In Search of the 'New Informal Legitimacy' of Médecins Sans Frontières

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For medical humanitarian organizations, making their sources of legitimacy explicit is a useful exercise, in response to: misperceptions, concerns over the 'humanitarian space', controversies about specific humanitarian actions, challenges about resources allocation and moral suffering among humanitarian workers. This is also a difficult exercise, where normative criteria such as international law or humanitarian principles are often misrepresented as primary sources of legitimacy. This essay first argues for a morally principled definition of humanitarian medicine, based on the selfless intention of individual humanitarian actors. Taking Médecins Sans Frontières (MSF) as a case in point, a common source of moral legitimacy for medical humanitarian organizations is their cosmopolitan appeal to distributive justice and collective responsibility. More informally, their legitimacy is grounded in the rightfulness of specific actions and choices. This implies a constant commitment to publicity and accountability. Legitimacy is also generated by tangible support from the public to individual organizations, by commitments to professional integrity, and by academic alliances to support evidence-based practice and operational research.

Introduction

Humanitarian action is a prominent part of the political and moral landscape of this 21st century. It has been a source of relief for innumerable people, and an essential expression of cosmopolitan solidarity. At the same time, it is a versatile concept, including Northern/Western expressions of mainstream humanitarianism, which encompass an ideology, a profession and a movement (Donini, 2010). Humanitarianism has been criticized on all these accounts (Pfeifer, 2004; Barnett and Weiss, 2008). Critics and analysts include scholars from various disciplines, such as political sciences, sociology and anthropology. Their reservations relate to the three broad categories of arguments: humanitarian actions themselves, political linkages (De Waal, 1997) and media representations (Hours, 1998a; Boltanski, 2000).

The first problem compounding these debates is the difficulty to set up boundaries to the sprawling constellation of occasional initiatives, structured enterprises or established organizations that make up the humanitarian movement. Expanding from a typology proposed by Stoddard (2003), Donini (2010) maps humanitarian organizations of Western origin between four broad categories of allegiances: the Dunantist tradition of the Red Cross movement, the Wilsonian tradition of pragmatic alignment with foreign policies, faith-based organizations and the 'solidarist' communities typically gathering around the banner of human rights. Importantly, these categories overlap to a great extent, and they do not necessarily include less visible but equally important forms of humanitarian action, such as local community initiatives, informal religious charities or remittances from disporas.

The second problem that underpins debates around humanitarianism is a lack of common understanding about the ultimate operating principles and the legitimacy of humanitarian organizations. As shown by multi-country empirical data (Donini *et al.*, 2008), there is agreement over the existence of a common core of universal humanitarian values, but their interpretation varies between communities. Practically, this leads to the observation that 'there is no situation where humanitarian action is totally principled and allowed to operate as such' (Donini *et al.*, 2008). Similarly, most members of the humanitarian movement operate in a lack of clarity about the sources of their legitimacy.[1] This contributes to a number of problematic situations, for example: misperceptions, concerns over the 'humanitarian space', controversies about specific humanitarian

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actions, challenges about resources allocation and moral suffering among humanitarian workers.

From qualitative multi-country data collected over a range of distinct community settings where Médecins Sans Frontières (MSF) intervenes, Abu-Sada (2011) showed recurrent and fundamental misperceptions by recipients of aid, over the humanitarian organization itself, its values and aims, humanitarian principles and motives of humanitarian workers. In African settings, many respondents interpreted humanitarian secular endeavours as expressions of religious values. Quality of care was recognized as the main criterion for judging MSF's work. Such observations call for additional efforts of communication to attended communities, for improved results-based accountability and for a reflective inquiry over the precise values that humanitarian organizations represent.

The latter can also be implied from the ongoing debate about the 'humanitarian space'. Hubert and Brassard-Boudreau (2010) allege that common statements about the 'shrinking' of the humanitarian space are misconceived and largely unfounded. In their analysis, however, they examine threats to humanitarian access, to the respect for International Humanitarian Law, or to the safety of humanitarian workers. These threats can result from blurred boundaries between traditional humanitarian relief, military operations and integrated UN missions, all elements shaping the current humanitarian landscape and which expose in some way how the legitimacy of humanitarian organizations is open to multiple interpretations.

Specific categories of humanitarian actions are not immune to objections either. For example, some scholars like anthropologists Bernard Hours (1998a,b) and Miriam Ticktin (2006), extend their criticism of humanitarianism to medical actions themselves, putting forward two sets of arguments: political and moral. First, medical interventions are instrumental to broader political interests or to the globalization of Western values, and their actors are oblivious of the root political causes of conflicts and catastrophes. Second, humanitarian medicine, especially through its representations, entertains an undignified and asymmetrical relationship towards the 'victims' that it pretends to rescue. There are also more specific debates raised by humanitarian medicine under particular operational circumstances, questioning the merits of medical practices, health systems interferences or engagement in global health policies. In such cases, the challenge can be variably addressed to humanitarian medicine in general, to a specific organization, to a specific project or action or to the means used to achieve an otherwise legitimate project.

Hurst *et al.* (2009) link the problem of fair resource allocation in humanitarian medicine to the issue of legitimacy, and call for further exploration of the topic.

