MSF Switzerland

Activity Report 2017

MEDECINS SANS FRONTIERES
ÄRZTE OHNE GRENZEN

MEDECINS SANS FRONTIERES
NOBEL PEACE PRIZE 1999

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.
This report is a translation. Only the French version is legally binding.

IMPRESSUM
Imprint: Médecins Sans Frontières Suisse – **Publisher:** Laurence Hoenig
Managing Editor: Florence Dozol – **Contributors:** Manuel Albela, Federica Alberti, Louise Annaud, Imad Aoun, Guillaume Aspromonte, Lauren Bell, Avril Benoit, Simon Beswetherick, Kristina Blagojevitch, Juliette Blume, Séverine Bonnet, Sara Chare, Ibrahima Diallo, Lucille Favre, Anja Gmür-Kozyra, Marjorie Granjon, Nicolas Joray, Kenneth Lavelle, Etienne L'Hermite, Alexandra Malm, Sally McMillan, Eveline Meier, Jose Michelena, Fabrice Ressicaud, Markus Schnetzer, Marie Zimmerman
Design: Latitudesign.com
Office in Geneva: Rue de Lausanne 78, P.O. Box 1016, 1211 Geneva 1, tel. 022/849 84 84
Office in Zurich: Kanzleistrasse 126, 8004 Zürich, tel. 044/385 94 44
www.msf.ch – **PC account:** 12-100-2 – **Bank account:** UBS SA, 1211 Geneva 2, IBAN CH 1800240240376066000

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2017

started with a tragedy that reminded us of the volatility and instability of the contexts in which we intervene. On 17 January, the displaced people's camp and town of Rann, in Borno, Nigeria was bombed by the army, killing at least 90 people and injuring many more. Six Nigerian Red Cross personnel and three workers contracted by MSF tragically lost their lives. The Nigerian military quickly claimed responsibility for the bombing, saying it was a mistake. An investigation by the military into the incident was undertaken, but the final report has never been published. This dreadful event is a reminder that acute crises are part of our reality, and accessing the most vulnerable populations, protecting our medical mission and negotiating with all parties in a conflict situation remain daily challenges for our teams. These challenges come with dilemmas that we must address, balancing needs and risks at every moment of our operations. How do we cope with operational compromises when trying to access populations in despair? How will people's perception of MSF be affected if we only have negotiation channels with some of the stakeholders in a given context? In addition, for several years, a number of emergency responses (besides epidemics) have turned into long-term conflict programmes due to the protracted nature of many crises where there are high levels of volatility and continuing needs. With a dynamic portfolio of projects encompassing the Middle East, the Lake Chad region, Burkina Faso, South Sudan, Democratic Republic of Congo (DRC), Kenya and Tanzania, MSF Operational Centre Geneva (OCG) is well positioned in several contexts to respond to the acute needs of vulnerable civilians caught in or fleeing the violence of war.

In this respect, 2017 was marked by major operational deployments, which included providing support to two hospitals in very sensitive contexts: one in West Mosul, Iraq and one in Al-Hasakah, Syria. While this enables thousands of people to access essential healthcare in very difficult situations, we are aware that from one day to the next we may have to withdraw, giving up those financial and human investments, if the conditions required for MSF to work are no longer met. While our limitations in such contexts cannot be ignored, the care we have been able to deliver has impacted thousands of people's lives. For instance, maternal and child healthcare and surgery were significantly scaled up in 2017 (Cameroon, Syria, Iraq, etc.). Addressing major epidemics such as cholera in Yemen and DRC was also among the key achievements of 2017. At the movement level, under the lead of Operational Centre Amsterdam (OCA), 2017 saw our re-engagement in Somalia, where OCG's operational model will be implemented in 2018.

Regarding political positioning, 2017 was marked by major crises that required a strong position of advocacy and speaking out from our organisation. Indeed, we took a stand on the so-called migration crisis in Europe and the search and rescue activities in the Mediterranean, the asylum-seeker reception crisis, the unacceptable treatment and living conditions of migrants held against their will in Libya merely because they were seeking a better life, and the fleeing of more than 800,000 Rohingya from Myanmar to Bangladesh to escape persecution and military violence. The lack of attention to and increasing neglect of humanitarian crises, particularly in Africa, has had disastrous consequences, such as the dire situation of displaced people in Tanganyika, DRC.

In 2017 again, OCG put a lot of energy into enhancing its preparedness, tools and protocols in order to be more responsive and more efficient in responding to emergencies in complex environments. Moreover, OCG took some major decisions, such as the closure of some projects, to maintain this capacity for responsiveness and operational deployment, while other actors depend on the availability of funds and disbursement processes. As a result, MSF continues to be a humanitarian actor like no other.

Last but not least, 2017 was quite a strong year in terms of human resources management. People are at the heart of MSF's work, be they staff, beneficiaries or donors. Re-emphasising the human dimension as a key component of MSF's DNA is crucial. In parallel, the growth of the organisation and the accompanying need for more processes, tools and internal systems to make it more professional, mean that we must take care not to fall into the trap of becoming overly bureaucratic. Aspects such as duty of care, investment in training, diversity to better serve our patients and their communities, and "engagement" versus "a job" were addressed last year and will continue to be addressed in the years to come.

Wishing you a happy reading of this retrospective of 2017,

Reveka Papadopoulou
President of MSF Switzerland

Liesbeth Aelbrecht
General Director of MSF Switzerland

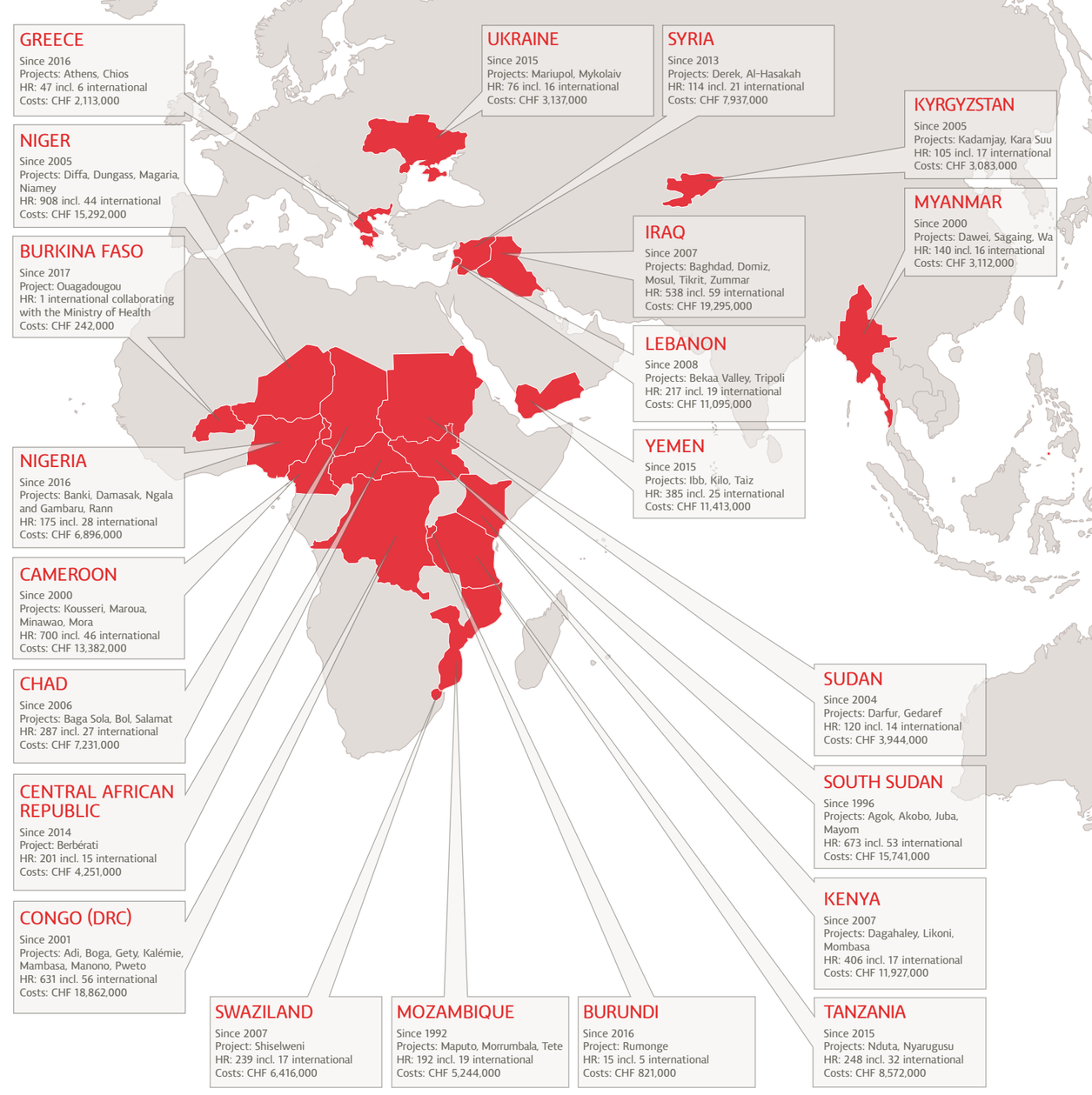
Contents

24 countries

75 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.

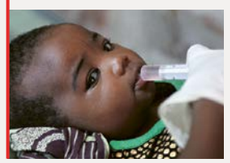


2017

JANUARY — **Nigeria:** In Borno State, the humanitarian needs are alarming and aid is almost non-existent. On 17 January, the town of Rann, where 40,000 people fleeing the violence have gathered, is tragically bombed by the Nigerian Air Force. At least 90 people are killed and more than 150 are wounded.

FEBRUARY — **Refugees:** Kenya's High Court rules the closure of Dadaab camp illegal. MSF speaks out for the refugees, 86% of whom say they do not wish to return to Somalia. In Tanzania, pressure intensifies in the camps in Nduta, where Burundian refugees continue to arrive in large numbers.

MARCH — **Rotavirus:** The results of a clinical trial conducted in Niger prove the effectiveness and safety of a vaccine against this virus, which causes severe diarrhoea. It is a hope in the fight against one of the main causes of child mortality in the world.



APRIL — **Iraq:** As fighting continues in West Mosul, MSF opens a hospital and medical outposts near the front lines to treat the war wounded and assist with life-threatening emergencies such as Caesarean sections.

MAY — **Yemen:** With a weakened health system that has been ravaged by nearly two years of conflict, the country faces one of the worst cholera epidemics in its history. Within six months, more than 660,000 people contract the disease. MSF sets up treatment centres in several governorates.

JUNE — **Somalia:** Nearly four years after having withdrawn its teams from the country, the international medical organisation MSF recommences its activities with patients in Somalia, in Puntland.

AUGUST — **Libya:** For more than a year, MSF has been witnessing the extortion, deprivation and physical abuse suffered by migrants and refugees at the detention centres in Tripoli. MSF denounces the inaction of European governments.

SEPTEMBER — **Mexico:** 48 hours after the violent earthquake that shook Mexico City on 19 September, MSF assesses psychological and medical needs in the states that are affected.

OCTOBER — **DRC:** The country is facing the largest cholera epidemic in twenty years. MSF intervenes, treating almost half of the cases throughout the country, particularly in Tanganyika.

NOVEMBER — **Syria:** In Al-Hasakah, in the northeast of the country, MSF continues the rehabilitation of the referral hospital. At the shipping container hospital, the teams care for patients on the emergency ward, and in the operating theatre and intensive care unit.

DECEMBER — **Rohingya:** A report produced by MSF in the refugee camps in Bangladesh reveals that at least 6,700 Rohingya died because of the violence in Rakhine State/Myanmar in the space of one month. This shows that the Rohingya were specifically targeted in the violence.

Overview of the year 2017

2017, a year of challenges and dilemmas

Closer to the front lines: accepting and managing risks

In 2017, the populations of the Sahel region were still caught between their national governments and the non-state armed groups (known as JAS or ISWAP) against which they are fighting. Large numbers of civilians are living in camps where conditions are very tough and they are subjected to violence from both sides. A tragic reminder of this was the bombing by the Nigerian army of the camp and town of Rann in Borno State, Nigeria, on 17 January 2017.

In the Middle East, the conflicts in Syria (which entered its seventh year) and Iraq have plunged the region into chaos, making the situation of the most vulnerable insupportable, despite the supposed defeat of one of the main actors, Islamic State (IS). Throughout the year, control of the regions has changed hands repeatedly and MSF's access to the population is becoming increasingly critical as the geopolitical situation becomes more and more complex. Operations have nonetheless been deployed in these extremely volatile contexts, such as at Nablus Hospital in West Mosul (Iraq) and Al-Hasakah National Hospital (Syria), where the high volumes of activity reflect the scale of the needs. Much of the region's population is now making its way back home and these return movements are giving rise to new risks, obstacles to accessing health services and security threats.

The risks facing our teams call for greater awareness from OCG and the implementation of tools and procedures to better prepare our staff to meet the needs of the population and guarantee the safety of our teams.

One important example of the limits of our action in both Mosul and Nigeria is the fact that it is impossible for us to negotiate with all parties to the conflicts, particularly the non-state armed groups in Nigeria and IS in Iraq. In these situations of armed conflict, we have no choice but to engage in talks with the forces controlling the territories we want to access. The consequences of this in terms of security and how we are perceived need to be taken into consideration and could clash with our principles of neutrality and impartiality. On the battlefields, where drones, mines, aerial bombings, snipers and chemical attacks are a daily risk, our presence on the front lines can sometimes be deemed too dangerous.

We must stand by our decisions to intervene in Mosul or Al-Hasakah (or even Nigeria) in the awareness that, from one day to the next, OCG may be forced to withdraw. Operational mobility is crucial and this capacity to quickly deploy teams, but also to leave, is a key element of our intervention strategies. In Al-Hasakah, we are supporting a secondary care facility in a conflict zone and an extremely volatile geopolitical environment (the regime in Damascus, the Kurdish authorities, regional and international stakeholders, etc.). We should also mention Yemen where, in 2017, we not only deployed operations on the front lines of a war that is entering its fourth year, but also tackled cholera and diphtheria epidemics resulting from the collapsed health system and weakened government.

Despite these constraints, in the course of 2017, 1,621,973 consultations were carried out, 14,563 surgical operations were performed and both our mother-and-child health and our surgical activities were significantly stepped up. In order to remain as operationally effective as possible in these types of contexts, we constantly assess our approaches and adapt to the circumstances, applying flexible and adapted tools and strategies.

