Moral Report 2025–2026

The past year has been marked by a succession of crises of rare brutality. In many contexts, armed groups and states have deliberately inflicted violence on civilians, each seeking to impose its domination through terror.

Compounding these crises are the rise of nationalism and the erosion of international solidarity and global health. Aid cuts are already having devastating effects: reduced access to food and water for refugees in Bangladesh and Chad, shortages of basic treatments in DRC and South Sudan, and exceptional supply orders for therapeutic foods to prevent shortages in several countries.

The year was also marked by a new hecatomb: more than 300 humanitarian workers were killed, including three of our colleagues in Gaza and Haiti since our previous General Assembly. Attacks on medical missions and hospitals continue, with a disregard for international humanitarian law that is at times event blatant.

Towards such adversity, I want to reiterate my deep admiration for the work of our teams, who have resisted reactionary trends while providing even more aid—particularly to women—a commitment we have upheld amid challenges to their rights, including in the area of sexual and reproductive health.

Our "progressive" commitments resonate both at headquarters and in the field: the fight against discrimination, the prevention of abuse, reflection on the patient-provider relationship, and the exploration of environmental medicine. I am also thinking of the courageous testimonies shared on the Souk that described experiences of unacceptable violence and discrimination and helped accelerate our safeguarding efforts, the mobilization for the inclusion of LGBTQIA+ people, the support for our Afghan female colleagues, and the gender plan in Yemen.

An encouraging fact: in a hostile environment, our donors continue to grow in number. Fundraising increased by 15% in France and by 11% across the movement.

1 – ACTION

While the war in Iran has pushed **PALESTINE** to the back burner of the news, the situation continues to deteriorate daily for Palestinians. This year has seen mounting evidence of the ongoing genocide in Gaza. In the West Bank, settlement expansion is proceeding at a breakneck pace, and a wave of deadly violence perpetrated by settlers is being unleashed with impunity against the Palestinian population.

By the summer of 2025, violence against the people of Gaza had reached a peak. Deliberately deprived of food, residents had no choice but to risk their lives to access GHF food distributions, whose outrageous practices claimed the lives of or injured several thousand people. Daily bombings killed thousands more civilians, while a major offensive on Gaza City displaced hundreds of thousands of residents and forced us to close our clinic. Four MSF movement colleagues (among 2 OCP) were killed: Abdullah Hammad while on his way to food distribution points, Hussein Al Najjar by Israeli strikes near his tent, and Omer Hayek and Abood (Abed El Hameed) while waiting for the bus to Nasser Hospital.

End of September, the U.S. President announced his peace plan for Gaza, raising hopes for a respite for the population. It was short-lived. The Israeli army is expanding its occupation of Gaza, and the bombings continue, with more than 900 people killed and 2,000 wounded during seven months of ceasefire. Today in Gaza, simply getting a little too close to the yellow line—which, incidentally, isn't even marked—is enough to get you killed. Contrary to what was outlined in the Trump plan, aid is trickling in only in small amounts. Living conditions and unsanitary conditions in the camps are unbearable. Rats and parasites are proliferating in the trash and rubble. Drinking water supplies barely reach 5 to 6 liters per person per day, and the little food that Israel allows into Gaza is deliberately of poor quality.

Attacks on humanitarian organizations continued throughout the year. 565 humanitarian workers and 1,700 healthcare workers have been killed in Gaza since the start of the genocide. Many healthcare workers, including our colleague Dr. Obeid, are still being held in detention by Israel under appalling conditions. In January, the UNRWA headquarters in Jerusalem was razed by the Israeli army, and in late December, we learned that our registration, along with that of 36 other NGOs, would not be renewed by the Ministry of Diaspora Affairs and the Fight Against Antisemitism. During this period, we were subjected to a smear campaign featuring online attacks of unprecedented intensity from Israeli officials accusing us of colluding with Hamas. The alleged proof: our reluctance to provide them with our staff's personal data, one of the conditions for registration. In consultation with our teams, we examined all possible options, but we were never able to meet with the Ministry of Diaspora Affairs despite our persistent requests. After discussions within the movement and in light of the Israeli practices I have just mentioned, we decided not to disclose any personal data.

Since February 26, we have been working without an international team in Gaza and the West Bank, and we are no longer authorized to bring in supplies in our name. We are registered in Palestine, have relocated our coordination team to Amman, and thanks to our numerous experienced Palestinian colleagues, we are able to maintain the same level of activity at Nasser Hospital and in Gaza City.

In the West Bank, given the high risks to our teams (who are within immediate reach of settlers and no longer benefit from any coordination with the Israeli army since the end of our registration), we have refocused our activities in Nablus, where settlements now surround the city in which all entry points are controlled by the Israelis. Access is difficult; patients travel by taxi provided by MSF. We are following a small cohort of 100 mental health patients and exploring every possibility to expand our work, particularly by supporting local organizations.

We have continued to fully fulfill our role as witnesses to the destruction of Palestinian life, while access for the international press remains barred and more than 250 Palestinian journalists have been killed. In the fall, MSF called for accelerating and increasing the number of medical evacuations from Gaza. While more than 15,000 people are urgently awaiting complex medical care, France has admitted only 27 patients from Gaza to its territory, and in Amman, only 66 patients have been referred at our hospital.

In June 2025, at our initiative, all MSF offices worldwide were mobilized to assist our staff who wished to leave Gaza. Twenty-eight MSF colleagues and their families were welcomed in various countries.

