, many thousands of residents especially in northern Rakhine State have been cut off from accessing medical services for months and it remains extremely difficult to resume some long-term medical activities focused on HIV and malaria. The planned opening of a new facility in Sittwe town aimed at providing continuity of care to HIV patients, the majority of whom are from the Rakhine community, as well as primary healthcare services to the poor and vulnerable of the town and surrounding areas, was disrupted last week by protesters. MSF still intends to open this clinic as soon as it is safe to do so. Resupplying MSF's malaria sites in the rural townships of Kyauktaw, Minbya and Paletwa, accessed mainly by Rakhine and Chin communities is vital as the peak of the malaria season approaches. UN officials estimate that thousands more are still afloat in boats used to flee the recent violence, seeking a safe place to land, including across the border in Bangladesh. In accordance with international law those fleeing violence and seeking refuge in Bangladesh should be afforded safe entry, where MSF remains willing and able to provide assistance

MSF is prepared to do much more and is calling for unhindered access, and for local communities to tolerate the provision of medical care to all who need it at this time of crisis and upheaval for all communities in Rakhine.

In addition, in order to offer services at an appropriate level, an increase in international medical staff will be necessary for which expedited visa processes are essential. In all of its activities worldwide, MSF's sole aim is to ensure that the most vulnerable people – regardless of ethnicity, origin or religion, receive the medical humanitarian assistance they require. MSF's medical programme in Myanmar is one of its largest anywhere in the world. MSF is the country's main AIDS treatment provider and has been at the forefront of the fight against malaria. MSF's high-quality medical services are free of charge.

Mainly for National Media:

- Principle of impartiality: MSF provides medical assistance to those in need – irrespective of ethnicity, religion, creed or political convictions. “Anyone who enters an MSF health facility is a patient. We make no distinction along ethnic, political or religious lines.”
- Principle of neutrality: MSF maintains its neutrality between all parties involved in conflict; while continuously looking to assist victims wherever they can be safely accessed. To do so, we are consistently in dialogue with all the relevant authorities, organisations and communities needed to facilitate its access to those in need.

- Independence: MSF provides assistance that is free from political, religious or economic consideration. 80% of our funding across the world comes from private donors. MSF is not affiliated to any government, or political, ethnic, religious, or economic group. In Myanmar in 2012, 64% of our projects are funded through private donations. The remaining 36% is funded by a diversity of institutional donors: the Global Fund, ECHO (the European Commission) and the Swedish and Norwegian governments.
- Transparent recruitment process: MSF recruits staff solely on the basis of merit and appropriate qualifications. Qualified individuals are selected in a fair and open competition assessed in relation to the position involved. All qualified applicants are encouraged to apply. In Rakhine we have a diverse staff base with Rakhine, Bamar, Chin and Muslim employees.

Q&A (all media)

- Does MSF have access to those areas affected by the new wave of violence?

In the past few days, where possible, MSF teams have assessed some pockets of people around Sittwe, displaced mainly in the last 10 days. The Government has provided some assistance to these groups and medical needs are generally not urgent amongst those the organisation has seen, but without homes and resources they are extremely vulnerable and their health status could deteriorate quickly. Many already gathered in camps from earlier violence are not fairing so well and, critically, many thousands of residents especially in northern Rakhine State have been cut off from accessing medical services for months. A scale up in the provision of medical care to the most vulnerable groups across Rakhine State is urgent. MSF is prepared to do much more and is calling for unhindered access, and for local communities to tolerate the provision of medical care to all who need it.

- Has MSF seen or assisted any victims of this new wave of violence?

Yes, MSF assessment teams have visited several pockets of recently displaced people. The Government has provided some assistance to these groups and medical needs are generally not urgent amongst those the organisation has seen, but without homes and resources they are extremely vulnerable and their health status could deteriorate quickly.[...]

- Does MSF believe this new wave is orchestrated? Will the violence spread or continue?

As a neutral and impartial medical/humanitarian organisation, MSF's immediate concern is for those affected by the violence, and for communities that have been cut off from accessing medical care for many months now. We make no predictions about what will happen next, we simply try to reach those in need. We call for an improvement of access, including greater tolerance for treating those from all communities with medical needs. [...]

- Has MSF witnessed violations being carried out against the Rohingya in Rakhine State?

In the camps, MSF has witnessed the result of the violence on both communities. Many people were left homeless and lost their livelihoods making them more vulnerable to malnutrition and communicable diseases. MSF is concerned about all groups affected by the recent violence that are unable to access healthcare. The organisation is operating at a mere fraction of its capacity due to access limitations and, more importantly, threats and intimidation aimed at staff members accused of treating the wrong people. MSF is seeking to re-establish all of its programmes across Rakhine State and to ensure all communities in need of assistance have access to these services.

- Is the Government blocking MSF?

MSF is working very closely with the authorities to increase the provision emergency and longer-term healthcare to those who need it. The biggest challenge we currently face is the intolerance of some people toward the provision of medical assistance to others and

the resulting threats and intimidation toward MSF staff. MSF still has considerable unused capacity and hopes to put it to good use as soon as we can.

- Recently MSF tried to open a clinic in Sittwe but was prevented from doing so? Will MSF continue to try to open this clinic? Why was there resistance to the opening of this clinic and who was responsible?

MSF will continue its efforts to reopen this health facility in Sittwe town so that we can effectively serve HIV patients in Sittwe town as well as addressing other health needs experienced by the most vulnerable of the community. MSF has over 300 patients on antiretroviral treatment in Sittwe, many of whom come from the town or surrounding townships. Without those facilities, there is a higher likelihood of HIV patients having their treatment interrupted, leading to a rapid deterioration in their health. People will not be able to access MSF's free-of-charge and high-quality malaria treatments, vital as the number of malaria cases increases as the rainy season slows down.

MSF would like to stress that it has the full agreement of the government, and most people in the community, for a reopening of MSF medical services in Sittwe town. They realise that without those facilities, it is the most vulnerable of the community in Sittwe town that will suffer.

- What about this quote from MSF saying that the Rohingya are the most likely group of people to go extinct? Did you say that?

No. MSF has worked in Rakhine since 1994 providing assistance to all communities in need of healthcare. MSF is an independent impartial humanitarian assistance organisation that provides medical assistance to those in need – irrespective of ethnicity, religion, creed or political convictions. Anyone who enters an MSF health facility is a patient. We make no distinction along ethnic, political or religious lines.

- Does MSF favour the Rohingya community in its delivery of assistance?

MSF makes its choice of intervention based purely on medical/humanitarian needs. MSF provides medical assistance to those in need – irrespective of ethnicity, religion, creed or political convictions. Anyone who enters an MSF health facility is a patient. We make no distinction along ethnic, political or religious lines, and we play no favourites; we simply provide medical care to those who need it most. Over the past 18 years, MSF has treated millions of people in Rakhine hailing from all ethnic and religious groups.

- Is MSF linked to the OIC or any other Islamic group in any way?

No. MSF is an independent impartial medical humanitarian organisation. We are not affiliated to any government, or political, ethnic, religious, or economic group anywhere in the world. Indeed, MSF is known around the world, for its independent, neutral approach to working in situations of conflict and tension. MSF provides medical assistance to those in need – irrespective of ethnicity, religion, creed or political convictions. Anyone who enters an MSF health facility is a patient. We make no distinction along ethnic, political or religious lines. MSF takes no funding from the OIC for its work anywhere in the world.[...]

- Aren't some MSF staff members still in detention, accused of having links to terrorist groups?

MSF confirms that two of its staff members remain in detention. We do not know what they are accused of. All our efforts at this stage are focused on ensuring that they remain in good health and are treated in accordance with the law and provided legal representation.



“MSF prevented from reaching most communities affected by violence in Rakhine State, Myanmar – Scale up in provision of medical care urgently needed.” MSF OCA **Press Release**, Amsterdam/Yangon, 5 November 2012 (in English).

As MSF medical teams work to reach communities affected by the violence in Rakhine state they face ongoing antagonism generated by deep ethnic divisions. In addition, thousands of patients benefiting from longer-term primary health care programmes are cut off from medical services as many of MSF’s activities have been suspended since June. In the past few days MSF teams, working together with the government and other international and national humanitarian organisations, have assessed the medical needs of thousands of people newly displaced by violence near the city of Sittwe and the surrounding townships. These joint teams have provided some food, water and emergency health assistance, but having lost their homes and resources many people are extremely vulnerable and their health status could deteriorate quickly. Ongoing animosity, aimed partially at organisations like MSF wishing to provide assistance, makes it increasingly difficult to support the Ministry of Health to run already overstretched clinics and reach out to newly displaced communities. *‘That we are prevented from acting and threatened for wanting to deliver medical aid to those in need is shocking and leaves tens of thousands without the medical care they urgently need’*, says MSF’s Operations Manager, Joe Belliveau.

The disruption also extends to MSF’s longer-term activities. The planned opening of a new health centre in Sittwe town to provide primary health care including AIDS treatment was postponed last week in the face of protests. Further, if disrupted drug supplies to MSF’s malaria treatment centres in the rural townships of Kyauk Taw, Minbya and Paletwa are not resumed quickly the number of untreated malaria cases will rise rapidly as the peak of the malaria season approaches

In Rakhine State MSF has been running one of its largest medical programmes worldwide for nearly 20 years. Since 2005 MSF treated more than a million people for malaria, and provided primary healthcare, TB and HIV/AIDS treatment, and maternal health services. Its patients hail from all ethnic and religious groups in Rakhine. But since the outbreak of violence in June MSF is operating at a fraction of its capacity due to access limitations largely stemming from threats and intimidation. Tens of thousands of long-term residents, previously receiving medical care, have gone without for months. *‘MSF could do much more to assist the recently displaced, those already in temporary camps and longer-term residents who have been cut off from medical services for far too long but antagonism from some groups prevents us from doing so,’* continues Belliveau.

A scale up in the provision of medical care to all affected in Rakhine State is urgently needed. MSF therefore calls for unhindered access and for tolerance of the provision of medical care to all those who need it.



‘MSF OCA **Operational Bulletin**,’ 7 November 2012 (in English).

Extract:

Myanmar: The press release we sent out on Monday has provoked a huge take-up across the world, both from established names and smaller local media. The New York Times and all the wires (AP, AFP, Reuters) covered the release and there was a lot of global pick-up from that. We also did tv/radio interviews with Al Jazeera, Voice of America, ABC [Australian Broadcast Corporation], Channel News Asia and more. In Myanmar the team has done interviews with all major outlets.

It was well reported, in that the information from the press release was used accurately. The message in the press release was twofold; to reinforce local messaging about impartial decision-making and to further strengthen the international pressure for the crisis.

INTERNATIONAL PRESSURE INCREASES

In November 2012, the diplomatic reaction and pressure on the government of Myanmar increased:

- **On 9 November 2012, ten embassies, including the USA, the UK, Australia, France, Saudi Arabia, Egypt, and Turkey called on Myanmar to allow free and safe access for humanitarian aid to the west of the country. They planned to establish coordination of humanitarian aid by the United Nations to be based in Sittwe. This would facilitate delivery and distribution with the agreement of the government.**
- **The same day, the UN High Commissioner for Human Rights called on the government of Myanmar to grant citizenship to the Rohingya.**
- **On 13 November 2012, UNHCR called on the regional governments to keep their borders open to “people coming from Myanmar seeking asylum and international protection.”**
- **On 15 November 2012, opposition leader Aung San Suu Kyi described the deadly violence between Buddhists and Muslims in western Myanmar as an “immense international tragedy.” Then she called for an end to “illegal immigration” on the border with Bangladesh. This was an allusion to the 16th century thesis that the Rohingya were immigrants who arrived from Bengal. This contention justified the denial of Myanmar citizenship to the Rohingya.**
- **On 17 November 2012, the President of Myanmar, Thein Sein, stated in the daily ‘New Light’ that Myanmar should put an end to communal violence in the west and address the root causes of the problem or ‘lose face’ in the eyes of the international community.**
- **The OIC called for the permanent members of the UN Security Council to “save” Myanmar’s Rohingya Muslim minority from “Genocide.”**
- **On 18 November 2012, the ASEAN while acknowledging that the community clashes in Burma showed a “worrying trend of ethnic violence,” refused to speak about “genocide.”**
- **The same day, Human Rights Watch claimed that in October 2012, local Burmese security forces killed Muslim villagers and attacked others trying to flee communal violence in the west of the country.**
- **USA President Barack Obama visited Myanmar and pleaded for continued political reforms.**
- **On 5 December 2012, during a visit in Myanmar, the Head of OCHA, Valerie Amos stated that “trust was not there” and called on the country’s leaders to support the efforts of the UN and humanitarian organisations in the region.**



“Myanmar: International Call for Humanitarian Access in the West”, **AFP** (Yangon), 9 November 2012 (in French).

Extract:

On Friday a dozen embassies called on Myanmar to allow free access for humanitarian aid in the west of the country where deadly riots between Buddhists and Muslims have left hundreds of thousands of people homeless. The joint press release urges Naypyidaw “to authorise safe, fast and unrestricted humanitarian access across the entire Rakhine State to anyone in difficulty”. “The international community is prepared to offer support in the form of humanitarian aid and help with long-term development in Rakhine State, and open to doing so as part of a coordinated effort to ensure maximum effectiveness.” [...] The United Nations have already indicated that the camps set up by the government were overrun by an influx of displaced people. Médecins Sans Frontières (MSF) meanwhile criticised the threats it and other humanitarian organisations had received, putting their operations in danger.



“Myanmar: Navi Pillay (UN) Demands Citizenship for the Rohingya”, **AFP** (Nusa Dua (Indonesia)), 9 November 2012 (in French).

Extract:

The UN High Commissioner for Human Rights, Navi Pillay, called on Myanmar on Friday to grant citizenship to the Rohingya, a stateless Muslim minority at the centre of communal violence that recently exploded in the west of the country. “I have many concerns, most notably regarding the situation in Rakhine,” declared Navi Pillay, referring to the Burmese state where clashes between Muslims and Buddhists had killed at least 180 people and displaced 110,000, mainly Muslims, since June. “The (Burmese) government has told me that this is not an ethnic problem, however from what I know, it is. The Rohingya have long been stateless and this calls for a political solution,” she added during an interview with the AFP, on the floor of the Bali Forum on democracy which came to a close on Friday on the Indonesian island.



“Myanmar’s Neighbour Must Open Its Borders to the Rohingya (UN)” **AFP** (Bangkok), 13 November 2012 (in French).

Extract:

“The UNHCR has urged the governments in the region to keep their borders open to people coming from Myanmar seeking asylum and international protection,” declared the UN agency in a release. “The agency is calling on States to continue to their long tradition of providing humanitarian aid to refugees instead of passing on the responsibility to another State,” she added, calling attention to a “growing humanitarian emergency”.



“The Community Violence in Burma Is an ‘International Tragedy’ (Suu Kyi)” **AFP** (New Delhi), 15 November 2012 (in French).

Extract:

On Thursday, Aung San Suu Kyi described the deadly violence between Buddhists and Muslims in the west of Myanmar a “major international tragedy” and called for an end to illegal immigration at the border with Bangladesh. [...] “Don’t forget that the violence

has been committed in both camps, which is why I prefer not to take a stand and also want to work towards reconciliation," declared the Nobel Peace Prize winner, who has disappointed her overseas supporters with her lukewarm reaction to the ethnic violence. "Is there still a lot of illegal immigration via the border (with Bangladesh)? We have to stop this otherwise the problem will never end," she added. "Bangladesh will tell you that all these people have come from Myanmar and the Burmese will tell you they came from Bangladesh," she said.



"Myanmar Must Solve the Rohingya Crisis or 'Lose Face' (President)" **AFP** (Yangon), 17 November 2012 (in French).

Extract:

Myanmar must bring the communal violence in the West to an end and tackle the deeply rooted causes of the problem at the risk of "losing face" in the eyes of the international community, announced Myanmar President Thein Sein on Saturday. In an article published in the daily newspaper *New Light of Myanmar*, which seemed to quote in part a letter sent to UN Secretary-General Ban Ki-moon, the head of state said that it was "impossible to hide" the events that had taken place in Rakhine State since June, leaving 180 dead. The violence "put a stop to development in Myanmar", he wrote two days after the arrival in Rangoon of Barack Obama, the first US president to pay an official visit to the country. "As a United Nations member, Myanmar has a responsibility to address humanitarian problems in compliance with international criteria," added Thein Sein. "If it fails [...], the country will lose face on the world stage."



"Violence in West Myanmar: The ASEAN Is Concerned but Does Not Talk About 'Genocide'", **AFP** (Phnom Penh), 18 November 2012 (in French).

Extract:

The Organisation of Islamic Cooperation urged the UN on Saturday to "save" the Rohingya from "genocide" and asked the US President Barack Obama, who would be arriving in Rangoon on Monday, to put pressure on the Burmese government "for it to protect this minority".

Questioned on Sunday about the term "genocide", the Secretary-General of the ASEAN, of which Myanmar is a member, did not want to answer on its behalf.



"Burmese Security Forces Attacked Muslims, According to Human Rights Watch", **AFP** (Bangkok), 18 November 2012 (in French).

Extract:

The local Burmese security forces killed Muslim villagers and attacked others trying to flee the communal violence the previous month in the west of the country, confirmed Human Rights Watch (HRW) on Sunday. Security forces in Rakhine State killed members of the Kaman ethnic minority in the town of Kyaukpyu while soldiers "were watching", according to the New York-based human rights organisation. Border guards meanwhile "violently beat" scores of members of the stateless Muslim Rohingya minority who were trying to join the capital of Rakhine State Sittwe by boat.



“Obama in Myanmar to Boost Political Reforms” by Stephen Collinson **AFP** (Yangon), 19 November 2012 (in French).

Extract:

On Monday, Barack Obama became the first sitting American president to step foot in Myanmar, a visit as short as it was historic during which he planned to bear witness to the wave of reforms that were leading a dramatic transformation of this Asian country in just 18 months. [...] “Thein Sein has already scored a major coup on the domestic front,” believes political analyst Mael Raynaud. “Obama positions him as an untouchable president, less and less likely to be overthrown by the hardliners.” But the American president also hopes to benefit from these reforms. He was the first, in 2009, to believe that dialogue with the military was needed in addition to sanctions.



“Top UN Relief Official Calls on Myanmar’s Leaders to Support Humanitarian Efforts” **UN News**, 5 December 2012 (in English).

Extract:

On a visit to a Myanmar state wracked by inter-communal violence, the top United Nations relief official today called on the country’s leaders to support UN and other humanitarian efforts in the region. “The trust is not there,” the Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, Valerie Amos, said after touring several communities across Rakhine state on Myanmar’s west coast. “We need the political leaders in Myanmar to support the important humanitarian work being done by the United Nations and our partners,” she added, as she spoke of the need for local leaders to “speak out and explain that they have asked us to be here to help.” Ms. Amos stated, according to a press release from the UN Office for the Coordination of Humanitarian Affairs [...] “Tensions between the communities are still running very high,” said Ms. Amos, who travelled with the Myanmar Minister of Border Affairs, Lieutenant General Thein Htay, to Myebon, Pauktaw and Maungdaw, and also to a series of camps outside Sittwe. “I was shocked to see so many soldiers everywhere keeping communities away from each other,” she added. Ms. Amos said people of both communities consistently gave her the same message: that they were living in fear and wanted to return to living a normal life. “There is an urgent need for reconciliation,” said Ms. Amos. [...]

“The level of assistance provided to people in the different camps varies significantly,” the Office said. Ms. Amos spoke of her concern over camp conditions, noting for example that the situation in Myebon is “dire”. “I saw thousands of people in overcrowded, sub-standard shelter with poor sanitation,” she said. “They don’t have jobs, children are not in school and they can’t leave the camp because their movement is restricted.” Ms. Amos said other challenges included a lack of partners on the ground, while inadequate funding was limiting the capacity to respond.



The goal of our contacts with the embassies was to turn the Rohingya into an international issue. The strategic goal of the international community, the Security Council, the UN and ASEAN was to tip Myanmar into democratic transition. All the diplomatic efforts were focused on the transition. When we talked about the Rohingya, we’d hear, “the Rohingya – that’s not a strategic issue. What counts is the democratic transition.” That’s understandable on the diplomatic level. But our answer was, “Watch out – you’re making a mistake. If you think that your mediation efforts can leave Rakhine out, you’re mistaken.

It's not a marginal issue at all – it's a time bomb." *And gradually, over time, the issues of the Rohingya and Rakhine moved back up the agenda and became very important. And then at one point, there was the realisation that Rakhine really was a time bomb and the problem of the Rohingya became completely international. Not only was the OIC deeply involved, there were also discussions within the Security Council.*

*Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).*

Meanwhile, a new team took over the Myanmar Programme in MSF OCA's Operations Department and an MSF OCA Emergency team was sent for a longer-term to Rakhine. This was to cope with the increasing needs resulting from the violence in the villages and displaced camps. MSF OCA managed to restart part of their TB and malaria activities in Rakhine and to resupply community health workers with medicines for ten main diseases.

Despite some progress in negotiating referrals for Rohingya to local hospitals, only one large-scale MSF clinic was fully functioning. Before the June 2012 clashes, OCA was running seven large-scale clinics at full capacity.

Threats against MSF OCA and its national staff continued, and served as a deterrent to recruitment of national staff for MSF. This lack of staff was the main obstacle to limited access for the population in seeking healthcare.

MSF OCG was running malaria, HIV/AIDS and TB programs in Kayah State and Thanitary Division since the early 2000s, but declined MSF OCA's proposal to intervene in Rakhine to support the needs.



'MSF OCA Operational Platform Meeting **Minutes**,' 21 November 2012 (in English).

Extract:

Myanmar: – HR problems are currently hampering OCA's response, with the loss of both PCs (for different reasons) a real setback. National staff capacity is still limited due to fear or unwillingness to work for MSF. Nevertheless, in Maungdaw South we have been able to restart TB activities and resupply our community health workers in order to provide primary healthcare for 10 main diseases. We have also had recent success negotiating referrals after referrals were initially outright refused. Our five malaria field sites are also again functioning with the inclusion of community health workers.

Out of the seven large-scale clinics that MSF ran before the outbreak of violence (in Sittwe and northern Rakhine) only one is again fully functioning, so a lot of progress still needs to be made, but recent successes are encouraging. [...] Joe and Hernan will plan a meeting – half a day, probably mid/end December – to discuss how we position ourselves in Rakhine, and discuss/debate some of the tougher questions and dilemmas related to the crisis and MSF's response to it.



'MSF OCA **Operational Bulletin**,' 12 December 2012 (in English).

Extract:

In eastern and northern Rakhine, the arrivals of emergency team expats have boosted capacity. A good number of inpatient medical and nursing staff have also returned to work, despite a continuing challenging environment for them. Both have allowed the team to increase the frequency of mobile clinics to the newly displaced camps, where conditions are quite appalling, and start to work on extending to camps closer to Sittwe.



'MSF OCA **Operational Bulletin**,' 21 December 2012 (in English).

Extract:

MSF has managed to resupply community health workers who treat 5 simple diseases, and are treating HIV and TB patients who were previously under care, and hopes to start mobile clinics to the area next week, now that permission has been received. In Maungdaw town, limited reproductive health services have been started. Additionally, MSF mobile teams are also still working in the camps/villages with Rakhine populations, whose villages were burned during the June violence, continuing to provide primary healthcare and referrals, and recently started with psychosocial support.

In ERS there remains a lot of fear, tension and polarisation of the communities. Violence and clashes between Rakhine and Muslim populations in June, and again in October, have resulted in large displacement of populations, particularly amongst the Muslim community. Many of the new Muslim camps are in particularly worrying situation, with extreme overcrowding, water and sanitation problems, and very limited access to healthcare, as populations cannot move from these camps due to limitations posed by the authorities, and fear for further attacks and violence. MSF has been trying to continue to restart activities from pre-June, particularly the treatment of HIV patients, and restarting malaria field sites, as well as provide healthcare to directly affected populations from both communities.

Mobile clinics are going to several sites in 4 of the most heavily affected townships – Myebon, Kyauktaw, Minbya and Mrauk U. The camps and villages (both Muslim and Rakhine) that the teams visit vary in size from a few hundred people to several thousand. Unfortunately, operations continue to be hampered by protests against MSF and other NGOs/UN and intimidation and threats against MSF staff for providing healthcare to Muslim populations. This makes recruiting and keeping national staff extremely challenging.



'MSF Switzerland Myanmar Complete **Project Summary**,' 13 June 2014 (in English)

Extract:

2012

November – OCA requests OCG to intervene, OCG declines



When I arrived there, we could not refer Rohingya patients to the Sittwe hospital. The Medco said: 'well, maybe you should be going to all the medical meetings with the state health director because it's all about advocacy and less so about discussing medical care.' I literally negotiated for a month, every day, to get our first patients into the city hospital. I will always remember the moment that we got a green light for our first patient to be referred. We were all crying in the kitchen because it was such a big thing. It's the most difficult negotiations I've ever done... Then we established that we could do lifesaving referrals to the Sittwe hospital. But at the same time, of course, from an ethical point of view, it meant that we asked doctors to wait until a patient was deteriorated to a state that they'd become a lifesaving referral.

In addition, we knew through someone who had access inside of the hospital that they were hospitalised in the prison ward. They were at the time forced to eat pork, they were badly treated. So where were we referring them to? We would give them money, foods to bring along, etc. Each referral was extremely intense. The harbour of Sittwe was a stronghold for the Rakhine hard liners. So, we needed police escorts to get the patients through. On the boat, the Rohingya asked us to hide them because they didn't want to be seen, and the boat captain would also be too afraid that something would happen. I found an affected mission. Until the June 2012 violence, they thought they had some very good acceptance and leverage. And then, it smashed right in their face that in Rakhine State, everybody hated us.

MSF OCA, Emergency Coordinator in Rakhine, Myanmar, November 2012 - April 2013 and June 2013; Myanmar Operational Advisor from December 2014 (in English).



The bigger issue was indeed the dramatic change in the context. That's what dictated everything that came after 2012. By the time Lauren [Cooney] took over, we had already been almost completely out ... Now to say out is wrong because there was all kinds of efforts to do emergency, the whole e-team was involved. There was actually quite a lot of emergency response activity because villages were destroyed, people were displaced, lots of violence ... so we were out there doing whatever we could but essentially losing our foothold. And then there was all this incredible negativity toward MSF itself. We had just very low community acceptance, besides the Rohingya themselves. And then on top of that, the Government didn't want us there ... it was just immensely difficult to get any kind of access after that.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).

SUPPORTING DETAINED STAFF

Meanwhile, the two MSF OCA staff members arbitrarily arrested in June 2012 (five were released), remained in detention. On 1st November 2012, the MSF OCA Myanmar head of mission sent a letter to the Myanmar UN humanitarian coordinator informing that MSF had yet to receive any official communication regarding their detainees including their health status, detained location, or the nature of the charges against them. The head of mission requested an appointment to discuss next steps to secure a fair process and resolution of this issue.

In December 2012, the president of MSF International sent a letter to the President of Myanmar, which stated that detaining and sentencing MSF staff without any proper legal representation was unjust. The letter expressed MSF's concerns about their well-being. After Head of OCHA's visit in Myanmar, some hopes were raised by rumours on a possible amnesty to be granted by the President of Myanmar in January 2013 but, were in vain.

Throughout 2013, supported by the MSF International HART, MSF OCA maintained the advocacy momentum towards the Myanmar authorities and key international stakeholders for the release of their detained staff. The two imprisoned national staff were visited by the UN special rapporteur for human rights in Myanmar, who reported that while their detention conditions had improved, they were suffering psychologically.

In November 2013, one of them was sentenced to five years in prison, while the other staff member, whose sentence had been commuted to six years in June 2013, submitted a last appeal to the Supreme Court, in vain.



“Re: A Summary of Situation of Detained Staff MSF Holland”, **Message** from MSF OCA Myanmar Head of Mission, to Resident/Humanitarian Coordinator Office of the RC/HC [Resident and Humanitarian Coordinator] UNDP [United Nations Development Programme] Myanmar, 1 November 2012 (in English).

Extract:

Since violence broke out in Rakhine in early June, MSF has had a total of 7 staff detained: 6 Muslim and 1 Rakhine. A first staff member (Rakhine) was released in July and a second staff member (Muslim) was released at an unknown point between July and August. A further three staff members (Muslim) were then released on 16/08/2012. As of 18 October, 2 staff remain detained in Buthidaung prison. Charges against them are unknown and despite repeated attempts both verbally and in writing towards both the Government of the Union of Myanmar in Naypyidaw and the State Government in Sittwe, we have yet to receive any official communication on their well-being, location and the nature of the charges against them. We have also not been able to access them, either through an official request or through a visit of an MSF MD [Medical Doctor] to HIV patients in Buthidaung prison. Family members of the detained staff do have access, but at a price. They report that our staff are in bad health, which makes access for an MD even more important. The prison authorities have confirmed that our staff have needed medical attention but say this is for minor issues. So far, MSF's attempts to gain legal representation for all staff detained have been unsuccessful.

With regards to the staff that have been released the circumstances of their release remains unclear. Only one staff member reports that he considers the charges to have been withdrawn and reports that he has not received undue attention from the security forces since his release. A second staff member reports close monitoring at the hands of military intelligence. A third staff member ... The final staff member is out of contact. Staff report differing experiences whilst in detention. Some were beaten and at last one now suffers from post-traumatic stress disorder as a result of his detention. Others report being generally treated well.

MSF remains very concerned for the well-being of our remaining detained staff members as well as the absence of a fair legal process in connection with their detention. We would like information as to the charges that they face, the ability to access them for the

purposes of medical assessment and we request the government to ensure that they have access to a legal defence. In addition, we would like clarity from the government as to the status of charges against those staff members that have now been released. We are very grateful for the continued attention of the UN to this matter, most recently in the statement of Tomás [Ojea] Quintana made on 25 October to the UN General Assembly but would like to meet to discuss further steps that can be taken in-country to secure a fair process and resolution to the situation of our colleagues.



“Re: Follow-Up on Myanmar Detained Staff – Update”, **Message** from Fabien Dubuet MSF Representative to UN in NYC to Hilary Bower, MSF OCA Operational Advisor and Emmanuel Tronc, MSF Representative to UN in Geneva,’ 19 December 2012 (in English).

Extract:

Just a quick message to advise you not to move further on the issue of our detained staff members after the letter you sent to the President. I don’t want to be too optimistic but it looks like an amnesty could be granted by the President himself in January. This was shared with us on a confidential basis after Valerie Amos’ visit in Myanmar. I am trying to cross-check that information discretely [...] but this could be a way out of this issue preserving some face-saving solution.



‘Rakhine Day: Office Discussion/Debate on the Rakhine Crisis, **Draft Minutes,**’ 20 December 2012 (in English)

Extract:

The President of MSF sent a letter to the President of Myanmar stating that to our knowledge our staff members have not received proper legal representation or due process and that detaining and sentencing under such conditions is unjust. We are very concerned about their well-being as assisting, including with medical care, where possible.



“Detained Staff: Update and Strategy Review + *Updates from Discussions in the Week Following, and from Court Appearances*”, **Note** Prepared by Hilary [Bower, MSF OCA Myanmar Operational Advisor], after Telecom with Vickie Hawkins, MSF OCA Myanmar Deputy Head of Mission, MSF OCA Myanmar Head of Mission, Lauren [Cooney, MSF OCA Myanmar Operations Manager] and J[...], Contracted Lawyer, 22 April 2013 (in English).

Extract:

Legal strategy and issues

All advice confirms that the convictions are very unlikely to be overturned in Rakhine courts; the only legal possibility to overturn will be at Supreme Court level. Even then, however, the decision will be entirely a political one, decided in Naypyidaw and not based on any legal process/evidence/case. There should be no illusion that different legal representation in the Rakhine courts will produce a different outcome.

Obtaining legal representation for Muslim defendants is extremely difficult – especially in this case where charged with events linked to the June violence. The majority of those approached have simply refused either through personal antagonism to Rohingya, or

through fear of repercussions. To date MSF legal support has been defined by what can be found, not by what is needed. Note also that neither of the lawyers currently involved speak English (or Rohingya) – this complicates intervention significantly as all paperwork needs to be translated. [J] has been approaching some higher-level human rights lawyers in Myanmar (without referring to MSF) to see if they would take on Muslim defendants, but no positive response to date. [...]

Advocacy Strategy

The decision to focus on bilateral and behind the scenes advocacy was reviewed but is still supported at this stage. All believe that public advocacy at this moment is likely to close off possibilities for the GoUM to release or pardon without losing face, without opening effective leverage elsewhere. Public advocacy also increases the risk of physical harm to the detained staff. This decision to remain with bilateral advocacy only will continue to be reviewed as the situation progresses. By contrast, continued pressure through bilateral advocacy is crucial, and is believed to be the most likely route to success. [...] On the question of whether to allow interlocutors [...] to name our detained staff in their discussions, it is still felt that this could put staff at risk, so the prohibition on naming remains.



'MSF OCA **Operational Bulletin**,' 15 July 2013 (in English).

Extract:

Myanmar: It is now one year that MSF staff members [...] remain detained in Myanmar. [They] were working for our programme in NRS. Both of them were arrested and detained in an arbitrary fashion, in the aftermath of the June 2012 violence. Since then, MSF has been extremely concerned not only at the lack of due legal process, including lack of access to legal representation, but also the credible reports we have of both men being beaten and mistreated in prison. MSF has continued to provide support, including international legal support, for both, and continues to advocate at all local and international diplomatic and government levels for their release.



'MSF OCA **Operational Bulletin**,' 23 August 2013 (in English).

Extract:

Myanmar: [...] The UN Special Rapporteur for Human Rights in Myanmar was recently able to visit the two MSF national staff who have been detained in jail in Buthidaung, northern Rakhine State since being arbitrarily arrested in June and July last year. He reported that although the two men were physically coping and are being treated better relative to when they were first detained, both continue to suffer psychologically from their detention. MSF continues to monitor closely the appeal and trial proceedings and to support them and their families through their protracted detention.



'MSF OCA Management Team Meeting **Minutes**,' 1 November 2013 (in English)

Extract:

Myanmar An update and reminder on the situation of our detained national colleagues in Myanmar: R[...] was sentenced in July 2012 to 10 years in prison without the benefit of legal counsel. Following the normal appeals process, in which MSF supported his right to counsel, his sentence was upheld, but commuted to 6 years in June 2013. Last week, on 17 October, R [...]’s lawyer submitted the last appeal possible to the Supreme Court. If this appeal is rejected, the only hope for R [...] is a Presidential Pardon.

Our other colleague, J [...] was detained in June 2012, and has been imprisoned since then pending trial. Last week, [J] trial went ahead. MSF also supported J[...] and his family with legal services. Despite strong witnesses in support of J[...]’s whereabouts during the time he is accused, we found out yesterday that he has been sentenced to 5 years in prison, along with 68 others who were also on trial with him. For all of us, and particularly his family, this is incredibly disheartening news. Within Myanmar law, appeals are possible, and therefore with the team and the lawyers involved in the cases, we will begin looking at those options.

BRAINSTORMING ON RAKHINE DILEMMAS AND ADVOCACY

Towards the end of 2012, MSF OCA engaged in an in-depth, collective analysis, reflection process about the dilemmas posed by the operational situation in Rakhine and Bangladesh, and which supporting advocacy activities to undertake. Public positioning was included in the discussions.

On 20 December 2012, a ‘Rakhine Day’ was organised at MSF OCA headquarters in Amsterdam. The announced objectives of this day and planned debate were *“to give people the space to reflect on some of the key dilemmas we face in Rakhine, to hold operations accountable for their choices, and to increase the ownership of this crisis to a wider group within OCA.”*

A series of guiding questions regarding the MSF OCA position on Rakhine were discussed first by a group of Operations managers, operational advisors, and humanitarian affairs advisors for Bangladesh and Myanmar, and then by all MSF HQ staff. These questions included: How do we describe what we are witnessing? Does what we are witnessing warrant an increased (public) advocacy effort? What are the relevant factors in this equation: Harm versus benefit? Through our actions and/or our partially silenced voice, are we complicit in a broader state-supported anti-Rohingya project?

Several suggested that more information/data was needed for advocacy. Others argued that the issue was more due to MSF’s stagnant messaging on the Rohingya. According to them, since the media spotlight was now on Rohingya’s plight, MSF should shift its public message toward the root causes of this situation: the government’s absence of protection, with some reference to the deeper long-running issue of persecution and the denial of citizenship.

The primary dilemma posed was, “would taking a public position endanger operations?” Some argued that MSF obtained limited access since the June 2012 events and that going public would lead to decreased operational space, because of the inevitable bureaucratic constraints and intimidation. Still others disagreed, expressing that the expected benefit of engaging in advocacy on behalf of patients is never guaranteed, so MSF OCA should just take the risks, regardless. In the same spirit, some argued that Rakhine hardliners would continue no matter what MSF says so MSF OCA should go public on certain issues.

The dilemma posed by a possible MSF OCA intervention in the Rohingya forced detention camps was about the risk of becoming de facto accomplices to harmful political policies of segregation. This was discussed and compared to the situation in the Rwandan refugee camps in eastern Zaire (Democratic Republic of Congo since 1997) and Tanzania following the 1994³¹ Tutsi genocide in Rwanda.

In conclusion, OCA agreed that there was space and value in stepping up MSF public positioning on Rakhine. However, MSF would not label the Rohingya crisis as ‘ethnic cleansing’ or ‘genocide.’ Instead, the word ‘persecution’ should continue to be used publicly and behind closed doors.

They agreed to produce a “Fatal Policy 2” report in the shortest possible timeframe in order to share with the main stakeholders including the Myanmar government. For the first time, a proposal was made to release this report publicly.



‘Rakhine Day: Office Discussion/Debate on the Rakhine Crisis, Draft Minutes,’ 20 December 2012 (in English).

Extract:

Chair: Tammam Aloudat [OSCAR]

Wider group session: all MSF staff

Smaller group session: Arjan Hehenkamp [MSF OCA General Director]; Ops Platform (Marcel Langenbach, Pete Buth, Chris Lockyear, Joe Belliveau); OSCAR (Hernan del Valle, Jo Kuper, Tarak Bach Baouab); Hilary Bower [Myanmar Operations Advisor], Gina (Bark, Humanitarian Advocacy Officer), Humanitarian Advisors for Bangladesh and Myanmar, Lauren Cooney [Emergency Team], Myanmar Head of Mission, Stephen Cornish (MSF Canada Executive Director), Tirana Hassan (HRW) [...]

Smaller Group Discussion (closed session) 12:00–15:30

Question 1: How do we describe what we’re witnessing?

Head of Mission. We have been failing to write up what we are witnessing, even though we have had a system in place for recording issues and incidents for years. In the past we were with a limited number of people in the field, lately the issue is more related to access. The information we get is mainly from our staff during our staff meetings. We didn’t do a good job with writing down and documenting testimonies of patients.[...]

Lauren. We can talk about what we are currently witnessing. We can say that there are new camps where people are displaced, living in appalling situations with limited healthcare and poor watsan [water and sanitation] conditions. The Rohingya population

31. See MSF Speaking Out Case Study – Laurence Binet, *Rwandan Refugee Camps in Zaire and Tanzania 1994-1995 and MSF and the War in the Former-Yugoslavia 1991-2003* <https://www.msf.org/speakingout/>.

is in fear for their lives and they are scared of the authorities who should be protecting them. When we talk with UNHCR colleagues they struggle with the same dilemmas.

Pete. It is important that we have a thorough contextual understanding in order to define our operational and advocacy response. Part of that is an analysis of the government's role in this (laws, actions, and positions). If the situation can be classified as ethnic cleansing or a similar serious crime, then we need to know. [...]

Arjan. How do we define the violence that happened in October, did these attacks constitute to ethnic cleansing? Do we have a particular description of the situation and how will this reflect on our operational actions and the patients we are treating if we decide to speak out?

Hernan. We should move away from this discussion. I call it a systematic neglect and if we decide to use the word genocide, it will start to become a legal discussion. [...]

Tarak. We can't just erase and forget the history when we look at the situation in Rakhine today. The government has a bad track record in terms of how it has treated minorities in the periphery states (Rakhine but also Kachin) so we cannot assume that the sweeping political changes will also affect its positioning on the Rohingya. We should think about our position within the country in relation to the government as it is the key, central actor in relation to our positioning.

Steve. I would like to support the idea of start documenting what we are witnessing. The events of June are a big red line, the tension between these two communities and the level of power. In Sittwe it was very well organised and the population was systematically moved. Describing things in legal terms would be useful, it is not our responsibility, but it could help us to identify what responsibilities we feel. We know what the world is feeling; but we should keep in mind the access issues and other challenges.

Joe. We need to get consensus on the quality and nature of what we have been witnessing since June. For years, prior to June we witnessed a systematic repressive and abusive approach of the state on how they treat Rohingya. [...] There is cause for concern that in ERS the current situation could evolve into something resembling what we have been witnessing in NRS prior to June, and that is cause for concern. However, I do not see that the quality of the State's involvement and treatment of the Rohingya in general has worsened since June. It is even possible that the government's treatment of the Rohingya will improve given how much attention is currently on this problem. The underlying issue is communal hatred and intense tensions. The red line, for me, is when the State would take a clear active side in the conflict. It's not clear that they've done that, though it is very clear that have at least, on many occasions and even now, failed to protect. Where do we feel is the red line? Clashes between communities are different from when the State takes a side, and our reaction and advocacy should also be different. [...]

Lauren. There are repeated requests from the Rohingya for us to come to the new camps every day. They do not trust the MoH and the government. We can provide 'protection by presence' and the population needs somebody present to talk to. [...]

Gina. There is fear about what is going to happen to them, insecure future. Not everyone identifies themselves as Rohingya. Due to the violence in June and October there has been a loss of presence of NGOs, especially foreigners and inpat staff fearing for their protection. They do not know what they want from us.

Tirana. You can document everything, but what do you want with this information? Is it systematic targeting against the Rohingya? There is the analysis and the speaking out about the situation. This also should involve a harm and benefit analysis. What are we doing, what are we able to do and what will the effect be in the future?

Arjan. We need to determine a position on the involvement of the State and based on that determine our next step.

Chris. Other actors are having a dialogue about the '82 citizenship law, there is actually something tangible about what the government is doing.

Question 2: Does what we're witnessing warrant an increased (public) advocacy effort? What are the relevant factors in this equation: harm vs benefit?

Head of Mission. We went from a lot of activities to no activities after the June violence. Now we seem to be getting more access to the newly displaced and increasing our activities elsewhere. We could probably go in the direction to where we were before the June violence; the access issue seems to be slowly going away and maybe we can get access to the other camps. We haven't been there in months so we don't know what we will find there.

Lauren. In NRS we are working to provide access to healthcare. In ERS the situation is more volatile and there are changing needs of populations. We should be responsive to that. Our priority is in emergency response, also in the June camps.

The accessibility, the internal HR [Human Resources] problems and the blockage by communities are threats. This fits into the whole 'Healthcare in Danger' issue. I consider this being one of our biggest threats and also important to target.

Vince. [...] Speaking out about the current situation is important, even if we risk access.

Tammam. What would make us change our mind and what do we aim for concerning our advocacy strategy?

Hillary. If we scale up our activities what would happen, for instance watsan projects in the camps as opposed to only in our clinics, is that something that we want to do? Is that supporting the camps? And what would the population that is against us think about that?

Tammam. How does the population that is against it see our assistance in the camps?

Joe. To give some background ... In 2008 we agreed to step up public advocacy re the Rohingya using a strategy in which Bangladesh was the launch pad for comms in order to reduce GoUM backlash. In 2009 and early 2010, we produced 5 public pieces in this way. By early 2010, the GOB rescinded MSF's FD-6 (official permission to work) and the space for public comms diminished drastically. Since then our advocacy has been primarily bilateral, culminating with the Fatal Policy briefing paper in Oct 2011 that was widely used with governments, donors and UN. The question is do we need to say more now about the current situation? I think there is something to be said about the Government's lack of protection, with some reference to the deeper long-running issue of persecution. I also think we should be public about who MSF is and how we work.

Jo. While we have lost the space to be more public about the plight of the Rohingya generally through losing that space in Bangladesh, we also have to be aware that with the context changes that even if we were able to talk more publicly about the Rohingya from Bangladesh, there has now been quite a spotlight on the Rohingya, and any public communications about the Rohingya would also have to address the root causes of the problems in Myanmar, in a way that we didn't need to so much when we were trying to tell the world about their plight in general.

Head of Mission. There are all sorts of advocacy we haven't done. We haven't confronted the government directly in the way we would have liked to yet. We should do that first.

Chris. We need to ask ourselves what is the most effective. [...] We could focus on much deeper issues, such as the citizenship law. Find out what is more tangible and measure how the government is responding. The basis should be what is it that we want to advocate for, how deep do we want to go with this and what has the greatest impact – based on a calculated analysis. [...]

Marcel. What were the impediments for not discussing this with the government before, and have these situations changed?

Head of Mission. We do have easier access to higher level government now. With this new set-up there is more possibility to target the right people. If we are going to be more critical towards the Government and other groups publicly, we would most likely lose operational space through intimidation and bureaucratic measures. We should always first target them in bilateral meetings. We are on safer ground linking policies to medical consequences; we need to collect the testimonies and start gathering information. Raising awareness has been very high on the agenda. We never target the big companies and that surprises me, because can use this as a pressure point.

Jo. Related in terms of producing a Fatal Policy 2, one of the issues I faced with Fatal Policy 1 was that I couldn't share it with trusted journalist contacts because any information used would directly link back to MSF operations. Of course, this is what gave it its strength but we also need to produce a spin-off briefing paper of some kind from FP2 that could be shared with trusted contacts.

Tarak. [...] Basing our decision to engage on public advocacy (or not) cannot only be based on expected benefits for our patients because those are never guaranteed, hence the logical positioning of taking more (measured) risks.

Joe. We need to do further analysis on the influence of other governments on the MM government. Lots of work has been done in this area, but it is a vast area and requires a lot of time and dedication. We need to think about how we as MSF position ourselves. There is more analysis needed in how to influence the MM government and find a form in what we are comfortable with.

Steve. [...] In order to endure there is no risk of complicity, we need to share information to local and federal government and the opposition. The care of our patients is our key essence. For the short-term issues special attention is needed. Citizenship could also be part of this short-term focus. Now there is more economic openness, is the government complicit? – there is a risk in this. The fact that we can't access some of the areas is our own impediment. In the current state of play the types of messaging and the sort of activities is the same as in GoUMa and Rwanda. We could be incriminating ourselves afterwards if we do not do something in advocacy/speaking out, 'false protection by presence'.

Joe. One of the most fundamental issues is that we have no clear information; there has not been enough systematic collection of data. Right now, we don't know what to say or what we are able to say. We only have some stories here and there. We have to analyse the information and we need to move forward, so we need more information. At this moment we don't have the information to base our advocacy on.

Jo. Need to be more strategic also in who and how we feed information, we brief journalists that we trust but it's quite ad hoc still, would be good (related to the wider advocacy about who influences MM govt etc.) to try to approach people that can influence those actors[...]

Gina. They are looking at the citizenship through naturalisation, that they are foreigners not coming from MM itself and many Rohingya might not want to accept this. [...]

Hernan. Wants to challenge the notion that we need more information; maybe there is no new message. It is time to go with these 'old' messages through the new avenues.

Vince. [...] In other parts of the world MSF would not have accepted this situation. We should talk about the consequences of speaking out. In this matter we will keep going in circles. What is the price we fear? I think the risks are very low. The government position has changed, the environment has changed.

Lauren. Focus should be on the access and that is why we should increase our advocacy. The old message remains important. It is maybe not our job to answer all the questions. We should be scaling up our operations and we should discuss this as well. The population has a need for medical assistance.

Chris. We should start with what has the most impact. And we should invest in data collection and not to rule out shorter term advocacy initiatives. [...]

Jo. It's starting to feel in Rakhine that it doesn't matter what we say or do, the Rakhine hardliners still hate us. We saw this when we tried to open the Sittwe clinic, so in that sense I think there is also a case for being more public about certain issues.

Question 3: Through our actions and/or our partially muted voice, are we complicit in a broader malign state supported anti-Rohingya project? [...]

Tarak. [...]there is no 100% guarantee that we will not pay some kind of price for taking a public positioning risk but we are one of the few actors that can have actual leverage in Myanmar because of our history and credibility there: this is the moment to use it.

Pete. Fear among our national staff and access are the biggest problems. How realistic is it to expect from the government to help us on that? They have the capacity and the responsibility, but there is probably not the political will. They do not want to be seen as pro-Rohingya.

Tarak. How [...]have things really changed there and should we be continuing to be shy (not silent as things have been tried over the years) in public terms if the government is not taking its responsibly to protect communities targeted by violence and humanitarian staff present to alleviate some of the worst outcomes of the violence? We could leverage our work in other parts of the country but how far do we want to push this logic in-country and at international level?

Head of Mission. Our HIV project is not part of the discussion if we speak out in Rakhine State or not. We can't leverage our patients and hold them hostage to the situation in Rakhine. Maybe we shall not push for the Global Fund then. We will speak out for either Rakhine and/or HIV and we keep the two separate. The change that has taken place is enormous. If we need to speak out on Rakhine the fact that we have more than 25,000 patients on treatment should not hold us back. [...]

Steve. There a risk of complicity and we need to speak about what we are witnessing, looking at the 'humanitarian imperative'. When Barack Obama visited Myanmar it was all over the news, there is definitely an interest in the subject globally.

Head of Mission. We have put out a press release and we did a lot of meetings, interviews on television and radio talking about the many wounded by machetes and the living situations of the Rohingya population. In the field we are struggling with the complicity issue as well, the impact on the staff has more impact as ever before. More interaction between HQ and the field is crucial, because it helps us a lot in our thought process.

Joe. There are two main questions. First, we need to stay vigilant regarding our discomfort on the question of complicity, and we need to have a more thorough analysis of the State's role since the June outbreak of violence. One of the key indicators will be whether or not communal separation devolves into a structural form of segregation with associated increased abuse and repression. Secondly, we should come to a consensus about speaking out more. I feel comfortable in the current situation to be quite public. [...] think we can and should put this kind of thing in the public sphere regularly. We should talk openly about the issue of threats and protection. We also need to recall the backdrop: for years we've known about land that has been stolen, innocent people that have been thrown in jail, arbitrary taxes, abuses, violence and so on towards the Rohingya. Are we going to speak out about these human rights issues? In the past we've insisted on some form of link between the policies, practices and behaviour of the State and its impact on peoples' health and well-being. That is very powerful advocacy (e.g. Fatal Policy) coming from a credible medical organisation, but it is also difficult and extremely time consuming to pull that sort of information together. There is space – perhaps more than ever – and a need to for (public) advocacy related to current

witnessing, and also for further deeper advocacy related to the underlying condition of the Rohingya and the causal factors related to their plight.

Conclusions

There was no intent to draw conclusions from today's meeting. The main purpose was to give people the space to reflect on some of the key dilemmas we face in Rakhine, to hold operations accountable for choices made, and to increase the ownership of this crisis to a wider group within OCA. The meeting met these objectives. That said, there are a few conclusions:

- MSF will avoid labelling this crisis with heavy legal terms like 'ethnic cleansing' or 'genocide'. We are not in a position to verify such claims legally and they are so morally charged that doing so would likely lead to more time spent bogged down in technical details than in advocating for practical change. 'Persecution' is the word we've used most often in past advocacy (including publicly) and may still be the more appropriate single word, short of going into longer descriptions.
- There is space and value in stepping up our public positioning on Rakhine.
- We agree to produce a 'Fatal Policy 2' (working title only) in the shortest possible timeframe. This paper, or a version of it, should be used publicly and bilaterally with the GoUM.
- We are concerned about the potential for contributing to harmful policies/practices of the GoUM through, e.g., feeding into a segregation agenda. However, at this moment we do not see current or planned activities significantly doing so, and so there is no plan to curb activities or ambitions for this reason. HQ and field teams need to remain vigilant on this issue.

In January 2013, the MSF OCA OSCAR team proposed a set of suggestions for discussion regarding an advocacy strategy. They were based on field analysis and a series of 'red flags' identified by the MSF OCA emergency coordinator in Rakhine. The analysis acknowledged that obstacles to access vulnerable populations were more due to threats and intimidation fuelled by radical Rakhine activists than from the Myanmar authorities' administrative harassment.

Therefore, OSCAR recommended to try and change the perception of MSF among the Rakhine population, through public communication on medical activities and constraints in reaching the most vulnerable. They pointed out that according to the field teams in Rakhine, MSF too easily expects to be intimidated or obstructed, which leads them, more often than not, to remain in their communication comfort zone. OSCAR instead, recommended pushing limits with proper risk analysis while maintaining possibilities to recoil in case of intimidation, as necessary.

A progressive approach should be adopted, starting with lobbying local authorities, then national authorities, and as a last resort, using a public voice, all based on solid risk analyses.



“Rakhine State Red Flags plus suggestions Advocacy Strategy,” **Note**, MSF OCA OSCAR/Operation Department, January 2013 (in English).

Extract:

Discussion Points:

1. Whether balancing of MSF medical/humanitarian activities between Rakhine and Rohingya, looking at our limited human resources, would go at the cost of our Impartiality principles: It would mean we are not prioritising to needs, but according to pressure and aggression and Govt implemented allocation of resources.
2. How can we best do Advocacy to UN, NGOs, Government on plight of beneficiaries, abuse, denial of rights, Government policies, involvement in obstruction, and MSF activities and constraints in implementing those activities.
- 3 How can we best change perception of MSF amongst Myanmar and specifically Rakhine population through public communications on our medical activities and constraints in reaching all the beneficiaries?
4. Continue thorough analysis on potential (perception of) complicity to a Government segregation in our strategy of operations.
5. Does our internal self-censorship in communications and updates potentially limit enough people getting the full humanitarian and medical picture?
6. As MSF do we stay maybe too much in our comfort zone concerning Rakhine state? Inside mission, perception that we too easily expect to be intimidated/obstructed and therefore might at times be too prudent in expanding our activities. Intimidation by a minority of hardliners will always be there but that we have to push our limits and monitor the result, through means of proper Risk Analysis. If pushing our limits then result in increased likelihood of threats and acts of aggression to staff occurring (rather than mere fear thereof) or limitations of our action, then we can always take a step back. But then at least we know the actual situation concerning obstruction and intimidation in balance with access to beneficiaries.



Summary Quotes and Humanitarian Concerns (MSF Threats NOT included) from [Emergency manager in Rakhine] Recent Comms (Emails and Sitreps), 24 January 2013 (in English).

Extract:

Jan 9 Feedback on the ‘red flags doc’.

Hey Hernan,

Thanks for this great feedback.

Some points from my side.

As for advocacy/lobby to local government: I do think there is some space there. It’s clear that the government is under pressure of the international community and another dynamic is that with the increased openness of the government in MM the government itself seems at times to be confused how to deal with the situation. In several cases it could work to ‘give/suggest the government’ the answers they are looking for (as well locally and national level).

There is also another dynamic: in several places part of the government tries to facilitate space for NGOs but they can’t control the Rakhine community and monks. So, the only way the government reacts is by force and forcing the community and monks to accept presence of NGOs (this is very clear in the current Myebon situation). We must not forget about the Rakhine vs Burmese dynamic which is quite clearly part of the problem.

[...]I do think we need to be more explicit but it can also have a big negative implication on our operations. I think we should start with an advocacy strongly funded our medical activities.[...]

23 Jan, meeting with a young monk

Subject: young monk

Short update as for renewed intimidation at the jetty and meeting with young monk from young monk association. We had already been receiving intimidation concerning the fact that MSF is bringing in Muslim patients in the jetty and that there is an extremist group that doesn't accept this. Since our inpat staff was very uncomfortable on this we put in place that:

- expat MDs do the referrals
- all movements to jetty with expat in vehicle as donkey to ensure security for NS.

New developments:

21/01: ICRC was warned by monk in the jetty that there are very angry people at the jetty who are against referrals and that maybe something would happen. Advice was to find another jetty.

22/01: SHD [State Health Director] addressed in morning meeting briefly this information concerning jetty and said that he's looking into other jetty for referrals and ambulance service.

22/01: evening: Malteser got a visit in the evening from a monk who asked whether Malteser was doing referrals.

23/01: we had a visit from a monk from the Young Monk society with whom we also had good contact in the past. (Marisa) It was a very good meeting. The highlights:

- He informed us that there is still a part of the population who is extreme and against support for Muslims and that he assembled their complaints.
- He had visited Malteser yesterday to address the issue that they have a flag hanging out of their house with their logo and that this is not accepted and that they should be more friendly with their neighbours.
- Concerning MSF, he addressed:

Today is not a good day for referrals at the jetty since the tensions are very high there. The hardliner group that is there is not against patients but their biggest concern is the caretakers, especially when they are male because they could start to wander around and do harm.

Monk advised different jetty.

Asked the monk whether he's in contact with the group at jetty to also explain this and he agreed to do this. I also asked the monk whether they had addressed this issue with the minister of security since the police and government is also responsible for the security in the jetty. He had not.

"he does not want to read in the world news that Rakhine is extremist".

- He addressed the issue of balancing services and we explained our programme, how our work is needs based and showed him that if you look at the size of population of the 2 communities and the activities of MSF these are perfectly proportionally balanced. He will explain this and share this in the Young Monk association.
- He emphasised that not all Rakhine are extreme: 20% is ok to live mixed with Muslims, 30% is moderate and a bit in the middle. 50% is against living together with the Muslims. Out of this 50% a certain part is extremist.
- When I asked him to define fear: he said fear for violence and violence against Rakhine women. He also said that the population has big problems with the loudspeaker of mosques and the early morning call for prayer.
- He said: they call themselves Rohingya and they say this is their land and that's the problem.



“Rakhine State **Sitrep** Week 52”, MSF OCA Emergency Coordinator in Rakhine, December 2012 (in English).

Extract:

Context: [...]

ERS:

• Myebon incident:

2 ACF Hindu staff members travelling with MSF to conduct MUAC [middle upper arm circumference] screening in Myebon were identified by Rakhine community as Muslim. MSF accused of working with Muslims and smuggling weapons. See separate incident report. To resolve the situation with the community MSF asked the township administrator to organise a small meeting with a select representation of the monks and community leaders. This ended up in a meeting with 200 hardliner Rakhine, amongst monks, commander of army and police, and members of state parliament refusing MSF in their community. [...]

Facebook intimidations:

1. 7 days news channel:

The ERS assistant techlog [...] has been mentioned on “7 days news channel” in a comment related to article on airplane crash. He was accused of secretly importing medicines for AZG³² and that these medicines are meant for the Muslim population. [...] “[...] Although the whole Rakhine community demonstrate that they don’t want AZG, but now we are very sad that we know that there are such national betrayers. So, starting from this day, they won’t be patient to the person, or any organisation which supports AZG anymore. Rakhine community is angry” [...]

2. Facebook RVS and Coral Arakan news agency:

- 06/01 The day after the meeting in Myebon concerning the access of MSF, postings were made on Facebook with intimidation messages. Also, a picture of the meeting was on Facebook with PC, Emco and inpat MD on it. New is that comments were made in English against the presence of MSF and against 1 of the expats of MSF.
- A peaceful demonstration planned by the Rakhine Youth association on 31 January was expected to create some trouble but the situation in town has been quiet. Rumour of the Rakhine trying to clean up Aung Mingalar at the end of the year increased tension within the Muslim community in Sittwe but nothing happened so far.
- MHAA[Myanmar Health Aid Association]/MRC [Mekong River Commission] stopped their activities in Pauktaw Muslim IDP camps due to Rakhine community resistance, not clear when or if they will resume activities in the Muslim camps. Unclear if they are still active in Myebon Rohingya camp.



Vince [Hoedt] my line manager in Amsterdam would always, three days or something after I arrived somewhere, give me a call and ask me the question: ‘Hey, what kind of shop do you have?’ And this time I said to him: ‘I’m standing here in a forest of red flags. I don’t know how long I can look at myself in the mirror, personally or as an organisation because every problem is related to protection.’

One example: there were villages, which before were combined Rakhine and Rohingya. For water they had these big basins. So, some village has three of them including one for washing, another one for drinking water, and one where the cattle can drink from. The Rohingya could no longer go to the drinking basins because they would literally be terrorised away. They could only use the ones for washing and cattle!

32. In Myanmar, MSF Holland/OCA was still registered under AZG (Artsen Zonder Grenzen = Médecins Sans Frontières in Dutch).

After this phone call, Vince said to me: 'Why don't you write down all these red flags?' So I wrote a couple of pages where I just described everything that I had seen and I sent it up to Vince who shared it with Hernan [del Valle] from OSCAR. Then Hernan reworked it and that became the 'red flag document', which then became a baseline for our advocacy. At a certain moment we had a strategy that we had some activities with Rakhine to get access to the Rohingya. In Myebon, there was first a very small displaced camp of Rakhine that you needed to pass to be able to reach a horrible, larger Rohingya camp. So, we would do first the mobile clinic in that Rakhine camp, and then the team would continue to the Rohingya camp. The population in that Rakhine camp started to protest against MSF, saying: "We don't want you here!"

So, the project coordinator, said to me: 'We have real tensions in Myebon. We now agreed with the township administrator to have a meeting with some people and some key stake holders. Could you please come along to see whether you can smooth it out?' I went there with a Burmese doctor as a translator. We went to the office of the township administrator. We talked a bit and nobody else was arriving. So, I asked: 'are we expecting more people?' And then the man who had welcomed us said: "Why don't you follow me to the meeting venue?" So, we walked through these big doors which opened up. I stepped into a hall with 400 people. On top of the stage there were five monks. I had to stand beside them, with the microphone, together with my translator. And then one hate speech after the other started from the monks. I was rationally trying to give counter arguments, but it went to a level that they said: 'you are watering plants, plants we don't want, so you cannot do that.' It was very much the dynamic: 'if you are the friends of our enemy, you are our enemy.' They were also distorting the whole history we had. They emphasised, 'MSF is biased, MSF is not neutral.' They were really screaming it and then all these 400 people would start applauding. In that audience, there were also policemen. Everybody was there applauding for the monks. We had done an intervention during Cyclone Giri and everybody in this room knew that. But they completely went along with these monks. It was unbelievable. I never heard such a level of hate coming out of the mouth of a person.

MSF OCA, Emergency Coordinator in Rakhine, Myanmar, November 2012-April 2013 and in June 2013; Myanmar Operational Advisor from December 2014 (in English).

EXPLORING ROHINGYA EXODUS ROUTES THROUGH THAILAND AND MALAYSIA

Meanwhile, Thailand and Bangladesh continued to deny Rohingya refugees entry, pushing them back to Myanmar. According to the UNHCR, 13,000 fled Myanmar in 2012 and hundreds of them died during the boat exodus to Malaysia.

From 9 December 2012 to 14 January 2013, an MSF OCA exploratory mission team did an assessment among the newly arrived Rohingya refugees in Thailand and Malaysia. Their accounts confirmed an increase in oppression from the Rakhine community since June 2012. According to some, the aggression from Rakhine extremists was with the complicity of the Myanmar government authorities. The team also witnessed Rohingya living in appalling conditions in camps at the Thai/Malaysia border. They were abused by human traffickers and the Thai authorities.

The exploratory team recommended that MSF begin operations in Malaysia, to stay in touch with the Rohingya, and to continue information gathering on

the overall situation in Myanmar by documenting their accounts. The practical medical impact of this programme would be low, but the main objective would be to feed a broader vision and advocacy strategy in order to fully advocate on behalf of the Rohingya.

MSF International HART and OCA's OSCAR team started to brainstorm about possible advocacy actions on the refugee issue. The trafficking and detention, the denial of legal status, and the extortion and abuses of the Rohingya were considered and compared in relation to the plight of other refugees MSF was assisting in various parts of the world, particularly in the Mediterranean.

In mid-April 2013, after a second round of assessments, the MSF OCA exploratory team in Malaysia again raised the alarm bells about the Rohingya 'boat people.' Out of 15,000 that fled by sea, 5-10% died over a two to three week period, while only 9,000 managed to reach Malaysia, the remainder of the refugees were blocked in India, Thailand, Bangladesh. In Malaysia, many were detained in prisons with high levels of tuberculosis cases.



'MSF OCA **Operational Bulletin**,' 14 December 2012 (in English).

Extract:

Rohingya: The E-desk is launching an explo focusing on Rohingya asylum-seeking routes out of Bangladesh/Myanmar and into Thailand and Malaysia. We've just learned that another boat carrying around 130 Rohingya sank off the coast of India with only 40 survivors. The survivors were picked up by a Vietnamese cargo ship, after floating in the sea for 30 hours. The ship is currently off the coast of Singapore, but Singapore is refusing it entry. This is the 4th boat we have heard of that has sunk in recent weeks. Every year, once the Bay of Bengal waters have calmed, numerous boats loaded with Rohingya asylum seekers head for Thailand and Malaysia. This year it started early and appears to be more frequent with, anecdotally, about one boat leaving every day to make the dangerous journey. The fate of those who make it to Malaysia and Thailand is unclear. Hence the explo that will look at both the boat routes and the situation at destination.



'Thailand Returns 73 Rohingya Refugees to Myanmar, **AFP** (Bangkok),' 3 January 2013 (in French).

Extract:

Thailand deported scores of Rohingya refugees to Myanmar, reported an official on Thursday, despite the UN calling on the region to accept members of this stateless Muslim minority fleeing communal violence in western Myanmar. The 73 Rohingya refugees, which included 15 women, were returned to Myanmar Wednesday after their boat ran aground south of Phuket Island, said Ditthaporn Sasasmit, a spokesman for the Thai Internal Security Operation Command, on Thursday.



'Myanmar: 13,000 boat people, including Rohingya, exiled in 2012 (UN), **AFP** (Rangoon),' 4 January 2013 (in French).

Extract:

In 2012, around 13,000 boat people fled the border region between Myanmar and Bangladesh and hundreds were lost at sea during the voyage to Malaysia, reported the UN Friday, confirming concerns of a growing mass exodus of the stateless Rohingya Muslim minority. "We estimate that 13,000 left on boats from the Bay of Bengal in 2012," UNHCR spokeswoman, Vivian Tan, told the AFP on Friday.



'MSF OCA **Operational Bulletin**,' 7 January 2013 (in English).

Extract:

Thailand Malaysia Explo We received the transcripts of about 20 interviews from refugees fleeing from Myanmar Rakhine State to Thailand. The stories that we hear from recent arrivals out of Myanmar confirm what we have heard in the past both inside Myanmar and in Bangladesh. The various testimonies suggest an ongoing if not increase of oppression, arbitrary arrests, abuse, etc. since June last year. Some suggest complicity of the authorities in the popular aggression against the Muslim minority.



'MSF OCA **Operational Bulletin**,' 11 January 2013 (in English).

Extract:

On 10 January 2013, Thai authorities have carried out a raid on a remote hillside camp, near the Thai-Malaysian border where hundreds of people recently fled from Rakhine state in Myanmar and generally referred to as 'Rohingya' were being held. Based on the findings of the explo team so far, such camps are used by human traffickers to stage refugees before transferring them to Malaysia, living conditions are supposedly appalling and people are often subject to extortion for additional payments. The MSF explo team arrived in a location just outside the town of Padang Besar and witnessed the Thai authorities (military and migration) transferring a group of several hundred people to a nearby police station. They managed to meet and talk with several of the people just liberated from the camp and now being arrested and transferred. The refugees were in a state of general exhaustion and desperately drank water and ate biscuits provided by the nearby local Thai community. The overall situation was very bizarre and it was shocking to see a group of refugees in extremely poor condition. We learned that this group of refugees will stay in the immigration office until further arrangements are done. During the whole witnessed process, the authorities treated refugees with general respect. No medical personnel were observed in any of the locations despite a few visibly sick individuals. We brought the health issue up to the immigration officers and were told that there are no doctors or nurses present. They asked us if we could do the triage. After a brief check-up done by us, we selected a few persons with general pain (after being severely beaten in the jungle camp and one individual with abdominal pain). Local (Muslim) population provided some assistance. We observed a general sympathy from the local, Muslim and/or Thai, community."



'Thailand/Malaysia Assessment **Report**,' 13 January 2013 (in English).

Extract:

Locations:

Thailand: Bangkok, Ranong, Phuket, Hat Yai, Padang Besar, Malaysia: Kuala Lumpur, Penang [...]

Conclusions

The overall conclusion is that most of the information that was known before this assessment is confirmed, but by being active on the ground in Thailand and Malaysia we gained more details and a better understanding of the process and about what the Rohingya must endure in order to escape Myanmar. [...] Because the elevated level of persecution continues, and because sailing season will last until April, we could expect the current number of refugees to double by the end of April (10–15k unregistered, 23k registered, x 1 boat/day leaving Myanmar or Bangladesh x 200–500 people). From interviews it is clear that despite the risks associated with fleeing, the Rohingya are now more determined and more desperate to leave Myanmar.