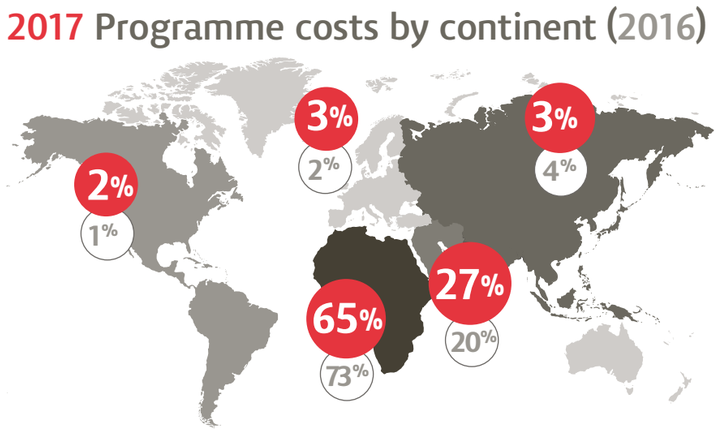
Responsiveness and flexibility at the heart of our operational deployments

In 2017, almost half of our operational portfolio was in contexts of conflict. We must carefully consider our deployments in these types of situations given that opening a project during a conflict can often mean staying there for the long term. And we must always maintain our response capacity and be able to disengage from projects that, despite the needs, take us away from our core aim of providing emergency medical humanitarian aid. Indeed, 2017 saw us close some projects and missions in order to preserve as much as possible that capacity and the resources required to respond to emergencies.

Sometimes, in the absence of other actors, particularly development actors, MSF ends up standing in for them in long-term projects, which diverts us from our social mission. Such situations must be temporary and an exception. For instance, OCG withdrew from Gety in the Democratic Republic of the Congo (DRC), and from the Central African Republic (CAR). In South Sudan, the activities in Mayom were refocused on essential primary care, increasing the capacity for referrals to Agok. Rationalising the portfolio of large-scale ongoing projects in order to retain that mobility is crucial. In a number of African countries, where the humanitarian crises, epidemics and conflicts are largely overlooked, receive limited media coverage and limited funding, it is imperative that we conserve our capacity to respond quickly and effectively. The conflict in Tanganyika in DRC and the resulting epidemics is a striking example of this.

Burkina Faso, where we have set up a project to fight a dengue epidemic in the capital, is in one of the contexts (Sahel region) where we know that a presence is necessary to address stark needs linked to geopolitical tensions, poverty and insufficient capacity of the health system.

Finally, in 2017, we set up an emergency support unit at OCG, attached to the Operations Department, which is responsible for preparing for and supporting emergency responses (scoping, tools and strategy). It is intended to improve our preparedness by mapping our existing capacities, at regional and local levels, in the countries where we are working. Regional strategies are also being developed, with the Dakar and Amman offices playing a vital role in enabling us to better understand local dynamics, more accurately analyse the context and, consequently, more effectively prepare for and address the populations' needs.



427,696
malaria cases treated

10,941
HIV patients on antiretroviral treatment

1,658
tuberculosis patients

272
MDR tuberculosis patients

117,311
children vaccinated against measles

Anticipating and adopting a stance on critical medical issues

Major medical challenges during the year

In countries where the health systems are failing, routine vaccinations are not carried out and whole generations are deprived of protection against potentially life-threatening diseases. Added to that are the dangers inherent in conflicts and the appalling health conditions in which abandoned or ostracised populations live, leaving them exposed to the emergence of large-scale epidemics or, even more worryingly, the resurgence of old diseases that had previously been brought under control. For instance, Yemen has seen the worst cholera epidemic since 1949, with a million suspected cases recorded. After this epidemic a outbreak of diphteria occured. The teams had almost never had to treat this disease on this scale.

Providing care for non-communicable diseases is also vital for patients who are suddenly deprived of treatment and at risk of untreatable acute episodes in war zones. It is important to note that the profiles of the people we assist vary significantly between low-income countries and middle-income countries. In Lebanon, OCG treats 9,000 people with chronic conditions such as diabetes and cardiovascular diseases – the movement's largest cohort of such patients. Usually treated by specialists, these people could, in MSF's opinion, be looked after by general practitioners. Our strategy includes simplifying treatment protocols and using generic medicines, which we consider to be the most efficient approach in terms of care and costs in these types of situations. Here, it is essential to have an innovative approach to healthcare that includes the refugee population.

For displaced people and migrants, who often continue on their way, access to treatments and medical follow-up is a challenge. In the summer of 2017, travel medicine activities were started in Greece. These activities aim to ensure continuity of care from the point of entry into the country through to the point of departure, and to anticipate as far as possible the potential problems to which these people may be exposed during their journey. The care offered by the teams includes vaccinations, gynaecological consultations for women of reproductive age, psychological support and monitoring of chronic diseases.

Although mental health was already a component of the majority of our projects, greater importance was placed on it in 2017 as the traumas linked to certain contexts of violence and insecurity amplified the needs of the target populations. Treating these pathologies in a holistic way involves detection in the community, primary health programmes and referral of serious cases to hospitals.

1,621,973
outpatient consultations

175,630
antenatal consultations

12,892
children admitted to outpatient feeding programmes

52,896
individual mental health consultations

7,348
group mental health consultations

Reproductive health remained at the heart of our concerns during the year, with the number of consultations and deliveries reaching record levels. In Iraq, in the district of Tal Afar, for instance, there was an average of 200 assisted births a month on our maternity ward. Neonatal mortality continues to be a challenge in many of our projects. To address this, additional care units for newborn babies are being set up alongside delivery rooms. Meanwhile, pregnancy terminations play a key role in reducing maternal mortality, particularly in sensitive contexts. This option is now offered in most MSF projects. Awareness-raising and training on this subject remain essential, and a team dedicated to these activities is now operational.

Innovative approaches and tools

In DRC, some suspected cases of Ebola were detected in May. The MSF teams immediately went there to prepare the response with local actors (training, treatment, etc.), in case they were confirmed. Discussions were also held with the Ministry of Health in order to set up a contingency plan to administer the vaccine, where possible. A similar dynamic was triggered for the suspected cases of Marburg virus in Uganda and Kenya, with community awareness-raising to help people recognise the symptoms. In addition, an innovative approach to tackling dengue was adopted in Burkina Faso, to control the transmission vector.

Finally, we note that tools and training were put in place to optimise the diagnosis of certain diseases. E-care tablets were rolled out to speed up the identification of urgent and less urgent cases and to rationalise the administration of antibiotics. Similarly, parents were trained in how to use MUAC (mid-upper arm circumference) tapes to screen for malnutrition in children. To make it easier to work in environments with very limited resources (electricity, etc.), medical and technological equipment is introduced or adapted to the field. This process was begun in 2017 and will continue in 2018.

The urgent need to speak out

MSF continues to shine light on forgotten crises through communication and accessing populations that have nothing. Our medical activities always go hand in hand with testimony. This is illustrated by the fact that while negotiations to authorise our teams to go to Rakhine State in Myanmar continued, at the risk of being expelled from the country, MSF wrote a report on the catastrophic situation of the Rohingya fleeing the country in 2017, detailing the number of deaths and the extent of the violence against them.

In the summer of 2017, when Italy asked NGOs to sign a code of conduct for search and rescue operations in the Mediterranean, MSF refused. An agreement between Italy, and by extension the European Union, and Libya greatly reduced the number of migrants attempting the crossing, as boats were systematically blocked or taken back to Libya, where arbitrary detention, torture and other forms of harsh and inhumane treatment await the migrants. After visiting the detention centres in Tripoli, Joanne Liu, President of MSF International, publicly denounced the mistreatment inflicted on the detainees, whose only crime is having sought a better life. The organisation has repeatedly reiterated its request for a safe and legal passage to be established to end the deaths at sea.

On the whole, medical advocacy actions to change the international health regulations have been successful. After years of advocacy, snakebites have been added to the official list of neglected tropical diseases. Regarding cholera, numerous recommendations made by MSF based on field research have been accepted by WHO and international decision-makers.

Meanwhile, in general, reference treatment for Kaposi's sarcoma used to only be available in Western countries. Thanks to the conclusions of studies conducted in the field and following discussions with the different health authorities, it has now been included in Mozambique's national programme. New standards are in place to treat this pathology. For hepatitis C, which is particularly prevalent in Ukraine and Myanmar, an agreement was concluded with the DNDi (Drugs for Neglected Diseases initiative) to go beyond the standard treatments. Finally, a shorter treatment for multidrug-resistant tuberculosis, with fewer side effects, is now being trialled for Kyrgyz patients.

Outlook for 2018

In 2018, the Middle East and the Sahel region will remain central focuses of MSF OCG's work, as the local populations continue to suffer in these tense and complex geopolitical contexts, caught between the warring factions and without access to aid.

The initiatives underway will continue, particularly to ensure that we remain responsive and flexible in all emergency situations and in contexts of great volatility in terms of security. We will closely monitor the issue of forced returns, so that displaced or refugee populations are not obliged to go back to their countries or regions of origin if they are still exposed to violence there.

Concerning issues around population displacements and migration, in 2018 we plan to extend our travel medicine activities, particularly in Central America and Lebanon.

Finally, the forgotten crises and neglected diseases that continue to wreak havoc, especially in sub-Saharan Africa, will also remain at the heart of OCG's operational portfolio. In particular, DRC, whose elections have been postponed until late 2018 and which is currently in the grip of extremely violent conflicts – manipulated and disguised as inter-ethnic conflicts – especially in Ituri, is likely be an important focus of our emergency operational deployment.

Christine Jamet
Director of Operations

Dr Micaela Serafini
Medical Director

119,081
patients admitted

31,948
births assisted

18,720
children admitted to inpatient feeding programmes

14,563
surgical procedures

The year in pictures

Improving **access to medical assistance as well as the quality of healthcare provided in hospitals is essential for patients,** whether at admission, in emergency rooms, or in operating theatres.


South Sudan, 2017 © Peter Bauza


DRC, 2018 © John Wessels


South Sudan, 2017 © Peter Bauza

In health centres or via mobile clinics, **teams provide primary healthcare, nutritional care and psychological support,** and refer patients to hospitals when needed. MSF also carries out **water and sanitation activities, and distributes water.**


DRC, 2017 © Lena Mucha

As the number of displaced people, asylum seekers and refugees has reached historic highs, **MSF has increased its presence among people forced to flee.**

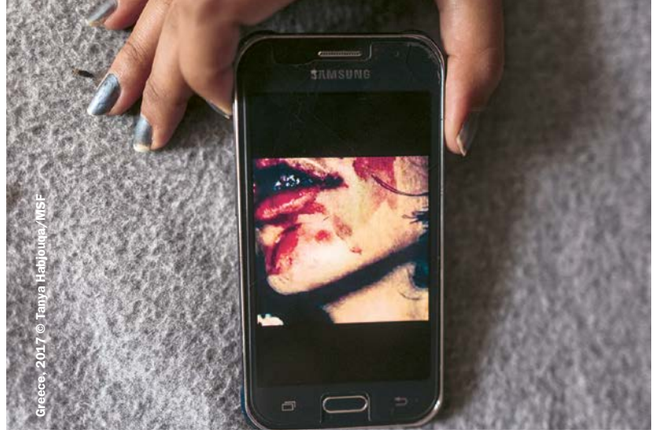

DRC, 2018 © John Wessels

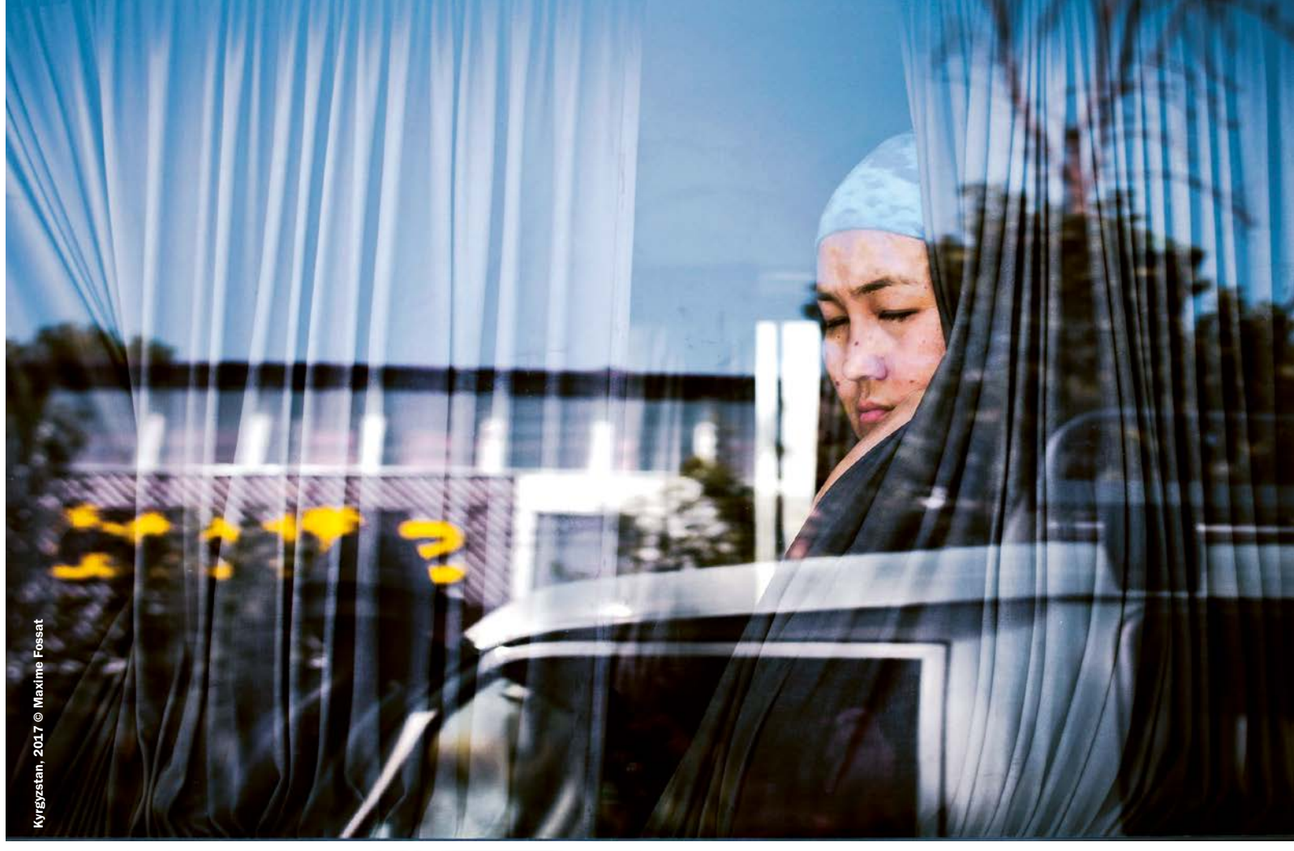

DRC, 2017 © Louise Annaud/MSF


DRC, 2017 © Pierre-Yves Bernard/MSF


Nigeria, 2017 © Sylvain Cherkaoui/Cosmos


Togo, 2018 © Louise Annaud/MSF


Greece, 2017 © Tanya Habjouqa/MSF


Kyrgyzstan, 2017 © Maxime Fossat


DRC, 2018 © Pierre-Yves Bernard/MSF

MSF continues to address maternal mortality in its projects. **The provision of medical care during pregnancy, and during and after birth, can reduce the causes of maternal mortality** such as haemorrhage and infection. For women who are victims of sexual violence, **access to emergency medical and psychological care is essential.**


Honduras, 2017 © Christina Simons


Mozambique, 2017 © Morgana Wingard/ANA/MSF

With more than 10,000 patients on antiretroviral treatment, **MSF is working to implement innovative testing strategies** to reach isolated groups and facilitate **access to lifelong treatments for people living with HIV.**

Kyrgyzstan, 2017 © Maxime Fossat


Swaziland, 2018 © Fanny Mostettler/MSF

Bringing neglected crises out of the shadows is in MSF's DNA

2017 was marked by unprecedented cholera epidemics. According to the United Nations, Yemen was hit by the "world's worst cholera outbreak" with more than 660,000 cases recorded by the Ministry of Health during the first six months. At the same time, the Democratic Republic of Congo (DRC) endured the largest epidemic in twenty years, which was met with complete indifference. Indeed, these critical humanitarian crises were almost entirely overlooked. Armed conflicts, violence, famine, population displacements, epidemics... These types of crises have multiple origins and take different forms, but all have one thing in common: they force millions of people to live in disastrous conditions that can be fatal for the most vulnerable. The affected populations receive too little attention from or are even invisible to the outside world. The aid they receive is insufficient, particularly due to a lack of funding. Humanitarian actors have the twofold role of delivering assistance and relaying the voices of those who are suffering, with the additional challenge of finding effective levers to ensure that these neglected crises and the humans enduring them are not forgotten.

