Activity Report 2011

MSF Switzerland

MEDECINS SANS FRONTIERES NOBEL PEACE PRIZE 1999

MEDECINS SANS FRONTIERES
ÄRZTE OHNE GRENZEN

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

MSF is a not-for-profit organisation that was founded by doctors and journalists in 1971. Today, MSF is a worldwide movement with 19 national offices and an international coordination office in Geneva, Switzerland.

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

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

IMPRINT

Médecins Sans Frontières Suisse, 2012

Publisher:
Laurent Sauveur
Managing Editor:
Natacha Bühler
Texts:
Jean-Marc Biquet, Franck Eloi,
Emmanuel Flamand, Nicolette Jackson,
Bruno Jochum, Eveline Meier,
Katharina Meyer, Simon Petite,
Nina Privitera, Abiy Tamrat
Design:
www.latitudesign.com
Printing:
Atar Roto Presse SA

Office in Geneva (Headquarters)
Rue de Lausanne 78
P.O. Box 116
CH-1211 Geneva 21
Switzerland
Phone: +41 22 849 84 84
Fax: +41 22 849 84 88
Email: office-gva@geneva.msf.org

Office in Zurich
Kanzleistrasse 126
P.O. Box 1942
8026 Zurich
Switzerland
Phone: +41 44 385 94 44
Fax: +41 44 385 94 45
Email: office-zuh@geneva.msf.org

Office in Lugano
Via Besso 28
CH-6900 Lugano
Switzerland
Phone: +41 91 967 54 68
Email: office-lugano@geneva.msf.org

www.msf.ch

DEAR FRIENDS

Abiy Tamrat,
President of MSF Switzerland

Bruno Jochum,
General director of MSF Switzerland

In 2011, MSF celebrated its fortieth anniversary and the Swiss office its thirtieth anniversary. The actions of our "Médecins Sans Frontières" have been and continue to be guided on a daily basis by our fundamental values: deliver emergency aid directly to populations in danger; practice neutrality and impartiality; refuse to give into obstacles to providing aid; advocate where situations require it; critically analyse humanitarian action and its limitations.

In 2011 our teams have once again been very much in demand. Our activities have been nearly at the same record level as the prior year, which itself had been exceptional due to the historic earthquake in Haiti. There are several events that explain this high volume. The cholera epidemic in Haiti which started in October 2012 is still on-going with 500,000 cases recorded in the country. Ivory Coast has gone through a brief but violent civil war. MSF has also persued its intervention in often forgotten situations in the Democratic Republic of Congo and with victims of urban violence in Central America.

From March to September 2011, MSF intervened inside Libya to assist wounded patients and provided aid to those who had taken refuge in Tunisia. Somalia has been the other huge crisis at the top of our agenda. The combined impact of an on-going war, drought and insufficient aid within Somalia, has led to massive population movements towards the capital Mogadishu and the refugee camps in Kenya and in Ethiopia. In the summer of 2011, our team in the Dadaab camp in Kenya had to deal with an enormous influx of Somali refugees. Both the hospital and the health centres managed by MSF were put to extreme test. There is no such gathering of refugees of this size anywhere in the world and some have been present there for now twenty years. Whether it is due to our capacity to meet the significant needs of these families or because we position ourselves to defend the dignity of populations that are victims of such cynical negligence, the situation in Kenya will remain a top priority for both our operations and our institution. As for our careful return to Mogadishu, this has undoubtedly saved the lives of numerous children that were part of the tens of thousands displaced, living in the Somali capital.

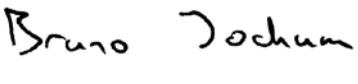
> "The situation of Somali refugees in Kenya remains a top priority."

In addition to dealing with these emergencies, we have focused our efforts twice as hard on fighting the dual HIV/AIDS and tuberculosis epidemic. Sadly, new medical opportunities have been overshadowed by the lack of international funding and the risk that state loans are withdrawn. In the Sahel, we have been pushing for new strategies to be put into place to prevent and help treat malnutrition. We are also calling for public health policies and food aid to be adapted in order to fight sustainably this avoidable chronic emergency.

We have achieved all this in what is now a dangerous and more uncertain environment. MSF's ability to respond to issues we have identified has often been limited by a lack of security and other restrictions to our gaining access, all this despite the continued efforts of our team and the desire to encourage the presence of our international staff. The kidnapping of our Spanish colleagues Blanca Thiebaut and Montserrat Serra from Dadaab in October 2011, followed by the murder, two months later, of Philippe Havet and Karel Keiluhu, both working for the Belgian section, have tragically come to remind us of this risk.

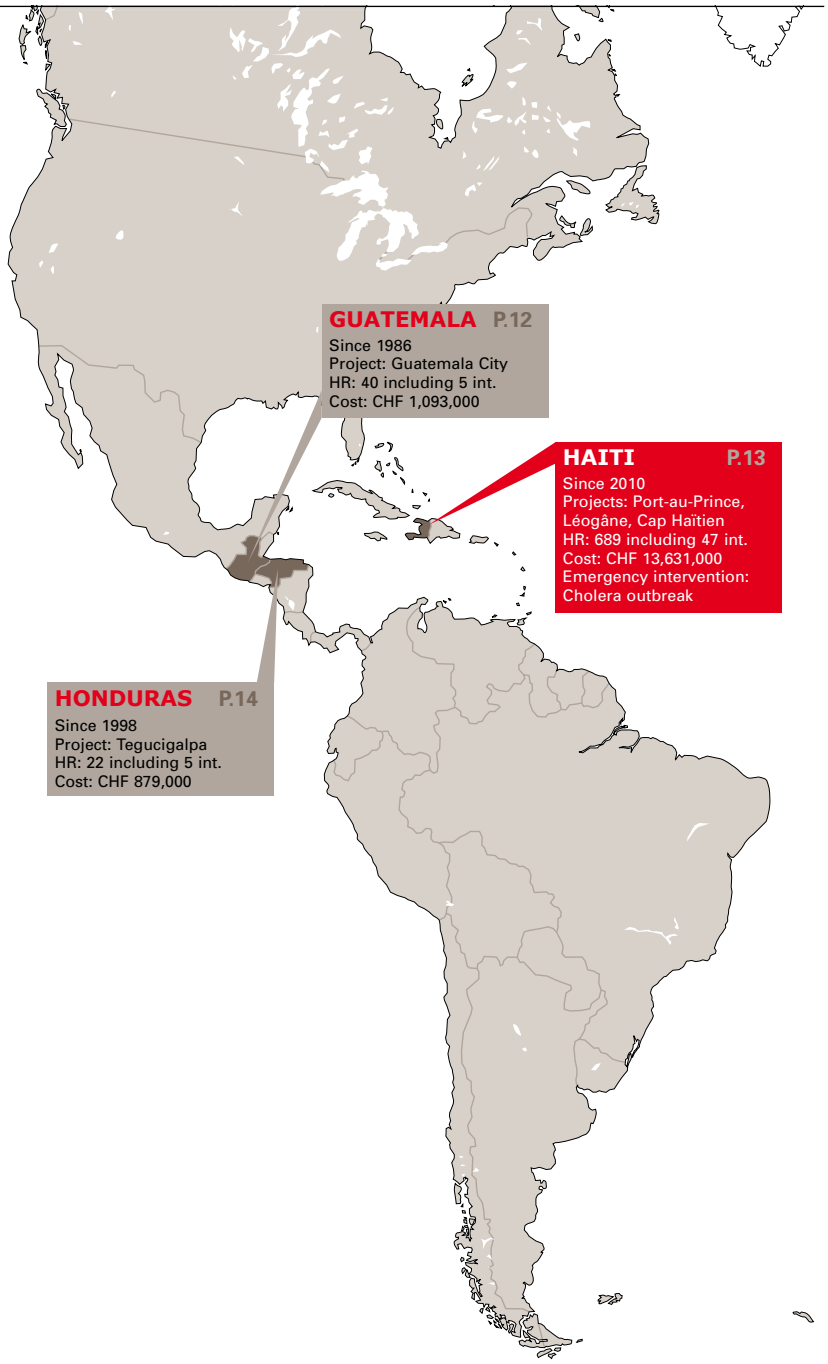
MSF continues to adapt to a constantly changing environment in order to be able to respond in the most effective manner to humanitarian disasters. None of this, however, would be possible without the help of all those who support MSF's work. This report, which provides an insight into our activities during 2011, is a humble account of our gratitude towards all those, each one of you have enabled us to act.

Abiy Tamrat,
President of MSF Switzerland



Bruno Jochum,
General director of MSF Switzerland

CONTENTS



JANUARY

Haiti: MSF's biggest ever response to a cholera epidemic.


© Tristan Pfund

Tunisia: Launch of the operation to support the victims of the Libyan conflict.

APRIL

Ivory Coast: Support for victims of the post-electoral violence.


© Nicola Vigilanti

< JAN 2011


© Natacha Buhler/MSF

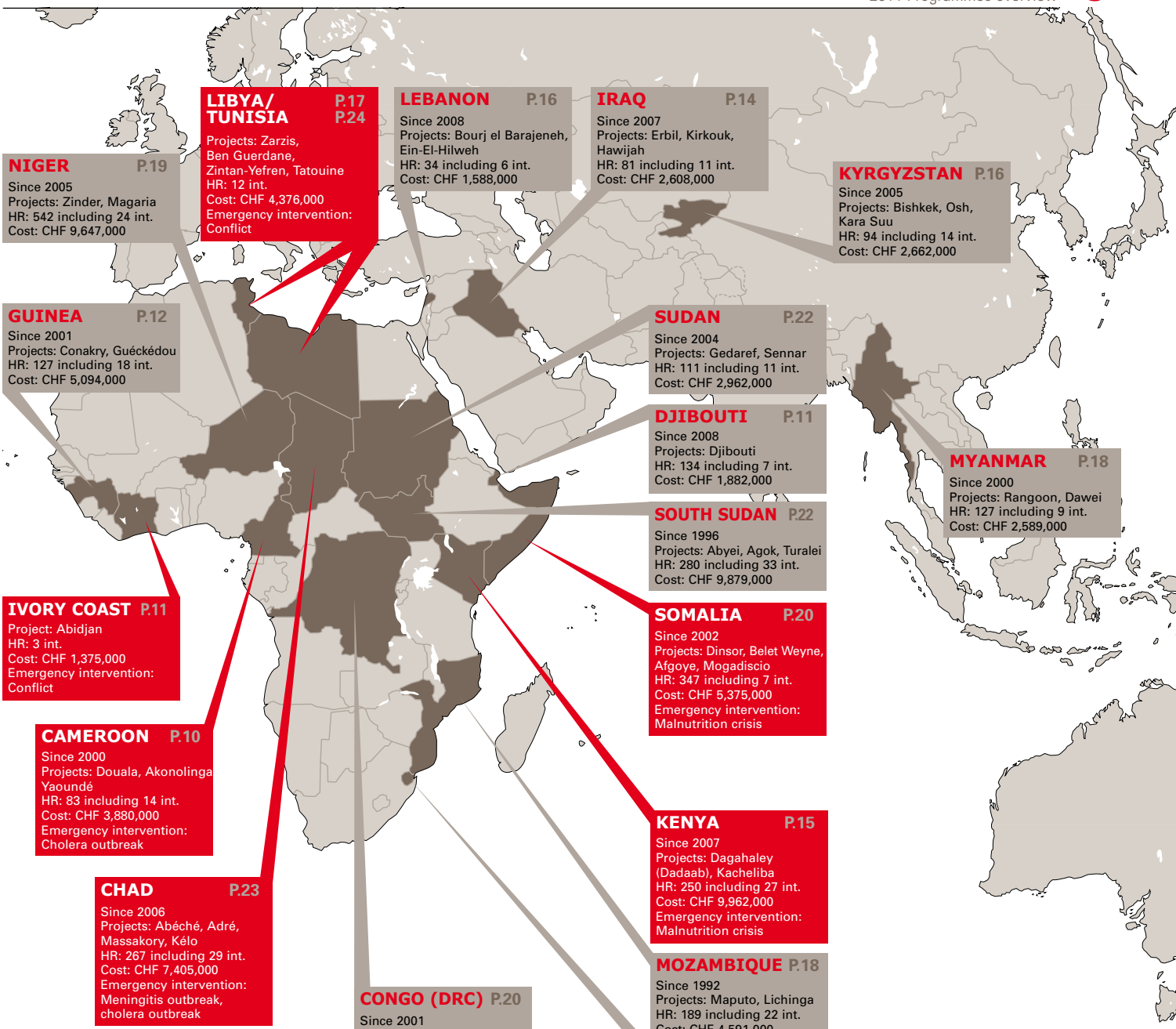
MARCH

Chad: Vaccination of 206,740 people against meningitis.

