



MSF Suisse

Activity Report 2016

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters.

As an independent and self-governed organisation, MSF's actions are guided by medical ethics and the principles of neutrality and impartiality. MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation.

MSF strives to ensure that it has the power to evaluate medical needs freely, to access populations without restriction and to control the aid it provides directly, giving priority to those in most grave danger. MSF does not take sides in armed conflict and demands unhindered access to patients and the space it needs to carry out emergency medical interventions. In addition, MSF accepts only private donations and never accepts funds from parties directly involved in any conflict or medical emergency that MSF is dealing with.

MSF is a non-profit organisation founded in Paris, France, by doctors and journalists in 1971. Today, MSF is a worldwide movement of 24 associations with an international office in Geneva, Switzerland, which provides coordination, information and support to the MSF Movement, and implements international projects and initiatives as requested. All of the associations are independent legal entities, registered under the laws of the countries in which they are based. Each association elects its own board of directors and president. They are united by a shared commitment to the MSF Charter and principles. The highest authority of the MSF Movement is the International General Assembly, which meets yearly.

The movement has five operational centres – MSF France, MSF Belgium, MSF Switzerland, MSF Holland and MSF Spain – which directly manage the missions. The partner sections contribute to the action of MSF through their recruitment efforts and by collecting funds, information and providing medical and operational support.

This Activity Report takes the place of the Performance Report. It was prepared in accordance with the provisions of the Swiss GAAP, FER/RPC 21.
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IMPRESSUM

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Thomas Nierle

In many ways, 2016 saw the materialisation of all the recent developments in the international environment. This forced MSF to take its work further, by providing assistance to those sacrificed by the power-holders, by bearing witness to inform public opinion and help improve the fate of the victims, and, lastly, by speaking out to denounce the consequences of certain political choices. Combining acts of solidarity, critical thinking and public positioning is more necessary now than ever before.

Identity politics is seriously impacting international dynamics; it is undermining the climate of trust and eroding the commitment to international cooperation, giving rise to struggles for power and leading towards global rearmament. This situation is particularly evident in the Middle East and North Africa, where the civil wars in Syria, Iraq, Yemen and Libya resulted in competing military interventions, leaving the civilian populations alone to face seemingly limitless violence. **Numerous states are choosing – with impunity – to breach their obligations, and openly acknowledge violations of the agreements and rules they have signed.** The very future of the United Nations and the main international treaties – cornerstones of the international order since the end of World War II – could now be in jeopardy.



Bruno Jochum

In the field, this translates into military strategies involving systematic attacks against civilians and public services (particularly hospitals), the use of chemical weapons and the criminal act of sending refugees back to danger zones, while hardly any protection or aid is being offered in conflict areas. High insecurity, combined with deliberate constraints on access, continues to considerably restrict the capacity to help those most in need in Syria, Nigeria, Sudan and Somalia. **While remaining faithful to the principles of independence and impartiality, the MSF teams must constantly make compromises and adapt their operational approach to find effective solutions for delivering assistance.**

Meanwhile, faced with no other choice, many forcibly displaced persons risk their lives on dangerous migration routes, in search of greater security for themselves and their families in neighbouring countries and in Europe. They encounter strict containment policies that prioritise security over humanity and solidarity, as symbolised by the outrageous agreement between a Europe that is withdrawing into itself and Turkey, and the wish to outsource the reception of migrants to a war-torn Libya. To express its rejection of the discrepancy between words and actions and urge states to assume their responsibilities towards affected populations, MSF took the decision to withdraw from the World Humanitarian Summit organised by the United Nations and held in Istanbul in May 2016. **The institutional violence that deprives families fleeing danger of their freedom of movement, rights, work and assistance, and keeps them in a state of despair within our societies, is intolerable and must be strongly denounced.**

As a consequence of that inward-looking attitude, the scant attention paid to humanitarian crises in Africa and the growing disinterest in them has become increasingly glaring. Some tragic events are barely covered by the media any more, having fallen well down the hierarchy of concerns: the dramatic child mortality and disappearance of men in Borno state in northeastern Nigeria; the pre-genocidal rhetoric, ethnic cleansing practices and physical elimination of opponents in South Sudan and Burundi; the unreported, ongoing fighting in Darfur and Kordofan (Sudan), as well as in Somalia and the Democratic Republic of Congo. For MSF and its teams, these situations, as well as the fight against epidemics, remain a priority and are the focus of our largest medical programmes. Indeed, three-quarters of our action is concentrated in sub-Saharan Africa.

Despite the tragedies and challenges, there are nonetheless many sources of hope and many opportunities to be seized. These include everyday examples of solidarity within civil societies, the ruling by the High Court of Kenya to reverse the government's decision to close the Dadaab camp for Somali refugees, the steady increase in resources to tackle public health issues, and the medical innovations that improve the impact on patients' health. All these measures and advances help restore the dignity of millions of people and give them the means to live better. Within MSF, medical aims and prevention are still a priority focus to constantly improve our interventions in the field in complex situations. Quick impact interventions that include a set of preventive tools – particularly multi-antigen vaccination, distribution of therapeutic foods and intermittent preventive treatment of malaria – have proven remarkably effective at reducing mortality in the displaced persons camps in Nigeria. Our Operations and Medical Departments have demonstrated how the cholera vaccine can be used upstream to minimise an outbreak, and are now tirelessly preparing hepatitis E vaccination campaigns in the event of an epidemic. In Swaziland, HIV/AIDS patients can now be kept in good health without having to wait for their condition to deteriorate before receiving treatment. Finally, the results of the thermostable rotavirus vaccine trial against diarrhoeal diseases affecting the youngest children have been positive, and we hope they will soon be applied in the field to avert numerous easily preventable deaths.

Our mission for 2017 will therefore be to stay on course and continue to help and care for people where the needs are most critical. Thank you for your support in 2016 and your continued commitment in 2017.

Thomas Nierle,
President of MSF Switzerland

Bruno Jochum,
General Director of MSF Switzerland

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MEXICO

Since 2013
Project: Reynosa
HR: 23 incl. 7 international
Cost: CHF 1,070,000

HONDURAS

Since 1998
Project: Tegucigalpa and Comayagüela
HR: 39 incl. 2 international
Cost: CHF 1,160,000

ECUADOR

Since 2016
Project: Portoviejo
HR: 1 international with the support of MSF's Mexican office
Cost: CHF 258,000

25 countries

63 projects

HR: Human resource data is provided on a full-time equivalent (FTE) basis.

Statistics do not include casual employees, or staff from ministries of health working within our programmes.

2016

JANUARY Ebola: The end of the Ebola epidemic in West Africa. MSF draws up a list of contagious diseases to watch and issues recommendations for lessons to be learned from this health crisis.



© Peter Casaer/MSF

MARCH Syria: Five years of conflict. The situation continues to deteriorate; attacks on markets, schools and hospitals intensify. In certain centres supported by MSF, over a third of the dead and injured are women and children.



© MSF

APRIL Europe: Agreement between the EU and Turkey on the return of irregular migrants arriving in Greece. On and offshore, MSF confirms its commitment to helping refugees affected by this unacceptable measure.



© Pierre-Yves Bernard/MSF

MAY Democratic Republic of Congo: Intervention in response to a particularly deadly outbreak of malaria in the northeast of the country. At the same time, MSF continues to work with victims of sexual violence in Ituri.

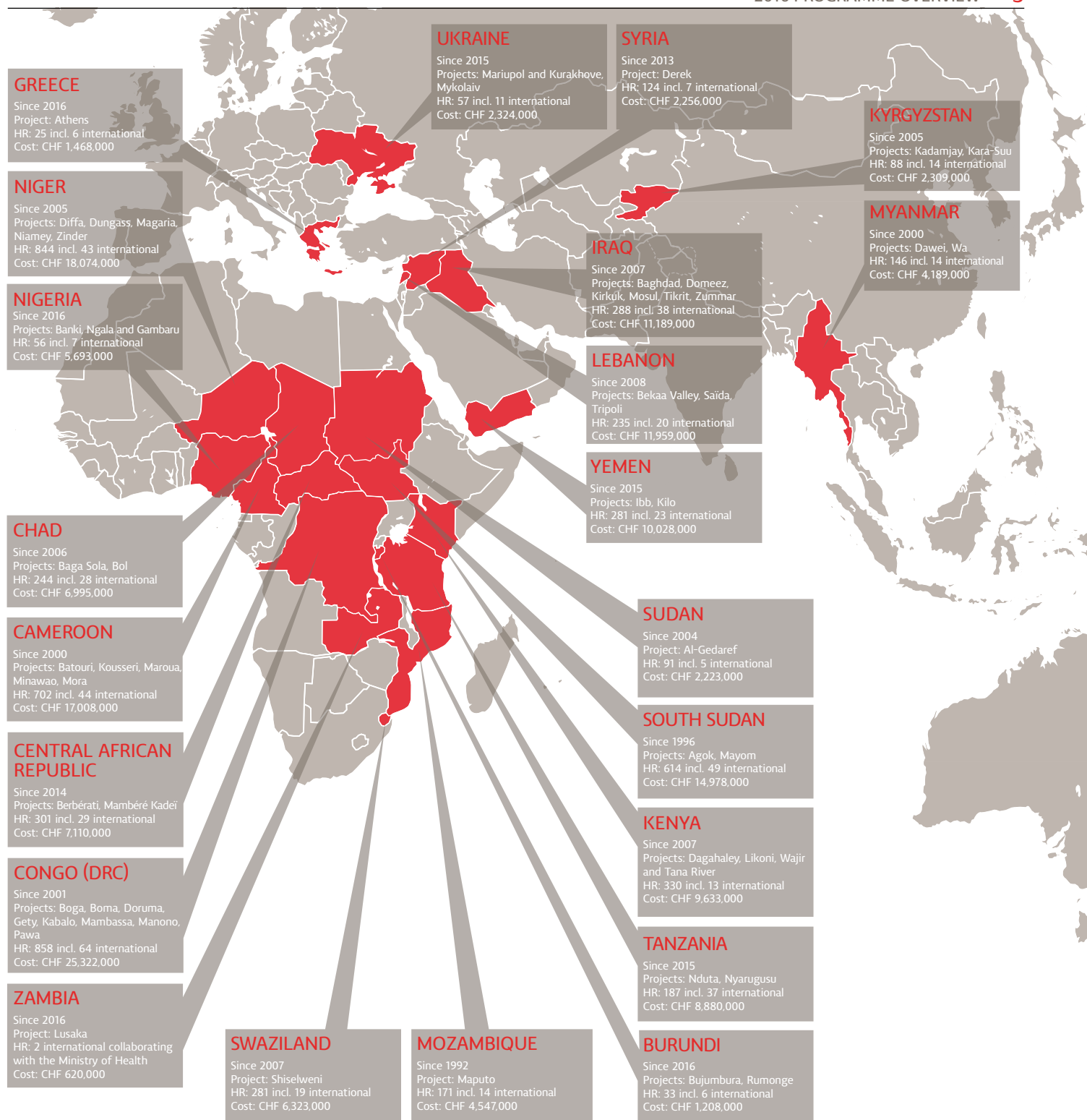


© Natacha Buhler/MSF

JUNE Nigeria: Atrocities committed by Boko Haram and the military response cause half a million people to flee their homes in Borno State. When the MSF teams manage to enter the enclaves of displaced people, they find an appalling situation in terms of health and nutrition.



© Sylvain Cherkaoui/Cosmos



AUGUST Yemen: Civilians and medical facilities regularly come under attack in this conflict. On 15 August, the hospital supported by MSF in Abs is bombed, and there are many casualties. MSF temporarily evacuates its staff from six hospitals in the north of the country.



© Mohammed Sanabani/MSF

SEPTEMBER Advocacy: Constant lobbying for the protection of facilities and medical staff. Although the UN Security Council eventually adopts a resolution in favour of this, MSF condemns its lack of impact, particularly in Aleppo, in Syria.



© Paulo Filgueiras

OCTOBER Kenya: Dadaab, the world's largest refugee camp, is threatened with closure. MSF speaks out publicly against the forced return of people to Somalia, which it considers inhumane and irresponsible.



© Brendan Banno

NOVEMBER Tanzania: Burundian refugee crisis in Tanzania, with all three camps at full capacity. MSF scales up its activities and appeals for an increase in international aid.



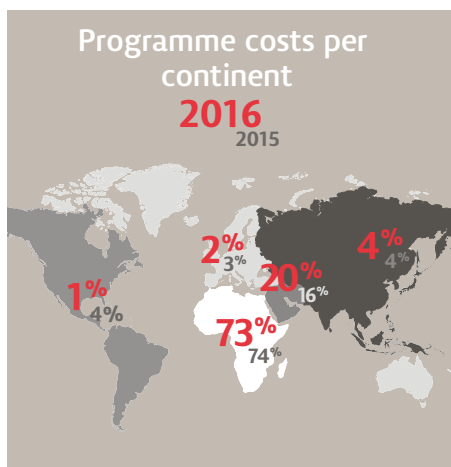
© Louise Annaud/MSF

DECEMBER Iraq: The Iraqi army launches an offensive to retake Mosul. MSF sets up an emergency surgical unit to operate on the injured and provides medical and humanitarian assistance to people fleeing the fighting.