Present where others are not

The first step in bringing crises out of the shadows requires a presence on the ground and the expertise to analyse the severity and level of needs. It is essential to be alerted in advance and to be able to access areas that are often completely cut off. Going to places that others cannot reach due to a lack of resources or capacity to respond urgently remains one of MSF's strengths. Responsiveness and a rapid deployment capacity are only possible thanks to active, regular information updates, effective alert systems and considerable experience of these types of missions.

In 2017, after months of negotiation, MSF managed to access displaced people living in camps in the northeast of Nigeria. The needs were huge and the population had received no aid until then. A team went to Banki to assess the health and medical situation and the potential to recruit local staff. By the second day, six trucks of equipment and four vehicles transporting staff had arrived there, ready to start distributing food and medicines, and to provide malnutrition screening and vaccinations. Deciding whether to intervene in a given context requires an in-depth analysis and precise assessment criteria. The first information to be gathered is mortality and morbidity rates, to ascertain the percentage of sick people within a given group. If these rates are higher than the usual rates in the region, an intervention is justified. Indeed, the main aim of an emergency medical organisation is to help populations survive during periods of crisis and bring mortality rates down to their pre-crisis levels.

Thus, our decisions are based on objective needs and this impartiality enables us to resist potential manipulation or exploitation. Independent of any political, religious or military powers, MSF is free to choose its contexts of intervention, unhindered by any political agenda. MSF Switzerland's guarantee of independence is rooted in the fact that more than 96% of its funding comes from the generosity of private donors. DRC, where the conflicts are chronic and the humanitarian crises in the different provinces are old and complex, rarely makes the front pages of the newspapers. Yet, with 10% of the annual budget spent there, this country still accounts for MSF's highest volume of activities. Meanwhile, in protest against the European Union's migration policy, MSF has refused EU funding for projects aimed at migrants in the Mediterranean, a decision with significant consequences but that expressly reaffirms the organisation's objectives and principles.

The sense of urgency around long-term crises tends to wane even though the needs are still very real. With this in mind, humanitarian actors must continue to ensure that the media reports the discrepancy between the needs on the ground and the aid available. The strength of the international MSF movement allows us to mobilise the media and domestic societies on behalf of those who are neither seen nor heard. While it is fairly easy to rally support for 'CNN emergencies', most neglected areas receive little media coverage due to a lack of access as much as a lack of interest. Photographers and journalists who choose to visit such projects are convinced of the importance of reporting on and conveying the voices of the planet's most forgotten people. And the relevance of the messages makes them even stronger. To illustrate this, we can cite Dadaab, the oldest displaced persons camp, where teams have been carrying out activities since 1992 and which was threatened with closure in 2016. In light of the proposed closure, MSF conducted a survey of 828 refugees at Dagahaley – one of the five camps that make up Dadaab – to gauge their reactions to the proposed repatriation: 86% of them did not want to return to Somalia. MSF publicly expressed its opposition to the closure, which would have jeopardised the lives of thousands of people, and asked for alternative solutions to be sought. In February 2017, Kenya's High Court ruled the closure of Dadaab camp illegal, which was a great relief for the Somali refugees who had been living under a shadow of uncertainty for 10 months.

From actions to words

In 1971, a group of doctors and journalists was outraged by the atrocities of the civil war and famine the Biafra region of Nigeria, which was seeking independence. The conflict between federal government troops and the Biafrans quickly led to population displacements and a famine crisis, which was exacerbated by a blockade that lasted for 30 months and left a million dead. Witnessing these events first hand, humanitarian actors felt compelled to alert international opinion to the famine whose cause was purely political. As a reaction to the International Committee of the Red Cross's duty of confidentiality, volunteers from Biafra set up Médecins Sans Frontières, an organisation whose aim is to rescue and treat people, but also to mobilise public opinion, political leaders and institutions around the fate of populations in distress.

For more than 45 years, in line with MSF's founding principles, medical action has been intertwined with bearing witness. The teams speak out publicly to try to bring crises out of the shadows, alert opinion to abuses committed away from the cameras, criticise shortcomings in the aid system or denounce the diversion of aid from its intended recipients to serve political interests. When teams witness massive human rights violations, genocide, crimes against humanity or war crimes, denouncing them is the only option. In these exceptional situations, humanitarian aid is powerless against the horror, and silence kills. So, speaking out is the organisation's last resort.

In 2017, denouncing what we see is still a way of acting on neglected crises. During the year, the Rohingya were forced to flee the omnipresent violence in Myanmar's Rakhine State, crossing the Bangladeshi border to take refuge. It was one of the largest ever flows of this ethnic group into Bangladesh. Since then, the majority of the refugees have been living in makeshift settlements, the official UNHCR camps or within communities, most of them in unsanitary, overcrowded and dangerous conditions. According to conservative estimates made in studies conducted by MSF in December at the refugee camps in Bangladesh, between 25 August and 24 September, at least 9,000 Rohingya died in Myanmar. Given that the violence is estimated to have been the cause of 71.7% of the deaths reported, at least 6,700 Rohingya are believed to have been killed, including at least 730 children under five years of age. These findings show that this ethnic group was targeted and provide the most tangible evidence to date of the widespread violence. The organisation's efforts to address this situation served to alert public opinion and call into question the international community's lack of response. Humanitarian actors have still not received permission to work in Rakhine State.

So, siding with the world's forgotten populations is in MSF's DNA. Communicating on a large scale and advocating to decision-makers is inherent to and crucial for MSF's ongoing work with its patients. The challenge now is to find new channels and new levers so that we can keep working for the world's most vulnerable people, to give them back their dignity and humanity.

Activities by country

BURKINA FASO

Treating a dengue epidemic

In the country since: 2017
Reason for intervention: epidemics

Emergency intervention: dengue

Human resources (FTE): 1 international staff collaborating with the Ministry of Health staff
Cost for 2017: CHF 242,000

Burkina Faso, a landlocked country in West Africa, shares borders with six countries including Mali and Niger. The provinces in the north of the country have long been affected by health and humanitarian issues, in part due to the volatile context of the border areas.

In September, a dengue epidemic was declared in the central region of the country, where the capital Ouagadougou is located. Dengue is a viral disease spread by mosquitoes that causes fever and acute joint and muscle pain. No specific treatment exists, but early diagnosis and appropriate care can reduce suffering and prevent death. MSF teams supported four health centres and the infectious diseases department at Ouagadougou's university hospital, providing access to rapid tests, referrals for severe cases, medication to control fever and care for those suffering from the disease, especially vulnerable groups such as pregnant women and children under the age of five. MSF also worked with Burkinabe medical personnel to improve detection of the virus and treat symptoms, for example by administering intravenous fluids and blood transfusions. Over 450 medical and paramedical Ministry of Health staff received training at 35 facilities. In addition to the supported health centres, MSF teams visited five health facilities for two or three days each to test and treat patients with dengue symptoms. This enabled MSF to monitor the progression of the epidemic in these areas. In total, during the intervention, 1,151 dengue-related consultations were undertaken in conjunction with the Ministry of Health.

Community awareness-raising activities were conducted at the health centres to encourage people to seek medical care rather than self-medicate if they showed symptoms of dengue, and to explain the importance of vector control in their homes.


Burkina Faso, 2017 © MSF

In September, MSF supported the Ministry of Health to tackle a dengue outbreak.

BURUNDI

Improving emergency care

In the country since: 2016
Reason for intervention: healthcare exclusion

Main activity: hospital care

Human resources (FTE): 15 staff including 5 international staff
Cost for 2017: CHF 821,000

In 2017, political tensions and economic difficulties continued to take a heavy toll on the people of Burundi, a landlocked country in the Great Lakes region of East Africa.

In March, a malaria epidemic was declared in eight provinces in the northwest of the country. MSF conducted an assessment of the situation in Muyinga province, which was severely affected by the outbreak, and offered to launch a response. Unfortunately, this was not possible due to administrative constraints.

MSF also pursued negotiations with regional and national authorities regarding a project to support emergency services at Rumonge hospital and nearby facilities. The project was intended to strengthen the hospital's response capacity in emergency care, and to provide training for Ministry of Health staff. However, once again administrative constraints prevented MSF from initiating activities and, in June, the decision was taken to close. The temporary emergency and triage activities, and equipment, were handed over to the hospital.

CAMEROON

Assisting people displaced by insecurity

In the country since: 2000
Reason for intervention: armed conflict, displacement

Main activity: hospital care, surgery, primary healthcare

Human resources (FTE): 700 staff including 46 international staff
Cost for 2017: CHF 13,382,000


Cameroon, 2017 © Alexis Huguet/MSF

At Maroua Hospital, the teams treat patients in the emergency room and operating theatre around the clock.

Since 2011, the conflict between armed groups and the Nigerian army has forced hundreds of thousands of people from northeast Nigeria to seek refuge in Cameroon, Chad and Niger. During the past three years, violence has increasingly spilled over from Nigeria into the three neighbouring countries, causing further displacement. By the end of 2017, there were around 88,000 refugees and 240,000 internally displaced people in Cameroon. This has put a further strain on the already weak and overstretched health system, especially in the area bordering Nigeria, where health facilities lack staff and supplies and many have been abandoned altogether. To address the needs, MSF provided medical care in several locations in the north of the country.

Since the first suicide attacks on Cameroonian soil in Maroua in 2015, there have been frequent bombings in Far North region. In response, MSF scaled up its emergency surgical activities and boosted its capacity to treat mass casualties following attacks. In the town of Mora, close to the Nigerian border, MSF rehabilitated the operating theatre and set up an ambulance referral service at the local hospital. The team stabilised patients and transferred those in need of specialised surgical care to Maroua hospital, where emergency surgery is available around the clock. MSF rehabilitated the surgical and post-operative wards at Maroua hospital in 2016, and now manages surgery there. This year teams carried out 3,136 surgical interventions in Mora and 2,556 in Maroua. MSF also trained Ministry of Health staff in the management of large influxes of wounded patients and donated mass casualty kits to local hospitals.

To increase provision of care for children under the age of five, especially those with complications, MSF teams ran specialised nutrition and paediatric programmes at these hospitals in Maroua, and in Kousseri. In addition, MSF staff worked in two health centres serving displaced people and local residents in Mora and offered nutritional care and outpatient consultations in three health centres on the outskirts of Kousseri. In order to detect early signs of malnutrition, staff trained parents to screen their children, using a MUAC (mid-upper arm circumference) measuring tape. Teams also vaccinated 28,748 children in Mora against diseases including polio, diphtheria, tetanus, whooping cough, measles and hepatitis B.

At Minawao refugee camp, teams had been providing maternity services as well as nutritional and psychological support to Nigerian refugees since 2015. By July 2017, when MSF handed over these activities to another organisation, teams had carried out more than 110,000 outpatient consultations.

CENTRAL AFRICAN REPUBLIC

Providing access to healthcare in conflict areas

In the country since: 2014
Reason for intervention: healthcare exclusion, epidemics

Main activity: hospital care, sexual and reproductive healthcare, vaccination

Human resources (FTE): 201 staff including 15 international staff
Cost for 2017: CHF 4,251,000

The Central African Republic (CAR) was plunged back into war in 2017. Fighting and violent attacks against civilians led to the displacement of 681,000 people – around 15% of the population – while in neighbouring countries, the number of refugees from CAR rose to 568,000. By the end of the year, in a worsening humanitarian crisis, non-state armed groups controlled 14 of the country's 16 provinces.

Despite growing insecurity in other areas of the country, Mambéré-Kadéï remained stable in 2017. After three years working in Berbérati hospital and surrounding health centres, MSF made the decision to hand the project over to the Ministry of Health. During this gradual process, the team worked closely with the ministry, for example training its staff to treat children suffering from severe malnutrition. MSF handed over its paediatric, maternity and reproductive health activities and nutrition services in September. Since the beginning of the project, MSF had admitted 20,700 children to the hospital's paediatric unit, treated more than 4,570 children under five years of age for severe acute malnutrition and assisted more than 5,799 births.

MSF also undertook a tetanus vaccination campaign in 2017, targeting over 22,400 pregnant women and women of child-bearing age to combat high levels of neonatal tetanus.

CHAD

Addressing the needs of the most vulnerable

In the country since: 2006
Reason for intervention: armed conflict, displacement

Main activity: hospital care, primary healthcare, sexual and reproductive healthcare
Emergency intervention: cholera

Human resources (FTE): 287 staff including 27 international staff
Cost for 2017: CHF 7,231,000

In the district of Bol, the teams provide mother-and-child care and assist deliveries in the maternity unit at the regional hospital.

The security situation in Chad remains fragile, and there is widespread instability in the neighbouring countries of Nigeria, Niger and Cameroon. In 2017, violent clashes between armed groups and military forces in the Lake Chad region, near the border with Nigeria and Niger, forced people to flee inland. In addition, Chad is also suffering from a weakened economy due to the ongoing crisis.

MSF continued its projects in Baga Sola and Liwa health districts, in the Lake Chad region, where access to healthcare is extremely limited for local residents as well as refugees and displaced people. Teams run frequent mobile clinics in these districts, providing primary healthcare, including psychological support and treatment for victims of sexual violence. MSF also launched a preventive malaria treatment campaign for children under the age of five. During the year, MSF teams carried out 79,363 outpatient consultations and 6,598 antenatal consultations, vaccinated 12,684 people and screened 11,108 children for malnutrition. MSF is constantly developing and applying new strategies to improve its response to emergencies, including malnutrition. For example, in this region, teams trained mothers to detect malnutrition in their children as early as possible, and also vaccinated malnourished children against common diseases. On the islands of Fitine and Bougourmi, MSF ran mobile clinics for remote communities with no access to healthcare.

MSF also continued its maternal and child healthcare project in Bol health district, strengthening the paediatric unit at the regional hospital and setting up a 'kangaroo care' section in the maternity ward. Kangaroo care is a technique in which newborn babies, especially those delivered prematurely, are kept in skin-to-skin contact with their mothers as much as possible. This technique improves the baby's heart and breathing rate and reduces the risk of hypothermia and mortality. In collaboration with Chad's Ministry of Health, MSF provided healthcare to children under the age of 15 and nutritional support to those under five at the hospital. In 2017, teams conducted 5,498 outpatient consultations, assisted 457 deliveries and admitted 2,505 patients for treatment.