The stateless status of the Rohingya, lack of protection, security and basic human rights expose these people to exploitation along the route, as well as in their final destinations. The organised crime, human trafficking, slavery (i.e. working on fishing boats to pay off the traffickers fees), corruption of Burmese, Thai, and Malaysian authorities exist and likely increases with more refugees fleeing Burma in the last few months. Even those refugees who are able to pay along the route may find themselves in a financial prison once they settle with relatives in Malaysia, so they remain vulnerable and without status and security.

UNHCR provides very minimal support to registered refugees in Malaysia, and after meeting two UNHCR officials it does not appear that they will be stepping up their efforts with the increase of refugees, and actually to the contrary as we were told that their budget for this year is less than last year. While it was not stated, it is our feeling that UNHCR has a quota for the number of refugees they are allowed (or willing) to register, and there does not seem to be a plan to adjust this at the moment. While the Rohingya do find it important to be registered, they stated (and it was very obvious) that there are few benefits to having this card. Therefore, we concluded that the Rohingya are pretty much alone when they arrive in Malaysia and UNHCR is not supporting them too much. [...]

In conclusion, after speaking face to face with many recent Rohingya arrivals, and after meeting with various actors and interested parties, it becomes evident that the 'state of the Rohingya' will not change for the better as long as Thai police/ISOC [Internal Security Operation Command]/military/immigration authorities are involved in trafficking, as long as traffickers (likely known to authorities) are allowed to exploit and extort, as long as the Thai and Malay governments do not recognise the Rohingya, and as long as the UN continues with their comfortable status quo and are too scared to 'rock the boat'.

Recommendations

Advocacy:

The overall recommendation revolves around a 'bigger picture' viewpoint with the main root problem of the Rohingya laying in the fact that they are not recognised by any country, and whether they are 'at home' in Rakhine State or in a second country, they are not citizens on earth anywhere. Therefore, a broader vision and advocacy strategy should be developed, and creative ways (whether public or through more low-profile channels) should be brainstormed in order to truly advocate on behalf of the Rohingya. In order to support this broader advocacy strategy, fresh information and timely

monitoring of the situation in Thailand and Malaysia is necessary. We propose to place a 2-person expat team in Thailand/Malaysia for initially 3 months. This team would work low profile, and would not be based in one place, but rather would be flexible and mobile, constantly jumping between locations. Activities would include: 1) maintaining and developing a wider network of sources of information, 2) following up tips and rumours acquired by such sources, 3) continuing to periodically interview new arrivals in Malaysia, and if possible in Thailand, 4) fill in some of the gaps of information that up until this point are still not clear, 5) frequently visit/meet UNHCR and other relevant UN bodies involved in Rohingya issues in order to 'put them on notice' that MSF is watching, 6) from HQ use (or leak) information to relevant sources that are in a better position to speak out publicly.

It would be important for this team to be experienced in this type of mission, and experienced in working low profile. If after the initial three months the results are positive and constructive in contributing to the wider vision advocacy strategy, then we recommend continuing monitoring the situation in Thailand and Malaysia. We recommend changing this mobile team periodically so as not to have one team getting 'comfortable' and ineffective in Bangkok or Kuala Lumpur, but rather by changing the team we maintain a dynamic and productive activity while also adding new and fresh insights.

Operational:

If MSF were to become operational in this region, Malaysia would be the logical place to establish programmes because the largest numbers of Rohingya refugees are living in Malaysia and not in Thailand. We recommend that MSF become operational ONLY if there is a long-term commitment to growing a programme.[...] The purpose of becoming operational in Malaysia would primarily be to have contact with Rohingya, and to continue information gathering/monitoring of the overall situation in Myanmar. The practical medical impact may be low compared to other traditional MSF projects.



FW: **Draft** Thai/Malay Rohingya Explo (Summary and Full) for Tomorrow's Debriefing, Hernan del Valle, MSF OCA, Head of OSCAR to Maria Guevara, MSF International Representative in South-east Asia, Vincent Hoedt, MSF OCA Emergency Coordinator, Joe Belliveau MSF OCA Myanmar Operation Manager, Jo Kuper MSF OCA Communication Advisor, 18 January 2013 (in English).

Extract:

Hola Maria,

[...] This chain of non-recognition/no legal status/vulnerability, extortion and abuse related to trafficking and detention mirrors pretty much what we have seen elsewhere (e.g., Choucha camp in Tunisia in the aftermath of Libya's implosion, and in MSF projects in the buffer zones of Europe). This remains a key humanitarian concern for us, and also for MSF (talk to Emmanuel about the reflection centre meeting in Geneva yesterday – I did a presentation on this same topic, and other OCs talked about other regions with similar dynamics). *For the specific case of the Rohingya, the legal categorisation as 'stateless' reinforces their vulnerability in neighbouring countries. As you know, it was reported this week the UNHCR has been granted access to Rohingya in Thailand. I have not heard more since then. Gina [Bark MSF Operational Liaison Officer] remains in Bangkok and can provide info on developments.* I would be happy to discuss with you what can be done with this in terms of advocacy. Even if the report is technically internal, we would be happy to share with listed contacts, or to make a shorter briefing paper version if we come up with an advocacy plan.



'Thailand Will Not Accept More Rohingya Refugees, **AFP** (Bangkok),' 28 January 2013 (in English).

Extract:

Bangkok will not be accepting any more members of the stateless Rohingya Muslim minority, hundreds of whom arrived by boat to the Thai coast after fleeing communal violence in Myanmar, Thai officials reported Monday.



'MSF OCA **Operational Bulletin**,' 15 March 2013 (in English).

Extract:

Explo Malaysia: We wrapped up the second explo in Malaysia. The first assessment of the explo team was focused on interviews documenting the conditions faced by the Rohingya leaving Myanmar (Rakhine) by boat. The second assessment intended to produce a story about a whole community, rather than a collection of stories of individuals. The findings were quite shocking. They estimated based on various media sources that about 15,000 people will be fleeing by boat from Rakhine to Malaysia and about 5–10% of them will die over a short 2–3-week period. About 9,000 of these refugees will arrive in Malaysia, but some will get stuck in Bangladesh, India or Thailand. The conditions in Malaysia are obviously better than the horrors people are facing in Myanmar or on the boats, but nevertheless they are denied some basic rights and freedom. Part of them go to UN detention centres or have been released from detention and live in the wider community. Others were never detained and live illegally in Malaysia. The conditions in these detention centres are poor, for example the TB rates (including MDR) are higher than in general populace. There is a whole variety of medical needs amongst the refugee population. Although the needs are not as clear as in the more classic refugee emergency situations, there is a strong wish to do something for what is after all a refugee population from a context that we know quite well at OCA, the current situation in Rakhine. The reality in Malaysia makes it look similar to what we find amongst undocumented or illegal migrants, one way or another, possibilities still to be discussed for programming could be including mental healthcare, TB, providing shelter for specific vulnerable groups, targeted healthcare for risk populations, etc.

In mid-January 2013, the President of MSF International, Unni Karunakara and the head of mission of MSF OCA in Myanmar met several key actors to whom they described the challenges that MSF must meet in order to be able to deliver emergency aid in Rakhine.

They also asked for access to detained employees, clarification about the charges, and the legal process they face. When they meet with Aung San Suu Kyi, the opposition leader, they chose not to address substantive issues related to the status and long-standing persecution of the Rohingya.



'Message from Unni Karunakara, MSF International President,' 15 January 2013 (in English)

Hi all,

Had a meeting, together with [MSF OCA Myanmar Country Management Team] with [...] Vice Minister of Home Affairs today. We reiterated our medical mission and need for safe spaces for medical teams to provide care and for patients of all ethnicities to receive them.

On the issue of extending medical care from the outer circle to the inner circle inside Insein prison their response was rather negative. They wanted us to expand clinical services in our current location but were not willing to give us access to the inner circle. There is some confusion as to who is in charge of providing health services, Ministry of Home Affairs or Health. So, we will raise this issue with the MoH tomorrow morning. We raised the issue of our detained staff and got standard responses back such as the importance of following laws of the country and importance of being careful when hiring staff. We, however, stated our demands clearly: clarification of the charges and the judicial process; independent legal counsel; and access to the detainees. The Vice Minister promised to look into the matter.



'MSF OCA **Operational Bulletin**,' 21 January 2013 (in English)

Extract:

Myanmar: Thursday we had the opportunity to meet with parliamentarian, opposition leader (NLD party) and Nobel laureate, Aung San Suu Kyi. MSF's President and the Myanmar OCA Head of Mission met her and discussed ART gap/scale up, escalation of the violence in Kachin and related humanitarian needs, and the current situation in Rakhine State. We focused on current humanitarian needs, especially in the October camps, and challenges to delivering humanitarian assistance with emphasis on continued threats/intimidation. We cautiously broached some of the deeper issues related to the long-time treatment of Rohingya as well. Overall she was very welcoming and positive towards MSF.

In late January 2013, Hernan del Valle, head of MSF OCA OSCAR briefed the new MSF OCA Humanitarian Officer in Rakhine, Tania Bernath, on the terms of reference for the report temporarily called "Fatal Policy 2." Production for this report was agreed at the OCA 'Rakhine Day' in December 2012.

Tania was in charge of researching and writing the report. Hernan advised her to describe the situation without holding anything back and to 'call a spade a spade.' While recommending the use of solid, medical data, Hernan highlighted that insistence on this issue should not justify a delay for positioning, as was done in the past. He gave her a full green light, assuring her that discussion about any risky content and how to use it would happen only once it was written, not before.



'Hernan's **Briefing** of HAO, Rakhine (Tania),' 28 January 2013 (in English).

Extract:

Dear Tania: Here are a few lines I put together in lieu of a proper briefing in Amsterdam. They stem from my own analysis of where we are, plus a summary of the several discussions we have had in HQ over the past few months, involving the mission (in particular, Rakhine day organised by Ops in Dec 2012, with presence of key people in the mission).

- Main deliverable is a report (referred to internally as Fatal Policy 2, although it has nothing to do with Fatal Policy in terms of content or tone. We want something more comprehensive and ambitious). There are many of us in HQ who feel the current contextual developments open an opportunity to be more vocal and ambitious in relation to the situation in Rakhine. In OSCAR (HAD, Advocacy + Operational Comms), we would be ready to push hard to raise the stakes with advocacy and public communications, provided we had a good report on which to lean.
- The departure point for this report should be describing the situation without holding anything back. We need to avoid starting with a sense of self-censorship that has affected OCA discussions around Myanmar for a long time (understandably, given the nature of the regime, but in an unhelpful way sometimes). The report we want should be clear in spelling out the humanitarian issues and call a spade a spade. The discussion about how to use it, or if content is too risky or controversial should only come after it is written.
- In MSF there is a perpetual circular discussion about the need of hard medical data to support our claims. Even if I consider accuracy and strong data as essential in backing our arguments, we need to recognise that that insistence on solid data has at times been used as a reason for delaying or postponing a positioning on a situation which we know way too well. The bottom line is that an imperfect report is preferable to no report at all. So, go ahead with it. You have our full backing. The key issue will be to work with the relevant people in PHD [Public Health Department] to extract the key elements from our medical data and include them in the report, hopefully showing how the politics of Rakhine are impacting on peoples' lives and health.
- Note the experience with Fatal Policy: it is a report based on two very solid surveys which provide data that nobody else had ever collected. Nevertheless, the potential impact of Fatal Policy was undermined by two things. Firstly, a formulation in the writing and conclusions which avoided much more explicit and stronger language to describe a situation. Secondly, a conservative approach in the dissemination strategy (which excluded any public dissemination, and consisted in distributing it under the table in secret briefings with policy makers. Looking back, it is difficult to discern the impact of this and difficult to cite concrete results. Hence, the discussion on how to go about it with a new report will need to take place once we have it). [...]
- Related to the situation in Rakhine, there is the issue of Rohingya refugees in Bangladesh, which can be described from our direct experience in those camps. A lot of information is already available from our mission there, which would be good to track down and condense to the essentials. This should be part of that comprehensive report I discussed above.
- Further afield, there is the phenomenon of the Rohingya fleeing to Thailand and Malaysia. The situation has been thoroughly described in the explo report by the E-desk in Jan 2013. There are important elements there that need to be linked back into the report. If additional information was needed, there is always the option of organising a fact-finding mission to collect further info and testimonies.

- All in all, we need to be able to come up with this Fatal Policy 2 report, based on which we will decide on advocacy and communications strategy. Your job is that of the main writer. Many of us (Gina, myself, Ops, Comms) are able to provide feedback to improve it if needed. You and I can agree on a small team of key people for that purpose.

On 7 February 2013, MSF OCA General Director, Arjan Hehenkamp, held a press conference in Yangon and a press release was distributed by the MSF movement. The message was based on the 'red flags' baseline strategy established in January 2013.

It was similar to the message developed by MSF's previous public communications about the situation in Rakhine entitled, "*MSF called on government authorities and community leaders to ensure that all people of Rakhine could live without fear of violence, abuse and harassment, and that humanitarian organisations could assist those most in need.*"

On 13 February 2013, in his Myanmar trip debrief to HQ, Arjan described a "complex and multi-layered" context in Rakhine, which he compared to the ones MSF had experienced in Rwanda, Somalia, and Former-Yugoslavia.

Arjan confirmed the field team's analysis regarding the probable involvement of the Rakhine state local security forces and local authorities in the violence against the Rohingya, while the national army was playing a somewhat neutral role, but was not preventing exactions.

Due to the lack of capacity of other INGOs, MSF OCA was almost alone in assisting the Rohingya population in the camps, despite ongoing harassment and intimidation of the teams. Nonetheless, MSF managed to rebuild both its international and national teams.



"Humanitarian Emergency in Rakhine State, Myanmar – Greater Protection Needed for Vulnerable Communities and Threatened Staff" Médecins Sans Frontières **Press Statement** Yangon/ Amsterdam, 7 February 2013 (in English, in French).

Eight months since deadly communal clashes first broke out in Rakhine state, Myanmar - tens of thousands of people are still unable to access urgently needed medical care. Médecins Sans Frontières (MSF) calls on government authorities and community leaders to ensure that all people of Rakhine can live without fear of violence, abuse and harassment, and that humanitarian organisations can assist those most in need. Since the June and October outbreaks of violence communities that were previously living side-by-side, or even mixed, remain deeply divided. Thousands of people have lost their homes and are living in makeshift camps, cut off from healthcare, clean water and basic provisions. According to official estimates, the vast majority of the displaced are a Muslim minority – often referred to as the Rohingya.

"It is among people living in makeshift camps in rice fields or other crowded strips of land that MSF is seeing the most acute medical needs," said Arjan Hehenkamp, MSF's General Director. *"Ongoing insecurity and repeated threats and intimidation by a small but vocal*

group within the Rakhine community have severely impacted on our ability to deliver lifesaving medical care."

Displaced people are telling MSF how hard life in the camps is.

"We are very worried about our women; we have more than 200 pregnant women in our camp. For their delivery they cannot go to a health centre and they will have to deliver here... in the mud without a doctor," man living in a displaced persons camp in Pauktaw Township, Rakhine State

Skin infections, worms, chronic coughing and diarrhoea are the most common ailments seen through more than 10,000 medical consultations in the camps since October. Malnutrition rates vary, but in several camps MSF's rapid screening shows alarming numbers of severe acutely malnourished children. Although clean water is often available in sufficient quantities, some of the displaced are denied access to it.

"The only drinking water pond we have is the one which we have to share with the cattle of the nearby village. Five minutes from here is a pond with crystal clear water. We don't dare to go," man living in a displaced persons camp in Pauktaw Township, Rakhine State.

While the needs remain acute, MSF medical teams face continued threats and hostility. In pamphlets, letters and Facebook postings, MSF and others have been repeatedly accused of having a pro-Rohingya bias, by some members of the Rakhine community. It is this intimidation, and not formal permission for access, that is the primary challenge MSF faces. The authorities can, however, do more to make it clear that threatening violence against health workers is unacceptable.

"Our repeated explanations that MSF only seeks to provide medical aid to those who need it most is not enough to forestall the accusations," continued Hehenkamp. *"MSF urges supportive community leaders and government authorities to do more to counteract the threats and intimidation so that humanitarian aid can be delivered to those who urgently need it."*



'MSF OCA **Operational Bulletin**,' 8 February 2013 (in English).

Extract:

Myanmar: We had a press conference in Yangon, Myanmar to launch the Rakhine press release. [...] it was very well attended with 20 print journalists, and 4 film crews. As well as Myanmar media, the Myanmar correspondents from AP, AFP and Reuters were present. The press conference included a slideshow of images of Rakhine and our programmes by a famous Myanmar photographer. These images were also released to media. It is the first time we have had MSF images of Rakhine in many years. Myanmar journalists asked lots of good questions about our perceived bias to the Rohingya, why the Muslim population had more needs, why they could not move freely, who was harassing us and why. Internationally the PR did very well, including major news outlets across Asia, mainland China Australia and the Netherlands.



'MSF OCA **Operational Bulletin**,' 13 February 2013 (in English).

Extract:

Myanmar: So, the team has not experienced any tangible fall-out after the press conference held in Yangon earlier this month.



'MSF OCA **Operational Bulletin**,' 13 February 2013 (in English).

Extract:

Myanmar: Arjan Hehenkamp, OCA GD, has returned from eastern Rakhine state and gave an update on the context. Arjan visited the area to support the teams and to participate in a press conference in Yangon which was well attended by most major news agencies. His call to national authorities and community leaders for attention to the plight of the Rohingya and support to humanitarian actors trying to address their needs, presented in neutral medical terms, was apparently clearly conveyed by the press. From his visit, Arjan was left with the impression that the context is complex and multi-layered. Division is entrenched at a community level and the role of the state is inconsistent, the national army seems to play a fairly neutral role, whereas other security forces and state and local authorities may well share a direct or indirect responsibility in the violence of last year. The situation is further complicated by local politics in which political parties vie for control over the state – ahead of the national elections in 2015. In combination, these factors make a continuation of the current situation, including potentially further violence, a likely scenario. In Arjan's view the context is a defining one and on par with those in which we MSF has worked in Bosnia, Rwanda and Somalia. At present we are the best placed INGO to react to the medical needs of the Rohingya and, despite our calls for other INGOs to enter the fray, it will take time for them to build enough capacity for a meaningful response. In addition, the approaching rainy season is likely to exacerbate medical needs in the Rohingya camps, located in areas susceptible to flooding. This, together with the harassment and intimidation the teams continue to face, makes the delivery of further emergency assistance but also very complicated. We have more expats on ground in Rakhine and in Myanmar than ever before. We are slowly rebuilding a national team, which is small yet very committed at the moment.



The “red flag document” advocacy strategy, set up with OSCAR [in January 2013], was used for the press release we issued [in early February 2013], the first one since a long time which very much focused on access to healthcare for the population. At that time, we still had two of our staff members in prison and we had a whole team of lawyers working to get them out. That of course was a very crucial point in our positioning. We had to get the right wording, keeping the nuance without killing the message and get everybody on board.

MSF OCA, Emergency Coordinator in Rakhine, Myanmar, November 2012-April 2013 and in June 2013; Myanmar Operational Advisor from December 2014 (in English).

MSF AND SOCIAL MEDIA IN MYANMAR

In Myanmar, in the wake of the political reforms, the media liberalisation including access to social media, was developing erratically over a few years, This affected a population that was never exposed to the media or to any level of freedom of expression.

For INGOs in general and specifically for MSF in Rakhine, the liberalisation was both an opportunity and a risk. While MSF could now disseminate more information about the organisation and its activities to the general population, MSF also had to

cope with hate campaigns and disinformation regarding their alleged bias toward the Rohingya.

In April 2013, MSF OCA and MSF OCG recruited a communications manager with the objective of increasing external and internal communication networks. This communications manager created a website with the support of MSF Hong Kong's digital communications team. The new manager also outlined a social media strategy while expanding, training and coaching the Myanmarese communications team to develop MSF outreach communications in Myanmar (Burmese).

In June and July 2013, the MSF OCA Communication teams reconsidered a plan for opening a Facebook page proposed in June 2012 by the MSF Hong Kong director of communications, which had been rejected by the mission for fear of endangering operations.



“Burmese Media Spring” Reporters Sans Frontières **Report**, December 2012 (in English).

Extract:

The first publications to be exempted from monitoring by the government censorship bureau – known as the Press Scrutiny and Registration Division (PSRD) – were the business and literary weeklies, which lost no time in stepping up their activities. The rest of the print media followed suit at the end of the summer of 2012, when they too were exempted from prior censorship. Most of the bigger privately-owned media companies are already preparing to launch dailies or even TV stations as soon as the government gives the green light. Mizzima News is “back” from exile and has launched a business weekly and a general news weekly, joining the hundred or so periodicals based in Rangoon [Yangon]. The editors of the leading weeklies are already thinking about the next stages in their development.

Rangoon-based journalists are already free to talk and work without feeling threatened or watched. [...] Burmese journalists are now able to meet and talk in public with representatives of international organisations and media without fearing for their safety. Journalists are receiving more and more foreign visitors in their newsrooms, the headquarters of their associations or their homes, and are ready to criticise the government and voice scepticism about certain aspects of its reform and even its real intentions. [...]

The government is not yet trusted but most journalists are confident that they have more freedom of speech and are determined to use it to express all their concerns and demands. The relaxation in government control of the media has been accompanied by an increase in internet activity by both the media and the public. Public internet access points, which had already become numerous in recent years, no longer seem to be controlled by the authorities. Asked about this, internet café owners said they were not getting police visits and no longer needed to keep logs of the computers used by clients. Draconian regulations such as a ban on external flash drives are still officially in place but no longer enforced and more and more people are freely surfing the internet in public places. [...] Some media such as the Myanmar Independent are planning to publish reports in English, especially online, in order to reach an international public, above all in nearby Asian countries that are following developments in Burma closely.



'MSF OCA Operational Platform Meeting **Minutes**,' 6 March 2013 (in English).

Extract:

Myanmar: [...] New Communications position opening in Myanmar (Deadline: 13 March). The MSF missions (OCG and OCA) in Myanmar are seeking a Communications Manager to support the development of their national and international communications work. The position will be for 9 months, with possible extension to 12 depending on review of progress. The overall objective of this position is to support the missions to build greater external and internal communication networks, including the development of, and management of, a country website and social media strategy, and to train and coach the national Communications Officer and recruit further staff as needed in order to build a small skilled communications team



'MSF and Social Media in Myanmar, **Draft** June 2013, MSF OCA Communication teams,' 8 July 2013 (in English).

Extract:

Introduction [...]

Based on the evidence we have [this document] concludes, that for the time being at least, Facebook is the primary outlet we should consider for any social media presence. To this end, I have annexed the Facebook proposal originally drawn up by Martyn Broughton [MSF Hong Kong Director of communication] in June 2012 – with a few additional comments from me. [...] A clear objective of the 2011 communications strategy is to engage more with Myanmar's burgeoning national media. [...] while social media usage is small it is fast growing with an increasingly active audience, including traditional media and politicians. Using social media, particularly Facebook presents unique opportunities to reach out to them and their readers and supporters. [...] Further, amongst our own staff – all increasingly social media literate (to the point that Facebook use is banned during office hours as it slows down internet speeds so much) it is also a forum for better engaging our staff about who we are and what we do. [...]

Benefits of social media presence in Myanmar

- Getting ahead of the curve. Communications is arguably one of the fastest moving developments in Myanmar, and social media – while still small – is fast growing with increasingly active users.
- MSF in Myanmar has a stated ambition (compounded by the Rakhine crisis but not only as a result of it) to increase awareness and visibility of its activities and principles.
- The best way to effectively promote things online – including the website and press releases will be via social media.
- Having a social media presence can allow us – where appropriate – to try to counter some of the negative perceptions and views that circulate about us on websites and social media in Myanmar – by linking to statements/stories outlining who we are and what we do. Our silence on these forums (due to not having an 'official' MSF voice with which to speak) also speaks volumes.
- The increasing role of social media for politicians in country also means that breaking stories on Facebook can be an alternative way to reach them as well (of course handled correctly).

Why Facebook?

Facebook is (behind Google) the most popular website in Myanmar, and the primary form of social media that people talk about using.

It is also easy to use and understand. The profiling of our Myanmar activities on the national website can also be easily transferred into Facebook updates and postings. There is also plenty of ready-to-use (except of course needing translation, but photos/text will have been cleared already) information already streaming through the international MSF official Facebook pages on projects and news that are relevant both to Myanmar projects (HIV / MDR-TB, Malaria stories) as well as that can help demonstrate our principles and ways that we work that can complement the profiling of our Myanmar activities. [...]

Risks of social media engagement

- Time management – (this is honestly the biggest risk that I see).
- Are we just opening ourselves up to a torrent of abuse?
- How much power do we place in the people controlling the info (see time management, trusted senior national staff will have to also monitor the site to see that postings are appropriate).
- Is there any operational risk associated with a Facebook page?

While the risks defined are real, these can be managed correctly with the proper time and resources allocated hence my belief that this is actually the biggest 'risk'.

Also, as we have seen over and over again, we are better positioned knowing what abuse is out there about us than not. While the power of any engagement with social media comes from being open, transparent and responsive (meaning we can't just ignore postings on our site simply because we don't like them), it does not mean that if comments are abusive, we have to respond nor that we have to respond to everything. [...]

The role of social media in anti-MSF sentiment – Rakhine [...]

Starting June 2012 MSF – targeted for its role in providing humanitarian assistance to the Rohingya – found itself at the centre of anti-NGO attack on Facebook, including the leaking of internal documents, tracking of staff movements and threats to bomb the office. [...]

In not having an official MSF Facebook page we were not able to try to respond to any of the accusations against us using these forums. We have for e.g. held briefings with national media posting untrue content on their websites/Facebook pages to try to change the tone of their reporting, but have not been able to directly comment on social media to counter many of the false allegations made against us. Many of the inflammatory comments we faced were posted on national news media sites such as Eleven Media, places where we may more comfortably, to a degree, be able to respond.

Rakhine integrity study findings [...]

It only takes one person to read an article/comment on social media and feed that into a rumour mill via other sources... Also, and importantly given the trust that is put into newspapers that was found (76%) the fact that all news outlets have active social media sites, particularly Facebook pages, must be considered into how and where people get and believe information.



People were absolutely not used to it and really not able to differentiate things that were said on Facebook that were true versus things that were said on Facebook which was just people saying. That was a big part of the whole anti-MSF because people were putting extreme hateful things on Facebook, about the Rohingya and about MSF. And the whole thing snowballed from there. It's a big part of the story.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English).



They'd been in that transition to civilian government in November 2010 and the internet was opened in July 2011. It took a while for the media and the social media environment to start to open up. But, by end of 2011-2012, it was doing so. Social media was exploding. So, a lot of our communications work was to media but a lot around social media as well and how we can use social media to build awareness and acceptance amongst the community. We had a very poor network in Rakhine prior to the violence. There hadn't been enough focus on this. The hatred of INGOs in Rakhine was very high because they were very much seen to stand with the Rohingya and be there because of the Rohingya. The objective was to advise the projects on not just the sort of traditional public comms talking to the media, but also, how we could get out messaging at a community level and basically build some trust. We wanted to make sure that it was visible that we were working with both communities.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting Head of Mission in February 2014 (in English).



In fact, MSF had been working in northern Rakhine for 20 years, but because northern Rakhine is extremely isolated and vast majority of its inhabitants are Muslims, its visibility was low. Then from June 2012, when the communal violence broke out and MSF started working in the Muslim camps in Sittwe area, they often had to go through ethnic Rakhine villages to get to these camps. So, there was a much higher profile and that's when the public reactions began and snowballed through social media, press, etc. Then internet access changed over the two years. We experienced an increasingly hostile press and increasingly hostile operational environment in Rakhine state. For instance, there was a deputy head of mission's photo on Facebook accusing her of smuggling guns and gold into one of the camps; newspaper headlines saying we had sterilised 20,000 Rakhine people. It had really gone quite extreme.

The national communication officer they had hired in December 2012 resigned. It had been an incredibly high-pressure time for him. It took me quite a long time to get the go-ahead from headquarters to be able to hire an additional communications officer, which was absolutely crucial at the time because we needed to know what was being said in Burmese. We had very little outreach in Burmese in terms of communications. So far, most of the press releases had been done in English only. We were talking to an international or regional audience more than engaging at the local level. I think there was a fear that if it was in Burmese, that it would be used against them. I quickly made a good case for the opposite. And we started doing everything bilingually.

Eddy McCall, MSF OCA, Myanmar Communications Manager, April 2013 to January 2015 (in English).



Suddenly you had a population that had had zero exposure to media having all the things that we see on social media. We got into a lot of debate about whether we should have a page and, if we did, who would manage it and how we would manage it and what the responses would be and who would sign off. Meanwhile, all the times that we

were not responding our silence spoke volumes and the narrative about us was built without us being part of the conversation.

Jo Kuper, MSF OCA, Myanmar and Bangladesh Communications Advisor September 2011-February 2014 (in English).



Now it's a well-known fact that Facebook was weaponised in Myanmar to back and steer support for the cleansing campaign in Rakhine. At that point, in 2012 we had this proposal to go proactively and try to have our own voice in that and saying: "okay, this is what MSF does."

The mission didn't want it. They thought it was dangerous to go on Facebook. I said: "look, if there are people spreading hatred and lies about our work, we need to somehow engage with it." All that is always within the context of an overriding fear. The desk and mission were over cautious. Nobody would disagree that you have to be cautious in a place like Myanmar. But one thing is to be cautious and the other thing is to be paralysed.

Hernan del Valle, MSF OCA, Head of OSCAR Operational Support Communications Advocacy Reflexion, 2011-2016 (in English).



We did it from Hong Kong. We had several calls with the communication team in Myanmar to discuss with them what they could do, and what they needed to do to really make use of social media. The initial idea was trying to mobilise the local staff, the national staff to disseminate the correct stand of MSF. But they got so many national staff there, how could they know if it was the official, correct message from MSF that was disseminated. They needed to have an official website to post the official message. The first thing that we figured out was to find someone who could help to do a lot of translation and to set up a website. It was quite challenging because they had a translator on the ground but we could not even confirm how accurate the translation was. It took a while to identify someone really trustworthy to do the translation and also to explore different solutions for the website infrastructure.

Eventually, they asked the MSF International Office to host a mini website for Myanmar on their website. We put all the basic information of MSF like neutrality, impartiality ... this kind of basic value to mobilise the staff to disseminate this correct information to their friends. We also tried to ask them to establish a Facebook group at the time, a centralised place so that they can disseminate information to the national staff. The challenge was that not all national staff had a smartphone. They would need to go to the internet café to get access to internet. So, it will be another challenge to really disseminate all the information to them.

Alan Cheung, MSF Hong Kong, Digital Officer, 2007-2014 (in English).

In the second half of March 2013, the head of MSF OCA OSCAR, Hernan del Valle visited the MSF OCA programmes in Rakhine State. He brought his analysis of the situation and his recommendations, notably in terms of advocacy and communication which included, among other things, elements advanced during the 'Rakhine Day' in December 2012:

- **Certain elements of the Myanmar government's segregation policies toward Rohingya, following the 2012 violence, can be defined as ethnic cleansing.**
- **The MSF OCA programmes in the Rohingya 'concentration' camps of eastern Rakhine were vital for this vulnerable population and should not be questioned. However, MSF should question their possible 'complicity with segregation' policies by working with "ethnically exclusive" clinics, recently set up to improve perceptions and acceptance of the organisation by general populations in northern Rakhine.**
- **The main argument for MSF to speak out should be an ethical one: "*choosing to remain silent or to reduce the problem to less controversial issues like 'the need for assistance' and 'medical needs' alone will be doing a disservice to MSF and to the people we intend to serve.*"**
- **MSF should move away from its long-term 'silent/behind the scenes' advocacy and raise the "red flags" as core message. This should be done the same way they would be raised routinely in any other setting, without talking about citizenship, human rights, or political solutions.**
- **A report on segregation actions, witnessed by MSF's teams should be produced by the humanitarian affairs officer in Rakhine and distributed to selected government officials in order to confront them with their responsibilities. The report should be widely shared with stakeholders engaged in Myanmar (donors, organisations, regional governments, businessmen, etc). It should be released publicly in order to take advantage of the Myanmar media 'spring,' targeting Myanmar public opinion.**

All field teams should be involved in open discussions, clearly documented decisions, and public explanations of compromises and difficult choices MSF is forced to make.



'Trip Report – Myanmar (Rakhine State), March 16–30, 2013 Hernan del Valle, Head of Humanitarian Affairs, Advocacy and Operational Communications,' 10 April 2013 (in English).

Extract:

My observations on Rakhine are based on dozens of in-depth conversations with community members, MSF patients, and staff (national and international, medical and non-medical). The variety of views and perspectives I gathered in those conversations is perhaps the best testimony of MSF's struggle trying to address medical needs in a complex political environment. I have a lot of respect for the work being done by our teams under difficult conditions. This report is intended to contribute a humanitarian affairs view and my personal analysis of some of our current challenges, offering a handful of recommendations for our operational positioning, advocacy and communications in an evolving context. [...]

The violence of 2012 marks a turning point in the history of ethnic/religious dynamics in Rakhine. If, before 2012, MSF characterised the situation as 'persecution' of the Rohingya minority based on state legislation, policy, and practice, the situation in Sittwe today has developed into a policy of segregation with no end in sight. In fact, an objective look at

Sittwe today cannot but identify some of the defining elements as an ethnic cleansing process. In addition to the mob violence, killings and targeted destruction of homes and places of worship in 2012, the government intervention today seems aimed at consolidating forced displacement and the removal of 95% of Muslims out of Sittwe town, with the seemingly permanent restriction imposed on them to go back. The plots of land on which Muslim houses used to stand in Sittwe town have now been claimed as property of the state. All mosques have been dismantled. The few remaining Rohingya still in town live confined in a ghetto-like situation in Aung Mingalar, behind barbed wire and under custody of the security forces, unable to move freely beyond that perimeter and having lost their livelihoods (some of MSF staff are still confined there). Under these conditions, the smuggling of Rohingya asylum seekers to third countries has intensified and its price skyrocketed (esp. Malaysia, Thailand, Bangladesh). The status quo described is enforced by state security forces in the name of the perpetuation of peace and order between the two communities. [...]

The violence and intimidation seen in 2012 have also had a critical and lasting social effect. They have created an environment in which fear is pervasive. A sense of vulnerability to unchecked violence cuts across local population in Rakhine (especially Rohingyas but also all those directly targeted last year, regardless of their origin). Not only families and communities are intimidated. Doctors trying to provide care also are. MSF and its staff have been subjected to a consistent campaign of intimidation by extremist elements which affects our operations to this day. Some of our former Muslim staff in Sittwe are still living in camps or in the ghetto, unable to move freely. Some of our ethnic Rakhine staff have not gone back to work either, due to intimidation or fear of Rakhine extremists. Most of our Burmese staff from other parts of the country (the 'inpats'), reluctantly carry on with work but are extremely sensitive to threats (real or imagined). The overwhelming intensity and power of rumours is perhaps the best indicator of the state of pervasive fear I am trying to describe. Fear is internalised. In this environment, in which state authorities have failed to send a clear message protecting minorities and those who provide aid, extremists who administer fear by the means of threats have found an effective way to exercise control. [...]

• Rakhine State – Key Humanitarian Issues for MSF

There are some basic elements of the situation in Rakhine which have been so well documented and witnessed by MSF that should be considered facts within our analysis. I will not repeat what has been documented in dozens of reports over the years (see previous footnotes), but will limit myself to saying that analysing the situation through the lens of what MSF has defined as 'red flag' situations in humanitarian action, Rakhine presents poignant and clear examples of all five of them: 1) violence against civilians, 2) forced displacement, 3) targeted exclusion and discrimination, 4) violence against medical/humanitarian staff or property, and 5) obstacles to providing and receiving medical/humanitarian assistance.

These five humanitarian 'red flags' continue to be a major source of concern in Rakhine today, and can be linked to a direct impact on the health and well-being of individuals and communities. In all cases, our analysis should not fail to reflect that both by action and by omission (failing to act), state authorities at local and national level are ultimately responsible for what is happening in Rakhine. This responsibility exists at three levels: legislation (denial of citizenship, papers, rights), policy (restrictions on births, marriages, movement), and daily practice (abuses by security forces committed with total impunity – from forced labour to rapes). [...]

• MSF Operations in Northern & Eastern Rakhine – Ethical Dilemmas

Rakhine is a text-book example of why we cannot keep the medical profession – in particular, the practice of medicine in humanitarian contexts – segregated from politics.

The medical act has a political dimension for two main reasons. Firstly, because operational prioritisation in Rakhine involves political and ethical choices. Secondly, because the presence and actions of MSF doctors are one of the tools used by political factions in Rakhine to play out their own agendas.

It is not surprising that operating in such context, MSF has continuously struggled to position itself with operations and advocacy. Deep ethical tensions are built right into the logic of our decision to intervene, and stem from the inability of humanitarian action to provide the urgent political solutions that are needed. It is therefore absolutely necessary that we regularly question our choices and assumptions when operating in Rakhine. We need a constant review of our contextual reading, based on thorough and explicit analysis, involving all levels: field teams, coordination, and HQ. I believe the multiplicity of perspectives is what helps MSF stay on its toes in a changing context. Ultimately, the quality of our choices will depend on the quality of this internal debate. I will document three 'dilemmas' that continually came up in discussions during my visit to Rakhine, and try to offer my analysis and personal views on them: [...]

a) The 'line in the sand' question. There has been much debate amongst the teams about defining a line, a limit beyond which it would be ethically unacceptable for MSF to continue operating in Rakhine, and would have to denounce the situation and if necessary, pull out. I do not find this discussion useful. Firstly, because it is virtually impossible to a priori define a set of conditions that would trigger a pull-out. But fundamentally, because we should not be wasting time wondering about when 'would be the right time' to disengage, but rather on how we can most effectively leverage a situation that is utterly unacceptable by any standards. The only thing that should keep us busy is how to continue operating while making sure we actively and through all available means (many of which we have not yet used) confront the state authorities with the devastating consequences of their own action and/or inaction, which we witness on a daily basis.

b) The 'speaking out' question. To be or not to be? Shall we or shall we not? I also do not find this discussion very useful, because it is often presented as a disingenuous zero-sum game between two alternatives – 'operational presence' vs. 'being kicked out' (either by the government or by extremist threats). I am convinced that providing care in a situation like Rakhine is the right thing to do. I am also convinced that choosing to remain silent about what we are witnessing is not an ethically justifiable option. 'Complicity', a word often heard in our discussions about Rakhine, is defined as follows: "An individual is complicit in a crime if he/she is aware of its occurrence and has the ability to report the crime, but fails to do so. As such, the individual effectively allows a crime to happen despite possibly being able to stop it, either directly or by engaging those who could, thus making the individual a de facto accessory to the crime rather than an innocent bystander." So, the question is not really if we should speak out or not, but how we can most effectively do so to have leverage and a positive impact on the lives of the people we serve. The dichotomy expressed as the choice between 'medical aid/presence' and/or 'speaking out/leaving' is not a zero-sum game. It is possible (and ethically imperative) to do both. One without the other is not good enough.

c) The 'complicity with segregation' question. This is an issue that definitely deserves analysis, because there is no one-size-fits-all answer. In the aftermath of the 2012 violence, MSF has been confronted with the segregation dilemma in two different instances, each of which merits a different answer.

The first case is the ethnically exclusive (segregated) clinics set up by MSF in northern Rakhine. A few months ago, MSF reluctantly agreed to requests from the Rakhine community to establish two separate clinics in Maungdaw: one for Rohingya Muslims and one for Buddhist Rakhine. Agreeing to this request was seen as a pragmatic

operational compromise to improve perception and acceptance, dispelling the allegations from the most radical elements in the Buddhist Rakhine community who in the wake of the violence last year accused MSF of working only for Muslims. Clinics 1 (for the Rakhine) & 2 (for the Rohingya) are now located walking distance from one another in the centre of town, with Clinic 1 being right next to the hospital to which the Rakhine otherwise have unrestricted access. Having sustained this set up for a few months, several things have become evident: Firstly, while Clinic 2 (Muslim) is constantly overwhelmed with patients (turning away an average of 150 women each day due to limited capacity), Clinic 1 is virtually empty (anywhere between 9 to 25 patients a day, mostly Hindu rather than Rakhine). This is not surprising given that Muslims are a sizeable part of the total population and do not have access to healthcare in the MoH hospital, while the Rakhine are fewer and can go to the local hospital. In these few months, MSF has chosen to turn away Muslims from its 'Rakhine only' clinic, directing them to Clinic 2 instead. More recently, we have gone as far as removing the last Muslim staff from Clinic 1, shifting him to Clinic 2, in case his presence had been a barrier for the Rakhine to attend.

It is not surprising that MSF teams articulate burning questions, both about MSF's impartiality and choices on resource allocation in this setting, and also more fundamental ones about the identity, image, and values the organisation stands for in Rakhine. Note that people in Maungdaw are not living in segregated spaces (as is the case in Sittwe), that the town market is open to everyone in a single building, that Buddhists and Muslims trade with each other and go about business in a mixed space, in spite of the heightened tensions that will continue to exist. In that setting, it is legitimate to question the message MSF is sending by establishing segregated clinics.

My personal view is the following: Ideologically, I believe MSF should – in a setting like Rakhine – be extra cautious to ensure that operational pragmatism does not translate into an unnecessary endorsement of a logic of apartheid in healthcare, especially in a community in which segregation has not (yet?) been imposed as an overall policy in other areas of social life. The establishment of segregated clinics was not a requirement imposed by the government, but a request from some community members.

From a practical standpoint, very valid ethical questions emerge about allocation of resources. I believe it is time to re-evaluate the operational need and real usefulness of this duplicated set-up, especially as we now have elements that show there is no medical justification to continue allocating what seems like a disproportionate amount of resources for needs that are not there (while at the same time neglecting real needs elsewhere – e.g., see assessment in Buthidaung). Impartiality is not about distributing our assistance evenly amongst two different ethnic groups. I believe there is space to carefully renegotiate and adapt the services we provide to the needs we see, eliminating Clinic 1 in the process and finding other ways to serve both communities in an impartial manner. The same goes for the six clinics we are currently running in Natala villages (the model villages promoted by government policy as an attempt to modify the ethnic make-up of Rakhine state). Even if these villages were directly targeted by violence last year, the houses have now been rebuilt, water pumps are in place, and access to healthcare from other sources does not seem problematic (source: Natala village leader himself). During my visit, we had only 8 consultations in Natala in an entire morning, with the doctor and nurse leading the clinic reporting a maximum of 18 or 20 in a busy day. Maybe there are options for substituting these clinics with mental health services only, since talks with community leaders suggest there might be a need (although this needs to be properly assessed by the MHOs).

The second dilemma presented by segregation is the case of Dar Pai (ERS). Dar Pai is one of Muslim settlements outside Sittwe, where 95% of the Muslim population has been relocated in the aftermath of the violence last year [...] for a full description). These

people (an estimated 80,000–120,000) continue to be prevented from entering Sittwe by state security forces (there is a clear demarcation line guarded by a checkpoint). In spite of the presence of some agencies (UNHCR, ACF, Malteser, etc.) medical needs are not catered for properly. ICRC runs an ambulance service for referrals to Sittwe hospital, which is the only way for Muslims to cross the checkpoint. Rakhine cross the checkpoint in the other direction without restrictions. So, the inevitable question arises: should MSF provide health services in Dar Pai, within those segregated settlements? Would we be facilitating a policy of segregation by doing so?

Given the level of need and vulnerability of this population, I would find it difficult to justify a decision to refrain from offering services that we are in a position to provide. Not doing anything is not an option. Even if we strongly disagree and reject segregation from an ideological standpoint, I believe this should not prevent MSF from offering the best possible services to communities who are clearly in need of them and will not access them otherwise. However, we should be aware of our role in such setting. We cannot become a mere provider of medical technical services, blind to what is otherwise a politically disgraceful situation. Next to the healthcare provision, and in order to dispel our dilemma of complicity, MSF should speak out clearly, loudly, and in no uncertain terms about the situation in Sittwe (segregation, loss of livelihoods, emerging needs, fear, obstacles set to referrals to Sittwe hospital, etc.), and the rationale of the operational choice we are forced to make. [...]

It would seem wise to position ourselves clearly and publicly on Sittwe today, while at the same time engaging and providing care where it is most needed.

Action Points & Recommendations [...]

Based on the observations and analysis above, the following recommendations are made:

1. Adapt our advocacy and communications plans to a changing environment: Until now, MSF efforts have been focused on silent diplomacy, behind the scenes (e.g., supporting Greg Constantine book 'Exiled to Nowhere', producing the 'Fatal Policy' briefing paper to support briefings with stakeholders, etc). The current context offers an opportunity to scale up efforts and shift gears into a new phase. This new phase should be in sync with developments in the country, which have significantly changed the points of leverage had two years ago [...]

2. MSF core messages: MSF's main concerns are clear, and outlined in the 5 'red flags' laid out above in this report. These are all core MSF messages. There is no need to talk about citizenship, human rights or political solutions. These are clear humanitarian issues that MSF would raise routinely in any other setting, and Myanmar should not be an exception.

3. Tactical dissemination. Advocacy & Communications: The discussion on how to go about it should move away from the binary 'public vs. not public' discussion, which is not helpful. The way in which we decide to disseminate the upcoming report should be based on a proper stakeholder analysis that identifies the most effective points of leverage internally and externally. In the current context we should have a more ambitious dissemination strategy, targeting the government of Myanmar at local and national level, something we have never done before. In fact, discussing these issues directly with selected government officials and confronting them with their responsibility to find solutions is an essential step. We should also make our report available (without unnecessary restrictions on further distribution) to key individuals, donors, governments, organisations, lobby groups, and private companies engaged in Myanmar.

Finally, public opinion is a critical factor both internally and externally. On the external front, western democracies and the business sector engaging with Myanmar are vulnerable to it, and the Myanmar government and elites have a key interest to keep this


engagement alive with nothing standing on its way. So not directing public pressure on them would be a missed opportunity. On the internal front, the 'media spring' (including social media) within Myanmar offers opportunities to start countering the hegemonic discourse on Rohingyas and foreign aid, dominated by extremist groups on the back of social media. It is at the level of public opinion in Myanmar that an important part of the work remains to be done. Burmese public opinion is an important factor standing in the way of national leaders and politicians to engage with the Rohingya question.

Having made the points above, it is important to remember that speaking out on the situation in Rakhine cannot be reduced to a utilitarian calculation. As we learnt from our experience in the country (see Humanitarian Negotiations Revealed for the 1990s example in Yangon), there are important ethical questions that cannot be set aside and link our silent assistance with a complicit attitude in relation to policies that are contrary to everything that MSF stands for (ethnic segregation and perhaps cleansing). Hence, choosing to remain silent or to reduce the problem to less controversial issues like 'need for assistance' and 'medical needs' alone will be doing a disservice to MSF and to the people we intend to serve. It would be, for sure, something we are bound to regret in the years to come. We are in a position to provide a full description of the humanitarian situation and take a proactive role in addressing it by using all the means at hand. Unless a thorough risk analysis identifies a concrete, serious, and immediate risk for our patients or staff that we are not able to mitigate by any means, we should not sacrifice the possibility of having maximum leverage at this critical point.

4. Expand the debate on operational choices and compromises: [...] We are responsible for those choices today, and we will be invariably judged for the way they will be understood in the future. We therefore need to share that responsibility and have open discussions involving the entire teams, clearly documenting decisions, and speaking publicly about unsavoury compromises we are forced to make. A constant review of our contextual reading should involve all levels: field teams, coordination, and HQ. I believe the multiplicity of perspectives helps MSF stay on its toes in a changing context. Ultimately, the quality of our choices will depend on the quality of this internal debate. Specific for northern Rakhine State: a) Prioritise expansion of services based on available medical assessments (Buthidaung, etc.). Some of this expansion should be possible with existing resources, b) Make adaptations in operational tactics, aimed at closing Clinic 1 and negotiating other ways to continue serving both communities in an impartial manner, allocating our resources where they are most needed, and not engaging in segregation of medical facilities in a setting in which segregation is not a government imposition and does not apply to other social interactions (market, trading, etc), c) Routinely document violence and abuse presenting in MSF clinics and find adequate and effective ways to report them to protection mechanisms, taking safety of patients and staff into account, d) Support the work of the Humanitarian Affairs Officer and benefit from it, by actively promoting team discussions on humanitarian issues, context, strategy and choices.

6. Specific for eastern Rakhine State: a) Prioritise consolidation of operations and increase of medical quality over further geographic expansion (unless more human resources and logistics means were suddenly available to do both. Note upcoming rainy season will come with additional challenges), b) Prioritise efforts to engage in Aung Mingalar, negotiating access for mental health activities, mobile visits or other alternatives. The humanitarian situation there should be a major source of concern, c) Continue negotiating our operational engagement in Dar Pai, making sure it goes hand in hand with speaking out in clear and no uncertain terms about the situation of segregation and the rationale of the operational choice we are forced to make, d) Continue to focus on rural areas through the boat and car clinics. These are the most

underserved areas, and therefore an impartial engagement with both communities makes sense in this setting.

In late March 2013, in Meiktila in the centre of Myanmar, clashes between Buddhists and Muslims led to dozens of deaths and to the burning of several mosques. The Myanmar president's spokesperson stated that, "a degree of 'chaos' is inevitable as Myanmar undergoes a transition to democracy" and called on society as a whole to speak out against religious violence. [V7](#) 

On late April 2013, violence against Muslims flared up again, 100 kilometres north of Yangon. Houses were burnt and mosques were attacked.



'Myanmar Must Unite Amidst the Post-Junta 'Chaos' (Spokesman) (Interview) by Didier Lauras Exclusive **AFP** (Naypyidaw, Myanmar), 5 April 2013 (in French).

Extract:

A degree of 'chaos' is inevitable as Myanmar undergoes a transition to democracy, President Thein Sein's spokesman, appealing for unity in the wake of deadly religious violence, told the AFP. While Muslim and Buddhist communities express growing concern following the confessional riots towards the end of March, Ye Htut, also deputy minister for the Ministry of Information, defended their intention to try and "strike a balance between freedom and responsibility of the society." And he admitted that the government had their work cut out with the rise of extremism in a country that had been kept quiet for half a century by the military and was now dealing with an onslaught of at times sickening opinions and ideologies.

When the censorship was lifted, "we found out that there was a lot of hate speech, extremist religious ideas, racial discrimination," he explained in his office, in Naypyidaw. "In the past, the military tightly controlled the press and the political movements. As in many other countries undergoing a democratic transition, new ideas have emerged," he added. "We cannot avoid this time of chaos but what we're trying to do is create a good legal framework to overcome all these challenges. We need to strike a balance between freedom and responsibility of the society."

At least 43 people were killed while mosques and homes were destroyed in Buddhist-Muslim unrest in central Myanmar in late March. The president, who has stepped up reforms since the dissolution of the junta in March 2011, has delivered some well-received speeches, bravely speaking out against 'religious extremists' and even calling out directly the Buddhist hierarchy, nationalist elements of which are explicitly inciting hate and discrimination.


"He has set a vision for a new democratic Myanmar and is asking the people to understand one another," explains Ye Htut. "His speech was a good example of how we can clearly rise above the extremism that risks disrupting our transition." But Muslim associations have since called for concrete actions. And human rights organisations have accused the security forces of passivity, and even complicity, while fears are emerging of a contagion of riots in the former capital and economic lung of the country, Yangon. Ye Htut has fiercely rejected this criticism, describing how the local police were initially overwhelmed by the situation in Meiktila. "On the streets, people fleeing were with the rioters and looters. You could not differentiate between all the groups," he said, adding even "very modern British police" could not control riots in 2011 in their major cities.


Today, while the violence has calmed down, “we are on maximum alert,” acknowledged Ye Htut.

Nearly 120 people were arrested. “Dozens more are on the run, but the authorities have issued arrest warrants. Some have already been charged with murder, arson and vandalism.” [...]

He believes the whole society needs to take responsibility to get through the crisis. “Speeches and good intentions will not be enough to convince the Muslims of the government’s sincerity,” he conceded. Civil society and religious organisations need to lay the foundations for a more open society and that will not happen overnight.

HRW ACCUSES MYANMAR GOVERNMENT OF ETHNIC CLEANSING

On 17 April 2013, opposition leader Aung San Suu Kyi publicly denied that she was neglecting ethnic minorities in Myanmar. She stated that she was “sad” for the Rohingya but never condemned the violence they suffer. This attitude was perceived as an effort not to anger Myanmar people ahead of the 2015 elections and to avoid tarnishing the international aura she acquired following her 1991 Nobel Peace Prize. [V8](#) 

On 22 April 2013, Human Rights Watch issued a report accusing the Myanmar government of engaging in a campaign of “ethnic cleansing” against the Rohingya. [V9](#)  The Myanmar government immediately rejected the accusation noting that the report was issued just before an EU vote to lifting sanctions against Myanmar.

On 23 April 2013, the final report of the official Inquiry Commission on the sectarian violence in Rakhine State, set up by President Thein Sein to investigate the violence between Buddhists and Muslims was released publicly. The report strongly recommended that aid and security be urgently increased in western Myanmar. Human Rights Watch pointed out that the “need” to find and hold those accountable for “crimes against humanity” committed in June and November 2012 was not mentioned in the report. HRW further requested the Myanmar government to accept an independent international commission inquiry.

On 1 May 2013, the United Nations special rapporteur on the human rights situation in Myanmar stated that while addressing the humanitarian situation in the region, the recommendations of the presidential Rakhine Investigation Commission report still restricted the movements of the Muslim populations in the internally displaced camps and in Muslim residential areas.



“Myanmar: Suu Kyi’s Aura is Fading Faced with the Light of the Muslims” Amélie Bottollier-Depois **AFP** (Bangkok), 21 April 2013 (in French).

Extract:

By refusing to condemn the attacks against the Muslims, the Burmese opposition leader Aung San Suu Kyi has lost some of her aura among international human rights champions, but it’s a strategy that has certainly prevented her from alienating herself from her own people before the 2015 elections. [...] “They feel like they don’t belong to any other place and you feel sad for those that aren’t able to feel they belong to our country either,” she

declared this week in Japan. But Suu Kyi, a member of the ethnic Burman majority who is a figure of mistrust among the minorities, has not explicitly condemned violence against Muslims nor the hate speech committed by extremist Buddhist monks. Just like in 2012 when violence that erupted between minority Rakhine Buddhists and the stateless Rohingya Muslim minority led to at least 180 deaths in the west of the country, she continues to emphasise the importance of the 'rule of law'.



“Burma: End ‘Ethnic Cleansing’ of Rohingya Muslims: Unpunished Crimes Against Humanity, Humanitarian Crisis in Arakan State”, Human Rights Watch **Press Release** (Bangkok), 22 April 2013 (in English).

Extract:

The 153-page report, “All You Can Do is Pray’: Crimes Against Humanity and Ethnic Cleansing of Rohingya Muslims in Burma’s Arakan State,” describes the role of the Burmese government and local authorities in the forcible displacement of more than 125,000 Rohingya and other Muslims and the ongoing humanitarian crisis. Burmese officials, community leaders, and Buddhist monks organized and encouraged ethnic Arakanese backed by state security forces to conduct coordinated attacks on Muslim neighbourhoods and villages in October 2012 to terrorize and forcibly relocate the population. The tens of thousands of displaced have been denied access to humanitarian aid and been unable to return home.

“The Burmese government engaged in a campaign of ethnic cleansing against the Rohingya that continues today through the denial of aid and restrictions on movement,” said Phil Robertson, deputy Asia director. “The government needs to put an immediate stop to the abuses and hold the perpetrators accountable or it will be responsible for further violence against ethnic and religious minorities in the country.” [...] Human Rights Watch urged the Burmese government to urgently amend the 1982 Citizenship Act to eliminate discriminatory provisions and to ensure that Rohingya children have the right to acquire a nationality where otherwise they would be stateless.

“Burma should accept an independent international commission to investigate crimes against humanity in Arakan State, locate victims, and provide redress,” said Robertson. “Burma’s donors need to wake up and realize the seriousness of the Rohingya’s plight, and demand that the government urgently stop abuses, promote the safe return of displaced Muslims, and ensure accountability to end the deadly cycle of violence in Arakan State.”



[Presidential] “Inquiry Commission on the Sectarian Violence in Rakhine State”, **Executive Summary of the Final Report**, 23 April 2013 (in English).

Extract:

The conflict and tension between the Rakhine people and the Bengali people go a long way back. Major differences between the two groups in religion, traditional practices, culture and social norms meant that each group did not easily accept the other. Relations between the two groups have seen attacks and killings, heightened feelings about racial identity, desire for political control, accusations and counter accusations. The bitterness and tensions have passed down from one generation to the next. Amongst the many episodes of violence, the sectarian violence that erupted in June and October of 2012 was particularly prominent.

The 2012 sectarian conflicts led to 192 deaths, 265 injured, and the destruction of 8,614 houses, turning an estimated 100,000 into internally displaced people (IDPs). The violence has affected not only the livelihoods and food security of these communities, but has also affected businesses throughout Rakhine State. Attacks and counter attacks, killings and counter-killings erupted between the Rakhine and Bengali, leading to heightened fears, lack of physical security and the inability of communities to meet their basic essential needs. In particular, the violence has affected vulnerable groups such as women and children both physically and psychologically. The result was a breakdown in communication between the two sides. The earlier hatred and bitterness between the two sides – which had been created because of certain historical events – provided fertile ground for renewed tensions, mistrust and violence.

Therefore, to address the root causes and problems, the Commission recommends the following: [...] The security forces to prevent the violence must be fully prepared and able to access all areas rapidly. To this end, they should be equipped with modern telecommunications systems, all-weather vehicles, speedboats and other suitable transport. The communities on both sides need to be educated on the relevant laws, regulations and policies and on the nature of sanctions for those who break the law. Rakhine State's civil service needs to be strengthened, in particular, the Office of General Administration and the Department of Religious Affairs.

The authorities need to ensure that those who break the law are tried and punished swiftly following due process, without discrimination between different groups, who should all be equal before the law. [...] The Government and various organisations are now implementing emergency relief and recovery/rehabilitation programmes that provide food, shelter, health and education services, and livelihood opportunities. Although there have been some modest achievements, the response still has many gaps. An estimated 15% of food needs are still unmet. Some 90% of needs are unmet in the construction and provision of shelter. The need for shelter is all the more urgent because of the imminent arrival of the rainy season. Basic and preventive health measures need to be improved and expanded. In the education sector, teachers are urgently needed, as are other measures to reopen schools and provide a safe learning environment for children. To address the above problems, the Commission recommends the following measures as urgent priorities: [...]

Rakhine State's economy and business environment need to be enhanced, so that livelihood and employment opportunities are created and expanded. However, this will happen only if the two groups are able to live side-by-side without conflict and tension.



'Violence: Myanmar Must Increase Aid and Security in the West (report) **AFP** (Yangon),' 29 April 2013 (in French).

Extract:

This unfortunately doesn't go far enough, says Human Rights Watch. "Doubling the number of security forces without first ensuring implementation of reforms to end those forces' impunity is a potential disaster," said Phil Robertson. The report doesn't respond to the 'need' to see people held responsible for 'crimes against humanity' committed in June and November 2012, he added, while HRW has accused Myanmar of undertaking a 'campaign of ethnic cleansing' against the Rohingyas.



“Myanmar: UN Expert Calls on Government to Address Impunity for Crimes in Rakhine”, **UN News**, 1 May 2013 (in English).

Extract:

While welcoming the most recent efforts of Myanmar’s Government to look into the sectarian violence that erupted last year in Rakhine state, a United Nations expert today stressed that much more needs to be done to end discrimination and hold perpetrators accountable for their crimes.

The Special Rapporteur on the human rights situation in Myanmar, Tomás Ojea Quintana, said that while the recommendations of the Rakhine Investigation Commission report address the humanitarian situation in the region, they still restrict the movements of the Muslim community in particular.

“The Investigation Commission’s report contains many worthwhile recommendations, which I encourage the Government of Myanmar to implement,” said Mr. Ojea Quintana after reviewing the recommendations of the 27-member Commission, set up last year by President Thein Sein in the aftermath of the violence between Buddhists and Muslims that spiked in June 2012 and then again in October. Those recommendations included measures on addressing the dire humanitarian situation in the Muslim camps for internally displaced people, such as overcrowding, access to clean water and sanitation, the risk of disease, food security and child malnutrition, as well as on improving access to education and livelihoods.

“However, in implementing them, I urge the authorities, as a matter of urgency, to ease the harsh and disproportionate restrictions on the freedom of movement of Muslim populations in the IDP camps and also in Muslim residential areas, such as Aung Mingalar in Sittwe and across northern Rakhine State, while also providing adequate security,” he said. Those restrictions greatly exacerbated the humanitarian situation, restricting access to food, healthcare, livelihoods and education, he said, adding: “Now we are at the beginning of May and the harsh restrictions for Muslim populations remain firmly in place.” In a report to the Human Rights Council, Mr. Ojea Quintana had previously noted that the Taung Paw camp in Myebon felt more like a prison than an IDP camp.

The Special Rapporteur praised the report’s recommendations to double the presence of police, military and border security forces in Rakhine, but said accountability for human rights violations must also feature prominently in the Government’s agenda. “I have received credible allegations that widespread and systematic human rights violations by state officials targeted against the Rohingya and wider Muslim populations have occurred and are continuing in Rakhine state. These involve the most serious of allegations, including extrajudicial killings, rape and sexual violence, arbitrary detention and torture and ill-treatment in detention, deaths in detention, and denial of due process and fair trial rights,” he said. “The Government has an obligation under international law to investigate these allegations effectively, promptly, thoroughly and impartially and, where appropriate, to take action against those responsible, in accordance with domestic and international law,” he said, adding that accountability is an integral part of restoring relations of trust and harmony among ethnic and religious communities. Mr. Ojea Quintana also expressed concern over the recommendation that communities should continue to be separated while emotions remain high, noting that the Government must plan for integrated communities as homes are rebuilt and people resettle to avoid permanent segregation.

MAY 2013 - 'MYANMAR: RESTRICTIONS SEVERELY IMPACTING ACCESS TO HEALTHCARE IN RAKHINE STATE' (RELEASED PUBLICLY)

In Rakhine, on 3 May 2013, an ongoing Rohingya IDP verification and registration process was stopped after it triggered violence in the camps. This was considered a first step towards a return to hometowns.

Anticipating the impact of the impending rainy season on the already dire situation of the population, MSF OCA decided to draft a press release to raise the alarm. Quoting the emergency coordinator, who just returned from an assessment in villages completely cut off from all services, MSF OCA pointed out the impact of the government restrictions regarding access to healthcare in Rakhine State. Further, MSF OCA called on the government and international actors to respect all humanitarian and international principles to ensure proper shelter and access to healthcare, food, water, and sanitation before the start of the monsoon season.

The press release was postponed due to the approach of a cyclone that would strike the region. Thousands of people were evacuated ahead of the storm most of them Rohingya IDPs.

On 13 May 2013, MSF OCA communications advisor sent a 'reactive line' regarding the cyclone to be used for requests from journalists. It stated that MSF teams were preparing for an emergency response, including provision of medicines, medical supplies, and pre-positioning relief items, to respond to wounded patients and those in need.



'MSF OCA **Operational Bulletin**,' 3 May 2013 (in English).

Extract:

Myanmar: [...] On the ground, verification and registration of IDP identities began on Friday in the camps as a first step towards returning occupants to their hometowns. In Sittwe camp, demonstrations and violence broke out in response to the process, with several injured and 50 arrested. The government has placed the registration process on hold and for now it is unclear how they will proceed. Should the process proceed and large numbers be forcibly returned home, the imminent return of the rainy season may put these people in even more jeopardy.



'MSF OCA **Operational Bulletin**,' 6 May 2013 (in English), edited.

Extract:

The team did an explo to an area with many cut off Muslim villages in Mrauk U area Rakhine State, Myanmar. These people have been experiencing similar violence as the people in the IDP camps, but without all being displaced. Apart from the stories we have heard before, here we also witnessed the impact of the violence on people's livelihoods. For example: people lost access to education, the possibilities to farm and the fact that

they can no longer go fishing, because their nets were taken away. We heard that both sides, Muslim and Buddhists, have trouble sleeping at night. The situation has a big impact on them, before they used to live together and share villages, and intermarry, now they are in a conflict.



'Draft Press Release, MSF OCA, Yangon, Myanmar,' 10 May 2013 (in English).

"How can we go, we don't feel safe to go to the health centre" – Mother of twins who died from fever and diarrhoea. Nearly a year since deadly inter-ethnic clashes in Rakhine state first broke out, an estimated 125,000 people are still living in makeshift camps, with limited access to healthcare – said Médecins Sans Frontières (MSF) today. According to official estimates, the vast majority of the displaced are a Muslim minority often referred to as the Rohingya.

The conditions in the displaced persons camps, combined with movement restrictions and ongoing segregation of Rakhine and Muslim communities, are severely impacting on healthcare said the medical humanitarian organisation. As well as direct victims of violence, tens of thousands more people that are still in their homes have been almost entirely cut off from health facilities, food, markets, their fields, and in some cases even clean water. "MSF has just returned from assessing areas where whole villages are cut off from basic services," said [MSF emergency manager]. "The results show that current policies such as movement restrictions are having a detrimental impact on people's health. This includes TB patients who can't access the treatment they need to stay alive, and pregnant women dying unnecessarily, because they have nowhere safe to deliver."

In other areas people are scared to move. In one village, MSF spoke to a man who had lost both his parents in a four-month period because they could not get medical attention. *"We can no longer go to the hospital because we are scared of what will happen to us, if we ask for security, we are told it cannot be guaranteed ... now both my parents are dead."* MSF is extremely concerned that some of the government's stated plans to relocate communities, combined with movement restrictions could have further detrimental effect on their ability to access their livelihoods and healthcare. MSF urges that any relocations must be voluntary, in line with guiding international principles for internally displaced people.

MSF also urges that displaced people are particularly vulnerable with the upcoming monsoon season. MSF has already seen makeshift shelters and its own clinic structures destroyed from the still relatively light rains. "With the rainy season beginning the risk of flooding in the camps and disease outbreaks as hygiene conditions worsen, is particularly high," continued Flokstra. "More must be done to ensure these vulnerable communities are not washed away, and that they can access healthcare." MSF calls on the government and international actors to ensure proper shelter and access to healthcare – including to primary and secondary level healthcare – food, water and sanitation, respecting all humanitarian and international principles before the start of monsoon season.



Rakhine PR Next Steps, **Message** from Jo Kuper MSF OCA Communication Advisor to MSF OCA Myanmar teams,' 13 May 2013 14:48 (in English).

Extract:

Hi all,

The impending cyclone means that we have had to change our strategy with regards to the Rakhine PR [...] . Depending on whether it hits and with what impact, the messaging of the original PR may have to change. This means I cannot tell you exactly when we will issue the release. I'm afraid, but expect it to be this week still. We are all very concerned about the potential impact of the cyclone, and very much hoping for the best. Please do let me know if you have questions.

Many thanks, Jo



"Reactive Line on Cyclone Mahasen" **Message** from Jo Kuper MSF OCA, MSF OCA Communications Advisor to MSF Movement Communications Advisors,' 13 May 2013 (in English).

Extract:

Hi all,

We've been getting some questions in Myanmar about Cyclone Mahasen. A reactive line should you need it is attached (and below). If you have any questions just let me know, thanks – Jo

[Reactive line on Cyclone Mahasen](#)

MSF is very concerned about the potential impact of Cyclone Mahasen on people in Rakhine, in particular on displaced communities. Many internally displaced people are living on rice paddies very close to the water with inadequate shelter, drinking water or sanitation. MSF has already seen makeshift shelters and its own clinic structures destroyed from the still relatively light rains over the last months, the consequences of a cyclone could be very severe on these extremely vulnerable communities. MSF teams are preparing for an emergency response to the impending cyclone, including ensuring medical supplies are available to respond to any patients with injuries. MSF is also looking into pre-positioning relief items such as plastic sheeting and jerry cans, to be able to support communities whose shelters or houses are damaged.



'Mass Evacuations in Myanmar and Bangladesh Before a Cyclone, by Hla Htay **AFP** (Yangon),' 15 May 2013 (in French).

Extract:

Myanmar and Bangladesh announced on Wednesday the evacuation of hundreds of thousands of people, while Cyclone Mahasen threatened to strike vast, densely populated coastal regions in the Bay of Bengal. The Burmese government announced plans to relocate to safety roughly 166,000 people in Rakhine State (west Myanmar), mostly Rohingya Muslims displaced the previous year by deadly religious violence, and who have since been living in overcrowded and squalid camps.



