



ASSOCIATIVE PROJECT





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# OUR FUNDAMENTALS

As members of Doctors of the World–Médecins du Monde (MdM), we want a world where barriers to health have been overcome and where the right to health has been achieved.

## > Social justice

We believe in social justice as a vehicle for equal access to healthcare, respect for fundamental rights and collective solidarity.

## > Empowerment

With our partners, the communities and their representatives, we help empower all socially and physically vulnerable populations to take action within their social environment, to become actors in their own health and to exercise their rights.

## > Independence

Our organisation is independent of all political, religious or financial authorities or interests. We are independent in the choice of our programmes and operating methods. We refuse all forms of subordination and foster dialogue with the people and the communities with which we work.

## > Commitment

As a movement of committed and militant professionals made up of volunteers and salaried staff, we provide medical services, bear witness and – strengthened by our diversity – support populations seeking social change.

## > And balance

We seek balance between national and international action, between emergency and long-term actions, between medical and lay knowledge and between public funding and private donations.

This balance is a key factor in our relevance and our originality. ■

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## OUR ACTION PRINCIPLES

### > Provide healthcare

We want populations to obtain real access not just to health care, but to all the components of health, whether physical, mental or social. In keeping with medical deontology, we support individuals and communities striving to influence the social determinants of health by providing medical services and adopting a community-based approach.

### > Bear witness and advocate

Beyond our indignation and revolt, we seek to expose and denounce the unacceptable. We produce expert assessments and testimonies based on our field work to mobilize civil society. We call on national and international authorities to facilitate access to health care and promote respect for human rights. We want to influence political decisions to obtain better health protection for individuals and communities. If necessary, we defend our causes in the courts until we obtain jurisprudence in our favour or legal and regulatory changes.

We campaign for state-organised health systems that are accessible to all and founded on the principles of equity and solidarity. We reject the commodification of health and human beings.

### > Support communities seeking social change

We are convinced that to achieve lasting change populations must be empowered to become actors in their own health. Their empowerment guides our action.

Beneficiaries are involved in the design, running and evaluation of our programmes.

We support them in developing public health policies that meet their needs. Medical and lay knowledge are combined to promote proactive policies reflecting both expertise and democracy.

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# TOWARDS SUSTAINABLE AND QUALITY PRACTICES

## > Social and political innovation

We work to reduce socially-determined health inequalities documented in particular by public health data.

When a population highlights gaps, malfunctions or incoherencies in the workings of ordinary law, we help to bring this population, experts and deciders together to discuss them.

We are active in the field of social and political innovation that we define as the translation of a social consensus into a law, a rule or a right that are jointly developed and effectively applied. When these rights are denied by governments, our action can, in the right conditions, extend to civil disobedience.

It is our responsibility to guarantee the quality and relevance of our practices by constantly evaluating them to ensure they are effectively meeting the populations' needs and demands. It is also our responsibility to ensure that our interventions are sustainable when our programmes come to an end.

## > Action at home and abroad

We conduct our activities in the national, European and international arena. Wherever we intervene, we provide medical services for and work with the most vulnerable populations and support the improvement of health systems.

## > Political partnerships

To ensure inter-dependant and balanced humanitarian practices, we foster partnerships with representatives of the populations concerned, with local NGOs and with civil society movements or institutions.

These partnerships are intended as political alliances and are founded on shared values and objectives for building joint and appropriate responses to needs.



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## FOR A DIFFERENT HUMANITARIAN MODEL

### > An ethic of responsibility

We adhere to a humanitarian model that offers an alternative to the “humanitarian market”, setting our sights on health and social democracy. This means empowering populations to refuse, denounce and take action against the unacceptable.

We measure the strength and relevance of our actions by their medico-social impact rather than by the amount of funding committed to them. We are accountable to our beneficiaries and donors for the consequences of our interventions.