Near Bol, MSF supported reproductive healthcare in Sawa district by raising awareness among traditional midwives of the importance of encouraging pregnant women to give birth at local health facilities.

At the end of the year, MSF supported the Ministry of Health to respond to a cholera epidemic that broke out in Salamat region in September. The team set up several cholera treatment facilities in the regional capital Am Timan, distributed hygiene kits containing 20-litre buckets, sachets for treating water and soap, and treated a total of 134 patients between late October and December.

DEMOCRATIC REPUBLIC OF CONGO

Responding to multiple emergencies

In the country since: 2001
Reason for intervention: armed conflict, displacement, epidemics

Main activity: hospital care, primary healthcare, sexual and reproductive healthcare, mental healthcare
Emergency intervention: measles, cholera, malaria

Human resources (FTE): 631 staff including 56 international staff
Cost for 2017: CHF 18,862,000

In Tanganyika, MSF tackles epidemics and assists displaced people living in makeshift camps.

MSF is running some of its largest programmes in the Democratic Republic of Congo (DRC), which is in the midst of a protracted and complex humanitarian crisis. In 2017, the UN estimated that 4.1 million people were internally displaced in the country, due to longstanding conflicts in the east and new emergencies developing in other regions.

The conflict in Tanganyika Province intensified, which led to the displacement of over half a million people. MSF arrived there in March to undertake a measles vaccination campaign and assess the needs. In and around Kalemie town, displaced people were living with host families, in makeshift camps or in school compounds. Teams started providing emergency assistance in Kalemie and Kansimba, distributing water, constructing latrines and showers and deploying mobile clinics to 17 sites. Services included basic healthcare and mental health consultations, and referrals to Kalemie hospital. Teams also supported eight primary healthcare facilities. A second round of measles vaccinations carried out in September reached over 20,600 children.

Also in Tanganyika Province, in April, MSF handed over its project in Manono to the Ministry of Health. Teams had been working in the regional hospital's paediatric department and health centres. The emergency team worked throughout the province, responding to outbreaks of measles and cholera, and treating people injured in violent clashes in a number of locations. The team assisted with case management and trained Ministry of Health staff, built cholera treatment centres and supported the ministry with the transportation of medical supplies in several health zones across the province.

In Ituri Province, in the northeast of the country, MSF continued to support six health centres in Mambasa, providing medical and psychological care for victims of sexual violence and treatment for patients with sexually transmitted infections. Overall, the team treated 590 victims of sexual violence this year. MSF also carried out awareness-raising activities regarding specific health promotion topics and the services it runs in the area.

In Adi, close to the borders with South Sudan and Uganda, MSF deployed mobile clinics serving both refugees and residents in the villages of Karagba and Ulendere. Services included primary and mental healthcare, treatment and psychological support for victims of sexual violence and hospital referrals. The team carried out more than 27,900 outpatient consultations and 1,269 mental health consultations. In addition, community sites were set up in the villages to treat simple malaria and diarrhoea.

After 11 years of working in Gety in Ituri, MSF handed over the last of its activities there to the Ministry of Health. Since 2015, MSF has been gradually handing over responsibility for various departments to the ministry, and with over 650 training sessions, has trained staff to ensure that they have the required knowledge and skills. Between 2007 and the end of 2016, teams conducted 541,800 outpatient consultations, 16,900 postnatal consultations, admitted 42,900 patients to hospital and assisted around 13,200 deliveries. As well as supporting paediatrics, women's health, neonatology, emergencies and intensive care, the teams worked to prevent epidemics through vaccination campaigns. MSF also helped to rehabilitate the regional hospital, by building or renovating certain departments.

MSF also handed over its activities in neighbouring Boga to the Ministry of Health. During the two years there, it worked to improve the quality of care in the hospital's maternity departments, operating theatre and emergency room, as well as in four outlying health centres.

The emergency response unit, which monitors health alerts in Ituri, Tanganyika and Haut- and Bas-Uélé, runs exploratory missions and responds to crises (such as epidemics, conflicts, etc.). In 2017, more than 6,000 people benefited from the unit's services.

GREECE

Intervening to help migrants

In the country since: 2016
Reason for intervention: displacement

Main activity: primary healthcare, sexual and reproductive healthcare, mental healthcare

Human resources (FTE): 47 staff including 6 international staff
Cost for 2017: CHF 2,113,000

In early 2016, thousands of people fleeing war were arriving on Greek islands every day, hoping to continue their journeys through Europe. The high influx of refugees stopped, however, when the European Union closed the Balkan route and the EU–Turkey deal was adopted in March 2016. Ever since then, many asylum seekers have been living in conditions that do not meet basic humanitarian standards. Greece's under-resourced public health system is not easily accessible to refugees, while those without paperwork have no access at all.

In order to address gaps in medical access in 2017, MSF continued to provide healthcare to the refugee population through its clinic in Athens. Teams carried out 3,552 sexual and reproductive health consultations, including antenatal and postnatal care, family planning and sexual violence care. The clinic also offers termination of pregnancy on request in the first 12 weeks of pregnancy, in line with the Greek health system. Teams also provided 1,707 mental health consultations and, from July, began treating non-communicable diseases, performing 609 consultations by the end of the year. Travel medicine services were implemented in September. This pilot project consists of three key elements: raising awareness of health risks along the route; providing preventive health services and tools to empower people to manage their health during travel, such as vaccinations; and aiming to ensure continuity of treatment for chronic conditions. MSF teams also ran mobile clinics in Elliniko, Rafina and Thermopiles, providing mental health and sexual and reproductive health consultations.

In December, MSF started a new project on the island of Chios, one of the entry points to Greece for refugees. Teams began providing cultural mediation services at the local hospital. The aim for 2018 is to offer primary healthcare to people living in and around Vial camp and to ensure they have access to the hospital for specialised care.

HONDURAS

Taking care of maternal and child health

In the country since: 1998
Reason for intervention: healthcare exclusion, sexual violence

Main activity: outpatient care, sexual and reproductive healthcare, mental healthcare, health promotion

Human resources (FTE): 63 staff including 7 international staff
Cost for 2017: CHF 2,038,000

Honduras, 2017 © Christina Simons/MSF

MSF offers sexual and reproductive healthcare in Choloma, where the services available to women include antenatal consultations, advice and psychological support.

Honduras has experienced years of political, economic and social instability. Drug trafficking, extortion, gang violence, a 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. Yet, despite the seriousness of the situation, there is currently no coordinated response.

In order to address critical medical gaps, MSF continued to run its 'priority service' project in the Central District of Honduras, which covers the capital Tegucigalpa and its twin city Comayagüela. The aim of this project, which started in 2011, is to ensure that victims of violence, especially survivors of sexual violence, have access to emergency medical and psychological aid, including emergency contraception. In 2017, MSF treated 589 victims of violence, including those who have suffered from sexual violence, and carried out 1,758 mental health consultations. In parallel, MSF offers training for medical staff on the effects of violence and psychological first aid. Over the year, the project was further integrated into the Honduran Ministry of Health. The organisation will nevertheless maintain its presence at the main hospital and two clinics, as well as in Nueva Capital, where the teams have continued to provide integrated primary healthcare, especially through the psychology clinic.

MSF has for many years been engaged in advocacy to convince the Ministry of Health to adopt a national policy on sexual violence and victim support. Until a comprehensive protocol is adopted and implemented, the organisation will maintain its involvement in caring for victims of sexual violence and will continue advocating for the adoption of such a protocol.

MSF also launched a project for sexual and reproductive healthcare in Choloma, a municipality in the northwest of the country where there are high levels of violence. In the area, few pregnant women were receiving antenatal care, resulting in high numbers of medical complications and childbirth-related deaths. MSF has been supporting the existing mother and child clinic since March 2017 and, in collaboration with the Ministry of Health staff, 19,271 outpatient consultations were carried out. In October, MSF began implementing its strategy for the prevention of unsafe abortion practices through activities such as family planning, counselling, contraceptive services and sexual violence prevention.

IRAQ

Treating close to the frontline

In the country since: 2007
Reason for intervention: armed conflict, displacement

Main activity: hospital care, sexual and reproductive healthcare, primary healthcare, mental healthcare

Human resources (FTE): 538 staff including 59 international staff
Cost for 2017: CHF 19,295,000


Iraq, 2018 © Lorine Arnaud/MSF

At Tal Maraq Hospital, the teams assist deliveries and look after children on the paediatric ward. Complicated cases requiring specialised care are referred to another MSF hospital in Mosul.

In 2017, events in Iraq were dominated by the battle to recapture the city of Mosul and other places held by the Islamic State group.

West Mosul bore the brunt of the fighting. The frontlines cut through densely populated areas, which meant many people were effectively under siege, sometimes for months on end. Only the walking wounded were able to access medical care, and even so, they often had to wait days before they could safely leave their homes and try to reach a clinic or hospital. The battle lasted for nine months, during which thousands of people were injured or killed, and hundreds of thousands displaced. By the time the violence subsided, the infrastructure in west Mosul, including medical facilities, had been decimated. In these circumstances, MSF's response had to be fluid and adapt to the changing needs and shifting frontlines. Firstly, in preparation for the battle of Mosul, a field surgical unit was set up north of the city. Then, in December 2016, MSF gained access to east Mosul and began operating in Muhareebeen hospital, focusing on providing lifesaving care for trauma, obstetrics and other medical emergencies. Medical outposts were also set up closer to frontlines to stabilise patients. At the end of May 2017, MSF entered west Mosul and opened a medical outpost in a school, as well as an emergency room and operating theatre and maternity ward at Nablus Hospital. For weeks, the frontline was less than two kilometres from the hospital. When the number of trauma cases decreased, the hospital expanded its maternity and paediatric care activities. Overall, teams managed 9,421 emergency cases, performed 455 surgical interventions, assisted 1,410 deliveries and admitted 469 children to the facility.

By the end of 2017, more than 3.3 million people were displaced in Iraq. In the areas severely damaged by the conflict, the displaced put a further strain on healthcare and other basic services, which are already insufficient to meet the needs of the local communities.

In Zummar, north of Mosul, MSF continued to run a maternity clinic, an emergency room and a paediatric inpatient department at Tal Maraq Hospital. The team offered sexual and reproductive healthcare, and referrals for complicated cases. In addition, mobile clinics were deployed to neglected communities in Tal Afar district to provide primary healthcare, including treatment for non-communicable diseases. After the Kurdish referendum in September and the subsequent border changes in that region, communities previously cut off from medical care suddenly had access to MSF's Zummar clinic. This resulted in a sharp increase in the number of people seeking help, and the team conducted a total of 10,600 sexual and reproductive health consultations and assisted 2,881 deliveries.

After five years working with Syrian refugees in Domiz camp, in northeast Iraq, MSF handed over its maternity and sexual and reproductive health activities to the local health authorities in November. More than 1,232 babies were delivered in the camp in 2017.

In Tikrit, west of Baghdad, a team offered primary healthcare to displaced people in Al Alam camp. MSF wound down its activities as people began to return home, but continued to assess the medical needs in the region.

In Baghdad Governorate, the number of consultations provided to displaced people in Abu Ghraib also decreased as people began to move away. Some activities were handed over to the Directorate of Health in July.

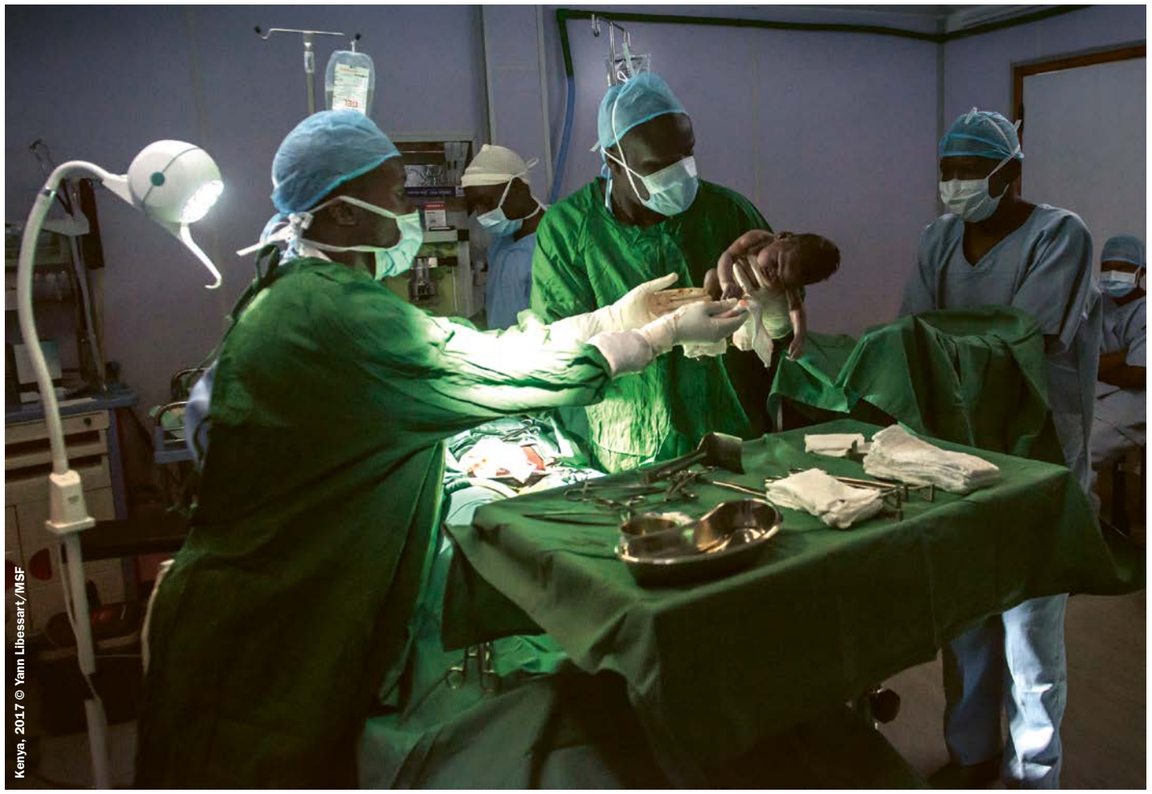
KENYA

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, mental healthcare
Emergency intervention: cholera, Marburg haemorrhagic fever

Human resources (FTE): 406 staff including 17 international staff
Cost for 2017: CHF 11,927,000



Kenya, 2017 © Yann Libessart/MSF

The maternity unit set up by MSF in a temporary shipping-container structure allows future mothers to give birth safely.

In 2017, Kenya faced serious political instability following the nullification by the Supreme Court of the presidential election in August. A second presidential election was held in October. In addition, the healthcare system was severely affected by two consecutive health worker strikes which started with a 100-day doctors' strike followed by a five-month nurses' strike. Furthermore, as 80% of the country's area comprises arid and semi-arid land, Kenya remains highly vulnerable to droughts. National emergencies were declared in February and April.

Kenya continued to host a significant number of refugees in 2017. According to UNHCR figures, there were 490,656 refugees in the country, half of which were in Dadaab, a camp complex on the border with Somalia. MSF continues to provide access to primary and secondary healthcare in Dagahaley, one of the camps in Dadaab. Teams run a hospital and two health posts. Medical care provided by MSF in Dagahaley includes sexual and reproductive health services, surgical operations, medical and psychological assistance to survivors of sexual violence, mental healthcare, HIV and TB care, palliative care to patients with chronic illnesses, home-based insulin management services for patients with diabetes and emergency response services.