Cameroon: MSF helps the Ministry of Health respond to a cholera epidemic in Yaoundé.

South Sudan: Emergency response following violence and the fleeing of the entire population of Abyei.

MAY



LIBYA/ TUNISIA P.17 P.24
Projects: Zarzis, Ben Guerdane, Zintan-Yefren, Tatouine
HR: 12 int.
Cost: CHF 4,376,000
Emergency intervention: Conflict

LEBANON P.16
Since 2008
Projects: Bourj el Barajeneh, Ein-El-Hilweh
HR: 34 including 6 int.
Cost: CHF 1,588,000

IRAQ P.14
Since 2007
Projects: Erbil, Kirkouk, Hawijah
HR: 81 including 11 int.
Cost: CHF 2,608,000

NIGER P.19
Since 2005
Projects: Zinder, Magaria
HR: 542 including 24 int.
Cost: CHF 9,647,000

KYRGYZSTAN P.16
Since 2005
Projects: Bishkek, Osh, Kara Suu
HR: 94 including 14 int.
Cost: CHF 2,662,000

GUINEA P.12
Since 2001
Projects: Conakry, Guéckédou
HR: 127 including 18 int.
Cost: CHF 5,094,000

SUDAN P.22
Since 2004
Projects: Gedaref, Sennar
HR: 111 including 11 int.
Cost: CHF 2,962,000

DJIBOUTI P.11
Since 2008
Projects: Djibouti
HR: 134 including 7 int.
Cost: CHF 1,882,000

MYANMAR P.18
Since 2000
Projects: Rangoon, Dawei
HR: 127 including 9 int.
Cost: CHF 2,589,000

SOUTH SUDAN P.22
Since 1996
Projects: Abyei, Agok, Turalei
HR: 280 including 33 int.
Cost: CHF 9,879,000

IVORY COAST P.11
Project: Abidjan
HR: 3 int.
Cost: CHF 1,375,000
Emergency intervention: Conflict

SOMALIA P.20
Since 2002
Projects: Dinsor, Belet Weyne, Afgoye, Mogadiscio
HR: 347 including 7 int.
Cost: CHF 5,375,000
Emergency intervention: Malnutrition crisis

CAMEROON P.10
Since 2000
Projects: Douala, Akonolinga Yaoundé
HR: 83 including 14 int.
Cost: CHF 3,880,000
Emergency intervention: Cholera outbreak

KENYA P.15
Since 2007
Projects: Dagahaley (Dadaab), Kacheliba
HR: 250 including 27 int.
Cost: CHF 9,962,000
Emergency intervention: Malnutrition crisis

CHAD P.23
Since 2006
Projects: Abéché, Adré, Massakory, Kélo
HR: 267 including 29 int.
Cost: CHF 7,405,000
Emergency intervention: Meningitis outbreak, cholera outbreak

MOZAMBIQUE P.18
Since 1992
Projects: Maputo, Lichinga
HR: 189 including 22 int.
Cost: CHF 4,591,000

CONGO (DRC) P.20
Since 2001
Projects: Bunia, Doruma, Dungu, Gety, Dingila
HR: 415 including 49 int.
Cost: CHF 9,804,000

SWAZILAND P.23
Since 2007
Project: Nhlangano
HR: 166 including 21 int.
Cost: CHF 7,539,000

■ : Emergency Operations

HR: Full Time Equivalent

Cost: including programme support costs

JULY

Kenya: Emergency response to a major nutritional crisis in Dadaab refugee camp.

Chad: Response to a cholera epidemic in the Massakory region.

© Christelle Ntsama/MSF

NOVEMBER

Cameroon: MSF helps the Ministry of Health respond to a cholera epidemic in Douala.

DEC 2011 >

© MSF

AUGUST

Somalia: Opening of a new programme in Mogadishu to meet the medical needs of 150,000 displaced people.

SEPTEMBER

Swaziland: Opening of the centre built by MSF to treat patients suffering from drug-resistant tuberculosis.

© Pierre-Yves Bernard/MSF


© Richard Accidat/MSF

HAITI: AN INTERVENTION OF UNPRECEDENTED SCALE TO FIGHT A CHOLERA EPIDEMIC

January 2011. The whole of Haiti is affected by the cholera epidemic. MSF is treating a daily average of 1,850 patients with cholera in its facilities and in the centres that it supports.

At the same time health education information is provided to affected communities about the disease: its origin and how it could be treated.

People are afraid of the disease and it is important to help them understand that opening cholera treatment centres in their villages would contribute to stopping its spread, rather than put them at risk.

The cholera epidemic in Haiti started in October 2012 is still on-going. MSF treated more than half the cases in the whole country.

© Ron Haviv/VII


© Brigitte Breuillac/MSF

IVORY COAST: WAR SURGERY

April 2011. A week after the fall of Laurent Gbagbo's regime, an MSF team opens a surgical unit at Attié Hospital in Abidjan.

Like most of the medical establishments in the capital town, the hospital is barely operational due to continued violence and unrest in the district of Yopougon.

MSF send staff to reinforce the Ministry of Health staff working at Attié Hospital and provides drugs and medical supplies – that are in short supply.

Normality is gradually restored and the hospital staff who had fled, starts returning.


© Chris de Bode

ON THE LIBYAN FRONTLINE

May 2011. Fighting has been raging in Libya for several months. In Misrata, large numbers of people are cut off from assistance. MSF organizes two medical evacuations by boat for 135 patients. Upon arrival, patients are transferred to a dozen Tunisian medical facilities.

Meanwhile over the border in Tunisia, MSF provides basic care in Shousha camp, to thousands of displaced people who have fled the fighting in Libya. The refugees are mostly migrants from sub-Saharan Africa who had been living in Libya; but who had been driven out by the fighting and persecution that erupted during the conflict. Traumatised by their terrible experiences – MSF provides them with psychological counselling as well as medical support.

MSF also denounces the deplorable conditions faced by the fleeing refugees and the fact that they had nowhere to go.

© Mattia Insolera


© Tristan Pfund


© Tristan Pfund

© Tristan Pfund


© Brendan Bannon


© MSF

© Brendan Bannon

SOMALIA: AN ONGOING CRISIS

Summer 2011. Somalia, a country in civil war for 20 years, is in the news once again as a serious food crisis descends.

Drought is not the only factor affecting the food insecurity: fighting made it impossible to deliver adequate humanitarian aid to the populations in need.

Somalis have no choice but to flee. In the refugee camps of Dadaab, in Kenya, the number of people seeking refuge grow.

Forced to settle outside the camps, new arrivals have to wait for weeks before receiving assistance. As a result, one child in five suffers from acute malnutrition.

To respond to the crisis, MSF doubled the capacity of its hospital in Dagahaley Camp, opened a sixth health centre and began distributing ready-to-use therapeutic foods to moderately malnourished children to prevent their health deteriorating further.

Inside Somalia, the situation is also critical. More than 150,000 Somalis have fled to the capital, Mogadishu to seek aid. Taking advantage of a lull in the fighting, MSF reinforces its teams there and several new hospitals are opened. A major measles vaccination campaign is launched in the displaced persons camps in Mogadishu and children are screened for malnutrition.

The most serious cases are transferred to one of MSF's intensive malnutrition rehabilitation centres.

© Martina Bacigalupo/LeMonde/AgenceVU

PROGRAMMES 2011

Medical consultation in the "Buruli pavilion" in Akonolinga. © Alberto Masias

CAMEROON

Treating HIV/AIDS and the neglected disease of Buruli Ulcer

In the politically stable country of Cameroun the main humanitarian needs MSF is responding to are HIV/AIDS and Buruli Ulcer.

MSF is one of only a few NGOs who has experience treating Buruli Ulcer, a neglected disease related to leprosy that attacks and destroys the flesh and is extremely painful, disabling and stigmatising. MSF began working in the small town of Akonolinga in 2002, with the objective of reducing the morbidity and suffering caused by Buruli Ulcer's chronic wounds. Since that time, a total of 1,083 patients have been treated and MSF's "Buruli pavilion", as it is known, has become an international reference centre for the treatment of the disease. Improving medical care for patients suffering from this disease is ongoing and it includes the introduction of new dressings, while easier diagnostics, drugs and surgical interventions are still needed.

HIV/AIDS is a major challenge in Cameroun. Supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the government response has resulted in tens of thousands of patients being given life-saving antiretroviral treatment. However, significant obstacles still exist in accessing effective, HIV treatment and care. MSF's medical teams, who are working in Douala's Nylon District Hospital, have been instrumental in lobbying for changes to HIV treatment protocols in Cameroun. MSF has worked with the Ministry of Health and international donors to advocate for a first-line HIV treatment that has fewer side effects and for a timely switching of patients to second-line therapies, after the development of drug resistance to first-line medication. In 2011, 54 patients were switched to second-line, while 1,500 patients received the new, first-line Tenofovir (TDF)-based combination treatment.

In 2011, MSF also helped the Ministry of Health respond to a number of cholera outbreaks. In March, MSF teams set up a 300-bed cholera treatment centre (CTC) near the general hospital of Yaoundé and 1300 patients were treated by MSF. In November, following another cholera outbreak in the financial capital Douala, MSF set up a 130-bed CTC, that remained open for nine weeks, treating a total of 1,100 patients.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2000

Human resources:
83 staff including 14 international staff

Cost for 2011:
CHF 3,880,000

IVORY COAST

Emergency medical aid during post-electoral violence

Following the post-electoral violence in the Ivory Coast that erupted in late March 2011, MSF provided emergency medical support to the affected population. The Swiss section of MSF focused on areas of the capital Abidjan, which had received little external support.

In Koumassi, medical teams began working in the General Hospital providing access to health care for a population of 600,000. Over a 7-week period, MSF's teams performed a total of 19,820 medical consultations, of which over 30% were for children under-five. In June, when the number of cholera cases began to rise, MSF set up a cholera isolation and treatment unit within the hospital.

Another cholera isolation unit was also set up in the community health centre of the Houphouët Boigny camp. In the camp, MSF organised temporary shelters to facilitate the triage of patients, decontaminated wells and repaired the water system.

In April, MSF started working in the emergency department of the Attié General Hospital in Yopougon, in the west of the capital. For eight weeks, MSF focused on surgery, treating patients with gunshot wounds and shrapnel, and obstetrical emergencies. Access for the wounded was difficult at times as fighting continued in the immediate vicinity of the hospital. Despite this, the hospital was able to increase its capacity: medical consultations increased by sevenfold and eight additional consultations posts were opened; plus a mobile clinic next to a church where people fleeing violence had sought refuge. At the end of the intervention, MSF had seen 83,540 patients.