About twenty staff members or dependents, approved by the WHO, are awaiting medical evacuation. Even though the numbers are small and this work is as complex as it is frustrating, I find it important and congratulate the teams responsible for it. I would also like to take this opportunity to highlight the work of the PSU (Psycho Sociological Unit) which has been mobilized since December 2023 to offer remote psychological support to all our colleagues in Palestine who wish to receive it. All of this is very little in the face of the ordeal they are going through, but we remain firmly committed to standing by their side.

While we have not yet defined the scope of our intervention in **LEBANON,** where we have just completed an assessment mission and where Israel is pursuing a similar policy of forced displacement of the population, massive destruction, and targeting of healthcare professionals, we remain present in **IRAN,** facing repression and massive bombardment. However, we have been unable to set up massive operations to assist the population or to communicate publicly about the situation.

Several colleagues have expressed wonders regarding the contrast between the strength of MSF's protests against Israeli atrocities and MSF's silence in the face of the horrors committed by the Iranian authorities. The major risk of reprisals faced by MSF teams in Iran is certainly an inducement to remain silent, but this silence is also supported by another reason: reprobation of the Iranian regime is widespread, sanctions have been imposed, and political sanctions without appeal have been pronounced. Meanwhile, the war of annihilation waged against the people of Gaza, the widespread practice of torture, and the numerous Israeli abuses are being carried out with the active consent of Western powers that would have the power to act.

Just as we were considering whether to maintain our presence in Iran under such helpless circumstances, a new war broke out in March 2026. Our medical services for Afghan refugees in Mashhad continued uninterrupted. In Tehran, the OCG clinic was converted into a forward medical post to treat the wounded. OCP has just obtained authorization to establish a new healthcare facility south of Tehran and to launch a project in southern Iran, in partnership with national organizations. We have initiated a project in Iraqi Kurdistan, which has been struck by Iranian drones and missiles, to prepare for a potential influx of refugees and the wounded.

YEMEN is the only front in the Middle East that has remained relatively calm. Nevertheless, this country, which is undergoing one of the longest crises in recent history, is among those most affected by the reduction in humanitarian funding. The deployment of aid is also limited due to the strict control exercised by the Ansar Allah movement over international organizations, which are few in number and regularly accused of being foreign agents. In November 2025, after Houthi authorities were hit by Israeli strikes, dozens of humanitarian workers were arrested, including MSF staff.

Despite the constraints, we are maintaining two projects in the north where the number of patients being treated continues to rise. We have publicly highlighted the dramatic consequences of reduced funding, particularly through the increase in admissions we are seeing in our pediatric ward in Khameer. In March, we also produced a report on the extent of malnutrition and the growing needs. However, it remains very difficult for MSF teams to bear witness of the scale of the health and nutrition crisis and the restrictions imposed by the Houthis.

As we enter the fourth year of war in **Sudan**—the world's largest humanitarian crisis according to the United Nations—no diplomatic progress has been made this year, the conflict is deadlocked militarily, and Sudan is *de facto* divided in two.

In Khartoum, the situation is improving. The government is beginning to rebuild the capital. Our teams are seeing a noticeable return of residents, though we are unable to quantify it precisely. Our support for the Turkish Hospital has played a key role in providing access to secondary healthcare. Between April and July 2025, 2,600 cases of cholera were treated there, and for the past year, we have been working in the emergency room, pediatrics, and the maternity ward. With the Ministry of Health now present, we will likely leave the hospital and launch exploratory missions as we expect to reach underserved rural areas in Khartoum State.

Over the past twelve months, violence has been widespread in Darfur. In July, we warned of a likely attack by the El Fasher and the risk of a large-scale massacre based on ethnicity, through the publication of a report as well as during a press conference. The city was attacked on October 26, after 17 months of a suffocating siege. Survivors described to us summary executions, detentions, kidnappings for ransom, torture, and sexual violence, including in neighboring towns and along the routes to escape. When our teams finally traveled to El Fasher three months later to conduct a rapid assessment, we were able to document the destruction of entire neighborhoods emptied of their inhabitants. Following the deadly assault, projects were launched in Guerni and Korma, as well as north of El Geinina in Um Baru, to attempt to care for the survivors who had fled.

The mass atrocities that culminated in October 2025 in El Fasher are part of a deliberate campaign aimed at starving, forcibly displacing, depriving of medical care, and killing civilians, often on ethnic grounds. We estimate that only 30,000 to 40,000 people were able to reach Tawila and Chad, while tens of thousands of residents are missing. Whatever the figures, numerous testimonies gathered by our teams in a report to be published shortly attest to large-scale massacres that a United Nations fact-finding mission recently described as acts of genocide.

In operational terms, we continue to work in Tawila, where approximately 800,000 people have been living as internally displaced persons for the past year under conditions that remain extremely precarious. Emergencies are a recurring issue there. For example, we responded to a cholera outbreak between July and September (6,400 cases). Surgical teams also admitted and treated many wounded people fleeing El Fasher (3,846 patients in two months). With the rainy season approaching, this year we are planning an initial malaria chemoprophylaxis campaign targeting 160,000 children under the age of five.

While the situation has calmed down somewhat and the transition from emergency response to routine operations is underway, it goes without saying that maintaining the capacity to respond to medical emergencies and spikes in violence remains a priority, given the uncertain political context.