169,347 outpatient consultations were provided and 8,974 patients were hospitalised. MSF assisted around 2,903 deliveries at the hospital. From April to December 2017, the camp experienced sporadic outbreaks of cholera, with 166 cases being treated by MSF. Since the launch of the voluntary repatriation initiative, 71,000 people have been repatriated to Somalia. However, the preconditions for this exercise remain unmet, such as access to healthcare, livelihood opportunities, education and security. There were also critical humanitarian aid shortages in Dadaab in 2017, which prompted the World Food Programme to reduce food rations for refugees by 30%.

In 2017, MSF implemented sexual and reproductive healthcare services and comprehensive emergency and neonatal obstetric care at the Mrima health facility in Likoni sub-county. A temporary container village was set up to accommodate the inpatient department, the lab and an operating theatre. 7,864 deliveries were assisted in this structure, as well as 1,656 C-sections. Construction and extension of the existing permanent health facility began in January 2017, and continued throughout the year. The project also has an important outreach component including health promotion activities and support for peripheral health facilities.

In October, after a Marburg haemorrhagic fever outbreak was declared in Uganda near the border with Kenya, MSF deployed response teams to both sides. In Trans-Nzoia County, Kenya, MSF set up a treatment centre. Teams organised training and donations to prepare for the isolation and case management of potential patients. No cases were identified and MSF withdrew its teams.

KYRGYZSTAN

Fighting against tuberculosis

In the country since: 2005
Reason for intervention: epidemics

Main activity: tuberculosis, primary healthcare

Human resources (FTE): 105 staff including 17 international staff
Cost for 2017: CHF 3,083,000

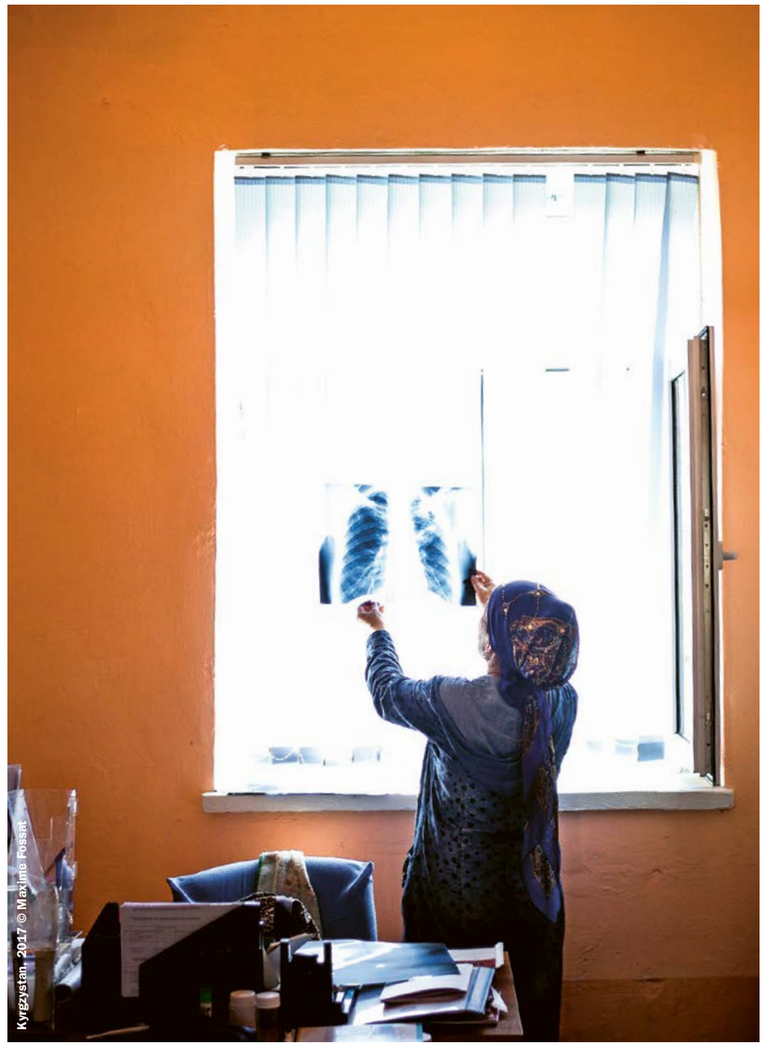
The prevalence of drug-resistant tuberculosis (DR-TB) remains very high in Kyrgyzstan, and many people struggle to access free treatment. Furthermore, the current treatment can last up to two years and produce severe side effects, so many patients fail to complete the course. MSF's main goal in the country is to encourage decentralised DR-TB care to improve management of the disease and patient adherence to treatment.

In Kara-Suu district, in Osh region, TB rates are among the highest in the country. In 2017, 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 following their treatment. Patients attend monthly medical consultations – which include psychological support to help them adhere to this arduous treatment – at one of the three Ministry of Health TB clinics supported by MSF.

If patients are unable to come to the clinic for check-ups, staff visit them in their homes. Those with the more severe forms of the disease are admitted to the hospital. MSF also supports Kara-Suu hospital, which has 40 beds for DR-TB inpatient care. In April, MSF started using two new drugs as part of the 'endTB' observational study to treat patients who have been diagnosed with extensively drug-resistant TB (XDR-TB) or pre-XDR-TB.

MSF also continued to train Ministry of Health staff. The decentralisation of DR-TB treatment has now been adopted as a key strategy by the ministry.

In Aidarken, Batken Oblast, MSF is supporting the Ministry of Health to deliver better care for non-communicable diseases, and to improve mother and child services through mobile clinics. In addition, a team is assessing the possible impact of heavy-metal pollution on public health.



Kyrgyzstan, 2017 © Maxime Fossat

In Kara-Suu District, MSF cares for patients suffering from drug-resistant tuberculosis using a new treatment.

LEBANON

Providing relief for vulnerable refugees and local communities

In the country since: 2008
Reason for intervention: displacement

Main activity: primary healthcare, sexual and reproductive healthcare, mental healthcare

Human resources (FTE): 217 staff including 19 international staff
Cost for 2017: CHF 11,095,000

Since the conflict in Syria began in 2011, more than 1.5 million Syrians have fled into Lebanon, making it one of the countries with 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. For vulnerable people such as Syrian refugees, and impoverished host communities, access to medical services continues to be a challenge. Political pressure on refugees intensified throughout 2017, with anti-refugee rhetoric growing stronger towards the end of the year. There was an overall decrease in humanitarian funding in all sectors. MSF is therefore stepping up its medical response and providing free, high-quality primary healthcare, including treatment for chronic diseases, reproductive health services and mental health support. The projects are mainly in neglected areas, such as the Bekaa Valley and the north of the country, which host large numbers of vulnerable Syrians and Lebanese. The escalation in fighting in parts of Syria towards the end of 2017 pushed more people into the Bekaa Valley. MSF continued to run four primary health centres in Baalbek, Aarsal, Hermel and Majdal Anjar, focusing on treatment for non-communicable diseases (NCDs) and also offering consultations for acute conditions (such as flu, skin, ear, nose and throat problems), sexual and reproductive care and mental health support. Overall, 2,830 mental health consultations and 44,239 NCD consultations were conducted in 2017. From November, MSF started referring stable NCD patients to a local organisation in Majdal Anjar and Aarsal, thus allowing its staff to concentrate on treating more complicated cases. Teams working at the two 24-hour mother and child centres in Aarsal and Majdal Anjar assisted 2,374 deliveries during the year. In addition, community health workers carried out health promotion in cities, towns and camps hosting displaced Syrians.

In Tripoli, north Lebanon, MSF provided primary health services, including general medical consultations and sexual and reproductive healthcare, as well as preventive activities such as vaccinations and health education. In the summer, MSF handed over its support for vulnerable Lebanese NCD patients in Jabal Mohsen to a local organisation. Syrian NCD patients were either stabilised or, if necessary, treated and offered a referral pathway. In 2017, a total of 36,871 consultations for acute conditions and 25,636 consultations for NCDs were carried out. At the end of the year, MSF ceased its activities, except mental health, in Bab al-Tabbaneh and Jabal Mohsen as a new clinic opened in the neighbourhood.

MEXICO

Offering medical care for victims of violence

In the country since: 2013
Reason for intervention: social violence, healthcare exclusion

Main activity: outpatient care, mental healthcare
Emergency intervention: earthquake

Human resources (FTE): 58 staff including 11 international staff
Cost for 2017: CHF 1,901,000


Mexico, 2017 © Consuelo Pagaza/MSF

The MSF teams provided medical check-ups and psychological support for victims of the earthquake.

Although Mexico has one of the highest per capita incomes in Latin America, there is social and economic inequality in the country, and drug-related and social violence is widespread. A large proportion of the population has limited access to healthcare.

In Reynosa in the northeast of Mexico, close to the border with the United States, violence and insecurity are endemic. Throughout 2017, MSF's activities focused on providing comprehensive care for victims of violence, including sexual violence. Providing the population with access to medical care, especially psychological support, is one of the main challenges for MSF. With 5,247 consultations carried out, including 2,076 mental health consultations, MSF continued to address the direct and indirect consequences of violence through fixed and mobile clinics, even though several mobile teams and health promotion activities had to be cancelled due to insecurity. Referral to other health services or local institutions is not currently available, nor is psychiatric care, although these areas will be addressed in 2018.

On 19 September, a 7.1-magnitude earthquake hit the southeast of Mexico City. 370 people were killed across the states of Morelos, Puebla and Mexico. Health facilities in the main cities responded relatively efficiently to the emergency and MSF filled the gaps, immediately providing an operational response. 48 hours after the earthquake, the first team was deployed in the south of Puebla State at the request of the state authorities, and a second team was sent to the north. They responded with medical, psychological and social care delivered by mobile teams, dealing with earthquake-related symptoms as well as the chronic situation of social violence.

One of the main challenges for the coming years will be the migrant population and its potential deportation in large numbers from the United States. MSF is currently preparing a response to address this eventuality.

MOZAMBIQUE

Improving quality of HIV/AIDS and tuberculosis care

In the country since: 1992
Reason for intervention: epidemics

Main activity: HIV/AIDS, tuberculosis, hepatitis C, mental healthcare

Human resources (FTE): 192 staff including 19 international staff
Cost for 2017: CHF 5,244,000

Despite efforts to halt the spread of HIV/AIDS and tuberculosis (TB) in recent years, Mozambique continues to be challenged by a severe generalised HIV/TB epidemic. It remains one of the countries with the highest HIV prevalence rates (13.2%) and, according to the World Health Organization, 34,000 people living with HIV are killed by TB annually in Mozambique. The key strategy of MSF and its added value in this country is to ensure and improve access to HIV/TB and viral hepatitis treatment by implementing innovative approaches and advocating simplification of diagnosis, management, treatment and follow-up.

In Maputo, MSF provides care for HIV patients who need second- or third-line antiretroviral treatment and therapy for co-morbidities like Kaposi's sarcoma and viral hepatitis. Kaposi's sarcoma is a cancer that particularly affects patients with poor immune function. MSF started giving these patients a new, improved treatment allowing quicker recovery. 1,498 patients were taking this new drug in 2017. Comprehensive care is also available for multidrug-resistant tuberculosis and extensively drug-resistant TB. A viral hepatitis C treatment programme was scaled up during the year to include treatment for injectable drug users.

The project in Morrumbala focused on unmet needs in sexual and reproductive health and maternal mortality. In 2017, access was improved through the decentralisation of care as well as the establishment of stronger linkages and referral between communities, health centres and the hospital. These activities were handed over to enable MSF to focus on new activities in the capital Maputo.

In April, a cholera outbreak in Tete city quickly spread to other districts and MSF decided to support water and sanitation improvement, and case management at cholera treatment centres. Teams organised an oral cholera vaccination campaign, with 297,598 doses administered through fixed posts and mobile clinics.

MYANMAR

Improving access to healthcare

In the country since: 2000
Reason for intervention: epidemics, primary healthcare, healthcare exclusion

Main activity: HIV/AIDS, tuberculosis, hepatitis C, primary healthcare

Human resources (FTE): 140 staff including 16 international staff
Cost for 2017: CHF 3,112,000

In August, attacks on police posts in Rakhine State prompted government forces to respond with grossly disproportionate security operations. This caused a catastrophic humanitarian situation in the state, prompting over 660,000 people – mostly Rohingya – to flee to Bangladesh by the end of the year. In spite of the ban on international staff and a lack of authorisation to carry out medical activities, MSF continued to liaise with the authorities to offer emergency and non-emergency healthcare support for the remaining population. In September, MSF publicly called on the Myanmar government to grant international humanitarian organisations independent and unfettered access, including for international staff. At the end of the year, MSF was still waiting for official permits, Rohingya continued to flee across the border into Bangladesh, and very few humanitarian actors were allowed to respond in Rakhine.

Due to a worsening political situation and the inability to secure access for MSF international staff, medical activities in Wa Special Region 2 ended in mid-2017. Before closing, MSF conducted over 2,438 outpatient consultations through fixed and mobile clinics.

In the second half of the year, MSF launched a new programme in Naga, one of the most remote corners of the country, focusing on primary healthcare and health promotion.

MSF also continued to run its clinic in Dawei, Tanintharyi Region, supporting government hospitals in the provision of decentralised HIV care. MSF provided viral load testing for all HIV patients in Tanintharyi Region, and worked with the community to improve early HIV detection and treatment. Teams also provided care for patients with tuberculosis and hepatitis C.


Myanmar, 2017 © Alex von Baargen

In remote regions, access to healthcare is very difficult. MSF offers primary care and is working to improve the detection of diseases such as HIV and hepatitis C.