Finally, there is a moral obligation of ideological clarity for humanitarian organizations, towards the relief workers whom they employ and whom they expose to emotional traumas. This was analysed on theoretical moral grounds by Slim (1997) as the 'by-stander anxiety', affecting members of non-governmental organizations (NGOs) who operate as third parties in the context of war zones. More recently, empirical data have been produced to confirm sources of moral suffering in humanitarian workers, and to expose in particular how moral tensions are created by policies, agendas and decisions over resources allocation by aid agencies (Schwartz *et al.*, 2010).

Methodology

I have so far put forward a number of morally and operationally relevant reasons for humanitarian organizations to clarify not only their fundamental values, but in a broader sense, their legitimacy. At this point, an important distinction should be made between humanitarian interventions and other forms of humanitarian actions. Humanitarian intervention is defined by strategists as one kind of military intervention.[2] The legitimacy of humanitarian intervention has been aptly examined through political theory (see for example, Kahler, 2011). In contrast, the legitimacy of other categories of humanitarian actions (qualified as 'aid', 'assistance' or 'relief'), including the activities of mainstream humanitarianism, is much more complex to define and has seldom been addressed as such. For most humanitarian organizations, their legitimacy relies on informal sources, variably expressed or interpreted within the humanitarian movement. Consequently, it is utterly difficult to distinguish between normative and descriptive sources of legitimacy for humanitarian organizations, and I will not make such an attempt. Instead, my approach is inductive. I start with a description of possible sources of legitimacy for MSF, one among prominent examples of a medical humanitarian organization (Box 1). I examine what the organization, its members or observers have to say about sources of MSF's legitimacy, and what problems such pronouncements can elicit or reveal. In order to map sources and boundaries of MSF's legitimacy, I apply an analytical framework defined by Hugo Slim (2002) in a review pertaining to NGOs in general. From the case of MSF, I try to see what generalizable sources of legitimacy (if any) could be

Box 1. Médecins Sans Frontières at a glance

The historical roots of MSF have been frequently recounted (Benthall, 2010; Fox, 1995; Valaeys, 2004; Redfield, 2005). MSF was created in 1971 by French doctors and journalists, out of ideological discontent with the practice of political silence by the Red Cross Movement during the civil war in Nigeria. MSF's original ideals have been perpetuated through a constant emphasis on the dual principles of medical action and '*témoignage*'.[a] MSF is also a movement ruled by an associative type of governance reproduced over 19 national associations. Values and principles of the organization have been expressed through successive self-referring documents (Médecins Sans Frontières, 1971, 1995, 2006); a foundational Charter (1971), the 'Chantilly Principles' (1996) and the 'La Mancha Agreement' (2006). Although MSF's scope of activities is still dominated by emergency relief, the organization has ventured into a broader range of medical interventions, navigating within the expanding boundaries of 'crisis' landscapes, between acute disasters, conflicts, neglected diseases (Balasegaram *et al.*, 2006) and underserved populations. MSF was awarded the Nobel Peace Prize in 1999. The prize money was used to create MSF's Campaign for Access to Essential Medicines, opening a wider dimension to advocacy and a deeper engagement in debates over global health policies (Redfield, 2008).

Attributes discussed for MSF in this article are not necessarily applicable to other medical humanitarian organizations claiming international outreach. Beside its prominence in the medical sector, MSF's most distinct features are: (i) a reference to the 'Dunantist' tradition, (ii) an associative mode of governance and (iii) an emphasis on '*témoignage*'.

[a]Generally translated as 'bearing witness' or 'testimony'. None of those terms convey a clear sense that 'témoignage' should also be a self-effacing attempt to give voice to victims.

identified for humanitarian medicine. I set aside the professional legitimacy of individual practitioners of humanitarian medicine, a topic that would raise separate but undoubtedly relevant issues of accreditation, integrity and conduct. Instead, I am addressing here the broader question of what sort of legitimacy grounds the practice of humanitarian medicine as a collective endeavour.

Since different understandings of humanitarian medicine obviously could lead to different legitimacy claims, I start with a proposal for a normative definition of humanitarian medicine. I next examine how MSF has characterized its own legitimacy as 'informal'. Following Slim's footsteps, I then consider from a broader perspective how the legitimacy of humanitarian medical organizations pertains to international law and moral principles. I next explore what kind of tangible actions and support can generate an informal legitimacy. Finally, I discuss some aspects of intangible sources of legitimacy.

What is Humanitarian Medicine?

The diversity of definitions of humanitarian medicine reflects at least three parallel trends. First, there is a tendency for health sciences to capture humanitarian medicine as a new academic discipline, in the same constructionist way as global health or health diplomacy theories are injecting fresh blood into the obsolescing domain of 'international health'. Second, there is frequent misappropriation of the expression 'humanitarian medicine', which appeals to all sorts of enterprises, whether genuinely humanitarian, or simply for-profit or linked to political goals. Partnerships between humanitarian actors and private sector companies are being encouraged under United Nations initiatives (World Economic Forum and OCHA, 2007) and we can probably see times ahead, when new brands of 'humanitarian medicine' will be offered under the label of corporate social responsibility (Hopgood, 2008). Third, recent history has seen a remarkable broadening of the scope of health projects undertaken by mainstream humanitarian actors, well beyond their initial remit of disasters and armed conflicts. The typology of MSF activities during recent years illustrates the growing variety of activities finding rationale under the heading of 'humanitarian medicine'.