In **CHAD**, we are still present in the east, in Adré, in the Sudanese refugee camps. The teams have dealt with several measles and meningitis outbreaks, taking the opportunity to organize multi-antigen vaccination campaigns. We are doing our best the gap to fill left by humanitarian actors who have withdrawn due to a lack of funding, and have decided to reopen a surgical program, justified by the

number of Sudanese refugees (1.3 million) who continue to arrive and the fact that the conflict has repeatedly spilled over into Chadian territory. In March, a drone attack targeting an RSF fuel depot in Chad resulted in civilian casualties who were treated at our hospital in Adré.

In April, the results of an intersectional evaluation of the emergency response in Chad (an evaluation initiated by our Director of Emergency Operations), were presented and discussed at the IB *(International Board)*. This evaluation, conducted by the CRASH and Epicentre, is particularly interesting because, based on qualitative and quantitative data, it examines nine criteria defining what contributes to a successful emergency response. Some are classic (being in the right place at the right time, the impact on mortality…), others are fairly new (such as meeting the expectations of patients and the community, and implementing measures for the prevention, detection, and management of abuse). The results are positive. I note, however, a prioritization by OCP for surgery and war casualties, while the high mortality rate in pediatrics might have required more attention. Furthermore, there was little discussion regarding food distributions, even though this was the population's primary request.

Following a journalistic investigation in November 2024 documenting cases of sexual exploitation of Sudanese women and girls in refugee camps, MSF sections in Chad investigated 59 allegations, the majority of which involved sexual harassment, abuse, or exploitation. Eighteen staff members, including national and international staff as well as daily workers at the operational centers concerned by the facts, were dismissed. The measures implemented on the ground are now moving in the right direction: the creation of a committee responsible for raising awareness among staff, including daily workers; the establishment of patient liaison officers and a hotline; and efforts to improve gender balance within the team. In addition, an effort towards transparency has been made by sharing the results of the investigations with the teams.

In 2025, **SOUTH SUDAN** saw an intensification of fighting in Jonglei State and Upper Nile State between supporters of President Salva Kiir and those of Vice President Riek Machar.

In a recently published intersectional report, MSF documented massive attacks against civilians. Witnesses describe horrific scenes: sexual violence, forced recruitment—including children—the killing of elderly people who were unable to flee, massive destruction of property, and the burning of homes, sometimes with people still inside. While violence is being committed by all parties to the conflict, the airstrikes—which have increased significantly this year—are clearly the work of South Sudanese forces, supported by Ugandan forces. These strikes have targeted densely populated areas, causing mass casualties and destroying houses, markets, and hospitals. Hundred thousands of people have been forced to flee to an entirely swampy area, where the deployment of emergency services is particularly difficult.

The MSF hospital in **Old Fangak**, which was deliberately bombed by government forces on May 3, 2025, has never reopened. Since then, our teams have been doing their best to restore access to healthcare for the populations dispersed across various islands. In February 2026, the OCA hospital in Lankien was bombed by the South Sudanese army, and in March, while we had been forced to evacuate on government orders, the MSF-supported hospital in Akobo was looted by local groups.

Since 2025, 12 attacks have targeted MSF staff and facilities across South Sudan, depriving approximately 800,000 people of access to essential care. Today, only two hospitals remain in the conflict-affected areas of Jonglei State, home to more than one million people. Both are run by MSF. Another attack would mean the total collapse of healthcare for an entire population. What can be done to protect our medical facilities? It is true that there are few political levers available: the country's traditional sponsors are turning away, the United Nations mission is gradually withdrawing, and some officials of SPLA are advocating a return to traditional medicine. MSF has described the atrocities and condemned the attacks, pointing out—perhaps a bit timidly—who is responsible. Over the course of the year, we have primarily focused on an approach based on international humanitarian law (IHL), conducting our own fact-finding and demanding explanations from the authorities, who have, incidentally, acknowledged the facts in bilateral discussions. Shouldn't we engage more resolutely in a public confrontation with the South Sudanese authorities, even if it means partnering with human rights or forensic organizations that document the evidence? We will discuss this this afternoon in the session dedicated to attacks on hospitals.

Since the AFC/M23, backed by Rwanda have occupies large parts of North Kivu in **the DRC,** the implementation of our four projects has become significantly more complex (from now on a visa issued by the M23 is required, the airports in Goma and Bukavu are closed, supplies subject to additional taxes must pass through Rwanda, and the banks in Goma are closed). Despite this, the teams have managed to respond to the cholera and measles outbreaks (including a vaccination campaign in Goma) and have expanded project activities in Kibirizi, Bambou, and Rutshuru following funding cuts by other NGOs.

The security situation remains extremely volatile, and the appearance of drones in the area—responsible in particular for the death of a UNICEF employee in March in Goma—further exacerbates the risks. Civilians, forced to demonstrate their loyalty to one side, are being forcibly displaced, taxed, and subjected to abuses, both by the M23 and its militias and by the armed groups opposing them. In January, for example, we treated a surge of wounded people at the Nyanzale health center and raised the alarm about violence committed by the CMC group, a coalition of several armed groups in North Kivu.

Goma has become highly unstable, and violence is omnipresent there. When the city was captured, the opening of the prison led to the release of several thousand inmates, and numerous weapons have been circulating since the FARDC soldiers fled. Despite the dismantling of the camps, sexual violence remains very frequent (more than 1,000 admissions per month at our health centers). Attacks occur mainly at night, in homes, in neighborhoods plunged into darkness and devoid of police presence. Host families, where many displaced people now live, are also a site of sexual exploitation.

Our communication sought to document this violence and the consequences of the climate of terror imposed by the M23 on the population. In June, we raised the alarm about the number of victims of sexual violence. In September, following two months of intense internal discussions, we released the testimonies of survivors of the massacres committed in the Binza region by armed men affiliated with the M23. These various statements have enabled the MSF International President to convey specific messages during a briefing to the United Nations Security Council.