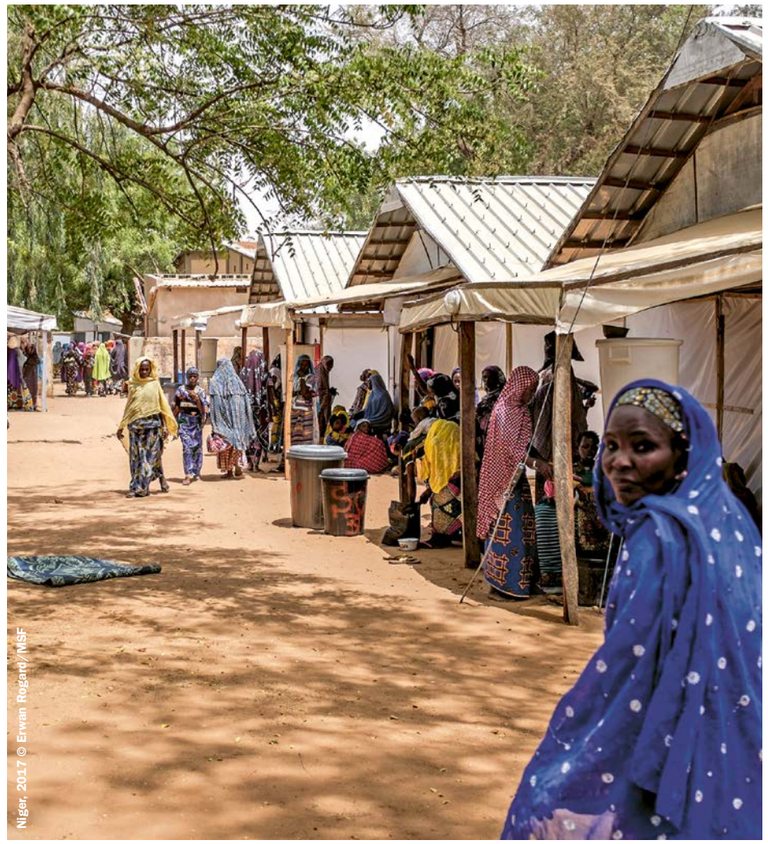
NIGER

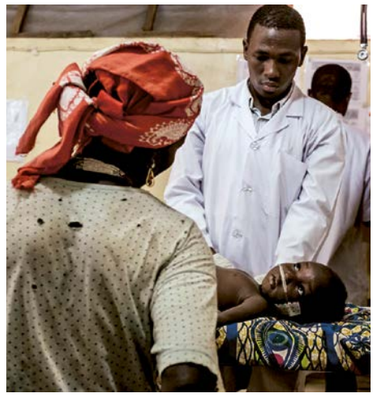
Tackling malnutrition and malaria

In the country since: 2005
Reason for intervention: epidemics, displacement

Main activity: hospital care, primary healthcare
Emergency intervention: malaria, hepatitis E, meningitis C

Human resources (FTE): 908 staff including 44 international staff
Cost for 2017: CHF 15,292,000


Niger, 2017 © Erwan Rogard/MSF



In Niger, MSF treats children suffering from severe acute malnutrition at Magaria Hospital.

In Niger, MSF focuses on reducing child mortality, particularly during the peak malnutrition and malaria season, responding to epidemics such as hepatitis E and assisting refugees and displaced people in Diffa.

People living in Diffa region, on the border with Nigeria, continue to suffer the consequences of the violent clashes between armed groups and the military forces. MSF works with the Ministry of Health to provide humanitarian assistance to both displaced people and the local communities. Through health centres, health posts and mobile clinics, teams offer primary healthcare, reproductive health services and hospital referrals, and also respond to emergencies. When a hepatitis E epidemic was declared in Diffa region in April 2017, MSF launched a range of water and sanitation activities to tackle the disease, for example chlorinating water and distributing community and personal hygiene kits containing soap, gloves and utensils, as well as active case finding. Niger also experienced another meningitis C outbreak this year. Between March and June, MSF teams worked with the Ministry of Health to vaccinate more than 297,804 people in Niamey.

Every year, people in Niger face the annual 'hunger gap' between June and September, when the number of malaria and malnutrition cases increases dramatically. Without early treatment, severe cases can result in medical complications. MSF has worked in Magaria, in Zinder region, since 2005, and this year continued to boost the capacity of the paediatric unit in Magaria district hospital by providing staff and training. Between June and December, when the number of admissions for malnutrition and malaria increased, the paediatric unit had a peak capacity of 600 beds. More than 14,849 children under the age of five were treated in the paediatric unit of Magaria hospital in 2017. In addition, MSF staff worked in six health centres and one health post to support primary healthcare for children and hospital referrals for the most severe cases. Observation rooms were set up in the busy health centres of Dantchiao and Magaria, where patients were stabilised before being transferred, if necessary, to the paediatric unit in Magaria. In the nearby district of Dungass, MSF opened a 200-bed paediatric unit during the peak season for the second successive year and MSF staff worked in five outlying health centres and two health posts. MSF teams also led awareness-raising sessions in Magaria and Dungass. In March, after 12 years of supporting the inpatient paediatric unit at the national hospital and an inpatient therapeutic feeding centre in Zinder city, MSF handed these activities over to the local authorities and the French Red Cross.

NIGERIA

Delivering life-saving assistance to internally displaced people

In the country since: 2016
Reason for intervention: armed conflict, displacement

Main activity: hospital care, primary healthcare, sexual and reproductive healthcare, vaccination, water and sanitation
Emergency intervention: malaria, measles, meningitis

Human resources (FTE): 175 staff including 28 international staff
Cost for 2017: CHF 6,896,000

Since 2013, the security situation has continued to deteriorate in Nigeria due to violent attacks by armed groups and the government's counterinsurgency operations. In Borno State, in the northeast of the country, more than 2.3 million people have been displaced, while another quarter of a million have taken refuge in the neighbouring countries of Cameroon, Chad and Niger. Insecurity prevents people from maintaining their livelihoods and they have little access to food and clean water. Furthermore, many people struggle to obtain healthcare, as 64% of all medical facilities in Borno have been damaged or destroyed. Those that remain lack qualified staff and drugs. In this challenging context, MSF continues to focus on reaching isolated displaced populations and vulnerable communities in Borno and addressing their most urgent needs. The volatility of the situation and the remoteness of the locations pose major challenges to delivering aid and the risk has to be constantly assessed.

Since 2016, the population of Ngala camp, located close to the Cameroonian border, has doubled and now stands at 60,000; its inhabitants are dependent on external aid for survival. In 2017, MSF worked in a 50-bed inpatient department which included an intensive care unit and a paediatric ward. Teams admitted 415 patients and provided 1,390 consultations for patients suffering from severe and moderate acute malnutrition. In April, the project started to offer sexual and reproductive healthcare and carried out a total of 5,086 consultations. Since September, patients in a critical condition have been referred to the MSF project in Kousseri, in Cameroon. To prevent the spread of diseases, teams vaccinated patients against diphtheria, whooping cough, tetanus, measles, poliomyelitis and tuberculosis. In addition, they organised four rounds of seasonal malaria chemotherapy for children under the age of five, administering a total of 51,742 doses.

The town of Rann, which is surrounded by swamps, is cut off from the outside world during the rainy season, between June and January. The 40,000 people living there are extremely vulnerable, and their access to water and sanitation is precarious. The first time MSF managed to reach Rann in January, a Nigerian air force jet bombed the town twice, killing at least 90 people and injuring 150 others. In the aftermath of the bombing, MSF staff treated the wounded and helped airlift seriously injured patients before evacuating. After reassessing the situation, the team resumed activities in February, deploying a mobile clinic to visit Rann on a regular basis, providing medical and nutritional care, health promotion and water and sanitation support. Since July, MSF has maintained a permanent presence in the town and scaled up its activities, mainly treating patients for malaria, malnutrition and illnesses linked to poor living conditions. A total of 10,362 outpatient consultations were conducted. As it is difficult to work in this area all year round, preventive activities are essential. Teams organised a number of measles vaccination campaigns, which reached 10,607 children, and provided seasonal malaria chemotherapy for 34,654 people.

In Banki, a town on the Cameroonian border, MSF assists the displaced population by offering medical and preventive care, as well as water and sanitation support, and distributing relief items. Some activities have now been handed over to other organisations, but the teams vaccinated 11,926 children against measles towards the end of the year.

MSF mobile clinics also carried out measles and meningitis vaccination campaigns and seasonal malaria chemotherapy in the town of Damasak, near the border with Niger, reaching 28,197 children under the age of five.


Nigeria, 2017 © Sylvain Cherkaoui/Cosmos

MSF is helping the vulnerable populations of Rann and Ngala displacement camps by giving medical and nutritional care and developing preventive approaches.

SUDAN

Treating outbreaks and neglected diseases

In the country since: 2004
Reason for intervention: healthcare exclusion, epidemics

Main activity: hospital care, primary healthcare, kala azar (visceral leishmaniasis)
Emergency intervention: acute watery diarrhoea, measles

Human resources (FTE): 120 staff including 14 international staff
Cost for 2017: CHF 3,944,000

Humanitarian needs remain very high in Sudan, with an estimated 2.5 million people displaced in the country. South Sudanese refugees continue to flow into Sudan and the country is also on the route for asylum seekers making their way to Europe. The level of malnutrition is significant in some places and an outbreak of acute watery diarrhoea has been ongoing since August 2016, with more than 30,000 reported cases. The humanitarian crisis is exacerbated by the dire economic situation, which is marked by high inflation rates and an increasing scarcity of basic commodities.

Access for humanitarian organisations improved over the course of 2017, allowing MSF to open two new projects and plan other evaluation missions. In East Darfur, MSF has been able to start providing primary healthcare services to the South Sudanese refugees in Kario refugee camp. In July, MSF took over the existing primary healthcare centre run by a local organisation, upgraded the services offered and, in September, added an inpatient department, including a maternity unit and a malnutrition stabilisation centre. The facility is the only health centre in the area for the refugees and the villages around Kario, where there is an estimated population of 47,000. The start of the intervention coincided with the outbreak of acute watery diarrhoea that hit the camp. More than 300 patients were treated by MSF teams. In December, a measles vaccination campaign benefited more than 19,000 children thanks to the participation of a community health workers network.

In West Darfur, MSF teams provided paediatric care for displaced children at Krinding camp. The project started in April, with outpatient consultations and the setting up of a stabilisation unit. During the acute watery diarrhoea outbreak, MSF supported the Ministry of Health in managing a treatment centre at Mornei camp. Teams provided technical support in two other locations. Training has been organised for Ministry of Health staff and donations have been provided to health facilities.

Since 2009, MSF has been operating in Gedaref State, supporting a visceral leishmaniasis treatment centre at Tabarak Allah Hospital, participating in national forums (for example to revise the national guidelines), conducting operational research and engaging with other stakeholders to organise a stronger response against this disease in Sudan. MSF also provides technical support to a hospital in the Al-Rahad area. From the end of 2016 to April 2017, the number of cases rose to a level not seen since 2011. In June, cases of acute watery diarrhoea dramatically increased in the state and patients were admitted to the hospital where MSF set up and ran a treatment centre.

In East Darfur, MSF has started a primary healthcare programme for South Sudanese refugees at Kario camp.

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, vaccination
Emergency intervention: malaria

Human resources (FTE): 673 staff including 53 international staff
Cost for 2017: CHF 15,741,000

In the difficult-to-access areas around Akobo, the mobile teams perform primary health consultations.

South Sudan is still struggling to recover from the devastating war that led to its independence in 2011, and is repeatedly beset by crises. Tens of thousands of people have been killed and roughly one in three have been forced from their homes since conflict broke out again in December 2013. Two million people have fled to neighbouring countries, while another two million are displaced within South Sudan. In 2017, insecurity and poor access continued to hamper the delivery of aid that millions of South Sudanese rely on. Security also remained a major challenge for aid organisations, as it became increasingly dangerous to work in some areas. In addition, the country is prone to life-threatening diseases such as cholera, malaria and measles. To address the shortage of health services, MSF provides essential primary and secondary healthcare in Agok, Mayom and Akobo.

MSF continued to work to improve the quality of care at Agok Hospital, the only secondary health facility in Abyei Special Administrative Area. The team focused on emergency surgery, maternity care, neonatology and treatment for HIV/AIDS and tuberculosis, as well as neglected diseases like snakebites. MSF also started to support the rehabilitation and extension of the hospital buildings. Overall, 9,806 patients were admitted, including 2,162 for treatment in the therapeutic feeding centre. MSF continued its malaria test-and-treat programme in remote villages and treated over 101,831 patients with the help of community workers.

In Mayom, in Greater Upper Nile region, MSF provides primary healthcare, including sexual and reproductive health services, and this year conducted 53,346 outpatient consultations. The team also stabilises patients and runs an ambulance referral service for those requiring specialist treatment at Agok Hospital. During the rainy season, this three-hour journey can take up to eight hours.

MSF launched a new project in Akobo, a town located near the border with Ethiopia. Access to healthcare is extremely limited in this remote area where years of conflict and displacement have taken their toll. In late 2017, mobile teams were deployed in boats and cars to offer consultations in villages. In 2018, MSF will set up a permanent health facility in the nearby village of Kier. Preparedness and response to potential outbreaks and mass casualty events are key components of MSF's activities. For example, in September and October, MSF conducted an oral cholera vaccination campaign in collaboration with the Ministry of Health in the capital city, Juba. In total, 195,965 people were vaccinated in fixed and mobile clinics.

SWAZILAND

Improving treatment for HIV and tuberculosis

In the country since: 2007
Reason for intervention: epidemics

Main activity: HIV/AIDS, co-infections

Human resources (FTE): 239 staff including 17 international staff
Cost for 2017: CHF 6,416,000

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 has one of the world's highest rates of HIV, with roughly one in three adults infected. The HIV epidemic is showing signs of stabilising. The country still has one of the highest TB incidence rates in the world. In 2007, when MSF was invited by the government of Swaziland to help address this public health challenge, the decision was made to focus on controlling the epidemics through two different projects in Shiselweni region.

In Hlatikhulu and Matsanjeni, MSF handed over HIV care at primary healthcare level to another organisation in order to concentrate on community-based treatment. Teams at the community project provide specialised care for patients with complicated HIV and TB and implement innovative prevention activities to reduce HIV incidence. For example, this year, the team started to offer oral HIV self-testing. More than 10,368 people were tested for HIV during the year and 363 patients initiated antiretroviral (ARV) therapy tailored to their individual needs. As a result of major efforts to decentralise cervical cancer screening and treatment, over 2,000 patients were screened in primary healthcare facilities.

The project in Nhlangano aims to improve the quality of comprehensive HIV and TB care in both health facilities and at community level, and provide better management of drug-resistant TB. To help patients stick to their treatment, MSF has set up community adherence clubs for adults and children. For people particularly at risk of contracting HIV, pre-exposure prophylaxis is offered as an additional means of HIV prevention. Overall, 5,886 patients received ARV therapy in 2017. In May, oral HIV self-testing was also implemented in Nhlangano, with a total of 1,328 self-testing kits distributed by the end of the year.

Advocacy forms another key part of MSF's work in Swaziland. MSF lobbies for equity of access to care and treatment for HIV and TB, essential medicines and medical testing.

SYRIA

Offering healthcare in conflict areas

In the country since: 2013
Reason for intervention: armed conflict, displacement

Main activity: hospital care, primary healthcare, sexual and reproductive healthcare

Human resources (FTE): 114 staff including 21 international staff
Cost for 2017: CHF 7,937,000


Syria, 2017 © Louise Annauld/MSF

In Al-Hasakah, in the northeast of Syria, MSF is rehabilitating the building and performing surgery on patients at the shipping-container facility set up in front of the hospital.

In its seventh year, the Syria crisis continued to take its toll on civilians across the country, where millions of people are in need of humanitarian assistance. Large sections of the population' were forced to flee deplorable conditions and indiscriminate violence. For example, in East Ghouta, people were trapped in enclaves and deprived of vital goods, such as food and medicine, while being ruthlessly bombed for weeks, sometimes months, on end.

In 2017, the situation in the northeast of Syria further deteriorated due to the offensives in Raqqa and Deir ez-Zor governorates. The health infrastructure was not spared, and many people had to escape. Indeed, UN data shows that, in 2017, Deir ez-Zor Governorate generated the highest volume of population movements in Syria, with 255,000 people displaced an average of three times that year alone.