The political dimension of humanitarian medicine is not foreign to such evolution either. Interestingly, Andrew Lakoff (2010) describes two new regimes of global health, grounded in quite distinct values and worldviews: global health security and humanitarian biomedicine. The apparent coherence between the two regimes reveals a rather unhealthy marriage between

different values. As Lakoff concludes: '. . . humanitarian biomedicine could be seen as offering a philanthropic palliative to nation-states lacking public health infrastructure in exchange for the right of international health organizations to monitor their populations for outbreaks that might threaten wealthy nations'. Beyond this particular case of outbreak detection, the practice of humanitarian medicine often lies at the center of a triangle linking health, foreign policy and security, where the apparent neutrality of health is being instrumentalized as a soft power (Ingram, 2005: 534) to further national interests more broadly.

Altogether, such trends contribute to expanding the nebula of 'humanitarian medicine' and, worryingly, to the risk to lose its identity as an essentially altruistic act. There is thus a need for a more cohesive definition of humanitarian medicine.

It is clear that the scope of humanitarian medicine cannot be defined under a coherent set of specific practices (e.g. emergency medicine, public health, tropical medicine, disaster medicine). Likewise, it cannot be defined only by circumstances (e.g. refugee camps, conflict zones, natural disasters), nor by specific categories of 'beneficiaries' (e.g. prisoners, migrants). None of such operational definitions would capture the full scope and essence of humanitarian medicine. Neither would they contribute to solving legitimacy issues. The key point is that humanitarian medicine can only be defined through its moral underpinnings. Tentatively, it could be described as:

> a set of medical or public health practices whose sole intent is to selflessly accommodate and address the tension created between compelling health needs and the ongoing deprivation of resources in a given population or community.

Such a definition, based on the moral intents of those who practice humanitarian medicine would encompass the range of activities generally recognized as legitimate humanitarian action (including responses to public health disasters and chronic crises), and at the same time, avoid co-optation for political, security or private purposes.

The definition also implies that moral tension is constitutive of the practice of humanitarian medicine, in the sense that the latter entails an almost constant confrontation to the unfair allocation of resources, viewed from a global perspective. In other terms, medicine ceases to be humanitarian in essence, when the needs are fulfilled through resolution of the sources of deprivation, or when the needs are not compelling.[3]

An example can perhaps illustrate the boundaries of humanitarian medicine, in light of the definition. Let us consider cardiac paediatric surgery performed by expatriate specialists in a state-of-the-art hospital established through international philanthropy in the capital of a low-income country. Here, the needs might be compelling (e.g. if the hospital recruits most children of the country suffering from congenital or rheumatic heart disease), but the practice does not entail any exceptional tension. Expatriate surgeons would encounter a working environment that is not any different from their familiar ones in industrialized countries. More importantly, they could avoid—if they wish—being confronted directly to the circumstances of deprivation that make rheumatic heart disease still prevalent in the country. This would be a case of generosity and altruism if expatriate personnel were giving some of their salary and free time to the project, but not a case of practicing humanitarian medicine. The claim of humanitarian medicine could, however, be made by the health care workers routinely attending the same patients in their living circumstances, and acting with professionalism through adapted medical practices. These health workers would encounter very different moral dilemmas from the expatriate surgeon in the capital, for example the need to balance resources between prevention and treatment of rheumatic heart disease, or the triage of patients to be sent to the capital for surgery.

The proposed definition is a unifying one in the sense that it relies on an uncontroversial and universal moral reason for practicing humanitarian medicine. It is of the same qualitative order as the 'ethic of refusal' eloquently spelled out by James Orbinski when delivering the 1999 Nobel Lecture, and further discussed by Redfield (2005). The moral tension implied in the proposed definition lies at a mid-level in the chain of moral reasons, between higher principles of moral philosophy and professional codes of ethics. In other terms, it does not make any assumption about the ultimate moral values endorsed by individuals accepting or seeking to work under conditions where such extreme tensions between needs and means exist. The range of ultimate moral reasons is expected to be diverse between individual humanitarian workers and, as we will see later, it is multiple between organizations. By putting emphasis on moral reasons for humanitarian engagement, I am not ignoring the fact that relief workers can have other or additional motivations to embrace humanitarian actions.[4] Such motivations could include, e.g. opportunities for professional development, or an escape from the legitimacy crisis of the liberal medical profession in Europe since the 1970s (Givoni, 2011). The role of organizations is simply to

offer opportunities, means and knowledge to exercise humanitarian medicine. A first source of legitimacy for medical humanitarian organizations thus relies on their capacity to enact and support in a collective way a morally principled definition of humanitarian medicine. A second source of moral legitimacy, as I will discuss later is a universalist view of distributive justice and collective responsibility.

