Internal membership democracy and motions for change
The case of the Medécins Sans Frontières Association

This thesis is submitted for obtaining the Master’s Degree in International Humanitarian Action. By submitting the thesis, the author certifies that the text is from his/her hand, does not include the work of someone else unless clearly indicated, and that the thesis has been produced in accordance with proper academic practices.
Abstract
The world is changing and humanitarian organisations need to be equipped to change with it. This case study has examined the internal democracy within the association of Medécins Sans Frontières (MSF), the creation of social capital and how it can be used to create bottom-up medical organisational change through motions. The selection of 6 motions was made to investigate if they have created the change they intended to create.

The aim of this study is to test the hypothesis that members have the power to create organisational change and that such changes depend on a high degree of internal membership democracy. Internal democracy is in turn a precondition for the formation of social capital. In total were 12 in depth interviews conducted with members, former and current board members as well as the executive. In addition to this has an analysis of video recoded motion debates and feedback session been analysed along with other relevant internal documentation. The study has found that the association of MSF is founded on democratic principles as a mean to guide and hold the executive responsible and fulfils formal criterion for a democracy. The internal democracy has a series of weaknesses in it, like lack of participation from members and unequal weight of influences of different members and national associations. It is also facing threats of executive manipulation due to weak boards. Despite this the association has created a strong social capital that unfortunately is unevenly distributed among the members and its social capital is at risk of declining. Regarding motions there is a lot of potential in this formal tool of influence, but often it is not the motion itself but what the motion writers and audience do with the information as well as if the executive agrees with the motions that create the intended change. It can be interpreted as if down-top approaches to operational medical organisational change only will be achieved if the “top” agrees to the change.

In conclusion, the assumption of this thesis has thus been proven to a certain extent. Members have the power to create organisational change through motions but their ability to do that depends on a high degree of internal democracy but also on informal contacts. Social capital is built in the process in the social networks that each association form individually as well as together with all MSF associations. However it is not necessarily a precondition to organisational change even though it is a product of the existing internal democracy. MSF has the opportunity to strengthen the democratic process and to be better equipped to create organisational change in the future.
Preface

The seed of this thesis was planted at the general assembly in Oslo 2016. There was a lack of participation of Swedish members and no proposed motions even though everyone had things they wanted to change. I asked myself, why? I also asked myself what have happened with motions that we had approved years ago? Now 18 months later I have grown as a member of the MSF. I have become more informed, I feel more confident to voice opinions and has a stronger sense of ownership of MSF. This is because of the shared knowledge and insights of all the respondents that have participated in the research. I owe them as well as the support of my classmates at the NOHA program a big Thank you. I am also very grateful to my supervisor Lisbeth Larsson Lidén for all her support and direction. I aim to use the information gathered to work on strengthening internal democracy and the power of members so that we can get better at guiding MSF into the troublesome future that lies ahead.
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## Abbreviations

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<tr>
<td>ARV</td>
<td>Anti Retro Viral (Treatment)</td>
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<tr>
<td>COSP</td>
<td>Common Operational Strategic Plan</td>
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<td>ExCom</td>
<td>Executive Committee</td>
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<td>FAD</td>
<td>Field Associative Debate</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>GA</td>
<td>General Assembly</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HoM</td>
<td>Head of Mission</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>IB</td>
<td>International Board</td>
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<td>IC</td>
<td>International Council</td>
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<td>ICRC</td>
<td>International Committee of the Red Cross and Crescent</td>
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<td>IGA</td>
<td>International General Assembly</td>
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<td>INGO</td>
<td>International Non-Governmental Organisation</td>
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<td>IPD</td>
<td>In Patient Department</td>
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<tr>
<td>MDM</td>
<td>Médecins Du Monde</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MSF</td>
<td>Médecins Sans Frontières</td>
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<td>NCD</td>
<td>Non-Communicable Disease</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>OC</td>
<td>Operational Centre</td>
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<td>OCA</td>
<td>Operational Centre Amsterdam</td>
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<td>OCB</td>
<td>Operational Centre Brussels</td>
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<td>OCBA</td>
<td>Operational Centre Barcelona/Athens</td>
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<td>OCG</td>
<td>Operational Centre Geneva</td>
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<td>OCP</td>
<td>Operational Centre Paris</td>
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<td>PMTCT</td>
<td>Prevention of Mother To Child Transmission</td>
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<tr>
<td>R&amp;D</td>
<td>Research &amp; Development</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>ToP</td>
<td>Termination of Pregnancy</td>
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<td>DirLog</td>
<td>International Logistics Directors Platform</td>
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<td>IDRG</td>
<td>International Directors of Human resources</td>
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<td>FinDir</td>
<td>Finance Directors</td>
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<td>DirFund</td>
<td>Directors of Fundraising</td>
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<td>DirCom</td>
<td>Directors of Communication</td>
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<td>ISM</td>
<td>Information and Systems Management</td>
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1. Introduction

1.1 The relevance of change to the field of humanitarian action

The world around us is constantly changing, but the last decades have seen change like never before. Population growth, globalisation and technological achievements have made our world both smaller and bigger at the same time, brought us closer and further away from each other. Our earth has seen an increase of natural disasters fuelled by man-made climate change and changes on the global political arena, which have increased the number and complexity of conflicts between and inside nation states. All this has resulted in more humanitarian emergencies and as a response more international humanitarian assistance in complex and insecure contexts (Clarke and Ramalingam, 2008). History, global policies and projections tell us that our world will continue to change and that we as a species stand in front of significant challenges that we have to choose to overcome. Drivers like climate change will make states more fragile, increase tensions between communities, create massive forced displacement that the world has never seen before and likely end in increase in conflicts. What is clear is that our future is filled with humanitarian emergencies of a more complex nature due to climate change and a continued increase of extreme weather events, forced displacement and antibiotic resistance, to name a few (Kent, Armstrong and Obrecht, 2013).

A changing environment demands change from its inhabitants and communities. Many different actors respond to humanitarian emergencies, from states, national and international organisations to individuals. The role of international humanitarian organisations has changed since the end of the cold war. There is an increase in number of actors, amounts of available funding and in capacity to respond. The capacities are still not sufficient and one might ask oneself if they are equipped to deal with the change that is demanded of them (Walton, Davies, Thrandardottir and Keating, 2016). This thesis will look at the possibilities for and the success of attempts to create organisational change by members of the medical humanitarian international private association Médecins Sans Frontières (MSF).

MSF has since its foundation in 1971 grown into becoming one of the largest medical humanitarian International Non-Governmental Organisations (INGOs) in the world. Working with the mandate to provide assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, MSFs actions are
guided by medical ethics and the humanitarian principles of independence, neutrality, impartiality, bearing witness and speaking out about unacceptable suffering around them (Médecins Sans Frontières [MSF], 2016a). MSF is an international association that consists of individuals all around the world that have formed national MSF associations. The international association and national associations is the guiding body of MSF’s social mission which defines its identity and which has delegated the operational activities to the executive body. The associations are holding the executive body accountable for its action against the MSF charter and different recognised agreements. MSFs different associations are according to their statutes governed by an internal democratic structure. Members that are all former or current fieldworkers can participate in debates and vote for a board that represents its interest and the interest of MSFs social mission. A member can also write motions directed to different governing bodies to promote organisational change. If voted through at a General assembly (GA) the board is bound to report back on the motion accordingly (MSF, 2016b). The international MSF statutes speak of a “collective commitment and desire of all MSF’s Members to constantly improve MSF’s medical humanitarian action in responding to the needs of people in crisis” (MSF, 2015b). How this work unfolds in practice is the main question, which this thesis will attempt to answer. This is relevant to the field of humanitarian action because how humanitarian NGOs go through change has not been researched to a great extent and especially not from a bottom-up perspective rooted in a democratic process. If an organisation like MSF is well equipped for change it may save lives and alleviate more suffering in the future.

**Previous research**

Organisational change has been researched from many different perspectives and approaches in the humanitarian sector, but none that the author can find that explores change as a result of a bottom up democratic process. There is research on top-down institutional approaches to change like that of Clarke and Ramalingam’s (2008) and also research on the authority patterns and democratic credentials among NGOs by Liston (2009). In this thesis Eckstein and Gurr’s (1975) definition of internal democracy will be used: “Democracy is defined as the presence of institutions and procedures through which citizens can express preferences about policies and leaders as well as constraint on the exercise of power by the Chief Executive [and the guarantee of civil liberties].” Liston (2009) and this thesis both define internal democracy as the extent to which an
organization meets the above criteria. In addition to this Robert Dahl (1998) has written that there are five criteria that are a prerequisite in a democracy.

1. “Effective participation”, meaning that citizens (or members) should have an equal opportunity to express their opinion.
2. “Equality in voting”, meaning that choices are equal in weight to others.
3. “Gaining enlightened understanding”, meaning that all should have equal opportunities to find and validate the options available to them.
4. “Exercise final control over the agenda”, meaning that the members should be able to influence the order of things on the agenda of discussion.
5. “Inclusion of adults”.

Lehr-Lehnardt (2005) further explains that democracy within a NGO means both if it follows democratic processes and rules but also if the people the organisation is claiming to speak for agree with the mandate and statements. A lack of democracy within an organisation weakens its accountability. If a NGO fails to be democratic it slows the growth of creativity and vision, both crucial for the survival of any organisation (Ghosh, 2009). Liston (2009) further argues that a lack of internal democracy should make us question the accountability of NGOs and how they can claim to represent the interests of communities in need. Based on this the author argues that it is of the utmost relevance to examine the degree of internal democracy and how it functions within MSF. The thesis aims to explore to what degree the internal democracy of MSF contributes to the formation of social capital among its members and if the two is a precondition for organisational change. The theoretical assumption is that if social capital is formed and exists, its precondition is internal democracy. The organisation will then be better equipped to create organisational change for guidance on how to act in future humanitarian contexts.

1.2 Objective

By exploring the features of internal democracy and MSF association members’ attempts to create organisational change this thesis aims to find evidence for and increase our understanding of how the democratic structures and processes within MSF unfold when practiced. The assumption of this thesis is that if members of the MSF association have the power to create organisational change, such changes depend on a high degree of internal membership democracy. Internal democracy is in turn a
precondition for the formation of social capital. It also aims to identify strengths and weaknesses within the structure. Findings will allow for recommendations on means to strengthen the democratic process, if found necessary.

The main research questions for this thesis are:

1. Is the MSF association a democratic organisation according to its own decision-making structures and statutes?
2. Has the MSF association developed into a more democratic organisation over time?
3. Is the MSF association an organisation with a high degree of internal democracy where social capital is formed?
4. Have motions directed at the medical direction of the organisation created the intended organisational change they meant to create? Why or why not?

The sub questions the thesis will attempt to answer are:

5. Do members of the MSF association perceive their organisation as democratic?
6. What influences the approval of motions at the MSF association?

**Research methodology**

This thesis is a case study of MSF. The case study approach is adopted from Robson (2011, p 135-140). It is based on qualitative interviews and a review of MSF documents to answer the identified research questions derived from the conceptual framework that is based on theories on social capital, democracy, and organisational change. Qualitative interviews have been conducted during the period from March to May 2017. The research has elements of grounded theory due to the evolution of the interview guide throughout the process and the knowledge gained from previous interviews. The changes in the interview guide were only additions to the probes on certain questions. The literary review that is the background and conceptual framework to the thesis is based on searches in Uppsala University Library’s databases with the following selection of key words alone or linked together: Organisational change, social capital, NGO, humanitarian, democracy. A content analysis of the organisation’s documents on structures and its statues is made. Interviews have been conducted with key individuals within the boards, association and executive staff. Content analysis of selected motions
directed towards the Operational Centre Brussels (OCB), video recordings of the debates on the respective general assemblies as well as written feedback from the boards on each motion has also been made.

The empirical data has been collected through semi-structured interviews with selected key individuals within the boards, associations and executive staff members. The interviews have been recorded, transcribed and complemented with written notes from the interviews. Video recorded debates from general assemblies on the selected motions have also been transcribed and analysed. Written feedback from the boards in newsletters was also a part of the data. An interview guide with open-ended questions were created (appendix 1) to fit the interviewees depending if he/she is a member, from a board, with additional questions specifically related to the identified motions to the executive side. The interviews were approximately 1 to 1.5 hour long. Skype interviews were used with some respondents because it facilitated a larger selection of respondents from different parts of the world. Skype interviews have both advantages and disadvantages. In this case the disadvantages of a lack of visual input and the lack of contextual information will have minor effect on the data collection, but they still have to be considered.

**Sampling procedure**

The sampling method selected in this thesis has elements of snowball sampling. The author started out identifying a few gatekeepers and the further interviewees were selected on recommendation of the first informants. 12 interviews were conducted and the initial informants were selected because they are active members, work or have worked with the association, sit or sat on a board or work in the executive responsible for the part of operations that is responsible for executing the motion. The Swedish section of MSF has been the starting point, but members from other associations have also been interviewed. See appendix 2 for a table regarding the respondents.

The inclusion criteria for motions to be analysed have been the following:

1. Aimed to create to have an impact on the medical mission of MSF

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1 MSF consists of 24 associations in 24 different countries all with its own board. In addition to this these different organisations belong to one of five different Operative Centres or OCs that all have its own board. There is also an international board (IB) that represents the movement as a whole.
2. Written towards OCB or the International General Assembly (IGA)
3. Written between 2009-2014

A total of six (6) motions were selected among a total of 28 total motions whereof 12 were directed at medical change. The selected motions were identified with the above-mentioned criteria and final selection was made with consideration of their relevance, controversy and my personal experience of their relevance.

**Qualitative data analysis**
A content analysis of the motions is adopted to explore how they address themes and ideas of organisational change as presented in the thesis. The material from the interviews will be analysed by categorising and finding patterns of relationships of key words and their interpretation and use by the interviewees. Core patterns identified will in turn be juxtaposed to the theoretical assumptions and key concepts and themes as presented in the introductory part and in the coming theoretical framework of the thesis. Comparison will then be made between theoretical assumptions as presented in the theoretical framework of the thesis and the empirical findings. Through the analytical process, research questions will systematically be reviewed and discussed and finally answered. Conclusions will be made by the author of the thesis drawing on similarities and differences between theoretical assumptions and how they relate to the empirical findings.

**Validity and reliability**
Research questions, interview questions, and aim have constantly been reviewed to establish a firm congruence between them. This has been done to validate findings as far as possible through the whole research process. A high degree of reliability of the sources is secured by the use of peer reviewed scientific journal articles within the field of democracy, organisational change, and social capital. Both secondary and primary sources are used. Interviewees have been selected from more than one decision-making body of MSF thereby allowing for triangulation of the data collected from the field. The data that emerged has been analysed manually, not with the use of data analysis software. It means that respondents’ answers have been categorised and analysed by the author in relation to the major research themes of the study.
There is a potential bias in the research since the author has worked with MSF in the field and has been an association member since 2013. There is a risk that the author will be seen as an insider, which can have a potential positive effect in information sharing but a potential threat is that the data will be coded based on all ready preconceived ideas about the organisation. This is mitigated by the fact that the author has never worked for OCB as an operational centre, but only worked for the operational centre in Amsterdam (OCA). The author has also been a part of evaluation projects of MSF projects as an external evaluator and hence can be critical based on the identified data.

1.3 Research limitations
This thesis has only reviewed a small number of motions and has also not explored all the tools of change that are available to associative members to influence organisational change, like field associative debates and informal power relationships. A further limitation is that the research has not been mapping the informal power relationships behind each selected motion. The small selection of participants is not representative for MSF as a whole and is mostly from the Swedish section of MSF and further mostly active members have taken part.

1.4 Ethical considerations
Ethical issues will always arise when it comes to involving people as a part of data collection according to Robson (2011, p 66). The respondents in this research were all informed about the aim of the research; that their participation is voluntary; that they can choose to withdraw their consent at any time and also that they can choose to be anonymous in the thesis. Each participant was offered to sign a written consent that can be found in appendix 3. Part of the bibliography are internal documents only accessible to members of a MSF association, but prior approval to use the data has been given by the president of MSF-Sweden.

1.5 Thesis Outline
This thesis consists of 8 chapters, excluding appendixes and references. The first chapter is where the topic is introduced and where the relevance to the humanitarian field is explored. It is also the part where the research questions, methodology and limitations are described. The second chapter deals with the conceptual framework developed, where theories on democracy, social capital, and organisational change are
explored. The third chapter explores MSF as an organisation, its founding and history of change. Most of all it gives the background to the structure of the organisation and its associational nature. The intended democratic structures and the rules regarding motions are described. The forth chapter is where the themes and codes coming out of the interviews and recorded debates are presented to answer the research questions regarding internal democracy. Chapter five presents the result based on the recorded debates and the interviews in regard to the selected motions. It explores why some motions are successful when others are not. Chapter six is where the result is tied to the theoretical framework and discussed from every possible angle. Chapter seven is where the reader will find the conclusive results that will answer the research questions as well. Chapter eight will follow that, in which the recommendations for improving the internal democratic structures are presented and in regards to motions within MSF.
2. Theoretical and conceptual framework

In this section the perspectives, concepts, models and definitions that form the theoretical and conceptual framework will be elaborated on. The assumption of this research is that for desired organisational change in MSF to be achieved, it necessitates a high degree of internal membership democracy, which contributes to the formation of social capital. The existence of internal democracy is assumed to be the independent variable in this formula and is seen as a key to develop the dependant variable social capital, which in turn creates a good environment for organisational change. The dependent variable with the development of social capital over time in turn may contribute to and creates a disposition for democratic values and norms among members in organisations. The theoretical assumption is derived from work by among others Robert D. Putnam. The components of these concepts you can find in the figure below and each aspect will be explained in detail below.

Figure 1 Conceptual framework

![Conceptual framework diagram]

**Source:** Jon Gunnarsson Ruthman

2.1. Internal democracy and association

“The virtues and viability of a democracy depend on the robustness of its associational life”. (Warren, 2001, p 3)
Democracy is a widely discussed subject, has broader socio-cultural dimensions and many different definitions exist (Ghosh, 2009). In this research the definition that Eckstein and Gurr (1975) brought forward will be used: “Democracy is defined as the presence of institutions and procedures through which citizens can express preferences about policies and leaders as well as constraint on the exercise of power by the Chief Executive [and the guarantee of civil liberties].” Liston (2009) and I both define internal democracy as the extent to which an organization meets the above criteria. The term citizens above will in text be referred to as members. In addition to this Robert Dahl (1998) has written that there are five criteria that are a prerequisite in a democracy.