Reason for intervention:
Armed conflict

Human resources:
3 international staff

Cost for 2011:
CHF 1,375,000

Following the post-electoral violence in the Ivory Coast, MSF medical teams provided 83,540 consultations. © Brigitte Breuillac/MSF, Chris de Bode

DJIBOUTI

Caring for severely malnourished children under-five

The Republic of Djibouti, located in the Horn of Africa, is largely desert. Life for the general population is precarious and food insecurity has resulted in malnutrition among communities living in both urban and rural areas.

MSF has worked in the country since 2008, targeting vulnerable populations living in the slums of Djibouti City. Our primary objective is to treat and care for under-five year old children suffering from severe acute malnutrition.

In 2011, MSF started to handover its projects to the Ministry of Health and to longer-term actors. The outpatient activities were successfully handed over to another international NGO in August. MSF continued working in its nutritional center for the rest of the year.

From January to August 2011, MSF supported the Ministry of Health in six health centres, offering medical and nutritional treatment for severely malnourished children.

Malnourished children with medical complications were referred to an MSF-run care centre. 2,280 children were treated in the ambulatory programme and 1,735 were hospitalised. 81 of the malnourished children were diagnosed with tuberculosis and were transferred to the national TB programme once their nutritional treatment was completed.

In the first part of 2011, screening by MSF teams found an increase in the number of moderately malnourished children and to preempt a worsening situation; MSF lobbied for the distribution of "protective rations" in the most affected parts of the city. Rather than the usual supplementary rations of corn-soy blend, fortified flours, MSF called for more nutritious animal protein rations. The advocacy was successful: the new rations were distributed and the Government is revising its national protocol for malnourished children under-five.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2008

Human resources:
134 staff including 7 international staff

Cost for 2011:
CHF 1,882,000

GUATEMALA

Treating victims of sexual violence

Guatemala is one of the most violent and insecure countries in the world and women are particularly affected. From January to November 2011, 3,970 cases of sexual violence were registered in the country; the real figure is likely to be much higher. Despite the pervasiveness of this crime, victims receive little support or medical care.

Since 2007, MSF has focused on reinforcing and improving access to medical and psychosocial care for survivors of sexual violence in public health facilities in the capital, Guatemala City.

MSF offers 24 hour-a-day services, working alongside other health providers. In addition to providing the first medical attention for patients and follow-up consultations, a team of psychologists provides counselling to help with acute post-traumatic stress and anxiety. The medical organization also offers medication to reduce the risk of patients contracting HIV/AIDS and other sexually transmitted infections.

One of the main pillars of MSF's action in Guatemala is also to influence policies and practices with regards to the treatment of victims of sexual violence. While many efforts still need to be deployed in this area, positive developments have taken place in recent years. In September 2010, the Ministry of Health adopted a national protocol on the treatment for victims of sexual violence, facilitating their access to health care. In June 2011, the Ministry of Health asked MSF to participate to the introduction of this protocol in various health facilities throughout the country – recognizing the key role of MSF in relation to this issue.

In 2011, MSF provided medical and psychosocial care to 780 new patients, as well as 1,500 follow-up consultations. In January 2011, MSF began handing over its services in two clinics to the Ministry of Health. In 2012 it will continue the handover of its activities.

Reason for intervention:
Social violence/Healthcare exclusion

In the country since:
1986

Human resources:
40 staff including 5 international staff

Cost for 2011:
CHF 1,093,000

Delocalized medical care for malaria in Guéckédou region. © Sarah-Eve Hammond/MSF

GUINEA

Community outreach for malaria is saving lives

MSF medical activities in Guinea focus on vulnerable populations living in the capital, Conakry and in the remote rural area of Guéckédou in Guinée Forestière.

Guinea's health system lacks staff, equipment and medicines and the system of cost recovery hinders health access for the poorest. Due to the poor services offered by the public health system, Guineans tend to go to private clinics or turn to traditional medicine.

Since 2009, MSF teams have been working in Matam, a district of Conakry, implementing a mother and child programme. MSF teams work in three health centres run by the Ministry of Health, trying to improve the quality of care for children under-five and pregnant women. Some 65 MSF community health workers go out into the communities to try convince pregnant women to come for antenatal consultations and seek care for their small children. The district is home to an estimated 43,565 children under-five and on average 11,000 pregnant women per year. In 2011, more than 48,600 consultations were carried out in Matam.

Guinea is considered to be hyper-endemic for malaria and 98% of cases are due to the most severe form of the disease, *malaria falciparum*. In June 2010, MSF launched a malaria programme in the Guéckédou region, 700 kilometres south of Conakry, aimed at decreasing transmission and improving the management of malaria.

MSF teams provide training and support the emergency and paediatric departments in the hospital and work in 15 health centres. 45 community health workers have also been trained in outreach prevention and treatment.

They provide rapid malaria diagnosis and treatment and administer an artemisinin-based suppository for severely ill patients before they are transferred to hospital. This innovative approach prevents many deaths. In 2011, more than 75,200 patients were treated for malaria by MSF.

Reason for intervention: **Endemic/epidemic disease, Social violence/Healthcare exclusion**

In the country since:
2001

Human resources:
127 staff including 18 international staff

Cost for 2011:
CHF 5,094,000

By the end of 2011, the five operational sections of MSF had treated around 170,000 patients for cholera symptoms. © Spencer Platt/ Getty Images

HAITI

Massive cholera outbreak and specialised health care

Haiti is a small country in the Caribbean that has been dependent on international aid for decades. Before the devastating earthquake in 2010, large portions of the population were excluded from the health care system. Following the earthquake, access to health care became even more challenging.

Cholera

A major cholera epidemic struck Haiti in October 2010 and continued to affect the population in 2011 with several renewed outbreaks. The five operational sections of MSF responded to this emergency by setting up operations on an unprecedented scale. At the height of the crisis, some 4,000 health care providers were working in more than 75 facilities in Haiti.

In Cap-Haïtien, the country's second largest city, MSF Switzerland opened 19 cholera treatment centres and 90 oral rehydration points, providing thousands of patients with access to care. All cholera-treatment activities were handed-over to the Ministry of Health and its partners in the Nord Department in October 2011.

In Leogane, from October 2010 till the end of 2011, MSF treated 5,100 patients in its cholera treatment units MSF is now focusing on complicated cholera cases (associated with pregnancy and chronic diseases) and is also working with health authorities to reinforce their capacity through the training of community health workers and local medical staff.

By the end of 2011, MSF had treated around 170,000 patients for cholera symptoms. Across the country, cholera killed 5,000 people and affected 520,000 up until the end of 2011. MSF remains vigilant to another potential, large-scale cholera outbreak with emergency preparedness plans in place.

Chatuley, a hospital built from shipping containers

MSF Switzerland has been working in Leogane, a port city, west of the capital of Port-au-Prince, since the 2010 earthquake. The city lacked functioning health facilities so MSF committed to establishing a hospital to provide secondary medical care for the population of 300,000 living in Leogane. Chatuley Hospital, which MSF initially set up in tents, has been replaced by a semi permanent structure made out of containers.

The 160-bed hospital focuses on medical and surgical emergencies, in particular obstetrics, pediatrics and trauma. An MSF-run outpatient department offers primary health care for children under-five years of age and a woman's healthcare package. In 2011, the medical staff treated 67,400 patients, performed 3,840 operations and assisted in 5,150 births.

Reason for intervention:
Endemic/epidemic disease, Natural disaster

In the country since:
2010

Human resources:
689 staff including 47 international staff

Cost for 2011:
CHF 13,631,000

HONDURAS

Providing healthcare to victims of violence

Honduras has the highest murder rate in the world.[1] Drug trafficking, gang violence and easy access to guns have resulted in spiralling crime. People living in the streets are particularly exposed to violence. They also face multiple barriers to access proper health care.

MSF has been providing medical and psychological care for children and young people living in extreme poverty since 2005. In 2010, the organisation decided to change its approach. It handed over its day-care centre for marginalised people, in order to better target victims of physical, sexual and psychological abuse living on the streets. This new programme was launched in early 2011, to bridge the gap between violence-affected populations and access to healthcare. MSF mobile teams crisscross the streets of the capital Tegucigalpa, to provide on-the-spot medical care, or referrals to health facilities.

The target population includes homeless people (children, teenagers, drug and alcohol users, sex workers) and any victims of sexual violence. MSF also works in four health centres providing emergency care to survivors of sexual violence, and will soon work in an emergency peripheral clinic in one of the city's most dangerous areas.

From March to December 2011, 5,440 people were assisted by MSF's medical teams and/or referred to health facilities. MSF is currently the only organization providing direct medical assistance to people living on the streets.

Reason for intervention:
Social violence/Healthcare exclusion

In the country since:
1998

Human resources:
22 staff including 5 international staff

Cost for 2011:
CHF 879,000

1. UNODC Homicides Statistics (2011).

MSF mobile teams provide medical care to victims of violence in the streets of Tegucigalpa. © Aurélie Lachant/MSF

IRAQ

Life-saving support for patient with chronic kidney failure and surgical assistance for patients affected by conflict

Access to quality health care for the Iraqi people has been severely undermined for decades as a consequence of economic sanctions, neglect, war and violence. Non-communicable diseases are on the rise, maternal and peri-natal mortality are high and acute communicable diseases are re-emerging.

MSF has been running two projects in northern Iraq since 2010, with the objective of responding to medical and humanitarian needs arising from Iraq's political instability and violence. Because of security constraints MSF has had to operate the projects by "remote support" to its Iraqi staff during the first six month but MSF's international medical staff were able to be present working alongside their Iraqi colleagues in Kirkuk since July 2010.

In Hawijah, a site of intense violence during the Iraq war, MSF is running a surgical and maternal health project. Most of the patients are civilians trapped by the armed conflict, who lack access to proper health care. In Hawijah Hospital, MSF's management of surgical cases includes emergencies and obstetrics.

In 2011, MSF's surgeons performed 370 surgeries and 2,110 anaesthesia. In Kirkuk, 200 kilometres north of Baghdad, MSF is running a non-communicable diseases programme. 88 patients with chronic kidney failure are receiving treatment in the dialysis unit at Kirkuk General Hospital.

Reason for intervention: Armed conflict, Social violence/Healthcare exclusion

In the country since:
2007

Human resources:
81 staff including 11 international staff

Cost for 2011:
CHF 2,608,000

KENYA

Medical care in the world's largest refugee camp and treating a neglected disease

Dadaab refugee camp in eastern Kenya has a population of 470,000 people – it is the largest refugee camp in the world. This "refugee city" is overcrowded and under-resourced and in 2011 became totally congested as 154,000 more refugees crossed the border having fled the drought and conflict in Somalia.

Dadaab is made up of five main camps and MSF provides health care in Dagahaley camp, for 125,000 refugees. The medical organisation has been the sole provider of health care in the camp since 2009.

In 2011, MSF's teams witnessed the deterioration in the health and nutritional status of newly arrived refugees, in particular amongst the under-fives. In June, a nutritional screening at the camp's reception centre found that levels of global acute malnutrition were well above the emergency threshold. In order to respond to this nutritional crisis, the team had to triple its capacity, setting up an emergency feeding centre with more than 200 beds, whilst maintaining a 110-bed hospital for maternal care, paediatrics, general medical assistance and emergencies.