The first time, I felt a bit surprised ... the conditions there in IDP camps were not what I expected. The conditions for them to survive there were really difficult. They were just living in tents, in a muddy area ... To reach them, we had to walk from our boat at the jetty to the camp for 15 to 20 minutes for the nearest one, more than an hour for other camps. We had to walk sometimes in the water, sometimes in the mud. It was particularly muddy when we reached to the middle of the tide. We could not build any permanent structure. We had to use a temporary tent, a medical box as a table for consultations. They could not access health services so they would only come to MSF mobile clinics, the only health service they could access. They could not go to hospital. So, for serious cases, when they had an emergency on other days than the mobile clinic days, they really had troubles to get healthcare services. Because of the crowded area, they were not getting clean water and they did not have enough soap. So, most of the cases were related to hygiene and sanitation: diarrhoea, abdominal pain due to worms, skin problems. There were also malnutrition problems for the children.

MSF OCA, Myanmar Staff (in English).

Cyclone damages were less serious than expected. However, in Rakhine 70,000 people were evacuated from camps and villages despite the mistrust and resistance of many Rohingya displaced people.

The announced press release was eventually issued on 28 May 2013. It strengthened the messaging of the earlier draft, blaming the “government-imposed restrictions on Muslim communities” for “preventing tens of thousands of people from accessing health care and other basic services.” It added some accounts regarding the IDP’s fear of moving again even under threat of the cyclone.

This press release came at the same time as the government announced the relaunch of birth restriction policies for the Rohingya. Therefore, MSF OCA teams decided to use information gathered in the ‘Fatal Policy’ briefing paper, drafted in 2011, to highlight the severe consequences of this policy on people’s health in interviews with local and international press.



“After the Cyclone, Bangladesh and Myanmar Relieved to Have Avoided the Worst” by Kamrul Hasan Khan, **AFP** (Chittagong), 17 May 2013 (in French).

Extract:

Bangladesh and Myanmar were recovering Friday after Cyclone Mahasen made landfall, killing at least 46 people and damaging thousands of homes along the coasts, relieved that the damage was not much worse. A million Bangladeshi, the majority from the Chittagong region, the country’s second-biggest city, and the tourist area of Cox’s Bazar, were evacuated from areas close to sea level. Most were able to return on Friday. [...] In Myanmar, the government media confirmed that 70,000 people had been evacuated from their camps and villages in Rakhine State, close to the border. But the situation is very tense in the region following clashes between Buddhists of the Rakhine minority and Rohingya that killed almost 200 people in 2012. Rakhine State is now home to 140,000 displaced people, crowded in camps where conditions are deplorable. The evacuations came against a huge amount of resistance in a climate of defiance towards the security forces. “The authorities came and told us that the storm was

coming, and we couldn't stay here. They told us to go into a school and a mosque, we all came yesterday (Thursday)," witnessed a 26-year-old displaced person in the village of Thet Kal Pyin, Soe Min, who usually lives in one of the 252 tents in a camp outside Sittwe, the capital of Rakhine State.

"Some returned to the camp and there wasn't any rice. The people in the school or the mosque have rice," he explained to the AFP. [...] According to the International Organisation for Migration (IOM), careful planning by both countries avoided a much heavier death toll. "If the cyclone had happened 20 years ago, there might have been thousands of dead. Today, the inhabitants are already leaving the cyclone shelters and returning home," said Brian Kelly, IOM's advisor for Asia-Pacific.



'Myanmar: Restrictions Severely Impacting Access to Healthcare in Rakhine State, MSF OCA **Press Release**,' 28 May 2013 (in English).

Extract:

Nearly a year since deadly inter-ethnic clashes in Rakhine state first broke out, conditions in the displaced persons camps, combined with movement restrictions and ongoing segregation of Rakhine and Muslim communities, are severely impacting on healthcare, said Médecins Sans Frontières (MSF) today. An estimated 140,000 people are still living in makeshift camps. According to official estimates, the vast majority of the displaced are a Muslim minority - often referred to as the Rohingya. The Rohingya are a stateless minority group, not recognized as citizens by the Government of Myanmar. As well as direct victims of violence, tens of thousands more people that are still in their homes have been almost entirely cut off from health facilities, food, markets, their fields, and in some cases even clean water.

"MSF has just returned from areas where whole villages are cut off from basic services," said Ronald Kremer, MSF Emergency Coordinator in Rakhine state. "What we have seen shows that current policies such as movement restrictions are having a detrimental impact on people's health. This includes TB patients unable to access the treatment they need to stay alive, and pregnant women dying unnecessarily because they have nowhere safe to deliver." Movement restrictions for Muslims were brought into the townships around Sittwe in June 2012, following the first clashes, and intensified after the October violence which saw thousands more people displaced. "We are only able to get to our farms very occasionally, and then only two or three of us at a time, and with military escorts. We cannot go to the hospital, to school, to fish, to collect firewood." said a man in Myebon township, Rakhine state. Sometimes we just want to die. We can't move. We can't leave. We can't fish. We just want to fish.

In other areas, people are simply too scared to move. "In one village, people told MSF that for months when people tried to move, they would get beaten up, and that after this happened 14 times, they simply stopped leaving their village," continued Kremer. "They told us that at least 3 people died because they could not reach the hospital. "This fear is so pervasive that even when people were living in the path of Tropical Storm Mahasen, many told us they were too scared to move. They did not know where they would be moved to, or what would happen to them."

MSF calls on the Myanmar government to take action to ensure displaced people, and those cut off from services, have proper shelter and access to healthcare. People must also be able to move freely, without fear of attack.



MSF OCA **Operational Bulletin**, 29 May 2013 (in English) edited.

Extract:

Myanmar: [...] The Myanmar government's re-statement of its two child policy restriction for Rohingya has received a lot of media attention recently, and we were able to use information from our previous medical activities about the severe consequences of this policy on the health of people to answer questions related to this and explain the negative implications in relation to it.

An increase in bilateral advocacy activities complemented this press release. Beyond the government of Myanmar and the Rakhine authorities, MSF OCA targeted the relevant UN representatives and diplomatic representatives from relevant countries. US Congressional representatives were approached at the time as the official USA visit of Myanmar's President Thein Sein. The Obama administration expressed support for Thein Sein's democratic reforms and economic openness.

At the same time, human rights organisations and international media denounced the inaction of the myanmarese regime in the face of increasing anti-Muslim attacks by radical Buddhists.

On 6 June 2013, the opposition leader Aung San Suu Kyi announced she would run for the Myanmar presidency in 2015. She acknowledged that the government must ensure that those who committed crimes be punished and assured that she would avoid adding fuel to the fire by stigmatising certain communities.

On 10 July 2013, in his opening remarks to the 'Group of Friends of Myanmar,' UN Secretary-General Ban Ki-moon warned the Myanmar government of "dangerous polarisation" between Buddhists and Muslims and stated that they should take steps to answer the Rohingya's demands for citizenship. This was considered the strongest statement ever on this issue.

On 16 July 2013, while welcoming the abolition of the Myanmar border security forces "Nasaka," the UN special rapporteur on the human rights situation in Myanmar called for an investigation on their serious abuses committed with complete impunity over the years.

On 20 September 2013, the Dalai Lama³³ called on the Myanmar Buddhist monks to respect Buddhist principles and stop the bloodshed against Muslims.

33. The Dalai Lama is the highest religious authority of Tibetan Buddhism. Myanmar practices Theravada Buddhism, a distinct and more conservative school than that of Dalai Lama. In this appeal, he refers to the principle of non-violence of Buddhism.



'Bilateral Advocacy **Talking Points** Myanmar,' May 2013 (in English).

Extract:

This note is internal for bilateral advocacy efforts and should not be used as general talking points for media or public domain. Some points are being developed for public dissemination by communications staff. The document starts with a summary of the main agreed messages, followed by more detailed analysis and examples which can be used as appropriate in bilateral meetings.

Target:

- Diplomatic representatives that may have influence on the GoUM and UN
- UN representatives within Country and at various levels including HQ Geneva
- GoUM

Goal: An improvement of the humanitarian situation in Rakhine State with a more robust response from the international community to both humanitarian need and the underlying issue of statelessness.

Summary of key MSF messages

- Detained staff: 2 MSF staff who were arbitrarily arrested after the June violence, continue to be deprived of their liberty and their right to fair trial including access to legal counsel. They have also been refused independent medical assessment. Both are believed to have been maltreated in prison. Based on its knowledge of the circumstances and the lack of evidence presented, MSF believes its employees to be innocent of the charges against them. Interlocutors are urged to raise this issue with GoUM officials at every opportunity to help maintain visibility and pressure on GoUM to deal with their cases in line with international legal norms.
- Impact of coming monsoon: MSF has serious concern that tens of thousands of IDPs will face drastically deteriorating conditions in the imminent rainy season, due to unsuitability of existing sites and to the lack of preparedness of essential services in sites proposed for relocation. Vocal and principled leadership from international interlocutors (both UN agencies and influential countries) is now critical to provoke a much higher and more urgent level of action if we are to avoid a catastrophe.
- Potential for forced relocation: [...] While the situation is clearly complex, international standards regarding voluntary return or resettlement must be adhered to. In this context, MSF believes this means:
 - IDPs must not be forced to move, even if this is intended to remove them from deteriorating conditions: IDPs must receive adequate explanations, safeguards and responses to their concerns (security, living conditions, future political situations) to allow them to consider voluntary movement
 - Sites proposed for relocation must have adequate essential services in place before IDPs move there
 - IDPs must have the possibility to voluntarily return to their villages of origin in safety: the GoUM has the responsibility to facilitate their return and assure their safety once there
 - IDPs who fear to return to their villages of origin must be offered a safe location in which to settle and restart their lives, and the means and essential services to do so.All the above are international standards agreed in the OCHA Guiding Principles on Internal Displacement, 2004
- Access to healthcare: MSF has two major concerns, while noting that overall healthcare provision is insufficient and fragile:

1. The majority of the Rohingya/Muslim population has no or minimal access to emergency secondary care because currently the only referral centre available for them is Sittwe General Hospital, [under] the directive of the state health authorities. [...]

2. There are still very significant gaps in access to primary healthcare not only in certain IDP communities but also in Rohingya/Muslim villages that have been cut off from previously accessible facilities due to movement restrictions or overall insecurity. More actors with capacity to implement healthcare programmes are needed.

- Assistance to 'cut-off' villages and communities: [...] Recent MSF assessments have identified large pockets of such people who have become very vulnerable and in need of attention. There is an urgent need for assistance actors, including the UN, to widen their reach beyond IDPs.
- UN positioning and capacity: MSF believes the UN and its agencies have insufficient capacity for the scale of the crisis, that they have given insufficient leadership nationally, and have not taken a strong enough stance with the GoUM on adherence to international guidelines/principles to adequately protect and support IDPs in Rakhine as well as on wider issues of statelessness and citizenship. [...]
- Intimidation: Humanitarian organisations and staff, as well as Ministry of Health staff who dare to offer service to both communities, continue to suffer intimidation and threat. GoUM must do more to counter this intimidation and act to protect medical and humanitarian staff and programmes.
- Rakhine Investigative Commission Report: MSF believes the report contains serious gaps in its analysis of key issues such as voluntary return, differential access to healthcare, the impact of movement restriction, socio-economic damage, and the challenges of providing assistance, in addition to dubious stances on human rights and reconciliation.



'Myanmar, **Message** from Fabien Dubuet, MSF International Representative to the United Nations to MSF OCA and MSF OCG Myanmar Operational Teams and MSF International HART,' 2 May 2013 (in English).

Extract:

FYI

Some quick information after a meeting with the UN Under-Secretary-General for Political Affairs [...] [UNSG Special Advisor for Myanmar] is very active on the situation in Rakhine but this file is now followed very closely and directly at the Secretary-General level and by his top aides in his Executive office [...] Good discussions among Security Council members after [Special Rapporteur]'s briefing last Friday. "Everyone is very, very concerned about Rakhine."



"Myanmar Leader in Historic US visit" by Shaun Tandon, **AFP** (Washington),' 20 May 2013 (in French).

Extract:

Myanmar's President Thein Sein will Monday visit the White House as Washington offers a strong symbolic gesture to back his reforms. In a scene that would have been unimaginable just a few years ago, the former general will meet President Barack Obama.



“Massacre In Central Burma: Muslim Students Terrorized and Killed in Meiktila”, **Report**, Physicians for Human Rights, May 2013 (in English).

Extract:

Conclusion [...]

The eyewitness reports detailed in this report demonstrate that the majority of police officers present during the violence in Meiktila fell far short of this professional standard, not only by failing to protect vulnerable children and others at risk but by failing to apprehend the perpetrators. The crimes in Meiktila indicate a failure of leadership within the Burmese police force that must be addressed through effective accountability mechanisms and security-sector reform. The testimonies of those interviewed by PHR [Physicians For Human Rights] demand a concerted and effective response from both the Government of Burma and the international community. The serious crimes documented in this report require immediate action: an independent investigation of the violence and accountability for all perpetrators in compliance with fair and internationally recognized legal standards.



“Attacks on Muslims in Myanmar”, by The Editorial Board, **The New York Times**, 30 May 2013 (in English).

Editorial

Terrifying anti-Muslim violence surged this week in Myanmar, exposing deep ethnic and religious tensions that are undermining efforts to stabilize the country and move forward with political and economic reforms. Myanmar’s democratic aspirations can never be fully realized if Muslims, who make up about 5 percent of the population, continue to be attacked and marginalized by Buddhists, the majority of the population. [...]

The clashes suggested that radical strains of Buddhism may be spreading. Many old hatreds have been unleashed in the last year as Myanmar struggles to make its transition from a half century of authoritarian rule to democracy. [...] The Muslim Rohingya people have been denied citizenship and are severely mistreated in the western state of Rakhine, where the local government recently restricted Rohingya family size to two children. Across Myanmar, hundreds of thousands of people, mostly Muslims, have been displaced.

All too often, police and security officials have been accused of failing to prevent attacks on minorities or being complicit in them on Thursday, Reuters reported that hundreds of Muslim families in Lashio had sought shelter in a heavily, guarded Buddhist monastery after mobs terrorized the city authorities move quickly to stem the violence by deploying troops, banning unlawful assembly and setting up roadblocks. But experts agree that security forces need better training and equipment to carry out their role in a fragile democracy. It will not be easy for President Thein Sein to achieve the multi-ethnic, multireligious vision for Myanmar that he outlined in a speech earlier this month, but that must be the goal. He has to make clear that extremism will not be tolerated and that those responsible for the violence, including security officials who refuse to protect minorities, will be brought to justice. He will need strong support from Daw Aung San Suu Kyi, the Nobel Peace Prize laureate and leading opposition politician, who has not always spoken out on minority issues.

The United States and other countries supporting Myanmar’s transition, as well as international companies eager to do business there, must impress on Mr. Sein and his government that Myanmar’s promise could evaporate if they cannot control the deadly sectarianism gaining strength there.



“Myanmar: Suu Kyi Announces Her Run for Chairmanship”, by Kelly MacNamara (Myanmar), **AFP** (Yangon), 6 June 2013 (in French).

Extract:

Aung San Suu Kyi, the Burmese leader of the opposition, cleared away any doubt about her political aspirations Thursday when she announced her plans to run for the chairmanship, two years before the 2015 legislative elections for which she is a strong favourite. [...] The opposition leader has, however, received strong criticism in recent months from overseas for her lukewarm reactions to attacks against Muslims. A silence which observers have interpreted as a sign of her desire to massage Burmese public opinion, mostly Buddhist and extremely concerned by the issue. But she assured on Wednesday that she was only trying to avoid stirring up matters.

“The government must make sure that those who have committed crimes are punished in accordance with the law,” she said at a press conference. “But I do not want fingers pointed at particular communities because it always aggravates the other side, and this seems to have started a vicious cycle of people getting more and more aggressive and more and more extremist,” she added. “That’s what I am afraid of.”



“**Opening Remarks** to the Group of Friends on Myanmar”, UN Secretary-General Ban Ki-moon, 10 July 2013 (in English).

Extract:

Excellencies,

I am deeply troubled by the communal violence that swept Rakhine and elsewhere. I remain concerned about the plight of the Rohingya population and their disturbing humanitarian situation. The actions that resulted in many deaths and widespread destruction are deplorable and unacceptable. The President has strongly condemned these acts and made clear his determination to punish the perpetrators. He also evoked the country’s religious and ethnic diversity and expressed resolve in protecting all lives. These commitments must be translated into concrete action. There is a dangerous polarisation taking place within Myanmar. If it is not addressed urgently and firmly, underlying tensions could provoke more upheaval, undermining the reform process and triggering negative regional repercussions. It will be important for the Myanmar authorities to take necessary steps to address the legitimate grievances of minority communities, including the citizenship demands of the Muslim/Rohingya in Rakhine. Moderate voices from religious leaders and civil society organisations could also help promote harmony.



‘Myanmar, **Message** from Fabien Dubuet, MSF International HART, Representative to the UN to MSF OCA and MSF OCG Myanmar Program Coordinators and Advisors and MSF International HART,’ 11 July 2013 (in English).

Extract:

Dear all,

[...] Ban Ki-moon’s remarks at the opening of a meeting of the Group of Friends of Myanmar. I have attached the verbatim of his speech [...]. As you can see, he is taking a clear stance on the issue of citizenship. This is quite something for the Secretary-General, a respected voice in East Asia, and in light of the usual diplomatic precautions around

sovereignty in the region, especially on this specific dimension of the Rohingya file so far considered as highly internal/domestic.



'Myanmar: UN Expert Welcomes End to Border Force, Calls for Probe into Rights Abuses, **UN News**,' 16 July 2013 (in English).

Extract:

A United Nations independent expert today welcomed the abolition of Myanmar's notorious border security force, known as Nasaka, and called for an investigation of human rights abuses committed by its members against the Rohingya population in Rakhine state. "I have received allegations of the most serious of human rights violations involving Nasaka, particularly against the local Rohingya population, including extrajudicial killings, arbitrary arrest and detention, and torture in detention," said the Special Rapporteur on the human rights situation in Myanmar, Tomás Ojea Quintana. "I have no doubt that the violations committed over the years with complete impunity have undermined the rule of law in Rakhine state, and had serious consequences for the peaceful coexistence of communities there."



'The Dalai Lama condemns anti-Muslim violence in Myanmar **AFP** (Prague),' 17 Sept 2013 (in French).

On Tuesday, the Dalai Lama urged Buddhist monks in Myanmar, accused of inciting deadly violence against the country's Muslim minority, to act according to their Buddhist principles to bring an end to the bloodshed. "Those Burmese monks, please, when they develop some kind of anger towards Muslim brothers and sisters, please, remember the Buddhist faith," the Buddhist leader said on Tuesday at an annual human rights conference in the Czech capital, Prague. "I am sure ... that would protect those Muslim brothers and sisters who are becoming victims," Tibet's exiled spiritual leader said.

At the end of June 2013, the MSF OCA team was authorised to enter the Aung Mingalar ghetto in a Sittwe township, where the survival of the Rohingya depended on the goodwill of the police. The team succeeded in providing three hours of consultations in their mobile clinic and negotiating weekly access to the ghetto.



'MSF OCA **Operational Bulletin**,' 26 June 2013 (in English).

Extract:

Myanmar: The Rakhine team finally gained permission to access a community of Rohingya Muslims who have been locked into a small sector of Sittwe township called Aung Mingalar in what is essentially a ghetto for over a year. The group includes families who live permanently in the quarter plus around 1800 IDPs who took refuge here in June 2012. Neither group is allowed to move outside the boundaries set by police-guarded check points, although other ethnic groups are allowed to move freely. The UN and NGOs have been prevented from entering to provide services or care. The community feels 'protected' by the police but they are also heavily exploited by them. The only way

for food to come in is through the police channel which includes high payments. Similarly, the only way for a sick person to receive care is to be transported out by police car and payments and even then, access to the hospital is severely limited. To raise money, the people of Aung Mingalar have been selling their possessions over the 'fence' to the people in the neighbouring quarters. The MSF team was given permission to do a 3-hour mobile clinic with 4 MSF staff including 1 expat accompanied by MoH staff. The team were able to make contact with a former MSF staff who is locked in Aung Mingalar with his family, and with his help the community were alerted. The team were able to offer care to 48 patients triaged from roughly 120 people waiting – the rest had to return home. The team is now urgently negotiating for weekly access and to do more thorough medical assessment.



In the middle of Sittwe, the main town in southern Rakhine State there was a ghetto. A real ghetto, I can't describe it as anything else but a ghetto. I was shocked when seeing it. And I have been inside of it. So, this was a Rohingya population living in the middle of Sittwe town, and ostensibly for their own protection, it was cordoned off. There were police posts surrounding them. They couldn't get out. But also, the Rakhine Buddhists couldn't get in. I am sure there was a certain security logic in order to be able to protect them. But the fact of the matter was that it became a ghetto in which people were basically stuck. We managed to negotiate access for a mobile clinic into it. It was not that people were dying within that ghetto. There was a flow of goods still into the area. But it was incredibly striking. I had never seen that ... We would see no clear practical medical facts on the population. They were nonetheless severely restrained and restricted on an incredibly arbitrary basis, and they were not being seen as full citizens or full humans.

Arjan Hehenkamp, MSF OCA, Operational Director [Programme Manager] from 2004 to 2006; Director of Operations 2006-2010; General Director 2010 to 2017 (in English).

REJECTION OF ADVOCACY DRIVEN PROGRAM FOR ROHINGYA REFUGEES IN MALAYSIA

On 10 July 2013, the MSF OCA operational platform discussed a proposal to open programs for Rohingya refugees in Malaysia. These programs, as previously acknowledged would have limited medical impact but would support and complement advocacy efforts for the Rohingya regionally. Some supported this proposal, while others considered that these activities would not significantly strengthen the advocacy efforts already carried out from existing programmes in Bangladesh and Myanmar.

The position of MSF OCA regarding speaking out was qualified as "awkward" and contradictory. On one hand, OCA refrains from speaking out publicly in the absence of programmes in a country and on the other hand, refrains from speaking out when programmes are running in the country for fear of endangering the programmes and access.

In October 2013, a 'concept note' on an MSF OCA intervention in Malaysia was rejected on the grounds it would not significantly strengthen the MSF advocacy strategy regarding the Rohingya situation, in any meaningful manner.



'All Ops Day **Minutes**,' 10 June 2013 (in English).

Extract:

Malaysia explo [...]

Possible intervention types:

- A. TB and primary healthcare inside the detention centres
- B. Providing shelters and healthcare for at risk populations, in detention including pregnant women, trafficked women, psychologically disturbed and unaccompanied minors.
- C. Mobile clinics focusing on the entry states with an emphasis on MCHC [Mother and Child Health Care] – to bring MSF into much more contact with the more vulnerable 'true illegal'. [...]

Main conclusions:

- Some support a programme with no medical impact with the main purpose being advocacy, as presence in Malaysia would close the loop (Myanmar, Bangladesh, Malaysia) and would provide a comprehensive picture of the fate of the Rohingya, and thus improve advocacy opportunities and messages.
- Others are not supportive, arguing we should first exhaust our advocacy opportunities coming out of the existing programs in Myanmar and Bangladesh.

Action: Vince, Lauren and Chris will discuss whether and how to take this forward.



'MSF OCA Operational Platform **Minutes**,' 16 October 2013 (in English).

Extract:

4. Concept Note: Malaysia Rohingya intervention

Purpose: Feedback OCA Ops Platform on the concept note, pre project proposal [...]

The concept note outlines the proposal to start a small intervention in Malaysia with the primary objective of gathering information to feed into the Rohingya advocacy campaign.

Comments:

- This is a principled issue. Advocacy is grounded in our medical action. This proposal turns it around: advocacy is the primary objective, medical action the vehicle to gather information
- Can we conceive it as an advocacy intervention only without a medical activity?
- Some in the OpsP [Operational Platform] do not believe that information we would gather in Malaysia would significantly enhance our analysis and 'ammunition' for the Rohingya advocacy. In fact, we could do much stronger advocacy with the material we already have. Others disagree and think that this intervention in Malaysia would make a real difference in our ability to do advocacy on the Rohingya issue.

Decision: The concept note is rejected as an intervention in Malaysia will not significantly strengthen what we do in terms of advocacy about the situation of the Rohingya. It is requested to revive the regional advocacy strategy that was developed in 2012 and use the material that we have already.

In July 2013, upon the request of MSF OCA, MSF OCG planned to open a project in Rakhine. The OCG Congress, an associative body that governs the Geneva operational centre, approved the project. One of the OCG Congress members,

Jacqui Tong stated that what was happening in Rakhine was worse than ethnic cleansing and expressed hopes that MSF would “use [...] muscles to prevent something horrible going on there.”

In September 2013, MSF OCG opened a primary health care program in the rural township of Kyauktaw. Their objective was to work with all Rakhine communities including the Rohingya.



‘MSF Switzerland Myanmar Complete **Project Summary**,’ 13 June 2014 (in English).

Extract:

2013

May: OCA request again OCG intervention. Explo launched in rural township: Kyauktaw

June: HQ: Operations approval [...] to start

July: First wave team arrives in Kyauktaw

End September: government approvals received and medical activities started



‘**Minutes** MSF OCG Congress,’ 5–6 July 2013 (in English).

Extract:

Mid-Year Operational Review [...]

Monica Rull [MSF OCG Programme Manager]: we don't have ambitions in the long term. We don't fear to be kicked out. We are linking it with the rainy season, excess mortality, malaria and diseases preventable by vaccination. Vaccination, it is our battle horse. We are going there and we will tell MoH that we will do that and that. If it is not possible, we will not go. That is something that no one has done. The situation is horrible. It may work or not. Nobody in Rakhine did something like that. It is naïve but it is the only bullet we have.

Thomas Nierle [Member of MSF OCG Congress]: it is the moment where we can change the way we work in Myanmar. There are some changes. We can hope that there will be spaces in which we can negotiate and push forward. It is a moment where we can test our strategies.

Jacqui Tong [Member of MSF OCG Congress]: I would take the word ethnic cleansing and throw it in the rubbish. What is happening in Rakhine is worse than ethnic cleansing. This is something beyond ethnic cleansing. I hope we can use our muscles to prevent something horrible going on there.



“Approval from Rakhine State Government for MSF Switzerland to Start Medical Activities in Kyauktaw Township, Rakhine State”, **Letter** from Duncan Bell, MSF Switzerland Head of Mission in Myanmar to Chief Minister Rakhine State Regional Government Sittwe cc: State Health Director Rakhine State, Deputy Director International Health Division,’ 13 August 2013 (in English).

Dear Sir, [...]

We have already made an assessment of the medical needs in Kyauktaw and urgent needs were identified. We would very much appreciate your direct support in providing

MSF Switzerland with written approval to start the medical activities proposed immediately. If you require any further information or clarification on this request, please feel free to contact myself or the Field Coordinator for MSF Switzerland in Sittwe at any time. We are looking forward to hearing your feedback on this important issue at your earliest possible convenience. Thank you very much for your continued support and cooperation to the medical activities of MSF Switzerland in Myanmar.



It took OCA some time to be ready for another OC to come in. And I fully understand why. Then things would evolve and at one point they came back and said: "Can you come and have a look and see what's to be done?" And initially at that time of the crisis, we believed that we would actually do something in Sittwe. There was this kind of 'concentration camp' for Rohingya right in the heart of Sittwe, and there were some other locations, some camps quite close. MSF OCA were more of the opinion that we'll continue to look after Sittwe. But the second day of explo, we looked at the region of Kyauktaw, which is about four hours' drive out of Sittwe. And that's where we went.

Kyauktaw was a township that had suffered violent actions against the Rohingya population. You had the two groups that were literally living side by side and all of a sudden this split between them. From the very start, our strategy was 50-50 regardless of the detailed population numbers. We would make sure that we assessed equally the number of villages because very quickly we realised that, even in the Rakhine population, the health status was way below standard. Now, some of the indicators for the Rohingya were even worse. But if you're talking about the vaccination coverage of a 10% for one and 5% for the other, you do both.

We didn't want to be labelled as helping one over the other. It was extremely sensitive. So, we did not want to start looking at what were the immediate consequences of the violence. We wanted to look at it very much from a medical angle, so we very much involved ourselves in vaccination. It was probably, an easier entry point to look at. So, with the Ministry of Health at regional level we agreed to do vaccination in both communities as well as the primary healthcare clinics. We would intervene in a small area, it was a small intervention. We didn't want to go too big.

Kenneth Lavelle, MSF OCG, Myanmar Deputy Programme Manager, March 2010-October 2014, Programme Manager, November 2014-June 2017 (in English).



We would go to a Rohingya village and it was incredible how many consultations the doctor would do in a day. It was far more than we would normally ask. Where actually normally we would be aiming to have about 30, 35 consultations a day, if you're looking to have quality consultations, it was up to a hundred consultations per consultant today. The health issues that people were facing were so basic that it was also representative of the level of oppression that we were witnessing in that. One of the biggest pathologies that we were treating, particularly in kids, was just skin diseases because they didn't have soap. And so, one of the biggest things we were doing was just giving them a cream for their skin disease and soap.

Brian Willett, MSF OCG, Project Coordinator in Rakhine State, December 2013-September 2014 (in English).



We thought that with another section, another name, that by itself might open up access. We'd made headway with the local authorities and even with the Rakhine communities in terms of being accepted, with mobile clinics out working in the two communities. They spent one day in a Rakhine community then the next day in a Rohingya community. In Rohingya areas, we set up a temporary structure each time using plastic sheeting. On the Rakhine side, the teams set up consultation rooms in existing MoH clinics. That wasn't easy because the mobile clinic in the Rakhine communities might only get three patients some days. Not much when you think the team would often travel from quite far away and apply for a travel permit, etc. Then they would go and take the mobile clinic to the Rohingyas. And that was actually just triage work. At the end of the day you could still have 300 people queuing. The teams in the field fiercely contested this decision as this system was difficult to manage. But then everyone understood and accepted that it was working for the time being because it gave us access to the Rohingya communities. But anyway, it was only a small project. It was our proposal to send mobile clinics into the Rakhine communities. The Ministry of Health was interested in our assistance. But what they asked for in terms of aid and support was never quite what we gave them. What they wanted more than anything was laboratory equipment, drugs. They absolutely weren't happy that it was us who came and did the work there ourselves.

The authorities told us that if we wanted, they could offer us protection, but we couldn't show any favouritism to the Rohingyas. In fact, they always said that it was the community who felt MSF's approach was unfair, that they didn't approve. So, they were on board with the new strategy from MSF Switzerland. We did things differently; we'd listened to them.

*Liesbeth Aelbrecht, MSF OCG, Head of Mission in Myanmar, January 2013-January 2015
(in English).*

In various regions of Myanmar, MSF OCA and MSF OCG continued to develop medical programs to treat tens of thousands of HIV/AIDS patients often co-infected with multidrug-resistant tuberculosis (MDR-TB).

On 22 August 2013, MSF OCA issued a press release to announce it was organising an MDR-TB drugs symposium in Yangon together with Myanmar's Ministry of Health and the World Health Organisation. The objective was to explore new avenues to accelerate treatment access for MDR-TB throughout the country. For MSF, this was a logical extension of their decades-long infectious disease treatment programmes already implemented in Myanmar.



'MSF OCA **Press Release**, Yangon/New York,' 22 August 2013 (in English).

Extract:

The international medical humanitarian organisation Doctors Without Borders/Médecins Sans Frontières (MSF), Myanmar's Ministry of Health and the World Health Organization will host a symposium this week exploring new ways to accelerate access to treatment for drug-resistant tuberculosis (DR-TB) throughout the country.

The symposium, 'Turning the Tide on TB: Tackling DR-TB/HIV-co-infection' in Myanmar, will be held today and tomorrow in Yangon. The symposium will see experts from Myanmar and other high-burden TB countries, along with international leaders in the

field, come together to share their knowledge and experience in tackling DR-TB. Opportunities to improve treatment and increase cure rates through patient-centred approaches to care, new diagnostics and new drugs will be discussed, as well as the specific needs of marginalised groups such as prisoners and migrant workers.

“High-burden TB countries must show leadership in tackling this crisis and seize new ways to increase DR-TB care today, as well as push for access to new drugs for tomorrow,” said Dr Unni Karunakara, MSF’s international president. “Myanmar is demonstrating this leadership through its expanding DR-TB programme, yet there remains a long way to go. Strengthened partnerships and innovation are needed at all levels, national and international, to ensure effective treatment reaches all those who desperately need it.” Close to 9,000 people in Myanmar are diagnosed with DR-TB every year, but only a fraction are currently being treated. In 2012, only 800 people were on treatment. Untreated, the airborne and infectious disease is fatal. Rapid scale-up of DR-TB care is urgently needed country-wide to save lives and stem the unchecked crisis.

New treatment approaches and regimens are critical to ensuring that more people are treated and ultimately cured. The current DR-TB regime lasts two years and is expensive. It is also highly toxic, producing excruciating side effects, including extreme nausea, deafness or even psychosis. Patients must swallow up to 20 pills a day and endure eight months of daily injections, yet only around half have a chance of being cured, according to global statistics. [...]

The symposium will conclude with recommendations for ways forward, in support of Myanmar’s ambitious plans to make DR-TB care widely available. “No country can afford to ignore the human and financial cost of the global DR-TB epidemic,” said Dr Karunakara. “It’s one of the most pressing medical crises today. All DR-TB patients in Myanmar, and throughout the world, do not have years to wait for a chance of cure – the time to act is now!”

SEPTEMBER 2013 - “FROM BAD TO WORSE: HUMANITARIAN CRISIS AND SEGREGATION IN RAKHINE STATE” - THE NEVER ENDING REPORT

On 30 September 2013, the former Humanitarian Affairs Officer in Rakhine, Tania Bernath was commissioned to draft an advocacy strategy for the entire movement, to accompany the December 2013 planned release of a publication entitled “From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine State.” She worked for several months on this report, meant to be a “Fatal Policy” version II. The original “Fatal Policy” had been distributed confidentially since the end of 2011.

Within OCA, the report was challenged by various people, which led to multiple revisions by various people. The recurrent criticism was that it was “too human rights- oriented” and weak in terms of solid medical data. In late October 2013, the release was postponed to January 2014 for security reasons, linked to the ongoing national staff members’ detention.

In late December 2013, the report’s content was yet to be validated and so the release was again postponed to first half of 2014. Further, the report was no longer planned for public dissemination, but instead for distribution as part of the bilateral advocacy process.



“Humanitarian Crisis and Segregation in Rakhine – Action Request at a Glance”
Draft Advocacy Paper, Tania Bernath, 30 September 2013 (in English).

Extract:

This advocacy strategy is aimed at the entire movement. It accompanies the forthcoming report *From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine* issued in December 2013.

Distribution

This advocacy strategy is an internal document however the report is an external document to be sent to ??? (pending decision on risk analysis) [...]

Advocacy on this issue so far

MSF and other actors on the ground carried out little public advocacy about the Rohingya situation in Rakhine State prior to the 2012 violence. Instead advocacy has largely been focused behind the scenes. In late 2011, ‘Fatal Policy: How the Rohingya suffer the consequences of statelessness’ highlights the impact of discriminatory policies on women’s health, characterised most dramatically by the increase in the numbers of unsafe abortions, was disseminated by MSF to a select group of key stakeholders such as diplomatic and political, NGO and UN actors. However, it has not been shared with the Myanmar government and nowhere is MSF mentioned in the document. It was again disseminated in 2013 after the government reiterated the two-child policy; however, the document has not been shared with the government.

In line with AP [Annual Plan] 2013 for Myanmar, one key objective is the ‘Increased protection, dignity, and humanitarian situation improved for Rohingya wherever they are’. Since 2012 MSF has been engaging in significant bilateral advocacy with the government at national and state level, highlighting the impact of restrictions on access to healthcare, with a particular focus on secondary health care. There has also been an extensive focus on bilateral engagement with humanitarian and diplomatic actors on the overall humanitarian crisis and the segregation and discrimination underpinning it. *Vickie Hawkins comment: These are not public advocacy reports in the same vein as our report, they are the outcome of technical assessments, so very different. I don't think either was ever launched publicly, but rather distributed to the humanitarian community.* And MSF has increased its public advocacy, largely focused on highlighting the humanitarian situation, including violence and movement restrictions. This has included 4 press releases in 2012 and 2013 (June + November 2012, February + May 2013), a web update and targeted reactive/proactive interviews (e.g. IRIN [Integrated Regional Information Networks, now The New Humanitarian], Irrawaddy). In addition, many background briefings with key journalists have been undertaken.

Since last year’s violence, the government has seemed at times to respond to international pressure in both their rhetoric and their practice. The President himself has tempered his statements on the Rohingya from “deportation or camps” in July 2012 to express government commitments to “address contentious political dimensions ranging from resettlement of displaced populations to the granting of citizenship” in November 2012. Following significant pressure from the international community to improve the shelter situation at the start of the rainy season, the government itself invested substantial resources in the construction of long-houses for the IDPs (even if this could ultimately be seen as part of enforcing a policy of segregation and thus in line with the government’s agenda). There have been some attempts to increase accountability on the side of perpetrators of violence [...] but to what extent this is down to public statements, such as the one issued by the US Embassy, or suits a government agenda, is unclear. However,

despite international pressure on other issues, such as the continued intimidation and harassment of humanitarian organisations, little political will has been demonstrated on the side of the government to address this issue. And despite the growing international pressure, there remains little in terms of concrete action on addressing the Rohingya's status.[...]

The report is a tool to:

- Engage directly with the highest levels of government on the issues that underpin the humanitarian crisis in Rakhine, in particular in relation to how these impact access to health.
- Improve the overall humanitarian and international response to the crisis at all levels, in terms of adequacy and impartiality of assistance and responding to the root causes, including discrimination and violations of human rights. The challenge presented to the humanitarian community in Rakhine by perceptions of bias towards the Rohingya community has led to an emphasis being placed on the need for acceptance and a perception of neutrality at times at the expense of an impartial response.
- Raise public awareness of the humanitarian crisis in Rakhine State and as a consequence, international pressure on the government [...]

3) Risk Analysis within MSF within Myanmar

- International and National MSF Staff in Rakhine and among the various groups including the International staff, Inpats, Rakhine and Rohingya.
- International and National Staff in Yangon and other projects: Risks to our detained staff [...]

7) The Launch of the Report (could be in New York, Bangkok or Yangon or all three simultaneously)

Should take place soon after the report has been given to the government. The later it is the more inaccurate and irrelevant the information becomes.

- Yangon: with press conference to actually launch the report. This way not only would there be the international community within Myanmar present, but also local media would pick this up. We would let them know in our targeted meetings how we would launch it and if done here it may be harder for the government to ignore it if it is done in country.
- Bangkok: Could be a way for the government to save face a bit and then the focus would still focus squarely on them but a good way to also bring in the regional dimension a bit more. The only danger here is that it may be more likely that the government would ignore it. We also may look a bit cowardly unless we explain to the government when we give them the report the reason, we are doing it in the region rather than in country.
- New York: ???? Follow up with Vicki on this??

My recommendation is for Yangon during the Asian Games [11 to 22 December 2013] given the media spotlight that will be on Myanmar and utilising the presence of Malaysia and Thailand and other countries.

VH [Vincent Hoedt]: our preference is for Bangkok and New York. The justification is that if the main reason we are launching publicly is to increase pressure on the international community, then by launching in those two places we speak to the international community i.e. the ASEAN/ regional community and the UN/diplomatic community.

Follow-up

Meetings as a form of follow-up every two months with government and international community. Six-month follow-up on internal report on how far they have come including both government and international community.

March 2014: Internal update on what has changed in terms of asks ... to be put together by the HAO.

Feedback and Evaluation

OSCAR is keen to monitor and evaluate the progress of this advocacy in order to feed into support of DHoM [Deputy Head of Mission]. OSCAR will also send out a questionnaire to other members of the building up evidence-based approach in terms of our advocacy in Myanmar. This is an ongoing process but should be summarised 6 months after the release of the report (HAO HART team to find out what types of changes they see on this issue).



“From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine State” MSF OCA **Draft Report**, Tania Bernath, MSF OCA Humanitarian Affairs Officer in Rakhine, June to October 2013 (in English).

Extract:

Preface: A Plea Towards the Government of Myanmar and the International Community

This report is a plea to the Government of Myanmar, communities and authorities of Rakhine State, the International Community – including non-governmental organisations – to engage in a dialogue that puts an end to the cycle of abuse, exclusion, marginalisation and suffering of Rohingya Muslims in Myanmar and across borders. [...]

In Rakhine as healthcare practitioners, we daily encounter the effects of the violence, displacement and access issues that this report will describe in their numerous and varied forms. The problems MSF faces in Rakhine in regard to the Rohingya are so deep rooted that simply providing medical care is not enough. This report, therefore, written from a medical humanitarian perspective, focuses on how the lack of access to healthcare for Muslim communities – predominantly Rohingya in Rakhine State – are indicative of a wider crisis of discrimination and targeted exclusion.

This report is not simply a reactive observation of the impacts of the violent episodes of 2012 but aims to be a deeper comprehensive reflection of the underlying issues that keep the Rohingya one of the most persecuted ethnic groups in the world. It seeks to find real solutions to securing a future for the hundreds of thousands of people we have endeavoured to assist with life-saving medical care for nearly two decades.

This report draws from a series of around 400 interviews conducted in 2012–13 in communities throughout Rakhine State. The information presented here is firmly grounded and verified by our everyday experience as medical practitioners. While it draws on information from MSF's operational medical data and previous surveys conducted in our ongoing programming, as well as from reports produced by other international actors, it is not a medical study but rather uses extensive and systematic qualitative testimony to demonstrate the human perspective. It seeks to convey MSF's thoughts and experiences, and to give a voice to those communities the organisation seeks to serve through its presence in Rakhine State.

This report is ultimately a plea from MSF to key stakeholders and governments inside and outside of Myanmar to engage on this issue, and to begin to effectively address the root causes of the Rohingya crisis. It suggests a way forward to all key stakeholders to

take the steps to end the unnecessary suffering and attacks on human dignity of Rohingya communities. [...]

This report will show:

- How across Rakhine State mechanisms of policy, fear, violence are used or tolerated by the government to significantly limit access to healthcare for Rohingya Muslims.
- How in the northern townships, where the vast majority of the Rohingya live (Northern Rakhine State), and where the crisis has been most chronic and the humanitarian situation most protracted for decades, the situation has deteriorated even further.
- How in the eastern townships around the state capital Sittwe, Rohingya Muslims have gone from a relative level of economic and social integration with some ability to access health services, to a situation of segregation and exclusion from health services.
- The severe limitations of the humanitarian response, and how it has been compromised by the environment in which it attempts to operate. How intimidation and administrative requirements severely impact on attempts to deliver aid where it is needed most.

The way forward proposed includes a plea to the Government of Myanmar (at State and Union level), and the international community, including donors and UN agencies, to change the discourse on this issue, and address the root causes of this crisis.

The key recommendations are that:

- Discriminatory policies must be abolished
- People should be protected from violence
- Barriers to accessing health care should be removed, and
- Access to humanitarian assistance should be prioritised [...]

Conclusions

The June and October 2012 violence significantly worsened the situation for the Muslims, especially Rohingya in Rakhine State. The situation has moved from a situation of 'persecution' of the Rohingya minority based on state legislation, policy and practice, to a campaign of targeted exclusion and segregation.

More than half of the 350,000 Muslims from Sittwe and surrounding townships where the violence was concentrated, have been forcibly relocated out of town centres to camps outside of town or displaced on their own land, restricted in their movements and unable to access basic services, they previously had access to. The rest, while not displaced, are also extremely vulnerable as they cannot access their livelihoods or basic services, including healthcare. Yet, have not been eligible for humanitarian assistance. The conditions of the camps, and the disparity between provisions and shelter given to Muslims compared with displaced Rakhine and Natala, as part of the government response, is discriminatory and highlights a bias in the delivery of aid as preferential treatment has been clearly provided to one group over another based on ethnicity. In NRS the impact of the crisis has been more hidden, but no less severe. Existing restrictions and abuses have become more severe and the impacts of this have created an emergency on top of a chronic crisis resulting in large numbers of Rohingya fleeing over borders to third countries, where they face further abuse and remain in a perpetual cycle of displacement and violence. The humanitarian response has systematically failed to recognise the plight of the Rohingya in NRS.

The government has done little to prevent the abuse and discriminatory treatment, nor to remove the barriers for Muslims to have access to healthcare. The hate speech and intimidation coming from the Rakhine community continues to be tolerated. Additionally, the lack of accountability of security forces, and the use of restrictive policies which deny

access to basic services impacting on health status, have not been challenged. The international community in turn has failed to effectively challenge the government's handling of the humanitarian crisis. Ultimately, there is no way to solve this crisis without addressing its root causes. MSF believes that improvement is possible if decisive action is taken now, and urges the Government of Myanmar and the international community to:

- Protect all people from violence
- Reduce all barriers to accessing health care and that impact on health status including the removal of discriminatory policies that impact on health status and access to health care
- Facilitate and ensure greater humanitarian access.



“Quick Update on Myanmar (Rakhine)” **Message** from Fabien Dubuet MSF International Representative to the UN to MSF HART Team,’ 20 October 2013 (in English).

Extract:

Dear all, [...]

- A final draft of the report will be shared with us next week for comments but the release of the document will be postponed due to new developments regarding our two detained staff.
- Before its publication (probably in December or January), the report will be presented to key official interlocutors in the Myanmar government. Then we will organise a round of bilateral meetings in several capitals (Jakarta, Brussels, Geneva, London, NYC, DC, Tokyo, Beijing, Sydney, etc.) with operational representatives [...]. This will require the support of HART.



‘Feedback on MyM Report, **Message** from Dr Maria Guevara MSF International Regional Humanitarian Representative (ASEAN) to MSF OCA Operations Manager Dr Lauren Cooney and Operations Advisor Reshma Adatia for Myanmar cc: MSF Humanitarian Advocacy and Representation Team,’ 10 November 2013 (in English).

Extract:

General views [...]

Overall there are a lot of powerful and convincing testimonies which build a good case. The report's purpose seems to be “the lack of health care is indicative of a wider crisis of discrimination and targeted exclusion”. This however is not as clearly defined as it could be.

The report still has a very human rights focus lacking a robust medical humanitarian angle that MSF should and is best placed to highlight. Unfortunately, it is notably weak in medical data.

It is unclear in the report for whom the message is and how the report in its current form and content should be used to provide the GoM and authorities with an opportunity to have greater space and open up dialogue with community leaders, etc.; to calm down violence for example [...] The report is too long and at times redundant/repetitive. [...]

Suggestions:

To make a more robust medical report, would it be possible to have an Epicentre-driven medical/epidemiological survey on humanitarian/medical situation in Rakhine that can

then be complemented with a 5-page narrative rather than a 25-page-HR-report? Considering the time constraints, this option may not be a valid one at this time. It is a query nonetheless.

Understandably that it is not a medical study, the methodology nevertheless should be better described, i.e. where, time period, which communities, templates or questionnaires used, criteria to define which population to interview, randomised selection or cluster approach, etc. [...] MSF is demanding GoM and Int. Comm. develop a code of conduct, but it is unclear in the document what exactly this means. Perhaps it would be good to develop it further as much as possible. Using the terminology plea leaves one rather uncomfortable but at the very least then we should be clearer on our expectations and with whom.

[...] It may be helpful to give a better sense of the scale of displacement and of numbers affected by the restrictions. Noting the differences in the proportion of Rohingya and Muslim population for example would be helpful. It is stated that the same limitations do not occur amongst the other communities, but perhaps this should be better précised and their constraints put in clearer perspective as well. "Restrictions" is a buzz word throughout the paper but perhaps it could be good to clarify better the direct impact to health they have.

With reference to Section V, better to have one conclusion where we highlight our expectations of key stakeholders, clearly stating which stakeholders. This will give more weight and clearly address the key persons with the key messages.



'MSF OSCAR 12 Months **report**,' December 2013 (in English).

Extract:

Myanmar/Bangladesh: Support for Myanmar/Bangladesh has been regular in 2013, including intensive support from the Comms Advisor and a visit from the Head of HAD to update the context analysis and provide guidance on humanitarian challenges. A HAO was deployed on the ground for several months, and a field comms officer became a permanent feature of the CMT in Yangon. Output on the advocacy and comms side include published interviews, articles, as well as rounds of meetings with donors, diplomats, NGOs, UN, academics and politicians on the humanitarian consequences of violence and segregation. We have also scaled up the dissemination of the Fatal Policy report, which remains relevant. National communications around the MSF TB Symposium were successfully managed, including participation and coverage by 20+ journalists (national, regional and international).

Nevertheless, we regret to report that our ambition to produce a comprehensive report on Rakhine was delayed. We have not managed to finalise it, and it will only be released in the first half of 2014. The content remains relevant as ever to the situation on the ground, which continues to be dire.



I was in charge of interviewing, trying to understand the situation, what was happening and writing the report. MSF Holland was deciding how they were going to release it or not. Overall, I spent over 8 or 9 months really working on this report. I was there in Rakhine from January to June 2013. In the field, everybody was super supportive. People who were working day to day, in Sittwe, in Maungdaw and even the Rohingyas they were like, 'Tania we really think this is going to help us.' But the people in the country management team were much more against a public report. They were more worried about losing access totally

which was understandable because they were also the people who were dealing with the government whereas we weren't. There were a lot of discussions throughout. At one point, they said: 'We just want something and we will figure out how to use it.'

I had really good access to Rohingya people because of our programmes and also to the Rakhine people. I also interviewed administrators, medical people in central towns. They talked openly because they did not think there was anything wrong in what they were saying, that they are being discriminatory or racist. I just wanted to focus on maternal mortality and the data of how many people were in the clinic. There were women who were dying because they were being blocked from the hospitals. I added the background of why this was happening: travel restrictions, discrimination and isolation and being sent into camps and not being able to travel to places where there were hospitals.

I would interview the patients about their journeys: how long did it take you to get here? What were some of the barriers that you had to get here? I used more qualitative data except for numbers of patients who had to come to the hospital. So, when people in MSF were complaining about lack of medical data then I would ask them: what medical data would you want to use? I definitely used the angle for right to health and why was this happening and that's where the human rights aspect came in.

My first draft almost was the best one. I remember people reading and saying: 'This is great.' And then they started to dissect little pieces of it and then all of a sudden it is not good any longer! I think I wrote like 25 versions of the report because different people were weighing in.

Only in the end some people said: 'We can't write it like this, it is so detailed. It is so long, no one will read it.' They asked me to come up with a strategy. I wrote up a strategy that was also weighing in risk assessment. And it finally came down ... one day towards the end of my contract. They called me in and they told me: 'We are not issuing the report.' There were two Rohingya staff who were in jail. There had been a discussion with them and their families about issuing the report and they had said: 'We think this is bigger than us and we want you to issue the report.' That was in the risk assessment. But still, the report died. They didn't do anything with it.

Tania Bernath MSF OCA Humanitarian Affairs Officer in Rakhine (Myanmar) from January-June 2013, then in MSF OCA OSCAR in Amsterdam from June-October 2013, Author of "From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine State" Report (in English).



Tania was very competent and knew what she was doing. When I was there in the field she was working on a report, we were going out and interviewing people. That report was supposed to be public, because the last report we'd come out with was the maternal mortality report ['Fatal Policy'] which we were silently putting around, not publicly. It must have been an agreement between all parts. Clearly everybody was on board that there was something that we need to document.

Tania came back to Amsterdam and she was trying to get this report out. Different iterations were going on in the headquarters. The document kept being shuffled around and people had issues and she had to rewrite. People weren't happy that there wasn't enough medical data. Of course, you need medical data but we weren't trying to put forward a case that this was a very high mortality rate or there is an epidemic of something. No, that wasn't the story. It would have been enough to put forward our case with confidence, to say 'numbers might not be perfect but it's comparable to other settings where people suddenly end up like this.' Then it got shelved. That was crazy.

There was this context where violence was going on and MSF had unique information and

had been there forever, being often the only ones as usual actually accessing it immediately afterwards. There were more and more gunshot victims because there were also clashes with the soldiers. So, of course we would get the actual gunshot wounded patients. The other NGOs were much more scared of being targeted by the anti-Rohingya community. But we, we pushed it much more than everybody else. So, the backlash on us was not surprising. Not even finalising that report just even for us internally, or to be able to pass it, at least to journalists and key stakeholders which we did with the last report, it's irresponsible. All these people who gave their stories to whom we said we were writing a report – and we were – and who believed that their voices would be passed on ... I find it so disrespectful!

Ingrid Johansen, MSF OCA Field Coordinator for East Rakhine, January 2013-January 2014, Member of MSF OCA Association, MSF Nordic Association and Representative of MSF Nordic to IGA in 2015 (in English).



It was a great report, a fantastic report, very strong, very well written. It was a lot of information. It was human rights focused and very clear in what it shows. But some people said: 'We can't use this because the medical data is not strong enough.' It was just not what people felt comfortable from what they call an 'MSF standpoint.' So, I tried to take the report and make it so that they would agree to use it. I said, 'okay, you want stronger medical data, you want to take certain things out? Fine. Let's try to put it together in another way with the humanitarian affairs department.' But I failed as well. It was not accepted.

Gina Bark, MSF OCA, Project Coordinator in Rakhine, 2009-2010; Operational Liaison Officer in Bangkok, 2010-2012; OSCAR Humanitarian Affairs Advisor, 2012-2017 (in English).



That report, it's one of those typical examples that if you haven't fundamentally agreed that you want to write out a case study on this, on what the limits are and what it is about and then do it, it will never see the light [of day]. She did so many versions and so much work on it. Never saw the light. But, if the report is not good, you have to tell the person what is it that is not good. Then you can improve it. But the fundamental discussion was not that. It was clear that people didn't want to tell her.

Hernan del Valle, MSF OCA, Head of OSCAR (Operational Support in Communication Advocacy Reflexion) 2011-2016 (in English).



There was a lot of resistance within MSF because it was very 'human rights.' When people said 'human rights' it meant it wasn't supported enough with the proper data that would be comfortable for MSF. We tried to make it into 'MSF speak' as opposed to 'human rights speak.' We can ask Human Rights Watch or Amnesty to do [that] and they would do it better but that's not what we were asking for.

Dr Maria Guevara, MSF OCA, Myanmar Medical Coordinator 2009-2012, MSF International Representative in 2012-2018 (in English).



The premise, at least for me of MSF is that the strength in our organisation is that we actually have medical data and we use that as the backbone of our advocacy. So, we connect our operations to what we actually want to say. We should preserve that. Saying that though, are there going to be occasions where you will not have enough medical data? Or your medical data may not necessarily be that conclusive? Can you still say something with the data that you have? Absolutely. Should you still say something with the data? Yes. How you say it, it's just a tactic. How you do that is just contextual. It depends on what actually works or not. Can you say things without having to use our own data? Possibly, in situations. So, I'm certainly not that black and white about it, but I would fundamentally say that our advocacy should in theory be driven by what we see and that, to make us legitimate and to actually objectify and quantify situations, you have to use medical data or data in general. Predominantly most of our medical data comes from what I call routine data collection. So, in any project in a hospital or healthcare centre, they will automatically just collect data that goes into our system. That is the backbone of essentially any advocacy that we do. In addition to that, we have other data sources. So, we can do ad hoc surveys where we collect information at one point in time. We can have research studies ongoing who are also collecting data. We have data also coming from every time we go into a new project when we do a health needs assessment. So, there are a number of different sources of health information that we could use for advocacy purposes. Many of those things don't necessarily have an objective of advocacy in mind. The primary objective is to actually either support, direct patient care, or to help programmatic design and improvements for our health interventions. A secondary purpose is advocacy. If advocacy is decided, you first use this data, and then you complete with another survey if necessary.

Dr Sidney Wong, MSF OCA, Medical Director, 2013 - 2019 (in English).



We had this report in the making and at the same time we were dealing to get our two detained staff released. I found it very difficult because people were like 'why don't we bring out the report.' I said, 'Oh, there are reasons why we can't ... and I can't mention them.' I understood why they were angry that we didn't do anything and I would have done exactly the same in their position but we had a reason why we couldn't ... At that moment we put a higher priority on the fate of our detained staff because they were our direct responsibility ...

Former MSF OCA Staff Member in Myanmar (in English).

NEW WAVE OF MSF ADVOCACY ON RAKHINE

On 3 October 2013, the Myanmar daily, "The Irrawaddy" published an article on the denial of access to Muslims in Rakhine hospitals, based on MSF OCA information and widely quoting Vickie Hawkins, the MSF OCA Deputy Head of Mission, in charge of advocacy in Myanmar and of Rakhine programmes. She exposed the gap between the number of consultations conducted by MSF OCA, the number of hospital referrals needed, and the number of hospital referrals actually made, which was far below the amount needed.



“Muslims Blocked From Hospitals in Western Burma” by Samantha Michaels, *The Irrawaddy* (Yangon), 3 October 2013 (in English).

Extract:

Of 70,000 medical consultations conducted in the state during the first six months of this year, Médecins Sans Frontières (MSF), an international humanitarian organization, could only make 46 hospital referrals, a number it says is far below the amount needed.

“There is a gap between the number of referrals we’re able to make and the number of people that need referral, and as a result people are dying,” Vickie Hawkins, deputy head of mission in Burma for MSF Holland, told *The Irrawaddy* on Wednesday. A number of life-threatening conditions cannot be treated at mobile clinics, she said, adding that women with complicated pregnancies were among those who most frequently required hospital referrals. Several actors have prevented referrals, she said. Among the biggest challenges is the fact that Muslim patients are not accepted at public township hospitals in the townships surrounding Sittwe, the state capital. MSF said these township hospitals cite security concerns as a reason for excluding Muslims, saying staff members in the past have been threatened by local community members for admitting the religious minority.

Muslim patients are accepted at township hospitals in northern Arakan State and some township hospitals in southern Arakan State. Muslims comprise about 5 percent of the 60 million or so population in Buddhist-majority Burma. In Arakan State, a Muslim group known as the Rohingya faces particular discrimination and makes up the majority of those displaced from their homes in clashes last year. They are seen by local Buddhists as illegal immigrants and are largely denied citizenship by the government, although many have lived in the country for generations. Township hospitals in townships surrounding Sittwe deny admission not only to the Rohingya, but also to Muslims of other ethnicities, such as the Kaman, who are recognized by the government as citizens. As a result, Muslim patients must travel far distances to Sittwe, where they are accepted at a state-level public hospital known as Sittwe General Hospital. For example, if doctors at a mobile clinic in Mrauk-U Township encounter a Muslim woman experiencing a difficult labour or another medical issue, they cannot drive her about 30 minutes to the nearest township hospital, but must instead refer her to Sittwe General Hospital, about three hours away by car. Once at Sittwe General Hospital, she would be confined to a separate ward for Muslims. The roughly 200-bed hospital has about 18 beds for Muslim patients, Hawkins of MSF estimated, while there is an identified target population of 178,000 in the townships surrounding Sittwe. Due to the limited number of beds, the hospital can only accept patients who meet specific referral criteria. The criteria, developed by state health authorities, are stricter for Muslims than for Buddhists, Hawkins said, because fewer beds are available for them.

State authorities must also individually authorize referrals for each Muslim patient, a process that takes time and creates a bottleneck. “I’ve never seen a situation where it has been so difficult to refer patients—never,” said Hawkins, who has worked with MSF for 15 years, including stints in Afghanistan, Pakistan, China and Zimbabwe. In Myebon Township, at a camp with about 4,000 Muslims, the humanitarian organization has made only two successful emergency referrals since last November, both when high-profile UN officials were visiting.

The referral situation has improved somewhat in recent months, however. Sittwe General Hospital has started accepting a broader selection of patients, including some Muslims who require specialized treatment but are not necessarily in life-threatening situations. MSF has doubled its number of emergency referrals in the last three months to 46, as opposed to the same number in the first six months of the year, and Sittwe

General has also started to accept outpatient referrals in the last eight weeks. But Hawkins added: "There's still a long way to go, there's still a big backlog and many more patients out there who still need a referral and simply are not getting it because of all the challenges," including lack of access to township hospitals and limited beds at available facilities. She said the increase in patient numbers at Sittwe General Hospital also placed enormous strains on the staff and resources there, considering the large population served.

Once a referral is approved, transportation from remote villages to the state capital is a challenge. Due to the geography of the coastal state, patients in some villages require boat transport, but local boat captains are reluctant to offer their services, fearing threats by community members for helping Muslims. A number of speedboats are deployed, primarily by UN agencies, but these agencies have other work ongoing. With a lack of available boats, MSF teams have been forced in some situations to defer a referral overnight. "Unfortunately, when the teams have returned the next day to transfer the patient, some of those patients have not survived the night," Hawkins said. MSF could not provide definitive concrete data on the number of people who have died due to a lack of access to hospital care in the state, but confirmed that this situation has arisen with its teams on a number of occasions even since establishing an improved referral system in March.



I was the one dealing for the referral cases. I had to ring the state health director, before referral and get approval. I had to ring the state government, asking approval ... to inform the police and to inform the jetty police. Then we had to inform the ambulance provided by ICRC at that time. We had to do a lot of procedures to refer one patient to Sittwe general hospital. Sometimes, I even have to go out to the camps for emergency patient pick-up and referral to hospital because the medical doctors in the team were very busy with their normal schedule, mobile clinic. I was responsible for coordinating with stakeholders, like state health department, state government, dealing with Sittwe general hospital and other related departments. I also had to represent MSF in some meetings when the medical coordinator was not available to attend. Ringing them many times for referral patients, sometime at night-time, it was really irritating for them ... They did not like us... It was not a burden for me but it was really difficult to deal with them. They even shout at me. Finally, they got tired of shouting and they began to calm down and became quiet again. Later on, they get friendlier with me and started to understand why we had to refer the patients.

MSF OCA, National Medical Staff in Rakhine, Myanmar (in English).

In October 2013, the MSF OCA Myanmar coordination team together with MSF International HART conducted a series of meetings with key international stakeholders in the region, UN representatives, and ambassadors.

After this Asian tour, they decided to reinforce their bi-lateral advocacy message with observations on political and 'human rights' dimensions of the crisis and its impact on the humanitarian situation and on MSF's operations.



“Meetings over the past week” **Message** from Vicky Hawkins, MSF OCA Myanmar Deputy Head of Mission to MSF OCA HQ Operational Team, cc: MSF International HART team, 3 October 2013 (in English).

Extract:

Dear all

With Fabien [Dubuet, MSF International HART]’s visit, we took the opportunity to make some new contacts and revisit some existing ones to discuss his observations on Rakhine, some priority concerns and the situation of our detained staff.

1. Assistant to the Special Advisor to the Secretary General on Myanmar

Primarily focused on our detained staff but we also took the opportunity to discuss some more general issues in relation to Rakhine, in particular the position of central govt towards the core issue of the status of the Rohingya. [...]

2. Indonesian Ambassador

[...] There was not a great deal of feedback but he emphasised the need for a ‘balanced approach’ (in response to which we explained about the differential need/impartiality). [...]

3. Head of Asia/Pacific Region, OCHA

she is convinced of the need to put a priority on Myebon partly as a process of picking up some ‘smaller’ issues that we might be able to make progress on rather than trying to resolve all of the issues of Rakhine. [...]

4. Japanese Embassy

A briefing mainly on observations from Fabien’s visit, focused on shortcomings in WASH [water, sanitation and hygiene] and UNICEF’s lack of leadership (Japanese 2nd biggest donor to UN after the US), the difficulties with medical evacuation and deterioration in NRS. [...] Followed up on a previous discussion about our detained staff [...]

5. US Ambassador

Very well informed, heard our concerns and I think we gave him some detail on certain issues e.g. the fact that we have to individually negotiate every single referral case, that he was not previously aware of.[...]

6. French Ambassador

Again, pretty well informed of the issues that we were raising.



“Quick Update on Myanmar (Rakhine)” **Message** from Fabien Dubuet, MSF International Representative to the UN to MSF International HART, 20 October 2013 (in English).

Extract:

- Green light to push again two key issues in the meantime (without waiting the release of the report): the sub-standard humanitarian response in Rakhine, notably the poor watsan situation in/around Sittwe displaced camps [...] and the serious difficulties related to referrals/medical evacuations and access to secondary health care for Muslim communities (obstructionism from the Rakhine State authorities + lack of support and leadership from UNICEF, WHO, UNHCR and the ICRC). [...]
- Meetings in Geneva and Brussels with the ICRC, UNHCR, UNHCHR and the EU before the visit of Georgieva and the General Director of ECHO. [...]
- Meetings in NYC [...] with Ban Ki-Moon [UN Secretary General] office, Nambiar [UN Secretary General’s Special Advisor on Myanmar], Adama Dieng [UN Special Advisor on the Prevention of Genocide] [...] ASEAN [...] and selected members from the diplomatic community (Myanmar, Indonesia, Australia, Japan, Thailand, China, Malaysia, OIC, USA).

These meetings will be held on 24, 28 and 29 October and, for some, the agenda will be broader than Myanmar due to Maria's presence.

- There is also an agreement that while we will continue to focus on the medical and humanitarian consequences of the discrimination policy of de facto 'apartheid' in Rakhine, we may share some observations related to the political and human rights dimension of the crisis when they impact the humanitarian situation and operations. [...] Maria [Guevara, MSF International Representative in Asia] and I will meet jointly with HRW, AI [Amnesty International], PHR, Refugee International and the Centre for the R2P [responsibility to protect]. We will also call the Asia Director of ICG to discuss the lack of political strategy/mediation at a national, regional and international level to address inter-communal tensions and the continuing hostility of several communities towards humanitarian organisations like MSF (as we will need a stronger support from political actors/mediation experts to open humanitarian space in several areas, such as Myebon where MSF efforts to reach out to communities have backlashed on our teams). ICG, the Centre for Humanitarian Dialogue or the Myanmar Peace Centre (MPC) could play a constructive role or provide advice/ideas/expertise.

OCTOBER 2013 - RETROSPECTIVE LESSONS LEARNED: LACK OF HUMANITARIAN POSITIONING STRATEGY

On 11 October 2013, the MSF Stockholm Evaluation Unit issued a "retrospective lessons learned report" on the MSF OCA emergency intervention in Rakhine from the period from pre-June 2012 violence through August 2013. This report was a synthesis of the main outcomes of the Rakhine retrospective workshop held on 19 September 2013, which brought the main actors of MSF OCA Myanmar together from the field, headquarters, and the MSF International HART team.

While acknowledging successes in MSF OCA's operational strategy, which allowed the organisation to remain in Rakhine and regain some access, the report underlined MSF OCA's inability to establish a humanitarian positioning strategy. Among the reasons for this failure, the report highlighted underestimation of the complexity and humanitarian challenges posed by the situation as well as the under-utilisation of both the services of the humanitarian affairs officer in Rakhine and the various reflections carried out on several different occasions within the organisation. Analysis, engagement, and establishment of a regional strategy were not seen as priorities and implementation was too slow, especially with regard to the Malaysia programmes.

On 14 January 2014, the MSF OCA management team discussed the outcomes and benefits of these "lessons learned." They acknowledged that it took too long to clarify a position and that even still, there was no consensus. Some suggested that the lack of available medical data explained the insufficient public communication, while others believed that more medical data would have weakened communication.



“MSF OCA Rakhine Emergency” MSF **Retrospect Lessons Report**, Stockholm Evaluation Unit for Operational Centre Amsterdam, 11 October 2013 (in English).

Extract:

Phase 1: Pre-June Violence (2012)–December 2012

Phase 2: ‘Rakhine Day’ (20th Dec 2012)–August 2013 [...]

Rakhine Retrospect Workshop, 19th September 2013, [...]

Learnings for others: Many of the related issues could have been lessened with a better understanding of the reality. Timely stakeholder analysis with HAO support, including role of authorities. Sound documentation of contextual analysis to allow for objective discussions.

Real-time evaluation or objective and inclusive review process allowing for immediate learning. [...]

No shared humanitarian position on Rakhine

[...] Appears that the ‘failure of understanding’ (previous) contributed to a lack of urgency in taking a position and towards generating a broader (internal) awareness of the humanitarian situation in Rakhine. There was no HAO focused on Rakhine until end of 2012, and HAO capacity in BKK [Bangkok] does not seem to have been utilised, no senior management in September meeting and outcomes not ‘owned’ in field or HQ. OCA divided on speaking out principle; is it an obligation or *is it a strategy?* [...] Necessity to procure timely stakeholder analysis with HAO support HAO on ground asap in ‘similar contexts’. Need for sound documentation of contextual analysis to allow for objective discussions. Prioritise humanitarian positioning in polarised contexts, and be clear on *témoignage* in general – *obligation or strategy?* [...]

