FINAL – LA MANCHA AGREEMENT – 25 June 2006, Athens

THE LA MANCHA AGREEMENT

The La Mancha process grew out of a need to address internal and external challenges facing MSF's work. After over a year of discussion and debate, it is clear that all sections of MSF have a common understanding of the basis for our action as both medical and humanitarian, and inextricably linked with the expression of public positions and describing our experiences ("temoignage") to the point that the separation of the concept of "temoignage" from operations has disappeared.

Our basic principles remain those expressed in the Charter and Chantilly documents. These principles should be referred to when taking and reviewing decisions, with the acknowledgement that every decision is a singular act and not made by the mechanical application of principles.

Complementary to the Charter and the Chantilly Principles, the La Mancha Agreement is not a comprehensive description of MSF action. It outlines aspects of our action on which we agree and feel are indispensable, taking into account our past experience, and identifying current and future challenges to this action. As such, the La Mancha Agreement is a reference document and the issues it raises will be regularly reviewed.

Our past experiences, including both failures and successes and related contradictory discussions, have had a great deal of influence on the evolution of the conception of our role. Some of these successes, failures and challenges are outlined below, and some of the conclusions we have reached on our action, in conflict as well as in response to specific medical issues, are contained in the document.

Due to our increasing interdependence within the MSF movement and our shared goals, we recognize that to continue to improve our work, we need a clearer and stronger governance structure based on what we value most, namely our social mission (our operations and public positions) and our associative nature. The La Mancha Agreement commits MSF to clarifying and strengthening our international associative governance.

The La Mancha Agreement also recognizes the urgent need to address any issues of discrimination within MSF that are undermining our ability to realize our full operational and associative potential.

To explain how the La Mancha process came to these understandings, it is essential to recognize the role played by the diversity of opinions and ongoing internal debate – one of the major strengths of our association – on both our failures and successes, and the challenges we are facing in various contexts.

In conflict settings in the past, MSF has called for specific political solutions, for example, military intervention in Zaire (1996). We have witnessed the failure of implicit or explicit "international protection" in Kibeho (Rwanda, 1995) and Srebrenica (1995). We have also been confronted with the massive diversion of humanitarian aid, including ours, for the benefit of war criminals (Rwandan refugee camps between 1994 and 1996, Liberia between 1991 and 2003). And, we are currently at risk due to a false perception of our involvement in International Justice in northern Uganda (2005). We have learned to be cautious in our actions in such circumstances without precluding MSF from denouncing grave and ignored crimes such as the bombing of civilians, attacks on hospitals or diversion of humanitarian aid. Taking public positions in reaction to such situations and confronting others with their responsibilities remains an essential role of MSF.

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In recent years we have seen the multiplication of military interventions that include the deployment of a "humanitarian" component among their strategic goals (Kosovo 1999, Afghanistan 2001, Iraq 2003) and the emergence of political and military forces that reject our very presence. This reality has led us to define our understanding of risk, and the reaffirmation of our independence from political influence as essential to ensuring the impartial nature of our assistance.

MSF has intervened in crises with medical consequences that are not armed conflicts, but can often be characterized as catastrophic. The numbers of people affected and the type of specialized care required in such situations has been beyond the capacity of local health structures. In these contexts, many people have been excluded from care due to a variety of factors, including the limited use of preventive medical techniques known to be effective, the unavailability of treatments for certain pathologies, the use of inefficient treatments for others and the existence of various barriers to treatment.

Our experience in such contexts has shown us that we cannot rely solely on the transfer of knowledge and techniques from the practice of wealthy countries to overcome such obstacles to care. Even when the pathologies encountered resemble those found in wealthy countries in a biological sense, their epidemiological profiles and the life circumstances of both patient and caregivers are often so radically different that they require innovations and adapted medical protocols and practices. In addition, certain pathologies are confined to populations who rarely constitute a focus for research and development. Therefore, we have learned to adapt, campaign for, and find innovative solutions to improve the medical care for patients in our programs and beyond.

There is no doubt that we have ignored or failed in various medical issues over time, including a lack of attention to the information given to patients, to consideration of their concerns and choices, to the management of pain, and to the prescription of the most appropriate medicines. We must question our acceptance of this status quo and try to address what we are neglecting today.

Our actions, both through our field medical interventions, as well as the Campaign for Access to Essential Medicines, have been concrete and led to significant results for those in our programs and beyond, but do not attempt to propose global or comprehensive solutions. We have also learned that our support for some global solutions in the past, while in good faith, turned out to be incompatible with our basic principles. A particular example of this being MSF's support of cost-recovery systems that have led to the exclusion of a great number of people from treatment both within and outside our programs.