My definition of humanitarian medicine is encompassing since it can accommodate all sorts of endeavours, from individual initiatives to multinational alliances.[5] At the same time, it is restrictive through its moral perspective. For example, it would exclude as legitimate medical humanitarian initiatives any organized attempts to subvert medical care toward other goals, such as: collecting intelligence or anthropological data about populations, winning hearts and minds for political or military achievements, increasing the acceptance of environmentally adverse extractive industries or promoting religious beliefs. Such goals could perhaps be seen as legitimate or useful from different perspectives, but not as a humanitarian one. The legitimacy of humanitarian medicine is thus simply grounded in collective moral intents and values. Within this framework, organizations display distinct additional values, operating principles or records of excellence that contribute to build up additional sources of legitimacy. At this point, I will now proceed by analysing what additional sources of legitimacy apply to medical humanitarian organizations, and how MSF makes claims about it.

MSF and the 'New Informal Legitimacy'

The implicit understanding of 'legitimacy' which has so far shored up this discussion has no bearing to strictly legal concepts (e.g. constitutional legitimacy). Instead, the kind of legitimacy which is frequently referred to in the humanitarian literature appeals more to feelings of 'natural rights' or 'rightfulness of action'. With an international mandate based on international humanitarian law, the International Committee of the Red Cross stands out as an exception to this general lack of clarity over the legitimacy of humanitarian organizations.

For MSF, legitimacy itself is not mentioned in the foundational documents. Instead it appears recurrently in the 1999 Nobel Lecture (Orbinski, 1999). James Orbinski declared for example that:

> MSF is not a formal institution, and with any luck at all, it never will be. It is a civil society organization, and today civil society has a new global role, a new informal legitimacy that is rooted in its action and in its support from public opinion.

This statement confirms that MSF's legitimacy does not necessarily fit within traditional frameworks of governance (it is 'new' and 'informal'), and it brings up two important determinants of this new sort of legitimacy: 'action' and 'public opinion'. However, it does not say what type of 'action' automatically would confer legitimacy. It does not elaborate either on who is the legitimizing 'public opinion', an important point to reflect upon for an organization with international outreach.

In his work on accountability of NGOs, Hugo Slim (2002) offers a more detailed account of the multiple dimensions of this new informal legitimacy. Slim's framework[6] implies that an NGOs legitimacy '. . . is both derived and generated. It is derived from morality and law. It is generated by veracity, tangible support and more intangible goodwill'.

The importance given to generated sources (the processes or output of humanitarian actions that are open to scrutiny) implies that legitimacy is not a granted attribute, but one that can be challenged at any time, and one that needs constant contributions to perpetuate itself.

Henceforth, in light of Slim's multi-dimensional framework, I will first examine sources of legitimacy for 'Dunantist' organizations in general and MSF as a medical organization in particular. The analytical framework considers successively: sources derived from law, sources derived from moral values, generated sources and intangible sources.

International Law

International human rights law, international humanitarian law (IHL), and refugee law are frequently mentioned, often inappropriately, as underlying the legitimacy of humanitarian organizations.

International Humanitarian Law

As noted earlier, the mandate to *oversee* the application of IHL strictly applies to the International Committee of the Red Cross. For other organizations, the relationship with IHL is much looser. Mackintosh (2000) observes that: 'The Geneva Conventions do not confer rights or impose obligations upon humanitarian agencies. The Conventions simply do not address these actors'. Medical organizations frequently operate in conflict

zones, where IHL applies between parties in conflict. A medical organization like MSF naturally abides by conditions specified in IHL. It gains additional operational space and access to populations in need, from the respect of IHL by combatants (Mackintosh, 2000). In other terms, legality contributes to the legitimacy of NGOs (Slim, 2002), but legitimacy is a much broader multi-disciplinary concept encompassing different principles (Kolín, 2007). The Red Cross principles of humanity, neutrality, impartiality and independence (Leader, 1998) are naturally endorsed by MSF[7] and other non-governmental 'Dunantist' organizations. However, adherence to humanitarian principles has an instrumental, rather than intrinsic value for NGOs. The same can be said for the ICRC, for whom traditional principles are a means to the end of assisting victims of conflict, and not ends in themselves (Hubert and Brassard-Boudreau, 2010). Furthermore, references to international law, as used by most NGOs, conceal in reality, implicit and unclear statements about moral values. For example, justifications for humanitarian actions, based on the versatile principle of 'neutrality' illustrate the complexity of the humanitarian language (Leaning, 2007).

Finally, the recent misappropriation of IHL as a justification for armed interventions in the name of 'responsibility to protect' makes it even more important for NGOs to remind that IHL does not fundamentally ground the legitimacy of their actions. As Weissman (2010) puts it: 'Arguments that link (responsibility to protect) and the concept of a "just war" draw on the same sources of moral and legal legitimacy as humanitarian action'. The misperception of IHL and humanitarian organizations as instruments of state interference could be further aggravated by ongoing attempts to expand the scope of protections authorized under IHL, to add natural disasters (including epidemics) within the purview of the 'right to humanitarian assistance' (Davies, 2010), and to allow forceful foreign interventions in such cases. The distinction between humanitarian intervention (Kahler, 2011) and humanitarian assistance is particularly crucial here.