Need for a regional perspective in humanitarian positioning [...]

The value of the ‘regional perspective’ appears to have been underestimated prior to and during the 2012 Rakhine emergency (boat people/Malaysian Explo, Religious/Political factors). Explo Thailand/Malaysia in Dec 2012 -> Bangladesh Report. Jan 2013 findings from explo. Apr/May second Malaysia explo. [...] Emphasis on humanitarian positioning and advocacy not timely/lacking, therefore the need for regional perspective concretely identified and prioritised too late. Explo follow-up slow. Generally very limited guidance from HQ on the issue. [...] There is a need to balance (complement) local and national knowledge and understanding with a regional perspective which needs to be routinely assessed within a humanitarian positioning and advocacy strategy. [...]

HAO Officer (Support)

[...] HAO position agreed in December 2012. HAO capacity available and not utilised during Phase 1. HAO not one of the 6 expatriate positions agreed in September. September to December there was a seemingly unnecessary absence of a HAO for Rakhine. [...] Severely limited access and movement for expatriates during Phase 1 until September 2012. ‘Failure of understanding’ on the level of humanitarian complexity and related failures of recognition and prioritisation have contributed to the lack of timeliness from September (possible) to December (actual). The inability to recognise the need and prioritise a position on the Rohingya plight has also been a contributing factor. [...] Missions should be supported by HAOs as early as possible when the context contains extraordinary humanitarian dilemmas related to exclusion/ethnic cleansing/apartheid.



'MSF OCA Management Team Meeting **Minutes**,' 14 January 2014 (in English).

Extract:

Key lessons:

After 1st wave of violence there was a perceived lack of recognition of the severity of the situation at HQ level. HQ didn't respond well in terms of priority setting [...] Long discussions about public position and how far we could have pushed this in denouncing.

MT feedback:

Lack of medical leadership: wonder how true this is given the lack of data available. Medical data and public comms; Sid [ney Wong, Medical Director] disagrees; we didn't have the medical data available to use in comms. Would not have added any further weight in fact could have even weakened the comms.

On 2 November 2013, following renewed clashes between Muslim IDPs and Rakhine Buddhists, the MSF OCA team transferred injured Muslim IDPs to the hospital. The Rakhine media and social media once again accused MSF OCA of "bias" in favour of Muslim patients. In response, the MSF OCA coordination team conducted a series of targeted print and radio interviews at the national level to reiterate the principles of humanitarian aid, including impartiality.

In all these interviews and articles, MSF OCA called on the government and the communities of Rakhine "to work together with international organisations to ensure that all patients in need of access to emergency medical services get the transport and care that they need, regardless of their background."

The MSF OCA Myanmar team asked the MSF international movement to refrain from public, proactive speaking out on the situation. This was in order to protect efforts underway to negotiate a potential joint statement on the impartiality of humanitarian aid, with international NGOs and the United Nations. Alternatively, MSF OCA sent a reactive line to be used only upon journalists' requests.

Finally, no collective statement was publicly issued because several UN agencies' leaders in Myanmar refused to speak out publicly, preferring to focus on bilateral advocacy. The draft collective declaration was abandoned.



'Sintemaw Incident **Message** from MSF OCA Myanmar Head of Mission to Lauren Cooney and Reshma Adatia, MSF OCA Myanmar Operations Manager and Advisor,' 4 November 2013 (in English), edited.

Extract:

Hi Lauren and Resh,

Some incidents happened over the weekend in Sintemaw camp (below the info as received by OCHA):

"In the morning of 2nd November at Sin Tat Maw IDP camp in Pauktaw Township, some IDPs went to the mountain to cut and gather wood. The group was attacked by Rakhine extremists. One Muslim IDP (age 55) was killed and the rest escape back to the Camp. The Muslim IDPs gathered and tried to go back to Sin Tat Maw Rakhine village to get the body but the security forces stopped and blocked them, which generated a clash

between IDPs and security forces. Police fired gunshots. As a result, three IDPs were injured. The IDPs were transferred to Sittwe hospital by INGO boat and one of them died early this morning (03 Morning).

The other referred incident happened also on 02 November at around 16:30 hrs, when a group of Rakhine women on the way back home met with a group of Muslim IDPs. One Rakhine woman was killed on the spot and another two were transferred to Sittwe hospital. Unfortunately, one of the two died due to the seriousness of her wounds. We did the emergency referral of the Muslims, while the Rakhine were transferred in another way (we and ICRC were not aware nor asked about these two). Situation was very tense yesterday with a crowd in front of the hospital. Today a meeting was called by the Chief Minister with all NGOs and UN (60 government people were present) to discuss the issue and especially the issue of non-equality in aid being delivered. Chief minister and security minister were moderate, but development minister (used to be planning) was very outspoken on the bias of organisations (apparently even shouting).

All boats to the [...] camps have been cancelled due to the fact that no boat captain wants to take the risk (pressured by the community). They only wanted to meet us outside the office and were in disguise, so we are back to where we were 15 months ago. No clue what would make them go back to work yet. There are reports of leaflets and Facebook messages on the incident where we are mentioned (PC [...] by name).

The authorities have stopped construction in the Utopia clinic (using admin reasons) and cancelled all OPD referrals this week. We are meeting with other NGOs today and the UN tomorrow to discuss any joint statement on the impartiality as we think we have to push this back, but should be done by the humanitarian community as one voice. It doesn't feel good, though, and we could see more things happening. Will keep you posted.



“MSF Slams ‘Politicisation’ of Aid in Arakan State” *The Democratic Voice of Burma* (Yangon) by Hanna Hindstrom, 5 November 2013 (in English).

Extract:

Médecins Sans Frontières (MSF) has slammed the “politicisation” of humanitarian aid in Burma’s Arakan state, after an outburst of local protests reportedly forced the group to suspend some of its operations. It follows accusations that the NGO displayed “bias” by taking three injured Muslims to hospital during the latest eruption of communal clashes to grip the state, while three Buddhist women had to seek medical treatment on their own.

The Burmese government subsequently gathered 18 leading international NGOs and UN agencies on Monday to remind them that all assistance must be distributed fairly. But a spokesperson for MSF on Tuesday denied allegations of bias, insisting all assistance is provided in coordination with the local authorities and based on patients’ medical needs.

“Since June last year, MSF and other humanitarian organisations have and continue to experience a great degree of hostility from elements within the local community,” said Vickie Hawkins, MSF deputy head for Burma. “MSF is outraged that healthcare in Arakan is being politicised in this way.” She explained that MSF had been contacted by leaders at the Sintatmaw Rohingya displacement camp in Pauktaw, two hours northeast of the state capital Sittwe, on Saturday after a confrontation between residents and local police left three people injured, one of whom later died in hospital. “With the approval of the state health authorities, MSF referred the patients,” she said, adding that they later heard about another incident in which three Buddhist women, who had been among a group

attacked by Muslims in Pauktaw, travelled to Sittwe hospital for treatment. “At no point was MSF contacted by leaders from the host community or local authorities to assist with the transfer of these patients,” said Hawkins. “If we had been contacted, MSF would have been very ready to provide emergency medical care and referral services.”

The attack on the Buddhist women, which killed one, was reportedly carried out to avenge an earlier episode of violence, which claimed the life of at least one Rohingya man and sparked the confrontation at Sintatmaw camp. Arakan state has been gripped by several bouts of Muslim–Buddhist clashes since last year, uprooting over 140,000 people and claiming some 200 lives. Local Buddhists, many of whom regard the Muslim Rohingyas as illegal immigrants from Bangladesh, have repeatedly accused aid groups of unfairly favouring the minority, even though the Rohingya community has borne the overwhelming brunt of the violence.

A spokesperson for the UN in Yangon told DVB that all humanitarian groups are guided by universal principles of “neutrality, impartiality and independence” [...] “In the current situation in Rakhine state, the unfortunate fact is that the people most in need tend to be from a certain ethnic group.” Rohingyas make up the majority of the displaced and have been confined to squalid camps, with limited access to food, healthcare and sanitation, which they are not allowed to leave, unlike Buddhists who can travel freely. [...] But Buddhists have staged numerous protests against aid groups working with the Rohingyas, sometimes forming physical blockades or threatening staff. According to a report in *The Irrawaddy* on Monday, MSF has been forced to suspend their medical operations in Sittwe following this week’s incident. “MSF is ready to transfer any patient that needs hospital services and we call on community leaders and local authorities to seek our support for any emergency case that the government is not able to transfer them themselves,” said Hawkins.



‘MSF OCA **Operational Bulletin**,’ 6 November 2013 (in English).

Extract:

Myanmar The situation in Myanmar has continued to be tense since the issues over the past weekend. We have been accused in local and social media to be biased in terms of focusing our treatment on Muslims and ignoring the Rakhine population. We have already sent some reactive responses and are now working on a more proactive response as well as a broader response together with the humanitarian community to reinforce that MSF and other NGOs will help anybody. The accusations have made it difficult for some of our staff. For example, our boat captains have refused to work because of concerns for their own safety. The programmes in NRS and some parts of ERS are relatively unaffected, although staff (national and expat) in Sittwe have reported direct harassment in the streets. We are monitoring the situation closely and are feeling the need to respond to some of these accusations.



“Patients Not Politics in Rakhine State” **OP-ED** by [MSF OCA Head of Mission], *Myanmar Times* (Yangon), 7 November 2013 (in English).

Extract:

MSF works in Rakhine State at the request of the government to provide healthcare to communities that the Ministry of Health finds difficult to reach. These challenges are largely a result of the intimidation and hostility that is directed towards their own staff

who are threatened when they try to provide services to Muslim patients. Put simply, Ministry of Health staff faces retaliation should they dare to try to provide healthcare to Muslim communities. Such threats undermine the very act of providing even basic health care in Rakhine State.

MSF provides services to communities cut off from health care, including those who are currently limited to their camps or villages due to movement restrictions. We also support nearby communities, where residents may have freedom of movement but suffer due to tension and fear. We transport patients to hospital in the absence of a government-provided ambulance. However, if there is no clinic operating in an area at the time of a medical emergency, MSF relies on community leaders and local health authorities to contact us.

This service is open to anybody that needs to be urgently transferred to hospital, regardless of ethnicity, religion or any other factor. According to universal medical ethics and humanitarian principles, which guide the work of organisations such as MSF, we consider only the needs of a patient when providing our services.

Aid organisations in Rakhine have worked in close collaboration with the government over the past year and half to provide humanitarian assistance where it is needed most. The provision of this assistance is foremost the responsibility of the government but to fulfil this obligation help has been requested from the international community. Following the violence on November 2, some figures within the government have reiterated a position that humanitarian assistance in Rakhine should be distributed on an equal basis because needs are the same across all communities. Such statements demonstrate a profound lack of understanding of the principles by which humanitarian organisations are bound to operate – most notably that of impartiality, which requires that humanitarian assistance be provided where it is needed most and without discrimination. The government has a responsibility to ensure that all communities in Rakhine State, regardless of their status, have access to basic services. But to describe the medical and humanitarian needs as the same between communities is a misleading representation of the situation. All communities in Rakhine have needs but those needs are very different.

Muslim communities have been cut off from fields, markets and government-provided services, with the exception of emergency health services at Sittwe General Hospital. Many of them are displaced, restricted to squalid camps situated on salt flats and rice paddies.

To access emergency health services in Sittwe General Hospital, every patient transfer has to be individually authorised by health and security officials and facilitated by an international organisation. No one else is willing to transport these patients. This situation has generated significant humanitarian needs among Muslim communities, who suffer from inadequate shelter and latrine provision, shortages in drinking water supplies and intermittent health services. These factors result in avoidable deaths and an increased likelihood of epidemic outbreaks.

Rakhine communities have also had their lives disrupted by violence and the tension and fear that has followed but have not been restricted in their movements. They have a greater ability to access fields, markets and government services. But Rakhine is one of the poorest states in Myanmar and rural communities in particular remain extremely impoverished, with increasing concerns over food insecurity due to the disruptions in agriculture, trade and the local economy. Rakhine communities have access to government health facilities but these remain under-resourced and understaffed, with no ambulance service. All communities in the state need substantial development support to help them overcome decades of neglect and marginalisation at the hands of the former military regime.

The central government has requested support from international organisations in the form of both humanitarian and development assistance, including healthcare. With this request the authorities also have a responsibility to explain to communities the role of these organisations. It should support, rather than politicise, the principles which guide our work. If providing medical care can ever be referred to as 'biased', it is a bias toward patients. It is a bias that is based on medical need, regardless of any other factor. MSF sees only patients, nothing else. That is and always has been our organisation's key underlying principle and is one of the reasons why we have been able to work in some of the most challenging places in the world, providing healthcare to people who really need it, for more than 40 years. MSF calls on the government and the communities of Rakhine to work together with international organisations to ensure that all patients in need of access to emergency medical services get the transport and care that they need, regardless of their background.



'Myanmar Incident Update & Reactive Lines **Message** from MSF OCA Myanmar Communications Manager to MSF Movement Communication Advisors,' 9 November 2013 (in English).

Extract:

Following an outbreak of violence last weekend in Rakhine, MSF has been accused of bias in the provision of medical aid towards Muslims in the state in media reports and through social media, particularly relating to the referral of people wounded in two separate clashes. In response, we have conducted a significant number of targeted print and radio interviews at the national level (both English and Myanmar languages). [...] We have also published an op-ed in both languages in one of the leading newspapers of the country, which explains the situation in more detail [...] We are also working on further national TV and radio outreach as well as publishing the same op-ed in a targeted influential regional newspaper.

For now, we are NOT looking to proactively pitch this at the international level as we are working on securing a collective INGO/OCHA/UN statement on the matter and increased global coverage/interviews by MSF alone could potentially undermine this important operational communications initiative in Rakhine. For your information and detailed background on the current situation, below are some reactive lines on the incident and developments should you be contacted by the media. Again, MSF Myanmar would like to stress that, for now, we would not like to have this proactively pitched to international media.

However, depending on developments in the situation and the evolution of the collective statement, this may change and we would greatly appreciate your support in future global outreach.

Reactive Line:

MSF has been working in Rakhine State for over 20 years. Since June last year, MSF and other humanitarian organisations have and continue to experience a great deal of hostility from elements within the local community. Recent accusations of providing 'bias aid' towards Muslim communities have emerged in national media and through social media networks.

MSF is outraged that healthcare in Rakhine is being politicised in this way. MSF is working in Rakhine to provide emergency medical healthcare to the most vulnerable people, regardless of religion or ethnicity. We work in close cooperation with Rakhine State health authorities and facilitating access to emergency hospital services for patients that

have no other choice should not be considered a biased provision of services. This is exactly the kind of activity that MSF does in more than 60 countries around the world. In Rakhine State, MSF works in close cooperation with local authorities and community leaders to provide access to emergency hospital services to the most vulnerable people. We do this regardless of ethnicity and based only on a patient's need to be transferred to hospital.

On the morning of the incidents in Sintemaw, MSF was contacted by leaders from the displaced camp, who informed our team of urgent cases that needed transferring to hospital in Sittwe. With the approval of the state health authorities, MSF referred the patients. Later in the day and in connection with an incident in the afternoon, we heard that three women from the host community had taken a boat to Sittwe general hospital. At no point was MSF contacted by leaders from the host community or local authorities to assist with the transfer of these patients. If we had been contacted, MSF would have been very ready to provide emergency medical care and referral services and have facilitated exactly this sort of activity frequently in the past. MSF is ready to transfer any patient that needs hospital services and we call on community leaders and local authorities to seek our support for any emergency case that the government is not able to transfer themselves. Indeed, a few days after the incident, MSF referred two emergency cases from an isolated Rakhine village in Sittwe township to Sittwe general hospital and at least once a month there is a referral of a Rakhine patient from northern Rakhine State to Sittwe general hospital. Contrary to some reports in national media, MSF has not suspended all our activities in Rakhine or in the townships surrounding Sittwe. We currently have close to 400 staff working in Sittwe and surrounding townships and another 150 staff in northern Rakhine State. For the moment, we cannot conduct our boat clinics to the camps in Pauktaw; however, we hope to resume full activities soon.



'RE: UN and/or Joint INGO Statement **Message** from Vicky Hawkins, MSF OCA Myanmar Deputy Head of Mission to Lauren Cooney and Reshma Adatia, MSF OCA Myanmar Operations Manager and MSF OCA Operations Advisor cc: MSF OCA Myanmar Head of Mission,' 11 November 2013 (in English).

Extract:

Hi Resh and Lauren

To answer your questions below, last week [the head of mission] participated in an emergency HCT [Humanitarian Country Team]³⁴ meeting on Rakhine. In that meeting it was agreed that an open letter would be written, signed by either the acting RC/HC or Valerie Amos [head of OCHA], expressing concerns about events over the past week in ERS and calling for a stronger voice on the side of the government supporting and reinforcing the role of humanitarian organisations. MSF was volunteered to draft something, [...] and I sent to OCHA on Friday [...]. The following day there was a UN meeting without NGOs present and I've been told afterwards that neither UNICEF nor UNFPA [United Nations Population Fund] will support the idea of an open letter and prefer to rely on behind the scenes advocacy. [...]

I just got the following text from OCHA "as expected, no joint public letter, but proactive advocacy through high level missions and Valerie Amos letter to the vice-president." More of the same... [...] I met with some NGOs this morning and there is a willingness at least from the ones I met with to do something collective which is pretty much along the

34. The Myanmar HCT, under the leadership of the Humanitarian Coordinator (RC/HC), is a UN OCHA coordination structure composed of humanitarian organisations acting in Myanmar who are committed to participating in coordination arrangements.

lines of the op-ed and aiming primarily at the Rakhine community. I think there is more of a realisation that we have to start trying to control the message a bit better because at the moment, extreme elements within Rakhine society have pretty much the monopoly on that. For me, that's a start.

On your other questions:

- OCG HoM has been away but I'm pretty sure he will be with us. Will update him next.
- [...] Locally, there is a great deal of attention to MSF and our Rakhine staff are once again really feeling the pressure – also from staff from other INGOs who blame us for a deterioration in the situation. Again, I think that collective approach can then help us not to appear so isolated.
- In terms of pick-up, good nationally but questionable what impact on local level and we need to do more. Eddy [McCall, MSF Communications Manager in Myanmar] is working on a couple of other more locally focused outlets and that will happen in the coming days.

We will work on the potential collective statement and will let you know when we have something more concrete.

At the end of 2013, international pressure regarding the situation in Rakhine increased.

- **On 19 November 2013, the UN General Assembly issued a resolution calling on the Myanmar Government to give the Rohingya full access to Myanmar citizenship and to put an end to the violence against them.**
- **On 21 November 2013, the Myanmar President's, Spokesperson, Ye Htut, stated that Myanmar could not grant citizenship to the Rohingya minority. He asked the UN to stop using the term 'Rohingya' and instead, to use 'Bengali.' Htut then announced a census was planned for 2014 that would not take the Rohingya minority into account.**
- **On 28 November 2013, during a discussion at the EU parliament, Human Rights Watch called on the EU to establish an inquiry commission on abuses committed against the Rohingya. The ECHO representative described a very serious humanitarian crisis and shrinking humanitarian space. MSF representatives warn of the risks of 'double jeopardy' for the most vulnerable people if donors and aid agencies are reluctant to intervene for fear of complicit in a policy of segregation.**
- **On 16 December 2013, the EU Foreign Affairs Council urged the Myanmar government to respond to the demands of the UN resolution on "the situation of human rights" in Myanmar.**
- **At the same time, after visits from the ambassadors of the UK and Canada in Rakhine, the UK embassy in Myanmar issued a press release expressing concern over the dire humanitarian situation in Rakhine. She urged local authorities to ensure that humanitarian agencies have free & unhindered access to deliver lifesaving assistance.**
- **On 30 December 2013, in a joint public statement, the European Union and the embassies of Switzerland, Turkey, and USA urged the Myanmar government to ensure immediate and unimpeded humanitarian access to the Taung Paw IDP camp in Myebon slum, where the situation was desperate.**

- **On 15 January 2014, Myanmar took over the ASEAN presidency. According to some observers, the Myanmar government was keen to seize this opportunity to “accelerate the process of opening up to the region and the outside world”.**



'Myanmar **Message** from Fabien Dubuet MSF International Representative to the UN to MSF OCA and MSF OCG Myanmar Operational Coordinators and MSF International HART,' 19 November 2013 (in English).

Extract:

Dear all,

[...] the resolution on Myanmar adopted by the UN General Assembly [...] was adopted by consensus and the OIC did not introduce a separate resolution. Some good and clear language on the Rohingya, humanitarian access and assistance (“full and unhindered through Rakhine”) and a number of human rights issues (discrimination, freedom of movement, arbitrary arrests, forced displacements, etc.). The mention of the need to speed up the set-up of an office of the High Commissioner for Human Rights was also maintained [...]

The mandate of the Special Rapporteur [on Human Rights in Myanmar] is secured. No change in the UN set-up for mediation efforts/good offices (Nambiar’s office continues to be the central mechanism to engage with the GoM). [...] [UN official] Analysis is that there is a need to maintain discrete efforts as much as possible and share advice and ideas on a low-profile basis to ensure ownership of the GoM but above all facilitate the buy-in by Rakhine communities and limit the role of spoilers and hardliners. [...] Too visible efforts by foreigners reinforce resistance and complicate ownership by the authorities.

Need for a stronger UN leadership fully acknowledged [...] President and his entourage are determined and sincere about Rakhine and want to address problems. But they have to navigate among spoilers, hardliners and segments of the Buddhist community + the upcoming elections do not create an easy political environment to make strong moves. Tough discussions and instructions from NPW [Nay Pyi Taw] to Rakhine government Sittwe reported on the humanitarian agenda and the accountability of perpetrators of violence. Minister of Immigration and Populations + Minister of Border Affairs are the two key (and supportive) officials for Rakhine, in addition to the President. Still, they are struggling about the how.

Idea to strengthen the presence of the army in Rakhine to create checks and balances vis-à-vis the police (seen as a problem) and to ensure better law and order and protection of communities. [UN official] is pushing on access to hospitals/secondary health care + referrals and is using the OIC visit as a window of opportunity on this front. [UN official] is in touch with the Special Advisor of the SG for the Prevention of Genocide and Mass Atrocities.



'Myanmar Not Ready to Recognise Its Rohingya Minority Despite Urge from UN, **AFP** (Yangon),' 21 November 2013 (in French).

On Thursday Myanmar rejected the proposal to grant Burmese nationality to its stateless Rohingya minority, despite the UN this week urging the country to move in this direction, as it considers this Muslim group as one of the most persecuted minorities in the world. “We cannot give citizenship rights to those who are not adhering to the law, whatever the pressure. That is our sovereign right,” Ye Htut said in a post on his Facebook page,

which he often uses to issue official remarks. [...] A resolution on Tuesday at the United Nations called on Myanmar's government to give the Rohingya full access to citizenship and to end violence against them.

But Myanmar contests even the term "Rohingya". "The government position on this issue is that we don't accept the term 'Rohingya'," wrote Ye Htut, insisting that the UN use the term 'Bengali' instead of Rohingya, the term commonly given in Myanmar to this Muslim minority without passports and therefore without any rights, with dramatic consequences on their access to health, jobs and education for their children.



"Discussion at EU Parliament on the Situation of the Rohingya Muslim" **Message** from Edouard Rodier, MSF International HART, Representative to the European Union to MSF OCA and OCG Myanmar Operations Managers and Advisors, 2 December 2013 (in English).

Extract:

Highlights:

HRW calls for an independent international commission of inquiry on abuses against Rohingya minority; ECHO denounces a very serious humanitarian situation and a shrinking hum[anitarian] space. It calls for more development funding to support the host Rakhine communities to avoid fuelling the tensions against minority and humanitarians; Concerning perspectives: ASEAN chaired by Myanmar in 2014 and the coming census that will not include Rohingyas. MSF warned against the risk of double punishment of the most vulnerable when donors and aid agencies show reluctance to intervene to avoid complicity in the segregation process. [...]

Among the concerning perspectives:

Myanmar will chair the ASEAN in 2014:

A census is planned where Rohingyas will not be counted. Unclear how much it can impact them.

Concerns raised by MSF:

- Dilemma faced by humanitarian agencies around the policy of segregation. The reluctance of donors and agencies to intervene to avoid complicity in the segregation process has resulted in a lack of response, which is not justifiable. Currently conditions in the camps as well as access to services are extremely limited. People are being punished twice.
- For non-IDPs the situation is also grave. Particularly in NRS – where humanitarian assistance since the outbreak of violence has actually decreased from what it was previously while needs remain huge.
- Underlined the chronic nature of the crisis in NRS.
- Denounced the continued intimidation faced by agencies and the difficulties around this.



"International Pressure Mounts over IDP Camp Conditions" by Kayleigh Long, **The Myanmar Times**, 3 January 2014 (in English).

Extract:

Pressure is mounting for the Myanmar government to ensure full humanitarian access to the Taung Paw IDP camp in Rakhine State's Myebon Township, with several international bodies decrying the conditions within the camp as "inhumane." A joint statement issued on December 30 by the European Union delegation, along with the

embassies of Switzerland, Turkey and the United States, has pointed to the “dire humanitarian situation” faced by the camp’s 752 resident families. Chief among the concerns outlined were the poor living conditions within the camp, including a lack of safe drinking water, limited healthcare services, widespread malnutrition, and the restriction of access beyond camp bounds. [...]

The December 30 embassies statement pointed to improved security and an easing of restrictions on international health workers in the camps as measures that could pave the way to improved living conditions. “The international community calls for increased security to allow camp residents to safely move in and out of the camp, in order to ensure their access to markets and livelihoods, and for international health workers to be allowed to spend the night in camps to increase healthcare access”, the statement said. [...] “The international community has received credible reports that local community members in Myebon township have harassed humanitarian staff and impeded access for humanitarian supplies to the people in need in Taung Paw camp. These actions are unacceptable”, the statement read. Representatives of the embassies behind the statement say they remain unconvinced by the publicly stated intentions of local, state and Union-level government groups to allow unimpeded humanitarian access.

“Union-level and local officials alike have publicly vowed to enforce this principle without delay. Despite these promises, we have yet to see effective action. The international community urges authorities to ensure humanitarian access immediately and without further delay to allow aid to reach those in desperate need, and take immediate and firm action against responsible individuals, including those who seek to block humanitarian aid and intimidate, harass, or harm humanitarian workers”. The groups emphasised their willingness to cooperate with government on an issue they say is of “utmost importance” to regional stability and progress. “Development assistance and inward investment to Rakhine State, for the benefit of all communities, will only come when situations like that in Myebon are adequately addressed.”



“Myanmar Steps into International Role at ASEAN Helm” By Hla Hla Htay, **AFP** (Naypidaw) (Myanmar), 15 Jan 2014 (in French and English).

Extract:

Myanmar begins its first international political role in decades this week as host of the Association of Southeast Asian Nations, with experts warning against “overinflated” expectations. [...] The long-isolated country has won international praise and the removal of most Western sanctions for wide-ranging political and economic reforms since the end of junta rule in March 2011, its powers transferred to a quasi-civilian regime. [...] While the regional bloc has often been embarrassed by the disastrous image of Myanmar since it joined in 1997, the country “promises to make a positive contribution,” said Sean Turnell, Associate Professor at Australia’s Macquarie University. “The biggest danger to Myanmar (...) might be overinflated expectations,” he added, noting that the successful management of the Southeast Asian Games might have raised unrealistic hopes of its ability to tackle more substantial challenges. “The international community didn’t expect much from [previous chairs] Laos, Cambodia, etc., so these countries quite easily exceeded expectation. This might not be the case for Myanmar.”

In 2006, in the face of criticism of its rights record, Myanmar was forced to renounce its previous turn. [...] Myanmar’s eagerness to take the chair this year – jumping in ahead of Laos – is a signal the government wants to “step up the process of opening up to the region and outside world,” said Southeast Asia expert Carl Thayer. [...] The chairmanship should be an “opportunity for the government to improve its human rights situation and

show it is serious about making the transition from military to genuinely civilian rule," said Human Rights Watch researcher David Mathieson, adding it still had "some hard convincing to do".

PUBLICLY CHALLENGING ACCUSATIONS OF BIAS TOWARD ROHINGYA

In November 2013, MSF OCG teams in Rakhine, driven by community pressure on their office's owners, were forced to evacuate Kyauk Taw and to re-settle in Mrauk U.

On 23 December 2013, local Rakhine radicals put pressure on Sittwe hotel owners to stop accommodating INGOs, which they accused of favouring the Rohingya.

MSF OCA's deputy coordinator for Myanmar repeated that MSF would cooperate with community groups provided that they channelled their requests through MSF's national partners, the Ministry of Health and the Ministry of Development Affairs.



'MSF Switzerland Myanmar Complete **Project Summary**,' 13 June 2014 (in English).

Extract:

November [2013] OCG forced to leave premises in Kyauktaw, base set up in Mrauk U [...] Accommodation: initially we had residences in Kyauktaw in a guest house and then in private housing however we were forced to leave these due to 'community pressure' and intimidation on the owners. There is only 1 guesthouse in Kyauktaw and we could not secure other private accommodation so we were forced to move to Mrauk U Palace Hotel (including office) where we stayed for the rest of the project as we could also not secure private housing in Mrauk U nor move back to Kyauktaw. It was very expensive and owners [were] unwilling to make contractual agreements meaning little stability in premises.



'Mrauk U Host Community Want to Stop Renting of Offices to INGOs Min Their Aung (Sittwe), **Radio Free Asia**,' 23 December 2013 (in English).

Extract:

The host community held a meeting with hotels and restaurants owners from Mrauk U Township. During the meeting, locals said INGOs provide humanitarian healthcare but they provide only to Muslim people, so local people want all INGOs to leave their land by Dec 20. [...] "We discussed about NGOs who stay in Mrauk U hotels and decided they must leave by Dec 20 because they did not accept our desires," Ko Pauk Sa said. MSF [OCA] Myanmar Deputy Head of Mission Mr Simon Tyler said via a translator that MSF was not against host community's desires, and that MSF provides healthcare through a State Government agreement. He added that MSF wants to cooperate with local people. "We did not refuse at any time to cooperate," he said. "We only asked that community groups make requests through our line ministry (Ministry of Health) and the Minister of Development Affairs, as they are our supporters/partners in Rakhine State. We will

cooperate fully with them and work closely to ensure that health care is provided where it is needed." On Dec 24, all hotels and restaurant owners will have to stop their renting to INGOs.



There were a couple of incidents targeting the houses the teams had rented. People were throwing some rocks and breaking windows of the houses. And then the community leaders of Kyauktaw, whom I assume were passing messages from the monastery leadership, asked the OCG team to leave the town. This occurred in the first couple of months of the project when it was being set up. Everything was quite new. There was quite some tension around the town and there were no other humanitarian or development actors that I know of in that area.

Brian Willett, MSF OCG, Project Coordinator in Rakhine State December 2013-September 2014 (in English).

On 3 January 2014, MSF OCA and MSF OCG held a press conference in Sittwe and gave interviews to national and regional media. Once again, they underscored the harassment of aid workers and explained that MSF teams were providing medical care to people in need no matter their origin, working with the Ministry of Health as their line ministry.



'Doctors Without Borders Holds Press Conference in Sittwe, Min Thein Aung (Sittwe), **Radio Free Asia** Burmese,' 3 January 2014 (in English).

Extract:

MSF (Doctors Without Borders) explained during the press conference that they want to provide only medical care to people who are in need. "One of the main things I would like to mention is the harassment of aid workers in general, who are only trying to provide medical care to people who need it," said Mr Simon Tyler, Deputy Head of Mission (Rakhine). "Distraction of emergency referral services is really unacceptable to people whose life depends on our intervention to save them. So, I would say that this is one of the major obstacles at the moment; it is really unacceptable." In December, the host community protested against MSF in Sittwe and Mrauk U. The community accused MSF of only providing services to Muslims, not local Rakhine people. MSF explained that they have always worked with authorities and their line ministry, the Ministry of Health, and always negotiate with the State Government before providing services.



'**Interview** with Country Director of MSF (Switzerland) Mr Duncan Bell by U Win Naing, **Radio Free Asia** Burmese,' 6 January 2020 (in English), edited.

This is the interview with MSF, which local people have accused of being biased. However, MSF explained that they are not biased and there have been some misunderstandings about their activities. So, we interviewed Mr Duncan Bell, Country Director of MSF (Switzerland).

Q: There have been some misunderstandings on the ground towards the MSF mission in Rakhine State recently: some minor protests occurred at Sittwe hospital and again in Mrauk U. There were other misunderstandings as well. Do you have anything say about this?

A: Yes, we understand that there is a perception among parts of the community in Rakhine State that MSF and other organisations are biased in their activities in the state. This is unfortunate for all concerned. MSF is a medical organisation only and nothing else. We are here to provide medical assistance to those most in need. [...]

Q: Some people have said or accuse MSF of being biased in recruiting staff – that you are biased to one group, not Rakhine. Is it true that you are more likely to hire Muslims?

A: I can say categorically that is not true. MSF in Rakhine State, and throughout Myanmar, recruits people on the basis of their ability to do their job. And that again is the sole defining criteria for our recruitment policy. So, whoever can do the job to the best of their ability, we will recruit that person rather than somebody less qualified. It would be true to say in Rakhine State that there is an issue of perception with regards to who is recruited and available and we do have recruited staff working in Rakhine from outside of the state. I think it is understood that we cannot always find qualified people within the state. Therefore, we have been advised and see a particular necessity to recruit from outside of the state. However, MSF in Myanmar as well as throughout the world has a principle of recruiting locally, wherever possible. And I will take the opportunity to actively encourage anybody in Rakhine State who sees a position vacancy within MSF to apply because we would prioritise people from the local community if they were available rather than people from outside of the state.

Q: How have you tried to overcome those misunderstandings, either working with local people or with the Rakhine State government? Is there any possible way that you can make them understand that your mission is for everyone?

A: I think that we need to repeat simple messages that hopefully everybody can understand that we are Doctors Without Borders. We are an organisation primarily composed of medical persons, doctors, nurses, laboratory staff and so on. We would like to support the government in the resumption and implementation of vaccinations for children for vaccine preventable diseases from all communities throughout Rakhine State. Vaccination activity has been interrupted because of the conflict. Vaccinations are something that INGOs staff have not been able to participate in previously. We hope that this might be replicated nationwide.

On 31 December 2013, a presidential amnesty allowed the release of political prisoners. One of the two MSF OCA national staff detained since June 2012 was on the list of prisoners to receive this amnesty.



'Rohingya Political Prisoners Released, Kaladanpress.org,' 3 January 2014 (in English).

Extract:

Eight Rohingyas were included in a presidential amnesty for political prisoners on New Year's Eve. Four were released from Akyab Jail and the others from Buthidaung, according to an anonymous humanitarian based in Maungdaw. [...] and [...] a Ward two administration officer, were among the four released from the Akyab Jail. [...] from Ward

six and [...] from Taungbro were released from Buthidaung jail, according to the anonymous source. Most of the prisoners were charged with leading sectarian violence against ethnic Rakhine in June of 2012, said a Maungdaw schoolteacher, who also didn't want their name used. The allegations were false, and they were not involved in the unrest, or given a fair trial, one of the victims' relatives told Kaladan Press Network on condition of anonymity. There are still many more Rohingyas that have been falsely charged languishing in Arakan state prisons, said [...] a Maungdaw shopkeeper.

CHAPTER 4 - 2014 - FROM TOTAL EXPULSION TO PARTIAL SUSPENSION

DU CHEE YAR TAN EVENTS

On 13 January 2014, members of the Rohingya community were attacked in Du Chee Yar Tan village, located in southern Maungdaw Township.

On 14 January 2014, the MSF OCA Deputy Head of Mission in charge of Rakhine serving as the emergency coordinator and an MSF OCA nurse went to the MSF clinic and mental health clinic in Maungdaw South, located close to Du Chee Yar Tan. Members of the local outreach team explained that they treated people traumatised by these violent events.

MSF OCA decided not to be proactive in disseminating the information. As MSF was the only organisation operating in the area, they were questioned by both the authorities and the media. MSF explained what they saw in these interviews but, in order to protect the local staff, MSF said that this information came from an expatriate nurse who took care of the patients. However, the nurse was not properly briefed and did not confirm the information to the authorities. This misstep allowed the authorities to claim that there were no civilian casualties.

In the days that followed, clashes continued in the area and the MSF clinic team treated more seriously wounded people. The local staff were threatened, and one of them fled to Bangladesh temporarily, to escape the police.



I was working as a mental health supervisor. In Maungdaw, we had three mobile clinics. While we went with the mobile health clinic close to Kilaidong [popular name of Du Chee Yar Tan] we saw that there was no one living there, people had run away. People were frightened and escaped to nearest village. We said that if anyone from Kilaidong needed healthcare, they just had to bring them to us. MSF decided that physical treatments will be given by expats and the mental health support will be given by an expat and nationals with my translation. A woman came with a small wound on the back. The registrar asked her where she was from. She was from Kilaidong. The expat did the physical examination and then the other expat and I we talked with her and ask what happened. We treated other patients with same wounds. The next day the DC [District Commissioner] called the MSF PC and asked to have us provide details: "who is the person, where is the person from." We said: "no, we respect confidentiality, we have no statistics." They said that we were not transparent, that if we didn't give them information, then how could they allow us to work there? One of our colleagues said that if they needed more information they go to the head of mission.

So, then we have to cut off some activities. The DC said that he could not allow us to work here anyway. The authorities were aware I was the one who had translated. So, some days later, they came to my house and asked if it was R's house. I said yes. They asked if R was home. I thought that they did not know me. They knew the name but not the person. So, I said no, that he went to the market. They asked my relationship with R, I said he was my cousin. Then they left, and I just ran away by the back door. Five minutes later they came again and asked my wife where was the person they just met. My wife asked who they met – she didn't know that they met me – and she said she didn't know the person they met. The next day I left the country. My family in-laws lived very close to the border, so I crossed the border from there. MSF activities were closed that day. I called the supervisor and told that I was going home. I never mentioned that I was going to Bangladesh. I just told that I was going for a few days.

R, Myanmar MSF Staff Member, fled to Bangladesh in 2017 (in English)



I was the only expat who was actually there at the time. It was going through a period where we still had the travel approvals to allow us to get to northern Rakhine. I got a phone call from one of the northern Rakhine staff saying there'd been an attack on a village, a community just north of Maungdaw, Du Chee Yar Tan. So, what I did, I got the boat that day straight up to Maungdaw, to northern Rakhine and spoke with one or two of the staff that were there. Me and a nurse decided to just go and open the clinic about two kilometres from this location where the attack happened. On the drive down, we passed the village, deserted, with only Burmese police and an army presence. Obviously, there was no way of stopping. There was smoke in the air, houses were burning. Dare I say it, that's what was happening in northern Rakhine all the time, so we carried on down.

We opened the clinic for the day and we had some of our outreach workers come to visit us to talk about what they'd seen, what they'd done, and the type of cases they treated. And so, we had these 'second hand' testimonies, for want of a better word, and "these" were our outreach workers: maybe 15 cases just showing signs of trauma but nothing serious. But also, at that time, there was no way they could be referred to any other facility because as soon as they walked in the door: 'boom' [they would be stopped]. So, we had this information that we didn't proactively give, it was questions that were asked to us by the authorities because we were the only operational NGO there at the time: 'what happened? Did you see anything?' And we said: 'well, we treated 15 patients or something showing signs of trauma.' And then of course, they said: 'who did see those patients?'

We were not going to give up our outreach workers because they would have been herded up and thrown into jail. So maybe that was a mistake but ultimately, we decided that one of our international staff would stand there and say, 'I did it.' He was the one who spoke to the outreach worker, so he was closely connected but he didn't physically put hands on. We wanted to be sure that having this information, we offered it when it was asked and only when it was asked but then covered it with the fact that it was one of our nurses who suggested he treated them. That's how it was going to be presented. But when he was then asked, as far as I was aware by the authorities, he denied it. So therefore, there was this contradiction. I don't know how this happened. Nobody briefed him at the time. And so, even though 15 people were treated, even though we stuck to our position to say, 'yes, these people were treated, etc.,' that little grey area came in. And then of course, anyway, the government said there were no casualties. We didn't say any more than that. But that's enough to serve a seed of doubt. That's

enough to just give a little bit of space for some more of the extreme parts of a community to start their process.

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)

On 16 January 2014, the *Associated Press* and *The Irrawaddy* broke the story. MSF OCA issued a first reactive communication stating that on 15 January their staff saw two wounded people suffering from injuries inflicted as a result of the violence: one from a gunshot wound and the other exhibiting injuries consistent with beating. They noted that the area was deserted and that very few patients came to the MSF clinic. MSF OCA expressed concerns about the unmet medical needs due to this situation and stated they were ready to support the local health authorities to assist those in need of care.

This reactive line was given to the *Associated Press* (AP) correspondent in Myanmar on 16 January and to *Agence France Press* (AFP), Reuters, Radio Free Asia on 17 January.

The MSF OCA Myanmar coordination team requested that this reactive communication be broadcast from the headquarters in Amsterdam, in order to protect the field team from possible reprisals. However, the headquarters decided to broadcast the message from both Amsterdam and Yangon, at the same time. On 17 January, the message was globally circulated to all the MSF international communications advisors.

In its dispatch, *AFP* did not mention MSF and reported that “an NGO” said that several people were killed during an attack against the Rohingya in western Myanmar. According to Reuters, the information came from “human rights groups” and the ongoing clashes that followed left at least sixty dead. However, *Reuters* quoted MSF OCA’s information that matched the reactive communication’s content, revealing the source as MSF OCA.

The US embassy in Yangon as well as the UN Special Rapporteur for Human Rights in Myanmar, Tomás Ojea Quintana, expressed concerns about these clashes and asked for an investigation.

In the following days, the MSF communication team in Myanmar continued briefing journalists on the basis of the reactive communication, but without giving any interviews.



MSF reactive line, **Message** from Igor G. Barbero; MSF OCA Communication Advisor to MSF Movement Communication Advisors, 17 January 2014 (in English).

Extract:

You may have seen some reports regarding violent incidents that have happened this week in the Rakhine State, in Myanmar. We are closely monitoring the situation. Should you need some information, here is our reactive line on the issue.

Reactive Use Only

“MSF has heard reports of a conflict in southern Maungdaw Township in Du Char Yar Tan village on Tuesday January 14. MSF confirms that on Wednesday our staff saw two wounded people suffering from injuries inflicted as a result of violence - one from a gunshot wound and the other exhibiting injuries consistent with a beating. Our regular medical clinic, which is nearby, saw an unusually low number of patients today. The affected area is currently deserted. MSF is concerned that there may be unmet medical needs among the affected population and stands ready to support local health authorities in providing medical support to those requiring care.” The situation has been highlighted by some relevant international media outlets.



Several dead in western Myanmar sectarian unrest (NGO) **AFP** (Yangon), 17 January 2014 (in French).

Extract:

Several people including women and a child have been killed in an attack on Rohingya Muslims in strife-torn western Myanmar after several outbreaks of communal bloodshed between Buddhist and Muslim communities since 2012, a rights group said on Friday, as the US embassy voiced alarm. Myanmar’s Rakhine State remains extremely tense after several outbreaks of communal bloodshed between Buddhist and Muslim communities since 2012 that have killed scores and displaced some 140,000 people, mainly from the Rohingya minority. Details of the latest unrest were unclear, but Rohingya activists said at least two women and a child were stabbed to death in an attack on a village near the border with Bangladesh earlier this week, with possibly several dozen casualties. “A police sergeant is still missing along with his weapon. We are looking for him”, a senior police official in nearby Maungdaw town told AFP on condition of anonymity adding that there had been civilian victims also. [...] Another police officer in the state capital Sittwe said dozens of people had been rounded up after the unrest, with 10 still in custody.



“UN Expert on Myanmar Calls on Government to Clarify Reports of Clashes in Northern Rakhine State” **Reuters**, 17 January 2014 (in English).

Extract:

The United Nations Special Rapporteur on the human rights situation in Myanmar, Tomás Ojea Quintana, today urged the country’s authorities to investigate and clarify reports about violent clashes between security forces and Rohingya Muslim residents in Du Chee Yar Tan village in Maungdaw, Rakhine State.[...] The human rights expert has received reports of Rohingya Muslims being killed and injured as well as a security official being killed following a security operation in the village in Maungdaw, and of Rohingya men, women and children being arrested following the clashes.



‘MSF Myanmar **Comms Sitrep**,’ January 2014 (in English).

Extract:

Jan 16: Gave validated reactive lines for [...] Maungdaw incident to AP

Jan 17: Gave validated reactive lines for Maungdaw incident to Reuters, AP, AFP, RFA

U.S. urges Myanmar to probe attacks on Muslim minority [MSF MENTION] [...] Rohingya deaths denied by Myanmar government [MSF MENTION]



We saw people from that village that came to our community health workers. So, we witnessed the extent of the violence and could verify the fact that it had happened. Of course, the rumours were swelling. MSF had a very good network amongst the international media in Yangon. Journalists approached us and asked: "MSF, what do you know?" And at that point we had only seen around two people. So, we gave that number. We said: "we have treated people with machete wounds who say that they're from that village." So, we didn't say the violence happened, but we could confirm that we had treated people correlated with what was being reported.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting Head of Mission in February 2014 (in English)



We were the only organisation there. We decided we could not just keep quiet because 'no comment' was really too weak. So, we made a kind of reactive statement where we said "yes, indeed. MSF has been treating 20 people for violence-related wounds in that area". Two big mistakes were made. One was the mentioning of the geographic area and the other one was that Amsterdam refused to sign it off alone. I had asked them to do so because it was very sensitive at the moment and after what we've just gone through for the last two years, it was not a good idea. There was medical information inside. It had to be signed by the medical director. But that was refused by Amsterdam. So, it was a co-signing, Amsterdam/Yangon. In my opinion, that reactive line where implicitly we were pointing fingers at the army and the police, was the trigger. On top of that there was this issue about one of the deputy minister of home affairs, who was not let into one of our clinics because he came with all his guys with guns. And rightly so. But they don't get that. For them it's like humiliating. He said: "MSF is not transparent, it's not letting me in a clinic and is publicly humiliating me."

Y, Former MSF staff member in Myanmar (In English).

MSF OCA COMPELLED TO SPEAK OUT

On 22 January 2014, MSF OCA's Rakhine team treated 20 victims of the Du Chee Yar Tan clashes either with injuries, psychological trauma, or both. Many of the victims were too scared to seek treatment at the clinic for fear of police arrest. MSF local staff suffered intimidation and harassment from the police.

The United Nations High Commissioner for Human Rights submitted a report to the Myanmar government, describing the conditions of 47 fatalities resulting from the Du Chee Yar Tan violence. The report recommended protection of civilians, access for humanitarian workers, and an independent investigation. Representatives of UN OCHA and UNHCR visited the area but were strictly monitored by official security personnel and were not allowed to freely talk with the population.

The MSF OCA Myanmar management team continued to refrain from briefing journalists for fear of endangering the national staff and of jeopardising access to the increasing number of victims arriving at the MSF clinic. They hoped that a strong statement from the UN would exempt MSF OCA from taking a public stand.

However, the disagreements between the various UN agencies in Myanmar prohibited them from taking any strong public stance. Moreover, it was not certain that a strong UN position, combined with other organisations' voices, would be sufficient to pressure the government.

The team began to wonder whether, faced with the government's denial, it was MSF OCA's duty to shed light on the scale of the massacres using evidence collected from their patients. An MSF OCA public stance was considered, "perhaps just by reactively updating patient numbers." The MSF International HART team was asked to inform its UN contacts in Geneva and New York.

On 23 January 2014, the Rakhine state authorities continued to deny the reports of violence in the area, which remained inaccessible to humanitarian aid workers. The villagers merely roamed around without food or belongings, and were harassed by local authorities.



Update Myanmar: NRS -> Situation MDG South", Vickie Hawkins, MSF OCA Myanmar Deputy Manager, 22 January 2014 (UTC + 6:30) (in English).

Extract:

Operations:

- We've now seen approx. 20 patients either with injuries or for counselling or a combination of both. It's a bit difficult to be really precise, because we only have intermittent contact with CHWs [Community Health Workers] and it seems patients do keep presenting.
- Injuries are so far: 1 gunshot wound, 1 severe beating, 3 beatings and the rest are knife wounds. We heard word today the more severe patients have crossed to Bangladesh. [...]
- We've given counselling to at least 7 patients and their accounts absolutely corroborate the information that UNHCR/OHCHR [Office of the United Nations High Commissioner for Human Rights] have collected. [...]
- Until today, the area/village was not accessible but today OCHA and UNHCR visited the affected village/village tract in the company of the Chief Minister. There is a meeting tomorrow morning at UNHCR to hear more about that visit.
- There is by now a slow trickle of patients into ALTK [Alel Than Kyaw] clinic and to the CHWs (we heard many were afraid to be arrested should they come to the clinic). We might see other patients come into clinics in MGD S[outh] in the coming days. The team today started to plan how we can better reach patients e.g. mobile clinic to the affected area and more on that tomorrow. [...]

Advocacy/comms:

- Between Yangon and Sittwe Coordination we had meetings yesterday with OCHA, OHCHR, UNHCR and the RC/HC's office.
- OHCHR report is ready and they have documented accounts of 47 fatalities, mostly on the night of the attack but also some villagers who tried to return to Du Chee Yar Than.

- This morning that report was submitted by the HC [High Commissioner] to the Vice-President together with a covering letter which called for, amongst other things: protection of civilians, humanitarian aid workers, humanitarian access, independent investigation.
- This afternoon Nambiar met with the Vice-president in NAY PYI TAW. He was going to call the HC and head of OCHA following that meeting, at which point they were planning to finalise the PR and send it out. As of 9pm, nothing has been received. [...]
- If a statement goes out, we can expect that we will get calls from journalists, particularly the correspondents we know well and that have already contacted us (AP, AFP, Reuters). Our plan for tonight was to hold off any update on patient nos. [numbers] to see if:
 - 1. The HC puts out a statement
 - 2. How much attention it gets
- If in the end the UN refrain from making a public statement, on the basis of all the evidence that we have that something pretty major has happened, then we think we should consider putting something out ourselves – pending risk analysis particularly bearing in mind the pressure local staff are being put under.
- If the UN makes a statement and it doesn't get a great deal of pick-up, then we could also consider adding our voice, perhaps just by reactively updating the patient nos.
- Our justification for not updating any journalists on that call tonight is based on the pressure that national staff are facing and the fact that we are seeing increasing numbers of patients and not to jeopardise their access to us. Drawing attention to the fact that we are seeing increased numbers of patients, some of which whom are classed as police cases, could lead to the authorities putting pressure on CHWs or monitoring movements of patients to our clinics.



'Update 23 January 2014 – Vickie Hawkins, MSF OCA Myanmar Deputy Head of Mission,' 23 January 2014 (UTC + 6:30) (in English), edited.

Extract:

Events of Du Chee Yar Tan (DCYT) – Maungdaw South, NRS

Accounts of the events (based on eye-witnesses MSF spoke to and CHWs' accounts). On 13 January, around 10 pm, a few policemen, and some Natala/Rakhine people reportedly entered the village of DCYT East/Muslim (south of Maungdaw town), as a meeting was being held after some villagers reportedly came across body parts. The villagers were scared and there was a confrontation between the policemen and a group of villagers. The Natala/Rakhine people and the police then reportedly fled the village, except for 1 policeman who was left behind in the chaos, and is since missing. A couple of hours later, a larger number of security forces came back to the village, as well as Natala/Rakhine people. The men from the village would have then fled the village, leaving elderly and women/children behind.

The following morning, the remaining villagers (mostly women, elders and children) were said to have been beaten by the police, including children, and in the afternoon, were taken to Maungdaw police station. The village then emptied of all people and local Natala/Rakhine reportedly entered and looted the village. Those who returned since said they counted between 8 and 40 bodies there.

Hundreds are believed to be currently running away from one village to another, in need of humanitarian assistance, while the rest of the population is being intimidated by police. Most of DCYT's villagers (total population is around 3,700) fled the village during the night of the event, on 13 January. They now seem to be running from village to village, with no food and no belongings. They got little assistance as Muslim populations in

Maungdaw South have been intimidated and threatened by the police not to do so [not to bring assistance to Muslims], otherwise there would be retaliations. The police is believed to have made searches in several villages, and several were reportedly arrested. Many are believed to be sleeping in the field at nights. Several patients MSF spoke to said they had lost track of their relatives since fleeing the village .

In total, since the incident happened, MSF saw 22 persons believed to be survivors of the attack, including 10 for medical care, 7 for counselling and 5 for a combination of both. Patients keep coming to MSF nearest clinic, but many reported to community health workers being too scared of being arrested by the police should they come to the clinic. Injuries so far included one gunshot wound, one severe beating, three beatings (one woman and two children, aged around 5 and 6), and the rest are knife wounds. The more severe patients have crossed to Bangladesh.

There has been increasing intimidation and harassment from the authorities, against its staff following these events. One MSF staff [member] was slapped on the face by a policeman in Maungdaw South on 19 January, he was wearing an MSF tee-shirt at the time. The temporary residence of one employee was also searched in her absence by the authorities who were specifically looking for her, and referring to her as an AZG [MSF in Dutch] employee. Another staff member was also warned by someone that he should stay out of the way as the authorities have big problems with MSF. [...]

Advocacy so far:

The US and the UK, as well as Quintana, issued statements urging the government to investigate the reports of violence. OHCHR documented accounts of 47 fatalities, mostly on the night of the attack but also some villagers who tried to return to the village, and their report was submitted by the HC to the Vice-President yesterday together with a cover letter which called for amongst other things: protection of civilians, humanitarian aid workers, humanitarian access, and independent investigation.

The RC/HC seemed to be keen on putting a statement out, calling the government to investigate the violence and to allow humanitarian access to the affected area. Yesterday, V. Nambiar [UN Secretary General's Special Advisor on Myanmar] met with the Vice-president in Nay Pyi Taw. He was going to call the HC and head of OCHA following that meeting, at which point they were planning to finalise the statement and send it out. However, so far, there has been no statement.

Main concerns are now:

- humanitarian access to the area;
- "de-securitisation" of the area: to have the police pulling out so to allow people to seek assistance;
- protection of humanitarian staff.



Update Myanmar: NRS - Situation MDG [Maungdaw] South", Vickie Hawkins, MSF OCA Myanmar Deputy Head of Mission, 23 January 2014 (UTC + 6:30) (in English).

Extract:

The big but perhaps not surprising news from today is that the visit that OCHA and UNHCR went on yesterday to Du Chee Yar Tan village was a total sham. They were accompanied by a massive entourage (including many security personnel) and had no ability to talk to people privately. [...]

In terms of the position of the govt so far:

- they continue with their line that there has been no violence on their side, the only person missing is the policeman and the only investigation is into his whereabouts.

- there is reportedly a directive to arrest every man and boy 10 years and over from the village.
- people have fled are not able to return to their village until the investigation is over.
- no one in surrounding areas is allowed to offer shelter to those that have fled, or they will be arrested.

While the push for humanitarian access is obviously vital, there is a risk that humanitarian actors in the area could act as a magnet and put people at risk. So really essential that the police pull back from the area first. In the meantime, we continue to see small numbers of patients coming into ALTK and CHWs, the total as of this afternoon was 22 with 10 for medical consultation only, 7 for counselling only and 5 for medical and counselling. We will stay open through the weekend again and in the meantime plan for mobile services as and when it becomes safer for people to emerge from their hiding places.

In relation to public messages, there's some sort of in-fighting going on with the UN. The HC is keen but the head of OCHA would seem to be more conservative. And it has now seemingly been taken out of the hands of the UN in-country and a statement will come from either NY or Geneva. To that end, we thought it might be useful to give the HART update and perhaps they can start to phone around their contacts and find out what is being said at that level. [...]

In relation to our own public messaging, no concrete plans at the moment, again we want to see how things evolve within the UN. Rationale for this is that public pressure is undoubtedly needed at the moment, NAY PYI TAW need to realise the seriousness of this situation and rein in the local authorities which is the only way that people may emerge from hiding and we can assist them. But perhaps a vocal UN in combination with all the other reports coming out is enough and there is no need to take the additional risks that could present by lending our voice to the fray. Those risks could be envisaged as:

- breaking the fragile access, we currently have (to only a few patients admittedly)
- the possibility to reach more of the affected community in the future
- local staff security

On the other hand, if the UN don't come out with a statement and/or it doesn't make sufficient public noise then perhaps we need to lend our own testimony in order to strengthen the collective voices and get NAY PYI TAW to step in. It is only NAY PYI TAW that have the ability to take decisions over the head of Maungdaw authorities, the state government will not do this.

There is also just the simple fact that we have evidence of the scale of the attack (through patients) in the face of a flat denial by the Myanmar govt, are we duty-bound to highlight this? And perhaps by doing so, we bring an element of protection to our activities (from my side, I'm not sure I believe this in the context of Rakhine but it's worth to consider).

On the evening of 23 January 2014, while the MSF OCA Myanmar management team held to its decision to “keep quiet and let the UN take the heat,” the headquarters decided to issue an update to the earlier reactive communication and send it to the movement's communication advisors.

This second reactive line stated that MSF OCA teams treated at least 22 patients, including several wounded, who were believed to be victims of the Du Chee Yar Tan violence. All of the movement's communication advisors requested that the reactive line be distributed to the international media on 24 January.

Meanwhile, on the same evening, the UN High Commissioner for Human Rights, Navi Pillay, called on the Myanmar government to investigate “credible information” gathered by the UN regarding 48 Rohingya Muslims who were killed in the violence of early January.

According to this information, the massacres were triggered by an attack on eight Rohingya Muslim men in the Du Chee Yar Tan village on 9 January. Then, on 13 January, a police officer was killed in the same village by Rohingya Muslims. This led to retaliation and the killing of at least 40 Rohingya men, women, and children by local security forces and members of the Rakhine community.

The OCHA Coordinator Valerie Amos, expressed her “deep concerns” over the massacre of many civilians and a policeman.

The Bangkok-based human rights organisation, Fortify Rights, stated they spoke with witnesses and other sources who confirmed the massacre.

The Myanmar President’s spokesperson rejected these claims as groundless, acknowledging only the policeman’s death. The Ministry of Foreign Affairs accused the international media and international agencies of misinformation, exaggeration, and distortion of the situation. However, the ministry announced that international observers would be allowed to inspect the site of the alleged massacres.

All this information was widely reported by national and international media, which continued to reinforce the idea that MSF OCA supported the UN’s “credible information” and challenged the Myanmar authorities’ denial.



Message from Igor G. Barbero; MSF OCA Communication Advisor to MSF Movement Communication Advisors, 23 January 2014 (in English).

Extract:

Dear all,

You may have seen some reports regarding violent incidents that happened last week in the Rakhine State, in Myanmar. We already issued a reactive line last week but as more information is being gathered, we have prepared an updated one while we continue to monitor closely the situation.

REACTIVE USE ONLY

MSF has treated at least 22 patients, including several wounded that are believed to be victims of the violence that erupted in Du Char Yar Tan village, in southern Maungdaw Township on January 14. MSF continues to be concerned by reports that there may be unmet medical needs among the affected population and stands ready to support local health authorities in providing medical care to those in need. We continue to request the Government of Myanmar to enable safe access to the affected population for humanitarian personnel and ensure the security of the civilian population in need of assistance.



“Burma Violence: UN calls for Rohingya Deaths Inquiry”, **BBC.com**, 24 January 2014 (in English), edited.

Extract:

The UN human rights chief has called on Burma to investigate reports that dozens of Rohingya Muslims have been killed in attacks by Buddhists in Rakhine State. In a statement, Navi Pillay said a “full, prompt and impartial investigation” was needed. The UN had “credible information” that 48 Rohingya Muslims had been killed in violence in early January. The government, however, has rejected the claims as groundless. In a statement sent to the BBC, presidential spokesman Ye Htut said the UN was not listening to its own staff on ground and was damaging its reputation in Rakhine State. [...]

In the statement, the UN said eight Rohingya Muslim men were attacked at Du Chee Yar Tan village on 9 January. On 13 January, a police official was killed in the same village by Rohingya Muslims. This triggered the killings of at least 40 Rohingya men, women and children by local security forces and Rakhine people, the UN statement added. The government statement only acknowledged the death of the police sergeant. “I deplore the loss of life ... and call on the authorities to carry out a full, prompt and impartial investigation and ensure that victims and their families receive justice,” Ms Pillay said. “By responding to these incidents quickly and decisively, the government has an opportunity to show transparency and accountability, which will strengthen democracy and the rule of law in Myanmar.”



Press Release Myanmar Ministry of Foreign Affairs, Nay Pyi Taw, 24 January 2014 (in English), edited.

Extract:

It is learnt that foreign media and some international agencies are issuing Press Releases based on unjustified conclusions drawing from unverified information in relation to the incidents which took place on 13 January 2014 in Du Chee Yar Tan (Middle) village, Maungdaw Township. Such misinformation and unjustified conclusions amount to exaggeration and distorting the situation eventually leading to misunderstanding between the two communities in Rakhine State. It is also confirmed that those Press Releases were issued without any attempt to inquire or verify the information with responsible government officials.

The truth about the situation of the incident is as follows:

During the routine patrol duty in Du Chee Yar Tan (Middle) village in the vicinity on the night of 13 January 2014, a five-member police patrol team was surrounded and threatened by over one hundred Bengali mob wielding sticks and knives. As the mob advanced with visible threat the patrol team had to leave the vicinity. During the withdrawal, the leader of the police patrol team was lost in the mob. Remobilized police and security forces revisited the same vicinity in search of the lost Police Sergeant. They were again threatened by over 500 Bengali mob armed with sticks and knives. In order to deter from being physically attacked, eight warning shots were fired. However, there were no civilian injuries or casualties. In search of the missing Police Sergeant in the following days, only clues such as blood-stained uniform, belt and a pair of boots were discovered. The Chief Minister of Rakhine State, local authorities, police and security personnel, religious leaders, Rakhine State Hluttaw (Parliament) Representatives, resident representatives from UNHCR and OCHA together made a tour to the area including Du Chee Yar Tan Village and met with the villagers.

A planned and pre-determined violent attack on the security personnel in the line of duty is an offence punishable by law. The attackers include those who took part in the arms training courses run by so-called Rohingya Solidarity Organisation. Law enforcement agencies will continue their efforts to expose and bring them to justice within the existing framework of law. The Union Government of the Republic of the Union of Myanmar and the local authorities are taking every step to ensure security, rule of law justice, humanitarian access, and reconciliation in Rakhine State. At this critical juncture of the political, socio-economic and administrative reform processes in Myanmar, only unbiased, constructive and well-objective activities will be helpful to the people of Myanmar. The international media and international agencies should release only information which is verified with responsible officials of the government. Failing to do so, releasing unverified information would be tantamount to interfering internal affairs of the host country. Resident Diplomatic Missions are also required to faithfully observe fundamental diplomatic practices in line with the 1961 Vienna Convention on Diplomatic Relations.



“Myanmar to Allow Inspection of Alleged Massacre Site”, *The Hindu Times*, 24 January 2014 (in English).

Extract:

Myanmar will allow international observers to inspect the site of the alleged killings of more than 40 Rohingya Muslims, a government spokesman said on Friday. “They can have a chance to ask questions and inspect the area freely,” said Ye Htut, a spokesman for the office of Myanmar President Thein Sein. He provided no further details and repeated the government’s denial of the reported incidents in the north-west of the country. The United Nations earlier condemned two reported attacks by local Buddhists in Rakhine State on January 9 and 13, and called on Myanmar to investigate. [...] The Under-Secretary General of the UN Humanitarian Affairs and Emergency Relief Coordinator Valerie Amos also said she was “deeply concerned,” about the killings of “many civilians and a policeman.”



“Medical Charity in Myanmar Says Treated Wounded Near Alleged Massacre Site”, Jared Ferrie, *Reuters*, 24 January 2014 (in English), edited.

Extract:

Medical charity Médecins Sans Frontières said on Friday it had treated 22 people in Myanmar’s western Rakhine state who had apparently been wounded last week around the time of a reported massacre of Rohingya Muslims, an incident the government denies. The United Nations and human rights groups say at least 40 Rohingya were killed by security forces and ethnic Rakhine Buddhist civilians in mid-January in a restricted area of the conflict-ridden western state. On Friday, government spokesman Ye Htut denied there had been any mass killing, in line with statements over the past week. But information provided by Médecins Sans Frontières (MSF) further erodes the position of the government, which is facing international pressure to investigate the incident. “MSF has treated at least 22 patients, including several wounded, that are believed to be victims of the violence that erupted in Du Chee Yar Tan village in southern Maungdaw township on Jan. 14,” said [...], the charity’s head in Myanmar. The organisation, which runs a nearby clinic, said most victims suffered knife wounds, while one had been shot and three beaten, one severely. MSF said it was concerned more victims could be in need

of medical treatment and urged the government to allow access to the area. [...] Bangkok-based rights group Fortify Rights said on Thursday it spoke to witnesses and other sources who confirmed the massacre, which would be the deadliest incident in Rakhine state since October 2012, when ethnic Rakhine Buddhists fought minority Rohingya Muslims. Ye Htut urged those who fled the village to return and cooperate with authorities investigating the officer's death. "The police force is giving protection to the people left in the village," he said.



'Message from Eddy McCall, MSF OCA/MSF OCG Myanmar Communications Manager to MSF OCA Myanmar HQ and Field Teams,' 24 January 2014 (in English).

Hi all,

The UN statements overnight [...] generated comprehensive global coverage, particularly in light of ongoing denials by the government, the Fortify Rights report, HRW statements and UK Foreign Minister comments (see below), etc. The updated reactive line sent out overnight by Amsterdam to the movement was shared this morning with Yangon-based foreign correspondents for AFP, AP, Reuters, The Times and Irrawaddy after they contacted us.



'MSF Myanmar Comms Sitrep,' January 2014 (in English).

Extract:

Jan 23-24: Second reactive line produced by OCA HQ sent to List press overnight Myanmar time.

Jan 24: Second reactive line on Maungdaw incident provided to Yangon-based correspondents for AFP, AP, Reuters, Irrawaddy, The Times & Al Jazeera [...] following phone calls.



Then the numbers started to increase and we sent a sitrep up to Amsterdam overnight saying that by that point our teams had treated about 20 people. And this is where the breakdown between medical and non-medical really started to show itself. That number hadn't been verified by our medical line. It was basically the number that I was collecting from a medic and a project coordinator on the ground. But it hadn't gone through the medical coordinator because the relationships and the communication line between the medical coordinator in Sittwe and the Maungdaw project had been broken down! So, as these numbers were being stacked up, there was no medical check happening in Sittwe and we were sending a real-time reporting to Amsterdam. However, I said in one email: "We don't consider that we need to be public with this number because UNHCR had already gone public by that point. So, the story's out there." We woke up the next morning and Amsterdam had spoken to journalists and given that number.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting Head of Mission in February 2014 (in English)



Our first reactive line had triggered a UN team to go and find out about stuff. I remember distinctly sitting with Vicky and talking about the fact that the temperature had gone through the roof and talking about whether we should do any more. We had received reports that we had treated 22 people from that area and we thought about it. We knew that the next day the UN was going to drop a report claiming that 47 people had been massacred and women raped, and they would have all these details. As for us, we had no confirmation of any deaths. So, we thought: 'let the UN take some heat for a time while our reactive line of 22 people is being treated.' It's logical from a communications perspective. Our messaging was far weaker than the UN's and they were bigger, and they could take it. And we'd been taking a lot of heat already by breaking the story. And that's the advice that we gave to headquarters.

We wake up in the morning and overnight Amsterdam had released the 22 wounded line that we advised them not to release. It was all over the news obviously. It was all been given out by MSF press offices all around the world. But in Myanmar we didn't give it to any journalists. So, we'd lost control of the messaging. More importantly, it had dropped on the day that the UN had dropped their big report but all the stories were about MSF and not about the UN report.

*Eddy McCall, MSF OCA/MSF OCG, Myanmar Communications Manager,
April 2013-January 2015 (in English)*

BILATERAL ADVOCACY EMERGENCY PLAN

The MSF International HART, together with the MSF OCA operational team rapidly established a bilateral advocacy emergency plan in order to exchange reliable information with diplomatic stakeholders. They planned to ask these stakeholders to maintain diplomatic pressure on the Myanmar government and lobby for immediate humanitarian access and delivery of assistance.



"Myanmar" Message from Fabien Dubuet, MSF International HART, Representative to the UN in NYC to Lauren Cooney and Reshma Adatia, MSF OCA Operations Manager and Advisor cc: Emmanuel Tronc, MSF International HART Coordinator,' 24 January 2014 (in English).