We are challenged by the very nature of the AIDS pandemic as a life-long disease and it has forced us to re-examine our modes of intervention. We have had some success: the introduction of antiretrovirals in our programs and the comprehensive approach to treatment, care and prevention. Our medical action has not provided a solution to the global pandemic, but has assisted a number of people and has underlined the necessity for an improved medical, political and social response to this disease.

MSF International Council, 25 June 2006, Athens

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1. ACTION

1.1. Providing medical assistance to the most vulnerable people in crisis due to conflict and, when necessary, exposing obstacles encountered, remain at the core of MSF's work.

1.2. In catastrophic situations that temporarily overwhelm individuals, communities and local health structures – especially in the absence of other actors – we strive to provide quality medical and other relevant care in order to contribute to the survival and relief of as many people as possible.

1.3. The individual medical-humanitarian act, as carried out by all MSF staff, the majority of whom live and work in the countries of intervention, is central to the work of MSF.

1.4. Considering the current poor response of humanitarian aid to meet the needs of people in crisis, MSF's primary responsibility is to improve the quality, relevance and extent of our own assistance.

1.5. Obtaining quality clinical results while maintaining respect for the patient must be the major criteria used to evaluate the progress of our medical practice.

1.6. MSF affirms its willingness to pursue essential innovation and to continue to undertake initiatives in the constant search for relevant and effective action. Consequently, different approaches and operational strategies can naturally co-exist within the MSF movement. Considering that diversity of action within the framework of MSF's common purpose and ambition is critical in improving our operations, different operational strategies can and should be implemented at national and international levels

1.7. While building on our direct experience with innovative strategies, MSF must measure its own impact and abandon ineffective therapeutic strategies and intervention methods, and make the best possible use of those that have been proven effective.

1.8. We should make the results and critiques of our actions public, and analyze and document our actions and any obstacles (medical, political, economic, etc.) preventing patients in our programs from access to quality care, underlining the necessity for change. This can, and at times, should contribute to elements of a response that can benefit people outside of our programs.

1.9. In the case of massive and neglected acts of violence against individuals and groups, we should speak out publicly, based on our eyewitness accounts, medical data and experience. However, through these actions we do not profess to ensure the physical protection of people that we assist.

1.10. MSF intervenes by choice – not obligation or conscription – and may decide not to be present in all crises, especially when targeted threats against aid workers exist.

1.11. We strive to prevent the work we do and our assets, both symbolic (i.e. our trademark and image) and material, from being diverted or co-opted for the benefit of parties to conflicts or political agendas.

1.12. Although justice is essential, MSF differs from justice organizations by not taking on the responsibility for the development of international justice and does not gather evidence for the specific purpose of international courts or tribunals.

1.13. MSF actions coincide with some of the goals of human rights organizations; however, our goal is medical-humanitarian action rather than the promotion of such rights.

1.14. The diversity of contexts, circumstances and cultures in which we practice requires us to turn each medical choice into a singular act rather than a mechanical application of principles. We must make such choices together with those we assist and with a careful consideration of the possible alternatives and a grave concern for the potential consequences. This entails being explicit and transparent in our choices and dilemmas related to medical ethics, which remain, for us, core points of reference.

2. ***GOVERNANCE***

2.1. All MSF sections are linked together by a common name and logo, and common principles as expressed by the Charter and Chantilly documents. The statutes of 'MSF International', the La Mancha Agreement, resolutions of the IC and a high level of interconnection and interdependence complete these links.

2.2. Mutual accountability and active transparency in MSF, both at sectional and international levels, are essential to improving the relevance, effectiveness and quality of our interventions.

2.3. MSF is accountable and actively transparent to those we assist, our donors and the wider public. Accountability to those we assist may be difficult to achieve in certain situations, but the minimum requirement is that we are actively transparent about the choices made and the limits of our ability to assist. This external accountability is also essential to improving the quality of our interventions.

2.4. Informed and active associations and their representatives are crucial to assuring the relevance of our action and the maintenance of a strong MSF international movement. Invigorating participation in the associative at all levels of MSF is essential to building and maintaining credible, competent and relevant international governance.

2.5. MSF staff members are personally responsible and accountable for their own conduct, in particular regarding abuse of power. MSF is responsible for establishing clear frameworks and guidelines for holding staff accountable for their conduct.

2.6. National Boards are accountable for the actions and the use of resources of their section to the other sections of MSF.

2.7. For practical reasons of international coherence, the responsibility delegated by national sections to their respective presidents for taking international decisions should be uniform throughout the movement.