Dagahaley hospital continued to operate beyond capacity from July to December. With most of the Somalis having had little or no access to healthcare for two decades, the outbreak of disease was a major concern. In consequences, MSF launched with the Ministry of Health, a measles vaccination campaigns targeting over 20,000 people.

In 2011, 154,000 new refugees fled the drought and conflict in Somalia to reach Dadaab camps. © Brendan Bannon

The humanitarian situation for refugees worsened significantly in October 2011 as insecurity grew. Two MSF aid workers were abducted from the Ifo 2 camp. The Government of Kenya launched a military intervention in Somalia and severely curtailed access to Dadaab, by stopping the transfer of refugees from the border; closing the reception centres and halting the registration of all new arrivals. The relocation of families to newly opened sections of Dadaab also ceased and humanitarian support by most NGOs and UN agencies was scaled back because of security concerns.

Despite the security challenges, MSF continued to run all its medical activities. In 2011 outpatient consultations totalled 189,860; 15,680 women received reproductive health services; 3,000 babies were delivered in the hospital and 1,200 surgeries were performed. 30,780 under-five year olds and pregnant/lactating women received supplementary food and 15,700 patients were treated in the therapeutic feeding programme.

Kala azar treatment for the nomadic Pokot

In Kacheliba, a town in the west Pokot district of Kenya, MSF has been running a Kala Azar treatment programme since 2006. Kala Azar is a neglected disease that is fatal if left untreated.

MSF has treated a total of 2,500 patients in Kacheliba since the programme's launch. In addition to the provision of treatment MSF's programme focuses on training health workers and increasing community awareness of signs and symptons in endemic areas. At the national level the medical organisation has helped to adapt Kala Azar guidelines to include more effective drugs and easy-to-use diagnostics, and supported the development of the country's first neglected tropical disease national control programme.

PATIENT STORY

Sultan is a 25-year old mother of four. She has recently given birth to premature twins, in an MSF car, on the way to hospital. "I still haven't decided on a name for my twins. They were two months premature, and it was a difficult labour. We had a horrific eight-day journey from Somalia: bandits ambushed us. They kept us prisoner for two nights in the bush and stole our savings. We have registered as refugees with the UNHCR[1], but we still haven't received any food rations.

In Somalia our family kept goats and cattle, but they all died in the drought. There was fighting in our town. Even if the central government returned, I wouldn't go back. The conditions we lived in were very cruel and harsh. I intend to stay in Dagahaley. I hope my family will be supported and that my children will grow up here get educated and do well."

1. United Nations High Commissioner for Refugees.

Reason for intervention: **Armed conflict, Endemic/epidemic disease, Social violence/ Healthcare exclusion**

In the country since:
2007

Human resources:
250 staff including 27 international staff

Cost for 2011:
CHF 9,962,000

KYRGYZSTAN

TB in prisons

TB incidence in prisons is at catastrophic levels due to the cramped living conditions in the cells, which contributes to spreading the disease amongst inmates. In 2007, it was 20-30 times higher than in the civilian sector, and mortality rates were 60 higher. Since 2006, MSF has been supporting TB control activities in the penitentiary system. MSF works in collaboration with the Ministry of Health and prison authorities, in two detention facilities near the capital Bishkek. In 2011, 330 patients were treated.

Resistance to first-line TB drugs is a significant problem in the penal sector; around two thirds of infectious TB patients have a drug-resistant form. Indeed, many people in the penal sector have pathologies which make it difficult to be adherent to treatment: alcoholism, drug injectors, etc. But also the infection control measures in prisons are difficult to apply because of the promiscuity. In 2011, MSF installed a molecular analyser for quicker detection of DR-TB cases. MSF also rehabilitated TB wards in two prisons, to improve infection control standards and living conditions for TB inmates.

About a third of prisoners with TB are released before finishing their treatment. The follow-up of these patients is crucial in order to support the completion of their TB treatment. Over ten months in 2011, 192 released inmates with TB were supported through an MSF network of 20 volunteer case managers. In June 2010, MSF provided life-saving medical care to victims of ethnic violence in the Southern City of Osh. Throughout the following winter and until April 2011, MSF continued to offer health care services providing in all 580 medical consultations and 2,600 mental health consultations. Teams also distributed blankets, cooking sets and hygiene kits to vulnerable people living in Osh.

Since July 2011, MSF has launched a new TB project in Kara Suu district in the Osh region.

Reason for intervention: **Endemic/epidemic disease, Social violence/Healthcare exclusion**

In the country since:
2005

Human resources:
94 staff including 14 international staff

Cost for 2011:
CHF 2,662,000

LEBANON

Emergency assistance to fleeing Syrians and mental health support for Palestinian refugees

In Lebanon, MSF is responding to a gap in much-needed mental health services, particularly for Palestinian refugees. MSF teams work in a Community Mental Health Centre in Burj el-Barajneh, Beirut's most densely populated area, where 18,000 inhabitants, the majority of whom are Palestinians, live in 1.5 km^2. In April 2011, MSF extended its community-based mental health services to Ein el-Hilweh refugee camp, in Saida, in southern Lebanon, where 75,000 Palestinians and other vulnerable residents are cramped into 1 km^2.

MSF's multidisciplinary mental health care approach includes screening patients, treatment, home visits, counselling, social support and mental health promotion activities. The aim is to facilitate the integration of mental health care within the primary health care system for Lebanese as well as Palestinian refugees in Lebanon.

A total of 2,240 patients have benefited from 15,560 mental health consultations since January 2010. The main diagnoses observed have been depression, anxiety, psychosis and personality disorders. Recently, MSF dispatched a medical team to assist the thousands of Syrians escaping the violence in their country. In November 2011, a mental health programme was set up for fleeing Syrians and the 20,000 Lebanese living in Wadi Khaled, in northern Lebanon. MSF is providing stocks of emergency supplies to health centres near the border, reinforcing epidemiological surveillance, vaccinations, and chronic disease management and emergency medical equipment.

Reason for intervention:
Social violence/Healthcare exclusion

In the country since:
2008

Human resources:
34 staff including 6 international staff

Cost for 2011:
CHF 1,588,000

MSF provides mental health care in Burj el-Barajneh Palestinian refugee camp. © Dina Debbas

In April 2011, MSF organized two medical evacuations by boat from Misrata to Tunisia. © Tristan Pfund

LIBYA

Emergency medical assistance during the Libyan civil war

Prompted by the escalating rebellion in Libya and violent clashes between government forces and rebels in February 2011, MSF Switzerland teams pre-positioned themselves on the Tunisian border from where they began providing medical supplies to health facilities. On the Eastern side of Libya, teams from other MSF sections managed to reach Benghazi in order to support the civilian population.

Providing medical care to war wounded

In several conflict zones, including Zawiyah and Misrata, large numbers of people were cut off from assistance. MSF repeatedly called for immediate unhindered access for the wounded, following reports of urgent medical needs. In late March, MSF sent a shipment of surgical kits for the wounded to Misrata hospital. Parts of the hospital had been bombed and the remaining functioning clinics were overflowing with severely injured patients. MSF donated an additional six tons of emergency medical material including: drugs, sterilisation materials, and intravenous fluids to the Libyan Health Committee in Misrata, to help cope with the influx of war-wounded people. MSF also began sending medical supplies and equipment to health facilities in the Nafusa mountains region in western Libya.

In April, MSF organized two medical evacuations by boat for 135 patients from Misrata to Tunisia. Upon arrival, patients were transferred to a dozen medical facilities, where they received specialized treatment.

Emergency surgery and psychological care in the Nafusa mountains region

In late April, an MSF Switzerland team was deployed to Zintan, which had become a battleground for pro-Gaddafi forces and the insurgency. By mid-June, as the fighting moved, MSF concentrated its medico-surgical activities in Yefren.

In Zintan and Yefren, MSF teams conducted surgical interventions and post-op care, donated medical equipment and material, provided training to Libyan medical staff and supported primary health care activities and hospitals' intensive care units. Most patients suffered gunshot and shrapnel wounds. Between April and October, MSF treated a total of 2,220 war-wounded and conducted over 270 surgical interventions.

In July, MSF launched a mental health care programme, offering psychological support to hospitalised patients, to medical personnel and to people living in the community, who were experiencing depression and anxiety. From July to October, 470 individual consultations were conducted by MSF's psychological teams in Zintan and Yefren and over a 1,000 people benefited from group consultations.

By September, an evaluation of the situation in the Nafusa mountains region showed that health facilities were back to being fully functional, MSF began to wind down its activities and withdrew by the end of October.

Reason for intervention:
Armed conflict

Human resources:
12 international staff

Cost for 2011:
CHF 4,376,000

MOZAMBIQUE

Innovative methods of scaling up HIV/AIDS and TB treatment and care

MSF has been pushing the HIV treatment agenda in Mozambique for the past ten years. By exploring innovative methods of providing care, it has demonstrated that scaling up ARV treatment in low-resource settings is feasible. Decentralisation of services from large hospitals to local clinics, staff training, task-shifting (where nurses provide treatment that was once the sole responsibility of doctors and lay people take on nurses' responsibilities) have been instrumental in increasing the number of people receiving HIV and TB treatment and care.

In 2011, MSF supported five of the seven health centres in Chamanculo district, in the capital Maputo and the Provincial Hospital of Linchiga. As well as providing ARV and TB treatment, the medical organisation cares for TB and HIV patients with complicated conditions such as: patients who are co-infected with HIV and TB, are suffering from severe side-effects, have Kaposi's sarcoma (a type of cancer) or a chronic disease.

Over the year, MSF teams provided treatment and care to 20,000 HIV positive patients and to 1,660 TB patients. More than 50% of the TB patients are co-infected with HIV/AIDS. The Lichinga HIV programme was handed over to the Ministry of Health in November, but the team continues its work in Maputo.

Reason for intervention:
Endemic/epidemic disease

In the country since:
1992

Human resources:
189 staff including 22 international staff

Cost for 2011:
CHF 4,591,000

PATIENT STORY

Carmen Pantie, a 32-year-old patient. "I cried when I came back from the hospital on the day I found out I was HIV positive. I had no idea what to do. It was my sister who encouraged me to do what the doctor said. I am glad I did because without the medication, I expect I would be dead by now. I take my pills twice a day. As soon as I began to do so, I started to feel better. The medicines have really changed my life – now I cook every day and I am running a small business from home. We also want to build a house on a piece of land that we have, down by the river. There is so much to live for."

In Dawei, 50 village health workers provide specialized care for HIV/AIDS and TB. © Matthieu Zellweger

MYANMAR

Filling critical gaps in HIV/TB treatment

Myanmar is the least developed country in Southeast Asia and suffers from a severely underfunded state healthcare system. Government health expenditure constitutes less than 1% of the national budget, compared to 23% spent on the military[1].

Access to health care is poor and there is a critical need for increased HIV/AIDS and tuberculosis treatment. MSF has been running an HIV/TB programme in Dawei, in Thanintharyi Region since 2004. MSF provides basic primary health care to vulnerable populations through a network of 50 village health workers and care for all HIV/AIDS and TB patients in the region. The provision of multidrug-resistant TB care is planned for 2012. MSF is also very involved in malaria control activities, including the distribution of bed nets by the organisations' village health workers. In 2011 MSF provided 69,825 primary health care consultations, treated 5,310 malaria cases, 2,230 HIV patients and began TB treatment for 415 people.

In Insein prison, Yangon, poor living conditions and reduced access to healthcare mean that prisoners are vulnerable to a wide range of health problems. In 2011, MSF put 150 prisoners on ARV treatment.