Extract:

After reading the two documents you shared with us, I think I should follow up with several trusted interlocutors here, such as [...], (the UN) and selected diplomatic missions (Indonesia, Japan, China, India, etc.). All these contacts are well-known and people with whom we have a sustained and transparent dialogue on Myanmar/Rakhine. The main objective would be to exchange information, to establish facts accurately and ensure diplomatic pressure for humanitarian access and the delivery of assistance to those in needs in the area without delay.

I would also suggest that Edouard follows-up with the EU, notably with ECHO and Ashton's cabinet³⁵, [...]. Maria could talk to some contacts we have in the Indonesian government and the ASEAN Secretariat in Jakarta. The growing rhetoric/tensions between the Rakhine authorities, including the security forces and MSF teams are also

35. 'Catherine Ashton was the first High Representative of the European Union for Foreign Affairs and Security Policy from 2009 to 2014.'

rather worrying. Let me know what you/(MSF OCA Myanmar CMT) think. We can talk over the phone if more convenient. It would be good to hear Marcel's [MSF OCA Director of Operations] perspectives after his visit.



“RE: Myanmar” **Message** from Reshma Adatia, MSF OCA Operations Advisor to Fabien Dubuet, MSF International HART, Representative to the UN in NYC cc: Lauren Cooney MSF OCA Operations Manager and Emmanuel Tronc, MSF International HART Coordinator,’ 24 January 2014 (in English).

Extract:

Dear Fabien,

Following a discussion with Lauren and feedback from the field, what you propose for follow-up is very valuable. Vickie also mentioned that it might be useful to follow up in Washington, given that there are signals coming from the Embassy that the human rights aspect of the situation in Rakhine is moving up Washington’s agenda – something about the kicking off of certain human rights mechanisms or something like that. It was just a hint from somebody at the Embassy, but could be interesting to know more about.



“Myanmar/Thailand” **Message** from Fabien Dubuet, MSF International HART, Representative to the UN in NYC to Lauren Cooney, MSF OCA Myanmar Operations Manager, Emmanuel Tronc, MSF International HART Coordinator; Monica Rull, MSF OCG Myanmar Program Manager; Kenneth Lavelle, MSF OCG Myanmar Deputy Program Manager; Reshma Adatia, MSF OCA Myanmar Operations Advisor; Andres Romero, MSF USA Operation Advocacy Advisor; Maria Guevara, MSF International Representative in Asia,’ 28 January 2014 (in English).

Extract:

Dear all, [...]

1/ Some quick information [...]

OCHA [...] agree[s] some people are still displaced/in movement in the area and in need of assistance with possible injuries, so they are pushing for humanitarian access. The UN was totally instrumentalised during the joint visit they did with the authorities and they were escorted all the time by security forces.

OCHA and the OHCHR have gathered information from various credible sources about this episode of violence and they take it very seriously in light of the gravity and nature of the violence, which included crimes against women and children, notably sexual violence. The UN is also concerned about people still in detention. [...]

3/ Follow-up by HART

=> Andres already had a discussion with the USG.

=> Edouard to follow up with ECHO and Ashton’s office.

=> Emmanuel to arrange a meeting with OHCHR and the ICRC.

=> Fabien to follow-up with UN interlocutors in written and targeted diplomatic missions orally. [...]

=> Joanne: what do you think for Beijing?

Main messages: stick to the reactive line issued by OCA about the latest episode of violence (more can be shared orally with trusted interlocutors insisting on the seriousness of the violence but indicating clearly this additional info is not first-hand/based on direct

witnessing by MSF teams but based on discussions with survivors and health professionals), highlight the very delicate position in which our teams are and how much pressure is put on them to provide information covered by medical secrecy with intimidation and threats (we need clear diplomatic back-up on this front), focus on the need for humanitarian access without delay to evaluate needs of IDPs and possible injured people. Focus on key talking points already approved and refocus the discussion on the medical and humanitarian consequences of the discrimination policy against the Rohingyas and the shortcomings of the humanitarian response in NRS and in/around Sittwe for IDPs and other communities, especially the lack of access to hospitals in/ around Sittwe.

Specific question for Monica and Kenneth [MSF OCA Programme Managers]: what is the status of your discussions with the GoM and the UN on your vaccination issues?



“Myanmar/Notes of Roundtable US Officials on Myanmar/Rakhine Washington DC”, **Message** from Andres Romero, MSF USA Operational Advocacy Advisor to MSF OCA, MSF OCG, MSF International Teams In Charge of Myanmar, 27 January 2014 (in English).

Extract:

My interlocutor was well aware of MSF challenges. [...] [They] reported to State Department MSF staff was under threats and some were “physically assaulted”. Also, interlocutor already aware of 22 cases treated by MSF (including knives, bullet and laceration wounds). I took this opportunity [...] to insist on the need to have a stronger UN leadership on HR issues; explain our reactive line and significant pressure our teams are facing; the lack of humanitarian access to assess the needs in the area following the violent events. The US “Mass Atrocity Prevention Board” is now focusing on Myanmar/Rakhine. [...] FYI The “Mass Atrocity Prevention Board” is an inter-agency mechanism created by Samantha Power when she was at NSS (National Security Strategy) in order to alert US officials on mass atrocity crimes and trigger funding and policy mechanisms to respond quickly.

In days that followed, the Myanmar government demanded that MSF OCA deny its account of the Du Chee Yar Tan events or provide a list of the patients that the MSF OCA teams claimed to have treated, including medical details of the treatments provided. They underscored the fact that MSF OCA was in a weak position because their MoU with the government was yet to be agreed and renewed.

State media published accusations against MSF and veiled threats against any media that published information about Du Chee Yar Tan. In particular, the threats were aimed at the Associated Press and *The Irrawaddy*, while intimidation of humanitarian aid workers increased.

On 27 January 2014, the MSF OCA operational department decided to provide the authorities with a letter explaining the ethical questions arising from their request concerning patients’ medical information. MSF OCA decided to provide aggregate data as a response as opposed to individual data.

Since the United Nations decided to stop speaking out on their “credible source-based” evidence regarding the several dozen deaths during this attack, MSF OCA decided to offer statements based on medical data. However, MSF OCA did not offer any indication of the number of victims. These statements angered many official Myanmarese interlocutors, including moderates who believed that MSF OCA supported the UN statements. The resentment towards MSF also undermined the ongoing negotiations for the release of the last national staff member detained since June 2012.

The MSF OCA Myanmar coordination team had no plan to engage in proactive communication, preferring to stick to the strategy of reactive communication and refusal of interviews. They considered the possible fall-out scenarios from the situation: the worst of which would be a scenario where MSF OCA is expelled from the country under the pretext of the unsigned MoU.



'Update Maungdaw South incident,' 24 January 2014 (in English) .

Extract:

UN waiting for official response to request humanitarian access to the affected area.

Presidential spokesperson issued a strong rebuttal of the UN statement. [...]

Advocacy/Comms: MedCo had a pre-scheduled meeting with Dep SHD and at the same time informed on our patient nos. He looked visibly shocked and said that he was in the area yesterday and saw nothing. He also advised this was very risky for our organisation as the patients are 'police cases'. Meeting held with DC to inform that we had been seeing patients with injuries sustained through violence. He called in the Chief of Police, TA [Township Administrator], TMO [Township Medical Officer], Dep DC [District Commissaire). Very hostile reception, absolute denial that these patients could have been in connection with violence as there wasn't any according to him. Told us we are in a very precarious position as we are operating without MoU and demanded details of all patients. We expect this to be followed up on Monday by the authorities with a formal request for patient details (there is a precedent for that for SGBV [Sexual and Gender Based Violence]). Meeting requested with Chief Minister Rakhine. To be discussed: Intimidation of humanitarian aid workers.

Access to affected area.

OCHA informed of intimidation of national staff.



'Update Maungdaw South incident,' 26 January 2014 (in English).

Extract:

Meeting with Security Minister/Dep HoM and MedCo

Also present in the room were Dep SHD, Minister of Electricity, Secretary of the State Govt, Chief Police Officer of Rakhine State, DC of Sittwe. Initially asked why we had requested a meeting with the Chief Minister and Dep HoM responded that the meeting was intended to request access to displaced persons in MGD South and inform them of some intimidation of our staff. In terms of access, they responded that the displaced women and children were returning home, and would be helped by the authorities. They asked for a more detailed report on the intimidation of staff, I responded that I was also

waiting for a more detailed report but that we had reported the matter to the DC [District Commissioner] and were confident that he would take the appropriate action. They then went on to raise in the meeting two previous meetings and asked us for an account of patient nos. allegedly seen in our clinics.

We explained that we had transmitted this information in the spirit of transparency and gave a full account of patient numbers (e.g. number of gunshot wounds, beatings, etc.). They requested more detail in writing, patient names, current locations etc. According to the Security Minister this was in order to be able to follow up with the proper healthcare. They repeatedly asked where the information was coming from, I always replied our team in north of Arakan State and international medical staff. The fact that these are 'police cases' was raised repeatedly, our duty 'according to our MoU' and to Myanmar law was to refer them to the appropriate authorities. NB: there is no mention of police cases in our MoU – anything in our registration? [...]

If we do not submit the full details, then our report will be discounted and we will be considered to be lying and in order to discredit and do reputational damage to the state authorities. We will be showing disrespect to the state authorities. The report must be submitted asap. Following the meeting we had 5 minutes with the Dep SHD. He said the situation is very serious, that we are obliged to report police cases and that 'all MDs in Myanmar know this'. I asked for this in writing, as I explained we have done a lot of research and not been able to find it written down anywhere. Following the above meetings there have been a number of other encounters with the authorities:

TMO called NRS PC assistant and asked for a letter that had stated we had not treated any victims of violence/police cases. [...] DC called NRS PC assistant and asked for date of MoU, name and phone number of the responsible person in Sittwe. TMO sent 7Day News representative to MSF office in Maungdaw to ask for comment. They were referred to the Dep HoM in Sittwe, but so far have not contacted me. Rakhine Investigative Commission members, sent to look into the reports of violence for one of the Presidential Advisors, asked for a meeting in Maungdaw. They were referred to the Dep HoM in Sittwe and I will meet them, as well as trying to persuade them to meet with [Head of Mission]. There is a serious concern though that they are not here in good faith but have come to look into reports that UN and NGOs are lying. TMO would appear to be leaking details of his conversation with NRS expat MD, in which he responded that MSF had not treated any patients in MGD South, to national media, namely 7Day News and RFA. The comms team have been in touch with both publications in the meantime, to be monitored whether they go ahead and publish.

For next week:

Letter to be submitted to the authorities in Sittwe. We need guidance on this – how much can we state without breaching patient confidentiality and putting patients/staff at any further risk?

Team starting to plan in case of possible suspension by the authorities in NRS. How would such a decision affect activities elsewhere in Rakhine? RC/HC's office, Head of UNOCHA, OHCHR and US/UK/EU ambassadors alerted to the threats we are currently facing. As of yet, not requested to take any action. [...] HART to also inform relevant contacts?



'MSF Myanmar **Comms Sitrep**,' January 2014 (in English).

Extract:

MSF's reactive line of 22 patients treated near the affected village is the only credible piece of evidence presented so far in the public debate, with the UN not elaborating on its claim of having credible evidence of dozens killed. This placed a great deal of pressure on MSF and our profile was increased to the extent that many in the local community (particularly Rakhine) believe, or have been led to believe, that in fact it was MSF that told international media that people were killed when at no time did we go on record with such a statement. We have never confirmed any fatalities but that may not be the public perception, particularly in some parts of the country [...]

Thinly veiled threats against AP & *Irrawaddy* published in state media. Government denials of any deaths continued and a large diplomatic gathering was convened in Yangon with selected media where MSF was named and our figure of 22 patients treated questioned. The story continues to have traction, due primarily to the denial of the government and rejection of international observers at any inquiry. National media initially tended to focus on the missing policeman and follow government line but have increasingly shifted towards protests against MSF, calls for MSF to leave Rakhine and questioning MSF figures, [...] In terms of key messages specifically, we are thinking about wanting to emphasise the following:

1. A clear message that police and/or security forces need to pull back from [...] area to ensure not only access from humanitarian actors but also for the population to us.
2. A clear message around security aid workers, and concerns about incidents related to our staff.



“RE: Myanmar” **Message** from Reshma Adatia, MSF OCA Operational Advisor to Fabien Dubuet and Emmanuel Tronc, MSF International HART cc: Lauren Cooney MSF OCA Operations Manager,' 27 January 2014 (in English).

Extract:

Dears,

We had a phone call with [MSF OCA Myanmar HoM] this morning, and there are some clear concerns as well as agreed steps forward that I wanted to update you on. The biggest issue at this time is significant pressure from the authorities to provide either information denying that we had seen patients affected by the violence (basically an admission to the authorities that we were in fact “lying” in our reactive statement) OR a list of all patients with the details of their medical cases. Of course, we feel strongly that we will not provide the former as in the reactive line we clearly only stated facts – and added the caveat of “believing they were victims of the violence”. The latter presents obvious medical ethical issues.

Following discussion with Sid [ney Wong] (DirMed) [Medical Director] we will provide a letter to the authorities clearly stating (but very diplomatically) the medical ethical issues with providing details and instead provide aggregate data - the minimal that we feel we can provide without consent (for example 60% of patients are male, 10% had xx complaints, etc.). We anticipate providing this letter in the coming 48 hours or so to the SHD, who is our direct line to the Ministry. We have tried, and will continue to try, to only have discussion based on information that is directly attributed to MSF – access to populations in need in the area, harassment and intimidation of our NS, as well as factual medical information in so far as is possible given confidentiality issues).

In terms of comms, there are absolutely no plans to engage in active public communications, and in the past week we have maintained the reactive line and not given any interviews. We feel strongly though that the reactive line was necessary to reflect our medical activities. However, even that reactive line has obviously caused major issues with the authorities (though interestingly only in Rakhine, and NAI PYI TAW has not formally said anything to us at all). The major concern appears to be that unlike the statement of the UN which cites credible sources, we site our own medical data – making it harder to dispute. From meetings that are being held related to the Zafar case (more on that below) we understand that there are quite a few people who are upset and/or refusing to meet us (including moderates) as MSF is “supporting the UN”. [...]

In terms of a general risk analysis – at this point, there are a number of possibilities. We remain without a MoU (though this is a long-standing issue) for either Rakhine or the rest of the country. This of course is something that could be used against us, but is the same also for our HIV programmes. Certainly, in terms of worst-case scenarios, we prepare for the authorities to suspend our operations (though we will NOT actively do so ourselves, as our main concern remains access to the populations) – either in Rakhine as a whole (though perhaps less likely) or NRS specifically (judged more plausible). As of now though, we continue to be “allowed” to move, and we will continue to do so until we are stopped ... a pretty basic strategy. The other possibilities of course, though seemingly less likely, is either a full expulsion from Rakhine (due to MoU or other “issues”) or a PNG [persona non grata] of a member of our management team. At this time, we judge unlikely that there will be specific backlash against our expatriate or national medical staff.

In the end, the only real backing we may have is from the diplomatic community. We have had, and will continue to have, in-country meetings with various embassies, etc. We have not had formal contact with Nambiar’s office. Clearly your input on how best to achieve this is invaluable. Certainly, it is possible that this is a “storm in a teacup” and this will all go away in a few days/weeks. However, the reflection from the team is clearly that this is the most significant reaction we have had from the authorities to date on any issue – and the strength of that reaction forces us to be prepared for possible backlash.



Letter from Dr Sid[ney] Wong, Medical Director Amsterdam Headquarters, MSF Holland, Head of Mission, Yangon Coordination office, MSF Holland to State Health Director – Dr Aye Nyein- Rakhine State Government,’ 30 January 2014 (in English).

Extract:

Your Excellencies,

Following your meeting of 24 January with our deputy Head of Mission and Medical Coordinator, MSF is happy to provide you with some details in relation to patients seen by our staff between the period of 14–22 January at Alel Than Kyaw and Myinn Hlut clinics and the surrounding area. We provide this information in the spirit of openness and transparency between our organisations, whilst also maintaining our ethical responsibility as a medical organisation to keep individual patient information confidential.

In total, during that period MSF saw a total of 15 patients with violence-related injuries and a further 7 patients that required counselling services. Of the 15 patients, 9 were female and 2 were children under the age of 16.

The injuries sustained included:

- 1 gunshot wound (arm)
- 4 cases of bruising

- 10 cuts and slashes

The above patients were attended by MSF staff and in line with the Myanmar medical oath and universal medical ethics requiring treatment of the patient according to their needs and all information on patients numbers and types of injuries was checked and supplied by international medical staff. Each patient was advised to attend Ministry of Health facilities for further care. Our standard practice when receiving any patient with injuries in relation to violence is to refer to the Ministry of Health so that it can be determined whether they fall into the category of police case.

We are available at any time of your convenience to answer questions in relation to the information we have provided.

MSF OCA REACTIVE COMMUNICATIONS CONTINUE

On 27 January 2014, at a press conference, the Myanmar government rejected the call for an international investigation into the Du Chee Yar Tan events, and declared that “alleged massacres of Bengalis are fabricated news.” A wave of repression was launched against the media that reported on these events.

On 30 January 2014, MSF OCA published a third reactive line expressing its regret that some people in Rakhine did not seem to tolerate the provision of basic services to people who otherwise would have none. MSF’s principle of providing support based on solely on the assessment of medical needs was reiterated. The MSF communication teams continued to reactively brief journalists.



‘MSF Myanmar **Comms Sitrep**,’ January 2014 (in English).

Extract:

Jan 28: Press conference held yesterday afternoon by central authorities in Yangon where reporters from Irrawaddy, Associated Press, Voice of America, *The Myanmar Times*, Mizzima and other media were not allowed to enter. AFP, CCTV [China Central Television], Channel News Asia, Eleven and various other state and quasi-state media were permitted. Govt calls alleged killing of Bengalis “fabricated news” [MSF MENTION] (2901 Myanmar Freedom)

Govt Rejects Call for Int’l Investigation into alleged Rohingya Killings [MSF MENTION] (2801 Irrawaddy) [...]

Reactive line BIAS ACCUSATIONS Thursday Jan 30

“MSF regrets that some people in Rakhine do not seem to tolerate the provision of basic services to people who otherwise would have none. We are humanitarian medical workers, working closely with the Myanmar Ministry of Health to deliver healthcare in Rakhine, as well as hundreds of thousands of people all over the country, including Shan and Kachin states, as well as Yangon and Tanintharyi regions. MSF is non-political – we are an independent medical humanitarian non-government organisation that provides life-saving services to millions of people in 60 countries around the world that do not have access to healthcare. Our support for people in all of the countries we work in is solely based on medical need only, regardless of race, religion, gender, ethnicity or any other factor.” [...]

Jan 30: Jason Motlagh informed via MSF HK that he is arriving in Myanmar on Jan 31 for reporting on Kachin and Rakhine for Washington Post. Potential briefing to be arranged, depending on senior staff movements. Reactive line provided to Wa Lone from Myanmar Times following email where he was also asking us to comment on the allegations by the government of international organisations providing false information to the media. [...] NY Times sending team to investigate MDG S incident



'MSF Myanmar **Comms Sitrep**,' February 2014 (in English).

Extract:

Media crackdown: Myanmar authorities have introduced new visa regulations for foreign correspondents as of early February, limiting foreign journalists to one-month visas, instead of the previous three-month stay. Seen as punishment for raft of Rakhine and MGD S-related reports by freelancers and AP/Irrawaddy. Affects dissident media as well, as many hold passports from country of refuge during junta regime, despite being of Myanmar origin.

Throughout February 2014, the MSF OCA Myanmar communication team continued efforts to counter anti-INGO protests and especially anti-MSF propaganda in the mainstream media. The message focused on the constant defence of data on numbers of patients treated by MSF teams after the Du Chee Yar Tan events.

The situation worsened after the 14 February 2014 publication of the report from the Myanmar Presidential Commission's Inquiry on Human Rights concerning the Du Chee Yar Tan events. In this report, MSF was accused of providing false patient figures.

The main constraint in the implementation of this defensive communication toward the Rakhine media was the lack of an experienced MSF spokesperson who could speak the Myanmar language coupled with the lack of staff able to validate translations from English. Another challenge was MSF's inability to counterbalance the impact of public misinformation on national staff.

However, efforts to develop communication tools targeting Myanmar society, especially in Rakhine resulted in the successful production of a website, leaflets, and other specific tools written in the Myanmar language.



'MSF Myanmar **Comms Sitrep**,' January 2014 (in English).

Extract:

Constraints & challenges

A key ongoing constraint for the Comms Dept in national media engagement is the validation of Myanmar language reactions to unexpected (i.e., impossible to plan for) reactive media inquiries after the validated English response has been translated. Only three senior OCA national staff are currently available for this final Myanmar language

sign-off process, all of whom have already very busy roles and other responsibilities. They all try to help out as much as possible when they can and have been extremely helpful and flexible considering their already very heavy workloads, but the current set-up is not viable in the long term, particularly given the fact that national media engagement is likely to expand, not decrease, with other major sensitive comms/advocacy activities in the pipeline [...] Add to this the upcoming need for validation of Myanmar content for the MSF Myanmar website and the current arrangements are not sustainable and need further discussion by the Coordination Management Team. [...]

Related to the above is a recommendation for strengthening internal communications when MSF goes public with such a powerful and sensitive pieces of media engagement, such as the MGD S reactive lines we produced and disseminated. The fact is that many of the stories would not have been written without those reactive lines. Our lines were used as pieces of proof refuting the government's denial and the incident itself would certainly not have had as much coverage without MSF's testimony of having treated 22 violence-related injuries in the area. While some expats may not think national staff are discussing things because they are not raised in department meetings, this may not be the case. I know this may sound obvious but there are different communication spheres which expats are not privy to. Large gatherings of staff (e.g. in coordination) to make major announcements regarding media engagement (or any other major issue) need not be exclusive of smaller department meetings, which may be more conducive to facilitating discussions. The two activities can be complementary. The above two points are also related to internally addressing public misinformation about MSF, such as reports where our medical data is challenged relating to the MGD S incident. Both points are also being made in relation to further internal preparations that should be discussed relating to any other forthcoming major sensitive comms/advocacy materials



'MSF OCA Operational Platform Meeting **Minutes**,' 5 February 2014 (in English).

Extract:

Myanmar: Last Monday there was large protest in Sittwe against potential Rohingyas citizenship and for better arming of Rakhine police. The protest was given official permission, and the route passed by the MSF office. The protestors stopped outside the MSF office, protesting against presence of MSF. Some of the crowd threw stones at the MSF office, fortunately no one was hurt. It is believed both the permission to pass by the MSF office and the focus on MSF in the protest, are directly related to the incident 2 weeks ago in Maungdaw South, and MSF's statements that we treated 22 patients directly affected by violence in the days immediately after the incident.



'MSF Myanmar **Comms Sitrep**,' February 2014 (in English).

Extract:

[...] Myanmar spokesperson needed for Rakhine-related media: This has been an issue for a very long time and no real solution can be found but suggestions welcome ☺
Senior Myanmar staff required for validation of English-Myanmar translation: So far, we have been getting by on an ad hoc basis but with key staff departure and expectation of more content, this is not a sustainable approach. [...]

• KEY MEDIA & COMMS CALENDAR

Feb 3: Sittwe protest of around 500 people stopped at our office. As one of their 5 demands, they are asking for all INGOs, UN and MSF to leave within a week (see news summary email for details). Contacted by People's Image [Ludu Pone Yeik weekly news journal], RFA, AP, Irrawaddy and another national freelancer working for Al Jazeera for comment. Provided validated reactive line in English and MM [language from Myanmar]. Lots of media coverage, e.g. below.[...]

Feb 5: Background briefing with BBC Yangon-based correspondent Jonah Fisher.

Feb 6: Weekly Eleven article on AZG denying injuries translated and distributed. More coverage of calls to expel MSF and/or INGOs from Rakhine within seven days, particularly at protest in Buthidaung, where UNHCR was singled out. The Myanmar MNHRC [Myanmar National Human Rights Commission] finds no evidence of massacre, which is widely reported. DVB [formerly Democratic Voice of Burma] contacts for comments. There is no evidence 40 Bengalis were killed and 20 injured, as international media reported [MSF MENTION] [TRANSLATED] (0302 Weekly Eleven). Burmese inquiry concludes no evidence of massacre in Maungdaw [...]

Feb 7: Comms sensitisation induction session with new national MDs. Reactive line provided to DVB in reaction to MNHRC findings (see below).

Maungdaw investigation to overlook allegations of Rohingya massacre [MSF MENTION] (0702 DVB) [...]

Feb 12: [...] MSF now specifically being accused of spreading misinformation, instructing villagers to lie etc. by Rakhine activists and quoted in mainstream media.

Feb 14: [...] Reactive lines/statement on protests provided to RFA (Min Thin Aung)/DVB (Colin) and MM Times (Kayleigh). [...] Myanmar Human Rights Commission (MHRC) statement in which MSF is basically called a liar over patient figures.

Feb 15: AP discussion called for background briefing on situation following MHRC statement

Feb 16: *The Voice* (senior reporter Le Yee Myint) called for responses to protests, threats of further sitting protests outside Sittwe office, and MHRC & community beliefs about our figures.

Protestors call on President to kick out Doctors Without Borders [TRANSLATED] [MSF MENTION] (1602 Mizzima Daily)

Feb 17: *Irrawaddy* [...] calls regarding MHRC statement. *The Voice* & *Irrawaddy* provided with answers based on combination of lines, including ones sent on Feb 14. [...]

MSF, Human Rights Commission at Odds Over Maungdaw Violence [MSF MENTION] (1702 Irrawaddy). Call to remove MSF from Rakhine State [TRANSLATED] [MSF MENTION] (RFA Radio 1702)[...]

Feb 19: Sitting protest called for after no response from MSF in Sittwe [TRANSLATED] [MSF MENTION] (1702 People's Image) [...]

Feb 21-23: RFA and BBC Burmese radio on Saturday. Eleven, The Voice, DVB (Yangon & Chang Mai), Mizzima and People's Image.

Feb 24: DVB interview TV (Ko Khant) & Radio/Web (Noreen), NY Times background briefing. AP Margie & Robin background briefing.

In the meantime, on 7 February 2014, a slightly updated strategy "proposal for a diffusion strategy" of the repeatedly postponed report (since October 2013) "From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine," was circulated to MSF OCG and MSF OCA Myanmar and Bangladesh programmes managers in headquarters. This was done ahead of a wider, internal distribution planned for

10 March 2014. This strategy included different dissemination scenarios to be employed “depending on the situation of the mission at the date of publication of the report.”



“From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine,” **Proposal** for a Diffusion Strategy, February 2014 (in English), edited.

Extract:

This proposal was prepared by the HAAs [Humanitarian Affairs Advisor] with support from the HAO to feed the discussion with the mission and the desk³⁶. The final diffusion strategy will [be] aimed at the entire MSF movement. It accompanies the forthcoming report *From Bad to Worse: Humanitarian Crisis and Segregation in Rakhine* written by OCA and to be released internationally on the 10.03.2013 [2014]. This diffusion strategy is for internal use only and aims at informing key persons related to the diffusion on the steps to be taken as well as MSF teams more generally, at HQs and field level, about this advocacy initiative. The report itself will be distributed outside of MSF (see targets below). Given the speed at which events unfold in the last weeks, this strategy includes different types of diffusion scenarios ready to be used depending of the situation of the mission at the report’s release date. For each scenario a risk analysis is to be made (to be fed by the mission and the operational management). The scenarios are designed to reflect both the advocacy objectives behind the report and the mapping of identified actors’ influence (based on the various actors mapping done by HAO and HAA [Humanitarian Affairs Advisor], with input from the mission).



We didn't discard this report. Later on, we started our preparation in our heads to do things even with a weak report that not everyone really liked so much the way it was written. We still thought we'd better go for it and do something with it than not do something with it. We did say as a team that we would go for it and we would start setting up meetings where we bilaterally with the government would put it in front of them. Then, based on the reaction, decide if we would make it more public or not.

Former MSF OCA Staff Member in Myanmar (in English)

THE MOU AT STAKE

Since October 2012, the MSF OCA Myanmar management team was striving in vain to renew the memorandum of understanding with the Myanmar government, which would allow MSF to continue activities. The previous MoU expired on 31 January 2013, meaning that MSF OCA was operating for just over a year with no MoU.

On 17 February 2014, surprisingly, the team was informed by the Deputy Minister of Health that they wished to progress with signing the protocol. However, the team was asked to draft a clause in the MoU certifying that MSF OCA would exercise caution in its relations with communities so as not to fuel the crisis. In

³⁶. The programme management team based at headquarters.

addition, the Ministry of Health maintained that no secondary healthcare activities could be included in the MoU and consequently, wished to discuss the number of expatriates in the field. There was no mention of and no progress on the case of the MSF detained staff.



“Meeting in NAI PYI TAW” **Message** from MSF OCA Myanmar HoM to MSF OCA Operations Manager and Advisor, Lauren Cooney, Reshma Adata, cc: MSF OCA Myanmar Rakhine MT; 17 February 2014 (in English), edited.

Extract:

Hi Lauren and Resh,

At least this time was not another wasted day in NAI PYI TAW. Saw both the Deputy Minister for Health, one of the ministers of the President’s Office [...] who we had been trying to reach for a long time. Open and frank discussion with both and main issue seems that they want to progress on our MoU. They both mentioned that has been an issue in the Friday meetings with the President, it is nice to know we are deemed that important (or risky, troublesome ...). Very anti-Rakhine talk clearly blaming the hardliners and even the state government’s inaction for many of the problems. We need to do some reflection on why suddenly the MoU signing is becoming in their interest. Pressure by diplomatic community, showing the Rakhine who is in charge, fuelling the community tensions, giving us a carrot after the stick around Du Chee Yar Than are just a few we should consider as we could well be part of a bigger political game. Maybe that is me overestimating our importance or me getting too much into conspiracy theories, but somewhere this doesn’t completely fit into the picture. Practically the following issues were mentioned:

- They would like a clause in the MoU about us being careful in how we deal with communities and contribute to the situation. It was rather vague but I think they need something to appease anyone opposing our MoU. It didn’t feel necessarily as something that would limit us, but that will only become clear when we have a clause in front of us. Having said that the interesting part is that they have asked us to come up with a clause that they could give feedback on. My suggestion (discussed with KNC) is along the following lines: “MSF as an independent humanitarian medical organisation will carry out its activities according to the principles of impartiality and neutrality while maintaining a spirit of collaboration and transparency towards communities and state and region authorities and the Government of the Republic of Myanmar. Within the framework of its principles MSF will pay careful attention to sensitivities within areas of (potential) conflict”. Please let me know suggestions on this.
- They want to discuss the number of expats, but again my feeling is not that they want us to go back to the old system. We mentioned the approx. 70 expats in country (40 in Rakhine) so we will see what their reaction to this is. [...]
- As the discussion was positive, I tried to get secondary health included, but it was made clear that was not for this MoU as they prioritised the signing over a complete rewrite. Under the current circumstances this seems fair enough and we will start the discussion again after signing.
- The downside was the discussion on (Z) where [minister of the President’s Office] quickly made it clear that this was not a political prisoner case (he mentioned that this process was finished already last year!!), but a criminal case and we should follow the normal procedures of appeal. Of course, I explained that we know him to be innocent (giving him the details) and that there has not been any due process according to any international standard, but to no avail. Reading between the lines his hands are tied by

the committee and not much hope of getting him on a list even if the process would be reactivated.



We were still using the old MoU which was out of date since 2012. The new one still hadn't been signed off by the government. The communities knew this and would tell us: 'you're not legally supposed to be here.' And yet we were tolerated and were allowed to have our people and our cargos to come in to run these programmes. But it was very thin ice, and we were quite vulnerable. We had the acceptance of the authorities but as soon as the community flared up, they might say: 'Oh, but you haven't got a MoU.'

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)

During the second half of February 2014, pressure continued to mount resulting in rising protests by Rakhine activists, sanctioned by the Rakhine authorities. Subsequently, incidents around the MSF OCA offices and residences increased.

V10

On 25 February 2014, Fortify Rights, a human rights organisation released a report denouncing abuses against the Rohingya in Myanmar. Without mentioning MSF as a source, the report used MSF's data on unsafe abortions taken from the report "Fatal Policy," circulated by MSF OCA 'behind closed doors' since 2011.



'Sitrep Rakhine, Compiled by: Simon Tyler, MSF OCA Deputy Head of Mission in Charge of Rakhine,' 27 February 2014 (in English)

Extract:

- On Saturday 22nd, at 20:30, 50–60 people gathered near the expat house 1, as there was a rumour there were Muslims in the house. The guard had to allow access to our compound for 4 of the group (including one monk) who then asked if anyone was in. He replied no, they then went into the house for approximately 5–10 minutes to 'investigate'. They left only 10 minutes before we returned. The security authorities were informed the following day and posted policemen near the house (other houses too?).
- 22, 23, 25 & 26 February saw protests everyday by the Rakhine Social Network and the Arakan Community Group. This included Rakhine Women's Groups and monks. They were all approved by the RSG [Rakhine State Government]. All went ahead peacefully. Hundreds were present during each protest. Policemen in plain clothes had been posted around the office since Tuesday 18th, after a group of ten/twenty individuals, including monks, had come and shaken the gate of the side entrance of the office, the same day.
- On Tuesday 25 February, Fortify Rights released a report: "Policies of Persecution: Ending Abusive State Policies against Rohingya Muslims in Myanmar" where "Fatal Policy" data linking unsafe abortions to restrictive policies in NRS were quoted.

On 26 February 2014, the MSF Rakhine management team was summoned to a meeting in Sittwe by the Rakhine State Ministers of Security, Development Affairs, and Agriculture, as well as the Rakhine Secretary of State and Deputy State Health Director.

The MSF team was told that since 31 January 2013, their activities in Rakhine took place without any MoU and that consequently, MSF's services in Rakhine state were no longer approved. MSF OCA was asked to hand over all activities to the Ministry of Health. The decision was presented as having nothing to do with community pressure but related only to the lapsed MoU.

Simultaneously, rumours that MSF OCA was forced to cease activities spread on social media, where the most radical opponents to MSF's presence expressed their great satisfaction.

However, the suspension decision was yet to be confirmed by the national authorities, who had previously appeared supportive of signing the MSF MoU. The MSF OCA Myanmar management team briefed members of the diplomatic community in Myanmar and asked for their support.

The MSF International HART team was asked to call on key contacts to deliver "strong messages" to the Myanmar government about the gravity of the situation.



'Meeting **Minutes** City Hall, Sittwe, Rakhine,' 26 February 2014 (in English).

Extract:

Present: Minister of Security [...], RSG; Minister of Development Affairs, RSG; Minister of Agriculture & Livestock, RSG; Secretary of State, RSG; Deputy State Health Director, RSG; Simon Tyler, Deputy Head of Mission, MSF; [...], Deputy Medco, MSF; [...] PS Advisor, Sittwe Project, MSF;

- Opening remarks made by the Min of Security detailing the role of MSF in Rakhine, our provision of healthcare followed by the status of MSF's MoU.
- He stated that the MoU with the MoH had expired since 31 January 2013 and MSF has been operating ever since without a valid MoU.
- He mentioned the recent concerns over the protests since the weekend.
- After this he stated, "We no longer accept the services of MSF in Rakhine State" and awaited a response from MSF.
- Deputy HoM then detailed the history of the MoU process, from submission in January 2013 until the present including meetings on 26 December 2013 (including the fact that the MoU delays were due to the [Rakhine State Government Chief Minister] awaiting feedback) & 17 February 2014 in NAI PYI TAW (requiring an inserted clause). Also mentioned was a meeting with Presidential Investigation Commission meeting in Maungdaw on Wednesday 19 February 2014. All provided positive feedback and direction into what was required to ensure our MoU was to be signed.
- It was mentioned that MSF had provided all what was required of ourselves to ensure that this document was signed on time.
- Min of Security was questioned by Dep HoM as to why if MSF had no MoU, did it take so long to make the comment to no longer accept our services? He replied that it was due to not having a MoU and also recent 'disturbances' in Sittwe.

- Dep HoM questioned, this matter could have been discussed 13 months ago upon the expiry of our old MoU but wasn't. Was it to do with community pressure on the RSG? The Min of Sec replied that it was only to do with the MoU expiry. He gave no further explanation.
- Dep HoM mentioned that this matter would be raised at Union level as they had recently shown positive feedback on dialogue over validating the extension. Min of Sec agreed that this is the next step for MSF.
- Dep HoM questioned if we had approval for the whole MoU including Rakhine State activities, would they allow MSF to resume activities? The Min of Sec replied proceed to [...] Union level. He gave no further comment.
- Dep HoM questioned, what are the next steps, operationally required of MSF to follow this demand? Min of Dev Affairs & Min of Sec said to meet with the SHD (only Deputy SHD present) to hand over all activities back to the MoH.
- Final summary by Dep HoM outlining the responsibility of the authorities in ensuring our MoU was provided.
- The Ministers then closed their books and it was clear the conversation as over.



Message from Head of OCHA office in Myanmar to Vickie Hawkins, MSF OCA Myanmar Acting Head of Mission, 26 February 2014 (in English).

Dear Vickie,

I have informed R[...], B[...] and others (including my own headquarters) of the very bad news that MSF has been instructed to cease its activities in Rakhine State. This is a huge concern to all of us and we will need to think carefully how best to respond. I would like to assure you that we take this extremely seriously as it will have serious consequences for vulnerable civilians if MSF is no longer able to carry out its life-saving humanitarian activities in Rakhine. I am ready to do all I can to help. As a first step, it is important for us to be clear on the facts. [...]. You informed me that MSF was instructed verbally by authorities in Rakhine State to cease its activities there. Was MSF also told that its MoU would not be renewed? And, if so, does this relate only to Rakhine or to the whole of Myanmar?



“Phone call [...] Ambassador 26/02/14” **Message** from Vickie Hawkins, MSF OCA Myanmar Acting Head of Mission, 26 February 2014 (in English).

Extract:

The most significant bit of information was that he has heard from a contact within government that there was a meeting in Naypidaw yesterday in which MSF's future in Rakhine was discussed. Whilst there was some arguing in our defence, the overwhelming consensus was negative towards MSF and there were “powerful people making powerful statements”. He would not say directly who those were but one of his comments in response to whom we would address our concerns at Union level was to ask if we would consider taking our arguments to the Home Affairs and Defence Ministry. [...]

One aspect of our meeting in Sittwe that reassured him was that there was a slight opening in terms of it being a suspension and we had to talk to Naypidaw. But, on the negative side, his contact had given him the impression that the conversation in Naypidaw did not leave such an opening.

He thinks they are looking at this through a very narrow lens, i.e. their direct issues with MSF. They are not thinking about how this will be perceived, i.e. that this is victory for

the protestors and the hardliners and sets a precedent that they will regret. In terms of the question about the power balance, even he says it's very difficult to make a read on that, but everything from our conversation pointed to a very high level of involvement from Naypidaw.

In terms of action from his side:-

- He will keep pursuing high level contacts on this issue over the coming 48 hours including Home Affairs and Defence
- He plans to be in Naypidaw on Friday morning and will be requesting face-to-face meetings
- He's realistic that he doesn't always get what he asks for in terms of meetings, particularly from the more conservative ministries



'Message from Lauren Cooney, MSF OCA Operations Manager to MSF OCA, MSF OCG and MSF International Staff in charge of Myanmar,' 26 February 2014, 10:19 (Amsterdam time).

Dear all

Thanks for your words and offers of support. Following discussion with field team and here in Amsterdam: [...]

Activities:

- For tomorrow we suspend majority of activities – exceptions will attempt to have expats to HIV clinic (start some contingency planning) and expats to the Thet Kae Pyin 24-hr site in Sittwe south, as we have inpatients (not critically ill) there.
- Risks -> may be stopped at checkpoints – don't think they will 'arrest' expat staff, we will not expose NS medics/logs, other than if driver will agree.

Comms:

- We already have multiple requests for information today/this evening (ongoing) because of the media reports today. We also hear from journalist contacts that all their attempts to get statement from the President's office are going unanswered. We expect this will have to change tomorrow morning Myanmar time
- We will put out very short initial statement -> 'audience' is in reality Union Govt: it will be very noncommittal -> we don't want to burn any bridges at this time given that we don't have clarity (yet) on the Union Govt position/involvement on this, and we want to leave room for 'back-tracking' of the Rakhine govt until we are 100% sure that this is not a possibility. Additionally, want it to be already clear that we consider the MoU as for all activities Myanmar, not Rakhine and non-Rakhine activities
- As such, reactive comment focusing that we work in MM with MoU with Union govt for X years, there is a misunderstanding about MoU now which has been under discussion of modalities in past months, and clearly the MoU is for Myanmar activities as a whole, not just Rakhine – clear this is a very short-term, immediate solution whilst we gather more info/strengthen analysis

Analysis:

- Currently we lack some information -> critically what the role of the Union level govt is in this, expect to have clearer picture of this by tomorrow morning latest and Lack clarity on the power dynamic between Rakhine state govt and NAY PYI TAW -> with transition, and elections coming up next year – e.g. even if Union-level govt is genuine in support, we may be a reasonable sacrifice for election support etc.
- Our most recent discussions with MoH/Presidential advisor, were in support of MSF, and pushing to get MoU signed -> negative comments by them [with] regards to Rakhine state govt and Rakhine hardliners]

- Even with this cannot exclude that there has been a complete turnaround of position at last minute by President Thein Sein, even in face of his advisors, he has done so before on presence of OHCHR office for example
- Cannot also exclude that the Union govt and RK govt playing this together; union govt protecting themselves by saying 'right things' whilst meanwhile supporting actions of RK govt.

Follow-up:

- At field level, Vickie was in discussion directly with [...] ambassador – he had promised full support and to get back to us with info -> he called back whilst we were talking, so waiting for her update.
- ECHO, OCHA informed -> they were contacting RHC [UN Resident and Humanitarian Coordinator for Myanmar] who is in NY at present.
- Fabien/ Emmanuel -> anyone of the usual suspects that you can have contact with will be much appreciated -> focus on two factors, adding to analysis of this situation, and requests to pass strong messages through whichever channels possible to GoM of the gravity of this decision.
- Any thoughts and input welcome. Monica – any thoughts of risks for OCG? I realise you are in completely different position, both in terms of visibility, perception, and activities more evenly spread between communities.

-> this is clearly an immediate response, and we are discussing different scenarios but we expect to see rapidly developing situation, and to have much clearer picture tomorrow morning Myanmar time, with strategy to be developed accordingly.



Quite quickly after the Du Chee Yar Tan events, we had 200 or 300 people outside of the gates of our office for one hour every day for five days. I just said to everybody: 'let's just let go, let's not antagonise this. Let's just take a step back, shut the doors and windows, they will shout and they will be gone in an hour.' But it was an incredibly intimidating atmosphere. Even just after that, trying to just walk home while people know who you are... Even though the majority was probably not ready to start throwing stones, it was clearly well organised and it was obvious it was allowed.

I went to the Rakhine State governor's office to just say: 'Look, allowing the people to demonstrate so openly is creating a very toxic atmosphere in the air. How can we deal with this? Can you talk to the people? Can you try and can we all enter into some joint dialogue?' The old state governor was an ethnic Rakhine himself, so clearly had huge sympathies for the people there and wouldn't be super objective. And he didn't see me at that time, which I thought was odd. Even the security minister didn't see me at that time.

Then I left the governor's office to go back to our office. And when I arrived at the office an hour later, I was then summoned back to their office whereby they delivered the simple statements saying we no longer require or tolerate the services of MSF in Rakhine State. It was one sentence, they didn't expand on it. I said: 'well, what does this mean?' They said: 'ask the boss, go to the top of the tree.' They kept pushing this one out of Rakhine and towards the capital and the federal government. That was just a small group: the governor, the security minister, me, one of my senior assistants.

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)



It was really hectic. I worked on it almost full time. There were very intense discussions with the US representatives, certain governments in the region, the Indonesians, ASEAN ... Some embassies and the UN special envoy got to work right away to convince the government to change its position.

*Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).*

On 27 February 2014, the Yangon management team received a letter from the Ministry of Home Affairs announcing that MSF OCA's registration was cancelled, and that all activities in Myanmar must cease. A spokesman for the Rakhine state government confirmed the information in an interview with Radio Free Asia.



'MSF OCA **Operational Bulletin**,' 3 March 2014 (in English), edited.

Extract:

Myanmar: The situation in Myanmar remains extremely concerning. On Wednesday last week Rakhine State authorities instructed MSF Holland to cease all activities in Rakhine, stating that the MoU is expired. MSF has been renegotiating the renewal of our MoU with the national government of Myanmar, for the past year. Since Thursday, only extremely limited activities have continued in Rakhine, with the vast majority of services, including PHC, RH, MH and emergency referrals, to a target population of over 500,000 people being suspended. On Thursday, we received a letter from the Ministry of Home Affairs that our registration is cancelled, and all activities to cease in Myanmar. As such on 28 Friday February all services in Myanmar were closed. Meetings the same day with authorities have enabled the reopening of the HIV/AIDS [centres] and other activities in Yangon, Kachin and Shan today. It is extremely worrying that permission for services to resume in Rakhine has not been given, leaving tens of thousands of patients without access to any healthcare. The authorities are still continuing to state that MSF Holland needs to 'hand over' activities in Rakhine. For now, all teams (approx. 600 national staff and 40 expats) remain in place on the ground in Rakhine, and we continue at all levels to press the government of Myanmar to allow the continuation of all activities in Rakhine.



And then we got a letter from the Ministry of Home Affairs that said: 'you're expelled from the whole country.' The head of mission was out of the country. So, I was acting head of mission. Myanmar hasn't kicked out NGOs in its history. They certainly have precedent at expelling individuals. But by this point, it was clear the head of mission and I were both leaving in a few months and then probably the government knew that as well. And in a way they didn't want to draw attention to themselves by purging people. They would much prefer to make it impossible for you to work. However, I really thought we would be expelled. When I got the letter, I was feeling this sort of bottom line: 'well, it fell out.' I knew it was a very big deal but I had not realised that they would go quite that far. I always thought our expulsion from Rakhine could be on the cards if we were deemed to cross the line. But I didn't think they would expel us from the whole country, because we are the biggest ART provider in the

country, including to lots of Burmese people. And the government was so unready to step into that vacuum if we had gone.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting as Head of Mission in February 2014 (in English)



They sent that letter saying that we should stop immediately: 'If you are still active tomorrow, you will be charged under the current regulations and law.' In the copy list of that letter they only addressed to Rakhine State, not to Kachin, Shan or Yangon. So, we partly understand that this might be a misunderstanding. It was sent to us without mentioning where. So, we thought: 'let's continue.' Some of the staff said: 'What if they arrest us? What about the staff working on the ground?' Then we announced to everyone that 'tomorrow we won't open the clinics.' In Kachin State, Shan State, and Yangon State health directors talked about that and then we asked them to give us space at the hospitals for the patients to be diverted to when they come to the clinics in the morning to get the drugs. They were fully supportive and they also opened the places for us. The Kachin State health director said, 'You don't need to close that clinic. It's not related to this programme, you just continue in my state.' But then we had to tell him: 'thank you for allowing us to continue there but we have to temporarily stop.'

MSF OCA Myanmar National Staff (in English)



On that letter, it said it was because MSF had released inaccurate information about Du Chee Yar Tan. They were referring to the last reactive line, not the first one, which was softly worded, but behind the scenes we were giving journalists much stronger information and say we're taking that forward. It was global news. It's one of those times that it was so frustrating because we had our fingers on the pulse, not just of the media, but of the authorities. And we had already pushed so far and so close to that line. We really thought: 'let's just step back a sec and let the UN take some heat.' But we were taking all the heat because headquarters did not follow our advice.

Eddy McCall, MSF OCA/MSF OCG, Myanmar Communications Manager, April 2013-January 2015 (in English)

On 28 February 2014, all MSF OCA programmes in Myanmar were closed. However, MSF teams managed to distribute some additional ARV supplies to HIV/AIDS patients. In Rakhine, MSF OCA teams maintained extremely limited activities, with the vast majority of programmes for the target population of over 500,000 people suspended.

On the same day, an officer from the Ministry of Health came to the MSF office in Yangon and demanded the return of the Ministry of Home Affairs' suspension letter. He explained that the suspension order was to be applied to MSF OCA programs in Rakhine only, and not for the rest of the country. This was confirmed a few hours later during a meeting with the Minister of Health who authorised the reopening of the HIV/AIDS programs and other activities in Yangon, Kachin,

and Shan states. However, MSF was warned that this MoH decision had to be confirmed by the Minister of Home Affairs, which was supposed to inform MSF in the following days.

Regarding Rakhine, the health ministry was categorical: they would not agree to sign a MoU with MSF OCA that included programs in Rakhine. The directive imposed by the Ministry of Home Affairs was based on *"matters of national security interests that take precedence over health."* He added that the health authorities were ready to support MSF OCA, provided that activities in Rakhine were discontinued. They wanted other actors to take over MSF OCA's work in Rakhine, even though they were aware that no other organisation was able to do so, given the limited access already experienced by MSF.

The Ministry of Home Affairs said the final decision was to be taken by the Central Committee³⁷ but only after a 'cooling off' period of a few months, in order to calm the anger of the Rakhine community towards MSF.

Meanwhile, MSF OCA, under pressure of multiple media requests, found it increasingly difficult to remain silent. Finally, Hernan del Valle, the head of MSF OCA's OSCAR confirmed the information to the BBC.



'MSF Requested to Cease All Operations Throughout Country **Message** from Head of OCHA Office in Myanmar to Heads of UNICEF and UNDP in Myanmar, Cc: MSF OCA Myanmar Management Team, MSF OCA Myanmar Operations Manager and Operational Advisor, MSF International Representatives to UN,' 28 February 2014 (in English).

Extract:

Dear [...] R and B,

This is to confirm that Vickie (Acting Head of MSF Holland in Myanmar while (HoM) is out of the country) told me that MSF Holland was informed by the Home Affairs Ministry late yesterday to cease all operations throughout the country with immediate effect. I have not seen any written instruction on this but I was informed that a spokesman for the Rakhine State Govt confirmed this in an interview with Radio Free Asia. As agreed with MSF and as agreed at our HCT³⁸ meeting yesterday, I am now on my way to Nay Pyi Taw. I have a meeting with the Deputy Minister of Border Affairs at 11 am today. Then I will join MSF and WHO at a health cluster meeting in the Ministry of Health at 1 pm today. This meeting will be vital to ascertain from the MoH how life-saving medical activities will be sustained if MSF indeed has to cease all activities in the country with immediate effect. Will remain in close contact with MSF and with you to ensure we all have accurate information, that we coordinate closely to ensure consistent and coherent advocacy with the Govt, and to ensure that we provide all necessary support to MSF and to all those in need of continued life-saving medical services.

37. The Myanmar Central Committee for Home Affairs was an ad hoc committee to guide and implement policies for the Ministry of Home Affairs.

38. Meeting with UN Humanitarian Coordinator Team in Myanmar



“Fwd: Today’s Key Coverage: Time to Say Something?” Message from Vickie Hawkins, MSF OCA Myanmar Acting Head of Mission To: Lauren Cooney, MSF OCA Myanmar Operations Manager; MSF OCA Myanmar Head of Mission, MSF OCA Rakhine Field Managers Cc: MSF OCA Management Team and Field Management Team,’ 28 February 2014 (in English).

Extract:

In the immediate term, MoH have okayed for Kachin, Shan and Yangon to reopen on Monday. MoHA [Ministry of Home Affairs] have not yet done so, they say they will call us on Sunday having checked with the minister but even so, we are confident we can go ahead and reopen them even without hearing from them.



It leaked to the media somehow that MSF activities were stopped in Myanmar. So, the media were calling us, calling us, calling us, calling us, in different offices of the MSF International Movement. We were told we could not talk to the media, we could not confirm or whatever. I said: ‘Guys, if we are being kicked out of the country, we might as well put it in the open. It’s a rumour, so why fighting this in a dark corner room where we are going to be beaten up. Let’s fight in the street. Maybe someone else comes to our help.’ That was my logic. But no, we couldn’t talk. I got a call from a journalist that I knew from the BBC and I told her: ‘Yes, I can confirm.’ And, there was a BBC headline that said: ‘MSF sources can confirm that.’ Around that time we had that meeting with everyone and I remember that right after that headline, the government told the management team: ‘No, no, no. It’s not the entire Myanmar. It’s Rakhine and it’s not a stop it is a suspension.’ So, the governments seemed to backtrack when they saw that BBC headline. Our confirmation became public. Then some guy – there are guys above the guy, who knows – said: ‘Call MSF and just tell them that it’s just this and it’s not this and that.’ So, I said: ‘Look, public pressure, there is something for it.’

Hernan del Valle, MSF OCA, Head of OSCAR (Operational Support in Communication Advocacy and Reflection) 2011-2016 (in English)

MSF OCA MT’S “BOTTOM LINE” DECISION

On 28 February 2014, the MSF OCA coordination team in Myanmar, supported by the operations manager, asked the MSF OCA management team to discuss and make a clear decision that would allow them to move forward in negotiations with the Myanmar authorities.

In the Amsterdam headquarters, the MSF OCA General Director, the Director of Operations, Deputy Director of Operations, Operations Manager, Operational Advisor for Myanmar, and the Head of OSCAR discussed the situation. They were divided on the answer to the field’s question: “Are we ready or not to sign the MOU without including our programmes in Rakhine?”

The MSF OCA executive council which included the Executive Directors or their representatives from MSF Holland, MSF UK, and MSF Germany held a full day meeting. At lunch time, an extended video conference discussion was organised with all headquarters office staff, those from the sections involved, and the

international office. Most agreed that this crisis posed an “intractable moral dilemma” which was debated at length.

Some were in favour of a ‘hard line’ which did not accept the government ‘deal,’ preferring to push the government to take responsibility for the HIV/AIDS patients if MSF was forced to leave the country. Others preferred that MSF OCA stay in Myanmar even at the cost of losing access to Rakhine. Their main argument was that MSF could not abandon 30,000 HIV/AIDS patients without any treatment, and that access to Rakhine was more likely to be regained if MSF OCA maintained a presence in the country.

At the end of this first day of discussion, the MSF OCA executive management team proceeded to an informal vote: three members were in favour of leaving Myanmar if Rakhine was not included in the MoU; three others, including the MSF OCA General Director and the Director of Operations voted to stay in Myanmar even at the cost of abandoning Rakhine.

Regarding MSF OCA’s decision making processes, decisions had to be made by consensus, or if this was not possible, then by a vote requiring a two-vote majority out of the three sections of the MSF OCA council³⁹. Because the vote was split, the MSF OCA management team decided to have a second discussion the next day to try to reach a consensus. It was also agreed to consult with the OCA executive council over the week end.

This second discussion took place over the phone⁴⁰ and resulted in the following decision: *“MSF OCA would try and protect its presence in other Myanmar projects, even if it was no longer possible to be present in Rakhine State.”*



‘MSF OCA Management Team “Myanmar Discussion” **Minutes**,’ 28 February 2014 (in English).

Extract:

Myanmar: Upon specific request from the field team and OM [Operations Manager], the situation with regard to the cancellation of our registration in Myanmar, and in particular the bottom lines for negotiations, were discussed and decided upon by the OCA MT [Management Team] with urgency. [...]

1. Decision making process:

Responsibilities:

- MT decisional, but want input and support from the [OCA] Council as felt to be an institutional decision due to risk of negative consequences.
- OCA MoU describes that OCA MT come to decision by consensus, and if not possible then by voting but with a majority of two required.
- For the next few hours OCA MT will discuss the issue at large, and then reconvene at 5 pm to come to a decision. MT fully agree on getting to a decision today.

Timeline:

- MT to come to a decision today which can then go to the (OCA) Council on Sunday and be finalised before the end of the weekend.

39. MSF OCA Council is MSF OCA’s associative body. It is composed of representatives from MSF OCA sections including MSF Holland, UK, and Germany.

40. Therefore, no minutes were taken.

- Arjan [Hehenkamp, MSF OCA General Director] will link with the ExCom [Executive Committee] on Saturday for their input.
- Lunchtime discussion today with all the offices.

2. Situation update

- Minister of Health has this morning said that they are not willing to stand up for us on Rakhine, but are willing to stand up for us if we give up Rakhine. President backs up this position.
- At this morning HoM is meeting with the Minister of Home Affairs on the issue.
- For the time being our assumption is that the President cannot overrule the Minister of Home Affairs. We think we will be presented with a deadline in this meeting.
- We need a position/bottom line regarding if we are willing to sign MoU without Rakhine.

3. Discussion

- Upcoming elections triggering this situation. Political situation of the country; can foresee more issues in the future because of this.
- Who do we want to mobilise for hard influence over Myanmar? Global Fund, but they do not appear to be willing. Cell already in contact.
- Can we continue to have meaningful presence in Rakhine?
- MoH are willing for other actors to take over our work in Rakhine but felt that no one will be able to manage this given our medical relevance is already limited ('best you can get').
- Faced with situation where the population just don't want us there. From security angle it is okay for expats however inpatients face high level of persecution (abuse, medical license revoked etc)
- Major question; are you willing to sacrifice 30,000 HIV patients for Rakhine? [...]
- Leverage: have to be realistic about what we can achieve. Discussion about how much we've had and how much we can achieve. Political situation of the country

4. Outcome of the Minister of Home Affairs meeting:

- Not with the Minister, but with another representative.
- Minister of Home Affairs has approved reopening all other projects (outside Rakhine) on Monday.
- Confirmed Minister of Health not going to sign MoU with Rakhine due to national security interests.
- If we insist on retaining Rakhine then Central Committee would have to decide on a 2-3 month 'cooling off period' (out of Rakhine).

5. Discussion continued:

- Cooling off period: felt it we wouldn't be able to get back in. Proposal of this implies they realise that a hard decision of kicking us out would have some ramifications. Indicates some pressure points.
- All pressure on these points to be exerted over the weekend for possible leverage.
- Central government have an interest in keeping us; Rakhine extremists want separation and they are who want us out.
- Already in the media. Leaked, and felt this is part of internal tactics.
- Government appear to be playing internally. Regardless of final decision we should be mobilising on this.
- Cooling off period: could we use this to do strong advocacy?
- Our decision will send important message to the rest of the humanitarian community.
- OCG to take over? Willing to consider but reality is that they are not willing or able to do what we are.
- Cooling off period: primary barrier to re-entry after this would be national staff. Relatively easy to remobilise the clinics, but getting staff would be difficult.

- Skeleton presence? Some room to remain, but today we need to establish bottom lines. Are we prepared to compromise? Are we prepared to stay in Myanmar if we cannot work in Rakhine? [...]
- 30,000 HIV patients makes it an impossible moral dilemma. MT fully acknowledge there is no right answer.

BREAK: Lunchtime discussion with all offices is held.

Time: 5 pm

1. Purpose of the next hour: to come to a position

2. Timeline:

- Timeline for decision making is challenged by the Council.
- Explanation: Reopening of the other clinics on Monday hinged on the understanding the mission are talking with HQ about our decision. Team will on Mon/Tue/Wed again have to talk with government so they need to know our bottom line so they can build a strategy around this.

3. Decision-making process:

- Proposed that if we don't go to a voting mechanism as this is an issue which we should try to achieve consensus on. Suggestion that we pull in Council guidance on Sunday on the issue. So provisional position today, confirmed by Council over the weekend.

4. Situation update

- No further updates except we have put out a press release now.
- Everyone agreed that over the weekend all support should be mobilised, even without any firm position established on the bottom lines.

5. Reflection on lunchtime discussion

- Most in favour of hard position of leaving if no Rakhine, though countered later by some key people. The strong position argument was anticipated.

6. MT opinions on the bottom line:

- 3 voice opinions for the hard line (leave if Rakhine is not on the MoU). 3 voice for staying in Myanmar even at the cost of losing Rakhine:
 - Marcel [Langenbach, MSF OCA Director of Operations]: at the moment that it is clear in the negotiations that they will kick us out then we should give in. Argument: 30,000 patients, space in Kachin, there is a better chance of going back to Rakhine if we're not out the country altogether.
 - Frank [Doerner, MSF Germany GD]: If the cooling off period is included then could consider signing MoU, but if Rakhine is completely out then we should pull out altogether.
 - Sid[ney Wong, MSF OCA Medical Director]: morally unacceptable to leave the Rohingya, so for that reason we shouldn't stay without them. Hope that we can push OCG to take over our HIV patients, realises they wouldn't get access to NRS. Can't quantify/scientifically back up reason, gut feeling of solidarity.
 - Polly [Markandya, MSF UK Director of Communications]: Can't accept not working in Rakhine, would have to put timeline to prepare re-entering if we are kicked out, as well as looking for handover with other actors.
 - Els [Niehaus, Resource Director]: notes that she doesn't have historical or contextual background like everyone else, but gut feeling that we should stay even if it means leaving Rakhine.
 - Arjan [Hehenkamp, MSF OCA GD]: stay in Myanmar even without Rakhine. Argument: for the foreseeable future humanitarian action is a goner and it won't improve with us leaving (don't foresee any impact of us pulling out), regardless of OCG, overall

minimal impact externally. Hence if we can work in Myanmar with OCA still having minimal presence in Rakhine then decision would be to stay.

- Other points raised during discussion on bottom lines:
 - Handover issue: would we be comfortable handing over 30,000 HIV patients with a timeline? MT always clear they want to have responsible handover if possible, but realise this would be very difficult. If we play hardline then responsible handover highly unlikely.
 - OCG not felt to be willing or capable to take over fully. Also don't have registration
 - International community reaction: there is a lot, but don't expect anything more than words behind it because this comes from Minister of Home Affairs with the argument of national security.
 - Lauren (Cooney, Myanmar Operational Manager's) opinion: to leave even though this means little room of returning. We have always communicated full package so have to follow through. Compromising on this has big impact on the message we send. Don't know about space for handover, we might be left that space if we do it quietly but it would defeat the purpose.
 - Paul [McMaster, MSF UK and MSF OCA President's] opinion: not comfortable leaving 30,000 HIV patients and doesn't think that leaving these 30,000 patients would make any difference to re-entering Rakhine. Preference to stay in country and work to get back into Rakhine.

7. Conclusion

- No clear position from the MT: 3 on each side.
- OCA MT all accepts that it is legitimate and morally understandable to support one decision or the other. But overall the MT will come to one position which is projected to the organisation. Not going to communicate split vote.
- Proposed that this split position is presented to the Council for their guidance.
 - Challenged by Council and other MT members: Council not equipped to help identify the final decision, doubtful they can give real direction on this.
 - Proposal dismissed.
- Final agreed process moving forward:
 - OCA MT to discuss against 8.30 pm CET tomorrow after time for reflection.
 - Interaction with the Council on Sunday will be for support of decision if consensus can be agreed tomorrow or for consultation if consensus has not been reached.
 - If Council are used for consultation (rather than support) then final meeting on Monday with the OCA MT will be called to conclude.
 - Reaffirmed MT's commitment to have one final communication and decision.
- ACTION. Lauren to email the outcomes of the Myanmar CMT meeting tomorrow morning.



There was a request by the head of mission, for guidance by the organisation, which had to be given in a very short space of time. I think afterwards we probably didn't need to accept that time constraint, but nonetheless that was the reality within which we operated. And that culminated into a discussion/debate in a very rushed fashion, within two days, whereby the management team had to take a position. We organised an office space debate. We invited in other MSF sections, MSF Switzerland in particular, to participate. We did that across OCA, with video conferences. And then events lead together with the desk coming into the management team, and then the management team deliberating. Within a period of two days, frantic consultations, international, internal discussion, debates, consultation with the association, in order to be able to basically determine what was our position going to be

on Myanmar. Should we accommodate, preserve, fight for presence, with consequences? Or should we escalate, fight at all costs in order to be able to go back to Rakhine, even if that would mean expulsion from the country or loss of programme access to our HIV patients elsewhere in the country? And that culminated eventually in a position that was explained in a letter by the management team, towards the rest of the organisation, which basically put priority on access and presence.

Arjan Hehenkamp, MSF OCA, Operational Director [Programme Manager] from 2004 to 2006; Director of Operations 2006-2010; General Director 2010 to 2017 (in English)



You could call it pressure, but also, we needed to know how to negotiate. Maybe it was a push on them to say: 'guys, look, how do you want us to approach this? Do we treat it as one Institute? Do we break it down? Are we comfortable to keep running that programme but sacrifice everything else?' I didn't think they were under any pressure. Actually, in Rakhine when the feedback came, we thought: 'That's fine guys. Perfectly fine. We know where to stand.' These are decisions that have to be taken, at the upper levels of the organisation, because it does affect the way we communicate. It's made us set of precedent for the future. Ultimately it did allow us to move on. Speaking out would have solved it one way or the other.

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)



It was late in the day, and we had a meeting, the management team and me and the desk. We did an analysis and I said: 'If push comes to shove, are we going to take the offer of staying in Myanmar, without Rakhine or are we going to bargain for all or nothing?' Meaning: 'Okay, we have 25,000 HIV patients and then Hep C patients in Yangon, we are the biggest ARV provider in the country, we are a big partner for that government health-wise there. They cannot manage this. I would not be that quick in taking the deal: oh, yeah, we'll resume activities and then we forget about Rakhine and we see if we ... no, let's say: you told us to stop, we stop everything. Let's go to that and let's have it another week at the negotiating table. MSF still hasn't resumed because it's not clear about Rakhine.' I pushed it: 'Are we gonna bargain for more? Or are we just going to say: 'okay, I accept, and leave Rakhine to the side and say we continue.' We did an informal vote around the table. I said: 'For me, I would bargain.' Pete said: 'I would bargain.' We were on the same line. That was clear. Marcel said: 'No, I would open the rest of the country and then leave Rakhine and see where ...' Arjan said alike, and Sid said, 'it's difficult.' At that point I saw there was a rift here in terms of where we're going to go. Clearly there was no agreement on this.

Hernan del Valle, MSF OCA, Head of OSCAR (Operational Support in Communication Advocacy Reflection) 2011-2016 (in English)



Teams function by putting all the considerations on the table and then through time and through conversation if you can, you end up with a single position. So, we went through a fairly, normal process of getting to that point. In the initial discussions there were not necessarily differing positions as such put on the table, but differing considerations

put on the table. And then in the end we felt in MT that we did need a single voice. So, in the end, we all agreed that that would be the position from the MT.

Dr Sidney Wong, MSF OCA, Medical Director, 2013-2019 (in English)



My feeling was that we should take the risk to say to the Myanmar government that if we were unable to work in Rakhine – and we were unable to provide services for everyone in need, including the Rohingya – that we wouldn't be able to continue working in Myanmar as a whole. And I didn't mean that it should be that we leave Myanmar from one day to the next. I did think that we should as much as possible, responsibly – considering the other communities and patients that we worked with, maybe with a 12-month or even a 24-month exit plan. My other point was that if we said this, then we had to commit to doing it. If the situation did not change, we couldn't just use it as an empty threat. At the same time in terms of speaking out, it was probably one of the hardest things I ever had to think about. I felt so strongly that if we had a chance to have access back with the Rohingya population especially in northern Rakhine where no one else really would have a big footprint on the ground that we really had to take it. I just couldn't imagine for that population, how the situation would be if there were no external witnesses there at all. Because of the type of government it is, speaking out would most likely negate our access forever and change very little and put out little information that we weren't already getting out through other channels. Anyway, the decision was that we would continue all measures to get access to Rakhine and through the Rohingya. That we would never exclude that we may leave at some point in time the country, but we wouldn't put that as a fait accompli to the government.

Dr Lauren Cooney, MSF OCA, Emergency Coordinator until December 2012, Myanmar Operations Manager, January 2013-January 2017 (in English)



Those discussions were ones that we didn't really sit down long enough to think about ...I was not satisfied with the decision...I had the memory of similar type of discussions, more hypothetical, that we've had in the past. So, in a way I was more prepared probably to go through the mechanisms because we had been thinking about what we would do. And that was for the MT more difficult ... and the MT felt pressured. They could have said "sorry guys, one more day" but they felt really pressured to have an answer within a few hours or something. It was really a short time period.

Former MSF OCA Staff Member (in English)



I wasn't involved in those conversations, but I didn't feel that there was really a massive time pressure to make a decision. But they were made to feel they had 48 hours to make a decision, which meant that they did make a decision very quickly and then sort of had a massive discussion with the office instead of actually saying: 'Let's slow this down. What is the rush to take this decision? This is Myanmar, come on. Nothing happens very quickly.' I guess with the benefit now of five years of Executive Director experience⁴¹, if I was in that situation, I would probably push back on what the time pressure was about. And don't rush this decision, allow for some debate in the office first, allow for that cathartic process.