© Karin Ekholm/MSF

OVERVIEW OF THE YEAR



Against a backdrop of growing international tension, 2016 was heavily marked by conflicts and consequent population displacements. Many of the affected areas were even harder for humanitarians to access. The year saw the deepening regional war in the Middle East, the regional consequences of the conflict in Borno state, Nigeria, the renewed civil war in South Sudan and many other neglected crises in Democratic Republic of Congo (DRC), Burundi and Somalia. While there have been advancements in terms of access to people in need thanks to major efforts in our negotiation strategies and capacities, MSF teams are nonetheless forced to make constant compromises and innovations in their modus operandi and activities to continue assisting people otherwise deprived of any aid. Additionally, epidemics – often not declared of international concern – remain significant killers in low-resource countries. Strategies to prevent or contain major outbreaks were put in place by MSF in several regions. Finally, concerns over the growing privatisation of the global health agenda as well as the planned reduction of UN funding by the new US administration create another layer of uncertainty that may affect response to medical humanitarian needs in the near future.

ADAPTING TO INCREASINGLY CHALLENGING SITUATIONS AND NEEDS

In 2016, after three years of savage conflict affecting people who were already extremely vulnerable, MSF finally gained access to key areas of Borno state in Nigeria. Security constraints were tight and, in the face of very high mortality rates, compromises had to be made regarding our modus operandi. Our teams were often accompanied by armed military escorts because of the high risk of attacks; and it took several weeks to obtain permission to visit certain remote areas such as the town of Rann, where operations did not start until early 2017. However, teams from MSF Operational Centre Geneva (MSF OCG, operating under the responsibility of MSF Switzerland) were able to access two sites, Banki and Ngala/Gambaru, and to adapt activities and strategies, enabling them to assist people quickly and effectively.

Understanding the regional dynamic in such a situation was key. MSF OCG had launched projects in Chad and in the Extreme North region in Cameroon a year before to assist Nigerian refugees, internally displaced and victims of violence. This presence at the periphery was crucial in terms of access, negotiations and operations. In 2016, we scaled up our activities in north Cameroon, particularly in terms of mass casualty planning and surgery in Maroua and Kousséri as a response for the victims of suicide attacks.

There are limits to the compromises that can be accepted, however. We questioned whether we should be working in Al Thawra hospital in Ibb governorate in Yemen, where it was difficult to establish a neutral medical space in which to work under normal conditions: armed guards were present within the facility and propaganda of belligerent parties was visible. Yemen is today a failed state, and despite all possible efforts and discussions with stakeholders, we ended up working in a conflict zone where the necessary neutrality could not be guaranteed, and our integrity was compromised to an unacceptable extent. This situation led to the closure of one of our projects in the country.

Finally, we spent most of the year developing an effective approach for responding to the urgent needs of displaced people, notably around Mosul in Iraq. As a result of our engagement and our tailor-made activities, we were able to open projects in Tikrit, redesign and adapt our programme in Zummar, northwest of Mosul, and start working in Mosul city.

STRENGTHENING AND TAILORING OUR NEGOTIATION STRATEGIES AND CAPACITIES TO IMPROVE ACCESS

In 2016, we implemented a variety of interesting negotiation processes that had different outcomes. The common element of these negotiations was that we always approached the stakeholders with a solid strategy, and constantly adapted to each situation, working with and drawing on the strengths of the whole MSF movement.

More than three years after we decided to withdraw from Somalia following a series of critical incidents affecting our staff, in 2016, the International Board of MSF gave the green light for teams to return. This is a key example of intersectional collaboration. MSF plans to work in Somalia again in 2017. Activities will begin cautiously and progressively, with a single representation, operational line and approach to security management. The aim is also to ensure that people are better prepared to work in this environment, and that greater responsibilities are assigned to national staff.

Our negotiation efforts in 2016 led to two new opportunities for projects: in Burundi, with the official registration of MSF OCG in the country, and in Sudan, where after several years of total impasse, talks opened to bring about changes in rules for West Darfur visas.

1,286,055
outpatient consultations

86,166
patients admitted

117,347
antenatal consultations

18,134
births assisted

380,904

malaria cases treated

20,994

children admitted to inpatient feeding programmes

34,901

children admitted to outpatient feeding programmes

18,723

HIV patients on antiretroviral treatment

1,582

tuberculosis patients

273

MDR tuberculosis patients

5,986

surgical procedures

36,273

individual mental health consultations

8,631

group mental health consultations

53,869

children vaccinated against measles

In 2016, we also focused on reinforcing the training of our staff in negotiation, particularly via the official launch of the Centre of Competence for Humanitarian Negotiations in collaboration with the International Committee of the Red Cross.

An official intersectional MSF visit to Damascus facilitated by the Russian authorities unfortunately did not translate into concrete steps for access to government-held territories, despite several years of effort and networking.

In many situations, negotiation efforts have to be significantly strengthened and oriented towards armed non-state actors (ANSA) such as Boko Haram, Daesh or Al-Shebab. This has to be done to ensure safety for our teams and to improve our ability to assist people. These specific groups are the focus of an engagement strategy with ANSA and other key actors that are at the core of our 2016–2019 Strategic Plan.

IMPLEMENTING MEDICAL STRATEGIES TO BETTER ANTICIPATE AND RESPOND TO EMERGENCIES

As we strove to constantly improve our response to complex challenges in the field, medical ambitions and innovations remained a priority for MSF OCG in 2016.

Mass casualty planning and hospital management

In Cameroon, in collaboration with the health authorities, we managed a massive influx of wounded patients using the mass casualty plan. This plan was then successfully replicated in countries such as Yemen and Iraq. In the event of a major incident, hospitals using this plan are ready to respond and manage a sudden influx of patients requiring urgent surgical treatment. The aim is to save as many lives as possible, even if the region's usual medical treatment capacity is overstretched.

In 2016, we invested significantly in opening several inpatient departments and hospitals, and increasing surgical activities. Because of the different expertise involved in the management of health facilities, we identified the need to guide our teams with a better coordinated support. Logistics, operational, medical and human resources departments will therefore define common priorities and produce the right material needed to implement improved hospital-level actions in the field.

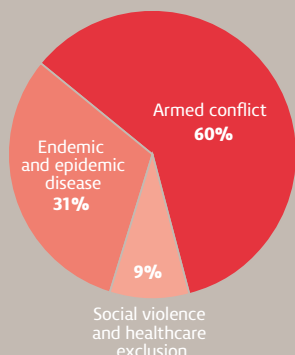
Vaccination strategies (including new products and operational approaches) at the heart of our emergency response

Following major international investments, measles deaths fell by 79 percent between 2000 and 2015. Nevertheless, reduced political commitment and therefore reduced vaccination coverage in certain regions of the world in recent years have led to large-scale measles outbreaks and a setback in the reduction of measles mortality. Katanga in DRC is the perfect example of a region where the lack of national commitment and investment resulted in a disproportional outbreak. This outbreak necessitated the intervention of several MSF operational centres including OCG, which played a critical role. Unless there is a coordinated effort from national authorities and global health organisations, these outbreaks will recur year after year, affecting the same people and exposing them to the repeated risk of excess mortality.

In 2016, a new vaccine against rotavirus was successfully trialled in Niger through a collaboration with Epicentre, MSF's epidemiology research unit. Diarrhoea is the second-biggest killer of infants and children worldwide. Most of these deaths occur in low-income countries, where access to water and sanitation is very limited and people are unable to get the medical care that could save their children's lives. In such situations, preventive measures such as vaccinations can have an enormous benefit. This is also the case with large population influxes and in refugee camps where the water and hygiene conditions are poor. Pre-emptive vaccination prevents unnecessary deaths from diarrhoea.

The new vaccine trialled by MSF OCG has several major advantages over existing vaccines. It is heat-stable for several months, allowing for easier transport to remote areas and communities that have limited access to health services and therefore need the vaccine most. It is adapted to the strains of rotavirus present in sub-Saharan countries. Moreover, the vaccine is affordable, so that even low-income countries in sub-Saharan Africa can sustainably introduce it into their routine immunisation programmes. We expect the vaccine to be registered in African countries soon and to receive the necessary WHO pre-qualification so that it can be purchased by the different UN agencies and used for displaced populations where water and sanitation are a challenge.

Programme costs per reason of intervention



Our Zambia project was a good example of the successful use of oral cholera vaccination. Taking into account the shortage of this product worldwide, OCG managed to prove the efficiency of administering one dose in a rapid response to an outbreak. The campaign was able to provide protection for 423,774 people, thanks to a preparedness plan and the excellent cooperation with the national authorities.

Policies and recommendations regarding cholera have improved as a result of OCG's significant investment over the past few years. Teams have demonstrated that the new vaccine is a vital element in the control of outbreaks, it does not require cold-chain storage, it can be used safely during pregnancy, and because one single dose is effective in an epidemic response. These findings have been incorporated into policies by the World Health Organization and some countries, and also into some national guidelines.

The meningitis vaccine covers only certain serotypes that are not necessarily responsible for a specific outbreak. In 2015, in Niger, when we had very few vaccine doses for serotype C, we decided to prepare a prophylactic protocol to see whether, by administering just one specific drug to prevent meningitis in a small population, we could reduce the possibility of an outbreak for which we do not have enough vaccines. Although no major outbreak occurred in 2016, the plan is ready and may roll out in 2017.

There were a few cases of hepatitis E in South Sudan, but because of the previous outbreak in Minkaman, we realised we were not effective enough or too late in our response. Despite efforts to improve water and sanitation, we had no major impact on the number of cases during an outbreak. The availability of a new vaccine ready to be used in an outbreak setting, even if it is not pre-qualified, is a major step, and should be integrated in an experimental response next year.

The product known as rVSV-EBOV seems to be the most advanced experimental vaccine for use in Ebola outbreaks. MSF aims to invest in a contingency plan that will allow for a safe use of this vaccine when an index case (the first case of a given disease or health condition) is identified.

LOOKING INTO 2017

Our activities in and around Mosul that took place at the beginning of 2017 will obviously represent a major operational deployment all through the year. When working in a war zone, close to patients' needs, such action reflects the core of our social mission. We have a huge added value as few other organisations are present in the area at the time of writing. Iraq and Syria will remain at the heart of the international geopolitical tensions in 2017 while the needs of the people trapped in these conflict zones continue to grow.

More generally, responding to people's needs in highly insecure situations will still be one of OCG's main concerns. We continue to run activities in war-torn Yemen, follow up on major population displacements related to crises in South Sudan, Nigeria and around Lake Chad, and will look at working again in Somalia, if feasible. Teams will closely monitor the UN's famine alerts, given that these dramatic levels of acute malnutrition are nearly always related to conflict situations, conduct of war and obstacles for access created by belligerents.

Responding to neglected epidemics will constitute a second major focus. We are currently facing a meningitis outbreak that started in Nigeria and is spreading to Niger, where hepatitis E is also causing concern. We are responding as well to measles in DRC and cholera in a few other places. Furthermore, we will continue to tackle hepatitis C, in particular with the introduction of a new treatment in Ukraine.

In Greece, where we launched activities to assist refugees in 2016, we will also be concentrating on implementing a travel medicine concept for migrants and people on the move, which we are planning to replicate in Honduras and Mexico.

Finally, one of the strategic dossiers that we will be pursuing in the coming year is a new platform for consolidating hospital management support, aimed at strengthening our capacity in 2017. There is also the new emergency preparedness and support project, which will enhance our emergency response in terms of relevance, volume and surge capacities.

Dr Jean-Clément Cabrol,
Director of Operations

Dr Micaela Serafini,
Medical Director

THE YEAR IN PICTURES

Whether in conflict zones, during epidemic outbreaks or after natural disasters, MSF provides medical assistance to people in need and improves their access to healthcare. The organisation speaks out whenever people who suffer are neglected.



Iraq, 2016 © Baudouin Nach/MSF



Yemen, 2016 © Malak Shafer/MSF



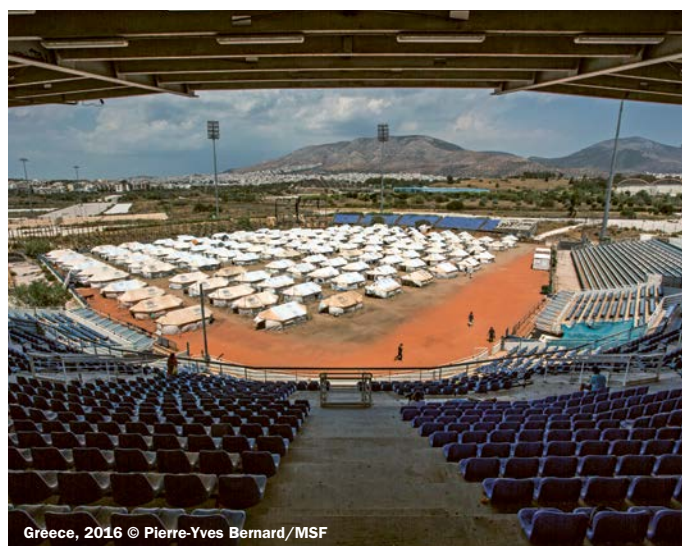
Tanzania, 2016 © Louise Annaud/MSF



Nigeria, 2016 © Sylvain Cherkaoui/Cosmos



Ukraine, 2016 © Maurice Ressel



Greece, 2016 © Pierre-Yves Bernard/MSF

In 2016, people who were forced to flee continued to risk their lives on their journey to exile. Borders were closed and tens of millions of migrants worldwide were stranded in camps, where living conditions were more often than not appalling.



