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# SUMMARY

THE MSF SPEAKING OUT CASE STUDIES

# MSF AND THE ROHINGYA 1992-2014

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The summary lays out the context and the content of MSF's public statements and the key dilemmas they sought to address.

It is part of a more detailed case study that reconstructs the events using excerpts from documents taken from the MSF archives or from media coverage at the time, as well as interviews with MSF personnel.

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# SUMMARY

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 Muslim[1] 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 Myanmar[2].

**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 UNHCR to ensure that repatriation was free from any constraints.

1. There are Rohingya Christian and Hindu minorities.
2. Human Rights Watch Rohingya population estimates, https://www.hrw.org/tag/rohingya

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/AZG[3] opened their first programme of basic healthcare in the Yangon townships. From 1994, under the leadership of the Coordinator 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 coordinator'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 coordinator'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.

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.

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.

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 Holland/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 Holland/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 Holland/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 Holland/OCA to publicly speak out. In February 2010, MSF Holland/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 Holland/OCA teams experienced increased government bureaucracy, monitoring, and investigation of their activities in Kutupalong camps. Further, the Bangladeshi government refused to grant MSF Holland/OCA official registration.

In July 2012, the Bangladeshi authorities ordered MSF Holland/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 Holland/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 Holland/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 Holland/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 Holland/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 Holland/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 Switzerland/OCG opened a primary health care program in Rakhine, also with separate clinics, similar to MSF Holland/OCA's approach. MSF Switzerland/OCG 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 Holland/OCA's advocacy activities concentrated on regaining lost access due to insecurity. In addition to regular, bilateral advocacy, MSF Holland/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 Holland/OCA's positioning surrounding ethical dilemmas and advocacy strategies. A proposed strategy based on "red flags" emerged. In 2013, MSF Holland/OCA and MSF Switzerland/OCG created a communications manager position in Myanmar to better coordinate communication and social media strategies. On 7 February 2013, MSF Holland/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 Holland/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 Holland/OCA and MSF Switzerland/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 Holland/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 Myanmarese authorities. As a result, on 27 February 2014, MSF Holland/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 Holland/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 Holland/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 Holland/OCA executive and associative bodies. In 2014 and 2015, motions were voted on by MSF Holland's general assembly to push MSF Holland/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 Holland/OCA struggled to regain access to Rakhine, despite local hardliner strong and often violent opposition. In early 2015, MSF Holland/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 Holland/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 particular, for those in Thailand and Malaysia. In August 2014, after several exploratory missions, MSF Holland/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?

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Thank you for reading.

If you would like to explore these events further, we invite you to consult the SOCS project website where you will find:

- the complete case study
- maps showing where MSF worked
- a detailed chronology
- MSF videos and extracts from the period

Some case studies have also been adapted into podcasts and online courses

Find all the MSF Speaking Out Case Studies materials here:
www.msf.org/speakingout/all-case-studies