41. Vickie took the position of MSF UK Executive Director in 2014.

There was a huge amount of emotion that stored up over the years. But instead the sequencing was all wrong: decision taken, thrown open for debate, massive push back.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting Head of Mission in February 2014 (in English)

Meanwhile, on 28 February 2014, pending the official response of the Ministry of Home Affairs regarding a potential reopening of the non-Rakhine programmes, MSF OCA issued a press release which was relayed by all of the sections in the MSF movement.

Announcing that MSF OCA was ordered by the government of Myanmar to cease all activities in the country, they expressed concerns about the fate of tens of thousands of patients currently under MSF's care across the country. They stressed that no other organisation was able to take over on such a scale.

The information was widely picked up by national and international media which had already started calling the MSF OCA communications team to verify rumours first spread on social media.

MSF OCG drafted a reactive communication informing that they were not affected by the request from the Myanmar authorities to cease activities and would not comment on ongoing negotiations between MSF OCA and the Myanmar government. At that time, MSF OCG was considering a possible ramp-up of programmes in order to take charge of part of MSF OCA's HIV/AIDS patients.



'MSF Concerned about the Fate of Thousands of Patients in Myanmar After Being Ordered to Cease Activities' MSF OCA **Press Release**, Amsterdam,' 28 February 2014 (in English).

Médecins Sans Frontières Holland (MSF) has been ordered by the Union Government of Myanmar to cease all activities in the country. MSF is deeply shocked by this unilateral decision and extremely concerned about the fate of tens of thousands of patients currently under our care across the country. Today, for the first time in MSF's history of operations in the country, HIV/AIDS clinics in Rakhine, Shan and Kachin states, as well as Yangon division, were closed and patients were unable to receive the treatment they needed. TB patients were unable to receive their life-saving medicine, including drug-resistant TB patients. This decision by the Union Government will have a devastating impact on the 30,000 HIV/AIDS patients and more than 3,000 TB patients we are currently treating in Myanmar.

In Rakhine state, MSF was unable to provide primary healthcare to the tens of thousands of vulnerable people in camps displaced by the ongoing humanitarian crisis or in isolated villages. This includes facilitating life-saving referrals for patients that require emergency secondary hospital care to Ministry of Health facilities, as well as family planning and care for pregnant women and new-born babies. There is no other medical non-government organisation that operates at the scale of MSF with the experience and infrastructure to deliver necessary life-saving medical services.

In our 22 years of presence in Myanmar, MSF has proven that we deliver healthcare to people based solely on need, irrespective of race, religion, gender, HIV status or political affiliation.

Since 2004, MSF has treated over 1,240,000 malaria patients in Rakhine state alone, where the disease is particularly endemic. Like HIV/AIDS and TB, malaria knows no ethnic boundaries.

MSF's actions are guided by medical ethics and the principles of neutrality and impartiality. MSF is in discussions with the Government of Myanmar to allow our staff to resume life-saving medical activities across the country and continuing addressing the unmet health needs of its people.



“Re: PR on Myanmar – Important Clarification” **Message** from Sally McMillan, MSF Switzerland Communication Advisor to MSF International Movement Communication Officers,’ 28 February 2014 (in English).

Extract:

Hi all,

Following this press release from MSF Holland, we just wanted to clarify that MSF Switzerland is indeed still present and operational in Myanmar, and at the moment has not been implicated in this decision by the government. We have drafted a line, which is REACTIVE only. If you are asked further about exactly what operations are remaining in the country, there is some ops info below you can use. [...]

Reactive Line

The Swiss section of MSF remains in Myanmar and has not been requested by the Myanmar authorities to cease activities. While negotiations between the Dutch section of MSF and the Union Government of Myanmar are ongoing, MSF Switzerland is unable to provide further comment. If you are asked further detail about activities, you can provide this information: Teams from MSF Switzerland remain in Rakhine State, providing primary healthcare via mobile clinics in and around Kyauktaw township. In 2013, 7,247 medical consultations were carried out. MSF Switzerland is also providing care for patients with HIV and tuberculosis in Dawei district, Thanintharyi region. Over 3,000 patients are receiving antiretroviral treatment in Dawei.



‘**Message** from Igor García Barbero MSF OCA Communication Advisor to MSF International Movement Communication Officers,’ 28 February 2014 (in English).

Extract:

As for now we will not have any spokesperson available for comments, but that might change in the coming hours as the situation is evolving very quickly. We will keep you updated accordingly regarding future comms initiatives. The issue has been widely covered already by the local and international press. [...]

BBC:

Medecins Sans Frontieres’ shock at Myanmar suspension

28 February 2014

The aid agency Medecins Sans Frontieres has expressed its shock at the order to cease operations in Myanmar. It said it was deeply concerned about the tens of thousands of people it was treating, particularly for HIV/AIDS, malaria and TB. A presidential spokesman alleged to the BBC that Medecins Sans Frontieres (MSF) was biased in favour of Rakhine’s Muslim Rohingya minority. MSF is one of the biggest providers of healthcare in Rakhine.

It provides emergency assistance to tens of thousands of Rohingya people displaced by recent violence. [...] MSF said no other medical organisation in the country operated on a similar scale, and that its actions were always “guided by medical ethics and the principles of neutrality and impartiality.” The BBC’s Jonah Fisher in Yangon, [...] says MSF is one of the few agencies providing treatment for Rohingya who would otherwise be turned away from clinics and hospitals. The government says that MSF has prioritised the treatment of the Rohingya community over local Buddhists. The final straw may well have been MSF’s statement a month ago that they had treated people after an alleged massacre of Muslims by Buddhists near the border with Bangladesh, our correspondent says.

The government’s own investigation found there had been no casualties, our correspondent adds.

The move comes days after another rights group said it had evidence of institutionalised local government discrimination against Rohingya. Fortify Rights said it had obtained leaked government documents setting out what amounted to “state policies of persecution” in Rakhine state.

Analysis By Jonah Fisher, BBC News, Yangon

Aid agencies in Rakhine state face a difficult choice. Keep quiet in a situation some have described as close to apartheid or speak out and risk infuriating the Buddhist majority. Most have opted to keep their heads down, reasoning that their priority is to try and assist the most needy. Medecins Sans Frontieres have not, and consistently raise issues of access and the dire conditions in camps for displaced Rohingya. With MSF already unpopular among Rakhine Buddhists, in January there was an incident which may have directly led to their suspension. A massacre is alleged to have taken place of Rohingya Muslims near the border with Bangladesh.

Two narratives quickly emerged, with the UN claiming that as many as 48 people may have died, while the Burmese authorities said there had been no casualties. Then much to the annoyance of the government, MSF confirmed that their medics had treated 22 patients near the site of the alleged attack. It suggested something serious had happened and may have been the final straw for MSF. Presidential spokesman Ye Htut told me their actions had clearly demonstrated their bias towards what he called the Bengalis.



‘MSF Myanmar **Comms Sitrep**,’ February 2014 (in English).

Extract:

Feb 26: Irrawaddy on protests, RFA follow up. RFA/AFP/MM Times/Evening/Reuters on MoU cancel rumours. [...] Later in afternoon, pretty much everyone called regarding MoU cancellation rumours and MSF in Rakhine.

Feb 27–28: Reactive lines sent to *MM Times*, *Irrawaddy*, AP, Mizzima x 2 (ENG & MM), Francis Wade, BBC, RFA, Messenger, The Voice, DVB x 2 (Yangon MM & Chang Mai ENG), 7 Days, *Midday Sun Journal*. Received written notice from MoHA to cease all activities in country.

Feb 28: All clinics closed. First MSF statement released. Reuters/BBC/IRIN/AP/Channel News Asia May Wong (CNA) [...] /BBC/IRIN/*Lancet* [...] / [...] (Echoing Voice) Journal [...] / DVB/Devex [...] /VOA/7 Day Daily/AP/*StraitsTimes*/various freelancers/*NY Times*/MRTV 4/*The Independent/Irrawaddy*/RFA/*Daily Eleven*/*The Voice*/*Democracy Today Newspaper*/Mizzima/VOA/BBC/IRIN/AP/AFP/WSJ [Wall Street Journal] [...] /*MM Times* /Myanmar International Television [...] /*Evening Daily* [...] [...] /*Midday Sun Journal* /and many others by phone. Declined interviews for now as instructed. [...]

- Other key comms-related

Experienced constant hallucinations of storks flying overhead dropping orange pills that morphed into little cabbage patch dolls due to sleep deprivation*.

*NB: That's just to check if anyone is still reading this ☺

- Coming up & ongoing

Trying to get back into Rakhine, if not possible I recommend going nuclear in public comms.



So, in 48 hours we turned around from being kicked out of the country to being kicked out of Rakhine only and internationally there was a lot of mobilisation. We went completely nuts with the media as it was on every front page. This was where the national media network that we had developed over that time came so handy because we were able to show the impact of 30,000 HIV/AIDS patients not receiving their medication. We did give them medication, but we told a different story obviously to the media. And they sent cameras, from Kachin to Yangon. They were interviewing patients saying "MSF's been great. They've been giving me all this medicine for years and now I can't get it." And we got all that out in Burmese. So, in a sense, as horrible as it was, the suspension from Rakhine State was – and here comes the communication side of me – an incredible opportunity for everybody to find what MSF is and what MSF does in the country.

Eddy McCall, MSF OCA /MSF OCG, Myanmar Communications Manager, April 2013-January 2015 (in English)



There were probably two stages in the discussion in OCG. The first one was: "do we take a stand in solidarity with OCA if really, they're forced out? Do we want to make a statement as well and say, 'we're one big MSF family, we're leaving now?' That was probably quite a short deliberation because, as in many countries, we actually had separate registrations. Initially they were registered as AZG and we were seen a little bit differently. We were always the small brother, sister, whatever you want. They were five times bigger in many metrics. So, we quickly moved from a solidarity position to a practical one. At that time there was change coming in Myanmar, they were reaching out to the economic neighbours. There was a lot of development. So, would that be the moment for MSF to completely step out of that country? Quickly, both sections came to an understanding that no, that was not the moment. Therefore, what OCA would do, would be for OCA, and what we would do, would be what we could, as a nice little Swiss in the corner, in some locations where we would be able to maintain a presence. We even got as far as discussing what if OCA had to leave, would happen to all those patients, to that massive HIV cohort. Now, it's not that we could have taken it over from one day to the next, but there was that thinking that in terms of responsibility to patients, MSF Switzerland could actually do something. I don't know what but we could certainly have scaled up to ensure that at least some of those patients for a period of time that would have to have been determined would still receive treatments. So, for us it was more that we should stay and stay quiet, be nice and that we would then be able, medically speaking, to ensure some continuity of medical care for whichever cohorts or projects.

Kenneth Lavelle, MSF OCG, Deputy Programme Manager, March 2010-October 2014, Programme Manager November 2014-June 2017 (in English)

MARCH 2014 - 'MSF TO RESUME ACTIVITIES IN MYANMAR BUT CONCERNS REMAIN FOR RAKHINE' (RELEASED PUBLICLY)

The MSF OCA Myanmar coordination team together with the MSF International HART strengthened their all-out bilateral advocacy activities reaching out to their contacts within the Myanmar government and the international diplomatic community.

It quickly became apparent that the decision to oust MSF OCA was taken by the military's 'old guard,' who believed that MSF was stirring up trouble in Rakhine. However, no one in the Presidency was prepared to endanger the image of democratic opening, which was instilled in recent years.

Eventually, the Minister of Health and the Minister of Home Affairs informed MSF OCA that they could restart their HIV/AIDS treatment programmes and other activities in Kachin and Shan states, as well as in the Yangon region on Monday, March 3, 2014.

On 1st March 2014, MSF OCA issued a press release relayed by the MSF international movement, announcing the forthcoming resumption of all activities in Kachin, Shan, and Yangon but not in Rakhine. Once again, MSF OCA expresses serious concern for the tens of thousands of vulnerable people in Rakhine state facing a humanitarian medical crisis.



“**Press Release:** MSF to Resume Activities in Myanmar but Concerns Remain for Rakhine” **Message** from Igor García Barbero, MSF OCA Communication Advisor to MSF International Movement Communication Officers, 1 March 2014 (in English).

Extract:

Please find attached a new PR on Myanmar following the statement we released yesterday. I know it is too late and Saturday, sorry!! You might have seen that our reaction to the initial decision of the Govt of Myanmar to order MSF Holland to cease activities in the country had very wide coverage in the press. See for example: [...] BBC [...] We have been getting many media requests but I want to ask you to put them on hold and stick to the PR. There will not be spokespeople available for today but it would be good that you tell some journos you trust that we might come back to them. You can put them in touch with me. Also, can anybody help us have the PR translated into French? Finally, I just want to remind that this specific situation affects only MSF Holland, which is the leading section in Myanmar. Should press officers have queries related to other activities of MSF OCG you can refer to the reactive line sent yesterday by Sally McMillan [MSF OCG Communication Advisor]. If you plan to send some bits of the PR via Twitter or Facebook, please remember to state that this a MSF Holland communication. [...]

Myanmar: MSF to resume HIV/AIDS and all other activities in Kachin, Shan and Yangon but concerns remain

Yangon, 1 March 2014 – On February 27, Médecins Sans Frontières Holland (MSF) received a written order from the Union Government of Myanmar to cease all operations in the country, which led to a full closure of all MSF Holland clinics on February 28. This act left patients confused and desperately concerned across the whole country. After

dialogue with the Union Government in Naypyitaw on February 28, we have now been informed by the Minister of Health and the Minister of Home Affairs that we can resume part of the activities as covered by our original Memorandum of Understanding on Monday March 3. This includes HIV/AIDS and other activities in Kachin and Shan states, as well as Yangon region. Whilst we are encouraged by this and will resume these activities for now, MSF remains extremely concerned about the fate of tens of thousands of vulnerable people in Rakhine state who currently face a humanitarian medical crisis. MSF Holland clinics in Rakhine remain closed since February 27, following a verbal communication from the Rakhine State authorities to suspend our activities. Prior to the suspension, MSF carried out a variety of activities in nine townships across in Rakhine, treating anyone who was unable to access the medical care they required. All MSF services are provided based on medical need only, regardless of ethnicity, religion or any other factor. MSF looks forward to continuing the dialogue with the Union Government to ensure that essential life-saving services continue to reach those that need them.



We went into overdrive just calling everybody that we knew. We had created good access to the President's office, which was a civilian department, even though there were former military inside and particularly to one the highest level in government, but also in diplomatic circles.

What we think happened was that the Ministry of Home Affairs had issued that letter without consulting with the President's office. So, it was essentially, the old guard, the military kind of, up to their old tricks in the way they would have been used to pre-2011. No doubt the military's objective was for MSF to leave completely. As far as they were concerned, we were an agitator that was stirring up trouble in Rakhine and they didn't care. But the President's office at that point was more powerful and obviously were getting heavily lobbied by diplomats that they were listening to at the time and by the UN. They were being told: 'this is not only incredibly detrimental to the people that MSF are treating, it's very bad for your image at a time when you are trying to open up to the world and encourage business to come, etc. You expel one of the highest profile NGOs and that doesn't make you look very good.' They just were at a time where they were really trying to court the donors and get investment in Myanmar. So, suddenly expelling MSF would be like they were back to their bad old ways. And that's, that was not the image they were trying to cultivate. Then the President's office had the ability to overturn the national expulsion. So, ultimately it was all about PR [Public Relations]. I don't think the HIV cohort really had a huge bearing on the decision of the President's Office either.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission for Rakhine, in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting Head of Mission in February 2014 (in English)



Then that expulsion of the country was very quickly made an expulsion of Rakhine. There is different interpretation as to what caused that. Personally, I think it was the pressure that we had already. We mounted right away a response from everybody in the diplomatic community that matters in this case, including the US. I think it was quickly taken back because of the pressures and everything at stake. But of course, that's also a judgement. We can never be sure. It was also all these different ministries, and this was the whole intelligence apparatus and the military on the back, and so they had probably not realised how big a stakeholder our MSF is for the Ministry of Health and for the HIV/AIDS patients, and

so a cohort of 30,000 at the moment. Also, the divide between the different ministries and so on.

Marcel Langenbach, MSF OCA Director of Operations (in English)



One of the theories that I heard from the major actors in the region was that MSF's expulsion was a test by the military authorities to see how the foreign embassies would react. Would they let that happen? It was a test run before trying something that would be much more significant to see what would happen in response to an effort at a coup d'état. Several diplomatic actors responded firmly, if discreetly, because they realised, 'If we let them kick MSF out, that opens the door to other initiatives that could be much more serious.'

Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).

On 1 March 2014, MSF's International Executive Committee, which brings together the general directors of all MSF sections in the movement, voted in favour of a strong reaction, but not a departure of all MSF sections from Myanmar.

As MSF OCG was the only other MSF section working in Myanmar, on 7 March 2014, the MSF OCA General Director, Arjan Hehenkamp, provided the MSF Switzerland board of directors with an update of the situation in Myanmar and an explanation of the OCA management team's decision. Regarding their own positioning, the MSF Switzerland board of directors asked for time to reflect, preferring not to "take lightly" their decisions on positioning in Myanmar in the face of "these kind of atrocities" in Rakhine,



'MSF Switzerland Board Meeting **Minutes**,' 7 March 2014 (in English), edited.

Extract:

Bruno Jochum: Dutch section is under threat of expulsion. It is a very acute issue that has consequences for us and the movement. We have invited Arjan Hehenkamp, general director of OCA.

Arjan Hehenkamp by phone: It is probable that the violence in Rakhine is, at its origins, political (and economic) rather than only communal. That it is strategic, purposeful and managed rather than spontaneous and uncontrollable. Violence, displacement and vituperate communal hatred are the means by which the Rakhine political party (RNDP) tries to sustain Rohingya marginalisation and wrestle political control over Rakhine State away from the President's (or the Army's) political party (USDP). In the last election the USDP gave the Rohingya the right to vote, offering eventual citizenship for the Rohingya as bait. With Rohingya electoral support, it secured a controlling majority, enabling it to form the government. This victory and the promise of citizenship to the Rohingya infuriated the Rakhine leadership, threatening as it does their control over Rakhine in the short and long term. I believe the national government is trying to manage the situation, without estranging the Rakhine people and its leadership, the general public (which is anti-Rohingya) or the international community (pro-Rohingya) – a next to

impossible balancing act. Its prime interest, however, is to maintain control over Rakhine. MSF is very unpopular. Incident in northern Rakhine – 22 wounded patients. First [kicked out] from country and could no longer work in Rakhine State. Once suspended, it would be very difficult to restart. [Have to decide] If we accept and continue our activities in other parts [of the country] or leave Myanmar if we are not able to work.

Decision: If not in Rakhine, we would stay in Myanmar, we have medical impact. Situation of near apartheid. Operational choices and medical choices are tough. Dilemmas result. Medical strategy that allows us a strong cohort of patients. This is one of the facts that we have to balance.

Bruno Jochum: Would you have any expectation of OCG?

Arjan Hehenkamp: Presence of OCG came up, movement decision not OCA position, difficulty in taking strong stance in OCA. We do not expect OCG to follow, to expand activities in months and years to come and to stay and continue activities is one expectation. It is a question of strategy. Something that we will have to analyse. Second issue: massive cohort.

Nicolas Cantau: How can we use [the] Global Fund to leverage the situation?

Arjan Hehenkamp: Not yet informed them on our bottom line. We will inform them. Responsibility beyond MSF. They will go far expressing concern but put limits on the amount of risk. Upcoming session on Myanmar before UN Council.

Abiy Tamrat: The next step will be quite critical for patients and what becomes of patients that were treated. We appreciate collaboration with OCA. We will do what we think is right. Putting patients first.

Karim Laouabdia: Position of IB [International Board]?

Bruno Jochum: We had an Excom teleconference last Saturday, OCA shared with us the choices they face. The majority of their staff is in favour of complete withdrawal, which is not the position of the operations director and Arjan. It is very tempting to make a big public stand, in the end of these last 2 days. There is also HIV, the biggest programme being mainly OCA's. Against this, the democratisation process is not. This is making political tensions more acute. It remains a real question what the outcome could be in 2–3 years. Excom was favouring a strong line but not to take decision to withdraw altogether but to continue negotiations. Most likely scenario for OCG, but we can't put a cross through all the other programmes in the country. Their operations directors will talk to the teams that are divided. We need to give them a bit of time to look at scenarios. What does it mean for OCG strategy? We propose to have a more in-depth exercise with the Board during the Congress.

Abiy Tamrat: We compromise, but if there are these kinds of atrocities...It is something we don't need to take lightly. Let's have a thorough discussion in April with elements. Joanne [Liu, MSF International President] is planning to go to Myanmar.

Meanwhile, on 5 March 2014, MSF OCA General Director, Arjan Hehenkamp and Medical Director Sidney Wong were invited by the MSF OCA operational platform, which included managers and advisors of the operations department, to explain the “bottom line” decision taken by the MSF OCA management team. They acknowledged the decision was taken “painfully but collectively.”

A majority of the MSF OCA operational managers and advisors disagreed with the decision. They would have preferred that MSF OCA completely withdraw from Myanmar if access to Rakhine was blocked.

On 8 March 2014, the MSF OCA management team sent a memo to all the MSF OCA heads of mission, operations managers, heads of departments, and heads of OCA sections confirming their decision and explaining it in detail.

In the following weeks and months, intense debates took place within the executive and the association of MSF Holland and OCA. While most admitted, albeit reluctantly, that the MT decision must be respected, many felt they were not heard and continued to be critical of both the process and the content of this decision.

Tensions and misunderstandings were fuelled by the existence of divergent accounts of events, the nature of the crisis, and the dilemmas posed. Some considered that decisions should be pragmatic and concern the type of compromise to accept in order to continue treatment for patients in Myanmar first and then renegotiate access to Rakhine.

Others argued that MSF OCA was in a strong position since Myanmar's MoH was neither able nor willing to support MSF's cohort of 30,000 HIV patients on antiretrovirals. Therefore, they felt MSF should use this leverage to impose its presence in Rakhine.

The debate spread to the MSF Holland association with the support of some members of the executive team, such as the head of OSCAR, Hernan del Valle and the Deputy Director of Operations, Pete Buth, who both wrote opinion pieces to feed the debates.

The question of the relevance of speaking out was approached from several angles. Some believed that speaking out publicly would offer effective support to the negotiations, while others believed that it would lead to the final expulsion of MSF from the country.

For others, especially members of the association, speaking out was part of MSF's core identity and should be activated to denounce a situation as serious as that of the Rohingya. If not, it would send a wrong signal beyond Myanmar, that the price to pay for expelling MSF was not too high after all, since the organisation does not speak out publicly and even seemed ready to work at the will of the government.



'MSF OCA Operational Platform **Minutes**,' 5 March 2014 (in English).

Extract:

Arjan Hehenkamp and Sidney Wong

Arjan and Sid were invited to the OCA Ops Platform to give an explanation about the MT decision concerning the expulsion from Rakhine, Myanmar.

Decision MT: After several lengthy and passionate discussions, the MT painfully but collectively concluded that, ultimately, MSF OCA would try and protect our presence in our other Myanmar projects, even if we could no longer continue our presence in Rakhine State. The MT felt that our commitment and responsibility towards the projects in Shan, Kachin and Yangon should be taken into consideration. And that to be forced to abandon the people in Rakhine should not translate into the organisation, by choice,

risking our proximity and support to marginalised people elsewhere in Myanmar. A discussion ensued about the MT decision and its implications for MSF's principles. The majority of the OpsP is not supportive of the MT decision.



“Myanmar” MSF OCA Management Team, **Memo** to Heads of Missions, Operations Managers, Heads of Departments, Tankred Stoebe MSF Germany President, Els Niehaus MSF Holland Director of Resource, Pete Buth MSF Deputy Operation Director, Martin Sloot, Head of MSF office in India, Steve Cornish MSF Canada Executive Director, Katrien Coppens MSF Hollande Delegate General Director, 8 March 2014 (in English).

Dear all,

Last week, the government of Myanmar informed MSF OCA (notably not OCG) that we must close down our projects across Myanmar and leave the country. Over the weekend, it modified this order and said that actually MSF OCA might stay in Myanmar and continue our activities except in Rakhine State. Many of you will know that MSF OCA has been working in Rakhine State for over 15 years. The reason for our presence is the sustained oppression of the Rohingya people who are denied Myanmar citizenship by the national authorities and, if they manage to flee the country, are unwelcome as refugees in neighbouring Bangladesh as well as elsewhere in the region. Two years ago, violence erupted across Rakhine State, predominantly affecting the Rohingya. In response, MSF OCA expanded our presence and medical activities, despite the major constraints we faced due to the immense polarisation between the Rohingya and the Rakhine communities. For instance, a referral of one single sick child of Rohingya descent can face resistance from Rakhine hardliners who may stop our ambulance. Even if we are able to get through, then the hospital may not actually admit the child. Even if they do, there is a likelihood the child will not be properly treated whilst in hospital. Every referral has become a fight.

With the upcoming elections, the situation is tenser than ever – the national government is fighting for re-election and is concerned for the integrity of the country; Rakhine nationalists, want, at a minimum, greater autonomy from the national government and also want to get rid of the Rohingya whom they regard as illegal immigrants threatening their rightful place in ‘their country’. The Rohingya, meanwhile, are so desperate they would do anything to fight for their right to exist and survive. Due to our longstanding presence, the volume of our activities and our willingness to speak on behalf of the Rohingya, MSF OCA has become a public factor in the political dynamics in Rakhine State. The Rakhine authorities and other influential figures in the community barely tolerate our presence, whilst the Rohingya have come to rely on us for much more than only our medical activities.

In this explosive situation, MSF OCA recently treated dozens of patients who were wounded in a violent attack in northern Rakhine State. Our public statements on this became the only independent source of information. The incident was condemned by the UN and other international actors, and put the Myanmar government on the spot. The authorities denied anything had taken place, and accused MSF OCA of fabricating information, thereby undermining stability and ultimately endangering national security. After weeks of popular (though orchestrated) demonstrations against MSF OCA in Rakhine, in which hundreds of protesters carried signs saying, ‘MSF OUT!’, we received the official expulsion orders.

Upon receiving these orders, MSF immediately mobilised international states and the media in order to put the facts of our expulsion out in the open, to rally support and to

protect our presence in Myanmar and in Rakhine, whilst opening bilateral discussions with the Myanmar authorities. We continue to do so. At the same time our field teams are still on the ground in Rakhine; we are not leaving 'voluntarily'. As we speak, Marcel Langenbach is in Nay Pyi Daw, Myanmar's capital, in order to meet and negotiate with the central authorities who have ordered our expulsion. It is clear, from multiple sources, that there is significant international pressure onto the Myanmar government to reverse the expulsion, to the extent that they have since softened their position and now speak of a 'suspension' or a 'cooling off period' of our activities in Rakhine State. We understand this to indicate division between reformists and hard-liners in the central government, and tensions between the central and the Rakhine State government. We do not, however, believe that if we leave Rakhine State we will be allowed to return. And so, we continue to press and to negotiate.

In this negotiation, and here comes the crux of the MSF internal debate around our positioning towards the expulsion from Rakhine, we had to define our bottom line, in order to allow our operations in the field and in Amsterdam to plan a negotiation strategy. Leaving aside the tactics we can use, and knowing that of course we will do our utmost to prevent it from happening, the question came down to: would MSF OCA leave our other projects and patients in Myanmar if we could no longer work in Rakhine State? Or would we accept to stay elsewhere in the country even if we could no longer work in Rakhine. In other words, are we willing to use the ultimate weapon at our disposal – the withdrawal of our services to tens of thousands of people in desperate need – in order to protest at no longer being allowed to work for the marginalised people in Rakhine, who are also in desperate need?

Given the time pressure and the necessity to provide a bottom-line position for the field team, the OCA MT conducted a rapid consultation process and several rounds of MT discussions and debate over the weekend. After several lengthy and passionate discussions, the MT painfully but collectively concluded that, ultimately, MSF OCA would try and protect our presence in our other Myanmar projects, even if we could no longer continue our presence in Rakhine State. The MT felt that our commitment and responsibility towards the projects in Shan, Kachin and Yangon should be taken into consideration. And that to be forced to abandon the people in Rakhine should not translate into the organisation, by choice, risking our proximity and support to marginalised people elsewhere in Myanmar.

Clearly, this is a horrible and impossible dilemma which confronts MSF with the limits of what we, as an organisation and an association of individuals, are prepared to accept. It opposes, on the one hand, the driving force which compels us to be present and to be practically relevant to populations in danger, with our ingrained sense of needing to stand up and fight for those worst off in the world today, and speak truth to power. How can MSF accept being forcibly prevented from supporting a group of people who are amongst the most mistreated in the world, whilst continuing to work elsewhere with the very government responsible for our eviction and for the mistreatment of the Rohingya? On the other hand, why, if we are forced to leave the Rohingya people, would we also leave our other projects, all of which we judge to be relevant and all of which have positive medical impacts for thousands of patients who suffer conflict, violence, marginalisation and an absence of medical care?

In the impossible balancing act between preserving operational and medical relevance in the short-term, versus inherently compromising our identity and principles and possibly the depth and strength of our humanitarian access in the long term, the OCA MT chose the former. In the end, the MT concluded that the political and public effects of our departure from Myanmar would be unlikely to measurably improve the situation for the Rohingya people and that, if we left Myanmar completely, the chances of returning

to Rakhine State or to exert any influence over the situation of the Rohingya would be very small. Better to be in Myanmar and fight for our presence and relevance, knowing that in the hard context of Myanmar MSF's access is never guaranteed, rarely emulated and always full of compromise.

All the members of the MT found this a hard choice. It is a choice that forces us to examine our organisational identity and principles, as well as our own medical and moral ethics. MSF is full of passionate and committed humanitarians, and views are strongly held across the organisation; we know that this decision splits opinion. Some feel that this decision betrays our most fundamental identity and principles if we do not fight with everything at our disposal to remain in Rakhine. Others say our refusal to fight as hard as we can will undermine our humanitarian access and that of other organisations in Rakhine State and in Myanmar. Some believe that MSF's *raison d'être* is to be present and maintain relevance, and that being present, particularly in a difficult place like Myanmar, necessitates compromises with our principles. None of us is unaware of the responsibilities we have taken upon ourselves towards our other projects and patients. In the end the MT believes that these deserve to be preserved even if we cannot be everywhere in Myanmar that we believe we need to be.

The OCA MT is fully committed to engaging with everyone in the organisation and in the association to explain our choice and to be accountable for this decision. We will create opportunities for this in the coming weeks and months. Whilst the MT appreciates and encourages ongoing debate, we also know we need to move forward, providing all the support necessary to the field and to operations through this difficult time.

[signed],

Arjan [Hehenkamp, MSF OCA General Director], Sid[ney Wong, MSF OCA Medical Director], Marcel [Langenbach, MSF OCA Director of Operations], Frank [Doerner, MSF Germany Executive Director], Polly [Markandia, MSF UK Director of Communication] and Els [Niehaus, MSF Holland Director of Resources]



“Blindfolded Charity: The Imperative to ‘Address Medical Needs’ At All Costs” **Opinion paper** from Hernan del Valle, MSF OCA Head of OSCAR (Operational Support in Communication Advocacy Representation), 2 April 2014 (in English).

This paper is written as a contribution to frame the debate organised by the MSF H[olland] Association on Rakhine. It raises questions on the controversial OCA MT[Management Team] decision right at the beginning of the current crisis, and its broader implications for the strategy that followed and for the identity of the organisation. It is meant for internal circulation only. A month has passed since MSF closed all its clinics in Rakhine following orders from the Myanmar government. As government spin doctors run a smear campaign to discredit MSF in the media, orchestrated ‘community’ intimidation of aid workers continues to be allowed by state security forces. Our response to the crackdown has been very restrained. We have avoided any public confrontation with the authorities and issued constructive statements in the hope that a conciliatory approach and mobilising diplomatic engagement might persuade the government to reverse its decision. From the outset, the OCA MT encouraged this approach by deciding that our fight for Rakhine should in no way risk our ability to provide medical treatment elsewhere in Myanmar. The MT made it clear that even if we lost Rakhine, we would continue to provide health care on behalf of the Ministry of Health elsewhere in Myanmar. This surprising ‘bottom line’ logic was endorsed by the OCA Council.

In the wake of the expulsion, many of us have argued for a stronger stance. We believed that expelling MSF was a bigger problem for the Myanmar government than it was for

MSF. Not having the capacity to replace the massive volume of MSF operations across the country, plus the political backlash derived from the inevitable publicity of our expulsion were real nightmares for a regime which is trying to improve its international image. We therefore argued we should never choose to give up this leverage in our fight for Rakhine. The strategy chosen was however softer, and whether it yields any results is something we will only be able to judge over time. So far, prospects look extremely bleak. Our operations have grinded to a complete halt in Rakhine and we have been forced to withdraw almost all our staff. This situation has no end in sight. Regardless of the outcome, the decision by the OCA MT and Council should be contested because it has implications beyond Myanmar. It affects the core identity of MSF and sends the wrong signal to other governments worldwide: the cost of expelling MSF is not too high after all. The organisation does not cry foul publicly, and is ultimately willing to continue to provide care wherever is convenient for the government.

The MT rationale and the 'bottom line' established should be questioned on three counts. Firstly, the decision is presented as if the choice had been either staying in Myanmar without Rakhine or leaving altogether. This is misleading. Nobody ever argued we should leave. The real decision was about how hard we would fight to get back into Rakhine, and whether we would be willing to leverage and risk our operations elsewhere in the country. By defining the continuation of our work in Myanmar as a bottom line objective from the outset, the MT has de facto determined a risk averse strategy aimed at not upsetting the authorities. They have chosen to continue our medical operations elsewhere, tone down the public outcry that followed our expulsion, and bring the negotiations to the arena in which we are weaker: bilateral discussions with a regime which is keen to expel MSF from Rakhine because our presence assisting unwanted Rohingya has always been a nuisance. The underlying assumption at MT level seems to be that there was no alternative. Fighting publicly and leveraging our operations across the country to make the problem a collective one for key donors and governments who have a stake in our massive HIV/TB programmes elsewhere was deemed a non-starter. Even if many of us disagree with the MT assumption, we will ultimately never know because the MT chose not to try.

Secondly, the MT describes its dilemma as an 'impossible choice' between patients in 'desperate need' across different regions of Myanmar. Talking about generic 'medical need' and framing the choice as either losing access to all patients or just those in Rakhine, the decision becomes a no brainer: we should keep whatever we can. However, underplaying the political context and reducing the problem to 'medical need' deprives us from having a politically informed judgement of the choice made. Myanmar is not a conflict zone or a matter of access to health care. There is a government in complete control, which for decades has been using legislation and its security forces to systematically persecute an ethnic minority. What makes the Rohingya different from other people in Myanmar is that they are the only group deprived of citizenship and rights, and deliberately excluded from state services. Arguing the compelling nature of 'medical need' sanitises the debate and becomes a way to avoid uncomfortable questions around our role providing healthcare in a country in which deliberate neglect, persecution and ethnic cleansing are state policy. Are we willing to continue to offer our services through a MoH which does not longer allow us to assist those being cleansed? Are we willing to tolerate expulsion silently in order to continue treating other patients outside the cleansing areas? Are we no longer willing to risk our medical activities to fight the right fight?

Thirdly, the MT presents their decision as a necessary compromise in order to maintain presence in the country. Nobody argues that humanitarian action requires a level of political compromise, especially in places like Myanmar. However, the MT seems to miss

the difference between accepting compromise and compromising the core of what MSF is. All compromise is based on give and take, but there can be no give and take on fundamentals. Compromise on fundamentals is rather a surrender. The fundamental at stake here is that we cannot reduce MSF action to mere healthcare provision. Treating 'patients in need' can never be an absolute imperative, an end in itself, stripped from its ethical and political implications. "The work that MSF chooses does not occur in a political vacuum," we said in our Nobel Peace Prize acceptance speech, "but in a social order that both includes and excludes, protects and attacks [...] Our responsibility is not to allow the humanitarian alibi to mask the state responsibility to ensure justice and security [...] We are committed to bringing medical aid to people in need [...] but with a clear intent to provoke change or to reveal injustice. Our action and our voice are an act of indignation, a refusal to accept an assault on the other."

What is taking place in Rakhine is precisely an assault on the other. Our presence was uncomfortable because it was a vital lifeline for those being persecuted, and for over 20 years we remained an outside witness to state abuse. Keeping silent in the wake of expulsion in order to protect the continuation of our medical programmes in the rest of Myanmar might look like the right instinct for a doctor, but it is certainly not the right answer for a humanitarian organisation.

There is perhaps nothing more difficult than to live up to the ideals we set for ourselves. This MT decision brings us a step further away from them, and widens the gap between our discourse and our practice. "The ultimate measure of a man," Martin Luther King said, "is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy." We will, I believe, be judged by our compromises more than by our ideals and our principles. Principles may tell us something important about what we would like to be. But compromises tell us who we really are.



'MSF Holland Board of Directors **Contribution** to OCA Council,' 9 April 2014 (in English).

Extract:

Why the council needs to discuss the situation in Myanmar [...]

The choice that MSF OCA has made so far – to try and protect our presence in our other Myanmar projects, even if we could no longer continue our presence in Rakhine State and have access to the Rohingya – is seen by many as a serious compromise of our identity and our principles. It is a choice to preserve operational and medical relevance, but it affects the core identity of MSF, and could have implications for the organisation beyond Myanmar. The balance between providing healthcare to populations in need whose human rights are fundamentally violated and speaking out on behalf of those populations risking our very presence for those populations is at the heart of our organisation, the core of our identity. For this reason, it is in our view imperative for the Council, as the ultimate guardian of the social mission of OCA, to consider the questions below.

Questions

- In case we cannot have a meaningful presence and activities in Rakhine State, is our strategy to tone down our outcry in order to not risk our operations elsewhere in the country, including marginalised minorities and 30,000 HIV/AIDS patients? If so, what level of advocacy do we envisage and agree upon?
- What is the role of the Council and of the MT regarding the approach in Myanmar going forward? When in the decision-making process will the MT inform the council? What

decisions require an active agreement upfront or a passive endorsement afterwards by the council?

• Given the uncertain future we need to be prepared for the most likely scenarios [...] in terms of our approach to operations, advocacy and/or handover. A risk analysis would need to be included to take into account the implications for OCA and the wider movement. Can the OCA MT provide the OCA council with such a scenario analysis and when?



'MSF OCA Management Team Meeting **Minutes**,' 17 April 2014 (in English).

Extract:

B. Myanmar: Decisions taken with regard to OCA's presence in Myanmar after incidences in Rakhine caused debates among staff. Therefore, sessions for debate will be set up.

Action: Sid [Wong] will prepare a session for all important stakeholders with our Ethicist on the Rakhine decision/process.

Action: Arjan [Hehenkamp] will ask Pete [Buth] to organise and prepare a session on Ops Platform

Action: Arjan will prepare a session open to all office staff where outcomes of the other two sessions will be presented.



'**Letter** from Pete Buth, MSF OCA Deputy Operational Director to MSF OCA Management Team,' 19 May 2014 (in English).

Extract:

Dear OCA MT members,

I am writing to you to express and explain my frustrations and concerns around the recent Myanmar bottom line decision. I hope that this clarifies the main reasons for my frustrations and thus contributes to overcome the unconstructive tensions that dominated some of the recent Strategic Plan discussions.

First, I would like to make clear that I appreciate that the bottom-line decision was difficult and I recognise that the MT [Management Team] must ultimately take the final responsibility for making such tough choices.

As I think you are aware, I fundamentally disagree with the decision, as in my view it constitutes an unacceptable compromise to the values and identity of MSF. However, my concern is not just with the outcome of the decision, but with the manner in which it was produced and managed. I feel that there are some serious concerns with the process that I want to share with you because I am not confident that the MT fully appreciates the quality or scale of the frustration with the decision and the process – not just on my part, but among other members of MSF too.

I am disappointed that, until very recently, and despite the commitments (to facilitate further debate) made in the OCA MT letter from 8 March, the MT appeared to either not recognise or not acknowledge the lack of support for the decision among many in the organisation. This includes not only the majority of the staff in the mission, the HoM, the OM [Operations Manager], and the HAO of the Myanmar mission, but also the majority of the office staff most directly tasked with implementing MSF's social mission: the majority of the Ops Platform members; the Head of Departments of PHD and OSCAR; as well as the majority of health advisors and HAD [Humanitarian Affairs Department] staff. In my view, the management of such a fundamental issue and the real gap between

senior executive and a significant part of the 'shop-floor' required strong leadership from the MT. However, instead of a visible and genuine effort by the MT to address this matter in a timely fashion, I – and I am not alone in this – felt that the MT's implicit message was: "We heard you, we made our decision, now move on." It is positive that the MT has now finally initiated some steps (Arjan's email 18/04), but I feel that this is only the result of some of us forcing it, rather than of proactive MT leadership.

Furthermore, considering the importance and weight of the decision, as well as the differences in opinions in the MT itself, I believe that it would have been appropriate to seek input from the Ops Platform in the decision-making process. I wrote to Arjan and Marcel about this on March 3rd, but have yet to receive a response from the MT. My last point concerns the OCA Council endorsement of the MT decision. I – and all others I spoke to who were present at the MSF Holland Association evening on Myanmar – were surprised and discouraged by the apparent inability or unwillingness of any of the three attending OCA Council members to defend and articulate the reasons for the Council's endorsement of the MT decision. This leads me to question whether the Council scrutinised and challenged the MT decision to the level its mandate requires it to. Whilst I of course do not fault the MT for this, it does not give me the impression that there is adequate OCA Council oversight in regard to identity issues – which in turn does not increase my confidence in the integrity of the bottom-line decision and the process.

In terms of process, the obvious disapproval of the decision by the vast majority (if not all) of those present, as well as the lack of proper explanation for it by the Council was another signal that I believe should have triggered a reaction from the MT (as well as the board). Whilst the main purpose of this letter was simply to share my view on the decision and the process, I would certainly appreciate the MT's perspective and thoughts on these issues. Moreover, I look forward to the upcoming meetings organised around this topic and hope they will allow us to discuss some of the broader issues raised by the Myanmar bottom line decision relevant for defining the future direction of the organisation.



Minutes of MSF OCA Management Team Meeting' 22 May 2014 (in English), edited.

Extract:

[Myanmar letter from Pete Buth](#)

The letter by Pete Buth that was circulated among OCA MT members will be responded to by Arjan in the course of next week on behalf of the MT transparently. Pete agreed to this. Therefore, Arjan asked the fellow MT members for their input regarding the answer. The OCA MT suggested the following:

Reject the accusation of a hasty decision: It was taken within a short period of time, but not hasty. The letter should also demonstrate that the decision wasn't taken lightly. Pete argues that the OCA Ops Platform was the place where the discussion should have been opened but given the short period of time this wasn't possible. The rationality of the quick decision should be reinforced as there were only 3 to 4 days in which to take it. Question is whether we could have afforded not to take the decision. But as the field pressured for this we could have otherwise been accused of not taking the field voice seriously. For the future the OCA might reflect how strong the pressure actually is. The whole topic does seem to have to do with a lack of attention. The MT argues that of course it would have been helpful to include the OCA Ops Platform further – but, the first meeting regarding the issue took place with Ops representatives, second as well someone present. So, there was involvement to a certain extent.

Pete and others don't feel heard and taken seriously. The letter should point out that OCA MT heard them but that there was a different decision made – in the end, they either move on or stop as this ultimately is the decision. One might also question the usefulness of taking the majority of the offices into consideration. OCA can't afford to have a completely blurred decision. Overall, the letter should be defensive in some respects. Maybe the MT's communication could have been better. The field's perspective was underrepresented in the letter. In terms of identity issue: not sure that the compromise is insulting to our identity. Letter is all about MSF and not about the population in danger. The letter shouldn't mention different opinions within the MT but rather stick to the MT's opinion as one – not explain how the MT got the 'collective' decision. Possibly include the proposal of another open discussion in the letter. As the Council was addressed in the letter as well, we might give them the possibility to respond to the letter as they were accused of being opportunistic.

Action: Arjan will formulate response and circulate it transparently. Further input by Arjan: GA MSF Holland: this is going to a key debate – it's therefore necessary for the MSF Holland MT to be there; motions being elaborated already; OCA Council and MSF Holland Board might be forced into conflict if MSF Holland members push it.



'Letter from Arjan Hehenkamp, MSF OCA General Director on behalf of the MSF OCA Management Team to Peter Buth, MSF OCA Deputy Operational Director,' 2 June 2014 (in English).

Extract:

Dear Pete,

Thank you for taking the time to articulate your concerns towards the OCA MT position on the Myanmar bottom line. This has been an important issue for MSF OCA and in recognition of that I would like to take the opportunity to respond to your letter and expand on some of the most pertinent issues that you raise. The points regarding the OCA Council will be addressed separately by the OCA Council themselves.

Process up to the decision:

The request by Operations was to make a rapid decision to inform their negotiation with the Government of Myanmar. This timeline played a major role in how the consultation and decision-making process was organised. With the time constraint, the OCA MT organised an OCA-wide office consultation, including participation of OCG and the IO [International Office], and compressed three layers into the OCA MT discussions by inviting the OCA Council Chair and the Myanmar Operational Manager into the MT meeting. Overall it is felt by the OCA MT that the process leading up to the decision was exceptional yet valid and as inclusive as it could be given the heavy time constraints.

Aftermath of the decision:

I am sorry that you have felt that proactive leadership from the MT has been lacking after the bottom line was established. I accept this was the case. As OCA MT Chair, I have underestimated the level of frustration felt by Heads of Department and Operational Managers in the aftermath of the decision. We have tried to be as transparent as possible, keeping doors open for questions and discussion, and we maintain a commitment to addressing this [...]. We recognise fully the weight of our decision and are very much aware this is a highly divisive topic. Response from the field and from other members of HQ has indicated that opinion is very much split and it is in recognition of this divide that we – albeit belatedly – held and supported discussions in the Operations

Platform (with the ethicist) and further office-wide discussion [...], and hopefully also with the OCA association during the OCA Café event.⁴²

Reflections:

The OCA MT could have pushed back more strongly on the urgency of defining a bottom line. We accepted this after repeated questioning. Creating more time would evidently have enabled wider consultation. The OCA MT opted for a wide consultation across OCA and with the movement, as opposed to more targeted and selective consultation with the Ops Platform and the relevant Head of Departments, for example. There is a tension between inclusive debate and targeted consultation when time is limited. In this case, arguably, the inclusiveness came at the expense of consulting those with actual and indirect responsibility (through the Operations Platform). In retrospect, this may have been the wrong choice. As an MT, we are responsible for ensuring we make the best decisions in the circumstances, or to organise ourselves in such a way that the best decisions can be taken. We felt that we had done that by organising the process in the manner that we in fact did. Bearing in mind the ensuing tensions and debate, we most regret not having identified a timely way of discussing these tensions after the MT decision.

This response has focused on responding to your concerns about the process up to and after the decision that was taken on the Myanmar bottom line. The decision itself we have also excluded from this response. But it should be reiterated that discussion on any aspect of this topic is welcomed by all of the OCA MT, and the upcoming session at the OCA Café on this topic we hope will provide further discussion and learning on this topic. Feel free to disseminate this letter if you so wish. I remain available to discuss any further matter with you, should you feel the need to do so.

On behalf of the OCA MT,
Arjan



My frustration with it is that it could have gone to the ops platform. The ops platform is where all the operational decisions go. It's where we have meetings every Wednesday with all the desks plus the emergency desk, the director of operations, the director of the public health or the medical department, and me. We discuss, we approve budgets for the missions, closures of mission. But it went straight to the management team. Pete Buth and I were not in the Management Team, we were in the ops platform. I felt: 'it's been taken to another place.' The mission supposedly requested a major decision in terms of how we were going to tactically fight this battle. It was not about: 'shall we stay in or leave Myanmar,' it was never about that. It was about: 'are we going to bargain the whole package or are we going to just take the piecemeal.' You had people in the ops platform that actually knew the mission. But they decided to take it to discuss in a forum of people that didn't know the mission... Ultimately, it was a tactical issue about how to go about this, a purely square operational issue? In the end it was made into a bigger issue and lit a different discussion. Then when I saw the MT letter, I got pissed off because for me it misrepresented what the discussion was. It was never about: some of us said, 'let's leave the country altogether' and some other people said, 'no, we have a responsibility for the patients, we need to stay.' I would have never been so irresponsible to say, 'let's leave the country.' No, I said, 'Let's go on and bargain hard.' So, I felt that the letter, which was widely circulated, was controlling a narrative and misrepresenting the issue: 'let me tell the entire organisation what the discussion is about.' When you frame it like that: "the MT had to make the decision whether to leave the country and abandon 30,000 patients..." Of course, people say: 'let's all stay!' Who would argue for abandoning the

42. The "OCA Café" is an associative event-debate organised by OCA bringing together all its heads of mission.

treatment of those people? And then there was another PR exercise. After the MT circulated the letter, they did a video conference with all the offices with India, with the whole OCA group to explain the situation. And in that, I publicly questioned Marcel. I said: 'Look guys, you have made the worst [choice] and it's not even correct.' And I went on. Nobody thought that I would say all this. But I said: 'Look, you guys you don't want to discuss it in the ops platform. But the only forum that I have available as an MSF member is this session ... Okay, well, I'll say everything here, voila!' So, Marcel was really angry at that point. Then I wrote a little paper.

Hernan del Valle, MSF OCA, Head of OSCAR (Operational Support in Communication Advocacy and Reflection) 2011-2016 (in English)



The decision was put in the hands of the management team. So, did we go to the ops platform after we made the decision and say: 'This is our provisional decision, what do you think?' No, but then I wouldn't expect an MT to do that. The correct order is we hosted several discussions in headquarters and there were discussions of the ops platform. The MT then took all those considerations and then came up with an opinion and a position.

Dr Sidney Wong, MSF OCA, Medical Director, 2013-2019 (in English)



One narrative is that it was between speaking out about being kicked out and not speaking out about being kicked out. My narrative was: are we willing to leverage our other programs to regain access or to confront the authorities? And speaking out may have been one strategy to do so. Many of those important nuances got lost in the very emotional, polarising discussion that followed. I disagreed with the MT's decision to not leverage our projects and to not speak out. I was fundamentally against that. And I wrote a letter to the MT. That was a very difficult period, less so because I accepted that the management had the responsibility to take a decision and they had reasons for that decision. I thought it was wrong, but I told Marcel at the time: 'I'm not going to resign over this because I accept it.' What I think was very frustrating for us was my perception at the time, that the management team failed to recognise how fractured we had become. The 'content' departments if you like, were fundamentally disagreeing about the decision, and a lot of people in the office that were also frustrated and that wasn't recognised by the MT. The way we perceived it was: 'there's a decision move on, end of story.' There was a lack of recognition that this discussion needed follow-up and needed leadership by the management team which I didn't see. That is what I tried to express in my letter. I felt it was typical of extreme utilitarian and pragmatic views of public advocacy that the Dutch have. And I felt frustrated that we feel our feelings were neglected afterwards by the MT. I myself became too emotionally engaged and I was very polarised.

Pete Buth, MSF OCA, Deputy Operational Director, 2012-2016 (in English)



There is a lot to be said about the process. But I think for that time, the real question is: "should we have just said: we don't make that decision now?" That would also be a bit odd because there was really the push on the MT, from the head of mission. The pulling out would have come with a loud statement, of course. That was a bit of a divide, and in the end, as MT, we decided not to do that, but instead to put everything into negotiations and lobbying. Some people think speaking out is a moral duty. I always try to keep morality out of these discussions, because it leads to nothing. But some people feel that that speaking out is the *raison d'être* of MSF, whilst others have a much more pragmatic approach. So, the

principles versus pragmatism. My answer is that there is always pragmatism but can also be very principled. Against pragmatism you should put dogmatism. I think dogmatism is actually what we suffer from too much, sometimes. It was very emotional, and divided. For instance, if I speak for myself, I had a good working relationship with Pete Buth, my deputy. He's a friend of mine, but we disagreed and we were not the only ones.

Marcel Langenbach, MSF OCA, Director of Operations, 2011-2019 (in English)



Within the coordination team, as tends to be the way with these things, there wasn't 100% percent kind of unity over what the right thing to do was. Where we did all agree was that in a way we wanted to not try and trade off the two patient groups against each other. We wanted to make decisions about the future of the mission on the basis of what was right in this situation in relation to Rakhine and not say 'we're going to put it all in the mix and say 'well, we'll stay because of the HIV cohort.' We just said: 'it's Rakhine we've been expelled from. That's what we want to focus on now.' And in a way we tried to put the other aspects of it out of our minds. There was disagreement over what was the right thing to do: was it to publicly condemn the expulsion, obviously drawing upon a lot of the testimony and experience we had gained over the last 20 years and say: 'this is the latest example of the Myanmar governments, attempts to annihilate the Rohingya people?' Or did we say: 'Right, we've crossed a line, we are the single most vocal and active NGO when it comes to the Rohingya with the biggest healthcare provider to the Rohingya people by far. Do we just recognise we've pushed it to the limits? We now need to pull back a bit and focus on regaining access.' There was a split in the country management team around that. The head of mission's people were strongly for speaking out. I was in the other camp and there were only two of us. I felt that we'd pushed it to the limits. Our expulsion demonstrated that. And actually, now was the time to focus on regaining access because once we had made that big splash, which would have lasted a few days, one or two days in the media, it would be over ... We would never ever get access again. I think largely the message that got communicated to Amsterdam was that the coordination team in Myanmar felt strongly that we should be speaking out. And the reason I say that is because when Marcel then came out and realised there was actually a divergence of opinion, he said: 'I hadn't heard that. I was told that the CMT was one and felt we need to speak out about this.'

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting as Head of Mission in February 2014 (in English)



Since 2012, when the Myanmar Coordination Team had this conversation the question was when the red lines are all crossed are we then going to say: 'we can't go because we have the HIV cohort' or do we say what we need to say and then see what the reaction is? We decided on that one. We even said: 'If there is a moment where we will have to prioritise the Rohingya issue, we'll have to speak out...'. Later on, the whole narrative was around 'because of the HIV cohorts, you stayed'. No, no, no, that is not the case. I really thought we had to deal with the Rohingya case on its own and then regardless of the ARV programmes. So, we shouldn't use the leverage and put it on the table at risk of losing 32,000 people on treatment. We were dealing with Rakhine the way we as an organisation should be dealing with Rakhine. And then whatever the impact is on the other things... It was more, in my opinion, about, 'do we speak out or not now we are being kicked out of Rakhine.' Are we now going to use all that information that we've built up after all these years,

all this frustration, all this moral anger that we have, outrage that we have, are we not going to use that by saying, 'world, this is what is happening?' Of course, we will be kicked out. But that's something I accept. And I don't think that the HIV cohorts should hold us back from that. The Global Fund will get other people, there are 32,000 people. The government will be accused of killing a lot of people. That was exactly what the discussion should have been but it didn't happen like that ... the discussion was: 'Shall we stay now that the letter has been withdrawn or shall we walk out because we think that being kicked out of Rakhine means we walk out of the whole country.' And my point was: 'Then, you speak out then you are being kicked out. That to me is a stronger element than walking out. I think walking out would be the weakest thing.' I didn't see any reason why we would. In a way we took the middle ground, which I've always been struggling with... which was: we stay and we will try to gain access in Rakhine...

Former MSF OCA Staff in Myanmar (in English)



When I was in the field [in 2013] we debated whether to speak out or not. We tried to make it clear that if we spoke out publicly that there was a risk of losing access. But people would answer: 'We want our stories to be heard.' The colleagues who were all really pro-speaking out where all my colleagues in Rakhine working with the Rohingya directly. People were really saying: 'When you see this and you experience it and you feel a human urge also, there's just no way you can be asked to stay publicly silent on this; it feels like the original MSF context, that classic case out of a textbook.'

Ingrid Johansen, MSF OCA, Programme Coordinator for East Rakhine, January 2013-January 2014, Member of MSF Holland Association, MSF Nordic Association and Representative of MSF Nordic to IGA in 2015 (in English)



Before the event, we had a country management meeting, and these were key questions that kept coming up: 'at what point do we say enough's enough. Stop!' Come on. We've got enough evidence to present to say these things are happening. We have the "Fatal Policy" document [from] over two years before which was not used. It is a great document. It displays those difficulties but using our medical data quite well in northern Rakhine state. We've been doing all of this work, but none of it is coming out.'

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of mission for Rakhine, September 2013-March 2015 (in English)



There was a period of time when the knowledge and our field presence gave us enough of an understanding of what happens to be able to speak out credibly about that. But once the teams were out, after the June 2012 violence, it became almost impossible to put them back in. So, we really lost our eyes and ears on the ground. Critically, over summer and then fall of 2012, we were not able to systematically collect data that we could probably use for témoignage. Over weeks, months, you no longer have the connection with what's really happening on the ground to be able to speak about it anymore and then you have to start speaking about the past ... it becomes too late. In OCA all the frustration was about: 'what happened here, let's at least explain to ourselves what happened' and 'let's speak out more.' By the time those conversations were really catching traction in Amsterdam, it was way too late to start actually speaking out. That ship had sailed. That was such a frustrating period of

time, first and foremost because we lost our access and just couldn't be there anymore. And then as an extension of that, we lost our ability to speak about it credibly anymore. In the follow-up months and even years after that, we just were unable to have any impact on the témoignage side of things, whatsoever because we said that to ourselves: 'We're just not gonna say anything because we are going to try to get access.' But then months go by, years go by and we have hardly any access ... there's been times since 2012 where we've had a bit more access but, it's a fraction of the access we had before 2012.

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English)

NEGOTIATIONS TO REGAIN ACCESS TO RAKHINE

In the days following the suspension of the programmes, in March 2014, the MSF Myanmar Deputy Head of Mission, Vickie Hawkins and the MSF OCA Operational Director, Marcel Langenbach began intensive negotiations at all levels with the authorities of the Union of Myanmar and of Rakhine state in order to obtain authorisation to reopen the programmes in Rakhine.

The head of mission, considered persona non grata by the authorities, did not participate to these negotiations.



So, then Marcel and I spent a week in Nay Pyi Taw, the capital. We really felt that having the HoM in those meetings was not a good idea. Even though it had been me who was on film and whatever, I was still deputy head of mission and wasn't the figure-head, as it were. Therefore, it was still felt that I wouldn't make Myanmar government officials lose face by being there. As in most South-east Asian cultures, keeping face is so extremely important. If you make people feel they've been embarrassed in any way, then it's over. It took a while to regain access and we knew that we were never going to get back to where we were in 2012, 2013.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting as Head of Mission in February 2014 (in English)



We made a choice not to bring the head of mission to our negotiation meetings. The authorities really didn't want to meet him. The authorities had the impression that we were always breaking the agreements we had made, that we still had the idea of public speaking that was hanging around, and that irritated them no end. It came up in our conversations, discreetly but it came up.

Dr Joanne Liu, MSF International, President 2013-2019 (in French)

On 3 March 2014, the director of the Rakhine health department declared that Rakhine authorities were ready to take over MSF programmes and that only an

accelerated transfer of these activities and definitive departure of MSF including all staff would put an end to community protests.

On 6 March 2014, a Myanmar government health official told the daily, "The Myanmar Times" that the closure of Médecins Sans Frontières operations in Rakhine State was "not permanent and would likely be rescinded in October or November."

The prospect of Myanmar's first census in thirty years, scheduled for 27 and 28 March, raised fears of renewed community tensions, particularly in Rakhine State.

The Rakhine state Emergency Coordination Centre (ECC), comprised of government officials and civil society leaders was officially established to oversee aid operations in the state. A "watch group" of civil society representatives was established in Sittwe to monitor INGO activities.

During this period, although MSF OCA refrained from proactively communicating with the media, comments about the ban on MSF from operating in Rakhine were all over the news.



"MSF Ban 'Temporary', Rakhine Officials Insist", *The Myanmar Times*, by Fiona Macgregor and Shwe Yee Saw Myint, 6 March 2014 (in English).

Extract:

Ministry of Health deputy director general Dr Soe Lwin Nyein told *The Myanmar Times* in Sittwe that MSF's expulsion from Rakhine State would not be permanent. However, he said he could not estimate the duration of the ban. Rakhine State Department of Health director Dr Aye Nyein said it would not likely be rescinded until October or November. He said fears that this month's census would prompt more communal violence had contributed to the decision to evict the organisation's staff. *The Myanmar Times* understands, however, that MSF has not been informed that the ban is temporary, or offered a date for a possible resumption of services:

The group has declined to comment publicly on the situation while negotiations continue but reports suggest MSF has been instructed to withdraw its staff from Rakhine as soon as possible. [...] UN agencies and major INGOs working in the region say local health organisations lack the facilities and human resources to replace the services provided by MSF. Patients in remote and rural areas, which aid organisations have been serving via mobile clinics, are said to be particularly vulnerable. Another key area of concern is the potential shortfall in treatments for the Rohingya Muslim population, many of whom face restrictions on movement that limit their access to the state health system.

A government statement released on March 2 indicated that the authorities would consider allowing MSF to resume operations in Rakhine if certain conditions, which were not specified, are met. [...] [Dr Soe Win Nyein] added the Ministry of Health was capable of managing the health needs of "the whole community" in Rakhine State, adding, "We don't need to lose any lives [because of the ban]." "The Ministry of Health is taking all the national health services to the community [including IDPs] ... the ministry is doing routine health services." Asked why MSF was being pressured by the state government to leave Rakhine immediately, Dr Aye Nyein said the government is "afraid" its staff could be targeted by Rakhine community groups if allows MSF to stay. [...] Dr Aye Nyein said the state government was also concerned about preventing "further social conflict at the

end of [this] month [when] we will start the census [and] we will be talking to both communities, Rakhine and Rohingya”.

While state and local authorities say all arrangements have been made for Myanmar's first census in 30 years, a number of observers have cautioned that the census, particularly its questions on race and religion, could inflame tensions in some parts of the country, particularly Rakhine State.

After the census is completed the state government “will have negotiations with both communities and [maybe] in October or November” MSF will be allowed to return.

Whether a temporary shutdown will be enough to satisfy hard-line Rakhine community leaders is unclear. Since the MSF closure was announced, a number of other INGOs and UN agencies in Rakhine State have been the target of online threats. Meanwhile, a “watch group” of civil society representatives has been established in Sittwe to monitor INGO activities. Asked if the banning of MSF would encourage activists to target other international aid organisations, Dr Aye Nyein said “depend[ed] on the activities of the organisation. They must have transparency about what they are doing for both communities.”



“Crisis **info Bulletin - Myanmar**” from Igor García Barbero, MSF OCA Communications Advisor to MSF Movement Communication Advisors, 9 March 2014 (in English), edited.

Extract:

It has been more than a week since our last public communication about the situation of MSF Holland in Myanmar. Many things remain unclear and many questions have been left unanswered. We know you have all been receiving many media requests. Our teams in the field are still in the process of high-level negotiations regarding getting access back to Rakhine State. When the outcome of these negotiations is a bit clearer, we might come forward with a comprehensive comms package. We have been working on it during recent days. Please keep on putting the journalists on hold or/and, as you have been already doing, forwarding some important requests directly to me.



It only took two or three days to reverse the expulsion from the country. But then we needed to work on getting again an MoU for Rakhine. My assumption was that our natural ally was the MoH, because of our long-term support to these malaria programmes etc. You get all sorts of dynamics between the state and the state ministers and the Union Government. But then it's also a matter of who actually has power. In the MoH, it was actually the deputy minister who had more power, more political support or better links than the minister at the time. During these negotiations there were dossiers of complaints of all sorts of authorities, including of the Ministry of Health. A lot of misplaced complaints would come back all the time about our medical quality, with a couple of incidents that had happened or that were perceived to have happened. A relatively small thing, if it goes through those mills can come back at all levels. I saw the file, and I said: 'Let us know what these accusations are, so then we can do something about it.'

Marcel Langenbach, MSF OCA, Director of Operations, 2011-2019 (in English)

In the meantime, the release of the report «From bad to worse: humanitarian crisis and segregation in Arakan», which had been rescheduled for 10 March, was cancelled again due to the uncertainties surrounding the future of MSF in Myanmar. In the end, the report would never be published.



We were prepared to organise these bilateral meetings with the government to present the report. But we got kicked out.

Former MSF OCA Staff Member in Myanmar (in English)



We were saying to ourselves: 'We've left, we've closed the door, we're not coming back. But who knows what's going on in the State when we're not there.' When you don't have operations on the ground, how can you really publish a report?

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)



Of course, there's nothing that escapes them, they've got their internal sources. So, they knew that we were working on a report. And who knows what actually led them to take that decision in February 2014? But certainly, the advocacy and testimony gathering that we had been doing over the years – not only the report – was cited during the meetings that Marcel and I had with government officials.

Vickie Hawkins, MSF OCA, Myanmar Deputy Head of Mission in charge of advocacy in Myanmar and of Rakhine programmes, May 2011-May 2014, Acting as Head of Mission in February 2014 (in English)

From 16 to 23 March 2014, the MSF International President, Joanne Liu sought to reopen dialogue with the Union of Myanmar authorities. She participated in an official visit of several sites in Rakhine as part of a high-level delegation made up of Union government officials, representatives of the UN, and INGOs.

On 24 March 2014, MSF OCA issued a press release acknowledging the resumption of “encouraging dialogue” but stated regrets that clinics were still closed and that state medical facilities were struggling to cope with the sudden influx of patients due to the suspension of MSF’s activities.



'MSF Acknowledging Encouraging Dialogue in Rakhine but Clinics Remained Closed, MSF OCA **Press Release, 24 March 2014 (in English).**

Extract:

Since Médecins Sans Frontières (MSF) Holland was ordered to suspend all activities in Rakhine State on February 26, the organisation has been engaged in high-level discussions with the Union Government of Myanmar on the need to maintain essential medical services for the many hundreds of thousands of vulnerable people in the state

currently facing a humanitarian medical crisis. MSF International President Dr Joanne Liu arrived in Myanmar on March 16 to participate in the discussions and was invited to take part in a recent high-level Union Government and joint UN INGO visit to Sittwe, Mrauk U and Minbya in Rakhine State. Dr Liu also met with the Minister of Home Affairs, the Minister of Health and the Deputy Minister of Border Affairs in Nay Pyi Taw.

"I have been encouraged by the open dialogue in the last few weeks on how MSF can work more closely with the Ministry of Health to deliver vital life-saving medical assistance to the people of Rakhine," Dr Liu said. "I was also able to have productive conversations with authorities and community leaders about working with them to improve mutual understanding and acceptance of MSF activities in the state, which remains a serious challenge."

Assistance to hardest reached communities

Prior to the suspension, MSF Holland provided medical services to a population of approximately 700,000 people, including almost 200,000 displaced people living in camps and isolated villages. More than 500 staff supported the provision of health services at over 30 sites in the state, including 24 camps for displaced people, treating anyone who was unable to access the medical attention they require. All MSF programmes are based on medical need alone and assist the most vulnerable people and hardest to reach communities. Based on consultation numbers for the last quarter of 2013, it is estimated that in the three weeks since the closure of MSF Holland's clinics, 25,000 consultations would have been carried out, including more than 5,300 for children under five years old. In addition, it is likely that an estimated 40 children would likely have been enrolled into feeding programmes for malnutrition; MSF Holland could have facilitated 223 emergency referrals; 1,471 pregnant women could have received antenatal care; and 1,500 family planning consultations have been missed.

Medical facilities struggling to cope

During her time in Rakhine, Dr Liu also visited several medical facilities struggling to cope with the sudden suspension of MSF Holland services. "MSF Holland was the largest and widest reaching INGO working in health in Rakhine and has been present for 20 years," Dr Liu said. "Over 100 of our medical staff, comprising doctors, nurses and midwives have now left the state, our activities remain suspended and all our clinics are closed. While the Ministry of Health has taken positive steps to try and fill the enormous gap created by the suspension, to replace a programme of this size and in this context is a considerable challenge. Many medical needs remain untreated." The focus of the ongoing high-level discussions is to restart medical activities, beginning with life-saving services such as emergency hospital referrals and ensuring that treatment for MSF's HIV and TB patients in Rakhine is not interrupted. "Even before the suspension of MSF Holland's activities, medical services in the townships where MSF was operating were not meeting the needs of all communities," Dr Liu said. "The scale of these needs is such that the contribution of MSF in collaboration with other actors, particularly the Ministry of Health, will be essential for the foreseeable future."

Rakhine a particular concern

With the rainy season approaching, any reduction in healthcare in Rakhine is of a particular concern and MSF Holland played a key role in previous responses to outbreaks of infectious diseases in the areas in which the organisation worked. "It is imperative that the next stage of discussions focuses on finalising concrete plans to address all the medical needs of vulnerable people in Rakhine," said Dr Liu. "We look forward to continuing a constructive dialogue with both Union and State authorities as well as local communities towards achieving this shared objective."