The fight against epidemics is one of MSF's top priorities. Cholera, meningitis, measles or malaria can be easily avoided through tailor-made prevention campaigns. This is why MSF dedicates a large part of its medical and logistic efforts to address epidemics.



Central African Republic, 2016 © Pierre-Yves Bernard/MSF



Niger, 2016 © Louise Annaud/MSF



Central African Republic, 2016 © Pierre-Yves Bernard/MSF



Tanzania, 2016 © Louise Annaud/MSF



Kyrgyzstan, 2016 © Joosarang Lee/MSF

Improving the quality of hospital care helps to reduce mortality rates significantly. MSF therefore supports emergency, maternity units and operating theatres in many hospitals and clinics. In 2016, over 86,000 patients were admitted to hospital.



Cameroon, 2016 © Louise Annaud/MSF



Cameroon, 2016 © Pierre-Yves Bernard/MSF



Lebanon, 2016 © Joosarang Lee/MSF



Yemen, 2016 © Malak Shaher/MSF



Niger, 2016 © Louise Annaud/MSF

Despite several resolutions adopted by the UN Security Council, civil and medical facilities repeatedly come under attack in conflict zones. Consequently, MSF continues to influence public opinion to compel international decision makers to take action.



Syria, 2016 © Karam Almasri



Yemen, 2016 © Rawan Shaif



Switzerland, 2016 © Reto Albertalli/Phoveo

FORCED TO FLEE: IN DEFENCE OF HUMAN DIGNITY

MSF has been helping displaced persons, asylum seekers and refugees since its creation; in 2016, around 40 per cent of MSF's projects were aimed at providing these groups with essential aid. The report entitled *Global Trends: Forced Displacement in 2015*, published by the United Nations High Commissioner for Refugees (UNHCR) on 20 June 2016, estimates that there were 65 million forced migrants worldwide in 2015, double the amount recorded five years earlier. As their numbers reach historic peaks, MSF has stepped up its support for people who have fled danger or lack means of subsistence in Africa, the Middle East and also in Europe. It is currently difficult for humanitarian organisations to access people and provide them with the help they need to survive in conflict zones; and neighbouring and host countries often react with restrictive policies and various forms of institutional violence or mistreatment that exacerbate refugees' state of vulnerability. To express its condemnation of these intolerable practices, MSF took the decision not to attend in the 2016 World Humanitarian Summit in Istanbul, in a move to urge states to fulfil their responsibilities and to make a stand against the policy of the European Union by rejecting, for an indefinite period, any further support for our programmes around the world from the EU and its member states.

HISTORIC LEVELS OF FORCED MIGRATION

In 2015, of the 65 million forced displaced persons, UNHCR estimated that there were 21.3 million refugees and 40.8 million people displaced within their own countries. Although the European media keep talking about the 'migration crisis', more than 85 per cent of refugees worldwide are in Africa, the Middle East and Asia. Many of the host countries face difficult political, economic and health conditions. The main reasons why people flee their homes are conflicts and persecution, which exacerbate the already endemic economic difficulties and poverty. Leaving all their possessions behind, huge numbers of displaced persons live in camps, deprived of freedom of movement and the right to work, and do not have access to healthcare or decent living conditions. Another striking fact is that 51 per cent of displaced people are minors, over half of whom are unaccompanied. These damning figures highlight the tragic plight of so many.

MSF'S RELIEF RESPONSE

With more than 2.7 million people displaced by violence, the Lake Chad Basin is the scene of a major humanitarian crisis. The abuses committed by Boko Haram and the disastrous consequences of indiscriminate military responses from the region's regular armies have compounded an already serious situation characterised by extreme poverty, nutrition insecurity, frequent epidemics and an almost non-existent health system. In Borno state in Nigeria, southern Niger, Chad and the far north of Cameroon, the MSF teams offer primary healthcare, nutritional care, psychological support and surgical assistance, in addition to providing medical consultations and carrying out vaccination campaigns in villages, towns, and displacement and refugee camps. In the camps, the health and nutrition situations are often worrying, as the refugees are living in overcrowded tents, without access to water. To improve those conditions, in parallel to providing healthcare, MSF is also carrying out sanitation and water distribution activities.

In the Middle East, the organisation is present both near the frontlines and alongside people on migration routes. Many patients have had their treatment interrupted because of war. MSF is concentrating its efforts on sexual and reproductive health, mental health and chronic disease management. A flexible approach is also encouraged through mobile clinics and surgical kits ready to be deployed in an emergency.

STATES SHIRKING RESPONSIBILITY AND EXACERBATING HUMAN SUFFERING

People on the move, whether refugees or migrants, are too often perceived as threats by host countries in Europe, Africa, America and Asia. Even though many of these families are in situations of immediate danger and are vulnerable to abuse by criminal networks, security tends to be the main preoccupation, together with the perceived threat that migrants pose to the local economic and social balance. Reactions of fear and rejection are on the rise, and the measures taken by some governments involve tightening of borders, limitations of freedom and even sending migrants back to conflict zones.

Indeed, the treaty between the European Union and Turkey provides for the return of irregular migrants arriving in Greece, without considering their asylum applications, even though the countries of Europe made a commitment to offer asylum and protection to refugees. The EU member states have even proposed outsourcing the processing of asylum applications to camps in Libya, a country locked in civil war, where migrants are subjected to appalling abuses, extortion and other forms of systematic violence. The message is clearly to discourage them, without any real consideration for their fate. The human consequences of these protectionist measures have been so dramatic that some humanitarian organisations have launched their own sea rescue teams and emergency programmes to mitigate the initial lack of a public response worthy of the name. MSF continues to save, care for and provide logistical support for afflicted people, while bearing witness to the dire situations prompting the ongoing flight of migrants northwards.

The Kenyan government was planning to close Dadaab, the world's largest refugee camp, which would have forced its inhabitants to return to Somalia, a country ravaged by war and on the brink of famine. Together with other humanitarian agencies, MSF denounced this flagrant violation in a report published in October 2016, describing the Kenyan government's plan as "inhumane and irresponsible". Kenya's High Court eventually declared the closure of the camp illegal.

Another example of state disengagement can be found in Tanzania, where refugees fleeing the crisis in Burundi continue to be crammed into three overcrowded camps. The decision to open a fourth camp has still not been taken, and the Tanzanian government is toughening up its measures against refugees fleeing persecution, making MSF's intervention even more difficult.

HUMANITARIAN ORGANISATIONS AS COMMITTED PARTIES

Providing humanitarian aid to victims means that NGOs constantly have to ask themselves how they can most effectively organise their aid programmes – for example, how they can best help people on the move – as well as about what vigilance role they should play in societies that are divided over the question of taking in those seeking refuge and security. For MSF, it is essential to reiterate that aside from questions of legal status, every human being in a situation of great vulnerability has the right to dignity, protection and care. Furthermore, in the interest of protecting people caught in violence, we have to stress to states involved in wars in any capacity – in the Middle East, Libya, the Sahel and Nigeria – that their first responsibility is to show solidarity when those same people try to flee the terrible consequences of those wars.

ACTIVITIES BY COUNTRY

BURUNDI

Emergency response to cholera outbreaks

In the country since: 2016
Reason for intervention: epidemics
Emergency intervention: cholera

Human resources: 33 staff including
(FTE) 6 international staff
Cost for 2016: CHF 1,208,000



© Roger Kiamvu/MSF

In 2016, MSF started working in Burundi, focusing on cholera response.

In 2016, the political situation was tense in Burundi, a country located in the African Great Lakes region. This was exacerbated by economic difficulties, especially in Bujumbura, the capital, and by inadequate agricultural production in the east of the country, which increased the risk of food insecurity.

Cholera is endemic in the southwest of the country and an epidemic was officially declared by the Ministry of Health between August and

November 2016. MSF responded to two cholera alerts during the peak season in Bujumbura Rural province, setting up cholera treatment centres in Ruziba and Kabezi. MSF's programme included providing medical care for patients, training staff to improve treatment of both simple and complicated cases, and epidemiological surveillance. Overall, MSF teams treated 295 patients. To prevent the spread of the disease, 2,832 homes were disinfected and 872,000 litres of water were distributed in Ruziba and Kabezi.

MSF teams also began planning the support they are going to provide to the medical emergency and referral system at Rumonge hospital and nearby facilities. The objective is to strengthen the hospital's response capacity in emergency care. The project, which will also involve training for Ministry of Health staff, will be implemented in 2017. MSF is ready to intervene the event of an emergency in the country.

CAMEROON

Bringing relief aid to people affected by violence

In the country since: 2000
Reason for intervention: armed conflict, displacement
Main activity: hospital care, surgery, water and sanitation

Human resources: 702 staff including
 (FTE) 44 international staff
 Cost for 2016: CHF 17,008,000



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MSF provides medical care and surgery for displaced people and host communities.

Since 2011, violent attacks by Boko Haram and the counterinsurgency operations of the Nigerian army have forced hundreds of thousands of people from northeast Nigeria to seek refuge in Cameroon, Chad and Niger. By the end of the year, there were around 86,000 refugees and 198,000 internally displaced people in Cameroon.

In response, MSF scaled up its activities in several locations in the north of the country, providing healthcare, including maternal services and nutritional support, in the UNHCR-administered Minawao camp. MSF staff carried out 58,147 consultations during the year. They also improved water and sanitation, trucking in 3,000 cubic metres of water per week and assisting with the construction of 32 kilometres of pipes to find a permanent solution to the scarcity of water in the camp. MSF had been running an inpatient therapeutic feeding centre and the paediatrics department at Mokolo hospital, but handed over

these activities to another international organisation in May.

In Mora town, near the Nigerian border, MSF offered specialised nutritional and paediatric care at the hospital and supported two health centres serving displaced people and local residents. The team also ran an ambulance service and started surgical activities in response to a large influx of wounded patients; 246 patients were treated following violent attacks in 2016.

MSF has completely renovated the operating theatre and post-surgical ward at Maroua hospital. Between August and December, the team carried out 737 surgical interventions at the hospital.

In Kousseri, on the Chadian border, MSF supported the surgical ward at the district hospital, performing caesarean sections and emergency interventions. MSF staff also provided nutritional and

paediatric care at the hospital and outpatient consultations in three health centres on the outskirts of the city. In addition, MSF trained Ministry of Health staff in the management of large influxes of wounded patients.

Since 2014, MSF has been supporting the Ministry of Health by providing medical, nutritional and psychological support to refugees from the conflict in neighbouring Central African Republic, as well as host communities, in several locations. As the situation stabilised, MSF gradually handed over its activities. In June, MSF handed over its last project at the district hospital in Batouri. Teams in Batouri had supported the local health authorities in managing patients with severe complicated malnutrition, the majority of whom were children under five. Since the 90-bed therapeutic feeding centre opened in March 2014, 2,853 children had been treated by the end of 2016.

CENTRAL AFRICAN REPUBLIC

Providing support to a fragile health system

In the country since: 2014
Reason for intervention: healthcare exclusion, epidemics
Main activity: primary healthcare, sexual and reproductive health, vaccination

Human resources: 301 staff including
 (FTE) 29 international staff
Cost for 2016: CHF 7,110,000

Ongoing political unrest and outbreaks of violence have resulted in a protracted humanitarian crisis in the Central African Republic (CAR). After the crisis in 2013, it was hoped that the elections in early 2016 would lead to a return to constitutional order, but large areas of the country remain under the control of armed militias. It is also estimated that one fifth of CAR's population are currently internally displaced or have fled to neighbouring countries. The health system is unsteady and malaria remains the leading cause of mortality in children under five in CAR.

In 2014, MSF opened a project in Berbérati, CAR's second-largest city. The aim was to reduce

mortality and morbidity rates in pregnant women and children under 15 by improving the capacity and quality of healthcare offered by the Ministry of Health, as well as the ability to detect and respond to emergencies. In 2016, MSF continued to support the regional university hospital in the city and four outlying health centres to improve access to both primary and secondary healthcare. At the hospital, MSF supported paediatric care, treatment for HIV, mental health and health promotion services, including medical and psychological care for victims of sexual violence. An MSF team also assisted in the laboratory. In the health centres, MSF supported paediatric and sexual and reproductive health, as well as nutrition services. Overall in 2016,

4,232 children were admitted to hospital, and 1,688 deliveries were assisted. MSF also trained medical staff to ensure that the quality of care is maintained after the team hands over its medical activities in Berbérati to the Ministry of Health in 2017.