1. “Effective participation”, meaning that citizens (or members) should have an equal opportunity to express their opinion.
2. “Equality in voting”, meaning that choices are equal in weight to others.
3. “Gaining enlightened understanding”, meaning that all should have equal opportunities to find and validate the options available to them.
4. “Exercise final control over the agenda”, meaning that the members should be able to influence the order of things on the agenda of discussion.
5. “Inclusion of adults”.

Lehr-Lehnardt (2005) further explains that democracy within a NGO means both if it follows democratic processes and rules but also if the members the organisation is claiming to speak for agrees with the mandate and statements. A lack of democracy within an organisation weakens its accountability to its members. (Liston (2009) poses the question: If participation of employees and representation of beneficiaries are low, how can the organisations be democratic and claim to speak for them? If a NGO fails to be democratic it slows the growth of creativity and vision, both crucial for the survival of any organisation (Ghosh, 2009).

The concepts below are all key components of a functioning internal democracy and they will be briefly introduced here.

2.1.1 Constraints on power
In Eckstein and Gurr (1975) a definition of constraints of power is mentioned. Liston (2009) also mentions it and further defines it as where members or employees can take
part in decisions that affect the organisation’s policy without worrying about sanctions. It also means that the member has the power to choose who governs and holds that person or persons accountable. The power of the leader/leaders lies with the membership base, and regular leadership change is an important aspect of democracy. (Simmons and Steinberg, 2006)

2.1.2 Mutual cooperation
Democratic organisations are structures of cooperation according to Moe (2005), cooperation between actors seeking mutual benefits. Ghosh (2009) states that NGOs are democratic because they are trying to establish cooperation to achieve good ends. Mutual cooperation for a greater good and mutual benefit is founded in a high degree of participation and the adherence to democratic rules and procedures, all needed for upholding trust and cooperation.

2.1.3 Rules
Democratic organisations are governed by a set of formally and informally agreed upon rules, norms and procedures (Ghosh, 2009). Over 90% of all associations are governed by the same rules, like for example members elect the board that governs at a general assembly (Torpe, 2003). This rule that the members elect its representatives is key in democracy and another is that a democracy should function by majority rule (Lehr-Lehnardt, 2005).

2.1.4 Membership
As a citizen in a state or a member in an organisation you have both rights and responsibilities. It is a relationship of give and take. It is a built-in idea in a democracy but it requires equality between citizens or members. The only way membership can grow is by having democracy and democratic organisations should motivate their members to govern themselves primarily through participation. Education of members is a key aspect in understanding the rules, norms, and values of the organisation and hence in increasing the strength of the membership basis (Ghosh, 2009).

2.1.5 Participation
Participation is one of the most central concepts of democracy and for an organisation creating a participatory culture equals creating stability according to Liston (2009).
When a member uses its power and voice within an organisation aiming to create change, the member is exercising a democratic right and the action has a greater meaning for the democratic society as a whole. The participatory aspect of democracy can be defined as “face to face cooperation in pursuits of collective ends”. These procedures secure organisational accountability (Fung, 2003).

2.1.6 Trust
Trust defines democratic organisations because it can predict human behaviour. For the organisation to uphold that trust, it has to generate justice and truth as well as reduce the risks of the members. According to Ghosh (2009), an evaluation of NGOs performance should be based on its capacity to generate trust both externally and internally as well as their service to the beneficiaries. Trust is key to the development of efficacy and a sense of participation among the members (Malik, 1979).

2.1.7 Tools of influence
This aspect links to the concepts of participation and rules. A member has to have an arena to use its power as well as tool of influence. Going back to Eckstein and Gurr’s (1975) definition there has to be procedures and institutions where citizens can express themselves in a democracy though an arena to discuss and debate and equal vote in an election. Through votes on discharge of responsibility members exercise their constraints on power. According to Stone (2008) the formal right to vote is what defines the organisational policy and the framework for what informal ways to influence there is. He states that the level of participation in decision-making and access to information defines informal influence.

2.2 Social capital and networks
After more than 20 years of researching what Robert Putnam (1993), ended up calling the civic culture syndrome, there have been just as many years of debates about his findings. His research was conducted in Italy and he compared different regions in the country and showed that regions that showed high levels of civic culture syndrome also had a more effective government, higher economic growth but also a happier population. He describes the syndrome as based on 5 concepts (Putnam, 1999).

1. Civic engagement
2. Political equality
3. Solidarity, trust and tolerance
4. A strong associational life
5. Law abidingness

All of these concepts are related to each other and he said that they have been created in associations and social networks that are driven by the norms of reciprocity. In short, what it actually means is that people who are engaged in public decision-making, showed a higher level of social trust, tolerance towards others and a higher belief in solidarity and equality. Tocqueville’s theory or strategy “self-interest properly understood” (Tocqueville, 1900) is interesting in the discussion, and Putnam states that it forms the base for his theory. The theory aims to explain the relationship between motivation and the reasons why people engage with each other. The theory is that every citizen or member of a society knows when to make short-term sacrifices for long-term advantages for the whole of the society. According to Edwards (2009), Putnam has failed to properly explain exactly how the relationship between the different concepts above manifests themselves. She coins a concept called the cooperative compact and defines it as “People come together to address an issue of common concern. They agree to coordinate their behaviour and govern the compact through just rules. The maintenance of cooperation rests on maintaining the legitimacy of the rules” (Edwards, 2009, p. 137).

Putnam links his civic culture syndrome to James Coleman’s theories on social capital but defines it as “features of social organization, such as trust, norms and networks, that can improve the efficiency of a society by facilitating co-ordinated actions” (Putnam, 1993, p 167). There are many forms of capital available to us, i.e. financial, cultural human and social capital. The difference between human and social capital is that social capital exists in the relations between people and not in the individual itself. An organisation loses its human capital when that individual leaves the context of the organisation but the individual leaves the social capital he or she has created. The characteristics, values and knowledge of individuals can be used to create social capital that in turn can be used as a resource by anyone in the network (Edwards and Fowley (1998).
The idea of transferability of social capital is a topic that has been debated and disagreed upon. Putnam builds on the strategy “self-interest properly understood” and states that individuals’ strategies can be transferred to other contexts through what he claims to be a collective cultural memory. This memory is available to all individuals in a culture and can be used to solve problems in the future by looking at the past. Some associations have high social capital and some have low social capital mostly because they do not have the collective cultural memory to use. Social capital cannot stand-alone of course but always has to be used together with other forms of capital (Edwards, 2009).

Edwards (2009) discusses Putnam’s and Coleman’s theories and the analytical tools they have used and create her own concept of ideational social capital. She says that Putnam chooses a rational analysis approach when discussing Coleman’s theories. A rational choice is that you expect people to show a certain behaviour, which is beneficial to their interests, as a response to the social environment around them. Edwards (2009) says that our actions are shaped by the choice on how to interpret the information available and that that choice is the ideational structure that will dictate the behaviour of individuals.

Social capital is developed through rules, norms and values in democratic associations that allows open debate and inspire trust towards the organisation and its members. Below some of the different components are explored further.

2.2.1 Values and norms
The norms and values I refer to is not that of individual members of an association or social network but the values and norms that the collective possess. This is the foundation of social capital along with the members ability to act in the best interest of the collective. The norms and values have to be used as a shared resource that can be used both internally and externally. As an example of an externally shared resource we can take the norm of what is accepted in the social context and as well how to behave oneself (Edwards and Fowley, 1998). By linking to the concept of mutual cooperation that we discussed in the previous section we can see that the values and norms are a requirement for this to work. The members can have strong values but need to have the norm of tolerance towards other people’s values. Solidarity is a key value and for that to
develop every member needs to be treated equally and with dignity (Edwards, 2009). The importance of this resource has been debated thoroughly. Coleman sees social capital as an ethically neutral resource that therefore can be used in any context and hence is more applicable. In contrast to Coleman Putnam’s attempts to add values to the equation limits the application of the theory according to Edwards and Fowley (1998). In their view it only leads to what is defined as “good” by the organisation, which in their opinion limits the possibilities to apply it in empirical research. Social capital in perceived “bad” networks are left out as well as all activities leading to “bad deeds and resources (ibid. p.131). Coleman (1988) discussed that norms and values together with social capital is the way to measure social trust and participation.

2.2.2 Feelings of trust
The members trust towards the association or social network can be seen as a consequence of conditions that help people predict that other people will behave in the spirit of cooperation. You would not trust someone or an organisation that just say that they will do something; you have trust because they have done it before and you know that they have the resources to do it again. Also trust is created when one knows that they value the relationship high enough to go against their short-term interests. This links to Edwards (2009) concept of the collective compact again.

It was mentioned before that social capital could be measured by the level of social trust the network has. This is the social trust towards other members of the network but also trust towards the governing body.

2.2.3 Reciprocity
The norm of reciprocity has been mentioned before and it deserves further explanation. A social network needs to have the norm of reciprocity to be able to make cooperative action. With reciprocity I mean the concept of giving back when someone has given something to you. If one person is doing something with good intentions, the best strategy is to cooperate because if they wouldn’t have good intentions you would refuse to cooperate in the future. In networks that use this norm, collective action is possible because people know that collaboration is built on good intentions and they have trust that they will get something back because if they don’t, they wouldn’t collaborate again (Edwards, 2009).
2.2.4 Networks

Social capital can only be acquired in social networks (Edwards and Fowley, 1998). A network is according to Edwards (2009) the first component of social capital. It is a group of people, the denser the better, that understands and applies self-interest properly understood along with holding the networks members accountable for their previous actions hence the norm of reciprocity.

Networks can be either bridging or bonding. To classify a network as one of these concepts is more challenging than one might think. A bridging network is a group of people from many different social divides, and a bonding one is a group of people that has a high degree of sameness with similar people that wants to create and identify together. MSF could be argued to be classified as both a bridging and a bonding one since its members come from all over the world and from many different social and cultural contexts. It could also be argued that people that are attracted to MSF has a high degree of sameness since they share their belief in the MSF mission.

Coleman and Putnam used social capital in different ways. Putnam as previously mentioned believed that social capital can be transferred from network to network stored in the ideational structure that has been created. Coleman on the other hand sees the networks as context specific and that individuals cannot transfer the capital. He saw relationships as assets and that an individual is a part of both empowering and constraining networks. He claims that it is the norms of the network that makes people feel comfortable to demand time from others and to demand your time as well. It is important to point out that in a network the social capital is not evenly spread out between the members (Edwards, 2009).

2.3 Organisational change

Most of the literature that is researching organisational change or change management is coming from the business world but a selection of articles has been identified dealing with specifically humanitarian NGOs. Organisational change is defined as “the process of continually renewing an organization’s direction, structure, and capabilities to serve the ever changing needs of external and internal customers” (Moran and Brightman, 2000, 111). The customers that the definition is referring to would in the world of
humanitarian action refer to beneficiaries, donors, employees, and members. Change is always present, both driven from external and internal factors and it is of the utmost importance for the survival and success of an organisation to manage that change. It is often challenging to predict change and the response is often due to external factors (By, 2005). According to By (2005) around 70% of all change programs fail to implement the intended change. There are no such studies in the field of humanitarian sector that the author has found.

The literature in general is investigating planned change and the different steps an organisation has to go through in attempting to transform itself from what it is to what they want it to be. Most organisational change has been based on a series of assumptions. Jansson (2009) has challenged the three main assumptions being that organisational practices are universal, resistance to change as a result of change itself and that change practitioners act as members defined by hierarchy. She performs a critical analysis to these assumptions and redefines them in a way that is more applicable in the humanitarian sector. The author redefines the universality of organisational change as “Organisational change practices are particular within contexts” because human action and discourse are unique in each context. The assumption of change resistance is redefined as “resistance is about human action, power, or practitioners holding the power of change”. What this actually means is that change cannot be completely predetermined because it is a result of many local interests and the constant influence that talk has on change and change has on talk. Every story is according to the author an example of change praxis because of the influence that each individual has on the change processes. Human power puts a crucial role in social change, and resistance to change is often a reaction to the power itself or the person wielding the power and not necessarily at change in itself. The final assumption is analysed through a practitioner lens. Here the author highlights the importance of organisational identity, meaning what we are and what we do as an organisation. Literature often labels practitioner as either promoters of recipients of change, but Jansson (2009) argues that a human being is more complex than that and redefines the assumption to “change practitioners act upon emotional, contextual and identify factors” (Jansson, 2009, p 1009).

To be successful in change within the humanitarian sector one needs to utilize the most effective and appropriate methods because change is a process that is constantly evolving.
and often tends to change the humanitarian context itself. Humanitarian actors can do more than just react to the external context. Most humanitarian actors have reacted to the context by increasing in size, broadening its mandate and the complexity of its operations, but some have also taken decisions not to grow and even narrow their mandate. Humanitarian actors can do more than be reactive; there is always a choice. There are many methods of change and most of the literature regarding change in the humanitarian sector deals with a top-down institutionalised change. Evaluation, policy development, training and internal communication activities are examples of such institutional approaches. Some of these approaches are successful but a majority fails and most feel that they are not creating the intended change. Especially evaluations and the recommendations coming from the evaluation have a low success rate. Clarke and Ramalingam (2008) have analysed why and have come up with the conclusion that applying a machine approach to change within the humanitarian sector is impossible. The machine approach is well suited when conditions are stable, operations are fairly straightforward and the aim is to reproduce the same product over and over again. They suggest to instead seeing humanitarian organisations as communities, minds and as complex and interconnected systems. What they mean with an organisation as a community is that an organisation has its own culture created by the members. The culture defines the world around them and the place of the organisation’s role in it and the social structure is the formal and informal rules that govern it. Why they claim it to be a mind is because it has the capacity to reflect and its members often have an emotional response to change. The emotional response is often due to a perceived threat on themselves or the identity of the organisation that they link to a threat to their worldview. The emotional response is preserving the culture and identities of the organisation and can create stability, but it can also make the organisation ill-equipped to deal with change. Lastly they call organisations complex and interconnected systems. With this they mean that an organisation is self-regulating and sometimes even an open and dynamic organic entity. Nothing is predetermined. Organisations can create themselves and change from within if the circumstances are right (Clarke and Ramalingam, 2008).

Change cannot be predetermined; the goal must be to create condition where organisations can create their own reality. The key to understanding the process is that the change reflects the values of people in it. Without that, the chance of success is low (Clarke and Ramalingam, 2008). Here we can bring in Putnam’s and Coleman’s ideas
of social capital as either value loaded or value neutral. Here it could be argued that the conditions required for organisations to create their own reality can be also based on “bad” values and resources. This supports Coleman’s definition of social capital as ethically neutral. The aim of change is to be more adaptable to the context and to better adapt to it. For an NGO to continue to have the trust, of beneficiaries, donors and members, and authority they need to be just that; effective, adaptable but most of all they need to have legitimacy. Legitimacy is the result of a functioning democracy, transparency and accountability (Lehr-Lehnardt, 2005).

2.4. Theoretical implications
Eckstein and Gurr’s definition from 1975 along with Dahl’s criteria from 1998 form the basis of understanding democracy in this thesis. Edwards’ (2009) continued work on Putnam’s civic culture syndrome and what she calls comparative compact will be used in framing the data. The theory on transferability of social capital as a collective cultural memory will also be used as well as Edwards’ (2009) theory on ideational social capital. In addition to this the thesis will make the assumption that social capital is value neutral and hence follow Coleman’s theory. The thesis will view humanitarian organisations as communities, minds and as complex and interconnected systems in its understanding of organisational change.
3. MSF and its organisational structure

“MSF is what we make of it” (MSF, 2017a).

The following chapter will serve as a background for better understanding MSF’s history and current structure. It will provide a foundation of understanding that is needed to frame the results and discussion.

3.1 The foundation of MSF and its history of change

The civil war that was the result of the Biafra break away from Nigeria in 1967 planted the seed that was to become MSF. At the time, the International Committee of the Red Cross (ICRC) was the main humanitarian aid provider and they had medical teams on ground with mostly French doctors. Bernard Kouchner was one of them and he and many of his colleagues were outraged with the Nigerian army’s embargo on Biafra that resulted in a manmade famine. By working for ICRC they had signed a statement where they promised not to speak publicly of the situation in Nigeria and the nature of their work (Borlotti, 2004). This rule was key to ICRC’s neutrality in the context but Kouchner and his colleagues were outraged about the silence and when they got home Kouchner left ICRC and broke his signed statement and communicated publicly “By keeping silent, we doctors were accomplices in the systematic massacre of a population” (Reiff, 2003, p. 83). He also organized media events to raise awareness about Biafra. In the meantime the idea of MSF grew and together with other Biafrans, as they called themselves, and a group of medical journalists formed on December 20\textsuperscript{th}, 1971 a humanitarian organization that would both deliver medical aid and speak out about the injustices witnessed in the field. MSF has been described as “the bastard child of a doctor and a journalist” and an organization that refuses to conform with the humanitarian community, MSF instead charts its own course of action (Borlotti, 2004, p. 46). MSF is today one of the world’s largest medical humanitarian organisation and in 2015 had 36,882 volunteers and employees, 446 projects in 69 countries (MSF, 2016c). MSF was created to be a critical humanitarian organisation mainly focused on relief aid but the organisation has evolved, often because of internal debate and guidance from the association, and today a big part of its operations is devoted to long-term care like treatment of HIV, tuberculosis and other neglected diseases in more stable contexts.
The evolution of MSF has been an organic one and always influenced by the world and context around the organisation. The increase of refugees to 6 million in the mid 1970s was an important influence in the organisations history. Claude Malhuret, a leading doctor within the organisation, returned from the border between Thailand and Cambodia in the midst of Cambodians fleeing the Khmer Rouge. He led the development of a more professional organisation with a more efficient and effective logistics and administration with longer-term mission. Another defining moment was in 1979, where refugees on boats outside of Vietnam were in the headlines. Kouchner wanted to send boat ambulance to save “the boat people” and to get media attention and hopefully action from states. The intervention divided the leadership. Kouchner, who was for the intervention, and Malhuret and Rony Brauman, another prominent doctor, who was against it and thought that the resources could be used more efficiently and effectively in Cambodia. The association voted in favour of Malhuret and Brauman with 90 out of 120 votes. This vote resulted in Kouchner breaking with the organisation and creating yet another NGO called Médecins du Monde (MDM, doctors of the world). After this the vision that Malhuret put forward was realized and MSF budget would triple within a year (Borlotti, 2004). In the 1990s the MSF movement grew significantly. From only being based in Paris the organisation now had operative centres in other European cities and offices dealing with recruitment, fundraising and communication started to spread to Canada, Japan, Hong Kong, Sweden and Australia among others. The many complex crises during the 90s challenged MSF to face the complicated reality; the limitation of aid and the shrinking humanitarian space in contexts like Rwanda in -94, Kosovo, Bosnia and Somalia. These emergencies would push the principle of neutrality to its limits but MSF remained fluid, constantly evolving through internal debate, which lead them to win the Nobel Peace Prize in 1999 (Borlotti, 2004). At that time international president of MSF James Orbinski accepted the price and in the acceptance speech he set out a new vision and an agenda for MSF. “More than 90 % of all death and suffering from infectious diseases occurs in the developing world,” these illnesses are killing people because, “life-saving essential medicines are either too expensive, or not available because they are not seen as financially viable, or because there is virtually no new research and development,” into new medicines. “This market failure,” Orbinski stated, “is our next challenge.” (https://www.nobelprize.org/nobel_prizes/peace/laureates/1999/msf-lecture.html)
MSF evolved yet again. HIV was spreading and the knowledge about the disease did as well with the first antiretroviral treatment (ARVs) coming a few years earlier. The treatment was not available to everyone because of the reasons previously mentioned. The MSF executive was not in favour of MSF getting involved initially because of the nature of HIV. It’s a chronic disease and the treatment is lifelong, which many thought was a commitment too big for a humanitarian relief organization. Two initiatives led to change. First a field doctor smuggled in ARVs in South Africa privately and started a few patients on treatment forcing the executive to respond; secondly the association approved a series of motions that forced the executive to start looking into how MSF could play an active role in both treatment and advocacy (Respondent 9, personal communication, 29 April 2017). Today MSF has over 250,000 patients under treatment worldwide (MSF, 2016c) and has created the Access to essential medicines campaign, which has helped reduced the prices of ARVs significantly and lessen the patent laws creating opportunities for low income countries to buy but also produce generic ARVs increasing access to treatment for all. Due to these actions and decisions, among others, MSF gained the reputation of being paradoxical by having a high technical competency and effective operations at the same time as having a very informal and decentralized organisation (Borlotti, 2004).