Although the fighting in northeastern Syria subsided towards the end of the year, civilians were far from being safe. As people began to return home, they realised that their houses and towns were littered with thousands of unexploded remnants of war, mines and booby traps. Daily household items like teapots, pillows and refrigerators were rigged to explode as soon as people used them.

After identifying a gap in access to secondary healthcare in northeast Syria, MSF decided to rehabilitate a derelict hospital in Al-Hasakah. Once completed, the project offered quality emergency and surgical care that was accessible day and night to people in the region, largely from the governorates of Raqqa, Al-Hasakah and Deir ez-Zor.

Between October and December, 563 surgeries were performed in the operating theatre, where trauma patients accounted for the largest number of procedures. From November to the end of the year, a total of 295 patients were admitted as victims of trauma caused by booby traps, mine explosions, gunshots and airstrikes, mostly from Deir ez-Zor and Raqqa. In parallel, psychological support was provided, mainly for patients with war injuries and burns. The inpatient department comprises 33 beds, including two isolation rooms and physiotherapy services (provided by another organisation), and MSF manages the 24/7 laboratory, blood bank and diagnostic imaging (X-ray). A referral system is also in place to transfer patients that cannot be treated at the hospital. The teams also managed two mass casualty incidents.

In addition, mobile clinics operated in a number of camps for people internally displaced by the fighting. Through these facilities, MSF supported patients with non-communicable diseases (diabetes, hypertension, etc.), mental health problems, and sexual and reproductive health issues, carrying out a total of 15,219 consultations. At the same time, teams enhanced the water and sanitation infrastructure at some of these sites.

MSF also continued to run activities at other primary healthcare centres to improve access to free-of-charge, good quality medical services for people living in different parts of Al-Hasakah Governorate. Teams provided mother-and-child services on a maternity ward for uncomplicated cases and direct support to two clinics for outpatient consultations. These included care for non-communicable diseases, sexual and reproductive health and mental health support. Teams provided 55,466 general consultations, and 1,325 non-communicable disease patients were in the programme this year.

TANZANIA

Assisting refugees living in camps

In the country since: 2015
Reason for intervention: displacement, epidemics

Main activity: hospital care, primary healthcare, mental healthcare
Emergency intervention: malaria

Human resources (FTE): 248 staff including 32 international staff
Cost for 2017: CHF 8,572,000


Tanzania, 2017 © Benoit Renard/MSF

At Nduta refugee camp, MSF provides access to primary and secondary care for people who have nothing.

MSF has been present in Tanzania since May 2015 to address the medical needs of the refugee population living near the northwestern border. There is an enormous refugee presence with over 315,000 refugees from the Democratic Republic of the Congo (DRC) and Burundi living in three main camps in the Kigoma district. At the end of 2017, Nyarugusu camp was holding 150,993 refugees, Nduta camp 118,635 and Mtendeli camp 45,528. In 2017, MSF worked in Nyarugusu and Nduta camps. The overall humanitarian response in this region is severely underfunded and the Tanzanian community is struggling to cope with the influx of refugees.

January and February 2017 saw the greatest monthly increase in the arrival of refugees from Burundi since the initial surge at the beginning of the Burundian crisis in April 2015, with 31,000 new arrivals recorded in Nduta by the International Office of Migration. Following the revocation of *prima facie* refugee status by Tanzania in late January 2017, arrivals gradually started to slow down. The main focus for MSF throughout the year was to ensure the availability of primary and secondary healthcare in Nduta. A new maternity unit and pharmacy were constructed and existing health facilities were refurbished, including a 175-bed hospital and six health posts. 18,002 patients were admitted to the hospital in 2017, and 6,365 births were assisted. Mental health and health promotion activities were conducted in the community, with 8,888 individual psychological consultations being performed during the year. Care was provided for a total of 540 cases of sexual and gender-based violence, and there were 682 HIV patients in the MSF cohort. With malaria rates remaining high in the camp, teams also carried out a mass distribution of mosquito nets in December.

MSF phased out its activities in Nyarugusu camp by the end of May 2017, donating some medical structures to the Tanzanian Red Cross. At the time, MSF was running two malaria clinics, and a 40-bed emergency room and stabilisation unit for the treatment of severe malaria among children aged under ten. The unit was closed in April after having admitted 1,112 patients. Mental health and health promotion activities continued until the end of May.

UKRAINE

Treating people along the frontline

In the country since: 2015
Reason for intervention: armed conflict, displacement

Main activity: primary healthcare, hepatitis C

Human resources (FTE): 76 staff including 16 international staff
Cost for 2017: CHF 3,137,000

In 2017, the conflict in eastern Ukraine entered its third year, taking a heavy toll on both sides of the frontline, as many people were displaced and essential services, including healthcare, did not function. The continued fighting further exacerbated 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.

MSF expanded its project in Donetsk Oblast to new locations along the frontline, in close proximity to the combat zone. By the end of the year, MSF was working at 28 sites. In this region, the armed conflict continues to severely affect the public health system. Internally displaced persons with chronic diseases can no longer afford to pay for their treatments. Many are also suffering from conflict-related psychological disorders such as post-traumatic stress disorder, depression or intense anxiety. In 2017, mobile MSF teams consisting of a doctor, a nurse and a psychologist held 24,614 consultations for people with chronic diseases, who are mostly over 50, and carried out 2,427 mental health consultations. MSF also ran two fixed clinics in Mariupol and Kurakhove offering healthcare to displaced persons and vulnerable residents, conducted training for medical staff and psychologists and donated drugs to other health facilities.

In Mykolaiv Oblast, in southern Ukraine, MSF started a new project for the treatment of hepatitis C, a disease that can lead to liver failure and liver cancer when left untreated. The programme, which is conducted in collaboration with the Ministry of Health and the Mykolaiv Regional Centre of Palliative Care and Integrated Services, is aimed at around 1,000 patients. Some of the patients are co-infected with HIV or on opioid substitution therapy, while others are healthcare workers infected with the virus. Patients in MSF's programme receive free effective treatment and are also supported with counselling and health education in order to improve adherence to treatment and help them manage social issues resulting from their disease. The project became operational in November and by the end of the year 328 hepatitis C consultations had been carried out. MSF has also provided state-of-the-art diagnostic equipment and medical items to the centre in Mykolaiv.

YEMEN

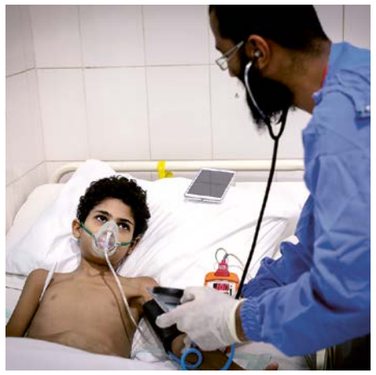
Helping the victims of war and fighting the cholera outbreak

In the country since: 2015
Reason for intervention: armed conflict, epidemics

Main activity: hospital care, health promotion
Emergency intervention: cholera, diphtheria

Human resources (FTE): 385 staff including 25 international staff
Cost for 2017: CHF 11,413,000

Yemen, 2017 © Nuha Haider/MSF



In response to the epidemic that began in April, MSF set up cholera treatment centres to look after patients. Teams also organised education sessions on preventing the spread of the disease.

Three years of war have taken a severe toll on the people of Yemen and created one of the world's worst humanitarian crises. Ongoing fighting is causing heavy casualties and significant damage to civilian infrastructure, including health facilities. The United Nations Office for the Coordination of Humanitarian Affairs estimated that more than half of Yemen's population of 28 million are unable to access adequate healthcare. There are shortages of medical supplies, materials and staff, and many government health workers have not received their salaries for over a year. Consequently, the deployment of humanitarian aid is a constant challenge and the conditions are ripe for large-scale outbreaks of disease.

In 2017, MSF continued to focus on meeting the acute medical needs of people caught up in the war and providing them with lifesaving healthcare. In Ibb Governorate, a team supported the emergency department at Al-Thawra Hospital,, strengthening its response capacity for mass casualty incidents and training operating theatre staff. MSF also donated medical and logistical supplies and equipment to other departments. The project was closed in April due to the lack of security guarantees for staff and restrictions that made it impossible for MSF to maintain its principles of impartiality, independence and neutrality in its operations.

April was also the start of Yemen's worst cholera epidemic. According to some estimates, nearly 1 million people were affected by the end of the year. In response, MSF set up three cholera treatment centres in Ibb and Taiz governorates and organised outreach activities to prevent the spread of the epidemic. Overall, 17,423 people were admitted to treatment centres. Teams also distributed hygiene kits and household disinfection items, ran health and education sessions and supported referrals to health facilities. In late August, the first suspected cases of diphtheria started appearing, another result of the poor access to medical care across Yemen. The majority of the cases were reported in Ibb Governorate. MSF opened two diphtheria treatment units and developed a patient referral system. Health promotion activities were also organised to raise awareness of the disease, its symptoms, treatment and prevention methods.

In Kilo, a city located between Ibb and Taiz, MSF continued to work on improving the surgical capacity, intensive care unit, emergency ward and inpatient department of one of the main hospitals. The teams trained staff in mass casualty incident preparedness and supported the maternity unit, laboratory and X-ray department with logistics and supplies. As more people became aware of MSF's activities at this hospital, the number of patients increased. MSF teams provided 3,886 surgical interventions and 3,644 emergency consultations, and admitted 7,737 patients for treatment in 2017.

Human Resources

Almost half of our projects are located in conflict zones. In 2017 we continued to scale up our activities, deploying more than 6,600 people, an increase of 8% in national staff and 15% in international staff compared with 2016. Working in the midst of conflicts is the norm for our teams in Iraq, Syria, Yemen, South Sudan, Democratic Republic of Congo, Niger and Nigeria. Notably in 2017, we began activities again in hospitals in Mosul, Iraq, and Al-Hasakah, in Syria. On several occasions, our staff were direct witnesses of violence, for example during the bombing of Rann in Nigeria at the beginning of the year.

In order to work in the safest and most responsible way in such contexts, it is necessary to establish a number of basic measures for managing human resources, relating to duty of care. Within this framework, we evaluated, and then revised the process of informed consent for all our staff. This involved systematically providing all the essential information to ensure that employees were aware of, and understood the risks of each mission as well as possible, both before and throughout the duration of their contracts.

As a responsible employer, we have also endeavoured to raise awareness with regard to potential abuse of power, and improve the way any such cases are addressed and subsequently dealt with, MSF will not tolerate such abuse as we are committed to upholding respect for each and every individual according to the values set out in our Charter. To this end, we have reinforced the system we already have in place and engaged in dialogue with our staff worldwide. Caring for our patients day after day, the human resources of the MSF teams are our greatest asset. We value each and every member of staff, and rely on their diversity, enabling us to adapt our medical care to all of our projects. We recognise the variety and strength that our diverse workforce provides us with, and we are constantly striving to improve our strategies of inclusion. One such strategy is learning and development, investing in developing the skills, competencies and careers of our staff. A key priority which has been identified is staff integration. This initiative was created and validated in 2017 and launched in 2018, with the aim of helping new staff adapt to their roles in the field. This is done by strengthening their adherence to our most important values: humanity, professionalism and commitment.

With integration being of great importance to MSF, we strive to include it in all of our policy frameworks. A notable example of this is our Human Resource principle on Mobility and Diversity, validated in 2017. These principles enable the development of our staff and promote the diversity of our teams, while guaranteeing the competencies that are key to our organisation. To increase the diversity of our international teams, we have continued to invest in our regional offices in Dakar, Kampala, Amman, Beirut, Prague, Seoul and Mexico in terms of staff recruitment, training and mobility. In 2017 for example, the training capacity of the Dakar office was doubled. The teams in our Geneva and Zurich offices also offer essential support to field-based teams on a daily basis.

I would like to take this opportunity to thank the numerous volunteers and all the staff who are at the heart of our organisation, and who continuously demonstrate exceptional commitment, professionalism and humanity.

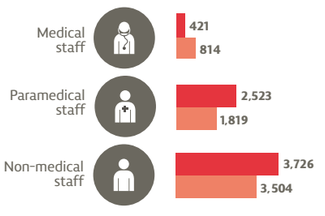
Aude Thorel
Director of Human Resources MSF OCG

6,670
field staff

256
headquarters staff

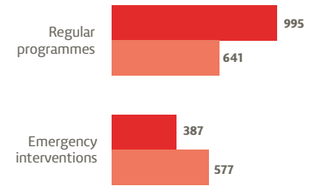
2,925
volunteer hours in Switzerland

Staff per occupation (FTE) 2017 - 2016



Total field staff:	in 2017	in 2016
	6,670	6,137

Field mission departures 2017 - 2016



Total numbers on their first mission:	in 2017	in 2016
	205	227

Financial results

In 2017, MSF Switzerland's expenditure increased by 6%, reaching a total of CHF 249 million.

Programme costs rose to CHF 191 million, an increase of CHF 8m (+4%) compared with 2016. They have therefore stabilised after three years of steep increases. A total of 75 projects were run in 24 countries – 12 more projects in one less country than in 2016. Burkina Faso is a new country of intervention for MSF Switzerland, while we ceased operations in Zambia and Ecuador. The growth in the number of projects is a reflection of protracted crises. Indeed, 11 projects opened in response to emergencies in 2016 were still running in 2017.

Our teams continued to be very active in the Middle East. They intervened in Iraq, Yemen, Lebanon and Syria, where the total cost of the 12 projects came to CHF 50 million, an increase of CHF 15 million compared with 2016. Iraq is our biggest mission today, with a total cost of CHF 19 million.

In West Africa, where our programme expenditure was CHF 41 million, a slight decrease (-2%) from last year, humanitarian needs remain significant. In 2017, MSF Switzerland provided medical assistance to people in this region through 17 projects in five countries: Cameroon, Chad, Niger, Nigeria and Burkina Faso.

The Democratic Republic of Congo continues to be the country with the largest number of interventions (nine projects), the same as in 2016. However, the crises we faced this year were on a smaller scale than last year, especially with regard to epidemics, and this explains the reduction in costs from CHF 25 million to CHF 19 million.

In terms of geographical distribution, Africa accounts for 65% of our operational expenditure, compared with 73% in 2016. This decrease is due to our increased involvement in the Middle East, which accounted for 27%, compared with 20% in 2016.

As forecast in our action plan, 2017 was a year of consolidation for the headquarters, including an increase of 13% in the cost of programme support. We continued to develop our support activities for decentralised programmes in our regional offices, particularly in Dakar for epidemiological surveillance, emergency response and recruitment. We also made major investments in fundraising (+16%) in view of the projected budgetary deficits. We have dedicated 91% of our expenditure to our social mission, and 9% to administration and fundraising.

Income for 2017 was CHF 249 million, a 6% increase over the previous year. CHF 101 million was raised in Switzerland, where 243,432 people supported us with donations. We also received a donation of CHF 6 million from the IKEA Foundation.

Private funds from MSF partner sections amounted to CHF 138 million, up 11% from 2016. The main contributors are MSF USA, MSF Germany and MSF Australia.

Income from public funding came to CHF 10 million, a decrease of 19% compared with 2016. Funding from the SDC (the Swiss Agency for Development and Cooperation), which contributed CHF 7 million, now accounts for 67% of the total from public sources.

The sources of funding for MSF Switzerland were therefore 96% private and 4% public.