Between December 2015 and June 2016, MSF undertook a multi-antigen vaccination campaign across Berbérati, with the objective of protecting children under five against up to nine common but vaccine-preventable diseases, including polio, diphtheria, tetanus, whooping cough, measles, hepatitis B and certain strains of pneumonia. MSF managed to reach 99,000 children in this campaign, which consisted of three rounds of vaccination.



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MSF supports the paediatric department of Berbérati hospital, with a special focus on newborns.

CHAD

Assisting people fleeing violence

In the country since: 2006
Reason for intervention: armed conflict, displacement
Main activity: hospital care, primary healthcare, mental healthcare

Human resources: 244 staff including
 (FTE) 28 international staff
Cost for 2016: CHF 6,995,000

With more than 2.7 million people uprooted from their homes, the Lake Chad basin is currently experiencing one of Africa's biggest humanitarian crises. Violence caused by Boko Haram and the military response of the government resulted in massive displacements of population. The situation in Chad itself is insecure, and there is widespread instability in the neighbouring countries of Nigeria, Niger and Cameroon. According to figures released by the United Nations in December 2016, there are around 105,000 internally displaced people and 8,200 refugees within the Chadian part of the Lake region, over 5,000 of whom have been living in Dar es Salam refugee camp since the beginning of 2015.

Because the under-resourced Chadian health system is struggling to meet the immense medical needs in this region, MSF provides support to both primary and secondary health services.

This year, MSF continued its project in Baga Sola, which opened in 2015, and developed additional activities in and around Liwa. In 2016, these activities included around 81,000 health consultations, around a quarter of which were for children under five, and approximately 57,000 antenatal consultations. Teams treated over 5,500 patients for malaria. Psychologists also provided consultations in Dar es Salam refugee camp: overall, around 1,500 individual mental health consultations were carried out.

Since 2015, MSF teams have also been supporting the management of sexual and reproductive health at the regional hospital in Bol, assisting more than 400 deliveries, including over 80 caesarean sections, and admitting more than 1,200 patients to the paediatric ward this year. The mobile clinic MSF runs from Bol provided around 20,700 primary health consultations, a third of which were for children under five. In addition, the mobile team screened over 6,600 children for malnutrition and treated more than 500 for severe acute malnutrition.

DEMOCRATIC REPUBLIC OF CONGO

Responding to numerous health emergencies

In the country since: 2001
Reason for intervention: armed conflict, displacement, epidemics
Main activity: hospital care, primary healthcare, sexual and reproductive healthcare
Emergency intervention: malaria, measles

Human resources: 858 staff including 64 international staff
Cost for 2016: CHF 25,322,000



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In DRC, MSF tackles medical emergencies, especially during outbreaks, and delivers care to severely malnourished children.

This vast country is plagued by ongoing regional conflicts, outbreaks of disease and poor or non-existent infrastructure, all of which result in bad health indicators and difficulty in accessing those who most need help. Moreover, elections were supposed to take place in DRC in November 2016 but have been repeatedly pushed back by current president Joseph Kabila. As a result, there have been tensions in the country.

Evolving health needs and epidemic outbreaks led to emergency projects being launched in Tanganyika province in 2016, while activities continued in the provinces of Haut- and Bas-Uélé and Ituri.

Nationwide military operations were launched in the eastern provinces in 2011, and clashes between armed groups continue. MSF has been working in the area since 2003, helping those with no access to healthcare. The project in Gety began in 2006 and assisted 196,424 people in 2016, including 57,879 internally displaced persons. Although MSF handed over the paediatric ward to the health authorities, it maintained a presence in the emergency room and intensive care unit. MSF also prepared for the gradual withdrawal in 2017

from Gety general hospital by focusing on improving the existing facilities.

The health zone in Boga hosts displaced people who were forced to flee attacks by armed groups in North Kivu in 2015. MSF teams work in Boga hospital, running the intensive care unit and supporting maternity services and the laboratory and preparing a handover in 2018. In the surrounding area, MSF has worked closely with the community, providing mental health services, sexual and reproductive health consultations and care for victims of sexual violence. In 2016, MSF also started providing medical care and psychological support to victims of sexual violence in Mambassa, and treating related infections. Almost a year after its launch, the project had treated 1,107 people.

Because of the high number of health emergencies in Uélé and Ituri, an 'Emergency Response Unit' is in place to monitor and detect alerts, manage exploratory missions and mobilise an emergency response team within 48 hours. In 2016, 12 alerts were investigated and 5 interventions launched, providing treatment for a total of 98,608 patients.



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© Diana Zeyneb Alhindawi

Since November 2015, the conflict in South Sudan has resulted in South Sudanese refugees and Congolese returnees flocking to Doruma and Dungu in Haut-Uélé. In Doruma, MSF has assisted the hospital's emergency and intensive care services, with 10,183 primary healthcare consultations taking place.

MSF teams launched an emergency programme in the province of Tanganyika in August 2015 in response to a measles outbreak. MSF decided to remain at the paediatric unit of Manono hospital in 2016 to treat cases of severe acute malnutrition with complications and other emergencies. In total, 6,639 children were admitted to the paediatric unit, 1,495 to the inpatient feeding programme and 4,983 were treated at ambulatory feeding centres.

At the beginning of May 2016, MSF responded to a malaria outbreak in the health zones of Pawa and Boma-Mangbetu. Two hospitals, sixty-eight health centres and rural health posts were provided with supplies, and the hospitals also received training and human resources support. A total of 29,604 patients in Boma and 51,882 in Pawa were treated.

ECUADOR

In the country since: 2016
Reason for intervention: natural disaster
Emergency intervention: mental healthcare, distribution

Assisting earthquake victims

Human resources: 1 international
 (FTE) collaborating with MSF's Mexican office
 Cost for 2016: CHF 258,000

In April 2016, a 7.8 magnitude earthquake struck the northern coast of Ecuador, killing 660 people, injuring almost 5,000 and leaving more than 33,000 homeless and displaced. The epicentre was in the province of Esmeraldas, and the infrastructure, including some hospitals and health centres, was severely affected in the cities of Esmeraldas and Manta. MSF deployed teams and staff from its Mexican office to assist people in the area between April and May 2016. MSF

conducted an initial assessment in Manabí province, one of the worst-affected areas.

Teams visited 11 localities and found that although the main hospitals showed good capacities and were able to keep running, access to medical care was disrupted throughout the region. It was difficult for the medical teams to reach communities that had been cut off by the earthquake, and people also struggled to get to healthcare facilities.

MSF focused its efforts on providing mental health support and distributing relief items. Overall, teams distributed around 500 hygiene kits, and the same amount of cooking kits and tents, as well as mattresses, blankets, plastic sheeting and 10 water tanks.

GREECE

In the country since: 2016
Reason for intervention: displacement
Main activity: primary healthcare, mental healthcare, vaccination

Supporting refugees and migrants on the road to exile

Human resources: 25 staff including
 (FTE) 6 international staff
 Cost for 2016: CHF 1,468,000



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Over 60,000 migrants and refugees are living in camps in Greece. MSF delivers primary healthcare, conducts vaccination campaigns and provides mental healthcare.

In early 2016, thousands of people fleeing war and persecution were arriving on the Greek islands every day, hoping to continue their journey through Europe. This changed in March, however, when the European Union (EU) decided to close the Balkan route and the EU–Turkey deal was adopted: around 60,000 migrants and refugees were left stranded in Greece, living in poor conditions without access to basic services, adequate shelter or information on their legal status.

In April, MSF started providing healthcare to refugees and migrants in Athens. From April until the end of the year, MSF's mobile teams carried out 2,030 sexual and reproductive healthcare and 733 mental health consultations in the camps of Elliniko (close

to the capital) and Thermopiles (in central Greece). In June and July, MSF supported Greek health authorities to carry out a vaccination campaign in the settlements of Elliniko, Thermopiles and Piraeus and in Athens. By the end of the year, over 5,000 babies and children under the age of 15 had been vaccinated against several childhood diseases, among which measles, tetanus, whooping cough, influenza, polio, hepatitis B and certain strains of pneumonia.

Given the dramatic humanitarian and medical consequences of the restrictive EU migration policy, MSF continues to advocate for people seeking protection, in order to provide safe passage for refugees and improve living conditions for those trapped in Greece.

Vazir's story

Vazir and Ameneh have been in Greece for six months: "We left Afghanistan because the Taliban were threatening our lives. I don't know which story to share first: the cold, the various difficulties? I'll tell you the scariest: when we reached Turkey, we were told we had to cross the sea on our own. I started to swim with my wife on my back. The water was very deep; it was impossible. We got very scared. Luckily we found somebody who helped us cross. Here in Athens, MSF is following my wife's pregnancy. I was a farmer in Afghanistan and I would like to start working again. Above all, we want a normal life."

HONDURAS

Treating victims of sexual violence

In the country since: 1998
Reason for intervention: healthcare exclusion, sexual violence
Main activity: outpatient care, mental healthcare, health promotion
Emergency intervention: dengue, Zika and chikungunya viruses

Human resources: 39 staff including
 (FTE) 2 international staff
Cost for 2016: CHF 1,160,000



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MSF offers psychological aid to victims of violence through workshops, which help patients acquire coping methods to deal with their trauma.

Honduras has experienced years of political, economic and social instability. Drug trafficking, extortion, gang violence, the proliferation of firearms and a weak judicial system are just some of the issues plaguing the country. Sexual violence is a widespread problem that has a major medical, psychological and social impact on the population.

MSF continued to run its 'priority service' project for people exposed to violence, especially sexual violence, in Tegucigalpa and Comayagüela – the two cities forming the country's capital, which together have around 1.5 million inhabitants. In collaboration with the Honduran Ministry of Health, this confidential, one-stop service offers emergency medical and psychological aid to victims at two health centres, at the attorney's office, and in Tegucigalpa's main hospital.

Medical treatment for rape victims includes post-exposure prophylaxis to prevent HIV infection and protection against other sexually transmitted infections and tetanus. Mental healthcare comprises counselling, group therapies and psychological first aid. In 2016, MSF treated over 900 victims of violence, including 561 who had suffered sexual violence, and carried out 1,830 mental health consultations.

To make people aware of the consequences of violence and inform victims about the 'priority service', MSF provided training for healthcare staff and individuals from other organisations in schools and other places in the community. A team continues to work directly in the neighbourhoods, thereby strengthening the connection with the local communities.

The emergency contraceptive pill remains banned in Honduras, despite ongoing debates in the Honduran Congress to change the policy on emergency contraception. MSF continues to advocate access to medical care (including emergency contraception) for victims of sexual violence.

MSF also supported the activities to improve control of the *Aedes* mosquito, the insect responsible for the transmission of Zika, dengue and chikungunya. These included a vector analysis to gather information and community outreach to inform people about fumigation and other ways of controlling the proliferation of the mosquito.

IRAQ

Providing access to healthcare in conflict areas

In the country since: 2007
Reason for intervention: armed conflict, displacement
Main activity: hospital care, primary healthcare, mental healthcare

Human resources: 288 staff including
 (FTE) 38 international staff
 Cost for 2016: CHF 11,189,000



In Iraq, MSF has to adapt continuously to the changing situation in the conflict zones, providing access to healthcare to those who need it most.

Armed conflicts still force millions of Iraqis to flee their homes in search of safety in other parts of the country or across the borders. Part of the population is still living in zones controlled by the Islamic State of Iraq and Syria (ISIS), which are bombed by Iraqi army planes and the international coalition. Because of obvious security constraints in active conflict zones, numerous checkpoints imposed by some warring parties and the impossibility to negotiate access in ISIS-held areas, humanitarian assistance is very scarce. According to UN agencies, an estimated 8 million people are in need of essential healthcare services in the country, the majority of them are women and children under five.

In the Kurdistan Region of Iraq, MSF continues to provide primary healthcare for Syrian refugees settled in Domeez camp. Activities include treating non-communicable diseases, offering mental support, and a programme for sexual and reproductive health including a maternity service running 24/7, which is now in the process of being handed over to the Ministry of Health. In 2016, 24,254 sexual and reproductive consultations took place and assistance was provided with

1,155 deliveries. In Zummar area, recently retaken from ISIS and a few kilometres from Tal Afar, MSF ran eight mobile clinics focusing on sexual and reproductive health, non-communicable diseases and psychological support. In 2016, 3,716 non-communicable disease consultations were provided. In October, the organisation opened a 24/7 maternity service in Tal Maraq, to provide life-saving obstetrics care. Patients in need of emergency surgery or blood transfusions were referred to other facilities via the MSF ambulance system.