DRC is in addition facing a particularly complex Ebola outbreak (Bundibugyo virus). The epicenter is in Ituri, a region in the midst of multiple armed conflicts where insecurity hinders deployment. Furthermore, effective medical tools are sorely lacking: there is neither a vaccine nor a specific treatment. All MSF sections appear determined to work together, and intersectional coordination hubs are in place. OCP is beginning activities in Goma, Butembo, and Kampala; OCG and OCB are in Ituri; and OCA is conducting an exploration on Beni. We will pay particular attention to security issues, with responses tailored to each context. We have built on lessons learned from previous epidemics and will ensure we do not repeat past mistakes. Medical care for infected national staff must aim for the highest possible standard of care, including the use of compassionate use treatments that have always been provided to infected Westerners. To ensure that treatment centers are not merely places of isolation, our teams are already mobilized to begin clinical trials as soon as possible. To prevent the emergence of new outbreaks and ensure continuity of care, security at our medical facilities has been strengthened, and isolation centers have been established across all projects. Many unknowns issues remain. At this stage, there is no proven community transmission in North Kivu, South Kivu, or neighboring countries. However, the true scale and severity of the outbreak remain unknown due to a lack of diagnostic testing.

The closure of borders is delaying the arrival of essential medical supplies and specialized staff, while we attempt to assess how the political dynamics between the AFC/M23 and the Congolese authorities in Kinshasa will influence the response. Addressing this outbreak will undoubtedly require a degree of medical audacity, but without significant progress, the response will remain challenging.

This year, pressure from armed groups on the military governments of member countries of the Alliance of **Sahel States (AES)** has intensified. Major cities, including Niamey and Bamako, have been attacked by various groups, and Bamako has been under siege for nine months. Violence against the population continues, and the use of drones has become widespread, resulting in the deaths of hundreds of civilians.

This year has also been marked by increased state control over civil societies and NGOs. In Mali, a new regulatory mechanism requires associations to pay a 10% contribution of their project funds to the government. And in Burkina Faso, a new law requires that the representatives and financial officers of international NGOs be Burkinabé nationals and reside in Burkina Faso. Despite this, thanks to negotiations led by a colleague from Niger, we were able to obtain visas for French staff in Burkina Faso as well as our registration in Niger, where we are now again able to work with international staff at our hospital in Madarounfa.

Our volume of activities in the three countries remains particularly high (more than 40,000 hospitalizations, 200,000 consultations, and we have treated 60,000 children suffering from malnutrition being treated in Niger alone). In Mali, we are still authorized to operate in Tenenkou, an area under heavy influence of JNIM. In the Mouhoun Loop in Burkina Faso, our activities have seen a significant increase due to the influx of internally displaced persons into the city of Dédougou. After some delay, the project has become clearer in **MAURITANIA.** We are working with a population of Malian refugees and their hosts in the Bassikounou region, and are launching a surgical program to respond to the eventuality of an arrival of wounded individuals from Mali. Finally, we have established a partnership with a Malian NGO, ProSSahel, which will begin its human and animal health activities in

Mauritania and expand them into the pastoral areas of northern Mali. After a full year without public communication regarding the Sahel, our presence in Mauritania has allowed us to bear witness—with caution and without assigning responsibilities—to the violence suffered by Malian refugees while they were still in Mali.

While there is no doubt about the severity of the health and food crisis, the question of the limits of what we can accept arises when, to preserve our ability to provide essential assistance to the population, we choose to remain silent in the face of abuses and atrocities committed by local authorities against civilians—and against our own teams. How can we break this ruthless logic? We must question the limits of this submission. I am thinking in particular of Burkina Faso, where the requirement to have Burkinabé MSF representatives seems to me to have been insufficiently discussed given the risks these individuals face. An MSF staff member was recently released by the authorities after more than a year in detention, and this is not the only example. We choose sometimes to intervene in particularly constrained contexts, but one minimum condition is essential: making this decision following extensive and repeated internal discussions, clearly outlining the compromises accepted and the risks assumed. It seems to me that these discussions were lacking this year in the Sahel, as well as in Yemen.

Once again in **AFGHANISTAN**, measures imposed by the Taliban have intensified violence and discrimination against women. In 2026, the authorities enacted new criminal regulations that have a particularly severe impact on women: the scope of criminal offenses has been expanded; domestic violence is permitted; and corporal punishment and torture have been institutionalized. These measures come at a time when our teams remain deeply shaken by the death of our colleague Raihana Rahimi, who was killed by her husband last December, while other women involved in our projects are also under threat. In last year's annual report, the Board of Directors emphasized that, in such an extreme context of deprivation of rights, it was essential to clearly include among our operational objectives enhanced support for our female staff and their daughters, going beyond our responsibility as an employer. During her visit in April, our General Director observed the positive dynamics within the team. Listening spaces have been set up to discuss with our colleagues the best ways to help them; their travel needs are being facilitated, and an education project manager joined the team in November. Several tracks are currently being explored: recruiting women who did not obtain their degrees but were close to the end of their training or supporting some of them so they can pursue a medical specialization—for example, in obstetrics and gynecology, which remains permitted. Of course, this work is complex: it is more a matter of slipping through the gaps that still exist than of hoping for real change. However, in November, our team had the courage to publicly protest against new dressing restrictions imposed in Herat province: patients, caregivers, and, more broadly, all female staff were required to wear the burqa to access public places, including healthcare facilities such as Herat Hospital. Since then, some flexibility seems allowed. This act of speaking out is undoubtedly a small thing in light of the deteriorating situation for women we are witnessing in Afghanistan. The price to pay for working in such a context is being a direct witness to violence against which one does not really know what to do. Fortunately, in Herat and Bamyan, there is still some room for space and resistance, which we support as much as we can.