Since its founding MSF has organically grown, always fuelled by controversy but stayed true to its social mission, always been self-critical, flexible, changeable and most often successful in the face of enduring humanitarian emergencies. The organisation has continued to grow and is now a complicated organisation with five (5) operative centres, 24 partner sections and an increasing number of branch offices around the world. This has raised questions regarding sustainable growth and the associative nature of MSF. In the La Mancha agreement from 2006, which grew out of a need to address internal and external challenges, MSF reconfirmed its commitment to its inclusive and effective associative structure. La Mancha was the result of a long process, over a year of internal debates and discussion, that created a common understanding on how the organisation wants to work and the need of a stronger governance structure (MSF, 2006). In the associative roadmap paper (MSF, 2015a) it is stated that MSF wants to use the experience in the movement to find the right balance between the executive and the association and ultimately improve the contributions from both branches to the social mission.
3.2 Guiding principles and documents

The charter of MSF from 1971 is still today central to the organisations identity. The Charter establishes MSF as a private, international association made up by profession that may help in achieving its aim, mainly health care workers. To be a member of MSF you have to abide by a set of principles. It means to provide assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict irrespective of race, religion, creed or political convictions.

Members abide by the principles of neutrality, impartiality and the right to humanitarian assistance as well as respect for their professional code of ethics and maintain complete independence from all political, economic or religious powers. All members are also volunteers and make no claim for themselves other than that which the association might be able to afford them. The charter in full text you find in appendix 4.

Another key document is the Chantilly Principles; this document reaffirms the commitment to the principles and describes what MSF is. It sets out that medical action comes first for MSF, meaning curative and preventative health care for people in danger, which is the primary objective for MSF. Besides clarifying the principles of neutrality, impartiality and professional ethics (mostly medical), MSF also abide by the principle of independence. This means that MSF operations are based on an independent assessment of the needs as well as direct control of the aid given. This principle is also applied in the finances of the organisation where only a small part is allowed to come from states. Some operations do not accept any state funding. The principle that sets MSF apart from many other humanitarian NGOs and the reason for the creation of MSF is témoignage. Témoignage is a French term that means to bear witness, just because MSF is impartial and neutral does not mean that it is always quite, MSF choses to speak out publicly about the atrocities that our fieldworkers have witnessed. MSF tries to bring attention to neglected conflicts, blocked access of aid and unacceptable suffering. Chantilly also reaffirms MSF as an association and states that:

“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… 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 association. Linked to the idea of volunteerism, the associative character of MSF permits an openness towards our societies and a capacity for questioning ourselves” (MSF 1996).

3.3 Internal Governance reform

The governance reform was a three-year participatory process that was triggered in many ways by La Mancha. La Mancha grew out of issues regarding governance and a need to review MSF’s identity in an at the time changing environment. La Mancha was the foundation but did not result in a governance system and many of the pre-la Mancha problems remained unsolved. In 2008 MSF realized that it lacked the governance structures to have meaningful movement discussions. People saw no meaning in participation so in 2009 the at the time highest authority, the International Council (IC), started the governance reform saying that “adjustments to the current set-up are needed to better respond to the needs of our social mission”. The IC gave the Governance work group the task to assess the current national association roles and responsibilities and to explore alternative and/or complementary associative models. The working group along with the different operational centres’ presidents developed the ambition for the reform process, which resulted in the following text (Bacchetta, 2013).

“MSF aims to develop a governance system that reflects the common ownership of our social mission. The future governance must organise associates around the social mission of MSF by strengthening leadership, clarifying roles and responsibilities, decision-making and accountability. It must ensure that the organizational setup is adapted to our current and future operational needs. Innovation and initiative are core elements of our action and will be articulated alongside the ability to develop movement-wide strategies to respond to internal and external challenges” (Bacchetta, 2013).

The was as mentioned a three-year process that started with diagnosing internal and external challenges and led to the movement’s wide debates and conferences on the topic. It all resulted in a proposal that was voted through in all national assemblies. The final result was new governance entities like the International General Assembly (IGA) and the International Board (IB), statutes, internal rules. In June 2012 the process was formally over but the practicalities of the reform remained, and still today many of the
challenges remain to be addressed according to Baccheta (2013), like how to interpret the relationship between the IGA and IB, the IB governance of the executive and the development of regional associations. The documents mentioned as a result are nothing more than pieces and will only be successful if implemented by the people in the organization. Baccheta (2013) concludes:

“There is a lot to be done, but a lot has been achieved… It is clear from the reform that MSF does not want a single pyramidal international structure. That makes good sense for the culture of the organisation, the mission and the ambition to retain alternative, innovative approaches through multiple operational directorates.”

3.4 Organisational structure today
MSF is an association; this is clearly stated in the Charter, Chantilly and La Mancha. The association and the executive are two crucial parts of MSF and as previously stated they have grown in most ways organically into the organisation. This was up until the governance reform. But the organisational structure is complex as a result of the organic growth. The governance reform created new entities to simplify and increase accountability in the democratic structure, below these entities will be explored.

Figure 2. Organisational map
MSF today consists of 5 operative centres (OCs) that is executing the social mission and running MSF humanitarian operations. These centres are all in Europe, in Paris (OCP), Brussels (OCB), Amsterdam (OCA), Geneva (OCG) and Barcelona/Athens (OCBA). All OCs have their own board (not legal entities) and association. In addition to the OCs there are 21 partner sections with three (3) primary functions: Recruitment of field staff, fundraising and communication/advocacy. In later years many partner sections initiated the creation of different departments which were meant to provide needed operational support like i.e. evaluation, innovation, mentorships to field workers and benchmarking of salary levels. All partner sections are legal entities in their respective home country and have their own associations and boards. Further there are also an increasing number of branch offices, most exist because of country representation and advocacy but many also do recruitment of field staff. These branch offices do not have their own associations. Then there are an increasing number of country offices with unclear status mostly because of country representation and advocacy.

All these entities are governed by an international board (IB), the international association and its highest deciding organ, the international general assembly (IGA). Below each of these entities will be explained (MSF, 2017c).
3.4.1 Membership

The international statutes from 2011 (MSF, 2011a) define who can be a member of the international association and what that membership means in terms of rights and responsibilities. All the partner sections statutes are not harmonized and national associations might have minor differences in the definition of a member. The international statutes state that a member is either the international president that receives membership by his or her election as president, a national association’s elected representatives or individuals meeting the criteria for membership. The criteria for individual membership are to have worked as an international staff for not less than six (months) and/or completed 2 separate international contracts and/or worked as a local employee of any of the different MSF associations for not less than a year and/or done unpaid work as a volunteer or intern for more than two years. In addition to this of course also follows the rules set out in the Internal Rules.
The membership means different things at the IGA and in the national associations. At the IGA the membership will give a member the right to participate in the debate but will not give the right to vote. That right is restricted to the elected representatives from the different national association that has two elected representatives present. The membership in a national association gives the member voting rights. For example a member in the Swedish association of MSF has the right to take part in the general assembly, elect the board for the national association, vote for discharge of responsibility for the national board and propose and vote for motions (MSF, 2017b).

3.4.2 International board

The IB consists of 12 voting members, an international president, one representative from each OC plus by members elected representatives from the IGA. Two thirds of the board must have a medical background. This system has been in effect since 2011 and the internal governance reform. The mandate of the board is to hold the executive accountable for the implementation of the shared vision and for the implementations of the decisions made at the IGA. In addition they are also opening and closing executive entities, make specific recommendations to the IGA and resolve conflicts within the movement as a whole. The IB is the only body giving directives to the executive platforms and holds the Excom\(^2\) accountable. Decisions taken by the IB needs to have a minimum 3/5s majority but some decisions even a 4/5 majority (MSF, 2013a).

3.4.3 International General Assembly

The IGA is the highest authority of the association and its members. It acts as the guardian and the decision maker regarding the MSF charter and the purpose of the association. The IGA consists of the president, representatives from institutional members and individual members of the international association and they meet at least once every year. The IGA has seven groups of responsibilities according to the international statutes (MSF, 2011a).

1. Membership and Association related tasks
2. Delegation of tasks and holding the IB accountable
3. Development/endorsement of an international shared vision

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\(^2\) The Executive Committee or the ExCom is the highest executive platform in MSF and it is the direct counterpart to the International Board. Please see section 2.4.6 for further information.
4. Strategic tasks (safeguarding the social mission, provision of leadership)
5. Election and removal of President, IB members and others
6. Finance related activities (Budgets, Accounts, Audits)
7. Amendment of Charter, Statutes and internal rules

For the IGA to take a decision on issues on the agenda it will need a 4/5 majority. For drastic change in the MSF charter for example there is a need for a unanimous vote.

3.4.4 International office
The international office is the secretariat of the association. It is the international board that appoints the Secretary General and the definition of the role. The Secretary General is the director of the international office with the primary responsibility of monitoring the relevance, effectiveness, efficiency and quality of operation. The Secretary General also chairs the ExCom, brings forward issues to the IB and most of all defend the principles, interests and image of the association and its members (MSF, 2011).

3.4.5 National or regional associations
With the growth of MSF along came an increasing number of national or regional associations. The recognized associations are all institutional members of the IGA and have two representatives with voting rights, one of which is the president of the national or regional association. Each association is a legal entity in their respective home country and has its own statutes and its own board and GA. For example the Swedish association consists of around 400 members (same definition as individual members as under the IGA section) (Respondent 1, personal communication, 8 March 2017).

3.4.6 Executive platforms
The executive is a big group of individuals that consists of all staff in the field missions, OCs and offices in partner sections and branches. The executive is more of a hierarchical structure and below some of the different executive platforms that interact with the association will be described.

The Executive Committee or the ExCom is the highest executive platform in MSF and it is the direct counterpart to the IB and it is accountable to it. This platform means to provide leadership of the MSF movement and direction in regard to the shared MSF
vision. In addition to this it is the ExCom’s role to implement the international work plan and ensure that operations and support activities are relevant, consistent, efficient and in accordance with MSF social mission.

**Figure 4: ExCom’s relationship with IB and IGA**

The ExCom has three levels:

1. The full Excom is a group of all General Directors (GDs) in all MSF sections together with the Secretary General, GDs from branch offices. The full ExCom only meets once per year.

2. Core ExCom consists of only the GDs of the OCs and two elected GDs from other sections. In addition to this, both the Secretary General and the International Medical Secretary are parts of this platform that meets around 10 times per year.

3. Core+ ExCom is a platform that only meets when required and it is the Core ExCom together with specific GDs that are in charge of certain portfolios or have knowledge about specific issues.

In addition to the ExCom there are multiple executive platforms some of them are mentioned below, but as they are not relevant to the subject they will not be described in depth (MSF, 2012a).
• Medical and Operational Directors (MEDOP)
• Medical Directors (DirMed)
• Directors of Operations (RIOD)
• DirLog, IDRG, FinDir, DirFund, DirCom, ISM (see abbreviations for clarification)

3.5 The mandate of the association

The MSF association has delegated the implementation of the social mission stated in the charter to the executive. The role of the association is to guide, advice and direct the overall implementation. Both exist to work together and the associative road map paper (MSF, 2015a) describes the relationship as reciprocal and symbiotic. This paper also describes that there are tensions between the two that some see as healthy because they force MSF to more clearly define its standpoint and also improve the overall quality of its actions. The formal role that the association has is to safeguard the identity of MSF and their principles as well as hold the executive accountable for the implementation of the social mission. Further the association is meant to create debates and space for innovation through participative working methods. The debates are according to MSF key in their work and the debates are not consensus driven or politically correct. With their debates they want to challenge the existing discourse both internally and externally. The association has the mandate to make sure there is space for this debate and that minority voices are heard. In short, the association is a counter balance to the executive and is responsible to deliver the best possible medical assistance in humanitarian emergencies (MSF, 2015a).

The governance reform intended to:

“Establish (i) a vibrant associative life through the creation of an International General Assembly that safeguards MSF’s medical humanitarian social mission, develops a movement-wide vision, and fosters participation and involvement of members through diverse associative groupings, and (ii) an active and functional International Board that provides guidance for the movement, promotes executive and medical leadership and, above all, supports innovative implementation of our social mission” (MSF, 2015b)

The statutes further expressed the “desire of all MSFs members to constantly improve
MSF’s medical humanitarian action in responding to the needs of people in crisis”.

3.6 Tools of influence and change
There are many tools of influence available to members, some formal and some informal. Here is an overview of the tools available (MSF, 2015c):

1. Vote for board representatives.
2. Participate in formal debates in associative meetings, general assemblies, associative forums, informal debates in the field, with the executive and board members.
3. Recommendations.
4. Motions.

The following section will describe the process of a motion from its creation to being brought up at a general assembly and to its feedback.

3.6.1 The life of a motion
A motion is one of the formal tools that are available to members to push issues they believe in either their home association, the international movement or in the field. The idea with a motion is that concerns the fundamentals and the identity of the movement as well as its mandate. There is another tool that is also available and that is recommendations to the executive, but those are merely suggestions regarding operational policies and they are not voted upon just discussed. A motion is a request to the association that speaks about the priorities and core mandate. The motion tool kit that MSF has put together to explain the meaning of a motion says that:

“Motions are a useful tool to provoke changes in the organisation and/or put an issue on the agenda of the association as a whole. The tool kit recommends that motions should be broad in the wording and applicable in many different contexts, bring something new or deals with long-term strategies” (MSF, 2015c).

The kit recommends members to find other likeminded members, discuss and let the motion mature as well as making sure there is not already another motion that has been passed on the subject or a policy on the same topic. For the motion to become a reality it
needs formal support from an associative gathering of field associative debate or a so-called FAD. Each step in the life of a motion you can find in figure 4, but the idea is that the field coordination team, associative coordinator and FAD review the motion and determine where the best place is for it to get addressed. It could be addressed at field level if it is more operational or specific for the context, but if it is meant to be discussed at a general assembly, the motion is passing a motion committee when it comes to OCB (not for all OCs) (MSF, 2015c). The role of the motion committee is to do a critical analysis of the motions that have been handed in, to avoid duplication, repetition and decides if it is supposed to be a motion or a recommendation. Sometimes motions need rewriting and the motion board does that, but the original authors must approve the new text. The committee selects a number of motions to be presented to the board that makes the final selection on what is supposed to be presented at the GA. At the GA all members of that association are allowed to vote for it and a majority decision will approve it. If the motion is meant for the international movement after it passes a national GA, it may be presented at the IGA. Motions are not binding text (depends on the topic) but the board responsible for the association is bound to work on the issue and report back to the association, the association then decides if the board has fulfilled the responsibility by giving them a discharge of liability. If they do not feel that the board has done its job then they force the board to step down and a new one is elected. If a motion is directed to the field it is the field coordination team that is bound to address the issue. The feedback coming at an associative level is given at different stages. The motion committee gives their feedback first before the motion is brought up at a GA and then the board responsible gives its response about what happened (MSF, 2015c).
Figure 5: The motion process

Source: MSF, 2015c
3.7 Plans for the associative future
In the associative road map paper, it is clearly stated that “MSFs primary responsibility is to improve the quality, relevance and extent of our humanitarian assistance” (MSF, 2015a, p. 1). A stronger governance structure is needed that is based on MSFs associative nature. The desire to have an effective association is expressed but how that will be achieved is not clear. It is expressed that MSF wants a motion that questions and not just validates the executive. In the road map the authors even raise the question if MSF still needs the association to play its role. Despite the question it is stated that MSF associative model should and will reflect MSF role in the world in the future and constantly develop its relevance to the movement (MSF, 2015a). A big topic for the association to tackle is growth and how to manage it. The movement needs to decide how much it wants to control institutional development. Initiative and action is in the DNA of MSF according to Bachetta and Mousseau (2016) but there are voices of concern about further bureaucratization. The main challenge is to find ways to support initiatives in the development of the future MSF.

3.8 Summary
MSF is an executive organisation governed by an association using democratic principles as a mean to guide and hold the executive accountable. The association fulfils all formal criteria in the Eckstein and Gurr’s definition from 1975. There are platforms and procedures where members can express their preferences regarding MSF policies and elected representatives. It can be done both through formal channels like at a general assembly and through organised debates as well as through informal channels like direct contacts with boards and executive and the platforms to start one’s own debates. The members can exercise constraints on power through votes on discharge of responsibilities of their elected board. When looking further at Dahl’s 5 criteria (1998), MSF also fulfils the inclusion of adults even though there is a membership criterion. All members have a vote each and members have opportunities in finding and validating options through different platforms as well as influencing the agenda of board meetings, general assemblies and other associational event. The internal democracy has improved over time with the latest larger
attempt being the governance reform.
4. Research findings: Examining internal democracy and the creation of social capital

“Democracy is not a goal in itself in MSF as long as this democracy doesn’t make it better for the populations in danger” (Respondent 11, appendix 2 p.96).