In preparation for the Iraqi army's offensive to regain Mosul from ISIS, MSF set up an inflatable temporary field surgical unit. When the fighting started in October, patients were stabilised with emergency medical care and referred to hospitals in Dohuk or Shikhan, if needed. To provide life-saving care closer to the frontlines, two advanced medical posts were set up in the periphery of the city and. Their location will change according to how the contact lines move.

In Kirkuk as well, MSF focuses on areas close to frontlines to offer quality primary healthcare to

displaced populations. Some activities were handed over to another humanitarian organisation in June.

In April 2016, after Tikrit was retaken, the MSF team assessed the situation and made plans to address the needs of the people recently displaced by the military offensive. In July 2016, two mobile clinic teams focusing on primary healthcare provided 15,769 consultations and held mental health sessions with 5,408 participants.

In Abu Ghraib Baghdad Governorate, mobile clinics and fixed structures provided a total of 34,276 primary healthcare outpatient consultations for the internally displaced and the local population. With the number of new arrivals starting to decline in mid-year, MSF's activities in Karma and north Abu Ghraib were reviewed.

Working space in Iraq is limited and has to be constantly renegotiated because of security constraints. Delivery of aid is a daily struggle for most humanitarian agencies, including MSF.

KENYA

Addressing the needs of the most vulnerable

In the country since: 2007
Reason for intervention: displacement, epidemics
Main activity: hospital care, primary healthcare, sexual and reproductive healthcare
Emergency intervention: cholera, chikungunya

Human resources: 330 staff including
 (FTE): 13 international staff
 Cost for 2016: CHF 9,633,000

Dadaab in the east of Kenya is the world's largest long-term refugee settlement. It currently provides shelter for 280,000 refugees, mostly Somalis fleeing the conflict and subsequent chaos that have been ravaging their country for a quarter of a century. Since 2009, MSF has been the main healthcare provider at the Dagahaley camp in Dadaab, running a 100-bed hospital and two health posts. In 2016, the teams provided 157,096 outpatient consultations, 8,723 patients were admitted to the inpatient department and 3,019 babies delivered.

In May, the government announced that the camps would be closed by November. Relief agencies were concerned that refugees would be forced to return to Somalia, despite an agreement stating that any returns should be "voluntary". To gain a better understanding of the concerns of

those living in the camps, MSF conducted a study among more than 800 of them in August 2016. Over 80 per cent of those interviewed consider Dadaab home and were unwilling to return, as they are afraid of the daily violence and the lack of healthcare in Somalia. After being pressured by humanitarian agencies such as MSF, the government postponed its decision until May 2017, but the refugees were still facing an uncertain future.

In December, a national doctors' strike paralysed the public health system, resulting in an increase in the number of patients coming to MSF-supported facilities. In Likoni, in the Mombasa area, MSF introduced sexual and reproductive healthcare in cooperation with the local authorities. While MSF started work on building a permanent structure, a temporary solution was found with a container

village, including surgical capacity for obstetric emergencies (around 60 per month).

In 2016, MSF responded to various cholera outbreaks in north-eastern and coastal Kenya, in particular by setting up a 120-bed cholera treatment centre and training Ministry of Health staff and distributing water treatment packages to 5,728 households. At the same time, MSF also treated around 1,150 patients suffering from the chikungunya virus and distributed 2,800 treated mosquito nets. Poor crop harvests in the southeast resulted in a food shortage for three million Kenyans, including 300,000 children likely to develop malnutrition. The government has stepped up its emergency-response efforts by distributing food and water. MSF is monitoring developments and will, if necessary, be ready to intervene further in 2017.



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MSF opened a maternity ward in Likoni to allow women to safely give birth.

KYRGYZSTAN

Continuing the fight against tuberculosis

In the country since: 2005
Reason for intervention: epidemics
Main activity: tuberculosis

Human resources: 88 staff including
 (FTE): 14 international staff
 Cost for 2016: CHF 2,309,000

The prevalence of drug-resistant tuberculosis (DR-TB) remains very high in Kyrgyzstan, and many people struggle to access second-line treatment when the first one is not effective, because the healthcare system is inadequate and underfunded. Furthermore, the current treatment can last up to two years and result in severe side effects, so many patients fail to complete the course. MSF's main goal in the country is to encourage decentralised DR-TB treatment to improve management of the disease and patient adherence.

In Kara-Suu district, in the region of Osh, tuberculosis (TB) rates are among the highest in the country. In 2016, MSF continued to provide

outpatient care for people with DR-TB, thereby limiting the time they have to spend in hospital and allowing them to stay at home while undergoing the treatment. Patients attended monthly medical consultations at one of the three Ministry of Health TB clinics supported by MSF. These consultations included psychological support, helping them to adhere to the arduous treatment. If patients were unable to come to the clinic for check-ups, staff visited them in their homes. Patients with the more severe forms of the disease were admitted to hospital. MSF supported Kara-Suu hospital, which has 40 beds for DR-TB inpatient care, and provided follow-up for patients receiving treatment at Osh TB hospital. MSF also mentored Ministry of

Health staff, and as a result of MSF's advocacy, the decentralisation of DR-TB treatment has now been adopted as a key strategy by the ministry.

In 2016, as part of the 'EndTB' project, MSF worked on the preparation of clinical trials to improve the treatments for DR-TB and make less toxic and shorter regimens available. These are set to start by mid-2017.

In December, in the south-western city of Aidarken in Batken district, MSF launched a project to address the higher incidence of non-communicable diseases, potentially caused by environmental pollution from mining.

LEBANON

Providing relief aid to refugees

In the country since: 2008
Reason for intervention: displacement
Main activity: sexual and reproductive healthcare, primary healthcare, mental healthcare

Human resources: 235 staff including
 (FTE) 20 international staff
 Cost for 2016: CHF 11,959,000



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In Lebanon, MSF addresses the needs of the most vulnerable, with a special focus on sexual and reproductive health.

More than 1.5 million Syrians have fled into Lebanon since the conflict began in 2011, making Lebanon and Jordan the countries hosting the largest proportion of refugees in the world. This influx has put an additional strain on the country's economy and infrastructure, particularly the health sector. Despite the efforts of the Ministry of Health and UNHCR, access to medical services has become increasingly difficult, if not impossible, for vulnerable people such as Lebanese returnees, Palestinian and Syrian refugees, as well as host communities. MSF therefore continues to expand its medical response and provide high-quality primary healthcare, including reproductive health services, mental health support and health promotion activities, mainly in the Bekaa Valley

and the north of the country. MSF also offers treatment for chronic diseases, such as diabetes and hypertension.

Based in four different locations – Hermel, Aarsal, Baalbek and Majdal Anjar – the project in the Bekaa Valley is aimed primarily at responding to the health needs of refugees and the vulnerable host population. New additions to the programme in 2016 were a mother-and-child centre in Majdal Anjar, which assisted with an increasing number of deliveries throughout the year, a laboratory to ensure immediate and accurate test results, also in Majdal Anjar, and a mental health project. A total of 137,463 consultations were conducted as part of the Bekaa Valley programme, nine

per cent more than in 2015. On a less positive note, the security situation in Aarsal prevents international staff from working there.

Since 2012, MSF has also been providing primary healthcare to Syrian refugees and vulnerable host communities in north Lebanon through three clinics in Tripoli – Jabal Mohsen, Bab el Tabbaneh and Dar Al Zahraa – and one in Abde. Services include treatment for chronic non-communicable diseases (only available in Dar Al Zahraa and Abde) and acute diseases, sexual and reproductive healthcare and mental health support. MSF teams conducted a total of 121,185 consultations in 2016, a considerable increase over last year.

MEXICO

Supporting victims of urban violence

In the country since: 2013
Reason for intervention: social violence, healthcare exclusion
 Main activity: hospital care, outpatient care, mental healthcare

Human resources: 23 staff including
 (FTE) 7 international staff
 Cost for 2016: CHF 1,070,000

Although Mexico has one of the highest per capita incomes in Latin America, there is widespread social and economic inequality in the country. Some rural areas are subject to seasonal epidemics and poverty-related diseases such as tuberculosis, cholera and Chagas disease, a tropical infection transmitted by the triatomine bug, but have limited access to healthcare. Mexico is also affected by drug-related and social violence, and much needs to be done to improve security for the general population.

In the coming years, Mexico will face significant challenges in its relationship with the US. New US immigration and deportation policies have caused alarm in Mexico and other Central American countries, particularly with regard to the plight of undocumented migrants.

In 2016, MSF continued to address the direct and indirect consequences of violence in Reynosa, a northern city on the Texan border. Between the end of 2015 and June 2016, MSF supported the expanded emergency department at Reynosa general hospital,

reinforcing medical services and training personnel with a particular focus on assisting victims of violence, including sexual violence. MSF set up a triage area to manage patients as they arrived at the hospital and introduced a treatment protocol for victims of violence.

After the project was successfully completed in June, MSF decided to remain in the city to extend comprehensive assistance to victims of violence in several neighbourhoods in the city, where they are often reluctant to seek treatment in a hospital.

MOZAMBIQUE

Improving the treatment of HIV/AIDS and tuberculosis

In the country since: 1992
Reason for intervention: epidemics
 Main activity: HIV/AIDS, tuberculosis, mental healthcare

Human resources: 171 staff including
 (FTE) 14 international staff
 Cost for 2016: CHF 4,547,000



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In Mozambique, MSF focuses on treating HIV-positive people with medical complications or those suffering from serious opportunistic diseases.

Despite efforts to halt the spread of HIV/AIDS in recent years, Mozambique remains one of the countries with the highest rate of infection, with an estimated adult HIV prevalence of 11.5 per cent. The country also has one of the highest rates of HIV and tuberculosis (TB) co-infection in the world, resulting in an increase in the number of cases of multidrug-resistant TB (MDR-TB). In 2016, MSF continued to collaborate with the government to develop innovative strategies to combat the epidemic and respond to emergencies such as cholera outbreaks.

Since 2001, MSF has been supporting the Ministry of Health to ensure access to comprehensive healthcare for HIV and TB patients. Teams operated in six health centres and one referral facility in the capital Maputo. In 2016, MSF's

activities focused on complicated HIV cases, including patients for whom treatment with antiretroviral drugs has failed or who have developed co-morbidities, such as MDR-TB, Kaposi's sarcoma and other cancers, viral hepatitis or other opportunistic infections. During the year, more than 2,300 patients, including 160 children, received specialised HIV care. As part of the strategy to improve quality of care, MSF teams monitored HIV patients' viral load. MSF also supported the Ministry of Health in a dedicated MDR-TB programme in which more than 170 patients received treatment this year. New TB drugs were also successfully registered in the country.

In early 2016, MSF started mental health activities for HIV and TB patients with the support of the

Ministry of Health. Overall, around 400 consultations were carried out. Not surprisingly, a large number of patients were diagnosed with depression. While most patients started psychotherapy, some were treated with medication. The more difficult cases were regularly discussed by a multidisciplinary team, including social workers, psychologists and doctors.

More generally, 2016 was marked by a deterioration in Mozambique's economic and political situation. Tensions between the opposition party's militia and state security forces led to sporadic fighting throughout the year and put additional strain on public services. A truce was declared in late December 2016.

MYANMAR

Providing care in vulnerable areas

In the country since: 2000
Reason for intervention: epidemics, primary healthcare, healthcare exclusion, vaccination
 Main activity: HIV/AIDS, tuberculosis

Human resources: 146 staff including
 (FTE) 14 international staff
 Cost for 2016: CHF 4,189,000

Although the National League for Democracy party took power in Myanmar in March 2016, the military retains significant control over the country. There has been little improvement regarding human rights and humanitarian access in many areas. The people of Myanmar are still suffering the consequences of decades of authoritarianism, and access to medical treatment remains limited, particularly for marginalised communities and certain ethnic groups.

In Dawei district, in Tanintharyi region, MSF is one of the main healthcare providers. Its clinic continues to target high-risk and vulnerable groups in the community such as sex workers, men who have sex with men and migrant workers. The main

focus is the treatment of patients with HIV/AIDS and tuberculosis (TB). In 2016, MSF had 2,355 patients on antiretroviral therapy for HIV and 111 patients on treatment for TB.

In addition, MSF treats HIV patients co-infected with diseases such as cytomegalovirus retinitis (a neglected opportunistic disease linked to HIV/AIDS which can cause permanent blindness) and hepatitis C. This year, some hepatitis C patients started a new, more affordable and more effective oral treatment which has fewer side effects.

In Wa Special Region 2, in the eastern part of the country, the provision of healthcare is extremely

reduced. Because of a worsening political situation and MSF's inability to secure access to the region for international staff, medical activities were limited in 2016. Despite this, in the remote Pang Yang and Lin Haw townships, MSF conducted over 9,000 outpatient consultations through fixed and mobile clinics.

Between January and March, MSF also supported the Ministry of Health's catch-up vaccination campaign for 10,951 children under five in Lahe township, Sagaing region. Children were immunised against a number of diseases, including polio, diphtheria, tetanus, whooping cough, measles and hepatitis B.