International Human Rights Law

On the other hand, the frequent confusion over the legitimacy of international medical NGOs and international human rights law has several sources. First, several NGOs have the explicit purpose to promote human rights (especially political rights). They use advocacy channels or strategies similar to medical NGOs, although the nature and purpose of advocacy messages are different in both cases. Second, members of medical NGOs happen to witness in their practice the consequences of abuses of human rights, through their presence among affected communities or sometimes through direct medical observations (Robertson *et al.*, 2002). This raises the central question of whether such NGOs can claim legitimacy of their medical actions through reference to international human rights law, and eventually make pronouncements to denounce violations of the right to health or other human rights. The matter is further complicated by several misinterpretations, for example, explicit references to human rights in MSF's foundational documents[8] or policy statements and by frequent mentions of MSF's defence of human rights in the academic literature.[9] Commenting on the debate over human rights and humanitarian action, Rony Brauman (2007) and James Darcy (2007) urge caution over the versatility of the human rights doctrine, and over the conflation of civil and political rights on one hand, and social rights (including health) on the other hand. Fundamentally, the mandate to enact the International Bill of Human Rights applies to signatory State Parties, not to NGOs. But taking some human rights as symbolic statements of universal values rather than legally binding prescriptions, could we say for a moment that the right to life[10] or the right to health[11] translate into obligations for medical NGOs? Brauman's and Darcy's analyses would suggest that this is not the case, when they appeal to 'needs-based' or 'duty-based' approaches, instead of 'rights-based approaches'. Such a position, inspired by political or legal considerations, implies also an important moral derivation. It shifts the claim for humanitarian assistance from the victim to the rescuer's ground. If what counts in humanitarian action are not victims expressing their rights, but rescuers responding to needs or exercising their duties, who has legitimacy to assess needs or decide upon one's duty?

Moral Legitimacy

The latter question brings up one aspect of a broader and crucial debate over moral values in humanitarian medicine, i.e. the problem of choices. Making rightful choices (over resources allocation for example) greatly contributes to the legitimacy of one organization, but the moral criteria for choices are utterly complex and variable, and they should not necessarily rely on the human rights doctrine (manuscript in preparation). Depending on circumstances and levels of decision, criteria can have different weights, and can include appeals

to empathy, public health principles, deontological arguments or utilitarian principles. Such important considerations will be discussed elsewhere. What we need at this stage is a more encompassing criterion of moral legitimacy for humanitarian medicine, seen as part of a movement, and regardless of how choices are actually made.

As a recognized movement, humanitarian medicine has become part of a post-Westphalian model of health governance, whereby states are just one category among multiple actors who all have some degree of legitimacy in both inter- and intra-state governance (Stevenson and Cooper, 2009). For medical NGOs, this sort of legitimacy is more about political relevance on the global arena than the genuine recognition of their capacity to act morally. However, aside from political relevance, the merit of humanitarianism as a movement (and one of the sources of its legitimacy), is precisely its cosmopolitan outreach and its capacity to deploy means to increase the proximity between victims and relief workers. In doing so, individual organizations converge on a (often implicit) claim for a universalist view of distributive justice and collective responsibility. For example, despite a lack of clarity over any system of moral values, notions of global distributive justice pervade MSF's stances and policies. This finds expressions in its systematic enterprise to facilitate universal access to essential drugs and diagnostic tools,[12] in efforts to prioritize the worst off or 'the most vulnerable',[13] and in a sense of collective responsibility or 'common humanity' embodied under the 'Sans Frontières' rallying call for medical action.

To the extent that MSF is representative of the humanitarian movement, an important and unifying source of moral legitimacy for medical humanitarian organizations is thus a universalist view of distributive justice and collective responsibility, enacted through cosmopolitan outreach. Depending on its allegiance, each organization can thereupon spell out additional and particular sources of legitimacy, or moral principles whereby, it will exercise its fair choices and collective responsibilities. For example, faith-based organizations would appeal to their own traditions of charity. Other organizations would rather make more explicit references to solidarity or compassion (Perkin, 2006).

Generated and Tangible Sources of Legitimacy

While collective moral principles constitute the backbone of the 'new informal' legitimacy claimed by MSF, generated sources constitute its living and evolving expressions. In that sense, the sources of legitimacy summarized in Box 2 constitute at the same time, a roadmap for humanitarian medicine and a set of indicators of how medical humanitarian actions are accountable outside of their respective organizations.

The 'tangible support' and 'tangible performance' criteria of Hugo Slim apply to all NGOs in general, but differ according to each organization's spirit or specific endeavours. For example, MSF International is one among the 185 NGOs in official relations with the World Health Organization (WHO, 2010). An associative mode of governance is also a tangible source of legitimacy, which is generated by the extent of participation from members and the openness of decisional procedures.

Humanitarian medicine standards and practice rely on a disparate corpus of knowledge, drawing from public health, tropical medicine and other disciplines. It is a field requiring experience, integrity and cross-cultural approaches. It is typically practiced as a team effort, involving health professionals with a wide range of educational backgrounds and experiences. Tangible professional relationships, knowledge and expertise imply partnerships with health sciences schools, proper accreditation of health professionals and a commitment to share accruing knowledge. Operational research and academic publications are integral parts of the practice of humanitarian medicine (Zachariah *et al.*, 2009, 2010), and the conduct of research in emergency contexts needs to obey adapted ethical principles (Pringle and Cole, 2009). The external sharing of knowledge collected during field practice (notably clinical experience under precarious situations) is an important and visible expression of legitimacy, and a testimony to the collective and universal character of humanitarian medicine.