This chapter will explore the answers to the research questions:
- Is MSF an organisation with a high degree of internal democracy where social capital is formed?
- Do members of MSF perceive their organisation as democratic?

The chapter is divided in three headings where the first one examines the internal democracy within the association then followed by MSFs creation of social capital. The last section will further identify strengths, weaknesses, opportunities and threats to democracy that do not fit under any of the defined prerequisites in the theoretical framework to be explored. This chapter relies fully on the in-depths interviews from where the data has been coded and an active choice to let quotes speak for the emerging themes has been made. The author of this thesis hereby refers to grounded theory and the use of open coding (see Robson, 2011, pp 489-492).

4.1 Examining the internal democracy

There are strengths, weaknesses, opportunities and threats or challenges to all democracies. The same applies to MSFs internal democracy. Below are the findings on what the respondents have to say about MSF and its internal democracy. This section will first display the findings under the same subheadings as in the theoretical section.

4.1.1 Constraints on power

All the formal constraints on power exist in the association and they are written down in the statutes. As a member you have channels to question the power meaning both the executive and board representatives. The final exercise of power by the association meaning giving discharge of responsibility to the elected boards is something that is taken seriously by the association throughout MSFs history. The respondents could remember twice where
discharge of responsibility was not given to the boards of Switzerland and Italy and new boards had to be elected (Respondents 1 and 9, appendix 2, page 96). Respondent 1 also describes the relationship between the association and the executive, which highlight that it works:

“So you have the constraints of the association that may go directly against what the executive wants but you also have the constraints of the movement which will also at times come in and direct you in what you can and can’t do.” (Appendix 2, p. 96)

The association is meant to be a counter balance to the executive and here many of the interviewees have concerns about the current structure. Respondent 11 expresses his doubts:

“We were so weak in relation to this very strong executive. In the executive (referring to MSF Sweden) you have maybe 50 or 70 people working full time on full salary and 40-50 hours per week they work on this and to counterbalance this you have a group of 5-6 people that is going to do this in their free time. It is pathetic to even think that can function as a counterbalance. How can it?” (Appendix 2, p. 96)

Respondent 9 brings in the international perspective with “We have an organization of 1,5 billion, soon to be 3 billion that theoretically is governed by boards that between their daily jobs, Friday nights and families have to take decisions of billions and 34,000 people out there” (appendix 2 p.96). Respondent 5 summarizes it in this way:

“As you delegate a lot of power to the executive, it is extremely important that we continue to be active members, debating, questioning, it is not a formal accountability process. If you delegate a lot of power you need a lot of people that question that power.” (Appendix 2 p.96)

### 4.1.2 Mutual cooperation

Democratic organisations are structures of cooperation according to Moe (2005), cooperation between actors seeking mutual benefits. Ghosh (2009) states that NGOs are
democratic because they are trying to establish cooperation to achieve good ends. Mutual cooperation for a greater good and mutual benefit is founded in a high degree of participation and the adherence to democratic rules and procedures, all needed for upholding trust and cooperation. According to Respondent 9 “you can find the space and the association can give this space even though it looks difficult” (appendix 2 p.96).

4.1.3 Rules
The formal rules are clearly stated in the statutes and the internal rules. The rules are based on that members elect their board representatives and that decisions are based on the majority rule. These rules are followed according to all respondents but respondent 4 expresses her concern that even though we have all the right mechanisms in place:

“We don’t apply them because the power lies with the boards at every level but our boards are weak to be quite frank, if you have a strong GD they will control their boards, So even though the rules are there is a risk of manipulation” (appendix 2 p.96).

4.1.4 Membership
Membership in MSF is unique due to the membership criteria setup in the statues. This came up in multiple interviews as key in creating ownership for the organisation.

“What is peculiar with MSF is that you have to have had MSF experience. Membership means a lot, working for MSF is more than just a job, with the structure that we have I think of MSF as a cooperative. You and me work for MSF and we own this place together with others” (Respondent 5, appendix 2 p.96).

And “the difference with MSF is that there is criteria, you feel the sense of ownership” (Respondent 4, appendix 2 p.96). “We have an exclusive membership for people that has actually understood a bit how MSF functions but also how the populations that we are trying to assist, has an understanding and a proximity to them” (Respondent 11, appendix 2 p.96).
“It is based on that you have to earn your membership, work in field or the office which means it is not for everyone… Most members in MSF would describe themselves as owning MSF or being MSF. That is at least how it used to be, maybe it is changing now” (Respondent 6, appendix 2 p.96).

This feeling of ownership creates a strong sense of responsibility towards the organisation. The last quote states that it might be changing, which is something that many also highlight. Respondent 6 continues with:

“Maybe the active ones are the ones that have that type of ownership feeling or identify them with MSF very much. Others might see MSF as an employer and only wants to go on a few missions so maybe you are not so active in the association either. So there are two layers of members” (appendix 2 p.96).

These two layers of members is something that many refer to in many ways, active, informed or meaningful members being one of the layers and non-active and uninformed members the other. This is a central challenge that many identify.

A member in MSF has both rights and responsibilities, rights stated in the statues like voting for board representatives, giving the board discharge of responsibility, voting for motions. A theme throughout the interviews is that these rights should actually be viewed as a responsibility with statements like “you have a right to have a voice but it also comes with a responsibility to be engaged and really commit to this task” (respondent 6, appendix 2 p.96) and “When I am putting the hat of the association I have to see the implementation of our social mission and really obliging myself to look on the big picture if what we are doing is still in line with our principles and with our core identity … …We have the responsibility to reframe the narrative” (Respondent 9, appendix 2 p.96), “in the field your responsibility is to create spaces where opinions are expressed and debated.” (Respondent 10, appendix 2 p.96), “My responsibility is to be bold enough and have commitment enough to voice and to manifest my beliefs and opinions on a certain subject but also help others doing the same thing” (Respondent 3, appendix 2 p.96).
“…a responsibility to follow issues a bit more closely, to vote, the biggest thing you do is to annually vote for your board of directors who are the ones that obviously will do the oversight throughout the year, and that is why for me it becomes a responsibility. Members see it as a kind of privilege; they should get some perks when you are a member… In theory that is what it is but honestly a majority of our membership does not quite understand that” (Respondent 4, appendix 2 p.96).

This is again linking to the challenge of the fact that a large amount of the members is not active or informed. Respondent 11 expresses that:

“If you work with MSF you have duties more than you have rights, you have duties to populations in danger, a duty to make their voice heard and not focus on that you have the right to vote. You have the right to vote if you have the conviction that what you are doing supports populations in danger…” (appendix 2 p.96).

The definition of active membership or what some call meaningful membership is defined by respondent 9 as:

“For me meaningful means three words, ownership and ownership can only be created by good understanding and information because if I am not informed I cannot own, meaningful means participation, participation in an active way which also means that if information is not given to me I have to request it, I demand it and meaningful means contributing in sense of putting forward my ideas and convictions, engaging in a dialogue about my ideas and the ideas of others” (appendix 2 p.96).

Equality is a requirement in a democracy. Equality or the lack of equality is a central theme coming out of the interviews, both in terms of individual membership but also depending on which association you are from. Regarding individual membership, different members have different power according to all respondents but in many different ways. Members that are not active in terms of not voting for the board or for motions have less power and of course board members have more power than normal members but also among the active members, respondents 6 says:
“Not in voting, in voting it is one vote per member but in terms of influencing yes. If you know a lot of people, I probably have more power than someone who went on their first mission. I am not saying it is right but that is the case. You are being listened to depending on who you are” (appendix 2 p.96).

But according to respondent 4,

“Anybody can actually stand up in a general assembly and if they have something to say and it is convincing enough it doesn’t matter who you are, you can be the general director or you can be a driver from a project, if you are able to articulate you will be listened to and here is why I believe that the association is a flat structure. The problem is that we say it is a flat structure but people are intimidated to stand up and especially if it is not in their mother tongue, it is way more challenging to be articulate and get your point across” (appendix 2 p.96).

Respondent 7 puts it this way:

“Some are more equal than others. Everyone is not equal, there is a language barrier, the better you are at expressing your selves… your voice is going to be heard. If you know the right people, you know what buttons to push, this is how it is in any country, organization, you need to know and then you need to see what you can do to level it out” (appendix 2 p.96).

This difference in power also reaches board members according to respondent 5 “If you are the president of an operational centre you are extremely well informed about what is going on inside the movement and normally decisions are quick” (appendix 2 p.96). Respondent 10 sums it up to “more vocal equals more power” (appendix 2 p.96). Respondent 4 again expresses the importance of informal contacts to be able to influence:

“That’s where everything actually happens. If you know who the decision makers are and you have those connections and you use those networks... direct connection to the board, we need that face to face connection, coffee breaks during meetings are always the most important because that is where you are going to do the networking, take real decisions and
that is why most people in this organisation smoke because that is where the real decisions happen” (appendix 2 p.96).

Different power depending on which association is also brought up. The issue of representation depending on the size of your association is described by respondent 1 with:

“If I am a member of MSF Luxemburg I have such power, I mean it’s like 60 members, so there is like you choose your board and the board choses two IGA representatives. If I am a member of the movement wide association there is potentially 20 000 members electing 2 people to go to the IGA to represent me, you know it’s not like one vote is not equal, it doesn’t have the same weight” (appendix 2 p.96).

Others argue that more members actually mean more power. Money is coming up as a factor in the power given to an association or taken by one, MSF USA comes up as an example, which brings in a big percentage of the overall MSF budget. Newer associations are also brought up as possibly having less power, and respondent 6 says “they have less means to work as a board, to organize events, they don’t have the direct link to an office, that is somehow impeding their capacity to be part of discussions…” OC associations have more power since “OC sections are heavier sections as they have permanent seats on the IB” (Respondent 5, appendix 2 p.96).

Circling back to the challenge mentioned above as the challenge of being informed or active. Respondent 4 discusses a problem with the induction to MSF as an association and what membership means:

“This is all missing, when people get their membership we just expect to know what it is. At that level it is about what is the responsibility of being a member, how do you engage as a member, then when you get into management positions, coordination, management in any of the HQs you actually need to have a better understanding of the governance and how it all fit together because when you get to Head of Mission or running for a board and you would be surprised, but most of our board members do not understand what the association is” (appendix 2 p.96).
Respondent 9 touches on the issue as well with her statement:

“For me MSF is the collective of committed individuals. MSF is a tool where you and I through our differences have our common thing, which is our strong personal interest to be in solidarity with the ones in need. We are now transforming the fundamental collective of individuals into a machine, an organization and there I would say that the vast majority of people in leadership positions today are not even members of the association” (appendix 2 p.96).

4.1.5 Participation
Participation is a key element of democracy and the interviewees highlight this in the interviews: “You have to participate in order to change things, and if you are not participating you are not able to change and therefore you can’t complain. If you don’t make your voice heard then you have no right to say that things are not being done well (Respondent 1, appendix 2 p.96). Participation is brought up as a key responsibility of a member (See further under membership), Respondent 5 reflects on participation: “You have to be an active member all the time, participate in debates and be critical. For me that is the essence of the associative function” (appendix 2 p.96). Many see participation and the debate as central in the identity of MSF. Respondent 11 puts it this way: “It’s not a consensus type of approach, it is arguing and discussing, that is very much the heritage of MSF. It is born in a debate between people where different opinions being discussed and challenged” (appendix 2 p.96). But there is also concerns about the number of inactive members that do not participate, Respondent 11 continues with questioning the decisions that the members are taking: “Very few of the members take the opportunity and if you should count, I mean comparing a general election in Sweden with how many people that has the right to vote that actually votes it is horribly low. For me it out rules that MSF is a democratic organisation, it is not” (appendix 2 p.96)

4.1.6 Tools of influence
The tools of influence available to a member can be divided in formal and informal tools. The more formal ones are voting for board representatives, writing and voting for motions,
participating in organized debates, running for board positions and voicing opinions in a number of platforms. The availability of platforms beside the yearly general assembly seems to vary from association to association.

The informal tools of influence depend on the member, how informed and active the member is but also who the member is. Respondent 1 puts it this way: “MSF is extremely personality based, it has to do with building trust, these people need to trust you to listen to you and once they trust you they tend to listen” (appendix 2 p.96). Experienced people with networks inside the executive have greater opportunities to influence agendas and the direction of the organization. Respondent 4 says regarding informal contact:

“That’s where everything actually happens. If you know who the decision makers are and you have those connections and you use those networks... direct connection to the board… we need that face to face connection, coffee breaks during meetings are always the most important… that is why most people in this organisation smoke because that is where the real decisions happen” (appendix 2 p.96).

It is up to every member to define the informal tools available, Respondent 3 puts it like this: “There is an almost limitless amount of ways that you can influence if you are bold enough. We are actually not regulated really and if you are bold enough you can do anything… Most people would just see that they have the formal channels. The informal channels are equally important…” (appendix 2 p.96).

4.2 The creation of social capital
The following section will present the result based on the components of social capital according to the theory section.

4.2.1 Values and norms
All interviewees express a sense of identification with MSF and the values expressed in the Charter, which is expressed like this by Respondent 9: "For me MSF is the collective of committed individuals. MSF is a tool where you and me through our differences have our common thing, which is our strong personal interest to be in solidarity with the ones in
need” (appendix 2 p.96). Respondent 11 sees it as: “The goal of MSF is not to fulfil the wishes of the members, the goal of MSF is to assist populations in danger” (appendix 2 p.96). The membership criteria is according to respondent 12 making sure that people share those principal values:

“The first layer is the values of MSF… I cannot just come from the street and say that I want to become a member so there is something that are reassuring that people joining MSF has those values and who understand what MSF is about… In the same time and that the sense of having an association, even if you have the same values and want the same thing but we don’t see it the same way…” (appendix 2 p.96).

This last statement shows that even though people share the fundamental values, they often have often different opinions but the norm of acceptance and tolerance of others opinions is there. Many describe the role of the association in similar ways, respondent 3 describes the association as if “MSF as an organisation is a human being the association is the soul and heart and it kind of directs the limbs and body what it should do and the rest of the body kind of being the executive” (appendix 2 p.96). Respondent 1 describes the association as “being the heart” (appendix 2 p.96).

4.2.2 Trust
Themes of trust identified in the interviews come down to three different directions of trust: towards the regular members, towards board representatives and towards the executive.

Trust towards regular members
In general, the interviewees have a basic trust towards the membership base. Respondent 5 sums it up with “I do trust the members, I really trust the wisdom of a group of people” (appendix 2 p.96), respondent 6 puts it as “Yes and no, there is a lack of realization of what it means to be a member, that it comes with a responsibility. The organization is putting a lot of trust in you if you become a member. There could be more engagement in general” (appendix 2 p.96) and respondent 3 continues with “I trust them but the weakness for me is that not everyone sees the same value of the association as I do and maybe doesn't take it as seriously or take as much responsibility as I do…. I believe that everybody has the interest
of the organization at heart” (appendix 2 p.96). Respondent 3 touches on a theme that comes back in almost all interviews and that is again a feeling of members not being informed and active enough. Respondent 1 is outing it this way: “I feel like to able to take good decisions you have to be well informed and I don’t feel that our members are not always super well informed. Their fault, our fault, whatever. As with any group of people there is always the risk of being emotional you know, so you act on emotions rather than on logic or facts or whatever it may be” (appendix 2 p.96). Respondent 4 continues on the same track with “I don’t think a majority knows what it means and take that responsibility seriously…” (appendix 2 p.96). Respondent 4 also expresses concern that members:

“…vote for the people that are going to represent their country, their needs, their whatever, which is completely the wrong idea about the association… It should be about what are the gaps on the board, what are the skills that we need and who is the best fit… it is so ironic we are doctors without borders but we are so border bound when it comes to our association, we have this very nationalistic view…” (appendix 2 p.96).

Trust towards board representatives
When it comes to the feeling of trust towards the board representatives there are similarities in the pattern of trust. Generally speaking, the interviewees trust the boards even though there is a lack of trust or a lower trust towards certain representatives. Respondent 5 again states that “…to me a board, generally speaking, is a collective wisdom, they will be wise because they sit together and debate things… and normally they come out with a well thought through and good decisions. I really trust this collective wisdom” (appendix 2 p.96). Respondent 1 continues “yes and no because I know how incredibly easy it is to be elected to the board… Again, I would like to think that everyone sitting around the table is doing it for the right reasons because we ask a lot for our board. If I trust them a hundred percent I don’t know…” (appendix 2 p.96). Respondent 6, who is a board representative says that “I trust them to take their assignment seriously and to represent their association but at the same time we are who we are and sometimes a board member represents his or her own interests and their own associations being the most important” (appendix 2 p.96). Respondent 4 also expresses concern but can see that something is changing:
“To be completely honest the executive is making the decisions not our boards so I don’t have a lot of trust. I shouldn’t make it a blank statement either because there are some that actually are… and the International board are getting in the three years that I have been here, you can see this shift” (appendix 2 p.96).

Respondent 8 that is working for the executive says: “I feel accountable to the board and I find it good if they challenge me which they never do unfortunately, I don’t think they challenge enough…” (appendix 2 p.96).

Trust towards executive
The trust towards the executive is a more well spread trust even though some have mixed feelings. Respondent 1 says: “I want to think that most people I have encountered in MSF, weather I agree with them or have liked them I think that most of them want the best for MSF and that for me equals trust” (appendix 2 p.96). Respondent 9 continues with “The executive is doing what we asked them to do, they understand their role, and they are delivering effective and relevant operations” (appendix 2 p.96). Respondent 10 expresses that “I trust the executive to do what they are doing and I trust that they are listening to our concerns or directions, there is a balance in these things and sometimes I wonder if it is working… if we are powerful enough” (appendix 2 p.96). Respondent 3 gives his view on the trust towards OCB level: “The credibility is strong, there is no way that they are going to disregard or marginalize the associative voice at all and I look everywhere and I just see competence and transparency, humility and transparency I see, transparency is probably the most important thing. I see those as very strong indicators of leadership” (appendix 2 p.96). Respondent 4 is linking her feeling to the shift that she referred to and the acceptance of governance from the association “I have mixed feeling towards that… if they see stronger boards they will play the game, right now they don’t…” (appendix 2 p.96).

