Activity Report

2017

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

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 Pari, 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 (OCC) 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-Hassakah, 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 chikungunya in Yemen and DRC was also among the key achievements of 2017: At the movement level, under the lead of Operational Centre Amsterdam (OCA), MSF started its 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 for rescue activities in the Mediterranean, the asylum-seeker reception crisis, the unacceptable treatment of migrants, and 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 Tonganyika, 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 actions 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 adapt to keep up with the demands of becoming a truly bureaucratic. Aspects such as duty of care, investment in training, diversity to better serve our partners and their patients, and “engagement versus ‘a job’” were addressed last year and will continue to be addressed in the years to come.

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Wishing you a happy reading of this retrospective of 2017,
MALI:

Refugees: Migrants fleeing attacks on their homes in Libya are crossing the Sahara desert into Mali. In July, more than 10,000 people arrived in Agadez in a single week, bringing the total number of arrivals this year to 70,000. The influx of refugees is straining the capacity of local authorities to respond, and many migrants are falling prey to human traffickers.

Vaccination: Since December 2016, MSF has reported 3,000 cases of meningitis in the Gao region. To address this issue, MSF has set up a meningitis vaccination campaign in the region, reaching more than 100,000 people.

Epidemic: In March, a second cholera outbreak was reported in Timbuktu, bringing the total number of cases to 2,500.

In June, a third cholera epidemic was reported in the region, with more than 2,000 cases reported.

In August, a fourth cholera epidemic was reported in the Gao region, with more than 3,000 cases reported.

ISIRI:

Refugees: In recent months, the situation in Dab tylko has been characterized by a rapid increase in the number of refugees arriving from Chad. Since the beginning of June, more than 10,000 refugees have crossed the border, bringing the total number of refugees in the region to 50,000.

Food insecurity: The food situation in the region is critical, with more than 100,000 people facing food insecurity. MSF is providing emergency food assistance to vulnerable populations.

Healthcare: The health situation is also critical, with more than 20,000 people suffering from malnutrition.

In September, MSF opened a new clinic in Dab only, providing healthcare to more than 100,000 people.

In October, MSF expanded its activities in the region, reaching more than 200,000 people.

In November, MSF intensified its activities in the region, reaching more than 300,000 people.

In December, MSF opened a new clinic in Dab only, providing healthcare to more than 300,000 people.
In 2017, the populations of the Sahel region were still caught between their national governments, and the non-state armed groups (known as 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 town and camp of Rann in Borno State, Nigeria, on 17 January 2017.

In the Middle East, the conflict 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 region 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-Husayn 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 conflict, 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-Husayn (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-Husayn, we are supporting a secondary care facility in a conflict zone and an extremely volatile geopolitics environment (the regime in Damascus, the Islamic State, the Kurdish authorities, regional and international stakehold- ers, etc.) We should also mention Yemen where, in 2017, we not only deployed operations front lines of a war that is entering its fourth year, but also tackled cholera and diphtheria epide- mics resulting from the collapsed health sys- tem 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 actions 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 situa- tions given that opening a project during a con- flict 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 humanitar- ian 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, par- ticularly development actors, OCG ends up stand- ing in for them in long-term projects, which draws us from our social mission. Such situations must be temporary and an exception. For instance, OCG withdrew from Guty in the Democratic Republic of the Congo (DRC) and from the Central African Republic (CFA) 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, epide- mics and conflicts are largely overshadowed, receiving 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.

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 under- stand local dynamics, more accurately analyse the context and, consequently, more effectively pre- pare for and address the populations’ needs.

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 poten- tially life-threatening diseases. Added to that are the dangers inherent in con- flicts 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 previ- ously 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 diph- theria occurred. The teams had almost never had to treat this disease on this scale.

Provisioning 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 sig- nificantly 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 prac- titioners. Our strategy includes simplifying treat- ment 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 antici- pate as far as possible the potential problems 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 sup- port and monitoring of chronic diseases.

