

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.

FINAL – LA MANCHA AGREEMENT – 25 June 2006, Athens

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.

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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.

FINAL – LA MANCHA AGREEMENT – 25 June 2006, Athens

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.

FINAL – LA MANCHA AGREEMENT – 25 June 2006, Athens

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

FINAL – LA MANCHA AGREEMENT – 25 June 2006, Athens

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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