There weren't real negotiations; rather, it was an effort to reopen a channel for dialogue that would be constructive. It was completely "Asian-style". When we made a field visit to Rakhine, I missed the boat and had to make a long return trip by car with the government representatives. That gave me an opportunity to talk with them. They said, 'You must be Christian – North American of Chinese descent?' I answered, 'No, I grew up Buddhist.' From that moment on, their attitude changed completely. They stopped, to show me temples, they told me the history of the region, and so forth. The next morning, they organised a meeting with the Minister of Security and a representative of the 'angry monks,' whom we never thought we'd be able to talk to. At the end of the meeting, when everyone stood up, in the shuffle, the Minister of Security introduced me personally to the monk. I spoke to him informally. It was all very symbolic, but it was important that the other monks see that he was talking to me publicly. The issue was that people could see, publicly, that there was a rapprochement.

Dr Joanne Liu, MSF International, President, 2013-2019 (in English)



We had the quiet but serious support of very influential actors. There were negotiations with various ministers, particularly the most important. Joanne was from a Buddhist background and she played that card. We talked about that at great length because it was still a bit sensitive, but it was possible during bilateral meetings. We managed to turn the situation around and prevent the expulsion order from Myanmar and Rakhine; it was changed into a notice of suspension from just Rakhine State. First, we had to find a way to save face because we were dealing with Asia. Then we initiated a second series of negotiations in order to resume operations.

*Fabien Dubuet, MSF International HART, Representative to the UN, 2005-2020
(in French).*

On 26 and 27 March 2014, just before the census started and after accusing an expatriate from the Order of Malta of having lowered a Buddhist flag, Buddhist mobs attacked UN and INGO offices in Sittwe. The MSF OCG team was unable to reach the Sittwe airport to evacuate, so were forced to begin a two-day trip by land on difficult roads to Yangon.

Many organisations were forced to suspend their activities and partially evacuate their staff including what was left of MSF OCA's staff. As a result, humanitarian assistance in Rakhine, which already suffered from MSF OCA's suspension, was dramatically reduced.

In order to get information out in a context of threats and intimidation, the MSF OCA Myanmar communications team organised "backstage" informal briefings for its network of international journalists through INGOs, provided that sources were not mentioned in publications.

On 30 March 2014, the UN Secretary General called on the Myanmar government to ensure safety of humanitarian workers and the protection of all civilians in Rakhine.



“**Situation Report** Daily Sitrep Template Rakhine”, 26–30 March 2014 (in English)

Extract:

Context

On 26 March, Rakhine groups and members of the Organisation to Protect Race and Religion protested in Yangon against the Bangladeshi Embassy on 26 March in reaction to an article published in the *Dhaka Tribune* and calling for a referendum in Rakhine on whether to secede Sittwe/Maungdaw from Myanmar to join Chittagong division. Some monks threatened to resort to violence to protect Myanmar’s sovereignty. The government had already summoned the ambassador to provide an explanation for this article.

On 26 March, a crowd – estimated at between 300 and 400 according to OCHA – formed in front of Malteser’s office in Sittwe, after one of their expat staff allegedly took down a Buddhist flag (Sasana) (monks had called on Rakhine to fly Sasana flags at their homes/ on their vehicles to show commitment to protecting their religion and race and to signify opposition to the census/self-identification of Rohingyas). The crowd stoned their office and tried to enter their expats’ house as well as the premises of other INGOs in the neighbourhood before being dispersed by police.

The following day, on 27 March, the mobs became larger (by some accounts up to 500 people or more) and attacked, and in some occasions ransacked, other INGOs and UN premises. Humanitarian staff were escorted by the police to Sittwe Hotel, the airport and a police compound.

On 28 March the authorities confirmed the death of an 11-year-old girl, hit by a stray bullet fired by security forces to disperse mobs targeting WFP’s warehouse on 27 March. [...] Picture of the girl’s dead body was circulating on all Rakhine social media. There were no reports of any other injured. Some have been pointing out that security forces’ reaction to the attacks has been slow, and attacks seemed to be very organised and systematic as they destroyed almost all properties except for a few [...] but without anyone being injured.

On 29 March, the focus for community aggression turned towards authority buildings regarding the census – there was a protest against Immigration office in Sittwe at 10:30 – and also to INGO/UN based in Sittwe. There were reports that the Ward Administrator was attacked and beaten by the community in Mrauk U, he was evacuated to SGH [Sittwe general hospital].

While the mob attacks triggered large international and national media coverage, as well as condemnation from members of international community, there seems to have been little focus on the humanitarian consequences of the events for vulnerable populations in camps, isolated villages, and NRS too.

Officials reactions to the attacks from the international community included statements from the UN RC/HC, as well as from the US Embassy who denounced the “lack of adequate security forces and rule of law on the ground in Sittwe, and Rakhine State more broadly, to prevent the outbreak and spread of violence and to protect aid workers, their offices, and other vulnerable populations in the area”. The European Commission’s Department for International Cooperation and for Development also expressed concerns over the attacks. On 28 March, ACF put out a short statement in French on their website, while UNFPA also released a statement continuing to commit to the census despite the recent violence, highlighting though that census could only be carried out properly “if safety and security of enumerators and respondents is assured”. More critically, on 30 March, the UN SG urged the government to ensure safety of humanitarian workers,

stressing that impunity could not be tolerated and calling for the protection of all civilians and the full respect for the rule of law.



'Hundreds of Thousands of People Severely Affected by Disruption of Humanitarian Assistance in Rakhine State, Myanmar, OCHA **Press Release**,' 3 April 2014 (in English)

Extract:

A UN delegation led by the Resident and Humanitarian Coordinator for Myanmar Renata [Lok-] Dessallien and country heads of UN agencies returned from Sittwe today after visiting camps for Internally Displaced People (IDPs) and meeting with State and Union level authorities. "What happened in Sittwe last week was not just an attack on international organisations, but an attack on the entire humanitarian response in Rakhine State," said Ms [Lok-] Dessallien. [...] The immediate effect of the disruption of humanitarian services is already being felt in IDP camps and isolated villages in Rakhine State. This is the peak of the dry season and water availability could reach critical levels within a week in some IDP camps, particularly in Pauktaw. Nearly 15,000 children in IDP camps no longer have access to psycho-social support, while life-saving therapeutic treatment for more than 300 children with severe acute malnutrition in Sittwe has been suspended. [...]

Despite efforts by the Ministry of Health which deployed rapid response teams to Sittwe, only a small number of IDPs are receiving healthcare services. International NGOs normally provide an average of 400 emergency medical referrals to hospitals every month in Rakhine. "The health system in Rakhine had already been severely impacted by the suspension of MSF Holland in February, and now health services for most of the 140,000 displaced people in Rakhine and over 700,000 vulnerable people outside camps is severely hampered, particularly in terms of life-saving emergency medical referrals," said Dr Liviu Vedrasco, Health Cluster Coordinator for the World Health Organization in Myanmar. The violence on the 26 and 27 March, during which UN and NGO offices, living quarters, and warehouses were seriously damaged or looted, was the culmination of months of increasing intimidation and harassment of humanitarian staff and local suppliers by a vocal minority of the Rakhine community.



I was sitting in the house one night. I was briefing everybody on the new plans and then suddenly I could hear the violence going on in the streets. And that one little incident at Malteser sparked it off? No, I don't buy it at all. Then of course it moved from one house to the next. This violence against all the NGOs couldn't have been planned it any better. This was not random odds. This was all pre-planned. Quite literally, piles of stones were left only in certain areas of town, so they could go and pick them up and throw them. It was clear as day. Buses were brought in from outside with people who were then going to be the main front of the violence, obviously not towards people, but towards property, which was enough to push everybody out. I've no doubt it was instigated by a part of the government. This type of events would not spring up immediately.

Violence against the NGOs was absolute classic case of organised protest and demonstration. So, if they can do that, they can do the next. And of course, they declared a state of emergency at the same time and a midnight curfew. The army was sitting in the airport and they only came out five minutes to curfew to make sure everybody had gone to bed. They didn't come anywhere near while the violence was going on. And they let it all go ahead. The bits I could see clearly were staged. The Facebook connections in the country did help organise some

violent events. A lot of them were manufactured by Buddhist leaders. But this violence was always part of a much bigger strategy. I absolutely have no doubt. I stayed with a few expats and two or three key local staff. We thought: 'what's the point in going back to Yangon? We're suspended anyway. Everybody else has had all their facilities destroyed.' So, any communication move at that point wasn't even on our radar. It was more about daily survival.

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)



From headquarters point of view, they may have just taken the view that there is a possibility to get back in. But that didn't shut us up in the comms. We just had to go at it from a different angle. In March 2014, when the riots happened, all operations stops. So, you had 140,000 people in camps in Sittwe, not to mention the isolated people plus northern Rakhine state. And suddenly there was absolutely nothing. So yes, there were lots to communicate about and lots of outrage to be had. These riots affected every international organisation with all the INGO offices ransacked and warehouses looted. It almost created a real sense of fear and intimidation among all the other NGOs who were not that outspoken to begin with, but they were absolutely terrified following the riots. It was complete craziness. And at that stage we actually began to play more of a backstage convening process where we would utilise the relationships with international journalists.

We would organise background briefings with these journalists and then actually convinced the very timid heads of INGOs to sit in a room with them and provide non-attributable messaging on whatever was their particular concern. And then we would work with the journalist to coordinate how those messages got out so that there wasn't overlap. So that the editors wouldn't get this off that they weren't getting an exclusive, but also so that there wasn't an immediate line that could be traced back to who was providing the information. We played a coordinating role. It was incredibly important that we did it because if we didn't do it, they would never have done it. And it couldn't be MSF because MSF was suspended in Rakhine State. These 'unbranded' briefings naturally helped us get out the messaging that we were indirectly drawing on others, whether it be watsan, whether it be malnutrition rates, whether it be medications or whatever. It was an interesting challenge. That was a significant amount of pressure that from a communications point of view we were able to leverage in that situation.

Eddy McCall, MSF OCA /MSF OCG, Myanmar Communications Manager, April 2013-January 2015 (in English)



Considering the perception of Rakhine population towards humanitarian organisations and international organisations etc there you can really see that it was building up towards something happening. I had thought that it was going to happen over 27, 28 March 2014 because that was the date of the proposed census. Recognition of Rohingya people or not through the census was a major political stake at the time. So that was very much the reason for the disruption on those particular days. That was when there were the big riots in Sittwe. And all of the international organisations, UN, NGOs, etc in Sittwe were all evacuated. Essentially Sittwe was closed to externals. The MSF OCG team did a three-day evac-

uation by road from Mrauk U to Yangon because they couldn't access Sittwe and take the plane. And so that evacuation was the close of the project. We never got back in after that.

Brian Willett, MSF OCG, Project Coordinator in Rakhine State,
December 2013-September 2014 (in English)

MSF HOLLAND ASSOCIATION CRITICAL MOTION

Meanwhile, the debate continued within the MSF Holland association. On 24 May 2014, the MSF Holland general assembly tasked the MSF Holland board and its representatives in the OCA Council to clarify their “bottom-line decision” taken in February 2014.

The general assembly asked them to ensure that MSF's interventions in Myanmar were in line with MSF's core identity, fundamental principles, and to make every effort to resume meaningful programs in Rakhine using all means at its disposal. MSF OCA should include, if necessary, leveraging the organisation's significant presence in the Myanmar health sector and speaking out publicly on denial of access and the plight of the Rohingya, even if it meant expulsion from the country.

The executive was asked to report back to the members of the general assembly within three months. The report should include details on the progress made to regain access to the Rohingya in Rakhine and on the efforts to speak out publicly on: the suffering of this population; and their needs for assistance in line with the above considerations.



'MSF Holland General Assembly 24 May 2014 **Report**,' Approved by General Assembly 2015 (in English).

Extract:

Debate: '[Silent Diplomacy versus Operationality, the Myanmar case](#)' [...]

[What was the 'bottom-line' in the decision as made?](#)

- We will not walk out of Myanmar proactively OR
- We want to protect access to our patients/projects?

[Wilna van Aartsen \[MSF Holland President\]](#): Protect our access to all our patients; these are the 30,000 HIV patients – and we do believe that, once having left the country as a whole, it is far more difficult to regain access again to Rakhine State and the patients over there.

[Arjan Hehenkamp \[MSF OCA General Director\]](#), clarifying the MTs decision: As MT we have asked ourselves the question, “Can we continue our other projects without being able to work in Rakhine?” And the answer was that we can, but we cannot imagine leaving without talking/speaking about it. Those were the two issues considering the bottom-line. [...]

[Tarak Bach Baouab](#), Dep. Advocacy & Operational Communications (OSCAR), gives a further introduction to the debate topic of today.

[MSF Purpose & Identity](#):

Purpose [...]

“The overall purpose of MSF is to preserve life and alleviate suffering while protecting human dignity and seeking to restore the ability of people to make their own decisions.”

Identity

- Accomplished through provision of medical aid & commitment to act as witness to events surrounding populations in danger
- Two inseparable elements are combined: medical aid and witnessing. We're both medical and humanitarian. [...]

Considering Myanmar: we started in this country addressing the needs of the Rohingya population. In a later phase we have developed other (HIV) projects in other parts of the country; the needs of these HIV patients are not questioned but the fact is that, in these HIV projects, we were working hand-in-hand with a government which was (still is) oppressing at the same time the Rohingya population.

When it comes to choices of how to speak out on the situation of the Rohingya (silent diplomacy or public communication) Tarak thinks the bottom line decision already pre-empts certain tactical choices on communication. He acknowledges that there are many shades of grey between silent diplomacy and publicly speaking out.[...]

Lauren [Cooney] clarifies that none of the choices on how to speak out in Myanmar were guided by our wish to protect our projects in other parts of the country; choices were made on what we see as the strongest way to get access to Rakhine again.

Debates in smaller group discussion on three sets of questions with a plenary session afterwards. Request to identify critical points, tensions, frustrations, and where we need more answers or investigation.

Question 1

- Are we trading global humanitarian principles (independence, impartiality) in favour of MSF operational principles (access, proximity) in Myanmar?
- Is this choice necessary in this context at this time?
- What are the potential implications of this situation for our identity in Myanmar and beyond?

Question 2

- What are the risks to our identity of MSF's self-imposed 'silent diplomacy' in Myanmar?
- By not taking a firm position publicly, do we give away too much too early in not only Myanmar but in other contexts where our perception could be equally affected?

Question 3

- Does our role in Myanmar render us de facto complicit with a government engaged in a programme of systematic denial of basic human rights, including access to health care?
- Can this compromise be reconciled with our organisational identity?
- When does it become a compromise too far? [...]

10. Member motions and voting on these motions

The following member motions have been submitted. The voting is by raising of ballot paper.

Member motion 1 | on Myanmar

Motion authors and presenters:

Joe Belliveau, Pim de Graaf, Ingrid Johansen, Leslie Lefkow, Kate Mackintosh, Hanna Nolan, Wouter van Empelen

Motion text

The members of the GA of MSF Holland request the MSF Holland Board and its representatives in the OCA Council:

- To clarify the 'bottom line decision'

- To ensure that MSF's interventions in Myanmar are in line with MSF's core identity and fundamental principles and continue to press to resume meaningful programmes in Rakhine with all means at its disposal, including, if necessary:
 - leveraging its significant presence in the Myanmar health sector; and
 - speaking out publicly about its denied access and the plight of the Rohingya, even if doing so risks MSF being expelled from the country;
- to report back, within three months, to the members of the GA on the progress made to regain access to the Rohingya in Rakhine and on the efforts to speak out about the suffering of this population and their need to receive assistance in line with the above considerations.

The GA votes in favour of this motion.



“MSF Holland Board **Response to the Association** on the Myanmar Motion of May 24,” Amsterdam, 29 July 2014 (in English).

Extract:

The MSF Holland Board stands with the association in acknowledging that MSF will do everything within its means and capacity to ensure that the plight of the Rohingya in Rakhine State is not ignored, as such persecuted group of people are at the heart of MSF social mission. The MSF Holland Board would like to reassure the members that this has been our concern from the onset of MSF's expulsion from Rakhine State and even prior to this.

The MSF Holland Board has no doubt of the Executive's commitment to uphold the principles that guide our mission and our work for all those in need of our assistance in Myanmar.

The MSF Holland Board notes that the bullet points starting with “leveraging ...” and “speaking out ...” define operational tactics. We would like to note that, in the typical MSF set-up with an associative and an Executive, it is the role of the Executive to make operational decisions and the Board's role is to hold them accountable. Therefore, decisions about operational tactics lie with the Executive.

Furthermore, this motion comes from the MSF Holland members, and is addressed to the MSF Holland Board and its representatives in the OCA Council. According to the MSF Governance structure, the OCA Council is responsible for safeguarding MSF's social mission, and is therefore the proper platform to discuss operational issues. In line with this, prior to the passing of the motion at the GA, the MSF Holland Board engaged in a reflection on choices and dilemmas faced by the Executive.

The MSF Holland Board thereafter proactively communicated with the OCA Council regarding the Executive's negotiation strategy in Myanmar, and requested a risk assessment and contingency scenarios, as demonstrated by the MSF Holland contribution to the OCA C dated 9 April 2014. Since the MSF Holland Board sees speaking out as a possible identity issue, this has been explicitly included in the MSF Holland contribution and subsequent discussions.

Moving forward, and in keeping with the Myanmar motion, the MSF Holland Board will take the following steps:

- The MSF Holland Board will continue to engage with the OCA Council and the OCA MT in order to ensure that full humanitarian access to the Rohingya people is being sought in line with MSF's identity and principles.
- The MSF Holland representation on the OCA Council will consider seeking OCA Council advice to request the OCA MT to:
 - clarify the bottom line and how this might evolve in the future, [...]

- keeps the OCA Council informed about the evolution of the negotiation strategy aimed at regaining a meaningful presence in Rakhine State,
- develops a risk analysis and contingency plan for the possible event that MSF will no longer be able to remain in Myanmar, be that as a result of speaking out publicly or for any other reason.



It is not that we thought we had more brains, that we had higher principles or a higher morality. There are a few crucial sentences in the letter of the management team on their bottom-line decision, which say they weighed it all up and they decided that in the end, they weren't going to risk the rest of the programmes, which was a huge ARV cohort that we had. But in the face of a population that was facing the ultimate threat to life, the genocide, our question was: did we strike the right balance? How did we strike that balance and how do you weigh these things up and how do you make sure that you have weighed all these considerations when you take such an important decision not to speak out? Therefore, with that motion debated at the general assembly, we asked the management team to look at how they had struck that balance and how they took the decision. There were strong, strong voices who thought very differently. So, you would have thought that the decision should have been much more debated, particularly with the associative, which had no role in it. It was just confronted with it after the decision was taken.

Hana Nolan, MSF Holland, Head of Humanitarian Affairs Department 1994-2003 then MSF Holland Board Member then MSF Holland Associative Member (in English)



In the association, there was a strong feeling that we had just been all the way through the history of the Rohingya-Rakhine experience, too willing to shut up for the sake of trying to have access. When we had large-scale programmes, massive medical impact in Rakhine and across the country, it wasn't enough to not say anything but we also weren't going to just go out and publicly denounce the government either. So we were just working with that balance. When we lost all of that presence and all of that ability to be relevant medically, we lost our connection to the data. But also that balance changes. And it was in that moment of loss of access and the pressure that we were receiving from the Buddhist communities in Rakhine State and the government ... when we should have been much more vocal and using the presence that we'd just recently and the data that we had to describe that situation.

That's where we didn't get the balance right. Once you lose your access, what are you going to say ... you can speak out about your own access. Our témoignage should be rooted in the experience of the people we are trying to help, but when you lose that connection [...] That dilemma existed before 2014 and before 2012 and it was part of the constant debate around témoignage. We had a very strong anchor in the country. We knew that the Ministry of Health, in particular, depended on MSF and really valued what MSF was bringing. And we knew that it would have been difficult for the government to just kick us out of all those programmes. On the other hand, even if not a junta it was still a military-dominated government that would not have appreciated MSF's presence the way that the Ministry of Health would. So we knew there were divisions within. So I always felt a little bit more towards we could use the legitimacy and the presence that we built up in the country to push the boundaries a bit more rather than remaining so quiet, so silent. I wouldn't say there was unanimous disagreement with the management team decision but rather unanimous discomfort. We were questioning "hey, where are the lines here?" I was in the conversation with some association members, Kate Mackintosh, Wouter van Empelen, Leslie Lefkow ... a bunch of us were crafting a motion

together. I was on the Board so I was trying to not influence it too much but I was very interested so I was in that conversation ...

Joe Belliveau, MSF OCA, Myanmar Operations Manager, 2007-2012; MSF Holland, Board Member, 2013-2016 (in English)



The point of this motion was really: 'Hang on a minute! This is a massive identity issue that has been at the centre of MSF Holland operations for more than a decade and suddenly there's this huge decision taken and there has not been enough discussion about this. This is not okay. Maybe that was the right decision. But it can't happen in that way.'

Kate Mackintosh, MSF OCA, HAD International Humanitarian Law advisor, 2003-2007; Head of HAD, 2007-2011; Member of MSF Holland Association (in English)

At the end of April 2014, the Rakhine state Emergency Coordination Committee continually insisted that MSF was expelled from Rakhine and should leave. Meanwhile, the Ministry of Health initiated MSF OCA's re-registration process with a letter of recommendation.

On 22 May 2014, the MSF OCA operational platform decided not to submit any MoU that did not include Rakhine. MSF OCA issued a series of prerequisites (bottom-lines) for resuming activities including requests for integration of MoH staff with MSF staff.

These MSF OCA prerequisites included:

- **A minimum relevant level of medical activity with an active presence in northern Rakhine**
- **MSF inpatient (Myanmarese from outside of Rakhine) medical staff making up at least half the team**
- **MSF identification as MSF workers working with the MoH**
- **Long-term remote management is not accepted**
- **Permanent presence of expats in Sittwe and Maungdaw, in contact with and establishment of a working relationship with the MSF medical teams at the MoH**
- **Acceptance of armed escorts to / from camp locations and camp clinics**
- **No armed presence in the clinics**
- **Government commitment to inform the ECC of MSF activities in order to avoid accusations of 'secret activities'**

In case defined minimum activities did not materialise by the end of May, MSF would consider resorting to a more visible, higher, public profile strategy. The

impact on other projects outside Rakhine would not be given priority in the decision-making process.



'MSF OCA Management Team Meeting **Minutes**,' 22 May 2014 (in English).

Extract:

Update Myanmar

Since the OCA could only work in integrated teams with MoH, the risk of not regaining access to independent work was often expressed. In order to avoid a long-lasting dependence of the MoH, bottom lines were set up during a discussion on the OCA Ops Platform on 30 April. These imply the following requests and statements: As the government still requires a re-registration/MoU, the OCA Ops Platform decided not to accept to submit MoU that does not include Rakhine.

A Minimum Relevant Medical Activity – integrated MoH has to be endorsed until 31 May:

This includes an active presence in NRS, meaning that mobile clinics at minimum 2x/week Maungdaw South, emergency referrals, support to HIV patients.

MSF inpatient medical staff has to make up at least half the team

MSF protocols, or jointly agreed MoH protocols, MSF medical supply need to be endorsed. Although activity as above only in NRS is bottom line, Ops will push to start in Pauktaw clinic and emergency referrals in ERS, however will accept.

Regarding the Presence of Expats, the OCA Ops Platform decided on a deadline for 31 July:

- Long-term remote management won't be accepted
- A permanent presence of expats in STW [Sittwe] and MDG [Maungdaw], with contact and working relationship with MSF medical teams in MoH RRT [Rapid Response Teams] will be demanded
- Acceptance short-term of no expats present in medical activities
- TAs [Travel Authorisations] or 'unofficial' acceptance required to allow expats

Further bottom lines agreed upon are the following:

Identity: MSF staff will remain low profile, however will self-identify (as required) as MSF employees/MDs [Medical Doctors] working with the MoH as part of the RRT. We will not hide or just claim we are part of the RRT

Security: Acceptance of armed escorts to/from clinic/camp locations. No armed presence in clinics

Communication/Transparency on MSF Activities: Government commitment that ECC made aware of MSF activities. Thereby, avoidance of accusations of 'secret activities' being used as excuse for further violence

Public Communication Strategy: Prior to 31 May deadline remains as currently is – unless significant change, Post-31 May – to be further defined: NB concern about non-Rakhine projects will not be primary consideration for decisions

In case deadlines and demands are ignored by authorities, the only possibility left shout or withdrawal.

In June 2014, after weeks of negotiations, MSF OCG finally declined the Rakhine authorities' proposal to work in Rakhine without expatriates.

Despite the suspension of activities, MSF maintained a small team of expatriates in Rakhine who organised a few authorised activities. These included activities were carried out by integrated MSF local staff and Ministry of Health's medical teams.

In June and July 2014, MSF OCA managed to work with the MoH in Rakhine villages, then gradually, in a few displaced camps under police escort.

Despite this satisfactory collaboration with the MoH's teams, MSF OCA struggled to negotiate more access with the representatives of the Rakhine communities. These communities now had a say in any decision regarding INGO status and activities.

In addition to the ECC created in March 2014, the MSF OCA teams had to negotiate with various groups of Rakhine elders, who interfered at operational levels.

The INGO Watch Group created in March 2014 that was very influential in Rakhine, began spreading false allegations and threats on social media.



“Shrinking Humanitarian Space in Rakhine: 9 June 14” MSF OCA **Memo**, 9 June 2014 (in English).

Extract:

This document provides a summary of some of the challenges that are currently faced by INGOs in Rakhine.

ECC

Many agencies are experiencing problems with the lack of openness and honesty in the decision-making by the ECC. At times, approvals for activities are given without the due consultation with the relevant partners, authorities and community involvement which leads to confusion and lack of trust of the RSG/ECC and more importantly the agency concerned. This is contrary to the role of the ECC in playing a facilitative role to ensure timely and effective humanitarian assistance. The ECC is compiling information that has been provided on movement plans and is starting to bilaterally criticise the time spent in one community compared to the time spent in another one.

Unofficial external controls

There is increasing interference by the elders and other groups at the operational level. INGO are being requested to have activities confirmed (not coordinated) by both the ECC and the newly founded INGO Watch Group. This has become a very influential group in Rakhine. They use social networks to spread false allegations and directly threaten agencies. On 7 June, on the NGO Watch Team in Rakhine Facebook the following statement was made (unofficial translation):

UN and INGOs only want to help Bengalis. It can be assumed that as long as UN and INGOs have the attitude of doing whatever they like to Rakhine in accomplice with authorities, Rakhine will continue to respond harshly. It is required that ECC handles UN/INGOs systematically and strictly. NGO Watch Team will share any information received with the public. It should be known to UN and INGOs that information received will be shared with the whole Rakhine public and agencies that cannot be accepted will be driven out conclusively with campaigns. All the leaders of Rakhine Social Network have decided that in case of a direct clash with the government, all possible means will be used to face the government.

The State Ministry Officer in Sittwe responsible of WASH [water, sanitation and hygiene] activities is refusing to provide support to WASH Cluster without official approval of

project by ECC, even if project has been formerly validated by RSG and the NAI PYI TAW Line Ministry. INGOs are now being requested to introduce the project to ECC detailing the amount of money allocated per community for ECC to validate the project and thus give the authority to line minister to provide support to agency. INGOs are being regularly challenged to show their MoU and TAs by community members who have no official standing and who clearly feel that are able to act aggressively.

Inability to conduct assessments

One INGO was conducting a needs assessment to prepare for a proposal for work for the Rakhine Buddhist population. Subsequently it was reported that they were trying to take back inputs from previous work done and that they could not be trusted! This appears to be a malicious rumour to cause difficulties and create community distrust. This is with a community that the INGO could have relationships with.

Health in Rakhine

MSF have only been allowed a very limited return to their activities, and the health needs in specific places previously covered by MSF have not been picked up by either MoH or other actors. This is both in ERS as well as NRS. Malteser has so far not been allowed to resume its medical activities in ERS.

Logistical challenges

While the ECC has been established to facilitate humanitarian action one INGO seems close to losing their office. The location had been previous approved by the Rakhine Security Minister and the Deputy Minister of Border Affairs from NAI PYI TAW. The NGOs' use of their office has been revoked, ostensibly due 'to community unrest' and for being 10–15 metres outside the Southern Zone. The agency has been unable to confirm the existence of community unrest and has not received any negative feedback in this respect from the neighbours. This indicates that the Union Government, with whom trust has been placed, is not ensuring that its own decisions are respected. Landowners and car rental owners are constantly threatened through social networks for renting to UN/ INGOs. Suppliers in markets are reluctant to supply INGOs in camps and always try not being seen working with INGOs.

Interruption to service provision in camps

Camp administrators and camp committees are requesting INGOs to rotate staff on monthly base and want to impose specific persons to be recruited. The 'community leaders' keep refusing to let INGO staff work as long as INGOs refuse to change their team and rotate them monthly. Local authorities and the ECC are failing to solve this issue and as a result there is interruption in the delivery of life-saving and essential services.

Constant threats and harassment of humanitarian actors

In addition to constant requests to INGOs to prove their legal validation to work, there is harassment of national staff and threats made towards suppliers, and premises and cars owners. National staff are receiving night calls with requests for weekly reports and activity reports from the ECC Elders or their subsidiaries which is intimidating.



“Rakhine Strategy Proposed As Of 14/12/2014 & **Context Document** on Resumption of Activities, Myanmar Mission (V8) Post September 8th, 2014” MSF OCA, 14 December 2014 (in English).


Extract:

Medical Activities in Rakhine


June 2014: National Staff (2 x MDs) working in Buthidaung and Maungdaw hospital to support ART/HIV

June 2014: 8 MSF (NS) Medical Staff in RRTs [Rapid Response Team] under MoH coordination. In the first 2 months (June/July) working in Rakhine villages only, then 1 team to Rakhine villages and 1 to Pauktaw IDP camps and Aung Mingalar. Police escort still present on PKT clinics.

June 2014: Informal referrals in NRS ongoing since June (MSF payment for transport and hospital costs), approximately 30–40 per month.

 *In Maungdaw, expats were gone and the Medco was there, dealing with medical issues with the medical team. Another national staff member was trying to deal the security part with the authorities. Staff was reduced. At Sittwe level, Simon Tyler was the one dealing with authorities. He came once a month, and gave an update, telling us that we still had hope. And even when he was not able to come, he would send a message. Then there was an agreement. The MoH was to provide 2 people, they made distribution ... The TMO said that we could have people to the hospital to treat them. Once the people went to the hospital, little by little we expanded.*

R, MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (in English)

 *We tried to negotiate returning to Rakhine. There was the famous meeting in the garden of a hotel in Sittwe. There were 12 people around the table: the MoH, the army, everyone was there and in particular the equivalent of the minister of defence who was practically the administrator for the entire Rakhine State. They'd done their homework. They told us very calmly: 'You can start up again but with no expats because we can't guarantee their safety...' Then they added: 'It's not the right time to come back, the community is extremely angry with MSF. But you'll be the first ones we call tomorrow if there's an emergency, a measles epidemic, floods...' A programme without expats, that was a deal breaker. Our national personnel were essentially relocated. And they'd received harsh threats from the community because they were helping Rohingyas, so that wasn't going to work. And neither did we, unlike OCA, have experienced personnel who could have managed the programmes. It was the kind of place where you absolutely needed expats to protect the national personnel. And we weren't going to put up with being manipulated in this way. So, after thinking about it a bit we finally said, 'Okay, we won't go ahead.' So, MSF Holland kept on trying to gain access to Rakhine while we gave up. But I still haven't made my peace with this decision. As a head of mission, that's my biggest regret. That meeting is still quite traumatic for me.*

Liesbeth Aelbrecht, MSF OCG, Head of Mission in Myanmar, January 2013-January 2015 (in English)

Intense lobbying and international pressure from diplomatic missions and donors as well as high level UN visits to Rakhine kept the situation in Myanmar on the media agenda. In this context, MSF OCA continued to negotiate with the Myanmar authorities at all levels while briefing journalists. They were supported by the MSF International HART and the MSF International President, Joanne Liu, who met regularly with the Myanmar ambassador in Geneva.

In May 2014, on the side-lines of the World Health Assembly, the MSF International president again met with Myanmar's Minister of Health. In June 2014, Dr Liu sent a

letter to the Myanmar government expressing dissatisfaction with the continued ban on MSF activities in Rakhine.

In early July 2014, the MSF OCA director of operations and the Myanmar programme manager met several high-level stakeholders in the USA. The US noted that while all their interlocutors were well aware of the situation, none of them had the slightest idea on how to reinstate humanitarian access to Rakhine.



'Message from Igor García Barbero, MSF OCA Communication Advisor to MSF Movement Communication Advisors,' 24 May 2014 (in English).

Extract:

The aim of this internal communication is to clarify the current position of MSF and provide some guidelines on how to deal with journalists, given that you may receive requests, particularly as the situation continues to attract attention with high-profile journalists and outlets covering the issue (see below), the rainy season approaching and ongoing high-level diplomatic visits to the country. [...]

Strategy

MSF continues to engage in negotiations with the Myanmar authorities with the objective of restoring vital medical humanitarian assistance to those in need in Rakhine. [...] At the moment the strategy to regain meaningful access in Rakhine includes significant advocacy efforts with various actors both in and outside the country as well as targeted media interaction on a background briefing basis. These briefings with key media are being conducted with our designated spokespeople only, and are strictly off the record but given on the basis that the information we provide may be used in the resulting stories without direct attribution. Keeping media attention on Rakhine is a positive measure in our overall strategy to restore our activities, but on a background/off the record basis only, i.e., information or quotes are not attributed to MSF.

At this point in time, other than the statements below, public MSF-branded communications is not considered supportive of operational objectives e.g. on-the-record interviews with MSF spokespeople, or press statements. This strategy is under constant review and may change at any time. We will keep you informed of any shift regarding media outreach on the issue. [...]

What to do with external articles containing MSF messaging?

You might have seen some of the external articles above include messaging regarding MSF. While we consider these articles very relevant for our efforts, the current position is not to promote them proactively with our social media channels or websites in order to avoid being identified/suspected as the facilitator of the story. But if people from trusted high-profile media or key organisations approach us for information, we encourage these kinds of links to be distributed.

What about social media guidelines?

As stated above, please do not post any external articles via MSF social media channels. Please also do not retweet or share. Myanmar-related materials (MSF-related or not), or tweet or post personal opinions on the issue from MSF accounts. In short, silence on social media for now is the strategy.



“There Is a Kind of Hush” **Op-ed, Nicholas Kristof, *The New York Times***, Sittwe, Myanmar, 4 June 2014 (in English).

Extract:

Buddhists are renowned for peacefulness, yet, here in Myanmar, Buddhist monks have marched through the streets, demanding the expulsion of humanitarian workers who would try to save the lives of Muslims. Obama and Aung San Suu Kyi will probably flinch as they read this, protesting that Myanmar is infinitely complicated. True. Muslims have also killed Buddhists in clashes, and no country should be judged solely based on its worst side. Yet, this spring, the Myanmar government doubled down on its repression by essentially cutting off one million Rohingya from access to doctors, leaving them, in some cases, to die unattended. This is grotesque, and some scholars think it approaches genocide.

I wish Obama and Aung San Suu Kyi could have sat down with Noor Begum, an emaciated 37-year-old woman who is confined to an internment camp without doctors and over the course of three days lost her husband and her twin babies. She doesn't really know what killed them; all she knows is that first one baby died, then her husband and, finally, the other twin. [...] What's at stake is ultimately Myanmar itself. The army is powerful but has allowed murderous ethnic clashes and attacks on aid groups, undermining the economy and fuelling ethnic nationalism on all sides. In the absence of schools, Wahhabi madrassas are popping up ominously in closed camps. The role of Aung San Suu Kyi is particularly sad. She has lost international stature because of her unwillingness to speak truth to her people, while at home many voters object that she is insufficiently chauvinist. [...] Myanmar is advancing in many directions, and it's exciting to see the political and economic transformation. But there's also a poison spreading, and Western governments do no one any good by pretending not to notice.



'**Message** from Fabien Dubuet, MSF International HART, Representative to the UN to MSF OCA and OCG Myanmar Operational Managers and Advisors and MSF HART,' 5 June 2014 (in English).

Extract:

FYI

I received a phone call this morning from [high level of UN] about this piece [Nicholas Xtof Op-ed]. I think it was to enquire (complain?) between the lines on whether this was based on discussions with MSF... :-). I was very frank with [him] that 3 months after our suspension and despite nice words by the authorities, there had been very little progress for us in terms of resumption of operations in Rakhine and that frustration was growing internally with even colleagues and people in our leadership advocating now 'to pull the plug', especially as we have many other emergencies around the world. I mentioned the recent 'frank' meeting between Joanne and the Minister of Health on the margins of the WHA [World Health Assembly] in Geneva. We also discussed the situation of our detained staff (interestingly, [he] enquired about his situation before I even had the time to raise the topic). He committed to redouble efforts on both fronts (activities in Rakhine and [detained staff]) and agreed that despite the right narrative by the Union government, their goodwill had not translated into practice or with "the right speed".



'MSF OCA Operational Platform **Minutes**,' 23 July 2014 (in English).

Extract:

All Ops Day Wednesday, 23 July 2014 [...]

Lauren Cooney [Myanmar Programme Manager] gave an update about the Myanmar situation and her visit together with Marcel Langenbach [Director of Operations] to the US.

In May we reached a moment of reflecting the situation. Particularly at the field level there was some progress forward. We had reasons to believe that things were moving forward in terms of gaining access to Rakhine. We received our re-registration in Myanmar, following the cancellation of the registration in February this year. Unfortunately, we remain without an MoU with the Ministry of Health. Our access and ability to work in Rakhine remain limited and we are also not seeing an improvement of humanitarian assistance after the violence in March.

In June we were discussing our options and a visit of MSF's International President, Joanne Liu to Myanmar. She sent a letter to the government expressing her dissatisfaction about the current situation.

We agreed to do a final round of meetings in the US targeting the US government and relevant organisations and the diplomatic community. We were able to have some high-level meetings. Most of the people we met were up to date, but it seems that nobody really knows what to do with humanitarian access as a whole. It was clear from those meetings that messages were getting through to Myanmar, the field got meetings cancelled referring to these international meetings. The UN and diplomatic community have been invited to a meeting with the government to discuss MSF and the access to Rakhine. We heard through sources that humanitarian workers, including MSF, can return to Rakhine. We will need to discuss the MoU and the details around Rakhine.



When I came back from Myanmar, I debriefed with the country's ambassador in Switzerland. I realised that his discussion points were identical to ours. I called the Myanmar team and said to them, 'You've got a mole inside your organisation. The ambassador and I had the same list of discussion points!' The Myanmar team had drafted the points and then we reviewed them in Geneva. The ambassador was not at all confrontational. We said we'd meet with the Minister of Health on the side-lines of the World Health Assembly. We did that in May and the negotiations continued. It was clear that HIV weighed heavily in the balance. We were polite, but we held to our position: we're staying in Rakhine. I followed the matter for a long time. Having some history with a health minister gave me a different status, which was an asset. I finished every meeting, without exception, talking about our concern for our detained staff member⁴³. This always led to a small clash when the meeting ended. It threw them off balance. They didn't expect that such a pompous organisation would show that kind of interest for one of its employees. It wasn't trivial because it put us in a vulnerable position each time. At the same time, it gave us a more human face, greater humility. They saw the incongruity of the situation. They heard and responded, 'Yes, we'll follow up on that.'

Dr Joanne Liu, MSF International, President 2013-2019 (in English)

43. In 2015, the last detained MSF OCA staff member was released.

LABORIOUS RESUMPTION OF MINIMAL ACTIVITIES IN RAKHINE

On 27 June 2014, MSF OCA received a signed registration document from the Ministry of Health for its programmes in Myanmar. However, they still awaited a signed, official Memorandum of Understanding.



'MSF OCA **Operational Bulletin**,' 30 June 2014 (in English)

Extract:

Myanmar: We received on Friday our re-registration in Myanmar, following the cancellation of registration in February this year. Unfortunately, we remain without an MoU with the Ministry of Health, which will be next process. Our access and ability to work in Rakhine remains severely limited, effectively only providing care for some of our cohort of HIV/TB patients in NRS. The whole medical humanitarian situation in Rakhine remains extremely worrying, especially concerning the access of all the humanitarian actors working in the area.

On 24 July 2014, during a press conference, the spokesperson for the Myanmar president's office, called on all INGOs to *"join hands with (them), especially MSF."* He added that Myanmar would guarantee the safety of MSF's staff in Rakhine.

Several state media confirmed that the Rakhine state government and the Union of Myanmar Ministry of Health encouraged INGOs, including MSF to *"participate in implementing the Rakhine Action Plan effectively at Union and state levels."* This plan was established after a meeting of ECC members with diplomats, UN agencies, INGOs, state government, and civil society organisations in late June. This led to an agreement regarding needs to increase development initiatives, mostly in the health and education sectors of Rakhine State. A member of the ECC stated that, *"MSF would need to win the hearts and minds of the state's majority ethnic Rakhine population if it wanted to resume operations in the state."*

On the same day, MSF OCA published a reactive communication announcing that it hoped to continue constructive discussions with the Ministry of Health.

On 25 July 2014, in a somewhat similar statement, MSF OCA declared *"we welcome the offer to resume operations in Rakhine,"* and was *"cautiously optimistic.* This statement was aimed at preparing the ground for a new round of negotiations. It was shared with all sections of the MSF movement with instruction *"not to push it proactively."* As a result, it did not receive significant coverage in international media.



“Holding Hands in Rakhine/Sobriety/Dr Malaria: Myanmar Invites MSF Back to Crisis-Gripped Rakhine”, **Message** from MSF OCA Myanmar Communication Manager, Eddy McCall to MSF OCA & MSF OCG Teams in Charge of Myanmar, 24 July 2014, 2:52 PM (MyM Time) (in English).

Extract:

Rakhine/Myanmar wants doctors group back [MSF MENTION]
Importance: High

Hi all,

Champagne popping on the international media scene with AFP getting some particularly unusual comments from U Soe Thein about holding hands together and errors ... while AP are more cautious and also mostly on holiday. Irrawaddy kept the cork in the bottle and takes a more sober look at things ... and the challenges ahead. MM Times were sloppy and therefore got there first. Reuters still to come with a focus on NRS, as with the kickback in Rakhine and folks realising this may just be positive-PR ballet prior to the visiting UN SR [Special Representative] press conference soon and Kerry's [US State Secretary] visit in a few weeks ... there's more in the pipeline that will no doubt drop overnight ... Tomorrow's national newspapers will be full of this and a gauge of a potential national kickback as well ... particularly on U Soe Thein's quotes... Don't mean to dampen the party but while I'm an optimist, I'm also a realist and this is rather surreal. Anyway, let's hope for the best in terms of actual operational outcomes.

FYI, the media frenzy was started by the second-last two articles below in today's state-run *New Light of Myanmar* regarding the invitation to return to Rakhine for “the MSF”, which were also printed in the Myanmar language state media newspapers and apparently the announcement was also made on state TV last night. Then a UN Agency/ diplomatic briefing this morning turned out to be more of a press conference for a select few media outlets and a couple of drop-ins.

- Myanmar invites MSF back to crisis-gripped Rakhine/Myanmar wants doctors group back [MSF mention] (2407 AFP)
- Arakan [Rakhine] Govt softens stance toward MSF [MSF mention] (2407 Irrawaddy)
- MSF invited back to Rakhine State [MSF mention] (2407 MM Times)
- Troubled Myanmar state invites back aid groups [MSF mention] (2407 AP)
- MoH calls for continued participation of international organisations in Rakhine State [MSF mention] (2407 New Light)
- Rakhine State Government announcement (1/2014) [MSF mention] (2407 New Light)
- Myanmar stepping up efforts to contain drug-resistant malaria (2307 Eleven) [...]

TITLE: Arakan [Rakhine] Govt Softens Stance Toward MSF [MSF mention] SOURCE: LAWI WENG/THE IRRAWADDY

DATE: Thursday, July 24, 2014

YANGON – The Arakan [Rakhine] State government and Burma's Ministry of Health have encouraged international humanitarian organizations—including the previously maligned Medecins Sans Frontieres—to work in the troubled state, where 140,000 internally displaced persons (IDPs) live in increasingly dire conditions after interreligious violence broke out more than two years ago. The Ministry of Health said in a statement printed in state media on Thursday that the assistance of international organizations would contribute to the stability and development of Arakan State. The Arakan State government said in the statement that “our government would like to invite all organizations, as well as other UN agencies and including MSF, to participate in implementing the Rakhine Action Plan effectively at Union and state levels,” referring to

a recently issued plan that covers development in the health and education sectors of Burma's second-poorest state.

The statements mark a notable improvement in at least the public stance of state and Union-level officials toward MSF, which faced a barrage of government criticism earlier this year and has been barred from operating in Arakan State. Members of Arakan State's Emergency Coordination Center met with diplomats, UN agencies, international nongovernmental organizations, state government officials, civil society organizations and representatives from the Myanmar Peace Center in late June. The meeting addressed how to improve humanitarian aid delivery and relief efforts, with the parties also agreeing to put an emphasis on development issues impacting the state.

The ECC, comprised of government officials and civil society leaders, was set up in March to oversee aid operations in the state. [...] Than Tun, who is a member of the ECC and a community leader in Sittwe, said MSF would need to win the hearts and minds of the state's majority ethnic Arakanese population if it wanted to resume operations there. "Arakan people did not like MSF. To let it come back, this depends only on our people," he said, adding that the Arakanese [Rakhine] would welcome any organizations working in the region, but only if they provided humanitarian aid in an impartial way.



"Myanmar Statement: MSF Welcomes Offer to Resume Operations in Rakhine, Myanmar but Remains Cautious," **Message** from Igor García Barbero, MSF OCA Communication Advisor to MSF Movement Communication Advisors, 25 July 2014 (in English).

Extract:

You may have seen some media reports on the offer made by the authorities of Myanmar to allow MSF have access in Rakhine State, where we were forced to halt our activities last February. [...] We are putting out a statement to welcome this step [...], but at the same time we remain cautious and alert about how these words will transform into a soon resumption of our activities in the Rakhine State. This decision/communication is affecting OCA. OCG officially closed its operations in Rakhine in June (this information is internal). We don't want you to pitch proactively media for interviews. However, shall there be very relevant requests, please contact me. There will be only headquarters spokespeople. We are not encouraging an active use of social media. [...]

MSF welcomes offer to resume operations in Rakhine, Myanmar but remains cautious
Amsterdam, 25 July 2014 – Médecins Sans Frontières/Doctors Without Borders (MSF) welcomes the announcement by the Union Government of Myanmar and the Rakhine State Government that MSF will be allowed to resume operations in Rakhine State, after it was forced to halt medical activities in February. "MSF is cautiously optimistic about this development," said Marcel Langenbach, Director of Operations for MSF in Amsterdam. "Given that for many people in Rakhine access to medical services remains a major challenge, we hope that MSF can restart treating patients as soon as possible. We believe it is critical that the Government allows humanitarian aid agencies to have unfettered access to ensure people can receive medical care," added Langenbach. "We understand that this is a sensitive environment, particularly with regard to inter-communal tensions. This makes it all the more important that independent international organisations can play their role in treating those most vulnerable."

MSF has been working in Rakhine since 1994, and until the suspension was the largest non-governmental medical provider in the state. Since the suspension in February, MSF has been in ongoing dialogue with the Union and State authorities. "We remain eager to

resume activities throughout Rakhine State and have a team of national and international staff ready to provide medical care immediately,” Langenbach said. Prior to February this year, MSF provided medical services in 24 camps for displaced people and in isolated villages across Rakhine. In 2013 alone, our doctors and community health workers performed more than 400,000 consultations in Rakhine addressing HIV, tuberculosis, malnutrition, malaria, antenatal and postnatal care and mental health.



'MSF OCA Operational Platform Meeting **Minutes**,' 30 July 2014 (in English).

Extract:

Myanmar: [...] The statement did not get a broad coverage in international media, given that we requested the movement not to push it proactively, the timing was bad (Friday) and the content was not radically different to our reactive line. The objective of the statement was to prepare the ground for a new round of negotiations with the authorities rather than creating a lot of noise.

In early August 2014, when the July announcements were slow to materialise and ahead of the US Secretary of State, John Kerry's visit to Myanmar, MSF OCA decided to mobilise the leading US and international media on the situation in Rakhine.



'MSF OCA **Operational Bulletin**,' 1 August 2014 (in English).

Extract:

Myanmar: Yesterday we received two travel authorisations for expat staff to go to Maungdaw in Rakhine. However, we have yet to have formal meetings with the authorities to negotiate the return of MSF, following the invitation of the Government last week. US Secretary of State John Kerry, is anticipated to be travelling to Myanmar on 9/10 August. MSF is looking at public communications in advance of this visit in order to highlight the concerns of the humanitarian situation in Rakhine and to clarify the most current status of MSF.



'Myanmar – Media Strategy on Rakhine, **Message** from Igor García Barbero, MSF OCA Communication Advisor to MSF Movement Communication Advisors,' 7 August 2014 (in English).

Extract:

As announced [...], MSF is giving a few interviews to targeted top tier US and international media regarding the situation in Rakhine State, Myanmar. This is the first time MSF gives interviews on the record on this topic since we were ordered to stop our operations in Rakhine on February this year. As most of you know, MSF has been engaging the Myanmar authorities to resume activities in Rakhine in the past five months. However, the recent positive announcements have not yet translated into facts.

Interviews

The interviews will be held with *Wall Street Journal*, AP, Reuters and will take place today. This communication initiative coincides with the visit to Myanmar of the US Secretary of State, John Kerry. Kerry is scheduled to arrive in the country on Saturday 9 to attend a series of gatherings including the ASEAN Regional Forum and East Asia Summit ministerial talks.

Reactive lines to be shared

Some reactive lines with key messages will be shared with the network later today, so you can feed media approaching you following the publication of the interviews/articles in the above mentioned media outlets.

Follow-up interviews

We are cautious about giving too many interviews in this initial phase.

The outcomes of this strategy will be carefully reviewed in the coming days.

Shall you have requests for interviews from relevant media, please don't hesitate to contact me.

Social media guidelines

We don't encourage to use MSF-branded social media channels to spread the links of the interviews once they are published, but we encourage to use your private accounts (Facebook, Twitter...) to do it. [...]

Communication Initiative Framework (CIF)

WHY

Since Médecins Sans Frontières (MSF)/Doctors Without Borders was forced to stop activities in Rakhine State in February 2014, there have not been significant advances to resume large-scale operations. The Government of Myanmar has done little to facilitate the resumption of our operations. The recent public announcement on July 24 to invite MSF to work again in Rakhine has not yet translated in any concrete measure to remove the obstacles we face to operate.

OBJECTIVE

Leverage

- We look forward to influencing international stakeholders to put the humanitarian situation in Rakhine in their agenda. The comms initiative coincides with a visit to Myanmar by the US Secretary of State, John Kerry. [...]

TO WHOM

General public, foreign governments, humanitarian community, Myanmar authorities...

In June 2014, MSF OCA conducted a third exploratory mission in Thailand and Malaysia.

The mid-August 2014 assessment report, as compared to the prior exploratory mission, showed exploding numbers of Rohingya refugees and healthcare needs. Concurrently, access to healthcare became more problematic so, the MSF OCA operational platform decided to open a mission in Malaysia.

Given Malaysia's influence in the region, a cautious and strategic advocacy in favour of unregistered refugees was to be integral to the intervention.



'Malaysia Explo III – June 2014 – **Executive Summary** MSF OCA' (in English).

Extract:

In 2013, the team concluded with a weak recommendation to intervene in Malaysia. Now, fourteen months later, we strongly recommend an intervention. The team has upgraded last year's weak recommendation for an intervention to a strong recommendation. This is based on:

- The number of refugees is increasing exponentially
- Their circumstances are deteriorating; arrests and barriers for accessing care are up
- The capacity of existing actors has been overwhelmed by the increased numbers
- All actors we talked to agreed that MSF medical capacity and experience is needed

[...] MSF Intervention

We recommend that an intervention start with two fixed clinics in the NE of the country; one in Penang State, the other in Kedah. These would focus on MCHC but would provide all basic PHC services, supplemented with M&E [Monitoring and Evaluation], outreach and health education services. With good negotiation skills, it should be possible to get access to new arrivals who are detained by authorities to provide medical care within hours of arriving. There is currently a window of opportunity that could, conceivably, enable MSF to start sending mobile clinics into detention centres within eighteen months (this is very fast). Within a year or two, it could be possible to have built enough trust and confidence that MSF could be told about new arrivals who have not been found by the authorities (the vast majority) and provide healthcare and shelter to them within days of arrival.

By the end of the second year we would expect the clinics to have expanded to include TB and HIV screening (for referral to existing care options), full sexual and reproductive health services. Other services such as EPI should have been debated and decided upon. The success of the mission will hinge on the quality of the expat staff. It is essential that they have experience working in Asia, have great networking and interpersonal skills, are proactive in building relationships, understand that MSF is 'a small fish in a big pond' here, have lots of patience and can think and work with a long-term vision and foresight. This is not an emergency, but it is a crisis; a crisis that has been slowly building for years into a complex and convoluted situation. Any response to such a crisis must adjust to this speed – 'quick fixes' and 'rapid responses' will not work here. The intervention will need to start small and act slowly. Results will be seen within a few months but they will be minor. Major results won't be seen for 24–36 months. MSF will need to plan for a three- to five-year presence as a minimum. Luckily, this presence does not need to be huge and should cost much less than a normal emergency response intervention.

On 8 September 2014, after months of negotiations hampered by the ECC and the elders of the Rakhine Community, MSF OCA and the Myanmar Ministry of Health finally signed a Memorandum of Understanding which established a framework for MSF OCA medical activities in Myanmar, including in Rakhine state.

On 9 September 2014, MSF OCA publicly declared it was "*committed to fully develop this agreement and stands ready in cooperation with the MoH to resume operations in Rakhine at any time.*"



'Project Progress **Report**,' 31 August 2014 (in English).

Extract:

- September 8: Signing of MoU

A small expat team based out of the Sittwe Hotel has had permanent presence in Sittwe. By the end of July the last of our premises (medical warehouse) were emptied and handed back to the owner. International organisations, including MSF, have been given access to the empty Technical College in Sittwe as storage location. For MSF this has included a small room that functions as an office for the remaining MSF Staff. After signing of the MoU there is a proposal on the table to the SHD and RSG [Rakhine State Government] for restart of some activities in ERS; a much smaller volume of activities, integrated into the RRT under management of SHD.

[...] 4. Requested adaptation and justification

The project has had to continually adjust to the enforced changes by the suspension and ongoing negotiations with the MoH and Union/RSG governments about our restart of medical activities.



“MYANMAR – MSF Holland Signs an Agreement to Work in Myanmar which includes Rakhine State”, **Message** from Igor García Barbero, MSF OCA Communication Advisor to MSF Movement Communication Advisors,' 9 September 2014 (in English).

Extract:

Médecins Sans Frontières Holland signed yesterday a Memorandum of Understanding with the Ministry of Health of Myanmar. This agreement establishes a framework for our medical activities across the country, including Rakhine State. [...] The signing of the MoU is a positive development but this document has yet to be translated into facts. The news has already made into some national media in Myanmar. [...] Please don't push this information to your media, but should you get requests, please don't hesitate to contact me. We are channelling all responses from Yangon and Amsterdam at the moment.



“MSF Signs New Work Agreement with Government, Eyes Rakhine Return”, **The Myanmar Times**, Tim MC Laughlin,' 12 September 2014 (in English).

Extract:

“MSF is committed to fully develop this agreement and stands ready in cooperation with the MoH to resume operations in Rakhine at any time,” the group said in a September 9 statement. “We hope this measure translates into an early resumption of our activities in Rakhine and provides the opportunity to engage with the communities on the ground.” MSF was invited to return to the state in late July, five months after it was abruptly forced to shutter its operations there.[...] During ASEAN meetings in Nay Pyi Taw last month, Minister for Information U Ye Htut, a spokesperson for the President's Office, said MSF had made some “mistakes in the past”, including failing to be transparent about its activities, and it was the responsibility of MSF to “find a solution to run their operation smoothly in Rakhine State”.

In the months that followed, the MSF OCA Myanmar teams continued to struggle to effectively relaunch activities in Rakhine State, particularly in the north.

Negotiations were obstructed by the representatives of the Rakhine communities, despite efforts to resolve problems of perception through dialog.



'Daily Situation Report, MSF OCA,' 22 September 2014 (in English).

Extract:

Context

On 19 September, MSF requested to meet with the Chief Minister (CM) on advice from the Min of Sec (SM) but mainly to follow up on the MoU signing and the next steps for full engagement in Rakhine. This meeting was preceded by a briefing from U Maw Hein (General Administration Director). He confirmed to MSF that elders would be present and to let them have their say, they might get emotional but do not worry as we have the support of the RSG/Union government. National media was present and covered the whole meeting which was later broadcast nationally. Mixed messages in the meeting and not wholly positive, detailed in the recent minutes. The media reporting has been mixed since, with some very neutral (and accurate) articles to the more extreme posts on Facebook which continue the lies that are spread about. [...] Either way, this was the first step in the process to restarting in Rakhine as requested by RSG/CM.



'MSF OCA Operational Platform Meeting Minutes,' 8 October 2014 (in English).

Extract:

Myanmar: We have reached an agreement with the State Health Director on the proposal for our activities in Rakhine. Next step will be a presentation to a small part of the ECC, followed by one to the broader ECC (which includes the Rakhine elders who are hostile to MSF).



'MSF OCA Operational Platform Meeting Minutes,' 29 October 2014 (in English).

Extract:

Myanmar: On Monday, the team was able to meet with officials of Rakhine State and ECC to present their plans to restart operations. The Rakhine elders, who are openly opposed to MSF returning to Rakhine, were not present at the meeting. Following the meeting, anti-MSF OCA speech began again on social media outlets, reminding the population that the government welcomed MSF back and not them. We are not sure how this is going to play out, however remain hopeful for an official restart of MSF operations in Rakhine in the coming weeks.



'MSF OCA Operational Platform Meeting **Minutes**,' 19 November 2014 (in English).

Extract:

Myanmar: The team had a positive meeting with the Minister of Health on Monday, and is hoping that we can deploy teams in NRS next week. We are engaging in preparatory work accordingly. Tensions in Sittwe against international actors are beginning to rise, especially after the visit of Ban Ki Moon [UN Secretary General] who referred openly to the "Rohingya". There have now been threats to forcibly remove all UN agencies from Rakhine unless there is a formal apology. We have 4 international staff on the ground in Rakhine now.



'MSF OCA Operational Platform Meeting **Minutes**,' 3 December 2014 (in English).

Extract:

Myanmar: In Rakhine, we're experiencing another delay in terms of starting in Maungdaw South with a demand that we go back to the ECC for another meeting, because the elders did not attend the last meeting and therefore did not have a chance to respond to our proposal for return. We have requested that this ECC meeting is scheduled by the end of the week. We have further stated that we will need to review our ongoing activities in support of the MoH in the absence of being able to restart in Rakhine. Given the ongoing access blockages, a review of the strategy is required before the end of the year.



We established a very good relationship with the MoH for the region. And we really did have a very strong connection. We did everything they wanted, with every step. We invited all members of Rakhine community at a conference where we discussed how we would like to restart activities and they were going to give us feedback. It was everybody's drinking tea and eating cake. It was a lovely event, but it still didn't mean they were quite ready to go. Then I got to the point where enough was enough and in a message to Amsterdam and Yangon I said: 'Come on guys, here's our cut off. This is it. I know we've had a few red lines, but we always made reasons why we can extend. I'm done. I've done everything we can do. I've bent over backwards. I've even sat in a room with the accusations from a Rakhine elder pointed at me with files like this on our 'malpractice.' I remember they briefed me before I went to him. They said: 'Look Simon, you've got to just take it on the chin. Just don't stand up and fight. Cause if you do, it'll go wrong. You're left with no place to go, you're gone.' Afterwards we then started the dialogue to re-engage. I went through a hell of a pretty hard time. The MoH were strong allies and stronger towards the end. I won't quite say we had that with anybody else.

Simon Tyler, MSF OCA, Emergency Coordinator and Deputy Head of Mission for Rakhine, September 2013-March 2015 (in English)



We resumed very small. At the beginning we were allowed one team composed of one doctor and one nurse. We had to submit the plan every morning and a MoH guy would accompany the team. So we started with one medical team, one person from the MoH

and three from MSF. Then we advocate saying that it was not enough, we should increase and very gradually we expand our activities.

R, MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (in English)

In mid-December 2014, MSF OCA began to question if they should continue to compromise to ensure a presence in Rakhine. A public communication strategy was prepared for mid-January, in the event that authorisation to restart activities was not forthcoming. The message focused on the lack of progress since the 9 September MoU signatures.

A reactive line was prepared to answer the recurring question from the media: How will MSF circumvent the fact that the Rakhine community is opposed to their return? Efforts were also made to strengthen and widen the scope of the content in routine communications to the Myanmar public by highlighting achievements in other parts of the country.

Eventually, in January 2015, MSF OCA resumed activities in Rakhine and issued a press release welcoming the progress made so far, but stressed that there was space to do more and that MSF was willing and ready.



'MSF OCA Operational Platform Meeting **Minutes**,' 10 December 2014 (in English).

Extract:

Myanmar: After 9 months of trying, we are about to conclude that the GoUM will not give us permission to return to NRS. Pending one last push this week, we will prepare public communications denouncing the denial of access.



"Rakhine **Strategy** Proposed as of 14/12/2014 & **Context Document** on Resumption of Activities, Myanmar Mission (V8) Post September 8th, 2014", MSF OCA, 14 December 2014 (in English).

Extract:

Updated strategy 14/12/2014 [...]

There is an identified 'deadline' of 14/01/15 where we expect to have the minimum activities working in MGD south. We can consider the action points for scenario 2 below if this has not been realised. This will be followed by a communications release (16/01/15). [...] Considering that 2015 is an election year, there is a high probability that there will be no major decision taken by any Ministry/Authority that could be seen as contentious or "rock the boat". This can also be seen by ASSK silence on the Rakhine issue as it would undermine her delicate position she holds now in the political environment in Myanmar. The prognosis is not good for 2015 with little hope for any change in the status of MSF beyond where we presently are at this time with or without a few mobile clinics promised in MGD south. The last question to be answered is do we continue to compromise to ensure we have presence in Rakhine (especially NRS). By providing 2–3 million euros to manage 3 mobile clinics per day and treat a cohort of 400 patients who are not even

acknowledged as MSF managed patients or to our standards, is this considered acceptable to ensure that presence is maintained? [...]

Communication and Transparency on MSF activities

Develop Communication strategy in addressing the perception issues. (Different state level authorities have highlighted a need for MSF to recognise past misunderstandings/ mistakes, and explain way of working for the future.)

- November 2014: Not necessarily a strategy but during October and November, planned activities have been openly shared to RSG, ECC (less the Elders), CSOs, all health partners and also into the public domain.

Develop (communication) mechanisms in engaging with community as well as ECC, and other groups.

- December 2014: An area which requires follow up but was delayed until other steps had been achieved as it was clear no one would meet MSF until we had the support of the RSG/ECC/MoH. A possible follow up after final discussion with CM after 12/12 remains an option.

Continue background briefings (proactively), as the announcement can be misinterpreted as a full/quick resolution. Both other actors as well as media need to be/remain aware of the reality.

- December 2014: The messaging now focuses on the fact that since 09/09 (MoU) there has been no progress at all. The MoH wants MSF to stay, we are working with them but this will only confuse the issue. MSF is to consistently state that RRT/HIV is not progress and is not an indication of MSF working again.

Address RSG and ECC on their intention to implement the Rakhine Action Plan and attempt to have an understanding of what this is

- December 2014: MSF has decided not to engage in this discussion forum as deemed too political. Will solely focus on health needs, gaps remaining since suspension etc.

Public Communication Strategy

Develop a reactive line on the question (repeatedly asked by national media) how MSF will deal with the fact that the Rakhine community is opposed to their return. Attempt to widen the communication scope by highlighting achievements in other parts of the country.

- December 2014: Partly addressed in other Q&A/Reactive lines produced especially around World Aids Day.

Need to give regular operational update as we move through this process (how? To who? Is public communication the only option?)

- December 2014: Routinely done by HoM to donors, diplomatic community and other relevant agency heads. No formal public communication though since MoU signing.
- December 2014: Need to provide a proactive communication line if MSF is to withdraw resources supporting RRT/HIV/Referrals in Rakhine. This does not mean withdrawal of the organisation but this is clearly one of the scenarios that needs to be planned for if a withdrawal happens.



'MSF Restarts Basic Medical Activities in Parts of Myanmar's Rakhine State, MSF OCA **Press Release**,' 20 January 2015 (in English).

Extract:

Tens of thousands of people in Myanmar's Rakhine State are able to access basic health care and emergency referral from medical humanitarian organisation Doctors Without Borders/Médecins Sans Frontières (MSF) for the first time in over nine months. Following instructions to MSF Holland to cease activities last February, these primary health clinics

restarted on 17 December 2014. MSF Holland has worked in Rakhine State since 1992 to provide basic healthcare, reproductive care, emergency referrals, and tuberculosis and HIV care. MSF has also treated over 1.2 million malaria patients in the state since 2004. All medical services have been provided based purely on the severity of individuals' medical need.

"We welcome the progress we have made so far, but stress there is space to do more, space we at MSF are willing and able to fill," said [...], MSF Myanmar Operational Advisor in Amsterdam. "We hope to continue this dialogue with the authorities to ensure that those who need it most in Rakhine state are able to access the health care they need," [she] added. Since restarting primary health clinics four weeks ago, MSF has conducted more than 3,480 outpatient consultations, seeing predominately people with watery diarrhoea, respiratory infections, and patients with chronic conditions who used to get the medications they need to manage their disease from MSF Holland before those services were suspended. The organisation has also done more than 550 consultations with pregnant women in this short period.

Despite being required to suspend activities in Rakhine last February by the authorities, MSF Holland has been working with the Ministry of Health in Rakhine since last July, providing medicine and personnel to support mobile primary health care teams in Sittwe and Pauktaw Townships, and has continued its support of HIV patients in Buthidaung and Maungdaw. Throughout this period MSF also continued to provide direct care and treatment to more than 35,000 HIV/AIDS patients, and more than 3,000 tuberculosis patients, most of whom are also HIV positive, across Myanmar.



After the decision of the MT, we were initially sort of a facilitator, a logistic service provider of the Ministry of Health, by supplying vehicles, cars. Then we managed to add on a staff and expand activities in the central part of the state. We continued to ask for permission to go back to the northern part of the state. We prepared press releases and plans to stop our activities at a certain date if we would not get access. We were basically ready to pull the plug. Then we received permission to go back to Maungdaw South. Several weeks afterwards, we made a very simple press release, just out of public accountability with a very dry message, where we said: 'MSF has regained access, we are very happy that we have access in Maungdaw South.' We have started to do our clinics, again, but we wanted to test the waters just to see what would happen, what would be the reactions on Facebook. There was one reaction only which said something in the line like: 'Well, we still don't want you but due to the international pressure, we have no way of stopping you.' Then I thought: 'Well it's good. Then we know where we stand.'

MSF OCA Emergency Coordinator in Rakhine, Myanmar, November 2012-April 2013 and June 2013, then from December 2014 MSF OCA Operational Advisor also for Myanmar (in English)

EPILOGUE

On 30 May 2015, considering that the 2014 Myanmar motion was not acted upon by the MSF Holland board of directors, the MSF Holland general assembly voted on a new motion. Essentially, it was calling for "an independent and comprehensive review of MSF's strategy vis-a-vis the Rohingya in Myanmar over the last 5 years"

through a *“transparent decision-making process. An open debate on the findings is to be organised.”*

This similar motion was previously passed by the MSF Nordic association, which brings together members of the MSF Norway and Sweden associations. Further attempts to put the motion on the agendas of the MSF OCB and the MSF international general assemblies failed.

In September 2015, the topic was discussed during the OCA Café session with all the mission heads in Amsterdam.



“MSF Norway 2015 General Assembly” **Minutes** (in English).

Extract:

We request that témoignage remain at the core of our operations and urge the IGA to adopt a strong position on the ongoing humanitarian crisis in which the Rohingya population is living under in Rakhine State. Further we request an international and public, relevant and well-coordinated advocacy campaign be launched in order to highlight the plight of the population and to advocate for a change.



MSF Holland General Assembly 30 May 2015 **Report**, Approved by the MSF Holland General Assembly 2016 (in English).