Intangible Sources of Legitimacy

Intangible sources of legitimacy, such as trust, integrity, reputation and personal relationships are particularly important for medical humanitarian organizations operating in diverse socio-cultural contexts. The way some humanitarian organizations have gained legitimacy towards North Korean authorities is a conspicuous example (Yim *et al.*, 2009). Such sources of legitimacy are intangible only to the extent that efforts are not made to formally explore opinions and perceptions of residents of territories where humanitarian medicine takes place. Such explorations are however feasible (essentially through qualitative surveys), and they can improve the quality of aid programmes and the legitimacy of the humanitarian enterprise by putting patients and

Box 2. Examples of generated sources of legitimacy in humanitarian medicine[a]

Tangible support

- Alliances with associations of beneficiaries and communities.
- Associative mode of governance.
- Awards.
- Participation in conferences or academic forums.

Tangible performance

- Health outcomes.
- Efficiency (cost-effectiveness).
- Narrative accounts.

Tangible professional relationships, knowledge and expertise

- Accreditation of professionals.
- Commitment to use of evidence-based interventions, to document innovative interventions, or to contribute to operational research.
- Alliances with academic institutions.

[a]Adapted from Slim (2002) and from Robertson *et al.* (2002).

communities on a more equal ground with those who strive to help them. Perceptions surveys carried out by MSF in 10 countries among a wide range of respondents (Abu-Sada, 2011) are of particular interest to identify intangible sources of legitimacy, and to correct misperceptions from both sides of the humanitarian mirror.

Conclusions

Defining the legitimacy of humanitarian action is complex and probably cannot be accommodated within simple normative criteria. Taking MSF as a case in point, several conclusions can be extended to humanitarian medicine in general. First, there should be a common agreement on what is the scope of actions that can be called 'humanitarian', and their underlying values. I have limited my demonstration to the realm of humanitarian medicine, leaving aside other disciplines that equally contribute to humanitarian action. My definition of humanitarian medicine is based on the selfless intention of individual humanitarian actors, and precludes any subversion of medical practice towards derived interests. Similar definitions could probably be proposed for other types of humanitarianism based on service provision. Second, neither international law, nor the humanitarian principles are sufficient to legitimize the actions of NGOs (aside from the Red Cross movement itself). Third, a moral principle common to medical humanitarian organizations appears to be their explicit or implicit commitment to universal distributive justice. This leaves it open for individual organizations to rely on additional and distinct moral principles, notably to ground the allocation of their resources. Fourth, the sort of informal legitimacy that humanitarian organizations can claim is mostly generated by their actions, which should be successful, accountable and professional. This is what allows them to operate with consent from the people whom they attend, and outside of any formal mandate. Informal legitimacy is not a granted attribute, but an ongoing, perfectible and challengeable process. An enumeration of generated sources of legitimacy is thus a roadmap for elevation in this process.

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Conflict of Interest

None declared.

Notes

1. I leave the definitions of 'legitimate' and 'legitimacy' open at this stage, appealing provisionally to the common intuitions that these words can elicit for readers.
2. For example, Kolín (2007) discusses the legitimacy of humanitarian interventions in terms of Aquinas's moral theory of 'just war'.
3. Resolution of the sources of deprivation would lead to a transition toward a development agenda. One example of non-compelling needs would be a cosmetic surgery clinic set up in the middle of a deprived area, in response to demands from a minority of well-off families.
4. As Donini (2010) points out, 'a thorough sociological research study of the motivations of aid workers has yet to be conducted'. Fox (1995) and Herzlich (1995) allude summarily to motivations as a mix of personal, altruistic and professional reasons.
5. For example, the practice of a Somali doctor or nurse declining offers for professional promotion overseas, and choosing instead to serve selflessly and with limited resources, a community in her own country should not be less recognized as 'humanitarian medicine' than the transient work of an expatriate European practitioner working in the same country under the aegis of a recognized international NGO.
6. Hugo Slim expands the framework from his definition of legitimacy as: 'the particular status with which an organisation is imbued and perceived at any given time that enables it to operate with the general consent of peoples, governments, companies and non-state groups around the world'. Although we might disagree on the proposed range of consenting stakeholders, the framework brings clarity over various understandings of 'legitimacy' expressed in the humanitarian literature.
7. This appears most explicitly in the Chantilly Principles. Oddly, the MSF Charter endorses neutrality and impartiality 'in the name of universal medical ethics'.
8. Under the fourth principle enunciated in the Chantilly Document, MSF:

   > ascribes to the principles of Human Rights and International Humanitarian Law', including 'the duty to respect the fundamental rights and freedoms of each individuals, including the right to physical and mental integrity and the freedom of thought and movement, as outlined in the 1949 Universal Declaration of Human Rights.

   Paragraph 1.13 of the La Mancha Agreement is more cautious:

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

9. See for example, Fox (1995), Hours (1998a,b), Lakoff (2010) and Annas (2010).
10. Article 3 of the Universal Declaration of Human Rights (1948).
11. Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966).
12. This is precisely the mandate given by MSF to the Campaign for Access to Essential Medicines.
13. Article 1.1 of the La Mancha Agreement.

References

Abu-Sada, C. (2011). *Dans l'Oeil des Autres. Perception de l'Action Humanitaire et de MSF.* Lausanne, Switzerland: Editions Antipodes.