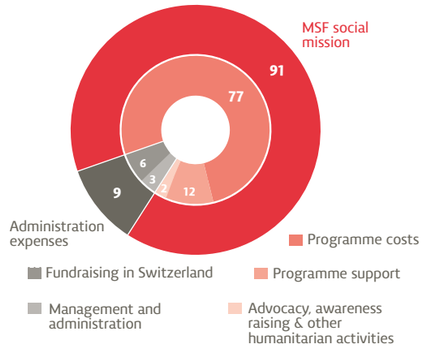
The financial results for 2017 are perfectly balanced since our total expenditure is equal to our total income. Taking into account a foreign exchange gain, this resulted in a small surplus of CHF 2 million. We warmly thank all our donors for their support which enables us to carry out our medical assistance programmes.

Emmanuel Flamand
Finance Director

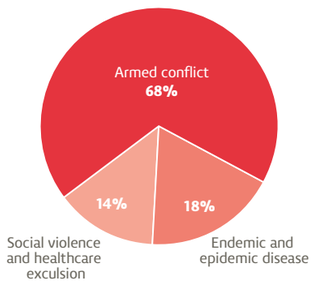
Expenditure (in thousands of Swiss francs)

	2017	2016
Programme costs	191,346	183,269
Programme support	31,214	27,685
Advocacy, awareness raising & other humanitarian activities	4,851	4,460
Social mission expenses	**227,411**	**215,414**
Fundraising in Switzerland	13,379	11,513
Management and administration	7,925	7,089
Administration expenses	**21,304**	**18,602**
TOTAL EXPENDITURE	**248,715**	**234,016**

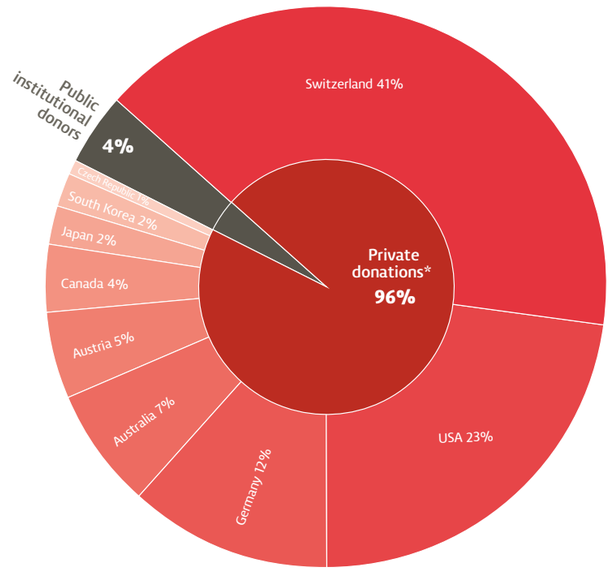
Expenditure (%)



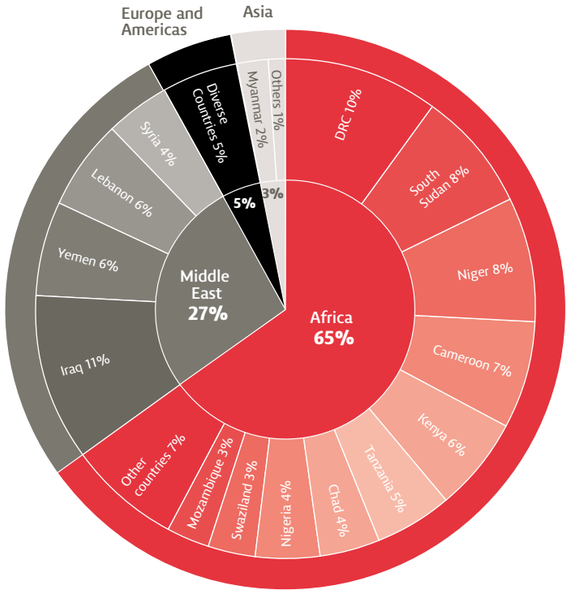
Programme costs per reason of intervention



Income (%)

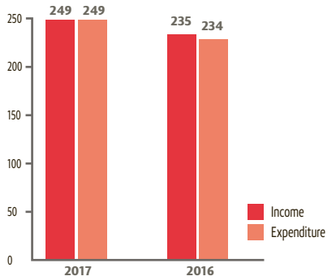


Programme costs per country

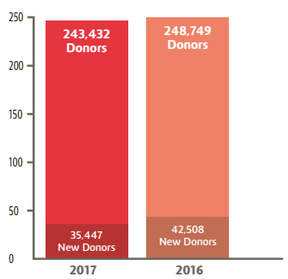


* Private donations from MSF Switzerland and other MSF partner sections.

Income and expenditure
(in millions of Swiss francs)



Swiss private donations



Active donors

Acknowledgments

We would like to thank all donors who made the work of Médecins Sans Frontières Switzerland possible in 2017. This year, 243,432 people generously supported our organisation – we thank them all for their confidence in our work.

We would like to thank the governments, governmental agencies and international organisations that have supported our projects:

- CIDA / IHA Canadian International Development Agency, International Humanitarian Assistance
- The Global Fund
- Save the Children
- SDC – Swiss Agency for Development and Cooperation
- UNHCR - The UN Refugee Agency
- UNICEF
- UNITAID
- WFP – World Food Programme

We would also like to thank the following foundations, businesses, towns and cantons:

- Cartier Philanthropy
- Chaîne du Bonheur/Glückskette
- Ernst Göhner Stiftung
- Fondation Pierre Demaurex
- Fondation Rifké
- Gebauer Stiftung
- Hilti Foundation
- IF! International Foundation
- IKEA Foundation
- Kanton Aargau
- Medicor Foundation
- Oak Foundation
- République et canton de Genève
- Tarbaca Indigo Foundation
- Wietlisbach Foundation

We would like to sincerely thank:

- ACE international SA
- Admeira AG
- Alfa Klebstoffe AG
- Ameos Spital-Gesellschaft mbH
- Anyweb AG
- Association des amis de Jost Steiger
- At Rete AG
- Bakus Bauphysik und Akustik GMBH
- Blooming Juniper Foundation
- Breitling SA
- BÜCHI Foundation
- C + S AG
- Caisse des médecins – Société coopérative – Romandie Direction
- Canton du Valais
- Capital International SA
- Carpi Tech B.V. Amsterdam, Balerna Branch
- Charlotte und Nelly Dornacher Stiftung
- Christoph Sax Data Analytics GmbH
- Cofra Foundation
- Commune de Bernex
- Commune de Collonge-Bellerive
- Commune de Cologny
- Commune de Plan-les-Ouates
- Commune de Troinex
- Consa Treuhand AG
- Couvent Ste Ursule
- DACHCOM.CH AG
- Daniel Swarovski Corporation AG
- Dinner for Two Kai-Henning-Fonds
- Dominikanerinnenkloster St. Peter & Paul
- Dr. Margrit Schoch-Stiftung
- duagon AG
- Duthaler AG
- Egon-und-Ingrid-Hug-Stiftung
- Elbro AG
- Elisabeth Nothmann Stiftung
- Ellix AG
- Erika und Conrad Schnyder-Stiftung
- Ernst & Young AG
- Euxinus AG
- Evang. Ref. Kirche Erlenbach
- Evang. Ref. Kirchgemeinde Urdorf
- Evangelisch-Reformierte Kirchgemeinde Wallisellen
- Exedra AG
- Fäh & Co. AG
- Fent AG
- Fight4Sight Foundation
- Fleurs Suisse Gmbh
- Flüchtlingshilfe Liechtenstein
- Fondation Abouzeid
- Fondation Alfred et Eugénie Baur
- Fondation Charitable Bienvenue
- Fondation de bienfaisance de la Banque Pictet & Cie
- Fondation Dr. Corinne Schuler
- Fondation Hubert Looser
- Fondation Idryma Georges Katingo Lemos
- Fondation Johann et Luzia Graessli
- Fondation pour l'aide humanitaire
- Fondation Stella
- Fondation Turangalila
- Fondation W. et E. Grand d'Hauteville
- Fondazione Casal
- Frischknecht AG
- Gebrüder Kägi Stiftung
- Gemeinde Baar
- Gemeinde Bassersdorf
- Gemeinde Zumikon
- Getzmann AG
- Giessenbach Stiftung
- Gom International AG
- Günther Caspar Stiftung
- Hans-Eggenberger-Stiftung
- Hemmi Fayet Architekten AG
- Hilfswerk GL Zürich
- Htp Hitech Photopolymere AG
- Huwa Finanz & Beteiligungs AG
- I+F Public Benefit Foundation
- Intellec AG
- JCE Hottinger & Co.
- Jonathan Heyer Fotografie & Film Gmbh
- Kanton Basel-Stadt
- Kanton Graubünden
- Kanton Thurgau
- Karelsie Stiftung
- kieferorthopaedie-thun AG
- Korporation Baar-Dorf
- Labmed
- Link Marketing Services AG
- Lions Club Aaretal
- Lions Club Weinfelden-Mittelthurgau
- Martin Nösberger Stiftung
- Mathilde Daudert Stiftung
- Medtronic (Suisse) SA
- Musgrave Charitable Trust Ltd
- Pelican Immobilien AG
- Pistorio Foundation
- POLYGONA Präzisionsmechanik AG
- Pratohaus AG
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- Röm. Kath. Pfarramt Aarburg
- Rosa und Bernhard Merz-Stiftung
- Rütli-Stiftung
- Sail to Win
- Savain AG
- Schumacher CHings Ingenieurs Sa
- Schweizerische Ärzte-Krankenkasse
- Sico Bauelemente AG
- Spline AG
- Srg Engineering R.G. Riedweg et Gendre Sa
- Stadt Rapperswil-Jona
- Stäubli International AG
- Stefanie und Wolfgang Baumann Stiftung
- Stiftung NAK Humanitas
- Stiftung Symphasis
- Stockwood INC
- Storz Medical AG
- Swisscom Health AG
- SYNERGON AG
- Teletrend AG
- The Kernco Foundation
- The Swatch Group SA
- The Tanner Trust
- Thurgau Travel AG
- Tschikali Stiftung
- Tumor- und Brustzentrum ZeTuP St. Gallen
- UK Online Giving Foundation
- Ville de Genève
- Ville de Lancy
- Ville de Meyrin
- Ville du Grand-Saconnex
- Walter Haefner Stiftung
- Wellington Partners Advisory AG
- WorldConnect AG
- Yellow Bird Foundation
- Zentrum Neuhof AG
- Züger Frischkäse AG

We also extend thanks to our event partners:

- Blofeld Entertainment GmbH
- FIFDH – International Film Festival and Forum on Human Rights Geneva
- foraus – Policy Lab
- Fumetto Comic Festival Luzern
- Human Rights Film Festival Zurich
- Interactions
- Paléo Festival Nyon
- Swiss Red Cross – Department of Health and Integration
- UNOG – United Nations Office at Geneva

Finally, we would like to thank all those who volunteered time and energy to help MSF in 2017:

- Abdullah Karnas
- Albertalli Reto
- Baleng Elise
- Bingler Viola
- Casella Jacqueline
- Chkolenok Anastassia
- Christe Javier
- Dabiri Pernian
- De Rivaz Romaine Josephine
- Gbegbeni-Perdrix Sarah
- Ghillani Bertolini Patrizia
- Larerad Sarah
- Lucifora Agatino Tino
- Mazuze Lucie
- Montani Rachel
- Nelson Brenda
- Palestra Francesca
- Pernet-Coudrier Doriane
- Perotti Cynthia
- Schleichert Lisa
- Stamenkovic-Zimmermann Andrijana
- Stracquadaini Daniela

For their loyal support over the years, we would like to extend our special thanks to:

- Fuchs Pia
- Meyer Madeleine
- Rasmussen Thérèse
- Serfass Irène
- Thiéry Cécile

Many thanks to our
243,432
donors

We apologise for any inadvertent omissions.

Governance structure of MSF Switzerland

Médecins Sans Frontières Switzerland is an association registered under 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 2017

- Reveka Papadopoulou, President (since May 2017)
- Liza Cragg, Vice-President (re-elected in 2017)
- Patrick Reybet-Degat, Treasurer
- Dr Philippe Sudre, Secretary
- Dr Slim Slama
- Miriam Kasztura (since May 2017)
- Gillian Slinger
- Claude Mahoudeau
- Dr Frauke Jochims

Co-opted Board Members:
- Dr Karim Laouabdia
- 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 Commission, composed of Board Members and external representatives. The Commission's mandate is to assist the Board of Directors to supervise the financial management of MSF Switzerland.

MSF Switzerland's Finance Committee in 2017

- Patrick Reybet-Degat, Treasurer of MSF Switzerland and President of the Finance Commission
- Reveka Papadopoulou, President of MSF Switzerland (since May 2017)
- Marcel Mittendorfer, Member of MSF Austria (until July 2017)
- Hans Isler, Financial Expert
- Frank Copping, Treasurer of MSF Canada
- Dr Philippe Sudre, Secretary of MSF Switzerland
- Beth Hilton-Thorp, Member of MSF Australia

The Board of Directors convenes a Human Resource Commission, composed of Board Members and other partners. Its purpose is to assist the Board to fulfil its governance responsibilities for human resources and human resource management.

It provides guidance and advice on the human resources of the organisation to ensure that it attracts, develops and retains the people needed to deliver its mandate and achieve its social mission.

MSF Switzerland's Human Resource Commission in 2017

- Beth Hilton-Thorp, Member of MSF Australia and Chairperson of the Human Resource Commission
- Reveka Papadopoulou, President of MSF Switzerland (since July 2017)
- Margaretha Maleh, President of MSF Austria
- Patrick Reybet-Degat, Treasurer of MSF Switzerland (until September 2017)
- Liza Cragg, Vice-President of MSF Switzerland (since September 2017)
- Ulrich Holtz, Member of MSF Germany
- Gillian Slinger, Member of MSF Switzerland
- Dr Frauke Jochims, Member of MSF Switzerland

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 2017

- Liesbeth Aelbrecht, General Director (since September 2017)
- Ralf de Coulon, Deputy General Director (since March 2017)
- Christine Jamet, Operations Director (since January 2017)
- Micaela Serafini, Medical Director
- Emmanuel Flamand, Finance Director
- Aude Thorel, Human Resources Director
- Avril Benoît, Communications and Fundraising 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 has performed this function since then.

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 risks associated with the environments in which MSF operates, as well as internal processes and procedures. An exercise is carried out to define the organisation's risk appetite, identify the risk events for 2018, their probability and impact, and decide on mitigation measures.

The analysis completed at the end of 2017 highlighted a number of risks within nine risk areas: strategy, safety and security, legal and compliance, human resources, medical, fraud and corruption, information and communication technology, financial and fundraising, and communication.

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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www.msf.ch

ccp 12-100-2

Twelve-year-old Ali (not his real name) arrived at Al-Hasakah Hospital, Syria, after sustaining a serious wound to his abdomen from a landmine. A week after undergoing an operation performed by the MSF teams, he was well enough to be discharged from the hospital. Syria, 2018 © Louise Annaud/MSF

MEDECINS SANS FRONTIERES
ÄRZTE OHNE GRENZEN