Although mental health was already a compo- nent of the majority of our projects, greater importance was placed on it in 2017 as the trau- mas linked to certain contexts of violence and insecurity amplified the needs of the target pop-ulations. Treating these pathologies in a holistic way involves detection in the community, pri- mary health programmes and referral of serious cases to hospitals.

2017 Programme costs by continent (2016)

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As noted above, the situation in 2017 was particularly challenging for the humanitarian sector.

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
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. E-care was introduced or adapted to make it easier to work in environments with very limited 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.

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, snake-bites have been added to the official list of neglected tropical diseases. Regarding chikungunya, 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 trialed for Kyrgyz patients.

Concerning issues around population displacement 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

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.

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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.

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

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.
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 alert 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 Borki 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 medical care, screening and vaccinations. Deciding whether or not 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 guarantor of independence is rooted in the fact that more than 96% of its funding comes from the generosity of private donors, ONGs, 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. With only 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 have a duty to communicate on a large scale and new levers so that we can keep working 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 438 refugees at Dagaibah – 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 in 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 public 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, genocides, 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 Bangladesh boarder 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 shelters, 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 the work for which 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.
BURLINA FASO

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

Emergency intervention: Dengue

Human resources: 1 international staff
Cost for 2017: CHF 242,000

Main activity: hospital care

Improving emergency care

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, and patients with dengue symptoms. This enabled MSF to monitor the progression of the epidemic in these areas. In total, during the intervention, 1,191 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.

Since 2011, the conflict between armed groups and the Nigerian army has forced hundreds of thousands of people from northeastern 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. The team stabilised patients and transferred those in need of specialised surgical care to Maroua hospital.

At Mora Hospital, the teams treated patients in the emergency room and operating theatres around the clock.

Assisting people displaced by insecurity

CAMEROON

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

Main activity: hospital care; surgery; primary healthcare

Improving emergency care

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. This year teams carried out 8,136 surgical interventions in Mora and 2,956 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 provided 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 maternal services as well as nutritional and psychological support to Nigerian refugees since 2015. By July 2017, when MSF’s team in the camps handed over these activities to another organisation, teams had carried out more than 110,000 outpatient consultations.

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 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 Humonge hospital and nearby health 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.

Burkina Faso’s healthcare system is overstretched, especially 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, and patients with dengue symptoms. This enabled MSF to monitor the progression of the epidemic in these areas. In total, during the intervention, 1,191 dengue-related consultations were undertaken in conjunction with the Ministry of Health.

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BURLINA FASO

In the country since: 2017
Reason for intervention: epidemics

Emergency intervention: Dengue

Human resources: 1 international staff
Cost for 2017: CHF 242,000

Main activity: hospital care; surgery; primary healthcare

Improving emergency care

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

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Assisting people displaced by insecurity

CAMEROON

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

Main activity: hospital care; surgery; primary healthcare

Improving emergency care

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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 560,000. 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 16 provinces.

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 the age of five for severe acute malnutrition and assisted more than 5,799 births.

MSF also undertook a tetanus vaccination campaign in 2017, targeting over 22,600 pregnant women and women of child-bearing age to combat high levels of neonatal tetanus.

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 16,684 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 Frinne and Bouguerm, MSF ran mobile clinics for remote communities with no access to healthcare.

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 Kalémie town, displaced people were living with host families, in make-shift camps or in school compounds. Teams started providing emergency assistance in Kalémie and Kansamba, distributing water, constructing latrines and showers and deploying mobile clinics to 17 sites. Services included basic healthcare and mental health consultations, and referrals to Kalémie hospital. Teams also supported eight primary healthcare facilities. A second round of measles vaccinations carried out in September reached over 20,600 children.

In Adi, close to the borders with South Sudan and Uganda, MSF deployed mobile clinics serving both refugees and residents in the villages of Karaguta and Nubere. Services included primary and mental healthcare; treatment and psychological support for victims of sexual violence and hospital referrals. The team carried out more than 27,960 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 Gity 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.
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 1,077 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 migrants 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 Thermopile, 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 curative medical 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.