Reason for intervention: Endemic/epidemic disease, Social violence/Healthcare exclusion

In the country since:
2000

Human resources:
127 staff including 9 international staff

Cost for 2011:
CHF 2,589,000

1. Jane's Information Group, March 2011.

Food insecurity is a recurrent problem in the Niger. It affected more than five million people in 2011. © Julie Rémy/MSF

NIGER

Nutritional support for severely malnourished children

Since 2005 MSF has been running malnutrition programmes in the Zinder region of southern Niger. Food insecurity is a recurrent problem in the country and in 2011 more than five million people were affected during the "hunger gap" months, between May and September.

The Zinder region is particularly prone to chronic food shortages and MSF's action focuses on the provision of medical and nutritional care to young children suffering from severe acute malnutrition in the cities of Zinder and Magaria and surrounding districts.

MSF adopts a preventive approach – by giving children under two, who are at risk of becoming seriously malnourished, nutritional supplements. In 2011, 110,000 children aged 6 months to 3 years across the Zinder region were given ready-to-use supplementary food. RUSF, as it's called, is a peanut-based paste enriched with milk proteins and contains micronutrients necessary for the development of a growing child. It is designed to complement breast milk and the family food a child is already getting. This innovative approach, which has now been adopted by the government of Niger and UN agencies, helped reduce global acute malnutrition in Zinder from 17.8% in 2010 to 11% by 2011.

MSF works in Zinder National Hospital alongside the Ministry of Health staff providing emergency care for severely malnourished under five years old kids. Zinder hospital has a paediatric ward integrated with a therapeutic feeding centre and in 2011 2,245 severely acute malnourished children were treated as in-patients. MSF teams also worked on nutrition programmes in 18 community health centres in the Zinder district. Following a measles outbreak, 25,400 people were vaccinated against the disease.

In the town of Magaria, close to the Nigerian border MSF's nutritional and paediatric activities include an intensive nutritional rehabilitation centre and six outpatient therapeutic feeding centres for severely malnourished children; and support to 18 community health posts and 6 health centres. A total of 17,700 severely malnourished children received nutritional assistance and 16,500 patients were treated for malaria in 2011. An estimated 30 to 45% of admissions to MSF's programmes come from neighbouring Nigeria.

Paediatric emergency care at the community level focused on reducing the mortality of children under five. In 2011 two health posts in Dan Tchao and Dungass health zones were revitalised.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2005

Human resources:
542 staff including 24 international staff

Cost for 2011:
CHF 9,647,000

DEMOCRATIC REPUBLIC OF CONGO

Medical attention to people affected by violence or suffering from neglected diseases

Despite living in a country that is rich in natural resources, the citizens of the Democratic Republic of Congo (DRC) are amongst the poorest in the world. Malnutrition affects many Congolese and the rate of infant mortality is one of the world's highest. In the east of the country fighting between government forces, rebel groups and rival warlord armies has led to mass displacement, suffering and high incidence of sexual violence.

In 2011 MSF Switzerland ran five projects in the eastern region that primarily target people affected and/or displaced by violence. In the districts of Haut-Uélé and Bas-Uélé, in Province Orientale, attacks by armed groups caused massive population displacement, 320,500 by the end of 2011. MSF is offering secondary and primary heath care to local residents and those displaced by the violence in the towns of Dungu, Doruma and Gangala. Support is given through a wide range of care, from surgical operations and community health education to mental heath support.

The Uélés are affected by a neglected disease known as sleeping sickness and could constitute one of the world's biggest reservoir of the disease. In Doruma and Dingila MSF partners with Ministry of Health staff screen and treat patients for this deadly disease, which is transmitted to humans by the tsetse fly. In 2011, 55,400 people were screened and 1,300 treated for sleeping sickness.

Further south in Province Orientale, MSF has been working in the city of Bunia where the main medical activities are related to paediatric HIV/AIDS treatment, responding to emergencies and supporting the victims of sexual violence. By the end of 2011, the medical organisation handed over its women's sexual violence project to Sofepadi, a local NGO that receives medical, technical and financial support from MSF. In Gety, a team provides basic and emergency health services and runs a 24-hour therapeutic feeding centre.

Reason for intervention: **Armed conflict, Endemic/epidemic disease, Social violence/ Healthcare exclusion**

In the country since:
2001

Human resources:
415 staff including 49 international staff

Cost for 2011:
CHF 9,804,000

In DRC, MSF activities target victims of sexual violence, internally displaced people and people affected by sleeping sickness. © Ben Milpas

SOMALIA

The never-ending crisis

Somalia's humanitarian crisis continues to be one of the worst in the world. In 2011, Somalis faced the devastating effects of drought, which has been exacerbated by high cereal prices, excess livestock mortality and conflict.

Somalia is in a permanent state of emergency where civilians are victims of indiscriminate violence. There is no functioning government or national health system and international organisations are severely limited from reaching populations in need of assistance, because of insecurity.

In 2011, the severe drought and violence forced the population already living under extremely precarious conditions to flee. 154,000 crossed the border into Kenya, Yemen and Ethiopia and tens of thousands became displaced in and around Mogadishu.

The high number of people who were displaced and living in makeshift camps heightened the population's susceptibility to communicable diseases and food insecurity. MSF launched an emergency intervention in Mogadishu for 8,000 internally displaced families in August. Inpatient and ambulatory feeding centres were set up and 4,900 malnourished children were admitted. MSF teams also vaccinated 16,215 children against measles.

Thirty kilometres from Mogadishu, MSF supports a local community hospital in Afgooye in the lower Shabelle region. It is the only health facility in the district and covers the health needs of 180 villages. In 2011, teams from the community hospital treated 3,300 malnourished children and performed 27,300 outpatient consultations.

In Dinsor, in Southern Somalia, MSF has been providing primary and secondary health care since August 2002. The comprehensive health programme includes maternity services, a 100-bed tuberculosis treatment department, a therapeutic feeding centre, minor surgery, kala azar treatment and emergency response to disease outbreaks.

In 2011 the teams provided 44,000 outpatient consultations, 2,000 patients were admitted to the inpatient department, more than 300 patients were treated for TB, a thousand safe deliveries were performed and 3,900 children suffering from severe acute malnutrition were treated in the nutritional programme.

Nutritional care for malnourished children in Mogadishu. © Martina Bacigalupo/LeMonde/AgenceVU

In Belet Weyne, a town in Hiraan region in Central Somalia, MSF provides secondary health care in a 120-bed hospital for 70,000 town-dwellers. It is also the referral hospital for the 120,000 people living in the district. In 2011, 18,000 patients attended the emergency ward and 1,400 patents were admitted in the hospital. More than 800 deliveries were conducted and 320 surgeries were performed. 2,000 severely malnourished children were treated in MSF's therapeutic feeding programme.

Reason for intervention:
Armed conflict

In the country since:
2002

Human resources:
347 staff including 7 international staff

Cost for 2011:
CHF 5,375,000

HUMANITARIAN SPACE IN SOMALIA

2011 proved to be very insecure for humanitarian actors in Somalia and despite intense negotiations with armed groups, MSF's access to the most affected regions in south-central Somalia remained difficult.

In August, MSF's emergency response in Mogadishu was scaled up and a permanent international staff presence was established.

In October Montserrat Serra and Blanca Thiebaut from MSF Spain, were abducted in Dadaab refugee camp in northern Kenya, while providing emergency assistance to the displaced Somali population and MSF is doing everything in its power to bring about their safe release.

On the 29th of December following the killing of two Belgian MSF workers, Philippe Havet and Dr. Karel Keiluhu, the medical organisation closed two projects in the capital. MSF projects continue to provide medical care in other districts, as well as in 10 locations in the rest of Somalia. MSF remains committed to continuing its activities in Somalia however the medical organisation's presence is dependent upon all parties to the conflict respecting the safety of its medical personnel, patients and medical facilities.

SOUTH SUDAN

Medical support for a conflict-affected community

Despite the political developments in the Republic of South Sudan, unfolding emergencies continue to require urgent humanitarian responses. Conflicts in the contested, oil-rich area of Abyei and in Blue Nile and South Kordofan states left thousands dead and hundreds of thousands displaced in 2011. Widespread crop failure, floods, trade disputes and inflation in the local markets made it very difficult for southern Sudanese families to feed themselves.

MSF has been present in Abyei, a disputed region between north and south Sudan since 2006. MSF's health support includes an outpatient clinic in the town and mobile clinics in the surrounding areas.

In May heavy clashes and bombing in and around Abyei caused a massive exodus of 100,000 people towards the south. MSF responded quickly and focused on performing life-saving surgeries, treating malnutrition, providing reproductive healthcare and vaccinating children.

In Agok, 40 kilometres south of Abyei, where MSF runs a hospital and an ambulatory consultation, they received 55 wounded in the first four days of the fighting and treated 2,300 people in the first two weeks.

Agok and the surrounding areas became host to thousands of people displaced by the violence. MSF's teams ran mobile medical clinics for the wounded and the displaced and provided them with basic non-food items such as plastic sheeting, mosquito nets and soap.

A nutritional assessment in November prompted the medical organization to start blanket supplementary feeding for children under five. 10,200 children were reached in December. A major component of MSF's assistance in Abyei and Agok is a comprehensive antenatal and maternal care program. Deliveries and other serious cases are referred to the hospital in Agok, which provides a wide range of services including surgical, maternity, inpatient and outpatient care, a paediatric unit, a tuberculosis ward and a therapeutic feeding centre for malnourished children. In 2011, MSF provided 26,000 consultations at the Agok outpatient department.

Reason for intervention:
Armed conflict

In the country since:
1996

Human resources:
280 staff including 33 international staff

Cost for 2011:
CHF 9,879,000

THE WORLD'S NEWEST INDEPENDENT COUNTRY

Once the third biggest country of Africa, Sudan split in two countries in 2011. During a referendum held in January, the population of South Sudan chose to become the newest independent country in the world and the separation was effective in July.

MSF has been working in the North and South Sudan for decades, providing care to conflict affected people, primary health care or specialized care for neglected diseases. The medical organisation continued to do so after the split of the country.

Despite the political developments in the Republic of South Sudan, unfolding emergencies continue to require urgent humanitarian responses. © Kate Geraghty

SUDAN

Emergency response and operational research for Kala Azar

In Sudan, MSF's medical teams treat people affected by Kala Azar, in two sites: Al Dinder and Atbara river areas in Sennar State and Gedaref State. Kala Azar (visceral leishmaniasis) is an under-researched disease that is endemic in parts of Sudan and is nearly 100% fatal if untreated. In 2011, 3,090 suspect cases were screened for Kala Azar resulting in 730 people treated for the disease.

MSF's Kala Azar treatment centre at Al Dinder is one of the few locations where the organisation can conduct operational research into this neglected disease, and can roll out the use of new treatment protocols. In July 2011, a new drug developed by the MSF-founded 'Drugs for Neglected Diseases initiative' (DNDi) and Sudanese scientists was introduced that will reduce the length of treatment from 30 to 17 days. The medical organization also responds to medical emergencies in Sudan. In June 2011 in Gedaref, the Ministry of Health and MSF jointly conducted a mass measles vaccination campaign – immunizing 44,000 children.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2004

Human resources:
111 staff including 11 international staff

Cost for 2011:
CHF 2,962,000

SWAZILAND

Responding to massive HIV and TB epidemics

The small kingdom of Swaziland is facing dramatic HIV/AIDS and tuberculosis (TB) epidemics. 26% of adults, aged 15-49, are infected with HIV/AIDS and 42% of pregnant women are HIV positive. HIV/AIDS co-infection with TB is very high and the management of drug resistant tuberculosis (DR-TB) is a growing challenge in Swaziland, with 20% of TB cases being resistant to first-line treatments.