NIGER

Facing malnutrition and malaria

In the country since: 2005
Reason for intervention: epidemics, displacement
 Main activity: hospital care, primary healthcare, health promotion

Human resources: 844 staff including
 (FTE) 43 international staff
 Cost for 2016: CHF 18,074,000



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In Niger, MSF provides care to children suffering from severe acute malnutrition. Prevention activities and response to epidemic outbreaks are also key activities in the country.

Niger's human development index remains one of the lowest in the world. By 2016, 20 per cent of the population were suffering from severe food insecurity, exacerbated by numerous epidemics such as measles, meningitis and malaria. One of MSF's primary objectives in Niger is reducing mortality among children under five, and responding to epidemics is a key part of its activities. In March, teams vaccinated 84,747 people against meningitis and 45,982 against measles when there were outbreaks in Tillabéri, Zinder and Diffa.

The Lake Chad area of Niger continues to suffer the consequences of the conflict between Boko Haram and the armed forces. According to local authorities, at the end of 2016 there were over 240,000 refugees and internally displaced people in Diffa, as well as 100,000 local residents living in precarious conditions, vulnerable to violence and disease. MSF started working in Diffa in

June 2015, to provide access to primary healthcare. Throughout the year, MSF worked in seven health centres in the area, and undertook 77,570 consultations.

Every year, the levels of childhood mortality and morbidity increase during the peak malnutrition and malaria season in Magaria health district, and in the rest of Niger. In 2016, MSF continued to support Magaria district hospital and offered high-quality care in a paediatric unit and an inpatient therapeutic feeding centre, which had 600 beds at the peak of the season. In addition, MSF supported 11 health centres by providing primary healthcare to children under five, and reinforced the hospital referral system for the most severe cases. More than 13,300 children were admitted to hospital in Magaria and over 66,500 were treated in rural areas. Of those admitted, over 50 per cent were suffering from severe acute malnutrition.

MSF teams also ran community-based activities to combat malaria, including seasonal malaria chemoprevention – the repeated administration of antimalarials as a prophylactic – for more than 117,000 children in eight health zones in Magaria district.

In the nearby district of Dungass, MSF opened another 200-bed paediatric unit during the peak season, and between June and December, 3,885 children were admitted. Of these, 47 per cent were severely malnourished.

Since 2005, MSF has been supporting the Ministry of Health-run national hospital in Zinder, south-central Niger, as well as the district of Zinder, to treat children under five suffering from malnutrition. Emergency paediatric care was also provided during the peak malnutrition and malaria season. After a progressive two-year handover, MSF withdrew from the project in December 2016.

NIGERIA

Delivering life-saving assistance to internally displaced people

In the country since: 2016
Reason for intervention: armed conflict, displacement
Emergency intervention: primary healthcare, water and sanitation, vaccination

Human resources: 56 staff including
 (FTE) 7 international staff
 Cost for 2016: CHF 5,693,000



© Sylvain Cherkaui/Cosmos

MSF works to reduce the main causes of death in internally displaced people's camps in Nigeria, where humanitarian indicators are far below the emergency threshold.

Since 2013, Nigeria has been in a state of chronic insecurity following the intensification of attacks by Boko Haram and the government's counterinsurgency strategy. In Borno, where most of the population is affected by violence, 1.4 million people have been forced to flee their homes and seek shelter in camps. The living conditions are extremely poor, with nearly no access to basic services or assistance until mid-2016. When MSF arrived, many people were in a very weak state of health, with indicators far below the emergency threshold. Today, humanitarian needs are still far from being met because of the difficulty of delivering aid in such a challenging security situation, which imposes operational compromises such as the use of armed escorts in certain extreme situations.

In July, MSF teams managed to start working in the camp in Banki, in the northeast of the country. The camp was established by the Nigerian authorities after the town was retaken from Boko Haram in September 2015. Medical care, sanitation activities and food distribution were organised by MSF to reduce morbidity and

mortality from malnutrition, malaria and diarrhoea. Before MSF's intervention, people were lacking food and basic items and had less than five litres each per day for drinking, cooking and all their household needs. Within four months, the water ratio per person had increased fourfold. MSF also provided nutritional support for 2,300 families, before the distribution was handed over to other relief agencies. To prevent the spread of disease, teams distributed malaria chemoprophylaxis during the peak season and organised a large-scale measles vaccination campaign, which reached more than 13,500 children under the age of ten. After several months of activities in Banki, it was evident that the living and health conditions in the camp had improved significantly.

In October, MSF launched another emergency intervention following the same model, further north, closer to the border with Cameroon, a region where violent attacks are rife. The camps in Ngala and Gambaru shelter 35,000 and 80,000 people respectively. The residents are cut off from the outside world and desperately in

need of food, water and healthcare. In and around the town of Gambaru, which had suffered several deadly Boko Haram attacks before it was retaken by the Nigerian army, MSF found that more than one in seven children were suffering from severe acute malnutrition.

In Ngala camp, the situation was catastrophic, with people having less than half a litre of water each per day. Here again, MSF implemented an efficient water distribution system, managing to increase the allocation to 12.8 litres per person per day. MSF teams also distributed soap and mosquito nets to decrease the risk of water-borne diseases and malaria. In addition, the preventive strategy against a potential measles outbreak employed in Banki was replicated in both Ngala and Gambaru, and more than 37,500 children were vaccinated.

Despite MSF's efforts to negotiate access to Rann, insecurity and later floods prevented the teams from reaching this small town hosting thousands of displaced individuals.

SUDAN

Treating neglected diseases

In the country since: 2004
Reason for intervention: healthcare exclusion
 Main activity: kala azar (visceral leishmaniasis)

Human resources: 91 staff including
 (FTE) 5 international staff
 Cost for 2016: CHF 2,223,000

Humanitarian needs were massive in Sudan in 2016. Ongoing conflicts and high levels of insecurity in many parts of the country had a severe impact on the population. It is estimated that 3,200,000 people are internally displaced, and refugees, mostly from South Sudan, continue to arrive. Sudan was also hit by numerous epidemics, particularly of water-borne diseases and measles, and the already limited health services struggled to cope. Medical care became completely

unavailable in certain regions when the authorities prohibited access for foreign organisations.

MSF has been working in Al-Gedaref state since 2009, and this year continued to run the facility for the diagnosis and treatment of kala azar (visceral leishmaniasis) in Tabarak Allah and supervise referrals to Al-Gedaref teaching hospital. Kala azar is a parasitic disease transmitted by sandflies, which initially causes skin sores or ulcers,

and in its more severe form attacks the immune system, leading to organ failure. In November, MSF started to support Bazura hospital, which is located in another high endemic area, providing logistical support and staff training. In 2016, of the 2,180 people screened, 545 were admitted to hospital, and 98 per cent of these were successfully treated.

Plans to open a paediatric care project in West Darfur were postponed until 2017 for administrative reasons.

SOUTH SUDAN

Ensuring access to healthcare in a volatile environment

In the country since: 1996
Reason for intervention: armed conflict, epidemics
 Main activity: hospital care, primary healthcare, HIV/AIDS and co-infections
 Emergency intervention: malaria, measles

Human resources: 614 staff including
 (FTE) 49 international staff
 Cost for 2016: CHF 14,978,000



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In South Sudan, MSF focuses on primary and secondary healthcare and treats patients suffering from neglected diseases or snakebite.

South Sudan is still struggling to recover from the war of independence that led to its creation in 2011. Not only is it the youngest country in the world, but also one of the least developed, and it is repeatedly beset by crises. Intense violence and fighting continue throughout most of the country, causing huge numbers of people to flee: 1.8 million had been displaced by the end of 2016. Three-quarters of the population do not have access to basic medical care and 80 per cent of health facilities are run by non-governmental organisations. To address the shortage of health services, MSF provides essential, high-quality primary and secondary healthcare in Agok, in Abyei Special Administrative Area, and Mayom, in former Unity state.

MSF has been working in Agok since 2008, and this year continued to focus on improving the quality of secondary healthcare, in particular emergency surgery, obstetric care, malnutrition and treatment of HIV, tuberculosis (TB) and snakebites. MSF has increased case detection and treatment initiation for HIV and TB and improved access to care for neglected diseases. Overall, 7,662 patients were admitted to Agok hospital. An around-the-clock obstetric unit is now available, and MSF assisted with 1,630 deliveries, including more than 90 caesarean sections. In villages around Agok, MSF deploys mobile teams to detect and treat malaria: 40,115 patients with simple malaria were treated in 2016. MSF's effective and accurate



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epidemiological surveillance system enabled teams to respond to two measles outbreaks, one of which was during the malnutrition peak. A total of 430 measles cases were detected, isolated and treated.

MSF's project in Mayom provides primary health-care, basic emergency treatment and stabilisation before referral to the main hospital in Agok if necessary. Prevention strategies and emergency response preparedness are key components of the programme. In 2016, staff carried out 50,748 outpatient consultations, admitted 1,580 patients to the emergency and stabilisation unit, and improved access to treatment for HIV and TB.

SWAZILAND

Improving the management of HIV and tuberculosis

In the country since: 2007
Reason for intervention: epidemics
 Main activity: HIV/AIDS, co-infections

Human resources: 281 staff including
 (FTE) 19 international staff
 Cost for 2016: CHF 6,323,000



© Alexis Huguet/MSF
 The decentralisation of treatment is at the heart of MSF projects in Swaziland.

The major humanitarian needs in Swaziland, a small landlocked country in southern Africa, are inextricably linked to the dual HIV/AIDS-tuberculosis (TB) epidemic. Swaziland still holds the unfortunate record of having both the highest estimated HIV prevalence in young adults (29 per cent in 15-49-year-olds) and the highest estimated TB incidence rate in the world.

Collaborating with the Ministry of Health to respond to these epidemics, MSF continues to improve the quality of healthcare and access to treatment for HIV and TB patients through further decentralisation of services in Shiselweni region, a rural area in the south of the country that is particularly affected. The programmes deliver care close to where patients live, taking it from the regional hospital and health centres to

primary healthcare clinics, and providing treatment for HIV and TB in the same consultation space. This eliminates the need for patients to travel long distances, improves their adherence to treatment and enables MSF to diagnose and treat more people. In 2016, MSF teams continued to support the integration of HIV and TB care in 22 primary healthcare clinics, and strengthened the implementation of community HIV and TB treatment strategies. Throughout the year, 15,773 patients received antiretroviral (ARV) therapy and more than 400 were treated for TB. A key focus of the programme is the control and prevention of opportunistic infections.

The HIV 'test and treat' pilot project continued in Shiselweni too, and by October 2016 it was adopted by the Ministry of Health as national

policy. This project provides ARV treatment to all HIV-positive people without restriction, because it has been demonstrated that it makes the virus almost undetectable in blood and other body fluids, thereby reducing HIV transmission by 96 per cent. It has proven to be one of the most effective tools currently available.

In 2016, the country suffered a major drought, and MSF distributed nutritional supplements to HIV patients to reduce gastrointestinal disturbances caused by their treatment.

In September, MSF started to offer cervical cancer screening and treatment with the aim of decreasing morbidity and mortality. MSF supported the Ministry of Health in the implementation of these activities, and 865 women were screened.

SYRIA

Providing relief aid to displaced people

In the country since: 2013
Reason for intervention: armed conflict, displacement
 Main activity: hospital care, primary healthcare, sexual and reproductive health

Human resources: 124 staff including
 (FTE) 7 international staff
 Cost for 2016: CHF 2,256,000

With the conflict showing no signs of resolution, the plight of the Syrian people continues to worsen. Since the war started five years ago, around 4.7 million people have fled to neighbouring countries and more than 7.6 million have been displaced within the country, trapped between the ever-shifting frontlines with no access to essential aid or healthcare. Medical facilities and staff have not been spared either, as they have come under frequent attack this year. The MSF project in Hassakeh governorate, in northeast Syria, provides free, high-quality healthcare, focusing in particular on

emergency assistance, mother and child health and non-communicable diseases.

In 2016, MSF continued to offer primary healthcare consultations to displaced and host communities. Overall, 44,873 outpatient consultations and 5,598 sexual and reproductive health consultations were carried out. MSF also assisted with 1,325 deliveries, including 281 caesarean sections, at Derek national hospital and the newly opened Tal Kocher maternity hospital, and conducted health promotion sessions targeting patients suffering from chronic diseases, to help them understand the importance of adhering

to treatment. Because of the volatility of the situation, the changing frontlines and the violent clashes between the various warring parties, MSF is still unable to work in some areas. The abduction in January 2014 of five staff members (liberated five months later) forced MSF to close several of its programmes. Although providing medical assistance to the Syrian people remains a priority for MSF, negotiations with the official government and the opposition continue to be difficult, and no long-term authorisation to work in the country has ever been given.

TANZANIA

Assisting refugees in overcrowded camps

In the country since: 2015
Reason for intervention: displacement, epidemics
Main activity: hospital care, primary healthcare, water and sanitation

Human resources: 187 staff including
 (FTE) 37 international staff
 Cost for 2016: CHF 8,880,000



© Louise Annaud / MSF

The humanitarian situation for refugees in the camps in Tanzania is critical. MSF works in clinics and hospitals to ensure people's access to healthcare.