4.3 Identifying further strengths, weaknesses, opportunities and threats

4.3.1 Strengths
Many of the respondents think that the democracy works well in theory and design. Respondents bring up the association’s structure of majority decisions. There is a strong sense of responsibility and accountability among board members towards the other members according to respondent 2 and 12, illustrated by “even if I don't agree I need to go for what is decided upon” (appendix 2 p.96). There is a high ceiling and open spaces for discussions respondent 1 and 4 see that there is a strive to improve and a clear improvement in the internal democracy after the governance reform and La Mancha illustrated by “we have institutional members that are connecting to multiple OCs and again this is one of the strengths of our structure to sit on multiple OC boards” (appendix 2 p.96). Respondent 1 continues with:

“We are definitely better than we were ten years ago. I base that on if you look at number of national staff members from seriously 100 members and after La Mancha… It grew to like 5000 in like 3 years so you can see how we are allowing more votes and voices…” (appendix 2 p.96).

A strength that many point out is illustrated here by respondent 6 with:

“That we maintain the model we have, that we allow the type of associative steering. There is a natural platform between the executive and the associative where you can debate and discuss… the strength is the platform it creates and the space for lively debate about operational topics that really informs the decisions that is taken” (appendix 2 p.96).

Respondent 4 seconds that with:

“…The fact that we have something that is functioning is already interesting if you compare it to other organisations. It is an extremely ambitious thing in a movement of xx number of members, to coordinate that and what comes out of all the different regions and platforms, it is all reversed cascade and filtered down into something that can be useful for the movement, fuck me it’s not easy. The fact that it functions at all and is improving and is held as a priority is magnificent” (appendix 2 p.96).
4.3.2 Weaknesses

As previously stated many see that the organization’s internal democracy is not perfect and needs improvement. The lack of an informed critical mass is touched upon by many, respondent 3 highlights this with this example: “You need a critical mass to have an effective democracy and I have noticed in Sweden at the last Nordic GA we didn't have the critical mass in order to have a really democratic election of the board” (appendix 2 p.96). Respondent 11 builds on that with “…if you are a popular person in the office for example, you might get elected because in the general assemblies now very often, probably 50 % of those voting are in the office, Is that democracy?” (appendix 2 p.96). Respondent 9 continues discussing the lack of board candidates with “Unfortunately we are struggling to find members to the board because we have failed in making the associative attractive so usually we have 2-3 positions to fill and if you have 2-3 candidates to fill with you are already happy” (appendix 2 p.96).

The lack of informed members is central to many respondents. Respondent 12 sums it up as “Of course it’s a danger in a democracy when people vote for things that they don’t understand” (appendix 2 p.96). Respondent 8 has a concrete example regarding that where French speaking national staff from DRC each had 20 proxy votes, but the session was in English and they voted for one position, when she asked them about it in French they had misunderstood the question and voted against their opinion. The association is based on the idea of co-ownership and respondent 6 states that: ”It is only as strong as its members and if you have this idea of co-ownership you have a right to have a voice but it also comes with a responsibility to be engaged and really commit to this task. According to most of the respondents a majority of members do not take this responsibility” (appendix 2 p.96).

Another weakness identified is that many of the debates are started top-down, “FADs are a bit too directed on to what to discuss, my feeling is that it is too much imposed on the FAD or the project, topics that the international movement needs to have discussed and debated” (respondent 7, appendix 2 p.96) and debates are not growing organically from regular members and “not just from important people and from South Africa because they are sexy” (respondent 3, appendix 2 p.96). MSF need to improve in recognising minority
voices is identified as an issue. Respondent 1 (appendix 2 p.96) explains, “I think it is a work in progress. I think we are taking steps towards a more inclusive and a diverse membership, but we are not there yet. …we are allowing more votes and voices but at the same time we are not giving them the same” (see more under membership).

The strong OC mentality is stated to be a barrier to change and democracy: “The concept that we have is fundamentally the same, it is around 5 OCs and any association or board, the IB included can’t really advance if they, the five OCs, don’t agree or they don’t have a strong buy in” (respondent 9, appendix 2 p.96). The OCs are not legal entities and are governed only by operational boards and “they are the ones that validate in the end of the day the strategic plans, the budgets.” Respondent 4 continues: “…we are a complex organisation that is trying to act as one but in reality we are 24 and actually we are really 5 but we are not applying it appropriately to its full right now” (appendix 2 p.96).

4.3.3 Opportunities
Many of the weaknesses and threats can be turned into opportunities if dealt with by both members themselves and by the boards. MSF has a set of values that the members have in common and are untied by, which can be utilised. Although the respondents report about the lack of involvement from many of the members there is an opportunity there. If the inactive members would get engaged, informed and participate the internal democracy would become stronger and it could lead to stronger boards.

Respondent 4 refers to a shift that has happened, a shift where after self-reflection the boards are starting to realise that “we need to start doing things like governance training, they recognise that there is a different skill needed to be on a board…” (appendix 2 p.96). The respondent sees this shift in the executive also as a response to stronger boards (referring to IB) and referring to the engagement in the IGA with “At the IGA, in the beginning you had to basically pull teeth to get people to come especially from the executive. Last year there was a request from the Excom to come an brief them ahead of the IGA” (appendix 2 p.96). That the Excom requests briefs ahead she sees as an increase of value of this event. Here is an opportunity to capitalise on and if investments are done in
the board members it could lead to stronger boards and a more healthy balance between executive and association.

The respondents refer to the diversification that has happened in MSF after the governance reform as an opportunity. With more associations outside of Europe, voices that were not allowed a space are now heard although not with the same strength and opportunities (see under membership). Respondent 1 says: “Vefore when everyone knew each other, it was like ah it is that one but today you can actually not be anonymous but it is more about what you say than who you are. People can’t keep track of who you are. There is an opening now” (appendix 2 p.96). The diversification and the new regional associations can lead to a stronger and more equal democracy if the weaknesses and threats are dealt with.

4.3.4 Threats
The respondents have identified some threats to democracy other than the ones described under the other subheadings.

A minority of members voting as been addressed above and so has the danger and risk of uninformed decisions, and another threat related to that is voting at OCB gatherings where a majority are members from the office in Brussels or the field and only a few voices from the partners sections (respondent 6, appendix 2 p.96). Respondent 4 also refers to an OCB mentality and especially with OCB: “It is very much the tight group, so then you get block running at the international, which is actually starting to change” (appendix 2 p.96). Although the respondent is referring to a change, block running or voting as a group with one position can be a threat to a strong internal democracy.

Building on the weakness stated in the section above about debates being created with a top-down approach, “I think we have to work on that important debates can come from anywhere and I think you shouldn't manipulate that too much or control it too much. …they (OCB board and motion committee) have their own agenda and they can manipulate the agenda to suit what they think is important. ...it is not organic it is somehow being infected” (Respondent 3, appendix 2 p.96).
The threat of uninformed decisions has been touched upon but to build on that with another threat is emotional decisions. Where the emotions or the short debate sways the voters to “taking the decisions that we are doing with our heart and not with an informed brain, that this 15 minutes discussion will direct the organization and so on” (respondent 11, appendix 2 p.96). Respondent 11 continues with giving an example of a motion: “There is motions that is putting [sic] forward and changing a lot in MSF and often sometime our structure and our way to be, this Medical education motion, this is a motion that is moving us from being an emergency organization to a development organization”\textsuperscript{3} (appendix 2 p.96).

The growth of MSF has been referred to as a threat by some respondents, with Respondent 11 stating “we are the victim of our own success in the sense that when you become such a big organisation it is impossible to counteract an executive” (appendix 2 p.96). Others don’t see growth as a threat but believes that it has to be redirected (respondent 4, appendix 2 p.96).

If a board is seen as weak by the executive there is a risk of manipulations. Respondent 4 illustrates this with “if you have a strong GD they will control their boards, one told me (GD), he was like – the fact is that I can basically present something in a way that I know will force the board to vote in a certain way, so I am manipulating the board in a certain way” (appendix 2 p.96).

Again, referring to the perception of weak boards respondent 4 is stating that “we have to do a lot of work with our boards, first of all to get the individual board member to understand what is governance and what is the association, to have them understand what is their role and gain at all three levels. If we don’t do that soon I don’t think that we can survive as an association” (appendix 2 p.96).

\textsuperscript{3} Medical Education motion was approved in 2015 at the OCB gathering after a few minutes of debate asking "MSF OCB to expand our mandate and to become an influential actor in medical education, with partners and scope to defined, to challenge the for-profit and lucrative basis of existing medical profession and education and to put patient care and humanitarian ethos at the centre."
The motion committee is a topic that all respondents have an opinion about, many see it as a threat and some see it as an opportunity. Respondent 6 that has been a members of OCBs motion committee for many years view the committee’s role as:

“You are there to make sure that the motions are touch on principle issues, new things, but of course one of the difficult parts is if you have 60 motions you have and there is only time for 8 of them, you have to pick on chose based on your own basement, it is good to be a group. It is a difficult task” (appendix 2 p.96).

Many see the committee as undemocratic because the members are not elected, and they have the power to choose what motions are to be discussed without external overview as well as there is no formal constraint on that power. Respondent 12 states that “why should they do that” when discussing a motion that had it’s texted diluted. “If you write a motion it is because you believe in writing it and the change you want to happen, it is only you that can say no and I accept the change, for instance, I think for the motion to pass I need to make things change, but then it is you who have written the motion that has to accept that or not and if you don’t accept that nobody has the right to change it because it is your motion and nobody else’s motion” (respondent 12, appendix 2 p.96). The necessity of the motion committee has increased due to what is touch upon above with FADs being directed to what topics to discuss. Respondent 7 states, “when you have FADs discussing the same thing of course you will have motions that are a bit too similar… The topic came from above and then you are asked to come with a motion, already there, there is something that I don’t think is healthy. Then you get 30 different motions of more and less the same topic” (appendix 2 p.96). Despite the critic of the committee all respondents see that due to practical reason there has to be a filter because there is simply no time to deal with all motions and some of them my by similar to others that already have been voted on or similar to each other. Respondent 3 says “Again, it is a consequence of practical limitations so I can see why it is there but in a perfect world we would have the time to review them all as a group as a association but it is simply not possible“ (appendix 2 p.96) A link that Respondent 12 (appendix 2 p.96) is missing is that the ones that haven’t been selected for debate and a vote are considered for the next years GA. Respondent 9 says regarding the committee’s role, “They perceive themselves as very technical committees, their life is a
few days before and is ending the day of the GA” (appendix 2 p.96). The respondent wants to see an expansion of their mandate in to a motion follow up committee” but most of all she points out that, “If we had spaces and channels for members where they felt able to have a dialogue, to share ideas, to somehow influence we way not find our selves exclusively depending ourselves on motions” (appendix 2 p.96). Respondent 12 continues with, “that goes back to us that we have to work on the motions before they are even written, How you write a motion, why you should write a motion, how you should not write a motion. That is a work that somebody has to do” (appendix 2 p.96).

Another practice or rule that has been brought up as problematic when viewing it from democratic perspective is the head of missions’ involvement in the FADs. This is not a formal rule or practice but something that has evolved informally even though on page 29 the field team is a part of the life of a motion. The head of mission or the field team is hosting the FAD and issues or the Head of Mission (HoM) can practically filter motions that come up if they are meant to be dealt with on a field mission or if they are to go to a GA. The idea is that the HoM is to be a fail safe and “…the assumption is that the HoM has more information and is more knowledgeable than the cleaner who have voted for it. HoM have a lot of power but every FAD has at least one board member that comes in from the outside and they have power to and if they think that the HoM has done something very wrong they could remedy that to a certain extent” (Respondent 1, appendix 2 p.96). But there are not enough board members to send to all FADS so the HoM, who is a part of the executive, has a lot of power. Few of the respondents don’t see this as an issue but many say that “democratically it is very wrong” (respondent 12, appendix 2 p.96). Respondent 9 brings a perspective to the issue and that is that, “we need to address that our top managers are not members of the association. That one of our most important associative moments are given to top managers that is not members. That is a contradiction that we need to address” (appendix 2 p.96). The respondent further clarifies that part of the issue is that “…we don’t have a clear link between the FAD and the general assemblies because the HoM remains responsible by strong tradition… it is not clear how far the motions from a FAD can come back to the GA… It should be an automatically link” (appendix 2 p.96).
4.4 Conclusion
The MSF association is based on democratic principles but has a series of weakness in it as well as faces internal threats. The largest weakness is the lack of participation and unequal weight of influence of different members. The threat of executive manipulation of weak boards is a serious one that threatens the foundation of the association. Despite this, all but one respondent perceive the MSF association as being democratic. That MSF has a high degree of internal democracy is difficult to state with the weaknesses and threats in mind, but it has the potential to strengthen it. The past and existing democracy has created a strong social capital illustrated by the values that members share, but the social capital is unevenly distributed between members and it can be argue that the social capital is in decline due to the lack of participation of a large majority of members.
5. Research findings: Motions as a tool for change

This chapter aims to answer the research questions:

- Have motions directed at the medical direction of the organisation created the intended organisational change it meant to create? Why or why not?
- What influences the approval of motions at MSF?

Ultimately it will attempt to assess if medical organisational change is possible though motions and what influence the approval of motions. The first five sub-chapters examines if the selected motions created the medical change they intended to create but also what influence the success of motions in general. First each selected motion will be presented along with its process and follow up today extracted from the in depth interview. Each motions background and motion debate that year will be summarized and placed in annex 5. A lot of the data in the first five chapters is based on analysis of recorded motion sessions on the OCB gatherings as well as written documentation regarding the follow up from boards. Chapter six will deal with what influence the success of a motion as well as what the respondents had to say about motions as a tool of change.

5.1 Nutrition motion 2009

Motion text
The OCB Gathering\(^4\) asks for MSFs increased commitment to the concept of malnutrition prevention instead of limiting its action to caring for patients. This prevention should be carried out using innovative strategies (linking up with other NGO), testing new products and strategies.

Process
The staff in Niger wrote the motion and it was directed at the OCB gathering where it was approved with 104 votes in favour, 58 votes against and 44 persons abstained from voting (MSF, 2009).

\(^4\) The name of the General Assembly of OCB
Feedback

At an operational update in January 2010 the board wanted to have an intermediate update on the progress of this motion. The executive answered, “It is especially during emergencies, when there is displacement of people that we can look, you know, lobby for general food distribution like we have done in the past. See how the food security is in the households, what role can there be for MSF?” (MSF, 2013c).

The at the time Nutritional advisor answered in the Life of a motion video that they have set up a pilot project in Niger where MSF has distributed nutritional supplements to all children between 6-24 months. She states that this motion has strengthened MSF’s commitment and has encouraged OCB to launch this pilot. She also mentions that it takes time to implement policies and to change operations. Conditions that she mentions are that the context has to be right, that the technical and logistical capacities have to be there (MSF, 2013c).

Follow up today

This motion is promoted as a successful motion one by MSF. The interviewees have mixed feedback. Today the project in Niger is closed, which many in the OCB board were critical of, “because it risk reducing OCBs capacity in the future in nutrition” (Respondent 5, appendix 2 p.96). Respondent 2 continues about the lack of nutrition programs in OCB, “…where we see that the executives is reducing the presence when it come to malnutrition… I am talking about curative. Prevention I am not sure we are not really engaged in that. Being on the board and working with OCB I cannot really see how we are working on prevention” (appendix 2 p.96). Initially there was interest from the OCB board in this motion. According to respondent 7, OCB has “changed the way we intervened in in nutrition programs. Many factors made it successful, was it the motion? I don’t know. It might have happened without it, but it made it easier to change standard. A motion is putting more light on it. But that alone can not do anything” (appendix 2 p.96). She thinks that the motion has had limited impact because “wouldn’t it be for Plumpynut5, operational

5 Plumpynut is a ready to use therapeutic food based on a peanut paste.
research and operations I don’t think we would have said that this is a success” (appendix 2 p.96). Respondent 8 says about the motion: “It was a push to start the general practice of supplementary feeding distribution, it was an gigantic research agenda that came after that… I think that is was successful. It shaped us” (appendix 2 p.96). Respondent 9 talks about the motion, “It has changed our way of looking at prevention. 10 years ago, even the word prevention created a war in MSF, saying prevention and you are risking of being beaten. Not a direct outcome but it raised awareness, reopening a debate for one neglected area in MSF and in silence contributing in changing the mentality of the organization on prevention” (appendix 2 p.96). Respondent 6, the vice president of the OCB, says that if you look at the motion and the wording of the motion, “Basically it hasn’t been implemented as far as I know, we are not looking at the root causes of malnutrition. We are not taking on food insecurity so in that sense no it has not been implemented” (appendix 2 p.96). But linking to the motion debate regarding the wording or the spirit of the motion, “I think MSF found a way to still stick with our mandate but address the issue. I think that the motion triggered the change” (respondent 4, appendix 2 p.96).

Conclusion

The motion triggered concrete operational change initially partly due to other factors like Plumpynut and operational research. The motion debate about prevention seems to have been one factor in triggering a slow silent change in the movement regarding attitudes to prevention in general. What the motion asked for it has been successful but based on the limited nutrition capacity that OCB has today the motion has not created long-term operational change even though a wider range of preventative tools are available in nutritional projects. Looking at the text that led up to the motion about tackling root causes of malnutrition that has not been addressed. The project that wrote the motion has been closed even though the chronic malnutrition situation in the area has not been solved.

5.2 Medical Male Circumcision 2012

Motion text

Given recent evidence that has emerged in the past years, the MSF international movement
and OCB in particular must make a more concerted effort to expand HIV counselling and testing, including at the house and community level; and prioritize effective biomedical prevention interventions, such as male circumcision, as part of a comprehensive package of services provided in all of its HIV projects.

Process
This motion came out of the Southern Africa FAD and was approved by the GA in South Africa; the motion then was approved at the OCB gathering with 150 votes in favour and 27 against with 43 people abstaining from voting. The motion was later adjourned at the IGA in 2012 with 20 votes in favour, 5 against and 17 abstaining.