2.8. Among other issues, the IC is charged with the responsibility to:
- Oversee the implementation and guide the strategic direction of MSF's social mission, in regards to both operations and public positioning, especially through the critical review of its relevance, effectiveness and quality;
- Provide a framework for managing the growth and the sharing of resources of MSF as an international organization;
- Uphold mutual accountability among sections.
Practically, a large part of this responsibility is delegated to and implemented by the sectional General Directors as members of the GD19.

2.9. In carrying out its responsibilities, the IC is accountable to MSF associations. Timely and transparent reporting is essential. The IC is responsible for putting mechanisms in place to ensure and evaluate the quality of its work and the ability of its members to fulfill their responsibilities.

2.10. In order to encourage diversity and innovation of action, a decentralized MSF movement should be maintained. However, for the sake of coherence and the overriding interests of the MSF movement, binding international decisions by the IC, to which all section must adhere, are required on some core international issues. These include:
- The development, direction and growth of MSF as an international organization. This includes the opening and closing of sections and operational centers.
- Issues that affect the Charter, the Chantilly Principles, the MSF trademarks and the La Mancha Agreement.
- Issues relating to MSF's responsibilities as an employer, including abuse of power.
- Active transparency and accountability, both internal and external, among sections.

2.11. Participation in international operational support projects is an option for sections and a way to encourage innovation to improve operations. However, there must be accountability and monitoring of the relevance and effectiveness of such projects as well as the appropriate use of MSF's resources.

2.12. When formulating an international MSF public position, serious effort should be made to seek a common voice in order to ensure more coherence, in the field and externally. However, considering that diversity of opinion in MSF is critical to the vitality of the movement, if agreement on a common position is not possible, it is acceptable that a majority (the international position) and a minority position coexist. If, after taking into consideration the impact of their action on the movement, the minority decides to publicly express its position, the minority is obliged to clarify that it is not

expressing the "MSF position", but its own. The minority sections, however, should not obstruct the implementation of the decision and should be involved in its follow up.

2.13. We acknowledge MSF's urgent need to provide fair employment opportunities for all staff based on individual competence and commitment rather than mode of entry into the organization (either through national or international contract). This is to address the under-utilization of human resources and inclusiveness in decision-making in MSF. This issue must be urgently and concretely addressed in order to fully engage our staff, thereby strengthening our operations.

2.14. We must take proactive steps to ensure fair opportunities for access to meaningful membership in associations, while preserving the spirit of volunteerism. In doing so, we accept the need to explore new avenues for associative participation, giving priority to regions where MSF is underrepresented, including for instance, through the creation of new MSF entities.

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WHO ARE THE MEDECINS SANS FRONTIERES

I THE PRINCIPLES

Médecins Sans Frontières (MSF) was founded to contribute to the protection of life and the alleviation of suffering out of respect for human dignity.

MSF brings care to people in precarious situations and works towards helping them regain control over their future.

1. MEDICAL ACTION FIRST

The actions of MSF are first and foremost medical. This primarily consists of providing curative and preventive care to people in danger, wherever they may be. In cases where this is not enough to ensure the survival of a population - as in some extreme emergencies - other means may be developed, including the provision of water, sanitation, food, shelter, etc.

This action is mainly carried out in crisis periods when a system is suddenly destabilised and the very survival of the population is threatened.

2. TEMOIGNAGE (WITNESSING) - AN INTEGRAL COMPLEMENT

Temoignage is done with the intention of improving the situation for populations in danger. It is expressed through:

- the presence of volunteers with people in danger as they provide medical care which implies being near and listening

- a duty to raise public awareness about these people

- the possibility to openly criticise or denounce breaches of international conventions. This is a last resort used when MSF volunteers witness mass violations of human rights, including forced displacement of populations, *refoulement* or forced return of refugees, genocide, crimes against humanity and war crimes.

In exceptional cases, it may be in the best interests of the victims for MSF volunteers to provide assistance without speaking out publicly or to denounce without providing assistance, for example when humanitarian aid is “manipulated”.

3. RESPECT FOR MEDICAL ETHICS

MSF missions are carried out in respect of the rules of medical ethics, in particular, the duty to provide care without causing harm to either individuals or groups. Each person in danger will be assisted with humanity, impartiality and in respect of medical confidentiality.

In other respects, this ethical consideration provides that no one will be punished for carrying out medical activities in accordance with the professional code of ethics, regardless of the circumstances or the beneficiary of the action.

Finally, no person carrying out a medical activity can be forced to perform acts or operations in contradiction to the professional code of ethics or the rules of international law.