The major humanitarian challenge in Tanzania stems from its geographical position as a relatively stable country surrounded by unstable neighbours. By the end of 2016, Tanzania had hosted around 65,000 refugees from Democratic Republic of Congo (DRC) and 215,000 from Burundi in three camps in the western region of the country. The political status quo in Burundi and a deterioration in the economic situation there triggered mass displacement across the Tanzanian border. The local community in Tanzania is struggling to cope with the flow, the capacities of both governmental and non-governmental organisations working in Tanzania's camps are stretched beyond their limits and the government's decision to open a fourth camp is long overdue.

The humanitarian situation is even worse in the overcrowded camp of Nduta, where MSF is the main healthcare provider. Opened in October 2015, Nduta camp had reached its capacity of 55,000 by

April 2016 (the number of occupants had climbed to nearly 90,000 in December 2016). Nevertheless, the camp has continued to receive most of the new arrivals from Burundi – around 10,000 per month. MSF is responsible for providing primary and secondary healthcare, working in a hospital (120 beds) and in five health posts, where a total of 186,346 consultations took place in 2016. In 2016, MSF assisted with 3,005 deliveries in the hospital's maternity unit. MSF also helped with water and sanitation activities, with 180,000 litres of water distributed daily. Furthermore, teams at Nduta camp have been providing mental healthcare and been involved in health promotion activities.

At the start of 2016, MSF continued to deploy mobile clinics for outpatient consultations and introduced a feeding programme at the hospital in Nyarugusu, in cooperation with the Tanzanian Red Cross. At the end of March, the general clinics

were replaced by specific health posts to treat malaria patients, as the disease is the major cause of mortality among children under ten. Poor living conditions in the mass shelters also increase the risk of transmission. By December, 46,383 malaria outpatient consultations had taken place. MSF also set up a 40-bed emergency room and stabilisation unit, with 1,847 patients able to consult medical staff over a four-month period. As the refugee population has also suffered emotional trauma, mental health support is an essential part of the project. In 2016, 82,360 people attended health promotion sessions. The teams have also been working on the camp's water-pumping activities, which were due to be handed over to a partner.

MSF fears that the already dire health status of refugees will deteriorate further as a result of the lack of funding and subsequent cuts in aid, and has been repeatedly calling for assistance at the camps from other organisations.

UKRAINE

Treating people along the frontline

In the country since: 2015
Reason for intervention: armed conflict, epidemics
Main activity: primary healthcare, mental healthcare

Human resources: 57 staff including
 (FTE) 11 international staff
 Cost for 2016: CHF 2,324,000



© Maurice Ressel

MSF runs mobile clinics to reach patients suffering from chronic non-communicable diseases.



© Maurice Ressel



© Maurice Ressel

In 2016, the conflict in eastern Ukraine entered its second year, taking a heavy toll on both sides of the frontline, as many people were displaced and essential services, including healthcare, ceased to function. Ceasefires were repeatedly broken, and shooting and artillery duels were commonplace. With little political progress, the fighting has continued, further exacerbating the physical and mental health problems of people living in or along the buffer zone separating the two sides, who have limited access to medical care.

In 2016, three MSF mobile teams based in Mariupol and Kurakhove, consisting of a doctor, a nurse and a psychologist, carried out close to 21,000 medical consultations and around 2,600 mental health consultations in 26 different locations in and along the buffer zone. MSF runs these mobile clinics in health facilities, community buildings or even empty schools and kindergartens. The majority of patients were elderly people unable to leave the area. MSF

continued to focus mainly on the treatment of chronic non-communicable diseases, a programme launched in 2015. Teams conducted nearly 18,000 consultations for these patients in 2016.

In October, MSF began to set up a project to manage integrated hepatitis C (HCV) treatment for high-risk and vulnerable groups in Mykolaiv. Ukraine has the highest prevalence of HCV in Europe and one of the lowest treatment rates. The situation is compounded by the lack of affordable generic drugs to treat HCV, particularly in Mykolaiv, an urban, industrialised region, which is also severely affected by the HIV epidemic, with rates three times higher than the rest of the country. In collaboration with the local health authorities, MSF will start to treat HCV patients in the third quarter of 2017.

MSF has been denied authorisation to work in non-government-controlled areas in eastern Donetsk since autumn 2015. By the end of 2016,

nearly all international humanitarian organisations were prohibited from operating there. MSF is extremely concerned about this situation, and remains committed to finding a way to restart its activities and assist people in urgent need of care.

Raisa's story

Raisa is 80 years old and lives in Taramchuk, a small village close to the frontline. In August 2014, her house was destroyed by shelling and she's now living in the house of a neighbour, who fled when the fighting intensified.

"We feel completely lost here and are very scared," says Raisa. "We hear bombs all the time. Life here is awful, and sometimes I even think of suicide. I'm so distressed to be in this situation at my age."

YEMEN

In the country since: 2015
Reason for intervention: armed conflict
Emergency intervention: hospital care

Providing life-saving care in a war-torn region

Human resources: 281 staff including
 (FTE) 23 international staff
 Cost for 2016: CHF 10,028,000

After nearly two years of war, the lives and safety of millions of people are still under considerable threat. Ongoing air strikes and fighting are causing daily casualties and frequent damage to civilian infrastructures, thus making it even more difficult to provide humanitarian assistance. It is estimated that more than half of Yemenis were not able to receive adequate healthcare in 2016. Since the beginning of the conflict in 2014, the number of displaced people inside the country has grown to approximately two million.

MSF has launched a series of new activities in the southern part of the country to meet the acute medical needs and provide emergency life-saving health services for the people caught up in the war. In the governorate of Ibb, MSF has been working with the Yemeni Ministry of Health and Population to provide medical care in the emergency room of Ibb Al Thawra hospital since the beginning of 2016. The teams have substantially

improved the emergency response procedures at the hospital and boosted the quality of care for the patients. More than 41,200 patients were admitted to the emergency room in 2016. MSF has also provided assistance by donating drugs and medical equipment. Furthermore, the teams have been giving mass-casualty training sessions, thereby improving patient triage to ensure greater efficiency when responding to incidents. Ministry of Health staff have been able to attend other training sessions as well, including epidemic response, where they learn how to manage cholera patients in the event of an outbreak. These training sessions are an important focus of MSF's work, as the most basic needs in the country are far from covered.

MSF is also improving the medical care provided at a district hospital in a small city in the south of the governorate, closer to the city of Taiz, where intense fighting occurs daily. The main objective

here is to reduce the mortality of the victims of the conflict by ensuring access to high-quality, life-saving care. MSF has improved the surgical capacity, inpatient department and emergency ward at the hospital. Up until now, 6,081 patients have been stabilised by the teams in the emergency room. Specified training sessions have also been provided for all doctors working in intensive care.

After numerous attacks against facilities that are either run or supported by MSF, including a deadly attack in Abs, causing the death of 19 patients and staff, MSF was forced to withdraw temporarily from the northern part of the country. One of the main challenges of MSF's programme in a country where armed conflict has become the norm is to acquire and maintain basic security guarantees for the teams and to boost respect for the organisation's principles of impartiality, independence and neutrality.



© Malak Shaher/MSF



© Malak Shaher/MSF



© Malak Shaher/MSF

MSF supports emergency and surgical units in Yemeni hospitals.

ZAMBIA

In the country since: 2016
Reason for intervention: epidemics
Emergency intervention: cholera

Vaccinating against cholera

Human resources: 2 international staff
 (FTE) in collaboration with the Zambian Ministry of Health
 Cost for 2016: CHF 620,000

Although cholera is a major public health issue in Zambia, with epidemics typically occurring during the rainy season, the outbreak in February was the first to hit the capital Lusaka since 2011. Around 1.2 million people live in overcrowded informal settlements in the city, and with such a long period since the last outbreak, they had little acquired immunity to the disease.

MSF, together with the Zambian Ministry of Health and the World Health Organization, conducted the largest oral cholera vaccination campaign to be undertaken during an epidemic during this outbreak. Between 9 and 25 April, the oral cholera vaccine was administered to 423,774 people aged one and over in the four areas of Lusaka

that had the highest rates of cholera, or had historically been prone to outbreaks: Kanyama, Bauleni, George and Chawama. At the same time, the Ministry of Health provided care for patients in cholera treatment centres and worked to improve sanitation and hygiene conditions.

Two doses of the oral cholera vaccine are typically recommended. However, because of the limited number of vaccines available globally, and to curb the Lusaka outbreak as quickly as possible, a single dose administered to twice as many people was deemed more efficient. More than 100 MSF and Ministry of Health staff, as well as 1,700 volunteers, worked in the vaccination campaign. The Lusaka health

authorities estimated that there were 1,079 cases and 20 deaths between February and June.

Mathilda's story

Mathilda got vaccinated with her daughter, Edna, who had just turned three.

"In our neighbourhood, we have no clean water. People leave their rubbish in the streets and nobody does anything. I came as soon as I heard about the vaccination. The vaccine will help protect us against cholera. It can save lives. I encourage other mothers and community members to come and get vaccinated ... it's important that we are all protected."

HUMAN RESOURCES

In 2016, we scaled up our activities, deploying 6,300 people in 25 different countries and at the Swiss headquarters (an increase of 17 per cent in comparison with 2015). Almost half of our operations now deal with unstable situations, which are continually increasing in number.

Our teams who work in Iraq, Yemen, South Sudan, Niger and the border regions of Cameroon and Nigeria have to manage these complicated situations so that they can care for patients. Repeated attacks against hospitals, the difficulty in accessing the places where patients are located and the daily security-related restrictions weigh heavily on our teams and the entire support chain, up to the head office and MSF partner offices. Some of the biggest humanitarian crises in history are currently unfolding in these places, unwitnessed, and every day we fight to provide medical care to those who need it most.

Our teams also set out on new missions, such as providing medical aid to refugees from Burundi in the camps of Tanzania, fighting epidemics in the Democratic Republic of Congo and malnutrition in Nigeria, and operating mobile clinics in Tikrit and Baghdad in Iraq.

These 6,300 employees, who are our most valuable asset, are overwhelmingly recruited in the country of the mission (90 per cent). They know the local cultures, the environment and MSF's mission particularly well. The remaining 10 per cent of our staff are expatriates who provide an outside perspective and specific skills and bring neutrality and impartiality, indispensable to humanitarian action. They are from very varied backgrounds: the majority of them are European (9 per cent are Swiss), almost 20 per cent are from Africa, 9 per cent from North America, 7 per cent from South America and 10 per cent from Asia, Oceania and the Middle East (2015 figures).

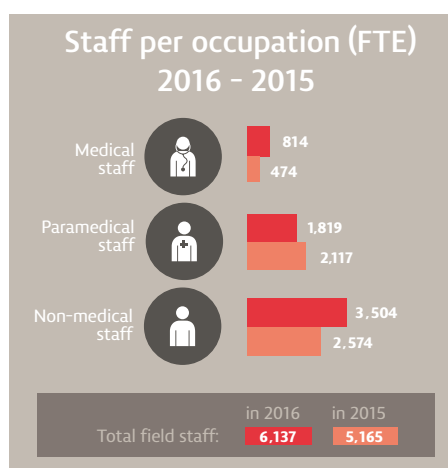
Of particular note are our MSF partner offices around the world, on which we rely more and more, in particular in Mexico and South Korea, and the remarkable work of the recruitment team in the Dakar office in Senegal, which opened at the beginning of 2016. They have enabled us to increase the diversity of our staff, making our teams all the richer; and they have also driven our growth and are helping us adapt to the ever-more complex challenges we face.

We are investing a huge amount in our staff, whatever their role, and particularly in developing their skills so that they can better understand their work, take on more responsibility and build their careers with MSF. This is why we have put in place programmes on knowledge management, support for starting work, career progression, inter-mission mobility and managerial and medical training. In 2016, we provided training for over 2,000 people (an increase of 400 per cent in five years) with a training budget that has increased by 55 per cent in five years. This will remain a priority in 2017.

Finally, the 230 employees at our Geneva and Zurich offices actively support our teams in the field on a daily basis. I would like to thank our many volunteers and all our staff who demonstrate such exceptional professionalism, humanity and commitment.

Aude Thorel, Director of Human Resources

*All data is provided on a full-time equivalent (FTE) basis.
Statistics do not include casual employees, or staff from ministries of health who work as part of our programmes.*



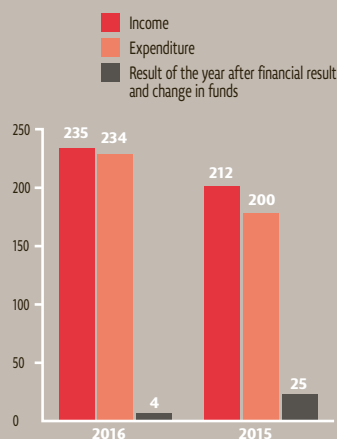
6,137
field staff

232
headquarters staff

2,606
voluntary hours

FINANCIAL RESULTS

Statement of operations (in millions of Swiss francs)



For MSF Switzerland, 2016 was marked by a 17 per cent increase in expenditure, which reached CHF 234 million. The growth in our activity was felt both at headquarters and in the field, with programme expenditure, in its third consecutive year of growth, increasing by 22 per cent (excluding funding to other MSF sections). Expenditure at our headquarters also grew, this time by 19 per cent. After remaining stable in 2015, this figure had to keep pace with the expansion of our missions so that it could continue providing them with high-quality support. Geneva was not the only location to experience this change, as MSF Switzerland has decentralised certain support activities to its regional offices in Dakar, Amman and Beirut.