Feedback from the board
At the 2013 OCB gathering, the feedback was presented by the board. One year after the motion was passed there is one project that has implemented the activity and that was Kwa Zulu- Natal in South Africa. A new technique for MMC has been investigated called PrePex and it will be piloted in another project in Nsanje, Malawi towards both adults and children. PrePex is a non-surgical procedure that can be done by lay counsellors. The OCB surgical advisor has also attended a training in Rwanda on the PrePex\(^6\) method. In February 2013 MMC was declared as one of the strategies for HIV interventions for the next OCB Prospects 2014-2016 in the new OCB HIV advocacy declaration in Johannesburg (MSF 2013d).

Follow up today
MMC is not implemented in all HIV projects (respondents 1 and 2) but it does exist as a prevention tool to reduce HIV transmission in MSF. From an operational side the motion has been taken seriously (respondent 5, appendix 2 p.96). The project where the motion came from is closed and the other projects that the tool was implemented in have reported some issues with the PrePex method. “PrePex has apparently had some secondary effects in Malawi so they can’t really do it systematically” (respondent 5, appendix 2 p.96), “MMC is not as effective as we thought in 2009/2010. It was not implemented in a global scale

\(^6\) PrePex is a non-surgical method where the foreskin of the penis dries and falls off.
because it never makes sense in a global scale. It only makes sense as a dimension of treatment as prevention and that only happened in 3 or 4 projects” (respondent 9, appendix 2 p.96). Due to the limited success “they (executive) prefer to put their energy somewhere else…” (respondent 8, appendix 2 p.96).

Conclusion
The motion built on the already existing MMC projects and possibly triggered the opening of other projects. MMC is now apart of the preventative toolbox in MSF and it is up to each project if they want to use the tool. The motion has been a success when looking at the motion text even though it is not implemented in all HIV projects.

5.3 Reconsider heavy investments in hospitals 2012
Motion text
We demand that:
– OCB guarantees that a focus on hospitals will not weaken other equally important fields of intervention.
– The operational department creates a policy where criteria for choosing to invest in new hospitals is described and respected, these criteria should include that basic requirements are in place before deciding on building and managing a hospital; i.e. management of hospitals, capacity in HR, basic care already provided in the context.

Process
The motion was approved in the Swedish GA and was directed at the OCB gathering in 2012 where it was approved with 143 votes in favour, 36 against and 36 abstentions MSF, 2012b.

Feedback from the board
The follow up one year later the board reports back that some new hospitals have been opened that were already in the pipeline at the time of the motion and some have closed unrelated to the motion. The board brought up a key point that was brought up at the 2012
IGA, that there is an advantage to work in hospitals in insecure contexts. Further the feedback was regarding the COSP (Common Operational Strategic Plan) indicator regarding IPD patients having increased with 3% from 2011-2012. The board reports back that in regard to the policy part of the motion, that OCB has developed a hospital management committee that follows up on quality, laboratory and water and sanitation related topic for example, but also management, HR and training needs. The board also reports back that there is on-going work on creating better proximity with the communities in IPD (In Patient Department) projects. Lastly, they report back that in the new prospects 2014-2016 the executive is going to look at the balance between secondary care and primary health care activities (MSF 2013d).

Follow up today
One of the motion writers was interviewed and she said, “The healthy debate about whether we should do primary, secondary or tertiary healthcare that had been going on for years had been lukewarmish and we started to invest in hospitals more and more without a debate. It was never thought that this would have had an impact, at least not for us that wrote the motion. We wanted at least a transparency, how much money do we put in it, if we do big hospitals what does that mean, what are the things we don’t do… I was afraid that this thing would have gone completely without democracy” (respondent 7, appendix 2 p.96). The intent of the motion seems to have been to create debate, both respondent 3 and 5 (appendix 2 p.96) refers to the motion as more of a success in terms that is kept the debate going. Both mention that in the Operational prospects of OCB 2014-2016 this topic was addressed. First of all, the targets were set out regarding number of IPD patients. From the actual number of 135 259 in 2012 to and 115 000 as a target each year 2014-2016. The prospects state that IPD and hospitals are to have a sustained level of attention. The document does refer to a goal being “Over the three years of these prospects, we aim to restore the balance between curative acts, often inside health facilities, and the direct interaction with the community as a whole.” A section was also devoted to “small is beautiful” where the issue was brought up again and the consequences of more complex projects were stated; fewer projects, more expensive projects, longer projects, more staff, less operational flexibility, higher management complexity and negative impact on
proximity. They aim to create space for smaller projects as well as increasing connections between projects and teams with their surrounding communities (MSF, 2013e).

The feedback from the board one year after reported that a hospital management committee had been created and so does respondent 5 (appendix 2 p.96) even though the respondent says that, “It could very well have happened without the motion.” Respondent 8 report “I heard that they strived to bring together the different departments on this but it failed” (appendix 2 p.96). The same respondent again recently attempted to create the committee again “We now have a hospital unit, but we are not yet listened to, we are trying to deverticalise it, quite some job I tell you because we have to start in our own garden first, start with having a deverticalised approach. We have in there the IPC, Nurse, HR person, management, biomed, pharmacist, WatSan and myself.” When respondent 8 (appendix 2 p.96) talks about this motion she/he says, “This is all gone in smokes… There is no decent planning, there is no decent objective let alone a long-term plan or an expected result, there is no real strategy on HR… This motion is forgotten.” The Stockholm Evaluation Unit⁷ is currently doing a review of the Operational prospects 2014-2016 and the results are yet to be showed but the answer to the quantitative questions that was brought up in the motion debate back in 2012. Beatrice Barbot at OCB headquarters (personal communication, 24 April 2017) first corrects the statement that 40% was directed at Hospitals, it was actually 29 % whereas as today its is 19%, these numbers are referring to project budget and not the whole operational budget. Regarding the target of 115,000 patients that was set the actual number of IPD patient in 2016 was 176,536 (see figure 6).

**Figure 6:** IPD cases over time

⁷ The Stockholm Evaluation Unit is a unit at the MSF office in Stockholm that is carrying out evaluation of MSF projects and operations with both internal and external evaluators.
Respondent 11 (appendix 2 p.96) gives a bit of a historical perspective on the topic: “If you look over the years it has always been moving up and down on that, sometimes we focus on, MSF hospitals are in, 5 years later hospitals are out, it is all about generations and trends...” Respondent 9 (appendix 2 p.96) is assuring that “the debate on secondary health care is strong inside the movement.”

Conclusion
The motion has been successful in keeping the debate on the agenda but in the actual change that was asked for it has been unsuccessful. There is no policy with the asked for criteria. The hospital management committee that was created after the motion failed and has recently been resurrected but not due to the motion and the committee is still not relevant according to initiator. The targets that was set up regarding number of IPD patients was exceeded with 53% which could be a sign of growth without direction. This motion is still relevant and has not been responded to in its full.

5.4 Women in need 2014
Motion text
The MSF Southern African Association calls upon MSF throughout all its operations to provide ToP services in order to save lives of all women in need, regardless of national limitations and beliefs - and to speak out in strategic ways about what we witness.

Process
This motion came from a FAD in Lesotho and was approved at the Southern Africa GA in 2014. The motion was directed at the OCB gathering where it was approved with 172 votes in favour, 27 against and 47 abstaining (MSF, 2014c).

Feedback from the board
The feedback from the board at the actual gathering had to be kept to a minimum due to time restraints but a written feedback was also provided. The board reported back that both the number of ToP performed and number of projects offering this service were decreasing and are not better than five years ago. They said that this needs further investigation and that they have requested an evaluation on how effectively the current policy is implemented. The board has requested that the people responsible for implementation support the reproductive health unit in keeping it on the agenda and for it to be one of the topics at the medical coordinators week. They also stated that if there was nothing more headquarters could do the board would ask the medical coordinators and Heads of Missions about why the policy is not implemented (MSF, 2015d). The board was pleased that the motion had come up again because it reaffirms MSF policy and where MSF stands on the issue because on ethical grounds it can easily be pushed away. The board also reported that the implementation of ToP is staff dependant. The executive had also brought up a challenge regarding this and that is because they do not brief as many people before departure anymore as previously done which limits expatriates’ knowledge on the policy. The board encourages the people at the gathering to implement the policy (MSF, 2014a).

Follow up today
The motion asked for implementation of ToP services in all MSF projects regardless of national limitations and beliefs. ToP is not implemented in all MSF projects and remains a challenging topic. There is an international working group on the topic and the reason for the lack of implementation is mostly internal and not external. The General Director of MSF-USA say in a webinar on the topic that this topic is “expressing the challenges with a top down approach in implementing a medical policy” (personal communication, 9 May 2017). The policy exists and the executive is clear in its strategy but it is not being implemented. “The problem is very deeply rooted and according to me there
is not a real commitment to work with this… This motion is very welcome, things are happening, but it is very slow” (respondent 8, appendix 2 p.96). Respondent 5 states “Operations was really happy for this motion because they needed this topic to be raised again. For me this motion has had big impact.” The debate is very much alive within the movement and OCB has ToP high on the agenda (respondent 2, appendix 2 p.96). The topic will be one of the debate topics on 9 or 10 GAs during 2017 including the OCB gathering and the IGA (Catrin Schulte-Hillen, personal communication May 9, 2017). Respondent 6 says, “on the debate side things are happening but in practice nothing” (appendix 2 p.96). Respondent 4 disagrees to some extent with, “The debate now is not about the policy itself, it is now to address the internal barriers to implement our policy… That motion was a trigger to start this whole discussion again” (appendix 2 p.96). Catrin Schulte-Hillen (personal communication 9 may 2017) who is a part of the international working group describes, in a webinar on the issue, how MSF is trying to address the topic in a technical way and not addressing the morals. A workshop that explores values where all staff attends and discusses the topic is available to all sections of MSF. The topic of ToP is now the third priority for the MedOps in the new International Working Plan 2017-2019 (MSF 2016).

Conclusion
The policy and the position of MSF officially are clear when it comes to ToP but internal barriers are blocking implementation. This motion has not been implemented as meant to, but it has kept the debate going and put ToP high up on the agenda for both the executive and association. Efforts are also being made to explore the internal barriers in the field but it has not yet resulted in the service being available to more girls and women.

5.5 Chronic diseases 2011 and Integration of HIV/TB and NCDs 2014
These two motions have been analysed together since they deal with the same topic, chronic disease or Non-Communicable Diseases (NCDs).

Motion texts
*Chronic diseases 2011:* OCB should increase its efforts to address chronic non-
communicable diseases as part of its core medical action, and should carry out a needs assessment beginning with what types of diseases we currently see in our projects. Once these have been identified, the Medical Department should develop innovative, context specific protocols and strategies, including for example integration with existing services (e.g. chronic HIV care) and collaborative approaches to both implementation and research and development.

Integration of HIV/TB and NCDs 2014: We call upon MSF to respond to calls to integrate HIV/TB and non-communicable diseases (NCD) services. MSF should support the setting up of Pilot integrated care systems followed by investigations of the impact, gaps and barriers created by this intervention with a view to advocating the roll-out of such comprehensive care models where appropriate.

Process
The 2011 motion was a rewritten motion coming up from four different missions and FADs. India, Kenya-Somalia, Pakistan and South Africa all came up with different motions directed at OCB raising the question about chronic diseases. The motion committee rewrote the four motions into one that was presented at the OCB gathering in 2011. The motion was voted down with 63 votes in favor, 64 against and 0 abstentions. The debate that took place and the small majority decision made the board still promise to report back on the motion at the next OCB gathering (MSF, 2011c)

The 2014 motion came out of the Zimbabwean FAD, 40 votes in favour, 2 against and 14 abstentions, directed first at the Southern African GA and was very similar to the one that they wrote in 2011 that was rewritten by the motion board. The motion was then voted on at the OCB gathering where it was approved with 83 votes in favour, 33 against with 87 abstaining (MSF, 2014d)

Feedback from the board
The follow up on the 2011 motion that was not passed but that was promised to be followed up on at the 2012 OCB gathering. At that gathering the people that were interested in the
follow up were just directed at a specific person in the board if they were interested (MSF, 2012d).

The feedback from the 2014 motion was showing on the strong example of integration in the Kibera project in Kenya. The board reported back that there are no new initiatives on the agenda but the Director of Operations is open to new initiatives coming from the field (MSF 2015d).

**Follow up today**

MSF is dealing with NCDs and “we are investing more in NCDs and it is becoming integrated in our projects” (respondent 2, appendix 2 p.96). External factors like increasing number of conflicts in middle-income contexts like Syria, Iraq and Ukraine in combination with “the willingness to be present in certain context has pushed the issue” (respondent 5, appendix 2 p.96). The war in Syria put the topic high up on the agenda according to many respondents (respondent 1 and 2, appendix 2 p.96). MSF now has a NCD referent and is trying to integrate it in many projects around the world as well as investing in screening and preventative practices. According to respondent 8 it is still lacking when it comes to HIV/TB projects. The debate is still on-going on how to define chronic disease: “We do try to stop focusing, or downsizing chronic diseases to hypertension and diabetes and forget about epilepsy, asthma and COPD, it is very complex, what are we going to do about oncology? It is about how long we invest” (respondent 8, appendix 2 p.96).

The reasons why the first one was voted down and the second approved seem to be time and a premature debate according to the respondents (respondent 3, 7 and 9, appendix 2 p.96) says that the first motion was a successful one, but that that “it would have happened without the motion but I consider it successful because it came in a moment, presenting a tension and somehow contributing and raising awareness even if it didn’t get approved.” “I think that the initial motion made people start thinking about it” (respondent 4, appendix 2 p.96). Respondent 7 said about the first motion, “The whole thing with the chronic disease was that people didn’t know enough about it. The debate was premature” (appendix 2
p.96). Respondent 5 says that because “the fact that it has been debated and coming back in the association and in operations have had an impact” (appendix 2 p.96).

Conclusion
MSF is working increasing in the field of NCDs but is yet to integrate it in its HIV/TB projects on a larger scale. NCDs has been on the agenda of the executive for a longer time but the debate in the association has grounded the issue but the development would have happened without the motions due to external factors like the war in Syria but also that the executive wanted it. The motion debates have helped in clarifying the challenges and dilemmas that MSFs work with in the field faces.

5.6 Motions as a tool of change
This section will describe what the respondents had to say about what makes a motion successful. This will be described under two headings: The first one will look at what factors are involved when it comes to getting a motion approved. The last one will look at motions as a tool of change. The subheadings are based on the emerging themes in the data analysis.

5.6.1 The approval of a motion
The presenter/motion writer
All respondents bring up the presenter and motion writer as an important factor in getting a motion approved. Not always a specific individual but a series of characteristics that the presenter or motion writer should have. Coming prepared, being a good presenter that is able to argue for it and being passionate about the motion “can also sway the room” (respondent 1, appendix 2 p.96). If you can’t “illustrate it with field experiences and your own conviction as to why you believe that this is right and this is wrong” there is a chance of failure (respondent 11, appendix 2 p.96). Respondent 3 sums it up as if they are deemed credible, important, likable. Many does bring up that who the individual is, actually has a big impact. To be a “heavyweight” (respondent 5, appendix 2 p.96) or to be known, have a position in the organisation and to have friends is important (respondent 11, appendix 2 p.96). Respondent 12 puts it this way: “The more you are known and the more people trust you the more chances you do to have the motion passed” (appendix 2 p.96). This trust is
coming back in many interviews, respondent 6 says when asked if it matters who presents it “Yes it does because you trust people more or less. It is all about who you trust in a way” (appendix 2 p.96). The trust plays a big role when the members are not well informed on the subject or don’t know what to vote: “Then they will tend to trust the people that are presenting the motion” (respondent 12, appendix 2 p.96). The opposite is also true according to respondent 1 “…some personalities are perceived as difficult or troublemakers… where people tend to vote against a motion because they don’t like the person behind it or the way it is presented might be unnecessarily adversary…2 To write the motion with other people, join forces and present it as a group is highlighted by respondent 6 to increase the chance of approval.

Vocal supporters
To have people in the audience be vocal in favour or against will also factor in. If a person that people have trust for stands up and supports a motion like for example the president “then there is an another five voting for it because she said she will vote for it and they trust her judgment because they know her. If you have some strong or vocal proponents on your side I think you have a fairly good chance to pass a motion” (respondent 1, appendix 2 p.96). It also matters to members, who are not informed on the topic, what other people in the audience vote for according to respondent 3 “if you know that this person is a little bit or you assume that this person is more aware of the situation, when it comes to voting you are going to look over and see what they are voting. It is just the way it is” (appendix 2 p.96).

The timing
Timing refers to two things, the timing of the motion within the general debate within the organisation and the timing of the motion session. First respondents say that the timing of a motion influences the success like if “they are already on the agenda of everybody” (respondent 8, appendix 2 p.96). Respondent 6 also highlights this “if you present a motion on a topic and something that is already on the agenda that brings something much higher chance of getting it through” (appendix 2 p.96). Respondent 5 also talks about the timing with “a motion cannot work in isolation from the rest, a motion is reinforcing something
that is already on its way and they it will have success because it triggers something that is ready to be triggered” (appendix 2 p.96). For the second aspect of timing respondent 3 highlights the importance of what time you get to present the motion at a GA. “…if you come up first you might have more time, people might be more energetic, if come up last and people are just thinking about their beer…” (appendix 2 p.96). After analysis of the video recorded motion session a trend has been identified, that being a lack of time for debate. The motions that are presented first are given the time but the debate often exceeds the time given and the motions that are presented last then get shorter time and the debate is often stopped prematurely by the moderator. Respondent 8 is also referring to that “In a 15 minute presentation you cannot present tings sufficiently for people to grasp” (appendix 2 p.96). This could be a threat if people take uninformed decisions.

The motion itself

The motion itself plays a big role naturally. For a motion to pass it has to be realistic, relevant, feasible and relate to an issue that people can feel about (respondent 1, 5, 11 and 12, appendix 2 p.96). The wording the motion matters, that it captures a more generalized concern and not only an individuals, that it “puts the finger on critical issues linked to our principles and identity” (respondent 8, appendix 2 p.96) and is “not something that applies in only one mission but at many levels” (respondent 7, appendix 2 p.96). That the motion has people thinking that it is important before a vote is important and if the motion writers have invested time and energy in consulting others when writing it will increase the chance of success (respondent 8, appendix 2 p.96). Another central theme in the interviews were the wording of the motion, Most agree that a motion should be more general a motion but that it is easier for it to get approved if it is specific respondent 12 says if a motion asks “…to investigate, to improve, I think its a strength…” (appendix 2 p.96) but according to respondent 3 the final destination of a motion changes the phrasing of it. The higher you want it to go i.e.:

“At the international level, the broader it is the more likely it is that it will get passed, if it is too specific there is no way it is gonna get passed”. If we are talking of the field, it is going to get approved if members honestly see it as if it is going to benefit them somehow… At a national level a bit the same thing but less. You start to see a bit more OC and international
level but it remains section focused so I think that people have a hard time with the broad which is in fact what a motion should be, the more specific a motion is the more likely it is to get passed” (appendix 2 p.96).