4. DEFENCE OF HUMAN RIGHTS

Médecins Sans Frontières ascribes to the principles of Human Rights and International Humanitarian Law. This includes the recognition of:

- the duty to respect the fundamental rights and freedoms of each individual, including the right to physical and mental integrity and the freedom of thought and movement, as outlined in the 1949 Universal Declaration of Human Rights;

- the right of victims to receive assistance, as well as the right of humanitarian organisations to provide assistance. The following conditions should also be assured: free evaluation of needs, free access to victims, control over the distribution of humanitarian aid and the respect for humanitarian immunity.

5. CONCERN FOR INDEPENDENCE

The independence of MSF is characterised above all by an independence of spirit which is a condition for independent analysis and action, namely the freedom of choice in its operations, and the duration and means in carrying them out.

This independence is displayed at both the level of the organisation and of each volunteer.

- MSF strives for strict independence from all structures or powers, whether political, religious, economic or other. MSF refuses to serve or be used as an instrument of foreign policy by any government.

  The concern for independence is also financial. MSF endeavours to ensure a maximum of private resources, to diversify its institutional donors, and, sometimes, to refuse financing that may affect its independence.

- From their side, MSF volunteers are expected to be discrete and will abstain from linking or implicating MSF politically, institutionally or otherwise through personal acts or opinions.

6. A FOUNDING PRINCIPLE: IMPARTIALITY

Impartiality is fundamental to the mission of MSF and is inextricably linked to the independence of action. Impartiality is defined by the principles of non-discrimination and proportionality:

- non-discrimination in regard to politics, race, religion, sex or any other similar criteria.

- proportionality of assistance as it relates to the degree of needs - those in the most serious and immediate danger will receive priority.

7. A SPIRIT OF NEUTRALITY

MSF does not take sides in armed conflicts and in this sense adheres to the principle of neutrality.

However, in extreme cases where volunteers are witness to mass violations of Human Rights, MSF may resort to denunciation as a last available means in helping the populations it assists. In these cases, simple assistance is rendered in vain when violations persist. For this reason, MSF will drop its strict observance of the principle of neutrality and will speak out to mobilise concern in an attempt to stop the exactions and improve the situation for these populations.

8. ACCOUNTABILITY AND TRANSPARENCY

Faced with populations in distress, MSF has an obligation to mobilise and develop its resources.

Aiming at maximum quality and effectiveness, MSF is committed to optimising its means and abilities, to directly controlling the distribution of its aid, and to regularly evaluating the effects.

In a clear and open manner, MSF assumes the responsibility to account for its actions to its beneficiaries as well as to its donors.

9. AN ORGANISATION OF VOLUNTEERS

MSF is an organisation based on volunteerism. This notion principally implies:

- an individual commitment to people in precarious situations. The responsibility of the organisation is based on the responsibility taken by each volunteer;

- disinterest, attested to by the non-lucrative commitment of volunteers.

Volunteerism is a determining factor in maintaining a spirit of resistance against compromise, routine and institutionalisation.

10. OPERATING AS AN ASSOCIATION

The commitment of each volunteer to the MSF movement goes beyond completing a mission; it also assumes an active participation in the associative life of the organisation and an adherence to the Charter and Principles of MSF.

Within the different representative structures of MSF, the effective participation of volunteers is based on an equal voice for each member, guaranteeing the associative character of the organisation.

MSF also endeavours to constantly integrate new volunteers to maintain spontaneity and a spirit of innovation.

Linked to the idea of volunteerism, the associative character of MSF permits an openness towards our societies and a capacity for questioning ourselves.

II. PRACTICAL RULES FOR OPERATING

1. Organisation and decision-making

MSF is made up of 19 national sections, with overall coherence ensured by an International Council.

The majority of members are volunteers who work or have worked for MSF. They constitute the General Assemblies of each section, and they elect a Board of Directors whose members are mainly doctors or medical professionals. Almost all are unsalaried.

The Board of Directors names the executive team. The Board guarantees respect for the MSF Principles, ensures that decisions taken at the General Assembly are executed, and controls the management of the organisation.

2. Non-profit

Each section is founded on the not-for-profit principle.

The principle of disinterest is part of the commitment of all MSF personnel. In their work for MSF, staff are not entitled to additional remuneration from the organisation, its satellites, suppliers, or any other individuals or legal entities with whom the organisation has relations, other than salaries or allowances. By choice, the proportion of salaried positions remains limited. Management staff salary levels are lower than those in comparable sectors of the employment market. All salaries are public.

The financial reserves of MSF are intended to ensure the smooth functioning of the organisation and to allow the organisation to rapidly react to emergencies and periodic shortfalls. In no case will they constitute a means for perpetuation. For this reason, the reserves, including property holdings, never exceed the annual operational expenses.