Finally, I would like to add that in May 2026, the European Commission announced its intention to invite Taliban officials to Brussels to initiate a dialogue on the return of Afghan migrants, particularly

those convicted by courts in the European Union. While several NGOs are concerned about this, the initiative is part of a broader trend toward stricter migration policies, marked by a growing desire to increase forced returns, limit the hosting of displaces or refugees, and cooperate with authoritarian regimes to outsource borders management.

This issue of **MIGRATION** and the treatment of people in exile is a major concern for us in a context increasingly prone to identity-based withdrawal. Although our work in Libya has been suspended since the beginning of 2025, our commitment to helping these people, who are so vulnerable to violence, drives us to persevere. It is with this same intention that we have conducted exploratory missions in Tunisia and the Comoros: we hope to begin operations there in 2026.

As for France, the context has been marked by the continued hardening of public speech and by violence against exiled people and those who come to their aid: our team was thus attacked in Calais by British far-right groups in early December, and complaints have been filed. The dire nature of the situation for exiles on the northern coast, particularly for women, prompted us to launch a project in Dunkerque. The only bright spot in this picture is that the City of Paris has committed to providing better support for the underage girls we care for through our Ile-de-France project.

Living conditions in the Rohingya camps in **BANGLADESH** continue to deteriorate, with armed groups fueling crime, insecurity, kidnappings, and extortion, while funding cuts are leading to the closure of several primary care centers. The announcement of a further reduction in food rations by the WFP is causing great concern among refugees. MSF is the main provider of healthcare: one project covers internal medicine and another focuses on women's and children's health. The volume of activity remains very high, exceeding 10,000 hospitalizations and 36,000 emergency room visits. Nevertheless, this year we are once again facing the challenge of identifying sufficiently effective levers for action to shed light on the plight of the Rohingya in the mega-camps of Bangladesh.

In **HAITI**, our teams continue to adapt their activities to the extremely high level of insecurity, particularly in Cité Soleil, where clashes between several armed gangs have been ongoing since mid-March, following a two-year truce. This violence is particularly affecting the area around our hospital in Cité Soleil, where many wounded people are flooding in and where we recently had to temporarily suspend our activities.

The resumption of fighting between gangs comes on top of clashes between gangs and the authorities, represented by the presence of several actors, each claiming—according to its own rules—the legitimate use of force: the Haitian National Police, neighborhood civilian militias (the *Bwa Kale*); a group of private mercenaries (Vectus Global, successor to the infamous Blackwater and responsible for introducing the widespread use of explosive drones); and finally an international force deployed under a United Nations mandate, eventually expected to number 5,500 troops.

In this fragmented context, where front lines and areas of control remain highly fluid, the Cité Soleil hospital still manages to treat the wounded and provide services to the many women who are victims of violence. However, we are no longer able to refer the wounded to Tabarre, an area controlled by the PNH: recently, a patient left the hospital against medical advice and was killed shortly thereafter, likely by police officers. Teams must therefore manage serious cases locally, and armed groups are

increasingly treating their own wounded in their facilities. Faced with these difficulties, compounded by a patchwork of parties to the conflict, our teams nevertheless continue to maintain contact with all stakeholders and to strengthen the networking efforts initiated several years ago.

Our Medical Activities

Between 2021 and 2025, our project expenses increased by 30%, and it is noteworthy that most medical activities followed this trend (number of hospitalizations, surgical procedures, or deliveries) or have risen significantly. This is the case for safe abortions, which increased sevenfold (17,800); care for cases of sexual violence, which increased fivefold (30,000); malnutrition (threefold: 230,000); and the number of patients in intensive care, which doubled. Consultations have also increased by 60% to reach 4.2 million.

The Patient Charter is currently being implemented in 15 projects. The patient experience is now recognized as a key indicator of quality of care. Thirteen projects teams are currently working with peer patients, and three have established patient committees. Additionally, 42 social workers across 19 projects provide support to patients with chronic conditions and survivors of gender-based violence. All these initiatives are a step in the right direction, but feedbacks from patients are rarely used by medical and coordination teams to guide projects. For example, peer patients are rarely involved in decision-making processes, and the positive results of their work are little known beyond the project. Similarly, our health promoters today tend too much to provide information to the community when they should also—and perhaps above all—be gathering it to adjust our operations. To reach our commitments to fostering genuine engagement with the people we help, a thorough review of our approaches to health promotion and community engagement will be necessary.

The **surgical and critical care** teams have been extremely busy this year. Emergency departments saw a 30% increase in activity, largely due to the influx of people fleeing El Fasher, and intensive care activity has been particularly impressive in the Herat and Madarounfa projects, each of which exceeded 8,000 admissions in 2025. In surgery as well, activity volumes were high in Gaza, Sudan and Haiti, although overall there was a 10% decrease in operating room visits compared to 2024. This will partly be rebalanced by the decision to launch new general surgery programs in Adré (Chad), and in Mauritania.