Annas, G. J. (2010). Chapter 13: Global Health. In *Worst Case Bioethics: Death, Disaster, and Public Health.* New York, USA: Oxford University Press, p. 198.

Balasegaram, M., Dejene, S., Tinnemann, P., Perkins, S. and Davidson, R. (2006). Examples of Tropical Disease Control in the Humanitarian Medical Programmes of MSF and Merlin. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, **100**, 327–334.

Barnett, M. and Weiss, T. G. (2008). Humanitarianism: a Brief History of the Present. In Barnett, M. and Weiss, T. G. (eds), *Humanitarianism in Question: Politics, Power, Ethics.* Ithaca and London: Cornell University Press, pp. 1–48.

Benthall, J. (2010). Chapter 4: The Cultural Styles of NGOs. In Disasters, Relief and the Media. Wantage, UK: Sean Kingston Publishing, pp. 124–139.

Boltanski, L. (2000). The Legitimacy of Humanitarian Actions and their Media Representations: the Case of France. *Ethical Perspectives*, **7**, 3–16.

Brauman, R. (2007). The Danger of a Conciliatory Approach. *Humanitarian Stakes*, **1**, 44–47.

Darcy, J. (2007). Humanitarianism and Human Rights. *Humanitarian Stakes*, **1**, 48–50.

Davies, S. E. (2010). Is there an International Duty to Protect Persons in the Event of an Epidemic? [online]. *Global Health Governance*, available from: http://blogs.shu.edu/ghg/files/2011/11/Davies_Is-There-an-International-Duty-to-Protect_Spring-2010.pdf [accessed 19 December 2011].

De Waal, A. (1997). The Humanitarian International. In *Famine Crimes: Politics and the Disaster Relief in Africa*. London: African Rights & The International African Institute, pp. 65–85.

Donini, A. (2010). The far side: the meta functions of humanitarianism in a globalised world. *Disasters*, **34(Suppl 2)**, S220–S237.

Donini, A., Fast, L., Hansen, G., Harris, S., Minear, L., Mowjee, T. and Wilder, A. (2008). *The State of the Humanitarian Enterprise*. Boston, MA, USA: Feinstein International Center, Tufts University.

Fox, R. C. (1995). Medical Humanitarianism and Human Rights: Reflections on Doctors without Borders and Doctors of the World. *Social Science & Medicine*, **41**, 1607–1616.

Givoni, M. (2011). Humanitarian Governance and Ethical Cultivation: Médecins Sans Frontières and the Advent of the Expert-witness. *Millenium*, **40**, 43–63.

Herzlich, C. (1995). Professionals, Intellectuals, Visible Practitioners? The Case of 'Medical Humanitarianism'. *Social Science & Medicine*, **41**, 1617–1619.

Hopgood, S. (2008). Saying "No" to Wal-Mart? Money and Morality in Professional Humanitarianism. In Barnett, M. and Weiss, T. G. (eds), *Humanitarianism in Question: Politics, Power, Ethics*. Ithaca and London: Cornell University Press, pp. 98–123.

Hours, B. (1998a). Chapter 1: La Médecine Humanitaire ou le Prétexte Démocratique. In *L'idéologie Humanitaire ou le Spectacle de l'Altérité Perdue*. Paris: L'Harmattan, pp. 23–59.

Hours, B. (1998b). L'idéologie Humanitaire ou la Globalisation Morale. *L'Homme et la Société*, **129**, 47–55.

Hubert, D. and Brassard-Boudreau, C. (2010). Shrinking Humanitarian Space? Trends and Prospects on Security and Access [online]. *The Journal of Humanitarian Assistance*, available from http://sites.tufts.edu/jha/archives/863 [accessed 19 December 2011].

Hurst, S., Mezger, N. and Mauron, A. (2009). Allocating Resources in Humanitarian Medicine. *Public Health Ethics*, **2**, 89–99.

Ingram, A. (2005). The New Geopolitics of Disease: Between Global Health and Global Security. *Geopolitics*, **10**, 522–545.

Kahler, M. (2011). Legitimacy, Humanitarian Intervention, and International Institutions. *Politics, Philosophy & Economics*, **10**, 20–45.

Kolín, V. (2007). The Legitimacy of Humanitarian Intervention: a Moral Perspective. *Obrana a Strategie/Defense & Strategy*, **1**, 5–28.

Lakoff, A. (2010). Two Regimes of Global Health. *Humanity*, **1**, 59–79.

Leader, N. (1998). Proliferating Principles: or How to Sup with the Devil Without Getting Eaten. *Disasters*, **22**, 288–308.

Leaning, J. (2007). The Dilemma of Neutrality. *Prehospital and Disaster Medicine*, **22**, 418–421.

Mackintosh, K. (2000). *The Principles of Humanitarian Action in International Humanitarian Law. Study 4 in: The Politics of Principle: the Principles of Humanitarian Action in Practice. HPG Report 5*. London: Humanitarian Policy Group, Overseas Development Institute.

Médecins Sans Frontières. (1971). Charter [online], available from: http://www.doctorswithoutborders.org/aboutus/charter.cfm [accessed 19 December 2011].

