ASSOCIATIVE PROJECT
DRAFT VERSION

MÉDECINS

OUR FUNDAMENTAL PRINCIPLES

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 is recognised.

> For social justice

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

> To help populations achieve 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.

> With complete independence

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

> On the basis of engagement

As a movement of engaged and militant professionals made up of volunteers and paid staff, we provide medical care, bear witness and, strengthened by diversity, support populations seeking social change.

> And balance

We seek balance between at home and abroad, between emergency and long-term actions, between medical and lay knowledge and between public funding and private donations.
This balance is a demonstration of our relevance and our originality.

We want a world where barriers to health have been overcome and where the right to health is recognised

OUR ACTION PRINCIPLES

> Care and cure

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 health approach.

> Bear witness and advocate

Over and above our indignation and revolt, we seek to expose and denounce the unacceptable. To do so, we draw on expert assessments based on our field practices and testimonies and use these to mobilise civil society.
We lobby national and international authorities to facilitate access to health care and promote respect for human rights. It is our aim to influence political decisions to obtain better health protection for individuals and communities. If necessary, we will fight for our causes in the courts until we obtain jurisprudence in our favour or legal and regulatory changes.
We lobby for state-organised health systems, 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 that reflect both expertise and democracy.

TOWARDS SUSTAINABLE AND QUALITY PRACTICES

> Social and political innovation

We work to reduce socially-determined health inequities confirmed by probative 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 to the same table 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 or a rule that is jointly developed and effectively applied.
It is our responsibility to ensure the quality and relevance of our practices by constantly evaluating them to verify that they are effectively meeting the populations' needs and demands.
It is also our responsibility to ensure the sustainability of our programmes when our interventions come to an end.

> Action at home and abroad

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

> Political patnerships

To ensure inter-dependant and better balanced humanitarian practices, we foster partnerships with representatives of the populations concerned, local NGOs and 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.

FOR A DIFFERENT HUMANITARIAN MODEL

> An ethic of responsability

We adhere to a humanitarian model that offers an alternative to the "humanitarian market", with our sights set 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 financial independence largely determines our political independence. We obtain it by diversifying our sources of funding.
We must ensure that donations from the general public continue to make up 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 to be 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 multiplying exchanges, decentralised inter-relations and interdependencies between MdM associations and their partners.
The member associations 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 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 working on specific themes or in support of specific causes.
More generally, we form temporary alliances to promote common causes, achieve political goals or reach shared objectives.

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 reinforcement of our common identity.

> An associative model founded on engagement

Voluntary work must be preserved as a source of energy for the dynamism of our organisation and its influence capability.
Citizen commitment is the lynchpin of our associative model. It underpins our responsibility, decision-making and power.
This commitment by MdM's volunteers and paid 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 our active participation in civil society.
We recognise and wish to enhance complementarity, activism, professional commitment and citizen adherence in our organisation and political project.
So that everyone is associated in the decision-making, our governance bodies open up and adapt to all the stakeholders: members of the international network, partners, employees, beneficiaries and donors.
And 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 moving forward towards real equality.
When these rights are denied by governments, our action can, in the right conditions, extend to civil disobedience.

MÉDECINS
DU MONDE

DOCTORS OF THE WORLD, 35 YEARS AND BEYOND

> 1980s : the first battles

Doctors of the World or Médecins du Monde (MdM) was born in 1980 in the wake of the "Boat for Vietnam" operation for bringing assistance to Vietnamese boat people in the China Sea.
MdM's founding principles were to go where no-one else went, working as volunteers and bearing witness to the unacceptable.
In a world still marked by the East-West divide, we ran projects in countries in crisis (Afghanistan, Poland, Salvador, Nicaragua, Armenia, etc.)
In 1986, we began our fight against exclusion from health care in France with the opening of our first care center. The following year, we set up the first free and anonymous HIV testing center in Paris.

> 1990–2000: aid organisations in the forefront

After the fall of the Berlin wall, humanitarian organisations became key players in the new world order under construction. Humanitarian action became more complex and more professional. MdM's own activities grew substantially.
We 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 and international humanitarian law and a believer in the duty to intervene, we actively lobbied for the setting up of the International Criminal Court.
In 1993, our international network was born. MdM associations were founded and began developing programmes in Europe, America and Asia. An international secretariat was established.
In France, MdM's political influence grew as we opened more health clinics, developed outreach activities and launched harm reduction programmes (needle exchange and methadone replacement therapy from 1994).
Battles fought by coalitions of which we were an active member led to the adoption in France of a law to combat all forms of social exclusion in 1998, followed a year later by the establishment of universal healthcare coverage (CMU), state medical assistance (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

LThe 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 discovering competition for access to funding, human resources or intervention zones.
Because it substitutes for failing state-based or international institutions, humanitarian action is at risk of political instrumentalization. It is faced with growing insecurity and has on occasions been rejected.
At MdM, faithful to our founding principles, we have developed a strategy of alliances in order to maintain our room to manoeuver and freedom of action. To avoid being dependent on the "foreign affairs" of states, we conduct our actions with local partners. These partnerships strengthen our legitimacy, help ensure the sustainability of our interventions and consolidate our associative model.
We run emergency and long-term programmes. They prioritize action for the most vulnerable and stigmatised populations, especially when it is proved that poverty or social injustice are worsening.
Since 2005, MdM has published a yearly report on access to health care in Europe which has confirmed the need and pertinence of this priority.
We are especially careful to the vulnerabilities generated by economic growth, climate change, the development of urban centres, the intensification of migratory flows and demographical trends.
We seek to measure and reduce the environmental impact of our actions.

> What legitimacy for humanitarian interventions ?

The legitimacy of humanitarian action has evolved over time.
Initially founded on universal humanist ethics, legitimacy was first found in 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. However, in the name of "universal" values, this approach permitted transgressions, 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, and then 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 (Cracow – 1990) that we applied at MdM via our doctrine, «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 notions of health disparities and social determinants, MdM's action began to focus on social transformation. Meeting basic needs and denouncing injustice and the violation of rights remained central, but the scope of our action 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.

> And now

Our organisation 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, new forms of mobilisation are appearing. Civil societies are becoming organised and structured in the countries where we work and we must listen to them, understand them and work with them. MdM wants to incorporate these changes and be part of these developments.
Drawing on our history and legitimacy, we want to reaffirm what brings us together and redefine our project for the future.

References :
International humanitarian law (Geneva Convention – 1949)
Universal Declaration of Human Rights (1948)
Declaration of Alma-Ata on Primary Health Care (WHO – 12 September 1978)
Ottawa Charter for Health Promotion (WHO-1986)
European Charter of Humanitarian Aid, known as the Krakow Charter (31 March 1990)
International Criminal Court (Treat of Rome – 1998)
Dunkirk Charter (2009)
World Charter of Migrants: http://charte-migrants.net
Granada Declaration (2014)

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