In 2011, the Kingdom went through a severe financial crisis. The government has had difficulties securing funds to buy HIV drugs and laboratory supplies. In such a context, the announce of the Global Fund, one of the country's biggest donors, to cancel its next round of funding is a very bad news.

Since 2007, MSF teams have been focusing their efforts on facilitating access to integrated HIV/AIDS and TB services at the primary health care clinic level, to allow patients to access services close to where they live. Today, there are 22 rural clinics supported by MSF in the Shiselweni region, offering decentralised HIV/AIDS and TB care for 2,000 TB patients and 18,000 HIV positive patients.

DR-TB treatment is very taxing for patients. They must receive a daily injection for at least six months and take up to 18 pills per day for up to 2 years. Adverse side effects are numerous and require even more medicines. MSF has opened a 30 beds DR-TB ward in Nhlangano that is jointly run with the Ministry of Health. The DR-TB ward was inaugurated in September 2011 by King Mswati III of Swaziland,

Other MSF activities in 2011 include the rehabilitation of 11 rural clinics, the introduction of a new rapid diagnostic test for DR-TB and HIV/TB and support to the National Reference Laboratory for Tuberculosis.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2007

Human resources:
166 staff including 21 international staff

Cost for 2011:
CHF 7,539,000

CHAD

Responding to medical emergencies and repairing obstetrical fistulas

Chad is one of the poorest countries in the world; 80% of its inhabitants live below the poverty line. In 2011 MSF was one of the main international medical organisations responding to Chad's emergencies including: a nutritional crisis, a cholera outbreak, measles and meningitis epidemics. MSF vaccinated 206,740 people and treated over 1,000 meningitis patients in Kelo and Gounou Gay districts.

In Massakory district, MSF treats children under five suffering from malnutrition and provides emergency paediatric care. A supplementary feeding programme also targets children under three in the district, by distributing ready-to-use supplementary food to help prevent malnutrition.

Close to 3,200 severely malnourished children were treated in MSF's outpatient programme and 1,400 children were admitted to hospital for malnutrition. Another 750 children were treated for malaria, meningitis, diarrhoea and respiratory infections.

Since 2008 the medical organization has been working out of the Regional Hospital of Abéché providing medical support to the maternity unit, performing surgery and providing care to women suffering from obstetric fistulas. The prevalence of fistulas in Chad is very high because of child birthing injuries. Fistulas can cause a woman to be incontinent.

In 2011 over 82% of the women who received MSF's surgery were cured of their incontinence.

Reason for intervention:
Endemic/epidemic disease

In the country since:
2006

Human resources:
267 staff including 29 international staff

Cost for 2011:
CHF 7,405,000

MSF vaccinated 206,740 people in Kelo and Gounou Gay districts. © Natacha Buhler/MSF

Mental health care for people who fled the conflict in Libya. © Mattia Insolera

TUNISIA

Medical assistance for refugees from Libya

When violence erupted in Libya early March 2011, MSF positioned medical teams and supplies in Ras Ajdir, a checkpoint at the border, in order to provide help both inside Libya and to the thousands of people seeking refuge in Tunisia.

Refugees congregated in Shousha camps. Tunisian authorities and NGOs were able to cope with the situation and to cover most of the medical needs. However MSF detected a need for mental health support for these refugees. Not only were they stressed by the uncertainty of their immediate future but also many had directly witnessed or experienced violence and persecution in Libya.

In the largest camp of Shousha, some 4,000 people – mainly sub-Saharan Africans – could not be repatriated, primarily due to dangerous situations in their countries of origin. Living conditions in the camp were totally inadequate for long-term stay and dozens of refugees would leave the camp each week to attempt journeys across the Mediterranean Sea, risking their lives in the hope that their reception would be better in Europe.

Because of the little respect shown to the Convention Relating to the Status of Refugees, MSF reminded all parties to the Libyan conflict and neighbouring countries of their responsibility to keep their borders open and to offer protection to those fleeing Libya.

From March to September 2011, MSF teams also deployed mobile clinics along the border between the towns of Dehiba and Ras Ajdir, where thousands of Libyan families had taken refuge. MSF provided a total of 10,500 medical consultations and 21,000 people received mental health consultations during this period.

In August, MSF began scaling down its activities, as the majority of Libyan refugees had returned to their home country. While the situation remained very difficult for those stranded in the camp of Shousha, the medical emergency had ended. MSF handed over its activities to other medical actors and donated medical supplies and equipment to Tunisian health facilities.

Reason for intervention:
Armed conflict

Human resources:
12 international staff

Cost for 2011:
CHF 4,376,000

PATIENT STORY

Mouhaydin, is a 27 year old refugee.

"I left Somalia for Ethiopia in 1994 because of the war, after my father was killed. I came to Libya eight years ago, to find work and build a future. I was working as a labourer and cleaner. Life was difficult. We were treated like slaves.

When the war broke out in Libya, the situation became very frightening for foreigners and I had to flee.

I arrived in Shousha camp on 6th of March, with my wife, who was three months pregnant. She decided to return to Libya and then to take a boat to Europe. She left without telling me of her plans. On April 5th she drowned after the boat she was on sank.

One morning I saw her and then never again. I am very sad, I try to keep my mind busy so I don't have to think, but I can't sleep."

HUMAN RESOURCES

> “In 2011, MSF Switzerland recorded almost 900 departures for missions.”

Responses to numerous emergencies set the pace for our human resources in 2011: cholera epidemics in Haiti, Cameroon and Chad; food crises and conflict in the Horn of Africa and South Sudan; and aid operations for populations affected by the crises in Libya, Syria and Côte-d’Ivoire. At the same time, MSF Switzerland’s regular programmes generated a continuous workload for our HR teams, and by the end of the year the number of staff deployed in the field had reached, for the first time, more than 4,000 humanitarian workers (full time equivalent – FTE).

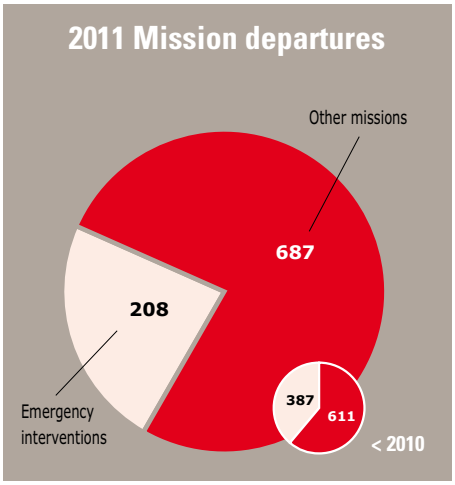
The murder of two colleagues, Philippe Havet and Karel Keiluhu, in Mogadishu, and the abduction of Montserrat Serra and Blanca Thiebaut from Dadaab refugee camp in Kenya, are stark reminders of the vulnerability of our teams in the complex, challenging environments where we work. Our hearts go out to our colleagues’ friends and families.

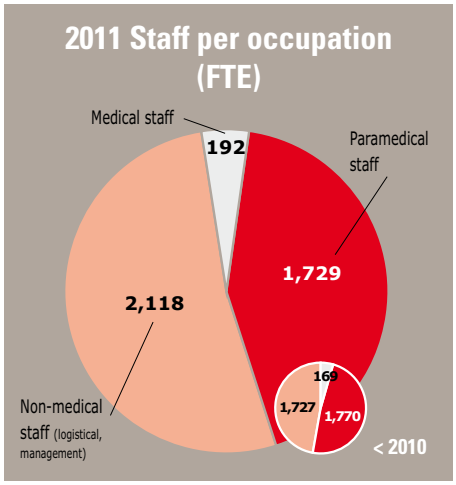
Internally, the reorganisation of the department’s operational HR structure is continuing: dedicated HR coordinators have been sent to the capital of each country where we work, to support expatriate and local staff. Human resources will remain a priority for the coming years. One key development will be the introduction of HR “best practice” at each level of the organisation to ensure respect for diversity.

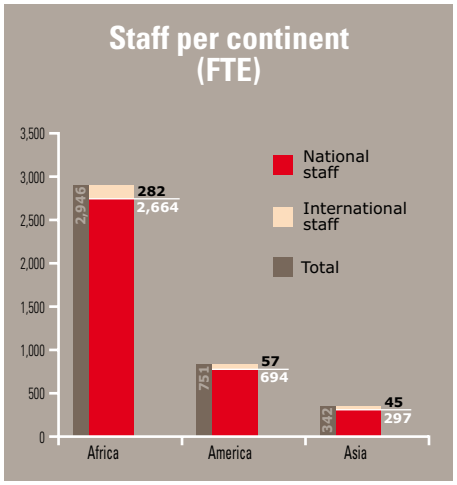
The year 2011 also saw the launch of major HR reforms across the international MSF movement, including the harmonisation of pay policies for national staff in the field, the selection of a common IT tool for managing HR across all MSF sections (which will be rolled out in 2014) and the reform of the pay and contracting system for our international staff. The successful completion of these major projects will contribute to stabilizing the autonomy of our field coordination, optimising the career management of our staff, thus improving retention and the availability of skilled staff.

I would like to take this opportunity to warmly thank my HR colleagues in the field, in Geneva and at the various MSF headquarters for their hard work in 2011, and to thank our 4,000 national and international staff in the field. All of them are indispensable in our efforts to help crisis-affected populations.

Franck Eloi, Human Resources Director







FINANCIAL RESULTS FOR 2011

As might be expected after an exceptional increase of 56% in MSF's Switzerland's programme budget in 2010, **expenditures** decreased slightly (by 4%) to CHF 112M in 2011 (compared with CHF 116.5M in 2010). This slight reduction in the operating budget should not negate the fact that the past year was extremely busy.

The substantial decrease in the emergency budget, after the record year of 2010 (CHF 47M, CHF 28M of it for Haiti), was offset by a budget increase for ongoing projects, such as our long-term aid to Leogane Hospital in Haiti and stepping up our activities in Guinea, South Sudan and Chad. Moreover, we launched numerous emergency operations in 2011, particularly to treat victims of the crisis in Somalia and the wars in Libya and Ivory Coast, and to respond to epidemics such as the cholera outbreaks in Cameroon and Chad, malaria in Guinea, meningitis in Chad, and measles in Somalia and Kenya.

More than half (56%) of our project expenditure went towards tackling endemic/epidemic diseases and over a third (37%) on contexts of armed conflict.

In geographical terms, Africa still receives by far the largest share of our project expenditure (76%), followed by Latin America (14%) and Asia (9%).

The operations which mobilised most financial resources in 2011 illustrate the diversity of the challenges faced by MSF: the response to the Somalia crisis (CHF 10M), Leogane Hospital in Haiti (CHF 7M), the HIV/TB project in Swaziland (CHF 6.5M) and the response to the war in Libya (CHF 4M).

As is often the case after a year with a large increase in operational spending, **HQ expenditures** followed the upward trend, but slightly later. In 2011, spending by MSF Switzerland's HQ was up 12%, by CHF 4.1M, bringing its total costs to CHF 35M. As a reminder, HQ expenditures rose by 8% in 2010, while operational expenditure was 56%.