Mental health services have expanded significantly in recent years and are proving very popular within our teams. Demand is high, but the reality is that we are struggling to keep up with the many ongoing projects. We know we need to make progress in two areas in particular. First, mental health care for people who have experienced various forms of violence, whether conflict-related or gender-based and sexual in nature: not all of these individuals will suffer from psychological trauma, but we must equip ourselves to identify and treat those who will develop disorders or severe psychological distress as a result of these experiences. The second area concerns psychiatric patients who can be treated in MSF clinics that manage “chronic illnesses,” provided we have access to trained and supervised doctors.

In our projects, routine **vaccination rates** have reached their lowest level in five years. Correcting this trend will certainly be necessary at a time when GAVI’s budget for implementing vaccination is declining. However, some progress has been made in vaccinating newborns against hepatitis B in South Sudan, Syria, and Bangladesh, although these vaccinations currently cover only one-third of births. This

year, 40,000 children were vaccinated by MSF in Chad with the R21 malaria vaccine, as part of a study comparing the performance of the vaccine integrated into the EPI with that of a vaccination campaign synchronized with seasonal chemoprevention. Discussions are underway regarding the best possible models for making this vaccine available, given the current context of declining funding. The MSF Foundation is exploring the potential of measles vaccine micropatches, which allow vaccines to be administered without needles or syringes, thereby facilitating vaccination coverage.

MSF responded to numerous **outbreaks** this year (cholera, measles, hepatitis E, diphtheria, meningitis). Sudan, South Sudan, and the DRC were hit by large cholera outbreaks. We were able to vaccinate in Tawila even though the vaccines intended for 300,000 people arrived several months after the outbreak began. The emergency teams also organized a mass diphtheria vaccination campaign in early 2026 in Maiduguri, combined with case management in hospitals and at home.

I cannot speak about **nutrition** without mentioning the death of our colleague and friend Emmanuel Berbain, who died in tragic circumstances that deeply shocked us and led to a joint investigation, which the Board of Directors will closely monitor.

These results are his. In total in 2025, MSF OCP treated more than 230,000 children suffering from acute malnutrition on an outpatient basis, and 56,000 were hospitalized. This year, MSF diversified its intervention strategies in Katsina State, Nigeria, by introducing financial assistance for the families of children transitioning from hospitalization to outpatient care. 600 tons of nutritional products were distributed to 70,000 children in one of the hardest-hit areas. Our public communication highlighting the scale of malnutrition in northern Nigeria initially caused significant tensions with local and federal authorities, before paving the way for a new phase of discussions. In October, a conference organized by MSF and Nigerian authorities was held in Abuja. Chaired by the governor of Katsina, it aimed to mobilize various stakeholders and donors in the fight against malnutrition. Nutrition was cited as a national priority, and the commitments made by the governor of Katsina are being reached, with the opening of nutrition centers and the implementation of economic measures designed to improve access to food.

In 2025, clinical innovations focused on the management of Kwashiorkor. A therapeutic milk specifically adapted for these children is currently being developed by the International Centre for Diarrhoeal Diseases in Bangladesh with support from MSF and Epicentre. A new care model inspired by specialized burn units will be implemented in Katsina. Finally, a clinical trial in Niger is studying the results of a new food for the outpatient management of severe malnutrition—milk-free but designed to boost the microbiome.

After a decade of rising numbers of children treated for severe acute malnutrition, the trend is reversing. A nutrition fund has been established within the MSF movement, and we are approaching potential donors such as the CIFF Foundation, which wishes to support our efforts in this area. We have also worked with other organizations to convince French parliamentarians to adopt innovative taxes as mechanisms for financing health and nutrition.

In line with our strategic priorities, the volume of medical services for **women** has increased, with 51,000 deliveries and more than 200,000 prenatal visits. The number of safe abortions has increased by 50%, expanding to new countries. Furthermore, while the high number of victims of sexual violence indicates

an improvement in our care, it above all reflects a worrying spread of this type of violence in contexts where such violence seemed previously less frequent. We have made progress in detecting malnutrition among pregnant and breastfeeding women in Sudan. We have also implemented a model focused on preventing obstetric abuse, which is particularly concerning in a large-scale project like the one in Jahun. Prescriptions for contraceptive methods are also on the rise. In contrast, the number of cesarean sections has remained stable since 2021. The ongoing effort to train general practitioners in certain surgical procedures is undoubtedly a promising avenue for increasing access to cesarean sections.

I will move on to **oncology**, which focuses primarily on cancers affecting women. In both Mali and Malawi, significant progresses have been made. One example is access to immunohistochemical diagnosis, without which effective management of breast cancer is impossible. Patients with HER2-positive breast cancer have received targeted therapy with Herceptin, significantly increasing their chances of survival. In Malawi, thanks to the joint efforts of the Foundation and the oncology unit, cervical cancer screening using the HPV self-test has become a routine part of the project, significantly improving the results of visual inspection of the cervix. In both countries, patients have access to individualized follow-up care; psychosocial support and palliative care are in place; data collection and analysis are improving; and close collaboration is underway with the Ministries of Health. All of this is positive, but I would like to draw your attention on three points.

In Mali in 2025, more than 70% of patients were at stage III at the time of diagnosis of breast cancer (by comparison, in France 80% of women are diagnosed at stages I and II). It seems to me that efforts to identify women at earlier stages remain insufficient. It is indeed difficult to imagine real results in breast cancer care without incorporating into our plans a commitment to identifying women at earlier stages. I do not see this ambition clearly articulated.

In Malawi, it seems to me that our project should more clearly target public health goals by implementing, on a significant scale, tools for primary prevention (vaccination), secondary prevention (screening for precancerous lesions), and tertiary prevention of cervical cancer. A project similar to the one in Ndiwha on HIV would be beneficial for patients and would compel us to address this public health issue in collaboration with the Ministry of Health.