National differences
Few of the respondents mention that there are national differences regarding motions when it comes to some of the above-mentioned themes. Most of the perspectives are from Sweden because many of the respondents were from Sweden. Regarding the presenter, respondent 1 describes the importance of the tone he or she has when presenting something in Sweden “…we don’t like people being accusatory or hot style, we in Sweden we tend to shy away from that, in France they would elect you president” (appendix 2 p.96). Respondent 11 also talks about political correctness as a national preference for Swedes with “in Sweden that would definitely be a factor. That it is something that is politically correct and not that controversial, I think that very few of the motions that have been passed in Sweden has been controversial, very few” (appendix 2 p.96). Something that also comes up is the value that different national partner sections view the wording of a motion “like Germany, they are very specific about the wording and they will follow it to the letter, if something passes it needs to worked on, whereas other association look at it more as what we in the membership want the board to look into…” (respondent 3, appendix 2 p.96) here it means that it is difficult to pass a motion that is specific.

5.6.2. Motions as a tool to create organisational change
“The motion in itself will not bring any change… The writing of a motion is an important moment to create a critical mass” (respondent 9, appendix 2 p.96).

The respondents’ views on motions in general as a tool of change differ greatly and that it depends on what kind of motions. Motions that aim to create change statutes and internal rules are immediately in effect after an approval (respondent 1, appendix 2 p.96) It is regarding operational motions where the opinions differ, from motions not working at all to motions being very powerful. Respondent 11 represents the view that for the way to create organisational change “It is not by writing motions at the general assembly” (appendix 2
A common trait is that it is the discussion in itself that is the real tool of change respondent 6’s point sums it up in a representative way with:

“We shouldn’t underestimate the debate... If you bring up a motion, that means that a 110 people in that room have heard that discussion. Some are vocal, some are listening, it is like at least you have heard it and maybe that has more value than the actual voting, those types of discussion are actually creating more change” (appendix 2 p.96).

The above statement is in accordance with statements made by many other members saying that even if a motion is not passed the intent of it can still be implemented. The issue of ownership also comes up; ownership in the sense that a motion can give ownership to a process that is already on going and kind of root the change in the movement but also the problem of lack of ownership. With this respondent 9 it means it is nice to say that the IB is following whatever but if the OC don’t take ownership of this motion because a motion can only be implemented through the executive machine and the only one that can hold them accountable is the OC boards. It is very limited the power that the IB can exercise. “We have no mechanism of implementing decisions” (appendix 2 p.96). Change takes time and there are many factors influencing its success. Motions can be a way to create change if as a tool used correctly but there is a long way to go. Respondent 4 says:

“I think that we haven’t tapped into our full potential... I don’t think that we need to change the structure; I think that we need to strengthen our members, their understanding of what is the association, strengthen our boards and their understanding of their role on three different levels and then you have this huge ability to impact the direction of this organisation and also the external world too” (appendix 2 p.96).

Many see the ability to change the organisation as an important reason why they chose to be a member highlighted here by respondent 12 “when I understood that people have the power to change things, that is when I realized that I want to be a member in this organisation” (appendix 2 p.96).

5.7 Conclusion
Based on the follow up of the selected motions the results are inconclusive regarding if a motion is an effective tool of change. Some motions have successfully been implemented or at least to some extent while with others nothing has happened. When change has happened it is not necessarily the motion itself that has created it but the debate itself, that the process had already started or that the executive liked the idea and therefore went along. What the motions have done is to force a debate to happen and for the board and executive to take a decision where it wants to go. To answer what influences the approval of a motion a number of factors have been identified but how many of them have to be fulfilled cannot be answered based on the results. Motions as a tool of change have potential to be a powerful creator of change if some of the weaknesses with MSFs internal democracy is fixed as well as that the participation of a larger group of informed members increases.
6. Discussion and analysis

Regarding the degree of internal democracy MSF as a whole is a very executive organisation due to its mandate and need to take reactive decisions. Democracy is not necessary the best governing function for the executive part so democracy is viewed as a means rather than an end. The association on the other hand is there to function as a questioning counterweight and is governed by democratic principles like in a representative democracy. The association fulfils all formal criteria in the Eckstein and Gurr’s definition. There are platforms and procedures where members can express their preferences regarding MSF policies and elected representatives both through formal channels like at a general assembly and through organised debates as well as through informal channels like direct contacts with boards and executive and the platforms to start your own debates. The members can exercise constraints on power through votes on discharge of responsibilities of their elected board.

Through the lens of Dahl’s 5 criteria the democracy of the association can be seen with other eyes. The association fulfils some to a larger extent than others. Yes it fulfils inclusion of adults but when it comes to effective participation and equality in voting the answer is different. All members do have one vote each but depending on who you are and from what association the member is from the vote has different weight when it comes to influencing. There is a series of barriers that prevent different members of having the same opportunities to express themselves for example; language barriers, financial means of both the individual and the association and direct links of the national association to an OC. When it comes to equal opportunities in finding and validating options available to members the information is there on a number of different platforms but the responsibility lies with the individual member. The association of MSF and the executive is difficult to understand and new members are assumed to understand often without a proper introduction, this makes different members’ opportunities to find and validate information unequal even though members has the power to change this. Members also have tools to influence the agenda through voting at general assemblies and propose debates.
There is a perceived weakness of the association as a counterweight to the strong executive due to a lack of participation from its members, a minority of voters casting their votes leading to a lack of a uninformed critical mass that questions power. The same perceived weakness extends to the boards in general. There is a fundamental trust that boards want the best for MSF and the beneficiaries but there are also voices of concern due to a perceived lack of understanding of the association and what governance is. It is also too easy to become a board member and voices from the executive do not feel challenged by their boards. There is even the threat of the executive manipulating their boards in fear of them taking uninformed decisions. There is on the other hand a strong trust in the executive and their execution of their mandate. There is general wisdom that the membership base forms but a fear of uninformed and emotional decisions as well as the members being too border bound is present. Measuring democracy is a complex process and there is no consensus on how to do it according to Elkins (2000) and therefor it is difficult to say if there is a low or a high degree of internal democracy within the association.

Regarding the creation of social capital each national MSF association can be viewed as a bonding social network with a high degree of sameness and the regional as well as the international association can be seen as bridging network. All associations together and the movement as a whole can be seen as its own network. All networks share their belief in the guiding principles and the MSF mandate. The strong values of humanity, solidarity and reciprocity are formed across national and cultural borders because MSF shows in practice that they are important. Social capital is formed in the process. These are values that the collective possess. The unique membership criteria create a bond between members and a feeling of ownership and responsibility towards the organisation and its beneficiaries. The association is struggling to foster that feeling to all its members. Some members focus more on their rights rather than their responsibilities and with the growth of the organisation new group of members see the organisation just as an employer to some extent. The members who are active show signs of Putnam’s civic culture syndrome because they are driven by the norm of reciprocity, solidarity and equality. There is a tolerance towards others and their values. The active members make short-term sacrifices for long-term advantages for themselves and the beneficiaries even though some respondents have pointed out that some
tendencies to vote for what is best for “my” mission, section and OC exist. People do come together to address issues of common concerns and have agreed upon a set of rules how the cooperation will be coordinated thus embodying Edwards’ concept of cooperative compact.

MSF has over the years created a strong social capital that stays in the network even though the human capital has changed over the years. Some new members are fostered in this social capital and can use this resource of values and knowledge. The difference in views regarding the transferability of the social capital that Putnam and Coleman had has shown that the social capital is transferrable at least between the different MSF associations. This is possibly also to other organisations if the human capital leaves even though the question if capital can be transferred to other external networks has not been a focus of this thesis. The social capital can therefore be viewed as the collective cultural memory that Putnam is referring to when he builds on “self-interest properly understood”. The memory is available to all if the members choose to be active and search for the information. Here there is clear that the different members, active and inactive, have different access to the social capital and that it is not evenly spread out. Here there is room for improvement though and members could get a better induction in this collective cultural memory.

The feeling of social trust towards the network was said to measure the level of social capital. The trust towards other members and the governing body, as previously discussed, here there is some friction. There is a general trust that people want the best for MSF and the beneficiaries but that due to members not being informed there is a fear that they will take uninformed and emotional decisions. The problems of trust also extend to the governing body, the boards, even though the same fundamental trust exists. See the section above. Linking to Edwards’ theory on ideational social capital is that the choices and decisions of members will be dictated by how they interpret the information available so it is crucial that members have equal access to information and that debate time is prioritised.

There is still sufficient trust that members behave in a spirit of cooperation and that the organisation will do what they said they would do but there is a lot of work to do and some of it has already started according to the respondents. It could be argued that the social capital that MSF has built over the years is at risk of declining due to the growth of the
organisation and the increasing growing part of inactive members. Reasons for this could be that a larger group sees MSF as only an employer and not as a part of their identity.

Regarding motions there is a lot of potential in this formal tool of influence. Motions exist to formally place debates on the agenda, force an answer from the elected representatives on certain topics as well as create organisational change if intended to do it. Often it is not the motion itself but what the motion writers and audience do with the information as well as if the executive agrees with the motion that creates the intended change. It can be interpreted as if down-top approaches to operational medical organisational change only will be achieved if the “top” agrees to the change. The reasons for the change resistance within the association and executive have not been explored in this thesis but linking the discussion to the theoretical concept; change resistance is often a consequence of a perceived attack on the organisational identity and the practitioners own worldview. Due to the active members strong link between MSF and their own identity change resistance can be expected to be present. The motions are often ways to react to an external context and not proactive. The analogy described in the theory by Clarke and Ramalingam (2008) to view a humanitarian organisation like MSF as a community, a mind and a complex interconnected system applies here. MSF is a community with a strong culture or, I would argue, a strong social capital created by the members over 40 years. This culture defines the world and what role the organisation plays in it as well as the rules that govern it. We can view MSF as a mind because, as written above, the perceived threats on the identity and culture are linked to the members’ worldview and therefor create an emotional response. As argued in the theory this emotional response preserves the culture and creates stability. MSF can also be called a complex interconnected system that is open and dynamic as well as self-regulating with the power to recreate itself if external and internal factors are right.

**Strengths and limitation**

The responses of 12 respondents along with documents and video recorded motion debates have been the material that this thesis draws its conclusions from. This is far from representative of the whole movement. All associations have not had representatives and all respondents have had a rather long experience with MSF. The long experience of the respondents allow for an increased understanding of their experience of changes in
decision-making structures over time. On the other hand it is a weakness of this research that not more voices from the newer members have been included in the study but also members that are not “active”. That would have made the results more representative but the results of the thesis can still be seen as important and as an evidence of strengths, weaknesses, opportunities and threats that the association possesses and faces in the views of its members. Another limitation is that part of the data and documentation is only accessible to members of a MSF association but the author will provide access to the reader if requested for transparency.
7. Conclusion

This thesis has aimed to explore internal democracy within the association of MSF and answer the question if MSF is an organisation with a high degree of internal democracy where social capital is formed. It also tried to answer the question if the members’ attempts to create organisational change through motions created the intended change it meant to create. In addition to this it wanted to answer what influences both the approval and successful implementation of a motion.

Is the MSF association a democratic organisation according to its own decision-making structures and statutes?
The MSF association fulfils all criteria for calling it a democratic organisation in theory according to its own statutes and internal regulations. Some informal practices could pose a threat to democracy like the informal responsibility of the HoM in a mission to filter motions from FADs as well as the current set up of the motion committee.

Is the MSF association an organisation with a high degree of internal democracy where social capital is formed?
The MSF association is based on democratic principles but has a series of weaknesses in it as well as faces threats. It is the same kind of weaknesses and threats that democracy is facing in many organisations and states worldwide. To measure democracy and classify it as having a high or low degree is challenging but the association has the potential to develop a stronger democracy. MSF has over the years developed a strong social capital through the sharing of the values of humanity, solidarity, democracy, reciprocity as well as the unique membership criteria that bonds the members together across national and cultural borders. Today there is a decline in its social capital and the capital is unevenly distributed. MSF has the possibility to become an organisation with a stronger degree of internal democracy, which would increase the social capital. The social capital can if used by the members be translated into organisational change that prepares the organisation for the future.

Has the MSF association developed into a more democratic organisation over time?
Since its beginning the MSF association has grown together with the executive and been held as a priority. Attempts to improve the governance and internal democracy have taken place through the history of the organisation with the latest large scale attempt being the internal governance reform that resulted in a more diverse membership base and more platforms for members to influence. Today the MSF association is not growing in the same speed as the executive and faces significant challenges with inequality and lack of participation.

*Do members of the MSF association perceive their organisation as democratic?*
All but one respondent describes the MSF association as a democratic organisation although not perceiving it as perfect. The respondent that do not agree believes that the low participation in voting session disqualifies the association as being democratic but agrees that MSF is using democratic principles to take decisions as a means.

*Have motions directed at the medical direction of the organisation created the intended organisational change it meant to create?*
After the analysis of the selected motions there is no definitive answer to the question. Some of the selected motions have created change and others have not. When change has happened it is not necessarily the motion itself that has created it but the debate itself, that the process had already started or that the executive liked the idea and therefore went along. The debate is ongoing for some of the motions and the intended change might still be ahead. What the motions have done is to force a debate to happen and the organisation to take a decision where it wants to go. The nutrition motion might have triggered a slow silent change in the movement regarding attitudes to prevention in general. The male medical circumcision motion has been included in a prevention package but it is up to each mission to utilise it. The motion asking to reconsider heavy investments in hospital has been forgotten even though the debate is ongoing. What the motions asked for have not been realised. Women in need restarted a debate that is very much on the agenda today but the motion itself cannot create the change as there has to be an internal attitude change. The first NCD motion started a debate but the organisation was not mature yet and with time the debate gave direction and the organisation started working with NCD in a more focused
way even though the integration of NCD and HIV/TB is now up to each mission to implement. It is not always the motion itself but what the motion writers and audience do with the information as well as if the executive agrees with the motions that create the intended change. It can be interpreted as if down-top approaches to operational medical organisational change only will be achieved if the “top” agrees to the change.

*What influences the approval of motions at the MSF association?*

The factors below have been identified but it is unclear how many of them need to be fulfilled for approval of a motion.

Factors that influence the approval of a motion are the following:

- If the motion is realistic, relevant and relatable
- If the motion is founded in an on-going debate or that it is so politically correct that no one can vote against it.
- The motion text is broad the higher it want to go and more specific the closer to the field it gets
- If the writers/presenters are deemed likable, credible, important and passionate and/or
- If there is “heavy weights” in the audience that stand up in support for the motion
- If the motion has joined forces with other people and sections

In conclusion, initial theoretical assumptions of this thesis have thus received support to a certain extent. Members have the power to create organisational change through motions but it can both depend on a high degree of internal democracy but also on informal contacts. Social capital is formed in the process in the social networks that each association form individually as well as together with all MSF associations. However it is not necessarily a precondition to organisational change even though it is a product of the existing internal democracy. MSF has the opportunity to strengthen the democratic process and be better equipped to create organisational change.
8. Recommendations

The following recommendations are given to strengthen the democratic processes, associational life and the creation of social capital as well as strengthen motions as a tool of influence.

Induction for all new fieldworkers, office staff and board members

Some associations are already organising inductions for new staff but it needs to be movement wide. The associative needs to be a natural part of all MSF trainings and events. An associative presence at the Pre Primary Departure course (PPD) and returnee seminars is needed because MSF cannot assume that new staff will have access to the same social capital and become informed and active members without being introduced to it. A common understanding of what the association is and what responsibilities comes with being a member should be aimed for. The induction should be design differently for new staff, staff moving up to coordination positions, members who work in the executive and to board members.

Redefine the motion committee’s mandate and structure

The motion committee’s current mandate and system should be redefined. A proposal is that each association has its own motion committee that is elected at the GA with the mandate to:

- Support motions writers in the process and provide a historical perspective
- Support in how to present a motion at the GA
- Link motion writers to appropriate board and executive counterpart within the movement
- Follow up on implementation progress of approved motions
- Follow up on status of previously approved motions

The motion committee should be comprised of regular members that sets up a working group for each approved motion and identifies board members and executives to work on the motion together with the motion writers.

Governance training
All board members should receive training in governance to better understand their role.

**Direct links between all associations and FADs to an OC**
All associations should have a clear direct link to an OC and so should the field associative debates. This would create more equal opportunities for all members as well as minimize the HoM’s involvement in the FADs.

**Equal distribution of funding for associations**
If all associations received it’s funding based on its number of members and not how much fundraising each section provides to the movement the financial barriers would be fewer for members to get sponsored to attend GA and other associative events. As a result a more democratic and representative process could be achieved.

**A survey among members**
Create a survey among member to identify what the association means to the members and what makes them participate and what are the reasons for non-participation.

**An assessment of barriers to becoming a board member**
A better understanding needs to be developed why MSF do not attract more candidates for the boards. What are the barriers and how can they be overcome? An assessment with a representative selection of members in all associations to identify the trends should be performed.

**Promote regionalisation of associations**
The merging of national associations to regional ones would strengthen the critical mass and the pool of which board candidates are identified. Just because the board and GA are regional does not mean that associational events and life cannot be national because the risk of reduced member participation needs to be taken in to account because of travel distance to events.

**Remunerated boards**
MSF should explore remunerating its board members for their work and what that could do for the strength of the movement. Today only the president is remunerated for a half time position and others are working voluntary. Even tough remuneration might be a small barrier it does provide a possibility for the members to demand more of their boards.
9. References


**Internal MSF document** to be requested by reader upon demand due to access only for members of an MSF association.


MSF.


Appendix 1 Interview guide

Introduction
- Objective, How to handle the data, Confidentiality, Consent

Opening questions
- Gender, age
- How long have you worked for MSF and in what function?
- What association are you active in?
- How long have you been a member of the association?
- Would you see yourself as an active member?