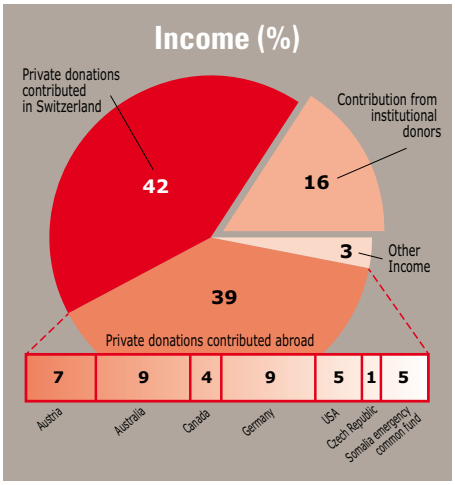
The most significant increases from 2010 to 2011 were due to strengthening the operational support departments (medical, logistics, IT) and MSF Switzerland's investments in setting up new offices (Czech Republic and South Korea).

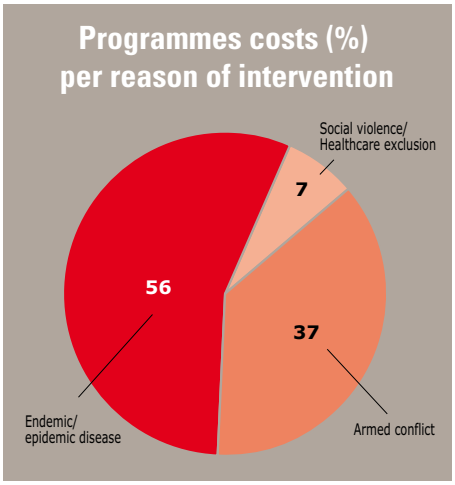
Total expenditures for the year were CHF 147M: similar to that for 2010. The share of this figure allocated to the MSF social mission fell from the exceptional level of 91% in 2010 to 89%, but was still within the average for the last five years.

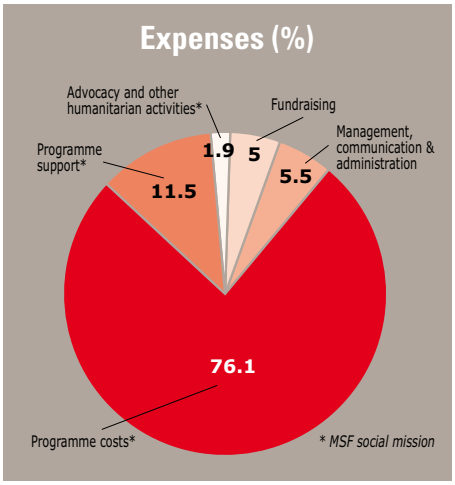
MSF Switzerland's **income** decreased from CHF 165M to CHF 154M between 2010 and 2011. That was mainly due to differences in donations received by MSF for the exceptional emergencies in Haiti in 2010 (CHF 24M) and Somalia in 2011 (CHF 8M). Excluding these donations for major emergencies, the section's income rose by CHF 5M in 2011.

This increase is explained by several factors.

- Firstly, a new record for private fundraising in Switzerland, which rose by nearly CHF 6M to reach CHF 65M in 2011. Our thanks go to all our donors! Swiss donors responded with particular generosity to our appeal for relief funds for the victims of the Somali crisis. MSF Switzerland received a further CHF 5.5M of private funds raised outside the country.
- Following the removal of the condition precedent for the investment grant that the State of Geneva gave to MSF in 2004 to purchase its premises, CHF 1.3M of the grant was recognised as income in 2011, instead of being amortized over 50 years.
- Lastly, institutional public funding fell by CHF 3M in 2011 to CHF 24.7M. This decrease was partly linked to the nature of major ongoing projects (the Haiti hospital and a growing proportion of HIV/AIDS and tuberculosis projects), which are difficult to fund from public donors. Another reason was that the emergency operations in 2011 were mostly conducted in politically sensitive situations (Ivory Coast, Libya, Somalia) where, for reasons of independence, MSF prefers not to involve public donors.







> “The share of expenditures allocated to MSF social mission is 89%.”

The year 2011 ended with a **surplus of CHF 4.3M**. That allowed MSF Switzerland to increase its cash reserve from 4.9 to 5.2 months of activity. This is vital for MSF, enabling us not only to continue launching emergency operations but also to fulfil our medical commitments to our patients.

We would like to thank the 215,173 Swiss donors who responded to our appeals in 2011 as well as the hundreds of thousands of others who - in the US, Germany, Austria, Australia, Canada, Italy, Mexico and the Czech Republic - financed our operations through donations to MSF partner organisations.

We would also like to thank the Swiss local authorities, cantons and Confederation for their support over many years, as well as the foreign governments and humanitarian aid agencies that help finance our operations.

In March 2012, MSF Switzerland had the good surprise to receive a private donation exceeding CHF 25M. This donation is not linked to any condition as to its use. MSF Switzerland decided not to simply absorb this exceptional gift in its regular budget and discussions are underway between the Association and the Executive Directors to find the best possible use of this money to the benefit of vulnerable populations. MSF is committed to be transparent towards the association members and MSF donors about the use of this money.

Geneva, 12 May 2012

Gilles Carbonnier
Treasurer

Emmanuel Flamand
Financial Director

FUNDING EMERGENCY OPERATIONS

Each year, a budget is approved by the MSF Associative Board. It establishes a provisional level of expenditure and income which reflects the operational choices decided for the coming year in financial terms.

A characteristic of MSF’s work is the unpredictable nature of its emergency operations. Consequently, the annual budget has an “emergency reserve” which enables it to respond to unexpected situations requiring humanitarian intervention.

For 2012, the operating budget breaks down as follows:

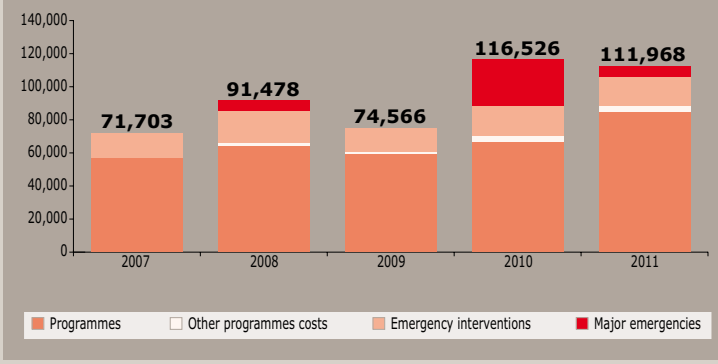
- 82% allocated to regular projects, often planned over several years. This category includes the running of health centres and hospitals and the treatment of chronic diseases such as HIV/AIDS or tuberculosis. MSF’s commitment to these projects is limited in time and they are handed over to local agents as soon as the context allows.
- 18% for the emergency reserve.

This reserve enables MSF to fund responses to crisis situations, such as earthquakes, conflicts, population displacements and epidemics. This budget allocation makes it possible to provide immediate relief without having to wait for the necessary funds to be raised, and can be particularly important for addressing ‘forgotten crises’ (low media coverage, isolated regions, etc.).

The level of this reserve is regularly reviewed according to the requirements. In some years, this budget accounts for a significant proportion of the operating budget (40% in 2010, with the post-earthquake operations in Haiti). The emergency reserve alone is not always sufficient to meet all needs, so we appeal to the generosity of our donors to make up the amount required to finance our aid operations. However, it does allow us to organise extremely urgent interventions.

The success of an operation can often be measured by how quickly it is launched. One of the strengths of our organisation is its financial independence, which ensures complete autonomy from any political or economic interests. The emergency reserve helps protect our intervention choices from the influence or pressure of institutional donors, political or media agendas, and so on. It also allows us to provide swift relief to those most in need.

Programmes costs per type of intervention



MSF: THE INVISIBLE FORCES BEHIND OUR ACTIONS

Whilst MSF's operations in the field and its "speaking out" on humanitarian issues are relatively well known to the public, how it actually functions is not very visible to those outside the organisation.

Over 80% of MSF Switzerland's funding comes from private donors and the organisation wishes to uphold its responsibility to be transparent to those that support it. This is why it publishes each year financial statements and an annual report outlining its activities and achievements. However, MSF goes beyond its purely legal requirements and has developed different tools to monitor and manage its activities, with the aim of continually improving the way it works. Here are a couple of examples of how it is doing this:

In 2011, more than 50 operational research projects were underway in order to provide the best adapted care to patients. © Sean Brokenshire

> "MSF is not spared from serious adverse events."

A network of experts who support the medical teams on the ground

MSF medical teams in the field are confronted by challenges on a daily basis: some medicines are not always age-adapted for children, or are ineffective against diseases neglected by pharmaceutical research; and on-going medical treatment can be difficult due to the distances patients face when trying to access medical care.

In order to respond to the medical needs of its patients, MSF researches and tests new ways of providing care that are adapted to the countries where it works. It does this by using the research undertaken by its medical and operational staff during project activities[1]. In 2011, more than 50 operational research projects were underway including: one focusing on improving treatment for pregnant women co-infected with HIV/AIDS and tuberculosis and another on the management of malnutrition in new-born babies.

But the initiatives do not stop there. The organisation has also put into place an evaluation process that reviews the results of medical programmes with a view to improving them, as well as a management procedure to deal with serious adverse events (SAE). These are incidents that can arise following a medical error or technical breakdown and that compromise the patient's health or require a longer period of hospitalisation.

MSF has put in place procedures that aim to provide the very best care to victims of such incidents and to ensure they do not reoccur. People who are trained specifically in incident management are on hand to offer immediate support to MSF staff and when necessary external experts can also be called in.

More broadly, MSF aims to identify and to respond to these situations, as the lessons that are learnt through the process, enable the organisation to improve the quality of care across its projects.

> “Security has been and remains a top priority.”

Research and analysis to support efficiency and security

One of MSF’s key strengths is the research it undertakes reviewing the ever-changing humanitarian contexts in which it is working. This analysis enables MSF to improve its response and remain relevant. MSF Switzerland has a research team who support the organisation in understanding how to position itself as a humanitarian organisation[2]. Aside from its daily work supporting MSF’s operations, the research team publish and present their work and in 2011 helped produce two books: “In the Eyes of Others” is the result of numerous field interviews exploring how MSF is perceived by its stakeholder populations and “Humanitarian Negotiations Revealed” is a collective work by a number of MSF offices, which asks what compromises the organisation is willing to make in order to be able to continue its work.

Both local and international MSF staff are aware of the risks they take by working in countries that are often politically unstable. MSF is duty bound as a responsible employer, to take all steps possible to ensure the safety of its staff and its patients, and security has been and remains a top priority. However despite taking all the necessary precautions, unfortunately serious security incidents do still occur. This was the case in 2011, with the kidnapping of two staff (from MSF Spain) and the murder of two others (from MSF Belgium).

In 2011 MSF decided to reinforce its operations department with the creation of a new position – to support its context analysis and risk management procedures. This security specialist will work with project managers in particularly volatile situations such as Somalia, Iraq, the Sahel and the northeast of the Democratic Republic of Congo. Crisis management protocols exist and are regularly updated, in order to deal with any critical incidents as they occur.

Early warning system for abuse

Since “the hand that gives is always above the hand that takes”, MSF recognizes the asymmetric power relationship between its staff and those it aims to help. The organisation seeks to pre-empt abuses of power (whether these abuses are intentional or not) by instituting a warning system where suspected abuse can be reported confidentially. An independent committee responds to these cases and aims to take into account the best interests of both parties.

MSF has also developed a procedure to manage any potential misuse of resources (wastage, fraud, etc.) and to correct any bad practice.

These procedures and mechanisms are invisible to the wider public but are an integral part of MSF’s work and contribute to helping the medical organisation be an effective, efficient and transparent provider of medical humanitarian aid.