Médecins Sans Frontières. (1995). *Chantilly Principles*. Geneva, Switzerland: Médecins Sans Frontières, International Office.

Médecins Sans Frontières. (2006). La Mancha Agreement, 25 June 2006, Athens, available from http://www.msf.dk/OmMSF/Hvemervi/Lamancha-aftalen/ [accessed 19 December 2011].

Orbinski, J. (1999). Médecins Sans Frontières - *Nobel Lecture, 10 December 1999*. Oslo: The Nobel Foundation, available from: http://nobelprize.org/nobel_prizes/peace/laureates/1999/msf-lecture.html [accessed 19 December 2011].

Perkin, E. (2006). NGOs as Political Actors: a Japanese Approach? *Humanitarian Exchange Magazine*, **35**, 38–39.

Pfeifer, J. (2004). International NGOs in the Mozambique Health Sector: the 'Velvet Glove' of

Privatisation. In Castro, A. and Singer, M. (eds), *Unhealthy Health Policy: a Critical Anthropological Examination*. Plymouth, UK: AltaMira Press, pp. 43–60.

Pringle, J. D. and Cole, D. C. (2009). Health Research in Complex Emergencies: a Humanitarian Imperative. *Journal of Academic Ethics*, **7**, 115–123.

Redfield, P. (2005). Doctors, Borders, and Life in Crisis. *Cultural Anthropology*, **20**, 328–361.

Redfield, P. (2008). Doctors Without Borders and the Moral Economy of Pharmaceuticals. In Bullard, A. (ed.), *Human Rights in Crisis*. Hampshire, UK: Ashgate, pp. 129–144.

Robertson, D. W., Bedell, R., Lavery, J. V. and Upshur, R. (2002). What Kind of Evidence do we Need to Justify Humanitarian Medical Aid? *The Lancet*, **360**, 330–333.

Schwartz, L., Sinding, C., Hunt, M., Elit, L., Redwood-Campbell, L., Adelson, N., Luther, L., Ranford, J. and DeLaat, S. (2010). Ethics in Humanitarian Aid Work: Learning from the Narratives of Humanitarian Health Workers. *AJOB Primary Research*, **1**, 45–54.

Slim, H. (1997). Relief Agencies and Moral Standing in War: Principles of Humanity, Neutrality, Impartiality and Solidarity. *Development in Practice*, **7**, 342–352.

Slim, H. (2002). *By What Authority? The Legitimacy and Accountability of Non-governmental Organisations*. International Meeting on Global Trends and Human Rights, Geneva, 10–12 January 2002. Geneva, Switzerland: [online]. International Council of Human Rights Policy, available from: http://www.ichrp.org/files/papers/65/118_Legitimacy_Accountability_Nongovernmental_Organisations_Slim_Hugo_2002.pdf [accessed 19 December 2011].

Stevenson, M. S. and Cooper, A. F. (2009). Overcoming Constraints of State Sovereignty: Global Health Governance in Asia. *Third World Quarterly*, **30**, 1379–1394.

Stoddard, A. (2003). *Humanitarian NGOs: Challenges and Trends. HPG Briefing Number 12*. London: Humanitarian Policy Group, Overseas Development Institute.

Ticktin, M. (2006). Medical Humanitarianism in and Beyond France: Breaking Down or Patrolling Borders. In Bashford, A. (ed.), *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present*. New York: Palgrave Macmillan, pp. 116–135.

Valaeys, A. (2004). *Médecins Sans Frontières. La Biographie*. Paris: Fayard.

Weissman, F. (2010). "Not in our Name": why Médecins Sans Frontières does not Support the "Responsibility to Protect". *Criminal Justice Ethics*, **29**, 194–207.

World Economic Forum and OCHA. (2007). Guiding Principles for Public-private Collaboration for Humanitarian Action. Geneva, Switzerland: United Nations. Available from: http://www.un.org/partnerships/Docs/Principles%20for%20Public-Private%20Collaboration%20for%20Humanitarian%20Action.pdf [accessed 19 December 2011].

WHO. (2010). English/French List of 185 Non-governmental Organizations in Official Relations with WHO Reflecting Decisions of EB126, January 2010. Geneva, Switzerland: World Health Organization, available from: http://www.who.int/civilsociety/relations/ngolisteb120.pdf [accessed 19 December 2011].

Yim, E. S., Choi, R. Y. and VanRooyen, M. J. (2009). Maintaining Health Sector Collaborations Between United States Non-Governmental Organisations and North Korea Through Innovation and Planning. *Prehospital and Disaster Medicine*, **24**, 153–160.

Zachariah, R., Harries, A. D., Ishikawa, N., Rieder, H. L., Bissell, K., Laserson, K., Massaquoi, M., Van Herp, M. and Reid, T. (2009). Operational Research in Low-income Countries: What, Why, and How? *Lancet Infectious Diseases*, **9**, 711–17.

Zachariah, R., Tayler-Smith, K., Ngamvithayapong-Yanai, J., Ota, M., Murakami, K., Ohkado, A., Yamada, N., Van Den Boogaard, W., Draguez, B., Ishikawa, N. and Harries, A. D. (2010). The Published Research Paper: is it an Important Indicator of Successful Operational Research at Programme Level? *Tropical Medicine and International Health*, **15**, 1274–1277.