Finally, work is underway to develop a care model that will enable the screening for cervical cancer and the treatment of precancerous lesions in MSF women's health projects. This is a positive step, but it seems to me that the issue of screening for and treating precancerous lesions without the ability to manage cancers that will be diagnosed must also be addressed.

The main objective of managing **insulin-dependent diabetes** is to develop patients' self-management of treatment at home, the only way to hope for control of the disease. This year, progress has been made. Within our projects, we estimate that between 400 and 500 patients with type 1 diabetes are managing their condition at home. Out of these, 150 to 200 are equipped with insulin pens. While visiting Aweil, I observed the satisfaction of the medical teams as they noted the decline in hospitalizations. The project teams wish to do more, provided they have the necessary supplies. To this end, we are testing less expensive blood glucose meters and working to lower the cost of insulin analogs pens. The MSF Foundation has focused on developing a clinical calculation tool that, in the absence of an endocrinologist, facilitates the management of pediatric ketoacidosis. Finally, the

partnership with the NGO Santé Diabète has significantly contributed to patient education and staff training. Additionally, a diabetes patient association was established in Carnot.

MSF is committed to managing **sickle cell disease,** a common pathology in sub-Saharan Africa that has historically been neglected. Approximately 2,000 patients are being treated in Niger, Uganda, Kenya, and Chad, in Adré. Thanks to work carried out with MSF Access and MSF Logistics, access to hydroxyurea has improved, and 200 children have been able to start treatment in Kasese. The introduction of this treatment is underway in Niger, and we are helping the National Pain Center in Bangui to procure it.

As you know, in recent years we decided to transfer our large cohorts of **HIV-positive** patients to the ministries of health. They are now facing difficulties, and estimations of new HIV infections and HIV-related deaths are rising sharply due to budget cuts by the U.S. government. What will be our priorities in this context?

Our work with key populations—who are highly marginalized and underserved—strikes me as particularly relevant in the current context. This work is facilitated by the emergence of long-acting injectable antiretroviral treatments for HIV prevention. In Malawi, we introduced Cabetogravir (which requires an injection every 8 weeks) as part of a project targeting sex workers. 54% of them accepted the treatment, with a retention rate of 71%. Our goal is to expand the use of these long-acting preventive treatments to Kenya, Haiti, and perhaps also the DRC. The semi-annual injectable Lenacapavir, for which Gilead has agreed to grant a voluntary license to six generic manufacturers and which is expected to cost $40, is eagerly awaited and will be a true game-changer. An ongoing exploratory mission is in place in Kampala, Uganda, focusing on gender-based and sexual violence, particularly against LGBTQIA+ populations.

Another aspect of our work, equally noteworthy, is the establishment of outpatient clinics specialized in the management of chronic diseases, including HIV, such as in Carnot, CAR. Finally, our presence in internal medicine, working with patients in advanced stages of HIV, such as in Homa Bay (Kenya), will remain meaningful only if treatments continue to be provided at the community level.

In 2025, OCP made significant progress in the management of **childhood tuberculosis,** with the full implementation of the TACTiC project across 15 projects and 9 countries for OCP. In Goma, for example, this integrated approach led to a 50% increase in the diagnosis of children with tuberculosis, thereby helping to significantly reduce the detection gap.

The large-scale **hepatitis C** screening and treatment campaign in Cox's Bazar (Bangladesh) is another success, with an 88% coverage rate and 94% of diagnosed patients having started treatment. In Pakistan, systematic screening for hepatitis C has been integrated into the MDR tuberculosis project, enabling the simultaneous treatment of co-infections. Regarding hepatitis B management, despite the simplification of WHO algorithms, only the MSF staff intersection clinic in Bangui, among all MSF projects, screens for and treats HBV infection.

In 2025, a climate and environmental health action plan was developed. It is structured around three priorities: adapting operations to climate-related risks (floods, heat waves), addressing the health impacts of environmental degradation, and strengthening collaboration with external stakeholders. The

implementation of responses to heat waves is in the exploratory phase, particularly in Mauritania. And an environmental health project is to be started in the Tondo slum in the Philippines.

2 – THE INSTITUTION

This year, I would like to highlight the efforts of the human resources teams, who have had to adapt to operations in an increasing number of unstable contexts.

Although the number of serious security incidents decreased in 2025 (from 38 to 29), we tragically lost three colleagues and had to deal with five kidnappings in Mali, Haiti, Yemen, Bangladesh, all of which were resolved fairly quickly.

In February 2026, it was with deep sadness that we learned of the death of our colleague Lucile Saint-Louis, who died as a result of Lassa hemorrhagic fever in Nigeria. In 2025, 16 colleagues died from medical causes, primarily cardiovascular diseases, with diagnoses often made too late. Most were relatively young and at the lowest levels of the pay scale. The priority of the new health care plan for intersection staff is the prevention and early identification of diseases, particularly chronic ones. Implementation is beginning in three pilot countries where several operational centers are located. In Niger, a systematic health screening of staff was conducted, which made it possible, for example, to identify cases of hepatitis B and put individuals on treatment: an initiative to be encouraged. The Solidarity Committee is now regularly consulted by Operations teams. The proliferation of crises has for consequence to provoke new situations involving MSF staff who fear for their lives if they return to their country of residence. Solutions are found on a case-by-case basis, with extremely limited options due to an increasingly hostile environment towards foreigners in many countries.