Both local and international staff are aware of the risks they run by engaging in humanitarian work. © H.J. Burkard

1. These studies are available at: http://fieldresearch.msf.org/msf/
2. The articles published by MSF Switzerland’s research team are available at: http://www.msf.ch/a-propos-de-msf/unite-de-recherche/introduction

ACKNOWLEDGEMENTS

We are grateful to all the donors who made the work of MSF possible in 2011. Last year, 215,173 people generously supported our organisation – we thank them for their trust.

We thank the governments, government agencies and international organisations that support our projects:

- ANRS – Agence Nationale de Recherche sur le Sida
- Swiss Solidarity
- CIDA – Agence canadienne de développement international
- DANIDA – Danish International Development Agency
- DFID – UK Department for International Development
- SDC – Swiss Agency for Development and Cooperation
- ECHO – European Community Humanitarian aid Office
- EUROPEAID – Development and Cooperation, European Commission
- Ministry of Foreign Affairs (Germany)
- Ministry of Foreign Affairs (Norway)
- Ministry of Foreign Affairs (Czech Republic)
- NORAD – Norwegian Agency for Development Cooperation
- Irish Aid
- SIDA – Swedish International Development Cooperation Agency
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Unicef

In particular, we would like to thank the following companies, foundations and local authorities:

- Canton de Genève
- COFRA Foundation
- Ferster Stiftung
- Fondation Assistence Vaduz
- Fondation de bienfaisance de la Banque Pictet & Cie
- Fondation Hans Wilsdorf
- Fondation Medicor
- Fondation Pierre Demaurex
- Fundacion Salamander
- Gamorsa Stiftung
- Gebauer Stiftung
- Hilti Foundation
- Kanton Aargau
- Leopold Bachmann Stiftung
- Hilfswerk PB (Pro Beatrice)
- RPH-Promotor Stiftung
- Vontobel-Stiftung

Our most sincere thanks also go to:

- 42 market research
- Accenture
- Alfred Richterich Stiftung
- Ameos Holding AG
- Ammann Schweiz AG
- Anne Frank Fonds
- Arcanum Stiftung
- Art & Trend
- Assessment Art AG
- Bank Vontobel AG
- Baumer Electric AG
- Binder Rechtsanwälte
- Blaser Swisslube AG
- Bolliger & Mabillard Ingénieurs Conseils SA
- Breitling SA
- Büchi Labortechnik AG
- C + S AG
- Cargill International SA
- Commune de Collonge-Bellerive
- Commune de Cologny
- Commune de Meyrin
- Commune de Plan-les-Ouates
- Commune de Troinex
- Commune du Grand-Saconnex
- Compass Asset Management SA
- Consa Treuhand AG
- Credit Suisse
- Dieter Kathmann Stiftung
- Dominikanerinnenkloster St. Peter & Paul
- Dosteba AG
- Duthaler AG
- Ecole des Champs-Fréchets
- Elbro AG
- Elisabeth Nothmann Stiftung
- Erika und Conrad W. Schnyder Stiftung
- Ernst Göhner Stiftung
- Evangelisch-Reformierte Kirchgemeinde Obwalden
- Exedra AG
- Feyco AG
- Finanziaria Indosuez International SA
- Fleurs Suisse Gmbh
- FMS Force Measuring Systems AG
- Fondation Alfred et Eugénie Baur
- Fondation Johann et Luzia Graessli
- Fondation pour l'aide humanitaire
- Fondation Pro Dimora
- Fondation Rifké
- Fondazione Green Island
- Gemeinde Herrliberg
- Gemeinde Küsnacht
- Gemeinde Meilen
- Gemeinde Rüschlikon
- Gemeinde Vaduz
- Gemeinde Wallisellen
- Gemeinde Zollikon
- Gemeinde Zumikon
- Generation Media AG
- Georg und Emily Von Opel-Stiftung
- Giessenbach Stiftung
- Göldi AG
- GOM International AG
- Günther Caspar Stiftung
- Hapmed AG
- Heinis AG
- Hemmann Schleiftechnik Gmbh
- Hirschmann-Stiftung
- Hotel Parnass
- Huwa Finanz & Beteiligungs AG
- IMC Energy Trading
- Immobilien AG Riesbach
- Infometis AG
- Intellec AG
- Interio AG
- Jost J. F. & Co
- Julius Bär Stiftung
- Kanton Appenzell Ausserrhoden
- Kanton Basel-Stadt
- Kanton Bern
- Kanton Schaffhausen
- Kanton Thurgau
- Kanton Uri
- Katholisches Pfarramt Liebfrauen Zürich
- Kenes International Organizers of Congresses SA
- Kirchgemeinde Vechigen
- Labmed
- Lifesaver Systems Ltd
- Loterie romande

- Marcuard Family Office AG
- Martin Nösberger Stiftung
- Metanet AG
- Musgrave Charitable Trust
- New Energy Scout GMBH
- Oak Philanthropy Limited
- Oce (Schweiz) AG
- Parmigiani Fleurier
- Partner & More AG
- Politische Gemeinde Herrliberg
- Preform (Schweiz) AG
- Profilsager AG
- Projet Luciana Life
- Provisa AG
- ProXit SA
- R. und R. Schlageter-Hofmann Stiftung
- Raab-Verlag und Versandhandel GmbH
- Ref. Kirchgemeinde Wallisellen
- Ref. Kirchgemeinde Zumikon
- Rolf Hänggi AG
- Röm. Kath. Kirchgemeinde Zollikon
- Röm. Kath. Pfarramt
- Rosa und Bernhard Merz-Stiftung
- Rosmarie und Armin Däster-Schild Stiftung
- Salans
- Säntis Analytical AG
- Scavi Robbiani SA
- Schiller AG
- SK Genossenschaft. In Liquidation
- Soltop Schuppisser AG
- Spitalschwestern-Gemeinschaft Luzern
- Stanley Thomas Johnson Stiftung
- Stiftung Barbara Christiane Koch
- Stiftung der Gemeinschaft der Liebfrauenschwestern
- Stiftung Fürstlicher Kommerzienrat Guido Feger
- Stiftung "Perspektiven" von SwissLife
- Storz Medical AG
- Sturzenegger Immobilien AG
- Sulzer Management AG
- Sun Store SA
- Swatch Group
- Tech-Insta SA
- The Aurora Light Foundation
- The Herrod Foundation
- The Tanner Trust
- Theben HTS AG
- Trollship SA
- Tschikali Stiftung
- Usines métallurgiques de Vallorbe
- Verein Medifest
- Victorinox
- Ville de Genève
- Voegeli & Wirz AG
- von Duhn Stiftung
- VP Bank Stiftung
- Wellington Partners Advisory AG
- Zünd Systemtechnik AG
- Zürcher Kantonalbank Präsidium

We would also like to thank our event partners:

- Zürich Film Festival
- Fumetto – Internationales comix – Festival Luzern
- Paléo Festival Nyon
- Nomos groupement d'Architectes
- GVA Studio
- La Cité du Temps

Finally, we would like to thank all those who offered their time or their talent to MSF in 2010:

- Agathe Denis
- Aude Jurenak
- Béatrice Junod
- Brenda Nelson
- Cécile Thiery
- Christiane Roth
- Cristina Gobbetti
- Cristina Pesolillo
- Danielle Maffei
- Daniela Equestre
- Elisa Fournier
- Elodie Baumann
- Irène Serfass
- Julia Schuerch
- Jacqueline Leroux
- Henri Spaeti
- Katharina Meyer
- Laura Piemontesi De Sassi
- Maryvonne Grisetti
- Nelly Humm
- Nelly Pfefferkorn
- Nicole Hoekstra
- Patricia Armada
- Paolo Consoli
- Peter Dietrich
- Rosemarie Mattei
- Sunita Maggon
- Sylvie Finocchiaro
- Thérèse Rasmussen
- Translators Without Borders
- Valeria Canova
- Viola Bingler
- Viviane Pedraza

Please excuse us in advance for anyone we may have unintentionally neglected to thank.

THE BOARD

President

Abiy Tamrat joined MSF in 1999. After holding the position of Head of Regional Health in the Ethiopian Ministry of Health, he worked for MSF first as a national staff member and then as an expatriate volunteer. In 2002, Abiy Tamrat came to MSF's Geneva headquarters as Deputy Emergency Programmes Manager. In 2006, he was appointed to the position of Medical Director of the Swiss section, where he contributed to developing the organisation's expertise, innovative approaches and medical policies. At the General Assembly of 21-22 May 2010, he was elected to the organisation's Associative Board and took on its presidency for a term of three years.

Vice President

Thomas Nierle, a doctor, joined MSF in 1997 for an initial mission in Afghanistan. He was then appointed Emergency Programmes Manager at MSF Switzerland and subsequently held the position of Director of Operations until 2004. At present, he is a senior doctor in the accident and emergency department of Moûtier Hospital and has been a member of the Associative Board since May 2010.

Treasurer

Gilles Carbonnier, a socio-economist by training, teaches development economics at the Graduate Institute of International and Development Studies (IHEID) in Geneva. A former ICRC delegate, Gilles Carbonnier has been a member of MSF Switzerland's Board since 2008.

Members

Gaëlle Fedida is a doctor of law. Gaëlle began working in the humanitarian sector in 1993. In 1995 she jointed MSF as a researcher for the MSF Foundation. She went on to become a Head of Mission and then a Programme Officer in MSF Paris. Gaëlle Fedida has been a member of MSF Switzerland's Board since 2009.

Joanne Liu is an emergency paediatrician who joined MSF in 1996 for field missions. She then worked at the headquarters of the French section of MSF and later became President of MSF Canada. She currently works as a full-time clinician in the emergency paediatrics department of Sainte-Justine University Hospital in Montreal.

Manica Balasegaram is a doctor specialising in internal and emergency medicine. He began working with MSF in 2001. After several field missions, he was appointed head of the Manson Unit, a medical support unit focusing on operational research. He joined the Drugs for Neglected Diseases Initiative (DNDi) in 2008 and is currently Project Coordinator for the development of drugs to treat these diseases. Manica Balasegaram has been a member of MSF Switzerland's Board since May 2011.

Karin Hartmann is a paediatrician. She has been working at Chur Hospital since 2007 as a consultant in paediatrics, neonatology and emergency. Karin Hartmann undertook her first mission with MSF in 2006 in Bunia, Democratic Republic of Congo. Since then, she has worked on several other projects in the field. She has been a member of MSF Switzerland's Board since May 2011.

Olivier Antonin currently manages l'Auberge du Cèdre in Lauret, France. He has been a member of MSF Switzerland's Board since May 2011. He worked as Emergency Programme Coordinator for MSF Switzerland from April 2002 to March 2011. Prior to that, from 1986 to 2002, he completed a total of 18 missions as Logistics Coordinator, Field Coordinator and Head of Mission.

Vicken Cheterian is a journalist and political analyst working at CIMERA in Geneva (www.cimera.org). He began his professional career as a journalist in Beirut, going on to work for several European newspapers. He is the author of "War and Peace in the Caucasus", published by Hurst and Columbia University Press. Vicken Cheterian has been a member of MSF Switzerland's Board since May 2011.

Antoine Chaix, Anne Perrocheau, Dominique Legros and Alexia Cusini left the Associative Board in May 2011.

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.

MEDECINS SANS FRONTIERES
ÄRZTE OHNE GRENZEN

Rue de Lausanne 78,
P.O. Box 116,
CH-1211 Geneva 21,
Switzerland
Phone: +41 22 849 84 84,
Fax: +41 22 849 84 88,
Email: office-gva@geneva.msf.org

www.msf.ch

A MSF nurse provide medical care to a severly malnourished child in Mogadishu, Somalia.