### > Diversifying our funding to strengthen our independence

Our political independence is intrinsically linked to our financial independence. We obtain this financial independence by diversifying our sources of funding.

We must therefore ensure that donations from the general public continue to constitute a large proportion of our resources.

This independence helps prevent us from being subordinate to governments and to their political, economic or military agendas which are often far removed from the needs of the population and must not be allowed to decide in our stead.

Our choices are dictated by humanitarian ethics and by our priorities. Our freedom of speech and action is not negotiable.

### > Fostering coalitions of common causes

We consider operating as a network as the best way to take effective action and influence a complex, chaotic and uncertain world.

We are therefore evolving toward a reticular, multi-nodal model and developing exchanges, decentralised inter-relations and interdependencies between Mdm chapters and their partners.

The member chapters of Mdm’s international network share the same vision, identity and values. Each works in its own country and runs or supports programmes in other countries.

This network also hosts associate members who relay our advocacy campaigns and contribute where necessary to data collection.

The network itself, or some of its members, take part in coalitions or are part of inter-associative platforms. More generally, we form temporary alliances to promote common causes, achieve political goals or reach shared objectives.

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## OUR GOVERNANCE IN PHASE WITH OUR ASSOCIATIVE MODEL

Principles of openness, diversity, sharing and collective development guide the governance of our organisation and its evolution. These principles ensure that information, ideas and innovations travel back and forth between the field and decision-making bodies. Our governance is built on shared adherence to our values, project and vision, and on strengthening our common identity.

### > An associative model founded on commitment

Voluntary work is an essential part of our organisation's dynamics in terms of mobilisation and influence.

Citizen commitment is at the heart of our associative model, underpinning our accountability, decision-making and influence.

This commitment of MdM's volunteers and salaried staff guarantees the quality of the actions implemented and extends the reach of our advocacy.

### > The practice of democracy

MdM's action is founded upon active participation in civil society.

We recognise the importance of and aim to enhance the complementarity of activism, professional commitment and citizen adherence in our organisation and political project.

In order for everyone to be associated in decisions, our governance bodies are accessible and adapt to all our stakeholders: international network members, partners, employees, beneficiaries and donors.

So that everyone can contribute to the present and the future of the society in which he or she lives, MdM supports all actions aimed at extending rights and making progress towards real equality.



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**DOCTORS OF THE WORLD,  
35 YEARS AND BEYOND**



## > 1980s: the first battles

Doctors of the World – Médecins du Monde (MdM) was born in 1980 in the wake of the “Boat for Vietnam” operation bringing assistance to Vietnamese boat people in the China Sea.

MdM’s founding principles were to work as volunteers where no-one else was working and to bear witness to the unacceptable.

In a world still marked by the East-West divide, MdM ran projects in countries in crisis (Afghanistan, Poland, Salvador, Nicaragua, Armenia, etc.)

In 1986, MdM began our fight against exclusion from health care in France with the opening of our first health clinic. The following year, MdM set up the first free and anonymous HIV testing centre in Paris.

## > 1990–2000: humanitarian aid organisations in the forefront

After the fall of the Berlin wall, humanitarian aid organisations became actors in the new world order under construction. Humanitarian action became more complex and more professional. MdM’s own activities grew substantially.

MdM began focusing on community health, where the emerging issue was how to involve the populations concerned and share power. As a promoter of human rights, international

humanitarian law and the duty to intervene, MdM actively campaigned for the setting up of the International Criminal Court.

In 1993, our international network was born. MdM chapters were founded and began developing programmes in Europe, America and Asia. An international secretariat was established.

In France, MdM’s political influence grew as more free health clinics were opened, outreach activities were developed and harm reduction programmes were launched (syringe exchange and methadone replacement therapy from 1994).

Key battles fought by coalitions of which MdM was an active member led to the adoption in France of a law to prevent and combat all forms of social exclusion in 1998, followed a year later by the establishment of universal health coverage (CMU), state medical aid (AME) and healthcare access centres (PASS). In 2004, harm reduction was incorporated into the Public Health Code.