Extract:

10. Member motion | MSF’s Humanitarian Principles in Myanmar [...]

Motion text:

The members of the MSF Holland Association request the MSF Holland Board and its representatives on the OCA Council to:

1. Ensure that an independent and comprehensive review is commissioned of MSF’s strategy vis-à-vis the Rohingya in Myanmar over the last 5 years. This review should:
 - Describe and reflect on the choices made by MSF about how best to assist the Rohingya population in the face of ongoing abuses against them;
 - Include specific consideration of how MSF used its voice and public positioning to this end;
 - Make recommendations for a possible future advocacy strategy and course of action.
2. Ensure a transparent decision-making process and organise an open debate on the findings of the review.

Approve: 174 Do not approve: 6 Total:180 Abstain: 85

GA 2015 decision: Member motion on MSF’s Humanitarian Principles in Myanmar has been approved.



Nothing happened and we were getting quite annoyed. So, in 2015 we said: ‘It’s so crucial to the history of MSF, to our identity and our humanitarian principles. We should then call for not an evaluation, but just a review of how we made that balance

between speaking out and operational presence in Myanmar in the past 10 years. What criteria were we using? How were these decisions made?’

Hana Nolan, MSF Holland, Head of Humanitarian Affairs Department 1994-2003, then MSF Holland Board Member then MSF Holland Associative Member (in English)



I had given up on Holland. I'm a member of MSF Sweden and had a lot of Swedish colleagues who had been in Rakhine. The communications department in Norway were still very angry because they weren't allowed to put the Rohingya crisis on the list of neglected and forgotten crisis. So, in 2015, we put forward a motion on speaking out in the Nordic General Assembly, which gather MSF Norway and MSF Sweden associations. It was saying 'let's call for a review just to keep the debate alive and to make sure we look back at how we did it in order to learn for the future and to have another method.' After the Nordic General Assembly, I sent the motion to the motions committee at the IGA. They came back saying that we can't talk about a specific context where there is only one OC involved. I argued that the whole movement had basically delegated the whole responsibility of Myanmar to OCA. But they turned it down. The motion also went to the OCB gathering. The OCB general director said: 'I see this issue and I would like to get involved but I can't because this is OCA and this is politics.'

Ingrid Johansen, MSF OCA, Programme Coordinator for East Rakhine, January 2013-January 2014, Member of MSF Holland Association, MSF Nordic Association and Representative of MSF Nordic to IGA in 2015 (in English)

In August 2017, an unprecedented wave of violence engulfed Rakhine which led to the massacre of thousands of Rohingya and the exodus of more than 700,000 people to Bangladesh. [V11](#) [V12](#)



My family came to Bangladesh with a group of people from the village. They had to leave the area because Rakhine people and the military started to burn the villages. They ran out on the hill next to our village where they stayed for eleven days. There were some old or sick people who couldn't get onto the hill. Some of them were paralysed. They stayed inside the houses and couldn't go out when military burnt the houses down. There were 22 people from our area. My wife's sister in law and three kids of her were killed by the military on the spot. They shot at five of them. Three of them were minors, under five years. My wife too could have been killed but she was hid and the military couldn't see her.

Z, MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (translated from Rohingya in English)



In August 25 the situation took shape in a massive way. We were hearing that everywhere in Rakhine military was going to make a raid in every household, looking for young children, young male persons, taking them away and killing them. On 29 August, in our village we noticed that more than 1,000 military were coming from south side and they were burning houses. Out of fear of being killed we got together, the whole village, and we left. There was a hill just next to our village we took shelter on the hill because we knew that mil-

itary will not go on the top of the hill. We stayed there for two nights with only a few blankets. We were sleeping in the mud. After two days, suddenly we heard some blast sound. They were throwing some grenades towards the hill and helicopters were throwing the rocket launchers. We left the hill in the evening because there was no military patrol. We came to the closest area to cross the border. We witnessed eight Rohingya being shot by Myanmar military, who accused them of being ARSA [Arakan Rohingya Salvation Army]⁴⁴ members. We left the area, we took shelter again on a hill and in the evening we buried them and we left the area to cross the border. I was holding my kids in both hands. I can still remember my son was telling me 'I don't want to leave the country.' We came here to Bangladesh. We got food and water from the community... at least we got a place to stay.

S, MSF OCA in Myanmar Staff Member, fled to Bangladesh in 2017 (translated from Rohingya in English)

On 14 December 2017, MSF issued a press release estimating that at least 6,700 Rohingya were killed during the attacks in Myanmar during the month between 25 August and 24 September 2017. [V13](#) 

This figure was based on surveys conducted by MSF OCA and MSF OCP teams in Bangladeshi refugee camps.



“MSF surveys estimate that at least 6,700 Rohingya were killed during the attacks in Myanmar” MSF International **Press Release**, 14 December 2017 (in English, in French).

Surveys conducted by MSF in refugee settlement camps in Bangladesh estimate that at least 9,000 Rohingya died in Myanmar, in Rakhine state, between 25 August and 24 September. As 71.7% of the reported deaths were caused by violence, at least **6,700** Rohingya, in the most conservative estimations, are estimated to have been killed, including at least **730** children below the age of 5 years.

The findings of MSF's surveys show that the Rohingya have been targeted, and are the clearest indication yet of the widespread violence that started on August 25 when the Myanmar military, police and local militias launched the latest 'clearance operations' in Rakhine in response to attacks by the Arakan Rohingya Salvation Army. Since then, more than 647,000 Rohingya (according to the Intersector Coordination Group as of December 12) have fled from Myanmar into Bangladesh.

“We met and spoke with survivors of violence in Myanmar, who are now sheltering in overcrowded and unsanitary camps in Bangladesh. What we uncovered was staggering, both in terms of the numbers of people who reported a family member died as a result of violence, and the horrific ways in which they said they were killed or severely injured. The peak in deaths coincides with the launch of the latest “clearance operations” by Myanmar security forces in the last week of August,” says Dr. Sidney Wong, MSF Medical Director.

In early November MSF conducted six retrospective mortality surveys in different sections of the refugee settlements in Cox's Bazar, just over the border from Myanmar,

44. The ARSA, Arakan Rohingya Salvation Army is an armed group created in 2016, considered a terrorist group by Myanmar authorities.

in Bangladesh. The total population of the areas covered by the surveys was 608,108 people; of which 503,698 had fled Myanmar after the 25th of August.

The overall mortality rate between August 25 and September 24 of people in households surveyed was 8.0/10,000 persons per day. This is equivalent to the death of 2.26% (between 1.87% and 2.73%) of the sampled population. If this proportion is applied to the total population that had arrived since August 25 in the camps which were covered by the surveys, it would suggest that between 9,425 and 13,759 Rohingya died during the initial 31 days following the start of the violence, including at least 1,000 children below the age of 5 years.

The surveys show that of these deaths at least **71.7%** were due to violence, including among children under 5 years old. This represents at least 6,700 people, including 730 children. Overall, gunshots were the cause of death in 69% of the violence-related deaths, followed by being burnt to death in their houses (9%) and beaten to death (5%). Among children below the age of 5 years, more than 59% killed during that period were reportedly shot, 15% burnt to death in their home, 7% beaten to death and 2% died due to landmine blasts.

“The numbers of deaths are likely to be an underestimation as we have not surveyed all refugee settlements in Bangladesh and because the surveys don’t account for the families who never made it out of Myanmar,” Dr. Sidney Wong says. “We heard reports of entire families who perished after they were locked inside their homes, while they were set alight.”

“Currently people are still fleeing from Myanmar to Bangladesh and those who do manage to cross the border still report being subject to violence in recent weeks,” Dr. Sidney Wong adds. “With very few independent aid groups able to access Maungdaw district in Rakhine, we fear for the fate of Rohingya people who are still there.”

Consequently, the signing of an agreement for the return of the refugees between the governments of Myanmar and Bangladesh is premature. Rohingya should not be forced to return and their safety and rights need to be guaranteed before any such plans can be seriously considered

A detailed overview of results of the survey is available at:

<https://www.msf.org/myanmarbangladesh-rohingya-crisis-summary-findings-six-pooled-surveys>

Reference links to full epidemiology surveys:

https://www.msf.org/sites/msf.org/files/coxsbazar_healthsurveyreport_dec2017_final1.pdf

<https://www.msf.org/sites/msf.org/files/report-rohingyas-emergency-17-vf1.pdf>

The 2015 review commissioned by MSF Holland entitled, “Access at All Costs” was rejected for various reasons.

Subsequently, two webinars were organised based on a new analysis in a reflection paper written by another researcher entitled, “Beyond Complicity: MSF’s Engagement in Myanmar - On Striking the Balance between Medical Assistance and T emoignage.”

In June 2019, the MSF Holland general assembly hosted another debate with the same title as the reflection paper. One of the keynote speakers, Liam Mahony⁴⁵, was an expert on protection. He questioned the Myanmar 'silent advocacy' strategy of INGO's, including MSF.



"Access at all costs" OCA Rakhine **Report**," Roger Persichino,' February 2017 (in English).

Extract:

Executive Summary

The guiding question from the Terms of Reference asks:

"Providing meaningful assistance to the Rohingya requires a constant balancing act for MSF. The medical needs of this persecuted people are uncontested, yet medical assistance is clearly not enough. MSF has struggled with how to maximise its impact through a combination of providing medical care and informing those with the power and mandate to act about the human rights abuses that lie at the root of the humanitarian needs."

How effectively has MSF struck this balance and maximised its impact over the past 10 years, with particular emphasis on the period following the June 2012 outbreak of violence in Rakhine State?

• Key findings

1. OCA's impact in Rakhine State degraded between 2012 and 2015.
2. The balance between providing medical care and informing those with power and mandate to act about the human rights abuses that lie at the root of the humanitarian needs has also significantly eroded since 2012. While there is no denying the scope and energy that OCA has devoted to both components, the fact remains that the situation of the Rohingyas has worsened between 2012 and 2015, and is likely to worsen further, as events in 2016 and 2017 suggest. OCA's stated objectives since 2001 to "advocate for an improvement of the [...] situation" of "discriminated minorities and population groups" have not met with success in Rakhine State.
3. The continuation of a strategy primarily based on securing operational presence, however modulated (fixed versus mobile teams, expatriate versus inpat presence, etc.) remains very unlikely to lift the formidable barriers that exist to referral, hospital follow-up and access to medical data.
4. Over the considered timeframe, MSF has mostly followed a strategy designed first to secure operational presence in Rakhine State and, second, to remove obstacles to medical referrals, hospital follow-up and medical data collection. In spite of a degradation of the situation, it has somewhat succeeded in the former, with diminishing rates of return, while it has gained very little traction on the latter.
5. From 2012 onwards, in particular, the strategy that was followed replicated those that had preceded rather than adapted to the changing circumstances. Accordingly, MSF succeeded again in securing access to Rakhine State, although to levels significantly lower than prior to the crisis. Barriers to referrals persisted.
6. Yet, the Mission and OM have displayed considerable energy in trying to address an issue that, by all means, they considered as unacceptable. Efforts to engage the national media locally, and international media through the Bangladesh and later

45. Liam Mahony is the Director of *Fieldview Solutions*, and an expert on protection who has advised and trained NGOs and UN agencies in the humanitarian sector, in human rights, and in peacekeeping. He has written several books on civilian protection and a study on the role of international organisations in Myanmar entitled, *Time to Break Old Habits: Shifting from Complicity to Protection of the Rohingya in Myanmar.* https://www.fieldviewsolutions.org/fv-publications/Time_to_break_old_habits.pdf

Malaysia missions are testimony to this. The unparalleled efforts in terms of engaging diplomatic representations (including multilateral bodies) are further evidence of this unflinching effort.

7. This continuity in replicating a strategy that has demonstrably achieved partial and ambiguous results at best must also be put in perspective. By all accounts, working conditions in Myanmar are extremely peculiar. Distinctly totalitarian for most of the considered period, and arguably for all, the regime – as well as outright hostility to Rohingyas – has bred a sense of disquiet and paranoia among staff deployed to the field. It is not illogical that such a climate should have fostered a conservative approach by default, favouring a strategy that had been shown to leave other options open, by remaining in country, in RS, and with varying degrees of access.
8. In doing so, the paramount objective appears to have been to always leave options open, at the cost of not discussing these options when events justified another course of action (forced displacement at a minimum, potentially crimes against humanity or genocide).



“Beyond Complicity: MSF’s Engagement in Myanmar – On Striking the Balance Between Medical Assistance and Témoignage”, **Reflection Paper**, Draft 2, Clea Kahn, 2019 (in English).

Extract:

Background, methodology and limitations

The original review commissioned to respond to the 2015 motion took longer than anticipated, shared only in February 2017. The final report, *Access at All Costs?* was judged unsatisfactory for a number of reasons and rejected by the motion authors. In July 2017 they requested it be redone. Events overtook the process, however. In August 2017 extreme violence against the Rohingya in Rakhine State resulted in mass displacement. More than 700,000 people fled to Bangladesh and hundreds of thousands more were internally displaced in Rakhine State. In those circumstances, it was considered that a full review would not be possible. A modified process was commissioned, to organise a workshop on “striking the balance between medical assistance and témoignage”.

This paper does not attempt to redo the work that went into *Access at All Costs?* To cover this ground again would require an investment of time that was not foreseen in this process, and substantially more support from OCA to locate and review documents and organise interviews. [...] Because this review does not draw on complete documentation, it cannot provide a rigorous assessment of impact or process, but efforts have been made to extract conclusions from the work that has already been done, and to draw conclusions on the basis of existing material.



“Striking the Balance Between Medical Assistance and Témoignage”: An Associative Debate Held at the MSF Holland General Assembly, **Minutes**, 14 June 2019 (in English).

Extract:

Some of the key questions, issues and conclusions from the day.


- Is speaking out, the way it is conceived in MSF, a question of morality – right or wrong – or a question of actually making a difference for the people we work with, or both?

- If there is a desire to have a practical, preventive impact with the use of our public voice in places where we work in a context of human rights abuses, the approach should be strategic and long term – like a strategy for having an impact on a public health problem. This requires long-term thinking and an investment in resources to allow that to happen.
- It is important to recognise that the decisions we make about how we tackle these issues have the potential to affect not only the people we work with today, but also those that may continue to be subject to violations ten years from now. It is a complex trade-off between an imminent, tangible good and a potential future one.
- Even accepting the points above, most people seem to believe that there is still a place for the ‘cri de coeur’ or expression of outrage in the face of violations against our shared humanity. [...]
- These discussions often focus on public speaking, which may obscure the many other kinds of intervention MSF uses. In Myanmar, MSF used a variety of avenues for addressing the violations witnessed, perhaps more than in most contexts. These efforts have been described as ‘extensive’, ‘strategic’ and ‘tenacious’. There was agreement that this should be recognised, but also a challenge that “there are very few examples of large-scale change that have happened solely on the basis of silent diplomacy”. [...]

Panel final statements [...]

Liam Mahony: Several months ago there was an interview in the Washington Post with one of the high-level ministers in Myanmar, and they asked him about the lack of freedom movement of the Rohingya and the human rights abuses. He answered, “there’s really no problem. I had a meeting just the other weekend with the whole humanitarian community and no one said a word about those issues.” You are part of the game. Your silence is as much a statement as your statements. Governments love it, and use it when they can. There’s nothing static about those relationships. You’re always either pushing or not pushing. [...] In these countries, if you are not pushing back, they will keep closing that space. Even a good relationship with the government has to have the ability to manage friction, because if you aren’t moving back, you are going to lose space.

In November 2019, three separate international legal proceedings were filed against Myanmar for crimes against the Rohingya:

- **Filed in the UN International Court of Justice, filed by Gambia, against Myanmar for genocide against a Muslim minority group and supported by fifty-seven States of the Organisation for Islamic Cooperation.**
- **A proceeding filed under the “universal jurisdiction”⁴⁶ procedure in Argentina, brought by BROUK (Burmese Organisation UK)⁴⁷ against Aung San Suu Kyi and top military and civilian leaders for crimes against the Rohingya.**
- **The UN International Criminal Court authorised a full investigation into alleged crimes of deportation, persecution, and any other crime, committed against the Rohingya by senior military and civilian officials. [V14](#) **

46. Under “universal jurisdiction” for certain serious crimes, any state can prosecute regardless of where the crime was committed and who was involved.

47. BROUK is advocating within the UK and Europe about the plight of the Rohingya people and human rights violations in Myanmar.

CHRONOLOGY

1992-2014

The main purpose of this chronology is to help the reader by reconstructing MSF's actions and public statements in regional and international news reports of the period. It is intended as a tool for this specific document, and not as an academic reference.

Please note: we are using 'Burma' and 'Burmese' until 1989 when the official names changed. From 1989 on, we are using 'Myanmar' and 'Myanmarese'

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1962		General Ne Win's military coup in <u>Burma</u> . Rohingya stripped of their rights.		
1978		Operation Nagamin (Dragon King). 200,000 Rohingya flee to <u>Bangladesh</u> .	MAY MSF France (F) exploratory mission in <u>Bangladeshi</u> refugee camps.	
1979		Rohingya refugees repatriated to <u>Burma</u> .		
1988		Military coup in <u>Burma</u> . SLORC takes power.		
1989		<u>Burma</u> renamed <u>Myanmar</u> by SLORC.		
1991		APRIL - DECEMBER 1991 New Rohingya exodus from northern Rakhine State (NRS) in <u>Myanmar</u> to <u>Bangladesh</u> .	MSF Holland (H) single expatriate in Yangon to negotiate with authorities to open programmes in <u>Myanmar</u> . DECEMBER 1991 MSF F exploratory mission in <u>Bangladeshi</u> refugee camps.	
1992			JANUARY 1992 MSF F refugee assistance programme in Dechua Palong in <u>Bangladesh</u> . FEBRUARY 1992 MSF F nutritional survey in Dechua Palong II camp in <u>Bangladesh</u> . High prevalence of child malnutrition.	14 FEBRUARY 1992 MSF F press release: " <i>Médecins Sans Frontières to send a supply plane to the Rohingya refugees in Bangladesh.</i> "

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1992	<p>MID-MAY 1992 UNHCR will not participate in monitoring the repatriation from Bangladesh to Myanmar. The start of repatriation operations is postponed.</p>	<p>28 APRIL 1992</p> <ul style="list-style-type: none"> • Governments of Bangladesh and Myanmar agreement to refugee repatriation. • Myanmar refuses to allow UNHCR to supervise repatriation. <p>LATE MAY 1992 Bangladeshi government accuses UNHCR and MSF of impeding repatriation process. They threaten not to register MSF H and MSF F projects.</p> <p>SEPTEMBER-OCTOBER 1992 Several dozen refugees forcibly repatriated from Bangladesh to Myanmar.</p>	<p>MARCH 1992 MSF H opens a programme in Balu Kali refugee camp in Bangladesh.</p> <p>MAY 1992 MSF H volunteers in Balu Kali refugee camps in Bangladesh witness violence against refugees. Confidential report to UNHCR.</p> <p>18 AUGUST 1992 MSF F nurse witnesses Bangladeshi police firing at refugees.</p>	<p>25 FEBRUARY 1992 MSF F press release: "MSF to strengthen its programme and open a 2nd nutrition centre."</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1992	<p>23 DECEMBER 1992 UNHCR press release calls <u>Bangladeshi</u> Prime Minister “to take all necessary measures, to ensure that refugees from Myanmar are not coerced into returning against their will to their country of origin.”</p> <p>24 DECEMBER 1992 US Department of State (DoS) asks <u>Bangladeshi</u> government to restrain from coercion and to let UNHCR conduct operations unhindered.</p>	<p>END OF SEPTEMBER Government of <u>Bangladesh</u> requests a six-month extension of humanitarian aid.</p> <p>NOVEMBER 1992 Repatriation from <u>Bangladesh</u> to <u>Myanmar</u>, resumption of low-scale and local operations. One-third of returnees forced back.</p> <p>4 DECEMBER 1992 4 Rohingya are killed by <u>Bangladeshi</u> soldiers.</p>		<p>NOVEMBER 1992 MSF F alerts European countries about forced repatriations of Rohingya refugees from <u>Bangladesh</u> to <u>Myanmar</u>.</p> <p>7 DECEMBER 1992 MSF International press release: “Bangladeshi soldiers kill Rohingya refugees demonstrating against forced repatriation to Burma.”</p>
1993			<p>DURING 1993 MSF H authorised to open programmes in two Yangon townships in <u>Myanmar</u>.</p>	

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1993	<p>MAY 1993 UNHCR signs Memorandum of Understanding (MoU) with <u>Bangladesh</u>.</p> <p>5 NOVEMBER 1993 UNHCR signs MoU with <u>Myanmar</u>.</p>			<p>11 JANUARY 1993 MSF F letter: to main institutional donors and key state stakeholders to express their concerns.</p> <p>26 JANUARY 1993 MSF F public report: "<i>Rohingya: Refugees repatriated by force to Burma</i>."</p>
1994	<p>JULY-AUGUST 1994 UNHCR states that situation in <u>Myanmar</u> is "<i>conducive for return</i>" and replaces pre-repatriation individual interviews with collective information sessions.</p>	<p>JANUARY 1994 Repatriation begins but quickly stalled due to lack of clearances from the government of <u>Myanmar</u>.</p> <p>SEPTEMBER 1994 Situation regarding forced repatriation deteriorates rapidly in refugee camps in <u>Bangladesh</u>.</p>	<p>EARLY 1994 MSF H opens malaria treatment project in Sittwe, Rakhine state in <u>Myanmar</u>.</p> <p>AUGUST 1994 MSF F and MSF H programme managers visit Rakhine state in <u>Myanmar</u>. MSF F concludes that voluntary nature of repatriation not respected.</p>	<p>20 SEPTEMBER 1994 MSF F proposes a joint advocacy plan on Rohingya to MSF H but receives no answer.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1994				22 SEPTEMBER 1994 MSF F communicates a dossier on forced repatriation from <u>Bangladesh</u> to <u>Myanmar</u> to key stakeholders.
1995	SEPTEMBER 1995 UNHCR note on internal protection: repatriation of Rohingya from Bangladesh		<p>3 FEBRUARY 1995 MSF H survey in a camp in <u>Bangladesh</u>: only 16% of refugees aware they can refuse to be repatriated.</p> <p>EARLY MARCH 1995 MSF F and MSF H to do a common survey in order to prove that repatriation is not as voluntary as presented.</p> <p>MARCH 1995 MSF F sets up an office in Yangon, <u>Myanmar</u>.</p>	<p>19 APRIL 1995 MSF F and MSF H programme managers present their survey results to UNHCR.</p> <p>1 MAY 1995 Release of MSF report: "MSF's concern on the repatriation of Rohingya refugees from <u>Bangladesh</u> to <u>Burma</u>."</p> <p>AUGUST 1995 MSF F strategy regarding Rohingya repatriation process shifted to a soft diplomacy approach.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
1995	to Myanmar can occur even if conditions not optimum.			OCTOBER 1995 MSF H and MSF F question UNHCR Executive Committee on UNHCR repatriation policy.
1996	JANUARY 1996 UNHCR officials in <u>Bangladesh</u> advise UNHCR Geneva headquarters to cease active repatriation promotion.	LATE 1996 Most Rohingya refugees now repatriated to <u>Myanmar</u> , but many continue to flee to <u>Bangladesh</u> to escape violence in Rakhine.	FEBRUARY 1996 MSF F closes office in <u>Myanmar</u> . LATE 1996 MSF teams in <u>Bangladesh</u> witness numerous refugee arrivals. Refugees no longer receive access to official camps.	JANUARY 1996 MSF H to support UNHCR <u>Bangladesh</u> office position.
1997			JANUARY 1997 MSF F last camp in <u>Bangladesh</u> closed.	NOVEMBER 1997 MSF H dossier: "Better off in Burma? The plight of the Burmese Rohingya" is circulated to key stakeholders only.
1998			THROUGH THE YEAR: • MSF H programmes allowed in north Rakhine State (NRS) where Rohingya refugees are resettled. • MSF H HIV/Aids awareness programmes in Yangon, Kachin and Rakhine states.	THROUGH THE YEAR: • MSF H researches <u>Myanmar</u> treatment protocols malaria. • MSF H HoM interviews on malaria and HIV/AIDS epidemic. • Setting up of 'Club Med,' a data collection system shared with human rights

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
				organisations and media to protect MSF's anonymity. • MSF H advocacy for Rohingya limited to 'silent advocacy.'
2000			MSF CH (Switzerland) begins programmes in Tanintharyi and Kayah state in <u>Myanmar</u> .	
2001			THROUGH THE YEAR: • MSF H begins malaria, tuberculosis, and HIV/STI activities in <u>Shan state</u> . • MSF F opens malaria programmes in Mon and Kayah states in <u>Myanmar</u> .	THROUGH THE YEAR: New MSF H Management Team (MT) changes advocacy strategy regarding Rohingya refugees in <u>Bangladesh</u> and increasingly challenges UNHCR to meet its mandate.
2002	LATE 2002 UNHCR plan for 'self-reliance' for the Rohingya in <u>Bangladesh</u> , including the handover of MSF H activities to MoH.	LATE 2002 <u>Bangladesh</u> starts to aggressively promote refugee repatriation to <u>Myanmar</u> .	LATE 2002 MSF H starts to provide ARV treatments (ART) to HIV/AIDS patients in <u>Myanmar</u> .	APRIL 2002 MSF H press conference and report: "10 years in Bangladesh for the Rohingya refugees - past, present and future." LATE 2002-EARLY 2003 Bilateral and 'behind closed doors' advocacy to extend medical activities and to warn against consequences of the UNHCR's efforts to disengage from Rakhine.
2003			MID-APRIL 2003 MSF H informed they must handover activities in Nyapara camp in <u>Bangladesh</u> to MoH before 1 July 2003. 14 AUGUST 2003 MSF H ceases activities in Nyapara Camp in <u>Bangladesh</u> .	

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2003				17 SEPTEMBER 2003 MSF H press release: <i>"Thousands of refugees harassed to return to Myanmar."</i>
2004		LATE 2004 Hardening of <u>Myanmar</u> regime. Increased restrictions and daily harassment against Rohingya and additional constraints for NGOs in Rakhine.	EARLY 2004 Change in MSF H Operational Centre Amsterdam (OCA) operational Directors: <ul style="list-style-type: none"> • Question growth of programmes in <u>Myanmar</u>. • Geographical freeze decision partly ignored by the field. 	EARLY 2004 Change in MSF H/OCA operational directors: <ul style="list-style-type: none"> • Question <u>Myanmar</u> HoM's all-out silent advocacy approach. • MSF OCA Humanitarian Affairs Department (HAD) commissioned to explore possibilities of doing more public advocacy about Rohingya. MARCH 2004 <ul style="list-style-type: none"> • MSF H confidential evaluation: <i>"Closure of the Bangladesh Teknaf Rohingya programme - An evaluation of MSF Holland's tumultuous departure and advocacy activities."</i> • MSF OCA HAD internal report: it is <i>"still morally justified for MSF to work in <u>Burma</u> in the same way as done during the past ten years."</i>
2005			NOVEMBER 2005 MSF F to close its malaria programmes in Mon and Kayah states in <u>Myanmar</u> .	

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2006			<p>26 MARCH 2006 MSF F departure from <u>Myanmar</u> (Mon and Kayah states).</p> <p>MAY-SEPTEMBER 2006 MSF H opens programmes in <u>Bangladesh</u> for local population and unregistered Rohingya refugees.</p> <p>LATE 2006 MSF CH/Operational Centre Geneva (OCG) reviews relevance of presence in <u>Myanmar</u> and decides to stay.</p>	<p>30 MARCH 2006 MSF F press release: '<i>Prevented from working, the French section of MSF leaves <u>Myanmar</u>.</i>'</p> <p>SECOND HALF 2006</p> <ul style="list-style-type: none"> • Reorganisation of MSF OCA operational department. <u>Myanmar</u> and <u>Bangladesh</u> in the same portfolio. • MSF OCA new advocacy strategy on Rohingya from Bangladesh.
2007		<p>7 MARCH 2007 Thousands of Rohingya refugees ordered by <u>Bangladeshi</u> authorities to leave Tal makeshift camps.</p>		<p>12 MARCH 2007 MSF OCA press release: "<i>Myanmar refugees in Bangladesh: stuck with nowhere to go.</i>"</p> <p>MAY 2007 MSF OCA briefing paper: "<i>Tal makeshift camp: no one should have to live like this: the Rohingya people from <u>Myanmar</u> seeking refuge in <u>Bangladesh</u></i>" posted on MSF website.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2007		<p>AUGUST-OCTOBER 2007 Series of economic and political protests in <u>Myanmar</u> (saffron revolution).</p>	<p>LATE 2007 MSF OCA in <u>Myanmar</u>:</p> <ul style="list-style-type: none"> • Launches systematic collection of data and testimonies on discrimination and stigmatisation of people living with HIV/AIDS. • Reorganises Rakhine data base to focus on abuse/violence related to access to health. 	<p>7 OCTOBER 2007 MSF OCA Myanmar HoM gives a defensive interview to CNN about MSF's possible role in taking care of wounded protestors.</p> <p>LATE 2007 MSF briefing paper: "<i>The ART of living in Myanmar</i>" is widely circulated to main stakeholders. Myanmar:</p> <ul style="list-style-type: none"> • MSF CH/OCG to develop two-fold advocacy strategy: passive communication activities to focus on website publications and active communication activities to gather this information in report. • MSF International Humanitarian Affairs and Representation Team (HART) to support MSF OCA to reach key stakeholders to scale up ART provision and to brief them about Rohingya situation.
2008		<p>JANUARY-FEBRUARY 2008 <u>Myanmar</u> regime tightens control over International Non- Governmental Organisations (INGOS), reinforcing constraints.</p> <p>2 MAY 2008 Cyclone Nargis hits <u>Myanmar</u>.</p>		<p>9 MAY 2008 MSF International press release: "<i>Cyclone in Myanmar (Burma): MSF teams intensify emergency response, as first relief plane lands in Yangon.</i>"</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2008		<p>MID 2008 Government of <u>Bangladesh</u> allocates a piece of land in Leda Bazar for the unregistered Rohingya.</p>	<p>MID 2008 MSF OCA <u>Myanmar</u> HoM to step down in May 2009 after 14 years of service.</p>	<p>16 MAY 2008 MSF International press release: <i>'MSF teams delivering aid to the Delta call for immediate and unobstructed escalation of relief operations.'</i></p> <p>SEPTEMBER 2008 New MSF OCA advocacy strategies for <u>Myanmar</u> to advocate for HIV/AIDS patients and for Rohingya.</p> <p>JUNE-NOVEMBER 2008 All MSF operational centres publicly describe seriousness of <u>Nargis</u> situation and call for increased aid to be authorised by regime and deployed in <u>Myanmar</u>.</p> <p>OCTOBER 2008</p> <ul style="list-style-type: none"> • MSF OCA submits op-ed to <i>Humanitarian Practice Network</i> (HPN), an ODI publication. • Debate between MSF OCA and <u>Myanmar</u> field teams about MSF's public positioning and risking programmes in <u>Rakhine</u>. • Op-ed postponed until 2009. • MSF OCA teams start to collect data on Rohingya reproductive health in <u>Rakhine</u>.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2008				<p>25 NOVEMBER 2008 MSF OCA and OCG press release and report: "A preventable fate: the failure of ART scale-up in Myanmar."</p> <p>22 DECEMBER 2008 MSF USA "Top ten most underreported humanitarian crisis" mentions Nargis and HIV/AIDS crisis in Myanmar but not Rohingya.</p>
2009		<p>JUNE 2009 Bangladeshi government violence to force Rohingya refugees to leave Kutupalong makeshift camps.</p>	<p>JULY 2009 MSF OCA interim HoM summoned to Myanmar MoH and MSF blamed for the report, "A preventable fate: the failure of ART scale-up in Myanmar."</p>	<p>FEBRUARY 2009</p> <ul style="list-style-type: none"> • Op-ed intended to be published in <i>HPN</i> published on MSF International and MSF H websites: "A life of fear with no refuge: the Rohingya's struggle for survival and dignity." • MSF OCA national staff in Rakhine state in favour of MSF speaking out. <p>MAY 2009 OCA's Myanmar HoM gives last controversial interview to <i>New York Times</i> before stepping down.</p> <p>18 JUNE 2009 MSF OCA press release: "Long-suffering Rohingya face unacceptable abuse – forced displacement, intimidation and abuse in Kutupalong makeshift camp, Bangladesh."</p> <p>MID-JULY 2009 MSF briefing paper: "Nowhere to go: A never-ending cycle of displacement and suffering for the Rohingya in Bangladesh" is posted on MSF website.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2009				<p>AUGUST 2009 Creation of operational liaison officer (OPLO)/humanitarian affairs officer position in charge of advocacy for Rohingya dossier in Bangkok.</p> <p>27 AUGUST 2009 MSF OCA discussion on Rohingya advocacy strategy: no negative impact from February 2009 website post.</p>
2010			<p>FROM FEBRUARY 2010 Increased bureaucracy, monitoring, and investigation of MSF OCA operations in Kutupalong in Bangladesh.</p>	<p>17 FEBRUARY 2010 MSF OCA managers for Myanmar and Bangladesh decision: advocacy strategy objective of "having Rohingya crisis on the agenda" if/when situation changes in Myanmar.</p> <p>18 FEBRUARY 2010 MSF OCA press conference in Bangkok and press release: "Stateless Rohingya victims of violent crackdown in Bangladesh." MSF OCA report release: "Violent crackdown fuels humanitarian crisis for unrecognised Rohingya refugees in Bangladesh."</p> <p>AFTER FEBRUARY 2010 MSF OCA continues international bilateral advocacy activities while maintaining a low profile in Bangladesh.</p> <p>APRIL 2010 Operational liaison officer (OPLO) to develop MSF network of stakeholders and experts on Rohingya issue in southeast Asia.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2010				<p>JUNE 2010 MSF OCA Myanmar coordination team issues an advocacy and communication strategy for Myanmar:</p> <ul style="list-style-type: none"> • External advocacy to remain mostly 'silent.' • Speaking out still considered an option to raise awareness on Rohingya situation. • Direct and aggressive confrontation with government rejected.
2011		<p>THROUGHOUT THE YEAR Tensions between Muslim and Buddhist populations in Rakhine, Myanmar.</p>		<p>JANUARY 2011 MSF OCA Review of advocacy and communication strategy for Myanmar.</p> <p>APRIL 2011 MSF OCA Re-discussion of advocacy and communication strategy for Myanmar.</p> <p>JULY 2011 MSF OCA launches an evaluation of operational risks in Bangladesh. Speaking out from Bangladesh presents no less risk than Myanmar.</p> <p>OCTOBER 2011 MSF OCA briefing paper: "Fatal policy: How the Rohingya suffer the consequences of statelessness" is circulated to regional governments, donors and UN agencies.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012	<p>LATE APRIL 2012</p> <ul style="list-style-type: none"> • EU suspends sanctions on <u>Myanmar</u> for one year. • UN Secretary General calls for further lifting of sanctions. • USA rules out lifting key sanctions. <p>11 MAY 2012</p> <p>Global Fund to free US\$ 1.7 billion, two-thirds attributed to needy countries.</p>	<p>THROUGHOUT 2012 AND 2013: <u>Thailand</u> and <u>Bangladesh</u> deny Rohingya refugees entry, pushing them back to <u>Myanmar</u>.</p> <p>EARLY APRIL 2012 <u>Myanmar</u> opposition party NLD wins legislative elections. Intervention conditions for INGOS significantly improved.</p>		<p>THROUGH THE YEAR: MSF OCA intensive bilateral advocacy on Rohingya in <u>southeast Asia</u>.</p> <p>JANUARY 2012</p> <ul style="list-style-type: none"> • MSF UK series of briefings of British foreign secretary on Rohingya situation. • MSFOCA bilateral advocacy campaign on consequences of November 2011 cancellation of 11th Global Fund cycle. <p>22 FEBRUARY 2012 MSF OCA and MSF Access Campaign report and press release: <i>"Lives in the balance: the need for ART and tuberculosis treatments in Myanmar."</i></p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012	<p>MID-MAY 2012 Several high-level visits in <u>Bangladesh</u>, including US secretary of state. Increase of international interest in Rohingya refugee plight increases.</p>	<p>28 MAY 2012 A Buddhist woman raped and murdered, allegedly by group of Muslim men in Rakhine state in <u>Myanmar</u>.</p> <p>8 JUNE 2012 Interethnic violence erupts in Maungdaw and spread to Sittwe in <u>Myanmar</u>, 75,000 displaced people from both communities.</p> <p>10 JUNE 2012 President of <u>Myanmar</u>, Thein Sein addresses the nation in effort to calm situation down.</p> <p>11 JUNE 2012 <u>Myanmar</u>: UN evacuates non-essential staff from Rakhine state.</p>	<p>22 MAY 2012 <u>Bangladesh</u>: MSF OCA receives letter from Kutupalong camp administrative authorities demanding suspension of activities of several INGOS, including MSF.</p> <p>LATE MAY 2012 <u>Bangladesh</u>: Suspension of activities in Kutupalong lifted for MSF.</p> <p>8 JUNE 2012 MSF OCA mobile clinics to treat victims of violence in displaced camps in <u>Bangladesh</u>.</p> <p>11 JUNE 2012 <u>Myanmar</u>: MSFOCA suspends activities in Rakhine state.</p>	<p>22 MAY 2012 MSF OCA <u>Bangladesh</u> team to work on communication strategy for Kutupalong camp in <u>Bangladesh</u>.</p> <p>12 JUNE 2012 MSF OCA reactive statement: consequences of forced suspension and disruption of life-saving primary healthcare services in Rakhine State in <u>Myanmar</u>.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012		<p>MID-JUNE 2012 Rohingya settled in <u>Malaysia</u> demonstrate in Kuala Lumpur to demand end to violence against their community in Rakhine, <u>Myanmar</u>.</p> <p>19 JUNE 2012 • 2 men sentenced to death for 28 May crime. • <u>Myanmar</u> asks for assistance to manage displaced camps in six Rakhine towns. • <u>Bangladesh</u> continues to repel refugees.</p> <p>20 JUNE 2012 Inter-ethnic and religious violence resume north of Sittwe in <u>Myanmar</u>.</p>	<p>20 JUNE 2012 • <u>Bangladeshi</u> authorities demand proof of MSF OCA operational legality and of expatriate work visas. • <u>Myanmar</u>: - Increasing administrative constraints prohibit MSF OCA from augmenting expatriate team size. - MSF OCA considers "composing teams along religious and ethnic lines and deploying them in corresponding ethnic areas."</p>	<p>18 JUNE 2012 • MSF OCA press statement: "Victims of recent <u>Myanmar</u> clashes must have access to healthcare." • Advocacy efforts towards Bangkok-based organisations working in Rakhine.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012		<p>12 JULY 2012 President of <u>Myanmar</u> to UN: <i>"only solution would be to expel the Rohingya to other countries or to resettle them in camps overseen by UNHCR."</i></p>	<p>LATE JUNE 2012 Twelve relief workers arrested and jailed by Rakhine authorities in <u>Myanmar</u>. Six of them from MSF OCA.</p> <p>6 JULY 2012 Buddhist MSF staff in <u>Myanmar</u> released from jail without any charge.</p>	<p>29 JUNE 2012 MSF OCA reactive communication on detention of staff.</p> <p>16 JULY 2012 MSF International HART UN representative meeting with representative of Rohingya diaspora association, BRANA.</p> <p>17 JULY 2012 MSF International HART UN representative meeting with UN Special Adviser to Secretary General on <u>Myanmar</u>.</p> <p>20 JULY 2012 MSF OCA operational coordinators for <u>Bangladesh</u> and <u>Myanmar</u> to closed-door meeting on Rohingya crisis in London with other organisations and British government representatives.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012	<p>AUGUST 2012 Human Rights Watch (HRW) report: <i>"The government could have stopped this: sectarian violence and ensuing abuses in Burma's Arakan state."</i></p>	<p>AUGUST 2012 Government of <u>Myanmar</u> considers placing displaced Rohingya in detention camps.</p>	<p>LATE JULY 2012 MSF OCA staff sentenced to 10 years in prison.</p> <p>24 JULY 2012 MSF OCA receives a letter ordering cessation of <i>"unregistered"</i> activities in Kutupalong camps in <u>Bangladesh</u>.</p> <p>3 AUGUST 2012 <u>Bangladeshi</u> government notifies MSF OCA to close programme in Kutupalong within 3 days.</p> <p>MID-AUGUST 2012 Three MSF OCA detained staff members released in <u>Myanmar</u>.</p>	<p>AUGUST 2012 MSF OCA:</p> <ul style="list-style-type: none"> • Decision to be more proactive and give interviews on situation in Kutupalong, <u>Bangladesh</u>. • MSF OCA's OSCAR tasked to analyse main dilemmas posed by Rohingya situation. • Agreement on need to improve communications with Rakhine Buddhist community in <u>Myanmar</u>. <p>17 AUGUST 2012 MSF OCA issues reactive line on concerns over lack of access to health-care for many people in Rakhine, <u>Myanmar</u>.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012		<p>23 OCTOBER 2012 Violence flares in several Rakhine towns, in <u>Myanmar</u>.</p>	<p>18 OCTOBER 2012 Official reopening of MSF OCA clinic in Buddhist area in <u>Myanmar</u> derailed by Rakhine extremist protesters.</p>	<p>3 SEPTEMBER 2012 MSF OCA, OCG and MSF International advocacy teams meeting to create an intersectional, regional advocacy strategy on <u>Myanmar</u> and <u>Bangladesh</u>. Bilateral meetings to be held with key stakeholders.</p> <p>LATE SEPTEMBER 2012 MSF OCA medium-term strategic framework for advocacy activities in Rakhine, <u>Myanmar</u>:</p> <ul style="list-style-type: none"> • ‘Acceptance’ of MSF by Rakhine community too ambitious. • Recommendation to strengthen networking and communication towards Rakhine. • Provide Rakhine useful and valued services. • In case all efforts fail, MSF OCA should be prepared to speak out publicly. <p>1 NOVEMBER 2012 MSF OCA Myanmar HoM letter on detained MSF staff to Myanmar UN humanitarian coordinator.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012	<p>9 NOVEMBER 2012</p> <ul style="list-style-type: none"> • 10 embassies call on <u>Myanmar</u> to allow free and safe access for humanitarian aid to west of country. • UNHCHR calls on <u>Myanmar</u> to grant citizenship to Rohingya. <p>13 NOVEMBER 2012 UNHCR calls on the southeast Asia governments to keep their borders open.</p> <p>17 NOVEMBER 2012 OIC calls for UNSC to “save” Myanmar’s Rohingya Muslim minority from “<i>genocide</i>”.</p> <p>18 NOVEMBER 2012 HRW claims that in October 2012, local <u>Myanmarese</u> security forces killed Muslim villagers.</p> <p>19 NOVEMBER 2012 USA President Barrack Obama visits <u>Myanmar</u> and pleads for continued political reforms.</p>	<p>15 NOVEMBER 2012 Aung San Suu Kyi describes violence in western <u>Myanmar</u> as an “<i>immense international tragedy</i>” but calls for end to “<i>illegal immigration</i>” on border with <u>Bangladesh</u>.</p> <p>17 NOVEMBER 2012 President of <u>Myanmar</u> states that Myanmar should put an end to violence in west.</p> <p>18 NOVEMBER 2012 ASEAN refuses to speak about “<i>genocide</i>” regarding Rohingya in Myanmar.</p>		<p>5 NOVEMBER 2012 MSF OCA press release: “<i>MSF prevented from reaching the majority of communities affected by the violence.</i>”</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2012	<p>5 DECEMBER 2012 Head of OCHA, Valerie Amos calls on <u>Myanmar's</u> leaders to support UN and humanitarian organisations' efforts in the region.</p>		<p>DECEMBER 2012 <u>Myanmar:</u></p> <ul style="list-style-type: none"> • MSF OCA emergency team sent for a longer-term to Rakhine. • MSF OCA restarts part of TB and malaria activities in Rakhine. • MSF OCG declines MSF OCA's proposal to intervene in Rakhine, to support the needs. <p>9 DECEMBER 2012 TO 14 JANUARY 2013 MSF OCA exploratory mission among Rohingya refugees in <u>Thailand</u> and <u>Malaysia</u>. Recommendation to begin operations in Malaysia.</p>	<p>DECEMBER 2012 MSF International President, Dr Unni Karunakara letter on detained MSF staff to President of Myanmar.</p> <p>20 DECEMBER 2012 MSF OCA 'Rakhine Day' in Amsterdam:</p> <ul style="list-style-type: none"> • Agrees that there was space and value in stepping up MSF public positioning on Rakhine. • Agrees to produce a "<i>Fatal Policy 2</i>" report.
2013				<p>THROUGH THE YEAR 2013 MSF International HART and MSF OCA maintain advocacy momentum for release of detained staff.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013				<p>JANUARY 2013 MSF OCA OSCAR:</p> <ul style="list-style-type: none"> • Recommends to try and change perception of MSF among Rakhine population. • Recommends pushing limits with proper risk analysis. • Progressive approach should be adopted, starting with lobbying local authorities. <p>MID-JANUARY 2013 MSF International President, and MSF OCA HoM met several key actors in <u>Myanmar</u> to discuss:</p> <ul style="list-style-type: none"> • Challenges that MSF must meet in order to deliver emergency aid in Rakhine. • Access to detained employees. They choose not to discuss Rohingya persecution with Aung San Suu Kyi. <p>7 FEBRUARY 2013 MSF OCA press conference and press release: <i>"Humanitarian emergency in <u>Rakhine</u> State, <u>Myanmar</u> – greater protection needed for vulnerable communities and threatened staff."</i></p> <p>LATE MARCH 2013 Analysis and recommendations after head of MSF OCA OSCAR's visit in Rakhine State.</p> <ul style="list-style-type: none"> • Certain elements of <u>Myanmar's</u> segregation policies toward Rohingya can be defined as "<i>ethnic cleansing</i>".

International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
	<p data-bbox="676 779 1048 856">LATE MARCH 2013 Clashes between Buddhists and Muslims in Meiktila in centre of <u>Myanmar</u>.</p> <p data-bbox="676 1156 1048 1259">17 APRIL 2013 Aung San Suu Kyi publicly denies she is neglecting ethnic minorities in <u>Myanmar</u>.</p>	<p data-bbox="1085 1022 1457 1125">MID-APRIL 2013 MSF OCA exploratory team in <u>Malaysia</u> raises alarm again about Rohingya 'boat people.'</p>	<ul data-bbox="1494 271 1866 747" style="list-style-type: none"> • MSF OCA programmes in Rohingya 'concentration' camps of eastern Rakhine are vital for this vulnerable population and should not be questioned. • MSF should question possible 'complicity with segregation' policies by working with "ethnically exclusive" clinics. • Main argument for MSF to speak out should be an ethical one. • MSF should move away from long-term 'silent/behind the scenes' advocacy and raise "red flags" as core message. • Report on segregation actions, witnessed by MSF's teams should be produced by the humanitarian affairs officer in Rakhine and released. <p data-bbox="1494 889 1866 991">APRIL 2013 Communications manager recruited by MSF OCA and MSF OCG for website and social media strategy set up.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013	<p>22 APRIL 2013 HRW report accuses government of <u>Myanmar</u> of engaging in a campaign of “ethnic cleansing” against the Rohingya.</p> <p>1 MAY 2013 UN Special Rapporteur on Human Rights (UNSRHR) in <u>Myanmar</u> states that recommendations of presidential Rakhine Investigation Commission report still restrict movements of Muslim populations in Internally Displaced Persons (IDP) camps and in Muslim residential areas.</p>	<p>23 APRIL 2013 Release final report from the Inquiry Commission on the sectarian violence in Rakhine state.</p> <p>LATE APRIL 2013 Violence against Muslims flares up 100 kilometres north of Yangon, <u>Myanmar</u>.</p> <p>3 MAY 2013 Rohingya IDP verification and registration process stopped after triggering violence in camps.</p>		<p>28 MAY 2013 MSF OCA press release: “<i>Myanmar: Restrictions Severely Impacting Access to Healthcare in Rakhine State</i>” complemented with bilateral advocacy.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013	<p>10 JULY 2013 UNSG Ban Ki-moon to <u>Myanmar</u> government:</p> <ul style="list-style-type: none"> • Warns of “<i>dangerous polarisation</i>” between Buddhists and Muslims. • States they should take steps to answer Rohingya’s demands for citizenship. <p>16 JULY 2013</p> <ul style="list-style-type: none"> • <u>Myanmar</u> border security forces abolished. • UNSRHR in <u>Myanmar</u> called for investigation on abuses committed over years. 	<p>6 JUNE 2013 Aung San Suu Kyi announces she will run for the <u>Myanmar</u> presidency. She acknowledges that government must ensure that those who committed crimes be punished.</p>	<p>JUNE 2013 One of MSF OCA’s detained staff’s sentence is commuted to six years.</p> <p>END OF JUNE 2013 MSF OCA team authorised to enter Aung Mingalar Rohingya ghetto in Sittwe, <u>Myanmar</u>. Team granted weekly access to ghetto.</p> <p>JULY 2013 Upon MSF OCA request MSF OCG to open project in Rakhine, <u>Myanmar</u>.</p>	<p>JUNE-JULY 2013 MSF OCA Communication team to reconsider abandoned plan for opening Facebook page.</p> <p>10 JULY 2013 MSF OCA operational platform:</p> <ul style="list-style-type: none"> • Discuss proposal to open programmes for Rohingya refugees in <u>Malaysia</u>. • Position of MSF OCA regarding speaking out qualified as “<i>awkward</i>” and contradictory.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013	<p>20 SEPTEMBER 2013 Dalai Lama calls on <u>Myanmarese</u> Buddhist monks to respect Buddhist principles and stop bloodshed against Muslims.</p>		<p>SEPTEMBER 2013 MSF OCG opens a primary health care programme in the rural township of Kyauktaw in northern Rakhine, <u>Myanmar</u>.</p> <p>OCTOBER 2013 'Concept note' on MSF OCA intervention in <u>Malaysia</u> rejected.</p>	<p>22 AUGUST 2013 MSF OCA press release to announce it is organising an MDR-TB drug symposium in Yangon together with <u>Myanmar</u> Ministry of Health and the UNWHO.</p> <p>30 SEPTEMBER 2013 The former HAO in Rakhine drafts an advocacy strategy for planned release of publication "<i>From bad to worse: humanitarian crisis and segregation in Rakhine state.</i>"</p> <p>OCTOBER 2013</p> <ul style="list-style-type: none"> • MSFOCA <u>Myanmar</u> coordination team and MSF International HART series of meetings with key international stakeholders. • Decision to reinforce bilateral advocacy message with observations on political and human rights dimensions of the crisis, impact on humanitarian situation, and on MSF's operations.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013		<p>2 NOVEMBER 2013 Rakhine media and social media accused MSF OCA of “<i>bias</i>” in favour of Muslim patients.</p>	<p>NOVEMBER 2013</p> <ul style="list-style-type: none"> • One of MSF OCA detained staff is sentenced to five years in prison. • MSF OCG teams in Rakhine are forced to evacuate Kyauk Taw and to re-settle in Mrauk U due to community pressure. <p>2 NOVEMBER 2013 Following clashes between Muslim IDPs and Rakhine Buddhists, the MSF OCA team transferred injured Muslim IDPs to the hospital.</p>	<p>3 OCTOBER 2013 Myanmar daily, <i>The Irrawaddy</i> publishes an article on the denial of access for Muslims in Rakhine hospitals, based on MSF OCA information and quoting MSF OCA deputy HoM.</p> <p>11 OCTOBER 2013 MSF Stockholm Evaluation Unit writes: “<i>Retrospective lessons learned report</i>” on the MSF OCA emergency intervention in period from pre-June 2012 through August 2013.</p> <p>EARLY NOVEMBER 2013</p> <ul style="list-style-type: none"> • MSF OCA coordination team conduct a series of targeted print and radio interviews at the national level to reiterate the principles of humanitarian aid. • MSF OCA Myanmar team asks MSF international movement to refrain from public, proactive speaking out on the situation.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013	<p>19 NOVEMBER 2013 UN General Assembly resolution:</p> <ul style="list-style-type: none"> • Calls on Myanmar government to give Rohingya full access to Myanmar citizenship. • Call to put an end to violence against them. 	<p>21 NOVEMBER 2013 Myanmar president's, spokesperson:</p> <ul style="list-style-type: none"> • States that Myanmar cannot grant citizenship to Rohingya minority. • Asks UN to stop using the term "<i>Rohingya</i>" and instead, to use "<i>Bengali</i>." • Announces a census planned for 2014 that would not take the Rohingya minority into account. 		<p>28 NOVEMBER 2013 Discussion at EU parliament:</p> <ul style="list-style-type: none"> • Human Rights Watch calls on EU to establish an inquiry commission on abuses committed against Rohingya. • MSF representatives warn of risks of "<i>double jeopardy</i>" for most vulnerable people if donors and aid agencies are reluctant to intervene for fear of complicity in a policy of segregation.
	<p>16 DECEMBER 2013</p> <ul style="list-style-type: none"> • EU Foreign Affairs Council urges Myanmar government to respond to demands of UN resolution on "<i>situation of human rights</i>" in Myanmar. 			

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2013	<p>• UK embassy in Myanmar press release expressing concern over situation in Rakhine and urging local authorities to ensure that humanitarian agencies have free & unhindered access.</p> <p>30 DECEMBER 2013 Joint public statement from EU and embassies of Switzerland, Turkey, and USA calling for immediate and unimpeded humanitarian access to Taung Paw IDP camp in Myebon slum.</p>	<p>23 DECEMBER 2013 Local Rakhine radicals pressure Sittwe hotel owners to stop accommodating INGOs.</p>	<p>31 DECEMBER 2013 <u>Myanmar</u>: one of two MSF OCA staff detained since June 2012 released after presidential amnesty.</p>	<p>LATE DECEMBER 2013 MSF OCA's "From bad to worse: humanitarian crisis and segregation in Rakhine state" report postponed to 2014. No longer planned for public dissemination.</p>
2014				<p>3 JANUARY 2014 MSF OCA and MSF OCG press conference:</p> <ul style="list-style-type: none"> • Underscores harassment of aid workers. • Explains that MSF teams are providing medical care to people in need no matter their origin.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014		<p>9 JANUARY 2014 <u>Myanmar</u> Attack on Rohingya community members in Du Chee Yar Tan village, southern Maungdaw Township, Rakhine state.</p> <p>13 JANUARY 2014 <u>Myanmar</u>: police officer killed in Du Chee Yar Tan by Rohingya Muslims. Attacks on Rohingya community in retaliation.</p> <p>15 JANUARY 2014 <u>Myanmar</u> takes over ASEAN presidency.</p>	<p>14 JANUARY 2014 <u>Myanmar</u>: Members of MSF OCA local clinic near Du Chee Yar Tan explain they treated people traumatised by violent events. Local clashes continue and MSF clinic team treats more seriously wounded. MSF local staff threatened.</p>	<p>14 JANUARY 2014 MSF OCA decides against proactive data dissemination but is questioned by media as the only organisation operating in the area. To protect national staff, MSF accounts presented as coming from expatriate nurse.</p> <p>16 JANUARY 2014</p> <ul style="list-style-type: none"> • <i>Associated Press</i> and <i>The Irrawaddy</i> break MSF and Du Chee Yar Tan story. • MSF OCA's first reactive communication: on 13 January MSF staff treated two wounded people suffering from injuries inflicted as a result of violence; very few patients came to MSF clinic. • MSF OCA <u>Myanmar</u> CMT requests reactive communication to be broadcast from Amsterdam, to protect field team.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014	<p>17 JANUARY 2014</p> <ul style="list-style-type: none"> • US embassy in Yangon and UNSRHR in <u>Myanmar</u> express concerns about the clashes and ask for an investigation. • Representatives of UN OCHA and UNHCR visit Du Chee Yar Tan area but are not allowed to freely talk with population. <p>23 JANUARY 2014</p> <p>UN High Commissioner for Human Rights calls on <u>Myanmar</u> government to investigate “credible information” gathered by UN regarding 48 Rohingya Muslims killed in early January violence.</p> <p>24 JANUARY 2014</p> <p>OCHA Coordinator expresses her “deep concerns” over the massacre of many civilians and a policeman in Du Chee Yar Tan, <u>Myanmar</u>.</p>	<p>24 JANUARY 2014</p> <ul style="list-style-type: none"> • Fortify Rights, states they spoke with sources who confirmed the massacre. • <u>Myanmar</u> president’s spokesperson rejects Fortify Rights’ claims acknowledging only policeman’s death. • <u>Myanmar</u> Ministry of Foreign Affairs accused international media and agencies of misinformation, exaggeration, and distortion of situation. 	<p>22 JANUARY 2014</p> <p>MSF OCA’s Rakhine team has treated 22 victims of Du Chee Yar Tan clashes. Police harasses and intimidates MSF local staff.</p>	<p>17 JANUARY 2014</p> <ul style="list-style-type: none"> • MSFOCA broadcasts reactive communication from both Amsterdam and Yangon. • In the following days, MSF communication team in <u>Myanmar</u> continues briefing journalists with reactive communication, but without giving any interviews. <p>23 JANUARY 2014</p> <p>MSF OCA headquarters decides to issue a second reactive line on 24 January: MSF teams treated at least 22 patients believed to be victims of the Du Chee Yar Tan violence.</p> <p>24 JANUARY 2014</p> <p>MSF International HART, and MSF OCA operational team establish a bilateral advocacy emergency plan in order to:</p> <ul style="list-style-type: none"> • Exchange reliable information with diplomatic stakeholders. • Ask stakeholders to maintain diplomatic pressure on the <u>Myanmar</u> government and lobby for immediate humanitarian access.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014		<p>27 JANUARY 2014 Myanmar government press conference:</p> <ul style="list-style-type: none"> • Rejects call for an international investigation into the Du Chee Yar Tan events. • Declares that <i>"alleged massacres of Bengalis are fabricated news."</i> 	<p>17 FEBRUARY 2014</p> <ul style="list-style-type: none"> • MSF OCA team informed by Deputy MoH of Myanmar of wish to progress with signing MoU. • MSF OCA team asked to draft MoU clause certifying that MSF OCA would exercise caution in relations with communities. 	<p>LATE JANUARY 2014</p> <ul style="list-style-type: none"> • Myanmar government demands that MSF OCA deny its account of Du Chee Yar Tan events or provide a list of patients treated. • State media publishes accusations against MSF. <p>27 JANUARY 2014 MSF OCA decides to provide aggregate data as response to request from Myanmar government as opposed to individual data.</p> <p>THROUGHOUT FEBRUARY 2014 MSF OCA Myanmar communication team continue efforts to counter anti-MSF propaganda in mainstream media.</p> <p>7 FEBRUARY 2014 An updated <i>"proposal for a diffusion strategy"</i> of the postponed report <i>"From bad to worse: humanitarian crisis and segregation in Rakhine,"</i> is circulated to MSF OCG and MSF OCA Myanmar and Bangladesh programme managers.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014		<p>25 FEBRUARY 2014 Fortify Rights report denouncing abuses against Rohingya in <u>Myanmar</u> uses MSF's data taken from 2011 briefing paper "<i>Fatal Policy</i>."</p>	<ul style="list-style-type: none"> • No secondary healthcare activities can be included in the MoU. • Myanmar MoH wish to discuss number of expatriates in field. <p>26 FEBRUARY 2014 • MSF Rakhine management team summoned to meeting by Rakhine government officials: MSF activities in Rakhine no longer approved for lack of MoU. • MSF OCA asked to hand over all activities to <u>Myanmar</u> MoH.</p> <p>27 FEBRUARY 2014 MSF OCA <u>Myanmar</u> CMT received letter from Ministry of Home Affairs (MoA): MSFOCA's registration is cancelled and all activities in Myanmar must cease.</p> <p>28 FEBRUARY 2014 All MSF OCA programmes in <u>Myanmar</u> closed. • Limited MSF OCA activities in Rakhine, • MoH officer tells MSF OCA that suspension order is for programmes in Rakhine only. • MoH authorises reopening of HIV/AIDS programmes and other activities in Yangon, Kachin, and Shan states.</p>	<p>26 FEBRUARY 2014 MSF International HART to urgently call key contacts to deliver "<i>strong messages</i>" to <u>Myanmar</u> government about gravity of situation.</p> <p>28 FEBRUARY 2014 MSF OCA press release: "<i>MSF Concerned about the fate of thousands of patients in <u>Myanmar</u> after being ordered to cease activities.</i>"</p>

2014	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
		<p>3 MARCH 2014 <u>Myanmar</u>: Rakhine health department director declares:</p> <ul style="list-style-type: none"> • Rakhine authorities ready to take over MSF programmes. • Only definitive departure of MSF including all staff would put an end to community protests. 	<ul style="list-style-type: none"> • MSF OCA is warned that MoH decision has to be confirmed by MoA. • MSF OCA discussions in Amsterdam HQ about relevance of signing MoU without including Rakhine programmes • MSF OCA management team “<i>bottom line</i>” decision: “<i>MSF OCA would try and protect its presence in other Myanmar projects, even if it was no longer possible to be present in Rakhine state.</i>” 	<p>1 MARCH 2014</p> <ul style="list-style-type: none"> • MSFOCA press release: “<i>MSF to resume activities in Myanmar but concerns remain for Rakhine.</i>” • MSF’s EXCOM, votes in favour of strong reaction, but not a departure of all MSF sections from Myanmar. <p>MARCH 2014 MSF <u>Myanmar</u> deputy HoM and MSF OCA operational director, start negotiations with Myanmar authorities and Rakhine state to obtain authorisation to reopen programmes in Rakhine.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014		<p>6 MARCH 2014 Myanmar government health official to <i>The Myanmar Times</i>: <i>"Closure of MSF operations in Rakhine state is not permanent and would likely be rescinded in October or November."</i></p>		<p>7 MARCH 2014 MSF CH Board meeting:</p> <ul style="list-style-type: none"> • MSF OCA general director update of situation in Myanmar and explanation of OCA management team decision. • MSF CH board of directors asks for time to reflect on positioning. <p>8 MARCH 2014</p> <ul style="list-style-type: none"> • MSF OCA management team memo to all MSF OCA operational managers and HoMs to confirm and explain their decision. • Continuing intense debates within MSF Holland and OCA executive and association. <p>16 TO 23 MARCH 2014 MSF International President Dr Joanne Liu visit of several sites in Rakhine as part of a high-level delegation.</p> <p>24 MARCH 2014 MSF OCA press release: <i>"MSF acknowledging encouraging dialogue in Rakhine but clinics remained closed."</i></p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014	<p>30 MARCH 2014 UN Secretary General calls on <u>Myanmar</u> government to ensure safety of humanitarian workers and protection of all civilians in Rakhine.</p>	<p>26 AND 27 MARCH 2014 <u>Myanmar</u>: Just before census, Buddhist mobs attacks UN and INGO offices in Sittwe.</p> <p>END OF APRIL 2014 <u>Myanmar</u>:</p> <ul style="list-style-type: none"> • Rakhine state Emergency Coordination Committee (ECC) insists that MSF is expelled from Rakhine and should leave. • MoH initiates MSF OCA's re-registration process with recommendation letter. 	<p>26 AND 27 MARCH 2014 <u>Myanmar</u>: Many organisations forced to suspend activities and partially evacuate staff including MSF OCA.</p> <p>22 MAY 2014 MSF OCA operational platform decides not to submit any MoU that does not include Rakhine.</p>	<p>MAY 2014 World Health Assembly: MSF International president Dr Joanne Liu meeting with <u>Myanmar's</u> Minister of Health.</p> <p>24 MAY 2014 MSF Holland general assembly:</p> <ul style="list-style-type: none"> • Tasks MSF Holland board and representatives of OCA Council to clarify MT decision.

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014		<p>JUNE-JULY 2014 INGO Watch Group created in March 2014 begins spreading false allegations and threats on social media in Rakhine, <u>Myanmar</u>.</p> <p>24 JULY 2014 Spokesperson for <u>Myanmar</u> president's office press conference calls all INGOS to "join hands with (them), especially MSF." Myanmar to guarantee safety of MSF's staff in Rakhine.</p>	<p>JUNE 2014</p> <ul style="list-style-type: none"> MSF OCG finally declines Rakhine authorities' proposal to work in Rakhine without expatriates. MSF OCA third exploratory mission in <u>Thailand</u> and <u>Malaysia</u> <p>JUNE AND JULY 2014 MSF OCA manages to work with MoH teams in Rakhine villages and some displaced camps under police escort.</p> <p>27 JUNE 2014 MSF OCA receives signed registration document from MoH for programmes in <u>Myanmar</u>.</p>	<ul style="list-style-type: none"> Asks to ensure that MSF's interventions in <u>Myanmar</u> are in line with MSF's core identity, fundamental principles. Asks to make every effort to resume meaningful programmes in Rakhine using all means at disposal. MSF OCA should, if necessary, speak out publicly on denial of access and on the plight of the Rohingya, even if it means expulsion from the country. Executive to report back to members of general assembly within three months. <p>JUNE 2014 MSF International president sends a letter to the <u>Myanmar</u> government expressing dissatisfaction with the continued ban on MSF activities in Rakhine.</p> <p>EARLY JULY 2014 MSF OCA director of operations and <u>Myanmar</u> operations manager meet high-level stakeholders in the USA.</p> <p>24 JULY 2014 MSF OCA reactive communication: MSF hopes to continue constructive discussions with Myanmar MoH.</p>

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2014			<p>MID-AUGUST 2014 MSFOCA operational platform decision to open programme in <u>Malaysia</u>.</p> <p>8 SEPTEMBER 2014 MSF OCA and <u>Myanmar</u> Ministry of Health sign MoU for MSF OCA medical activities in Myanmar, including Rakhine.</p>	<p>25 JULY 2014 MSF OCA statement: “MSF welcomes offer to resume operations in <u>Rakhine, Myanmar</u> but remains cautious.”</p> <p>EARLY AUGUST 2014 Ahead of US secretary of state’s visit to <u>Myanmar</u>, MSF OCA mobilises leading US and international media on Rakhine situation</p> <p>MID-AUGUST 2014 Strategic advocacy in favour of unregistered refugees to be integrated in MSF <u>Malaysia</u> intervention.</p> <p>9 SEPTEMBER 2014 MSF OCA publicly declares they are “committed to fully develop this agreement and stands ready in cooperation with the [<u>Myanmar</u>] MoH to resume operations in <u>Rakhine</u> at any time.”</p> <p>MID-DECEMBER 2014 MSF OCA begins to question if they should continue to compromise to ensure a presence in <u>Rakhine</u>.</p>
2015			<p>IN 2015 Release of last detained MSFOCA staff member.</p>	

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2015			<p>JANUARY 2015 MSFOCA resumes activities in Rakhine, <u>Myanmar</u>.</p>	<p>20 JANUARY 2015 MSF OCA press release: "MSF restarts basic medical activities in parts of <u>Myanmar's Rakhine state</u>."</p> <p>30 MAY 2015 MSF Holland general assembly: <ul style="list-style-type: none"> • Considers that 2014 <u>Myanmar</u> motion is not acted upon by MSF Holland board of directors. • New motion calling for "an <i>independent and comprehensive review of MSF's strategy vis-a-vis the Rohingya in Myanmar over the last 5 years</i>." • Open debate on findings to be organised. </p> <p>SEPTEMBER 2015 OCA 'café' in Amsterdam: MSF advocacy regarding Rohingya discussed by all MSF OCA heads of mission.</p>
2017		<p>AUGUST 2017 Unprecedented wave of violence in <u>Myanmar</u>: <ul style="list-style-type: none"> • Thousands of Rohingya massacred in Rakhine. • Exodus of more than 700,000 Rohingya to <u>Bangladesh</u>. </p>		

	International	Myanmar, Bangladesh and South East Asia	MSF Operations	MSF Public Statements and Advocacy
2017				14 DECEMBER 2017 MSF International press release: "MSF survey estimates that at least 6,700 Rohingya were killed during the attacks in <i>Myanmar</i> ."
2019	<p>NOVEMBER 2019</p> <p>Three separate international legal proceedings are filed against Myanmar for crimes against the Rohingya:</p> <ul style="list-style-type: none"> • In UN International Court of Justice (ICJ). • In Argentina under "universal jurisdiction." • By International Criminal Court (ICC). 			

The Speaking Out case studies is a series of studies from Médecins Sans Frontières (MSF) that openly examine and analyse the organisation's actions and decisionmaking process during complex humanitarian interventions focusing on dilemmas surrounding speaking out.

The methodology aims at establishing the facts and setting out a chronological presentation of the positions adopted at the time. It enables the reconstruction of debates and dilemmas without pre-judging the quality of the decisions made.

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