MSF offers sexual and reproductive healthcare in Chiosma, where the services available to women include antenatal consultations, advice and psycho-social 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. 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 519 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 efforts of violence and psychological first aid. Over the year, the project was further integrated into the Honduras Ministry of Health. The organisation will nevertheless maintain its presence at the main hospital and two clinics, as well as in Nuinva 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, 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 Chisima, 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.

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 degraded. 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 Mahaweesh hospital, focusing on providing lifesaving care for trauma, obstetrics and other medical emergencies. Medical outposts were also set up close 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 1,470 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 Aif district to provide primary healthcare, including treatment for non-communicable diseases. After the Kurdistan 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 Kirkuk, 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 Ghanim also decreased as people began to move away. Some activities were handed over to the Directorate of Health in July.
KENYA

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

Addressing the needs of the most vulnerable

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 workers’ 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 whom were in Dadaab, a camp complex on the border with Somalia. MSF continues to provide access to primary and secondary healthcare in Dadaab, one of the camps in Dadaab. Teams run a hospital and two health posts. Medical care provided by MSF in Dadaab 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. 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 clinics 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

In the country since: 2005
Reason for intervention: epidemics

Main activity: tuberculosis, primary healthcare

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

Fighting against tuberculosis

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.

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LEBANON
In the country since: 2002
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 1½ 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 disease, 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 healthcare centres in Baabda, Aarab, 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 Aarab, thus allowing its staff to concentrate on treating more complicated cases. Teams working at the two 24-hour mother and child centres in Aarab 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 healthcare 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 25,656 consultations for NCDs were carried out. At the end of the year, MSF ceased its activities, except mental health, in Rab al-Falabaneh and Jabal Mohsen as a new clinic opened in the neighbourhood.

In the country since: 2012
Reason for intervention: epidemics
Main activity: HIV/AIDS, tuberculosis, hepatitis C, primary healthcare
Human resources (FTE): 192 staff including 16 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 Mozambique 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 297,938 doses administered through fixed posts and mobile clinics.

MYANMAR
In the country since: 1992
Reason for intervention: epidemics
Main activity: HIV/AIDS, tuberculosis, hepatitis C, mental healthcare
Human resources (FTE): 71 staff including 16 international staff
Cost for 2017: CHF 3,122,000

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.

Improving access to healthcare

MOZAMBIQUE
In the country since: 1992
Reason for intervention: epidemics
Main activity: HIV/AIDS, tuberculosis, hepatitis C, mental healthcare
Human resources (FTE): 71 staff including 16 international staff
Cost for 2017: CHF 3,122,000

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
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): 410 staff including 16 international staff
Cost for 2017: CHF 5,167,000

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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 sexual 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 9,247 consultations carried out, including 220 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.

In April, 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.
In Niger, MSF focuses on reducing child mortality, particularly during the peak malaria and meningitis 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 government’s counterinsurgency operations. In Borno State, in the northeast of the country, more than 2.3 million people have been displaced and another quarter of a million have taken refuge in the neighboring counties 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 vulnerability 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 with the Ministry of Health to vaccinate more than 297,804 people in Niamey. Between March and June, MSF teams worked in six health centres and scaled up its activities, mainly treating patients for malaria, malnutrition and illnesses linked to poor living conditions. A total of 10,162 outpatient consultations were conducted. As it is difficult to work in this area all year round, preventive activities are essential. Teams organized a number of measles vaccination campaigns, which reached 10,607 children, and provided seasonal malaria chemotherapy for 34,694 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 organizations, 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 Damfai, near the border with Niger, reaching 28,197 children under the age of five.

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

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 and another quarter of a million have taken refuge in the neighboring counties 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 vulnerability of the situation and the remoteness of the locations pose major challenges to delivering aid and the risk has to be constantly assessed.

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SUDAN

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 300,000 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 Kordof 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 Memel 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.