63 projects were carried out in 25 countries with a budget totalling CHF 183 million, an increase of CHF 33 million. We have set up new projects in Nigeria, Greece and Burundi, and also carried out one-off missions in Zambia and Ecuador. In contrast, we were not present any longer in Sierra Leone, Liberia, Haiti and Austria/Slovenia.

Africa receives almost three-quarters of our budget, accounting for 73 per cent of our programme expenditure, a similar figure to last year. With nine projects and a budget of CHF 25 million, the Democratic Republic of Congo is still the largest beneficiary of our work in the field. We should also mention the Lake Chad region, where we are running nine projects in four countries (Nigeria, Cameroon, Chad and Niger), with a total budget of CHF 29 million. The portion dedicated to the Middle East has risen from 16 per cent to 20 per cent, with a significant increase in our activities in Yemen. The rest of Asia remains stable at 4 per cent. The American continent's share has once again decreased this year, dropping from 4 per cent to 1 per cent, as has that of the European continent, which decreased from 3 per cent to 2 per cent of our programme expenditure.

MSF Switzerland dedicated 92 per cent of its expenditure to its social mission, 5 per cent to fundraising and 3 per cent to management and administration.

Revenue for the year was CHF 235 million, an increase of 14 per cent. CHF 98 million was raised in Switzerland, which is CHF 4 million less than last year (although an exceptional donation of CHF 15 million was received in 2015). Conversely, private funds from MSF Switzerland's partner sections totalled CHF 124 million, an increase of 41 per cent that was largely thanks to MSF United States. Public funding stood at CHF 13 million, down 20 per cent from 2015.

This reduction is the consequence of MSF's decision to suspend all financing from the European Union and its member states as a move to highlight its disagreement with the policies adopted by the EU in response to the migration crisis. The Swiss government now accounts for 54 per cent of our state-funded income.

Overall, 95 per cent of our revenue came from private funds, and 5 per cent from public funds. This reflects MSF's substantial independence from governments.

The financial results for 2016 show a good balance between our expenditure and income, translating into a small surplus of CHF 4 million. Finally, our reserves currently amount to 7.1 months of activity, compared with 8.6 at the end of 2015. These reserves ensure our operational responsiveness and freedom of action.

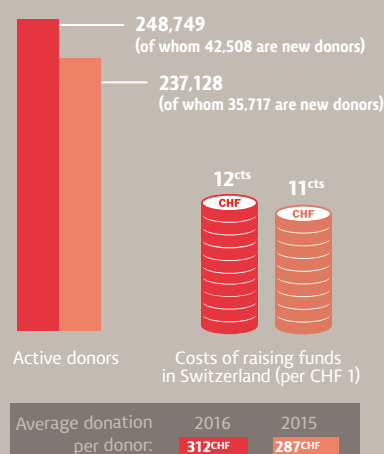
We would like to express our warm thanks to all the donors who have supported us, without whom our work would not be possible.

Geneva, 13 May 2017

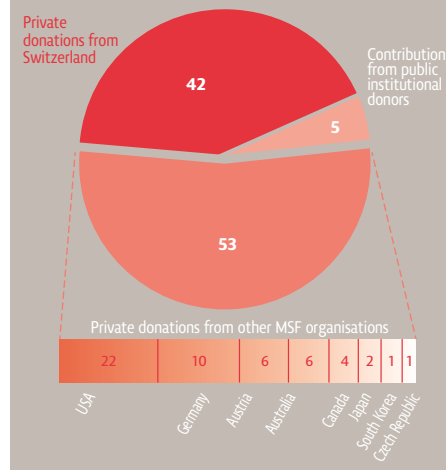
Patrick Reybet-Degat
Treasurer

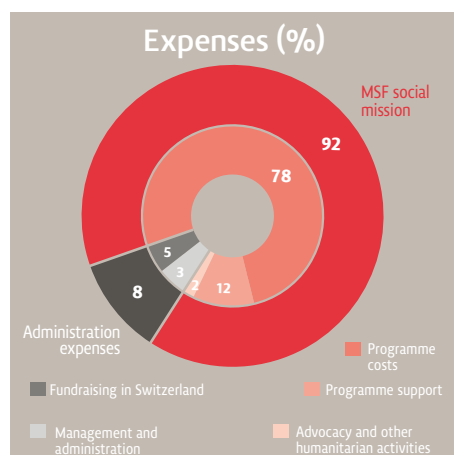
Emmanuel Flamand
Finance Director

Swiss private donations



Income (%)





Expenses (in thousands of Swiss francs)

	2016	2015
Programme costs	183,269	157,385
Programme support	27,685	20,116
Advocacy and other humanitarian activities	4,460	3,757
Social mission expenses	215,414	181,258
Fundraising in Switzerland	11,513	10,700
Management and administration	7,089	7,974
Administration expenses	18,602	18,674
TOTAL EXPENSES	234,016	199,932

Expenses and revenues by project (in thousands of Swiss francs)

	Public funds*	Private funds and other income	Total income	Expenditure 2016	Expenditure 2015
Burundi	-	1,208	1,208	1,208	343
Cameroon	-	17,008	17,008	17,008	13,244
Central African Republic	20	7,090	7,110	7,110	5,751
Chad	4	6,991	6,995	6,995	8,561
Democratic Republic of Congo	2,008	23,314	25,322	25,322	17,749
Kenya	529	9,104	9,633	9,633	8,047
Mozambique	1,125	3,422	4,547	4,547	4,986
Niger	1,109	16,965	18,074	18,074	12,986
Nigeria	-	5,693	5,693	5,693	-
Sudan	400	1,823	2,223	2,223	3,283
South Sudan	2,025	12,953	14,978	14,978	15,490
Swaziland	1,227	5,096	6,323	6,323	6,265
Tanzania	277	8,603	8,880	8,880	6,232
Zambia	26	594	620	620	-
Other	90	2,125	2,215	2,215	5,511
TOTAL AFRICA	8,840	121,989	130,829	130,829	108,448
Iraq	27	11,162	11,189	11,189	9,814
Lebanon	-	11,959	11,959	11,959	9,848
Syria	-	2,256	2,256	2,256	2,311
Yemen	-	10,028	10,028	10,028	2,162
Other	-	128	128	128	-
TOTAL MIDDLE EAST	27	35,533	35,560	35,560	24,135
Kyrgyzstan	400	1,909	2,309	2,309	2,085
Myanmar	1,289	2,900	4,189	4,189	3,084
Other	-	-	-	-	189
TOTAL ASIA	1,689	4,809	6,498	6,498	5,358
Ecuador	-	258	258	258	-
Honduras	-	1,160	1,160	1,160	1,230
Mexico	200	870	1,070	1,070	1,150
Other	-	-	-	-	3,044
TOTAL AMERICA	200	2,288	2,488	2,488	5,424
Greece	-	1,468	1,468	1,468	-
Ukraine	-	2,324	2,324	2,324	3,822
Other	-	-	-	-	191
TOTAL EUROPE	0	3,828	3,828	3,828	4,013
Transversal activities	300	3,766	4,066	4,066	2,428
Financing other MSF sections' projects	-	-	-	-	7,579
TOTAL	11,056	172,213	183,269	183,269	157,385

* Public funds include donations from Swiss cantons and municipalities.

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- AA Germany – Ministry of Foreign Affairs
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- DFATD / IHA – Department of Foreign Affairs, Trade and Development, Canada
- ECHO – European Community Humanitarian aid Office
- Irish Aid – Department of Foreign Affairs and Trade
- SDC – Swiss Agency for Development and Cooperation
- SIDA – Swedish International Development Cooperation Agency
- The Global Fund
- UNFPA – United Nations Population Fund
- UNHCR – The UN Refugee Agency
- UNICEF
- UNITAID
- WFP – World Food Programme

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- Chaîne du Bonheur/Glückskette
- Eckenstein-Geigy-Stiftung
- Fondation Pierre Demareux
- Fondation Rifké
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- Google, Inc
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- IKEA Foundation
- Medicor Foundation
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- République et Canton de Genève
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- Ville de Genève
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- Fondation pour l'aide humanitaire
- Fondation Turangalila
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- Stiftung Symphysis
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- Sunside Treuhand- und Verwaltungs AG
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- Centre hospitalier universitaire vaudois
- CERAH Genève
- Ecolint Genève
- Festival du Film et Forum International sur les Droits Humains Genève
- Fumetto Comix-Festival Luzern
- Hôpital cantonal de Fribourg
- Hôpital Neuchâtelois
- Hôpitaux Universitaires de Genève
- Human Rights Film Festival Zurich
- Inselspital Bern
- Jung von Matt/Limmat AG
- Kantonsspital Luzern
- Kantonsspital Winterthur
- Paléo Festival Nyon
- Planète Santé Lausanne
- Swiss TPH
- Universitätsspital Basel
- Universitätsspital Zürich
- ZHAW Winterthur

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Many thanks to our
248,749
 donors

GOVERNANCE STRUCTURE OF MSF SWITZERLAND

Médecins Sans Frontières Switzerland is an association registered under the Swiss Civil Code in 1981 and governed by legal articles of association, updated in May 2016.

The General Assembly is the supreme governing body of MSF Switzerland. It elects members to the Board of Directors, approves the President's report as well as the annual financial statements and the annual report (also referred to as the activity report), and deliberates on all matters indicated on the agenda.

MSF Switzerland's Board of Directors in 2016

- | | |
|---|--------------------------------------|
| - Dr Thomas Nierle, President | - Gillian Slinger |
| - Dr Anne Perrocheau, Vice-President (re-elected in 2016) | - Claude Mahoudeau |
| - Patrick Reybet-Degat, Treasurer (since May 2016) | - Dr Frauke Jochims (since May 2016) |
| - Dr Philippe Sudre, Secretary (since May 2016) | <u>Co-opted Board Members:</u> |
| - Dr Slim Slama | - Dr Karim Laouabdia |
| - Liza Cragg | - Andreas Wigger |

The Board of Directors is responsible for the overall management and supervision of MSF Switzerland, including setting the organisation's strategic direction, action plans and annual budget.

The Board of Directors has appointed a Finance Committee, composed of Board Members and external representatives. The Committee's mandate is to assist the Board of Directors to supervise the financial management of MSF Switzerland.

MSF Switzerland's Finance Committee in 2016

- | | |
|--|---|
| - Patrick Reybet-Degat, Treasurer of MSF Switzerland and President of the Finance Committee (since May 2016) | - Hans Isler, Financial Expert |
| - Dr Thomas Nierle, President of MSF Switzerland | - Frank Copping, Treasurer of MSF Canada |
| - Marcel Mittendorfer, Member of MSF Austria | - Dr Philippe Sudre, Secretary of MSF Switzerland |
| | - Beth Hilton-Thorp, Member of MSF Australia |
| | - Ralf de Coulon, Financial Expert |

The Board of Directors elects a General Director, who is responsible for executing decisions made by the Board of Directors and overseeing the smooth running of daily operations at MSF Switzerland. The General Director is supported by a Management Team of Directors.

MSF Switzerland's Directors in 2016

- | | |
|--|---|
| - Bruno Jochum, General Director | - Franck Eloi, Human Resources Director (from January until March 2016), Aude Thorel, Human Resources Director (since March 2016) |
| - Susanna Swann, Deputy General Director | |
| - Jean-Clément Cabrol, Operations Director | - Avril Benoît, Communications and Fundraising Director |
| - Micaela Serafini, Medical Director | |
| - Emmanuel Flamand, Finance Director | |
| - Mathieu Soupart, Logistics Director | |

The General Assembly appoints an auditor to audit MSF Switzerland's annual accounts. PricewaterhouseCoopers SA, Geneva, was appointed by the Board of Directors in May 2014 and will henceforth perform this function.

Risk evaluation

MSF Switzerland has conducted within its annual planning process an analysis of potential strategic, operational and financial risks to the organisation. This analysis is led by the Management Team and is subject to approval by the Finance Committee and the Board of Directors. The report covers areas of risk associated with the environments in which MSF operates, as well as internal processes and procedures. Risk mitigation procedures are defined, implemented and evaluated for any identified risks.

The analysis completed at the end of 2016 highlighted a number of issues in 10 internal and external risk areas, including staff security, medical practices, behaviour management, availability of resources and the changing legal landscapes in the countries where MSF Switzerland works.



THE MSF 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:

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.

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