Key questions
- What is the association according to you?
  - Probe: Objective, function, mandate, other
- Why have you chosen to be a member and what does the membership mean for you?
  - Probe: Participation, responsibility, way to influence and hold accountable, other
- How do you see the internal democracy working within MSF?
  - Probe: Challenges, strengths, threats, opportunities, other
- How would you explain your feelings of trust towards other members, executive, governing representatives?
- What do you feel are your tools of influence and change?
  - Probe: Debates, motions, participation, informal contacts, other

- What do you think influences the success of a motion?
  - Probe: well planned, approved with a strong majority or many abstained, executive agrees or disagrees, depends on the person that wrote it i.e. head of mission or field, the commitment from the board, informal power relationships, context, other

- What is your opinion about the association’s power to create organisational change?
  - Probe: Strong, weak, why? Should it have the power to make changes?

Closing questions
- What barriers do you see for the internal democracy to function as it is intended to do?
- What would make you not to continue to be a member?
- Anything else you would like to add?

Motion specific questions to the executive and board
- Nutrition motion 2009
  - How did MSF OCB change its operations after this motion?
  - Would this have happened without the motion?

- MMC motion 2012
  - How did MSF OCB change its operations after this motion?
  - Would this have happened without the motion?
  - This activity already started in SA before the motion. What did the motion actually do?
  - In “all” projects?

- Heavy investments in hospitals motion 2012
  - How did MSF OCB change its operations after this motion?
  - How big of a percentage of the MSF budget is directed at hospitals?
  - What is the COSP now compared to 2011?
  - What is the strategy now?
  - Would this have happened without the motion?

- Women in need motion 2014
  - How did MSF OCB change its operations after this motion?
  - Would this have happened without the motion?
- Chronic diseases from 2011 and Motion to integrate HIV/TB and NCDs from 2014
  o How did MSF OCB change its operations after these motions?
  o Why did the first motion fail and the second succeed?
  o Would this have happened without the motion?
## Appendix 2 List of respondents

<table>
<thead>
<tr>
<th>Respondent number</th>
<th>Position</th>
<th>Place and date</th>
<th>Means of interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent 1</td>
<td>Member, former association coordinator, current executive MSF Sweden</td>
<td>Stockholm, Sweden 8 March 2017</td>
<td>Face to face</td>
</tr>
<tr>
<td>Respondent 2</td>
<td>Member, current president of a MSF board</td>
<td>Stockholm, Sweden 13 March 2017</td>
<td>Face to face</td>
</tr>
<tr>
<td>Respondent 3</td>
<td>Member, Executive MSF Sweden</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
<td>Respondent 4</td>
<td>Member, Association coordinator</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
<td>Respondent 5</td>
<td>Member, Association coordinator</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
<td></td>
<td>Respondent: Stockholm, Sweden</td>
<td>Respondent: Brussels, Belgium 5 April 2017</td>
<td></td>
</tr>
<tr>
<td>Respondent 6</td>
<td>Member, former president of a MSF board and current OCB board member</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
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<tr>
<td>Respondent 7</td>
<td>Member, former president of a MSF board</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
<td>Respondent 8</td>
<td>Member, Executive OCB</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
<td></td>
<td>Respondent: Brussels, Belgium</td>
<td>Respondent: Brussels, Belgium 13 April 2017</td>
<td></td>
</tr>
<tr>
<td>Respondent 9</td>
<td>Member, Current OC president and former IB member</td>
<td>Chania, Greece 29 April 2017</td>
<td>Face to face</td>
</tr>
<tr>
<td>Respondent 10</td>
<td>Member, former IB and regular board member and association coordinator</td>
<td>Chania, Greece 29 April 2017</td>
<td>Face to face</td>
</tr>
<tr>
<td>Respondent 11</td>
<td>Member, former board member</td>
<td>Interviewer: Heraklion, Greece</td>
<td>Skype</td>
</tr>
<tr>
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<td>Respondent:</td>
<td></td>
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</tbody>
</table>
Appendix 3 Informed Consent form for participation in research

**Title of project:** Internal membership democracy and motions for change: The case of the Medécins Sans Frontières Association

**Researcher:** Jon Gunnarsson Ruthman  
**University:** Uppsala University  
**Program:** International Humanitarian Action

By signing this consent form I have confirm that:

- I have read and understood the attached information sheet giving details of the project.
- I have had the opportunity to ask the researcher questions about the project and my involvement.
- My decisions to consent are on voluntary basis and that I can withdraw at any time without giving a reason.
- I understand that the data gathered in this project will form a master thesis and possibly be presented at MSF associative events.
- I understand that my name will not be used in any report or presentation and that all my information will be coded and kept anonymous for everyone but the researcher.

Participant’s Name: Date:  
Participant’s signature:  

Researcher’s signature: Date:
Appendix 4. The MSF charter

The Médecins Sans Frontières Charter

Médecins sans Frontières is a private international association. The association is made up mainly of doctors and health sector Workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

The MSF Charter:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, or religious powers.

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.
Appendix 5 Background and motion debates of selected motions

**Nutrition motion 2009**

**Background**

This motion was written by the mission in Niger dealt with the challenge that MSF faces in context like the one in Niger. The challenge is that despite the effectiveness of MSF curative malnutrition programs MSF faces in Niger among others cyclic periods of malnutrition. The project in Niger brought up this challenge and asks MSF to also deal with the causes of malnutrition and not only the consequences. They questioned MSF relevance in these contexts. They ask MSF to consider other innovative ways to tackle malnutrition and test them in pilot projects (MSF, 2009).

**Motion debate**

The motion and its background were presented by two field staff members from the Niger mission. During the motion debate the main concerns was that many interpreted the motion as MSF getting involved in food security, which lies outside the mandate of MSF. Some reacted to that the motion meant to address poverty as a root cause of malnutrition and felt that the issue what too complicated and too big (MSF, 2013b). Other voices said that the association should listen to the spirit of this motion and that we should explore innovative strategies and explore the role MSF could potentially play in prevention. The argument came up that there is often many other actors’ present dealing with prevention and food security and that MSF should lobby for them taking their responsibility and MSF should keep focusing on the curative aspects (MSF, 2009).

**Medical Male Circumcision 2012**

**Background**

WHO has promoted medical male circumcision (MMC) as an effective preventive method with up to 60% reduced risk in transmitting HIV and other STIs. In the new donor context where less focus is put on the fights against HIV, MSF has to not only provide treatment but also explore interventions to reduce the rate of new infections (MSF, 2012b). MMC
should be an integrated part of MSFs prevention package. The Field Associative Debate\textsuperscript{8} (FAD) asked MSF to analyse high HIV prevalent context where MSF is present whether there is any actors providing this service, if not MSF should step in and provide the service. They also asked for a MMC policy and that the capacity is created to support projects in implementation of MMC activities. MSF already supports MMC activities run by the province of Kwa Zulu-Natal in South Africa and there are plans to implement MMC program in the Musina\textsuperscript{9} project (MSF, 2012e)

Motion debate
A Nurse presented the motion and its background from the Musina project in South Africa. During the debate that followed different voices was heard, none debated that MMC is not an effective preventative measure but concerns were raised. One man raised the question that MSF is working in resource poor settings and was worried about the sustainability of this activity in case MSF leaves. Concerns were also raised about the increased risk of transmission in the weeks after the intervention for adult males if the target population was also to include them. The response from the motion presenters was that it is about the message that MSF formulates for the community for them not to misunderstand and to tackle this risk of increased risk behaviour. A woman from Zimbabwe supported the motion and said it will be easily to implement due to the cultural acceptance of this practice in many contexts. A doctor in the audience supported the motion but said that this is one of the prevention tools available and we should focus more on prevention as a whole. He also raised the concern that there are problems with implementing these projects and that MSF could play a role in piloting interventions on how it can be done. Another man stood up and expressed fear about the wording in the motion, that it should be implemented in all of our HIV projects. He instead promotes that it should be based on the specific HIV projects overall goal. This statement was supported by others that said that it should not be a mandatory requirement for HIV projects and instead promoted PMTCT (Prevention of Mother To Child Transmission), which has a higher efficacy rate and is still not implemented in all MSF projects. A ethical problem was raised by a man in the audience,

\textsuperscript{8} A FAD is a debate and motion generating platform in the field and contexts that do not have their own association
\textsuperscript{9} Musina is located in South Africa close to the border of Zimbabwe.
he had a problem with MMC being a irreversible surgical procedure done on children without their consent and said that the target population should only be consenting male adults. He also raises the dilemma where MSF promotes mutilation of the genitalia of boys but advocates against female genital mutilation (FMG) (MSF, 2012c).

**Reconsider heavy investments in hospitals 2012**

**Background**

This motion came out of OCB’s heavy investment in building, managing and sustaining hospitals to be able to deliver secondary care. The motion writers feel that the rate that OCB is taking on hospitals in its operations is stretching the capacity of MSF in terms of HR and expertise and poses challenges when it comes to long term planning and commitment. Further challenges are that hospital care highlights the need of basic hygiene and quality of care, areas that are already challenges to MSF. Another reason for the motion is that along with HIV projects, hospitals stand for around 60% of OCB operational budget leaving only a third for emergencies and other needs. The motion writers ask for a reinvestigation of division in operational costs and letting hospitals grow from small projects while learning from them and developing the needed expertise (MSF, 2012b).

**Motion debate**

The President of MSF Sweden and member of the OCB board presented the motion. The debate started with a man questioning the comparison between small HIV projects and hospitals projects saying that they are too different to be able to use the same strategies, that you can’t make “small pilot hospitals”. The motion presenter responded by saying that this motion is not targeting one specific hospital but 23 hospitals and the notion that “we are only involved in secondary care if we can build our own hospitals…”. She also provides examples of where MSF has started supporting one department in an existing hospital, learning from that before taking on new departments. She states that MSF needs to push for innovative ways of working in secondary care. The motion was commended for its wording and for MSF Sweden to bring up this important topic, a man from the executive added that the budget division for hospitals are close to 40 % and HIV 25% but that the hospital budget numbers also include all hospital interventions in emergencies. He also stated that
these big hospital projects in high security contexts have disconnected the MSF teams from the communities as well as the expatriate staff from the national staff. This has to be avoided according to the man. A man from the OCB board voices that it is also possible to provide primary health care in a hospital and brings attention that at the point where MSF challenges itself to accomplish something it often do not have the know how or resource to follow through but it is the challenge or ambition it self that makes MSF develop that and it is for that reason that he choses not to support the motion. A man stood up to challenge the motion writers about the second part of the motion and the demand for a policy saying that the policy already exists. A woman stands up and says that there is a contradiction between this motion and the previous motions that had been voted on (MMC and a gynaecological complications), both the previous motions demand surgical capacity, which is found in hospitals. The motion presenter responds that the debate had gone to a place that she didn’t want it to go, where it is either or. The motion is not meant to create a hospital free MSF but only to reconsider and justify the investment and how MSF works with secondary care. She also responds to the existing policy statement saying that it does not touch on criteria for when to get into secondary care. Another board member stands up and states that this motion is about defining where we are and where we are going with hospitals nothing else. A woman states that MSF should for each big hospital rethink what is it aiming for and what is the exit strategy. She also criticises training of medical staff as a main objective for a hospital, these projects has to be more strategic. A man from the association challenges the notion that being in a hospital reduces the capacity to respond to emergencies. He also challenges that the motion do not have a timetable and that it would be better as a recommendation. The motion presenter brings back the debate to the limited capacity of MSF when it comes to HR and quality management of hospitals, she states that MSF needs to have the capacity and be good at it before it duplicates the model. Another man from the gathering brings up how hospitals will shape the MSF identity for the coming 15 years since they are often long-term commitments and he highlights the need to have this debate. Another man states, “The context should determine what should be our strategy”. The last speaker states “motions are good because they give us the opportunity to debate” but challenges that the motion in its working has already stated that MSF has gone to far with hospitals and that we have to turn back. He supports the spirit but not the wording. The
motion presenter gets the last word in saying that current operations has not been a conscious decision but an organic one and that the motions just wants to define the strategy and create this debate. She ends with “is this what we want to do” MSF, 2012c).

**Women in need 2014**

**Background**

The background of this motion is the context of southern Africa and the high maternal mortality in for example Lesotho. The field team in Lesotho makes the direct link between mortality and unsafe termination of pregnancies (ToP) due to religious, cultural and legal reasons. This is a topic that has been addressed previously in MSF through a motion back in the mid 2000 that was approved. In 2004 there was a resolution, by the at the time highest associative authority called the International Council (IC), regarding MSF’s position when it comes to ToP, that the availability of safe abortion should be integrated as a part of reproductive health care in all contexts. This resolution was evaluated in 2009 and they came up with that MSF position when it came to ToP was clear at HQ level but in the field it was not well known how the policy was to be implemented. The evaluation also showed that different OCs had different recruitment practices for Expatriate\(^\text{10}\) midwives, where some required acceptance of the policy, a requirement for being hired, but some did not. This led to that the implementation of ToP in the field often depended on who was the Medical Coordinator or Midwife in charge. Obstacles to implementation were also identified in the evaluation and legal, cultural, religious reasons where some of them, but also possibly security reasons, meaning the potential of attacks on staff that perform ToP. Another reason that was brought up us that ToP is difficult to implement because it’s a taboo for many national staff and the “expats” often need translation help in providing the service. The International Working Group did a lot of work from 2009 up until the motion was written. The reproductive health and sexual violence policy was revised to include ToP and the new obstetrical guidelines has a new ToP chapter. An abortion leaflet for internal use has also been produced as well as multiple trainings have included ToP. OCB also moved ahead during this time with the issue by supporting ToP context analysis and how to

\(^{10}\) An expatriate or expat is what international staff in MSF is called.
implement ToP in the field. ToP indicators had been developed since there was none before 2009. The statistics available for OCBs projects was showing a decreasing in both number of projects where ToP was offered and the number of interventions that was performed had decreased since 2009 (see figure 7 below).

**Figure 7**: ToP statistics 2009-2013

<table>
<thead>
<tr>
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<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nb of projects</td>
<td>14</td>
<td>13</td>
<td>9</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Nb of ToP</td>
<td>1474</td>
<td>1856</td>
<td>1774</td>
<td>1639</td>
<td>553</td>
</tr>
</tbody>
</table>

Source: MSF, 2014a

The big drop from 2012 to 2013 was because a large project closed. Of the numbers in 2013 there was two projects responsible for the majority of the ToPs performed. In 2012 the IB reaffirmed the position of MSF after seeing this decline (MSF, 2014a). In 2014 MSF’s sexual and reproductive health policy lists abortion as a priority and mentions, "MSF will respond to girls’ and women’s needs for the termination of pregnancy on request (Pre-IGA webinar email invitation 8 May 2017).

**Motion debate**

A member of the field team in Lesotho presented the motion and the debate started with challenging the motion with questions of the validity of the background. The woman stated that she cannot support this motion and wondered if there were surveys backing up that the high mortality was due to unsafe abortion. She further asked why don’t MSF promote the use of contraceptives instead of promoting abortions. A women from the OCB board responded to the woman stating that it is proven that unsafe abortion are the third cause of maternal mortality. She also supports the motion by saying that it is the obligation of MSF to try to help these women in need but reacted to one sentence in the motion. She reacted to the sentence that mentions that MSF has to speak out. MSF should speak out regarding maternal death but not become a pro-abortion organisation she states. A man from Malawi followed stating that this issue should be addressed with a behaviour change and family planning instead. The medical Director of OCB, followed with supporting the motion but
he states that this is already in the OCB and intersectional policy and says that it is a little bit strange that this motion is coming up. The head of mission of South Africa stood up and said that he was in the room when this motion was discussed at the GA in South Africa. The motion created a huge debate due to the conservative traditions in the region and quoted a Zimbabwean doctor that said, “that we have to take morality out of medicine”. He also returned to the Speaking out part and that the field team in Lesotho actually want to attempt to change laws in countries where ToP is illegal. The last word came from a woman that wanted MSF to challenge religious authorities and not only include ToP as a family planning method. The debate was cut of due to lack of time (MSF 2014b).

**Chronic diseases 2011 and Integration of HIV/TB and NCDs 2014**

**Background**

The background of the first motion is that chronic disease burden is increasing in all the world's contexts. 80 % of the deaths due to NCDs are in low and middle-income countries. It is a lifelong treatment without cure and the main objective is related to public health. In a population it is possible to reduce mortality and morbidity but one could not say that one patient that receives treatment is helped (MSF, 2011a).

**Motion debate**

The topic of chronic diseases was at the agenda at the OCB gathering that year so the motion debate was a continuation on that debate. A representative presented the 2011 motion from the mission in India. She opened with stating that this disease group is a group that MSF has neglected historically and that it is a need that MSF cannot neglect any longer. She continues saying that MSF needs to be smart in how, when and where it starts with NCDs. The at the time Operational Director responded that it is an important motion but that MSF needs to be careful with doing too much, too quick. He agrees with the general term of the motion but believes that integration of NCDs in HIV projects is taking it a step too far. A man from the Pakistan mission followed supporting the motion but wants the motion to be more specific in what it asks from the executive. A member of the OCB board responds that the more specific a motion is the more difficult it is for it to get
approved. She hears that there is support for the spirit of the motion but people have issues with the wording. The operational coordinator for cell 6, continuing with expressing exactly that he has a problem with the wording of it, being a part of its core medical action and proposes it to be taken out and replaced by part of. Another OCB board member responds that it is not possible to change the wording of a motion at this stage. He continues by saying that most of MSFs agree with it being a part of the medical action since it is in the 2011 operational strategy but this motion actually wants it to be a core medical activity. A man from the research unit reminds the gathering that this motion comes from five different countries so it is a clear demand from the field. He encourages the gathering to look at the spirit of the motion that says that MSF should move forward in supporting this field demand or not. A member of MSF-Sweden, asks, regarding the assessment that is asked for, how much resources this would take from the medical department. The Medical Director MSF-OCB, answers that it is difficult to answer because he doesn’t know which of all the chronic diseases will be included. He continues with saying MSF needs to select specific contexts and specific diseases and linking with Ministries of Health and the communities. A man from the mission in Guinea expresses his hesitance for MSF to step into this field because MSF is not yet capable to implement a correct global strategy when it comes to HIV. Another member of the OCB Board, states that he thinks that the motion is taking it a bit too far. He is in favour of specific projects doing NCDs but it should not be integrated in MSFs core medical action (MSF, 2011b).

The motion debate in 2014 started with the motion being presented by a member from the South African mission. A man stands up to explain to the gathering that this pilot already exists in the Kibera project in Kenya and it is planned for a five-year project. Giselle from the Haiti mission follows with supporting the motion and highlights the importance for MSF to be active in treating these pathologies. The debate was cut off due to time constraints after only two inputs to the discussion MSF, 2014c).