There are a large number of MSF incentive-based staff in our projects (5,300). Most of them are recruited by the Ministry of Health at MSF's request but without a MoH contract, they often receive only the remuneration we pay them—generally half the salary of an equivalent MSF position. Although they perform the same work, they have neither MSF health coverage nor paid leave. This precarious category consists mainly of women—nurses and nursing assistants—and, in some countries such as the DRC, represents the majority of project staff. Should we continue down this path, and why is this category growing? These are all questions I am asking myself. While it is difficult, and sometimes even unjustified, to put everyone on an MSF contract, I believe a thorough review is necessary this year.

Regarding the gender imbalance within our teams, a positive trend is beginning to emerge. Nearly 60% of new IMS staff recruited in Paris are women, and similar trends are observed in Dakar, Dubai, and most recruitment offices. The overall percentage of female colleagues among departing IMS staff has stabilized at around 40%. However, no new female hires were recorded in 2025 for medical coordination, logistics, supply, or finance roles. Furthermore, the imbalances remain particularly pronounced among locally recruited staff. The initiative launched in Mali and Niger—TIC Gender—has focused on reducing internal barriers by ensuring, in particular, that women have access to training and are given equal opportunities in recruitment; the result is a higher percentage of women being recruited.

The year 2025 marks a significant increase in the number of reports brought to the attention of the EAMA cell. A total of 205 complaints were received, compared to 169 in 2024. Although this increase reflects the gradual strengthening of institutional capacities, several testimonies highlight persistent vulnerabilities: reporting mechanisms that remain insufficiently accessible, excessively long investigation times, limited communication with victims, and a disciplinary framework deemed insufficiently robust. In response to these findings, complaint-handling and case-management capacities have been strengthened with the addition of three positions at headquarters. In the field, we have a pool of 12 Safeguarding Coordinators deployed on the missions. Their mandate is to analyze specific risk factors and support teams in preventing and managing alerts, in close coordination with initiatives on diversity, equity, and inclusion, particularly those aimed at strengthening the inclusion of women. Finally, progress has been made in improving communication with victims and complainants regarding the findings of investigations and the measures decided upon. This development addresses a strong and recurring expectation among victims and serves as a key lever for strengthening trust in reporting and response mechanisms.

On a positive note, the complaint mechanisms are being utilized by a diverse range of individuals. 44% of complaints come from national staff (LHS); 33% from international staff (IMS); and 19% from patients, caregivers, and members of the community. Women account for 64% of those who filed a report. Regarding the individuals implicated in confirmed cases, 92% are men, 57% are IMS, and 43% are LHS.

19% of the complaints received in 2025 led to 34 confirmed cases of abuse, half of which involved sexual harassment, assault, or exploitation. For these cases, and often, the available evidence is insufficient to open an investigation or reach a conclusion. They require special attention, as the victims are always individuals in highly vulnerable situations.

In December 2025, the Magani project came to an end following a pilot phase whose assessment revealed a number of uncertainties and vulnerabilities—including our lack of in-house expertise—raising doubts about the feasibility of the project as it had been developed and scaled. I would like to thank the entire project team and its contributors, who took this pilot initiative as far as possible. While the project has ended, the initial observation and rationale remain relevant: the lack of access to high-quality, affordable medicines for noncommunicable diseases, which remains a priority for MSF. The experience has highlighted several lessons. The world of “non-SRA” medicines—which vary in quality but are more financially accessible—constitutes a gray area that we should explore more resolutely, especially as our projects increasingly address chronic diseases and the issue of diversifying our supply sources is a priority for supply teams.

These teams, constrained by the conflict in the Middle East (and especially the Dubai team), have managed to demonstrate creativity to ensure the supply chain to the field. Intersectional work has continued; for example, the mutualization of ongoing purchases across multiple sites has already saved over 1.5 million euros.

The logistics and emergency team has also worked on mutualized resources; the Modular Field Hospital has become the shared emergency medical facility for all sections. In 2025, OCP continued its efforts to find construction solutions that would provide buildings capable of withstanding high temperatures,

such as the passive design of the new hospital in Ténenkou or the neonatal unit in Aweil. The logistics teams are tackling another complex project: the management of non-medical waste. Management plans are progressing in several countries, including Malawi, Uganda, the DRC, Nigeria, and Chad, and a two-year cross-sector pilot project has been launched in South Sudan to develop a replicable model.

International Operations and the OCP Group

Last February in Paris, the GCM OCP—which now includes South Korea—unanimously approved the 2026–2031 strategic orientations. Thanks to a joint effort, a motion proposed by the entire OCP group and entitled "Solidarity with Gaza" was approved during the last International General Assembly. It was implemented by the movement throughout the year, for example through the campaign *"Doctors cannot stop a genocide. Our leaders can."*

One final thought: the current geopolitical landscape, marked by actors who are more violent and more inclined to deprive people of the aid they need, is not going to change anytime soon. How should we respond to this? I believe we must continue to forge alliances with actors capable of rallying behind the ideas and practices we defend: standing united, but only on the condition that the price we pay is not remaining silent about serious crimes. It's the same within the movement: not isolating ourselves, but not being afraid to take different positions.

I congratulate you once again on the work accomplished this year. I warmly say goodbye to Philippe Le Vaillant and Sirantou Tata Dena, who are leaving the Board of Directors this year. It has been a pleasure to have you on the team.

I wish all of you a very nice General Assembly here at the Palais de la Femme, a particularly well-chosen venue to host our association this year. The Board of Directors will answer your questions, and at the end of this session, we will pay tribute to our colleagues and friends who have passed away.