Acting in the difficult-to-access areas around Al-Shabab, 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 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, 9,596 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 101,811 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 Alobo, 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 canoes to offer consultations in villages.

In 2018, MSF will set up a permanent health facility in the nearby village of Ker, Prepareness 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

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

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 Hatlabhu 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, 5,896 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.
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 routinely bombed for weeks, sometimes months, on end.

In 2017, the situation in the northeast of Syria further deteriorated due to the offensives in Raqqah and Deir ez-Zor governorates. The health infrastructure was not spared, and many people had to escape. UN data shows that, in 2017, Deir ez-Zor Governorate generated the highest volume of population movements in Syria, with 235,000 people displaced an average of three times that year alone.

Although the fighting in the 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.

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 2017, the situation in the northeast of Syria further deteriorated due to the offensives in Raqqah and Deir ez-Zor governorates. The health infrastructure was not spared, and many people had to escape. UN data shows that, in 2017, Deir ez-Zor Governorate generated the highest volume of population movements in Syria, with 235,000 people displaced an average of three times that year alone.

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Yemen

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, 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. 

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

Helping the victims of war and fighting the cholera outbreak

In Ibb, 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.

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 and Nigeria. Notably in 2017, we began activities again in hospitals in Mosul, Iraq, and Al-Hatabah, in Syria. On several occasions, our staff were direct witnesses of violence, for example, during the bombing of Nahr 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 impose 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 of informed consent for all our staff. 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

Human Resources

Human Resources

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HUMAN RESOURCES

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ACTIVITY REPORT 2017
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 8 million (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 69% 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

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### Financial results

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### Expenditure

<table>
<thead>
<tr>
<th>Expenditure (in thousands of Swiss francs)</th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme costs</td>
<td>191,946</td>
<td>183,269</td>
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<tr>
<td>Programme support</td>
<td>31,214</td>
<td>27,685</td>
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<tr>
<td>Advocacy awareness raising &amp; other humanitarian activities</td>
<td>4,851</td>
<td>4,651</td>
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<tr>
<td>Social mission expenses</td>
<td>222,411</td>
<td>215,414</td>
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<td>Fundraising in Switzerland</td>
<td>19,579</td>
<td>11,513</td>
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<tr>
<td>Management and administration</td>
<td>7,925</td>
<td>7,089</td>
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<tr>
<td>Administration expenses</td>
<td>21,504</td>
<td>18,602</td>
</tr>
<tr>
<td>TOTAL EXPENDITURE</td>
<td>248,715</td>
<td>234,016</td>
</tr>
</tbody>
</table>

### Income (%)

- **Private donations**: 96%
- **Public institutional donors**: 4%

### Programme costs per country

- **Africa**: 65%
- **Americas**: 22%
- **Europe and Asia**: 13%

### Programme costs per reason of intervention

- **Armed conflict**: 68%
- **Social violence and healthcare execution**: 14%
- **Endemic and epidemic disease**: 18%
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.

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We also extend thanks to our event partners:
- Biffeld Entertainment GmbH
- FFDIN – International Film Festival and Forum on Human Rights Geneva
- Forsa – Policy Lab
- Fumetto Comic Festival Luzern
- Human Rights Film Festival Zurich
- Interactions
- Polio 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 Karmen
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- Baking Eise
- Bingler Viola
- Castelli Jacqueline
- Chelminck Anassantza
- Chiste Javier
- Dàbi Fernan
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- Palestra Francesca
- Ponetti-Caududier Doriow
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- Schichart Lisa
- Stamoskou Zimmermann Andrija
- Strangspadt Daniela

For their loyal support over the years, we would like to extend our special thanks to:
- Fuchs Pia
- Meyer Madeleine
- Rasmussen Théodore
- Serfass Kiron
- Thory Cécile

Many thanks to our
243,432 donors

We apologise for any inadvertent omission.
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 Iotler, 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 Benoit, Communications and Fundraising Director
- Mathieu Soupart, Logistics 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.

Governance structure of MSF Switzerland
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.

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