The transposition into ordinary law of a part of MdM’s programmes and advocacy was a success.

## > 21st century: humanitarian action restructured in the face of globalisation

The terrorist attacks of 11 September 2001 marked the start of a new era.

The security of aid workers has since become a major issue.

Increasingly well-trained local actors have emerged. Non-western international operators have appeared. International NGOs are now competing for access to funding, human resources or intervention zones.

By substituting for failing state-based or international institutions, humanitarian action is now at risk of political instrumentalization. It is faced with growing insecurity and has on occasions been rejected.

MdM remains faithful to its founding principles and has developed a strategy of alliances in order to maintain room for manoeuvre and its freedom of action. To avoid being dependent on the foreign policy agenda of states, MdM conducts our actions with local partners. These partnerships strengthen its legitimacy and help ensure the sustainability of its interventions and consolidate its associative model.

MdM runs emergency and long-term programmes for the most vulnerable and stigmatised populations, treating situations of worsening poverty and social inequity as a priority.

Since 1995 in France and 2006 in Europe, MdM has published a yearly report on access to health care which confirms the need and pertinence of this priority.

MdM is particularly attentive to the vulnerabilities generated by economic growth, climate change, the development of urban centres, the intensification of migratory flows and demographical trends. MdM seeks to measure and reduce the environmental impact of its actions.

## > What legitimacy for humanitarian interventions ?

The legitimacy of humanitarian action has evolved over time.

Initially founded on universal humanist ethics, this legitimacy was first drawn from acts of solidarity driven by compassion. The aim was to reach out to others in difficulty, to relieve their suffering and take care of them. This approach permitted transgressions in the name of "universal" values, imposing its presence wherever it saw fit and crossing borders.

This extremely "unilateral" position next drew its legitimacy from major reforms in the law. The development of international humanitarian law (Additional Protocols to the Geneva Convention in 1977) and the advent of international criminal law (ad hoc

courts for Former Yugoslavia and Rwanda, followed by the International Criminal Court) broadened and structured the legitimacy of humanitarian action. The duty to intervene became a responsibility to protect. Aid agencies drew up a Charter (Krakow – 1990) that MdM applied via doctrine of "Providing Care and Bearing witness".

In addition to ethics and law, there was also a third basis for the legitimacy of humanitarian interventions, this time social and political. With the introduction of the notion of socially-determined health inequalities, MdM's action began to focus on social transformation.

Meeting basic needs and denouncing injustice and the violation of rights remained central to MdM's action, but its scope was extended to include working towards social change and involving populations in the transformation of their own environment.

Bringing a citizen perspective to humanitarian action by involving all the stakeholders – aid beneficiaries and aid workers – became a major objective. It took different forms and was experienced differently according to national contexts.

## > 2015 and beyond

MdM came into being in a bipolarised world that no longer exists. Today's world is increasingly characterised by financialisation and short-termism, as well as by a growing urbanisation (by 2030 two-thirds of human-beings will live in towns) that is changing relations between and within communities.

With new technologies have come new forms of mobilisation. Civil societies are becoming organised and structured in the countries where MdM works. MdM wants to incorporate these changes and be part of these developments.

### Références :

Droit international humanitaire (convention de Genève – 1949)  
Déclaration universelle des droits de l'homme (1948)  
Déclaration d'Alma Ata sur les soins de santé primaires (OMS – 12 septembre 1978)  
Charte d'Ottawa pour la promotion de la santé (OMS – 1986)  
Charte européenne de l'action humanitaire, dite de Cracovie (31 mars 1990)  
Cour pénale internationale (traité de Rome – 1998)  
Charte de Dunkerque (2009)  
Charte mondiale des migrants : <http://charte-migrants.net>  
Déclaration de Grenade (2014)