3. Management of Resources

At least half of the global resources of MSF must come from private funding.

MSF directly carries out its operations for populations in danger, so 80% of the resources of the organisation are exclusively dedicated to operations.

MSF retains continuous and direct control over the management and delivery of its aid.

Funds received by MSF are allocated as the organisation considers them most useful, in conformity with its principles. However, if a donor wishes his or her donation to be used in a specific mission, MSF will respect this request.

4. Financial Control and Transparency

The use of MSF funds is regularly controlled. In addition, each section makes public its audited financial reports.

Different categories of expenses are clearly identified in the accounts, clearly showing the disbursement of funds. It is therefore easy to distinguish the expenses for operations, administration, communications or fund-raising.

The accounts are then published and provided to all donors through different newsletters and communications support materials produced by MSF. The accounts are also available to anyone upon request.

MSF Behavioural Commitments – Definitions

Assignment

Is considered on assignment:

1. Any staff member, in the following circumstances: 1) when he/she is performing duties for MSF inside or outside of his/her usual place of work, and/or 2) he/she is present on MSF premises, and/or 3) during his/her working hours.
2. *At all times*, any staff member being perceived as a member of or representing MSF. This includes:
    - when using MSF cars or wearing MSF signs of identification
    - when being assigned in a location different from his/her place of recruitment (international staff and any other staff being temporarily or permanently relocated in order to perform duties for MSF)

    It is expected that all members of MSF leadership, all board members of MSF entities, all GDs, all Directors or Heads of departments in all entities, all advocacy and representation staff and all coordinators at all times base their professional and personal behaviour on these behavioural commitments.

Children

- Article 4 of the MSF Behavioural Commitments states: "MSF staff members and partners shall not accept child abuse, exploitation and violence and not engage in sexual relations with children;"
- The definition of children comes from the UN Convention on the Rights of the Child, which defines a child as *"every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier"*. This means that the age under which an individual is considered as a child can vary from one country to another.
- In terms of implementation, this means that each MSF entity will apply the article of the Behavioural Commitments according to the local laws applicable to the child. For international staff, the law applicable in the country issuing the employment contract must also be respected.

Staff members and operational partners – Scope

- Members of staff: all employees on assignment, volunteers, daily workers
- Operational partners: consultants, any staff receiving incentives (MoH, NGOs…) and guests (visitors on MSF projects and offices such as journalists, visiting scientists or major donors)
- The Behavioural Commitments also apply to all Associative members and dependants of international staff located in the country of mission.

Behavioural Commitments

Preamble

MSF considers itself a responsible employer and association, and this rests on the responsible behaviour of its members. There is a mutual and complementary role of the employee and the employer to prevent, detect and address unacceptable behaviour and MSF staff should deploy the means to inform its patients and direct beneficiaries on the behavioural commitments stated below.
Within MSF, all members of staff (employees, including staff on international assignment, volunteers, daily workers) and operational partners (including consultants and guests) understand and adhere to the commitments below, incorporate them into their professional and personal conduct, and abide by them. Should this not be the case, MSF offers channels for reporting at every level of the organisation and any non-compliance will entail due consequences.
These Behavioural Commitments are considered as a minimum behavioural standard, more specific rules may apply to MSF staff members depending on the context in which they work and their area of activity.

Behavioural Commitments

1. MSF staff members and operational partners shall behave respectfully and not discriminate against patients, colleagues or members of the local population on the basis of their race, opinions, lifestyle, gender, sexual orientation, socio-economic background, origin, religion or beliefs and others markers of identity;

2. MSF staff members and operational partners shall not abuse anyone physically (i.e. physical violence, sexual aggression or other form of physical abuse) or psychologically (e.g. bullying, abuse of power, harassment, discrimination or favouritism);

3. MSF staff members and operational partners shall not accept, under any circumstances, behaviour that exploits the vulnerability of others, in the broadest possible sense (sexual, economic, social, etc.). This includes exchange of goods, benefits or services for acts of a sexual nature, including the use of sex workers' services while on assignment;

4. MSF staff members and operational partners shall not accept child abuse, exploitation and violence and not engage in sexual relations with children[1];

5. MSF staff members and operational partners shall not take advantage of their position for personal gain. Each member shall use MSF resources (including premises, goods, money, reputation, image etc.) with respect and care and in the interests of the organisation and the populations it seeks to assist.

[1] Article 1 of the *United Nations Convention on the Rights of the Child, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990, in accordance with article 1*: "For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier."