



MSF Switzerland

Activity Report 2012

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

MSF is a non-profit organisation. It was founded in Paris, France, by doctors and journalists in 1971. Today, MSF is a worldwide movement of 23 associations 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.

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MEDICAL ACTION IN DANGER

2012 was undoubtedly marked by the war in Syria, which posed enormous challenges to humanitarian organisations seeking access to a population trapped by this extremely violent conflict.

Whilst the humanitarian world is used to dealing with obstacles, the situation in Syria is particularly shocking. Medical aid is being overtly targeted *per se*, hospitals are bombed and medical staff threatened, arrested or worse killed. Providing treatment to an opposing side makes you the enemy and therefore a legitimate target.

This targeting of medical aid has become a distinctive feature of the Syrian conflict. It is in itself a tactic of war, to the extent that some communities have even refused to the set up of a MSF health centre in their village for fear of being bombed as a result. Given these violent circumstances, of which Syrian health workers are the first victims, we have only been able to provide limited aid within Syria. However, we have quadrupled our assistance to refugees fleeing to neighbouring countries, in particular to Lebanon and Iraq.

At this point it is critical to improve working conditions for our Syrian colleagues, who provide the majority of care to the population. We have an obligation to stand alongside them. Medical action is in danger in Syria, but also in Sudan and in the Democratic Republic of Congo (DRC). We are highlighting this message across communication campaigns being launched in our missions.

We need to ensure that fighting parties recognize the importance of protecting humanitarian, medical missions. Medical ethics demand we treat all patients, independent of their ethnicity, religious or political views. And accordingly to humanitarian principles, care provision must remain independent, neutral and impartial.

We must focus on the spirit behind the Geneva Conventions. These treaties form the basis of humanitarian law and ensure that the best interests of both warring parties are maintained. Treating the wounded and prisoners in a humane manner, limiting violence against civilians are the best ways to ensure that the other side acts in the same way. It is critical that all fighting parties reach agreement on this basic necessity, and that other stakeholders make a priority of this issue.

This is not only a question of life and death for patients and health workers, but also the only way to guarantee the safety of "doctors without borders" while providing life-saving medical aid. Humanitarian workers, all too often, pay an unacceptable price for their involvement.

Our thoughts remain with Montserrat Serra and Blanca Thiebault. They were kidnapped in October 2011 from the Dadaab refugee camps in Kenya, whilst helping Somali refugees in need. Our two colleagues from MSF Spain are still held captive and MSF continues to work tirelessly for their release.

This report is also a record of our thanks to each and every one of you, without whom we would not be able to work alongside populations in distress. We would like to express our gratitude for your commitment and constant support.



Abiy Tamrat,
President of MSF Switzerland



Bruno Jochum,
General director of MSF Switzerland

“2012 was
undoubtedly
marked by the war
in Syria.”

Abiy Tamrat,
President of MSF Switzerland

Bruno Jochum,
General director of MSF Switzerland

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DRC:
Response
mounted to
cholera epidemic.
1,160 patients
treated.

JANUARY



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APRIL

Guinea:
Vaccinated
117,000 individuals
against cholera in
Boffa prefecture.



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JUNE

Kenya:
Lobbied against
the lack of aid in
the Dadaab camps.

< JAN 2012

Cameroon:
1,800 patients
treated during
measles
epidemic.

FEBRUARY

Djibouti:
Project dealing
with infant
malnutrition
concluded.



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MAY

Chad:
Vaccinated
358,850 individuals
against meningitis
in the Massakory
region.

Niger:
Cholera epidemic in
the Tillabéri region.
1,200 patients treated.



DEC 2012 >

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2012 IN REVIEW

Managing the impact of wars on ordinary people in Syria and Mali, providing healthcare to Somali refugees, supporting health workers in Democratic Republic of Congo as they struggled with repeated epidemics... In 2012, MSF Switzerland was active in 21 countries and ran 54 medical projects.

2012 was a year marked by intensified fighting in Syria and an exponential increase in the number of refugees crossing into neighbouring countries. The volume of our operations was quadrupled, as refugees struggled to cope with increasingly difficult living conditions. In addition to bringing the lack of aid to the public attention, the humanitarian community and the main funders, we stepped up our distributions of blankets, fuel and first aid supplies to help refugees dispersed across the Bekaa Valley to survive the long, cold winter. We provided a total of 22,060 medical consultations in Lebanon during the year. In May 2012, we set up a health centre in Domeez refugee camp in Iraq that offers 24-hour medical care. After three years of negotiations, we successfully obtained access for foreign workers to Hawijah hospital in the Iraqi "Sunni triangle", an area always under threat of potential war.

21 countries

54 projects

1,287,591
outpatient
consultations

74,479
admitted patients

300,895
malaria cases treated

18,016 children
admitted to inpatient
feeding programme

38,552 children
admitted to ambulatory
feeding programme

21,027
deliveries

44,518 HIV
patients on first-line
ARV treatment

The crisis in Mali also resulted in a refugee situation, leading us to start working in a number of camps in the Tillabéri region of Niger. The deteriorating security situation, escalated by France's intervention in Mali in early 2013, posed huge challenges to our projects across the whole of the Sahel region, over and above the recurrent food crises and epidemics that routinely hit the region. In Chad, MSF launched an emergency meningitis vaccination programme and provided care for the most complicated cases. As in previous years, seasonal peaks in malnutrition resulted in large numbers of severely malnourished children requiring care within our projects in Chad and Niger. Despite the difficult context, we continued to implement new strategies to try to alleviate the seasonal peaks in malnutrition and meningitis.

In Democratic Republic of Congo (DRC), we launched several emergency projects in the northeast of the country, following epidemic outbreaks of malaria, cholera and measles. In some areas, the mortality rate was three times higher than the emergency threshold. This region remains unstable and functioning health centres are rare, which is part of the reason why we had to intervene in so many occasions.

MSF was also involved in combating cholera in Guinea-Bissau and Guinea-Conakry. In addition to setting up treatment centres to isolate and care for the sick, in early 2012 we launched a vaccination campaign in the areas around the capital, Conakry. This was a first-wave vaccination plan to hold off a threatened cholera epidemic across Africa. Our campaign was successful in reducing the occurrence of new cases in the covered zone. As a consequence, a stock of vaccines was created internationally in order to be ready in case of a new outbreak. In Haiti, where the cholera epidemic is still not under control, we continue to care for the sick in Léogâne. MSF operates a 160-bed hospital there, built after the earthquake of January 2010, to tend to the numerous health needs of the local population.

The fight against the pandemics of HIV/AIDS and tuberculosis (TB) remains a very significant focal point for MSF, particularly in terms of ensuring that the very latest scientific advances are put into practice. In Swaziland, alongside caring for tens of thousands of individuals in the wake of the double epidemic, our team has put in place an innovative strategy to prevent the transmission of HIV between infected mothers and their children, a first step before using for every patient the treatment as prevention. In Kyrgyzstan, we launched a new initiative against drug-resistant TB with the aim of reducing the treatment time and toxicity of the anti-TB drugs, and increasing the efficiency of new medicines that will enter the market. In Mozambique, our work caring for individuals co-infected with HIV and TB was refocused on patients requiring second-line treatment and on complicated cases.

MSF Switzerland remains equally engaged in the fight against neglected tropical diseases. Our teams were active in combating sleeping sickness (human African trypanosomiasis) in DRC, kala azar (visceral leishmaniasis) in Sudan and Buruli ulcer in Cameroon.



© Spencer Platt/Getty Images

In Central America, we have continued to care for victims of violence. Our experience in Guatemala and Honduras has shown that, all too often, victims are unable to access care.

The insecure environments in which we so often operate have become increasingly uncertain, and we have been constantly forced to adapt the ways in which we operate so as to reach people in need. This explains why, in late 2012, we relied mainly on local Sudanese staff in the fight against yellow fever in Darfur. That said, a number of foreign staff are now working in this Sudanese province – something which had not been possible in the previous five years. We also undertook several missions to vaccinate and care for malnourished children in Afgooye, in Somalia, where a significant number of displaced people are living. In the Somali capital, Mogadishu, the paediatric hospital we opened in the summer of 2011, at the peak of the food crisis, was reinforced with the presence of semi-permanent international staff.

Finally, in Kenya we managed, despite the security situation, to continue providing medical services to refugees in Dagahaley, one of the five camps within the Dadaab complex that together form the largest concentration of refugees in the world. Our two colleagues who were taken captive in Dadaab in October 2011, Blanca Thiebaut and Montessarar Serrat, are still being held hostage somewhere in Somalia. All of our activities are therefore driven by the need to keep them out of further danger. Following the abduction, all sections of MSF have suspended new projects in Somalia, with the exception of emergencies, until our colleagues have been released.

4,382

TB patients

12,383

surgical procedures

43,465

individual mental
health consultations

Mariano Lugli, Deputy Director of Operations

2012 MEDICAL PRIORITIES

In order to provide ever more efficient, simple and acceptable treatments to our patients, MSF implemented in 2012 several medical innovations which reflect MSF Switzerland's priorities: emergencies, treatment for victims of conflict, HIV/AIDS and tuberculosis, malaria and tropical diseases, mother-child treatment and malnutrition. They enable us to improve our protocols and health policies in the countries we work.

For example, during the major intervention in DRC, MSF adopted a new strategy during an exceptional malaria epidemic. Called "test & treat", the strategy is to go door to door and systematically test all inhabitants in the targeted zone, treating them on the spot if the test is positive, even if they show no symptoms (treatment would usually be given once a patient has fever). The aim is to limit the epidemic peak by minimizing the number of patients with fever and substantially reducing the number of serious cases, whereby reducing the number of deaths.

With a similar objective, MSF led a vaccination campaign against cholera in Guinea, in collaboration with the Ministry of Health. For the first time, a two-dose oral vaccine was given at a 15-day interval to more than 70% of the target population and successfully demonstrated the value of vaccinating during the peak of a cholera epidemic. We documented and shared our experience with other organisations, which has led to the setting up of an international vaccine stock, available for similar epidemics in the future.

MSF also innovated in its response to multi-resistant tuberculosis by investing in a new diagnostic method called "GeneXpert" for Swaziland, Mozambique and Kyrgyzstan. Simple to use, this small machine quickly detects the presence of both tuberculosis bacteria and potential drug resistance, without requiring additional microscopic testing. As a result, patients can receive appropriate treatment immediately and the risk of drug resistance within the community is reduced.

A "test & treat" strategy for HIV is going to be launched in Swaziland and anti-retroviral drugs will be given to all carriers of the virus, irrespective of their immune system levels (treatment is usually offered once the level of immune cells is <350). This will reduce contagion and the risk of transmission and curb the population's rate of infection.

In Niger, as well as treating severely malnourished children in health centres, MSF trained community workers to early detect malnutrition cases in the villages. In parallel, the diagnosis and treatment process for the main diseases that cause infant mortality (malaria, respiratory diseases, diarrhea) was decentralized to the health clinics. In Chad, health workers were also trained in the villages to carry out treatment themselves and to provide nutritional care to children not requiring hospitalization. A study is also underway to evaluate the impact of monthly ready-to-use food supplement distributions in relation to morbidity and mortality rates due to malnutrition.

In parallel, MSF has published several articles in scientific reviews and has participated in international scientific conferences to include and promote our medical strategies, notably in "AFRA VIH" in Geneva, the "Congress for Tropical Medicine and Malaria" in Rio and the "World Conference on Lung Health and Tuberculosis" in Kuala Lumpur. We have also organised internal seminars on increasingly common medical issues such as Hepatitis-C, substance abuse and diseases linked to extractive industries, which are not yet appropriately treated.

We hope that, in parallel to the primary and secondary health care provided by MSF, these innovations will also be of significant benefit to patients.

Annick Antierens, Deputy Medical Director

“To improve knowledge, diagnosis and treatment of diseases we face is our first concern.”

EMERGENCY OPERATIONS



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CHOLERA IN GUINEA: VACCINATING FOR THE FIRST TIME DURING AN EPIDEMIC

In April 2012, MSF teams in Guinea vaccinated 117,000 individuals against cholera in the Boffa region, 150 kilometres north of the capital Conakry. This was the first time in Africa that populations received protection during a cholera epidemic, thanks to a two dose oral vaccine. This vaccine provides more than 60% protection for two years.

Whilst this anti-cholera vaccine is a promising new tool in the response to cholera epidemics, it is still critically important to focus on raising awareness, preventing the disease and improving hygiene in the communities. It is also particularly important to ensure access to quality drinking water.



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DRC: A SERIES OF EPIDEMICS

In 2012, MSF responded in DRC to epidemics of cholera, malaria and measles. In Orientale Province, a region that is 12 times the size of Switzerland, health infrastructure is rare and vaccination coverage is extremely low. The majority of the population live in isolated villages and have no access to health care.

In this "health care desert", epidemics are devastating and levels of infant mortality is abnormally high. MSF has had to overcome huge logistical challenges to bring care to local populations.



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SYRIA: HUMANITARIAN AID IN DEADLOCK

For more than two years the Syrian population is enduring an extremely violent conflict.

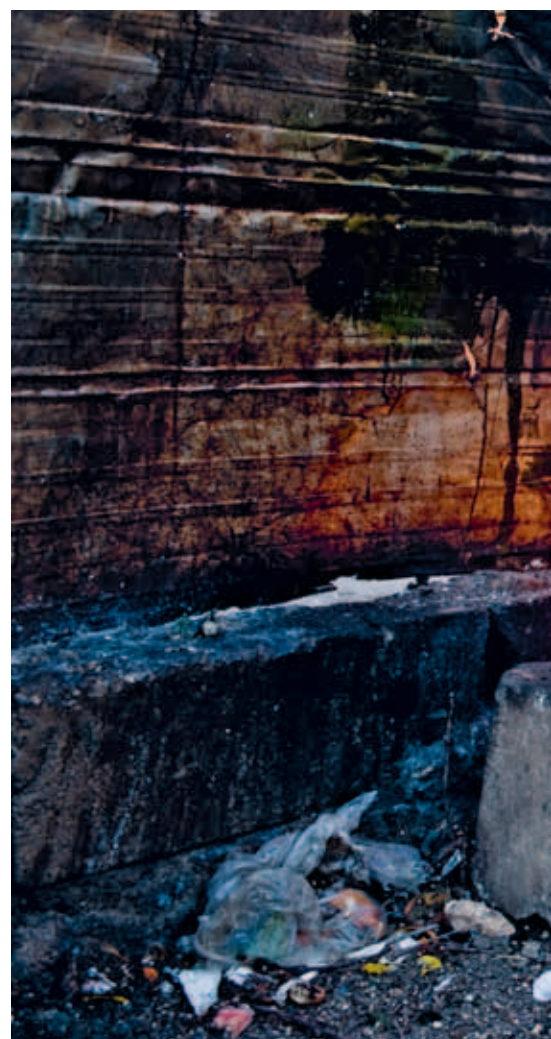
There have been tens of thousands of victims and more than 1.5 million Syrians have left everything to seek refuge in neighbouring countries. Compounding this, medical aid is overtly targeted, hospitals are bombed and staff threatened. Without official authorization, MSF can only provide a limited response in the country. Despite all these difficulties, MSF has quadrupled its aid to Syrian refugees in Lebanon and Iraq, but this is still insufficient to meet their needs.



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ACTIVITIES BY COUNTRY



Raising awareness of Buruli ulcer in the streets of Akonolinga in Cameroon. © Christelle Ntsama/MSF

CAMEROON

Limited access to healthcare for a majority of the population

Cameroon is a relatively stable country compared with its neighbours. Despite this, significant poverty still exists, with 70 percent of workers earning less than the legal minimum wage, while access to healthcare remains a major issue.

The provinces of Adamawa, the North and the Far North are particularly impacted by health crises, and health indicators in these provinces are at their most alarming. In February 2012, MSF responded to a measles epidemic, supporting the Ministry of Health by providing medication and training for local health staff on treating simple and severe cases of measles. More than 1,800 patients were treated in government health facilities and 175 were admitted as inpatients to a treatment unit for severe cases run by MSF at Garoua regional hospital.

In September, MSF mounted another emergency response in the region after heavy flooding forced thousands of people to leave their homes. MSF set up a health centre in a camp for displaced people, in collaboration with the Cameroonian health authorities. Medical teams conducted more than 40 consultations a day over a three-month period and treated a total of 2,000 families.

In Akonolinga, MSF has been treating people with Buruli ulcer since 2002. This neglected disease is similar to leprosy in that it destroys tissue and causes painful physical deformities.

The treatment involves binding wounds, surgery to remove lesions and infected tissue, and antibiotics and physiotherapy to reduce spasms. Some 100 patients each year are cared for at MSF's purpose-built "Pavillon Buruli".

While first-line antiretroviral (ARV) treatments have been available at no cost in Cameroon since May 2007, there is more work to be done to ensure patients follow their treatment and that the quality of medication is consistent. In Nylon Health District, in Douala, MSF hopes to demonstrate to the Ministry of Health and international donors that ARV drugs containing tenofovir are effective and have fewer side effects than the alternatives. Some 650 new patients started this treatment in 2012. A second-line treatment was made available for 89 other patients who developed resistance to first-line drugs.

Reason for intervention: Endemic/epidemic disease

Main activities:
Tropical neglected disease, HIV/AIDS

In the country since: 2000

Human resources (FTE): 96 staff including 17 international staff

Cost for 2012: CHF 4,009,000

DJIBOUTI

MSF concludes its involvement in Djibouti

In April 2012, MSF closed its hospital specialised in treating children with severe malnutrition and transferred the remaining patients to the care of the Djiboutian health authorities. In the space of four years, 10,600 children under the age of five had been cared for in this centre.

MSF began working in Djibouti in 2008 in response to an increase in the number of children suffering from malnutrition in both rural and urban communities after a steep hike in the price of food.

MSF mobile teams worked in the areas of Balbala, Hayableh, Arhiba and PK12, providing

nutrition services to a total of 6,890 children under the age of five. Of these, some 3,700 were severely malnourished and suffering from medical complications, and were admitted to MSF hospital to receive intensive care. 154 children admitted also had tuberculosis (TB), and MSF ensured that they were admitted into the national TB care programme once their nutrition treatment was finished.

MSF supported the Djiboutian Ministry of Health in six medical centres until July 2011, when the project began to be scaled down, providing technical support, drugs, medical equipment and training staff.

In 2012, in parallel with the nutrition activities in its hospital, MSF teams also provided care

to 75 children admitted as inpatients due to complications from measles.

Whilst MSF continues to be concerned about the nutrition situation in Djibouti, the transfer of activities has been finalised and is now the responsibility of the Djiboutian authorities. The Ministry of Health has recently opened a nutrition centre, constructed with funds from various international organisations, which will provide inpatient care for children suffering from severe malnutrition.

Reason for intervention: Endemic/epidemic disease

Main activity: Nutrition

In the country since: 2008

Human resources (FTE): 31 staff including 3 international staff

Cost for 2012: CHF 754,000



From 2008 to 2012, MSF has provided medical and psychological treatment to victims of sexual violence in the most violent areas of Guatemala City. © Natacha Buhler/MSF

GUATEMALA

New protocol for treating victims of sexual violence

Guatemala has been torn apart by decades of armed conflict. Today the growth of gangs and drug cartels is jeopardizing an already fractured society. In the poorest parts of the capital, violence is reaching levels usually only seen in a warzone. Thousands of sexual assaults are reported each year while many more go undeclared.

After more than 20 years of intermittent presence in the country, MSF closed its final project in Guatemala in December 2012. Until then, MSF had been providing medical and psychological care to victims of sexual violence since 2008 at public health centres in two of the most violent neighbourhoods in the capital. We also worked in the emergency department at one of the town's main hospitals to help provide first aid and preventive treatments to sexual violence

victims as quickly as possible, in order to minimise the risk of sexually transmitted diseases and unwanted pregnancies. Our teams also gave medical assistance to rape victims as they lodged complaints at the Ministry of Justice itself.

In the four years from 2008 to 2012, MSF treated 3,600 victims of sexual violence, and provided a total of 11,000 consultations.

In addition to providing direct medical care to victims, MSF was also successful in lobbying the Ministry of Health to recognise that sexual violence requires urgent medical attention. In 2011, Guatemala adopted a new nationwide protocol to provide emergency prophylactic antiretroviral treatment to victims within 72 hours. Having achieved this objective, the MSF teams started to hand back activities to the Ministry of Health and continued to monitor the provision of care up until December 2012.

On 7 November 2012, MSF responded to an emergency situation on the country's Pacific coast, which was struck by an earthquake measuring 7.2 on the Richter scale. A team distributed medicines to municipal health centres in the affected areas and handed out more than 300 hygiene kits to families rehoused in temporary shelters. It also provided initial psychological care to people experiencing panic attacks.

In the future, MSF teams in neighbouring countries are ready to intervene in Guatemala if the need arises.

Reason for intervention: Social violence/ healthcare exclusion

Main activity: Medical care for victims of violence

In the country since: 1986

Human resources (FTE): 23 staff including 3 international staff

Cost for 2012: CHF 896,000

GUINEA

Innovative oral vaccine prevents spread of cholera epidemic

Guinea has experienced socio-economic difficulties over recent years, while political instability has sparked periods of violence in the capital, Conakry, as well as elsewhere in the country. The Guinean health system faces major challenges: health facilities and medical staff are poorly located geographically; there are shortages of medicine and medical supplies; and the system for procuring drugs needs to be improved.

In April 2012, when cholera broke out in Boffa prefecture, in the coastal region north of Conakry, MSF organised a mass vaccination programme to halt the spread of the disease, using a two-dose oral vaccine – the first time the vaccine had been used during an epidemic in Africa. Over a fortnight, teams from MSF and the Guinean Ministry of Health vaccinated 117,000 people, while another 50,000 were vaccinated

against cholera in Forécariah, to the south of the capital.

The vaccine was successful in providing protection against cholera in Boffa prefecture and Forécariah. Conakry, however, was badly hit. In June, MSF treated 4,700 sufferers in four temporary cholera treatment centres. The teams also provided information to the local population on sanitation and sensible precautions to prevent the disease from spreading.

In Guéckédou, in Forest Guinea, MSF treated 77,000 people infected with malaria, which is the principal cause of death in the country. MSF has been running a malaria prevention and treatment project in the region since 2010. The team supports emergency and paediatric services at Guéckédou hospital, and works at six health centres and nine local clinics. In addition, a network of community health workers spreads the message about malaria, makes early diagnoses and administers

artemisinin combination therapies (ACT) for non-complicated cases, whilst they refer serious cases to the nearest health centre. Almost half of the cases treated by MSF in 2012 came via community health workers.

MSF's mother and child health programme in three health centres in the Matam district of Conakry continued in 2012, facilitating access to medical care for pregnant and breastfeeding women and children under five. Preparations continued to return the programme to the Guinean health authorities in June 2013. MSF held 57,000 consultations for children under five and assisted at more than 7,000 births.

Reason for intervention: Endemic/epidemic disease

Main activities: Tropical medicine, reproductive health

In the country since: 2001

Human resources (FTE): 208 staff including 25 international staff

Cost for 2012: CHF 7,296,000



In 2012, Guinea was severely impacted by a cholera epidemic. MSF responded with a preventative vaccination programme in the coastal region and by treating patients in Conakry. © Holly Pickett

GUINEA-BISSAU

Emergency response to cholera outbreak

Cholera is an endemic disease in West Africa. Epidemics break out regularly every three or four years. MSF first mounted an emergency cholera response in 2008 and returned to Guinea-Bissau in October 2012 following an alarming rise in cholera cases. MSF supported the Ministry of Health in the capital city, Bissau, as well as in the regions of Biombo, Oio and Cacheu.

MSF teams set up a cholera treatment centre in the capital with space for 60 patients and sent mobile teams into the worst affected areas. In three months, MSF teams treated over 1,500 patients.

MSF also helped treat patients at 15 regional health centres and provided logistical support, in particular by isolating cases of cholera to limit the spread of the disease, providing medical supplies and improving hygiene and the treatment of wastewater. The teams

also organised sessions for the local population to educate them on the disease and its transmission.

MSF pulled out of Guinea-Bissau in December 2012 as the cholera epidemic came to an end.

Reason for intervention: Endemic/epidemic disease

Main activity: Tropical medicine

Human resources (FTE): 2 international staff

Cost for 2012: CHF 364,000

HAITI

Much work still to be done to improve people's access to healthcare

Three years after the earthquake, Haiti's health system is still devastated. In 2012, MSF managed four hospitals, built to replace the temporary structures erected by medical organisations in the days following the quake. Tens of thousands of Haitians benefit from free, quality healthcare thanks to these hospitals.

MSF Switzerland runs a 160-bed hospital in Léogâne. Close to the epicentre of the quake, the town was largely destroyed. MSF set up in Léogâne immediately after the earthquake and treated survivors in tents. This temporary hospital was replaced in September 2010 by a prefabricated structure made from containers.

The majority of earthquake survivors have today been rehoused. However, the MSF hospital remains the only one in the region providing free and accessible emergency healthcare 24 hours a day.

The hospital has a surgical team in place, in addition to the maternity team. Alongside caesarean sections, the most common surgical procedures are for the treatment of road accident victims – 3,330 operations were performed in 2012. Another building is used for outpatient consultations for pregnant women and children under five years.

In 2012 more than 12,580 patients were admitted to Léogâne hospital. More than 6,620 women gave birth in the maternity and

the team provided more than 48,360 consultations in mobile clinics.

The cholera epidemic has still not been curbed. During 2012, 3,490 people were treated at MSF's cholera treatment centre next to Léogâne hospital. The number of cases increased in the wake of hurricanes Isaac and Sandy in the autumn of 2012, as rains caused open sewers to overflow and led to the spread of the bacteria.

Reason for intervention: Endemic/epidemic disease

Main activity: Hospital

In the country since: 2010

Human resources (FTE): 534 staff including 25 international staff

Cost for 2012: CHF 8,908,000

HONDURAS

An epidemic of violence

In Honduras, violence and territorial gang warfare seriously impact public health. Access to medical care, particularly for the poorest communities, is a significant issue.

The political, economic and social climate in Honduras is very unstable. In recent years, the country has also become a hotbed of cross-border crime, and a sharp rise in drug trafficking has caused a spike in violence. In five years, the number of homicides has doubled, and most Hondurans have been the victims of violent assault at least once in their lives.

The public health system in Honduras is overstretched, while there are only two hospitals in Honduras that treat patients without social security. Hospitals' emergency rooms are overwhelmed, while health centres are unable to provide adequate first aid due to shortages of medical supplies and qualified health staff.

In the capital, Tegucigalpa, MSF medical staff work with those communities at highest risk of violence, providing medical care to the wounded and traumatised. MSF's activities cover the city's poorest neighbourhoods, home to 95,000 people. Some 9,000 people in these areas are believed to be recent victims of violence, in need of medical or psychological assistance. An MSF team patrols

the capital's streets each day to provide direct assistance to those who need it. In the 18 months, MSF's medical teams conducted more than 10,000 street-based consultations. Victims of violence who need more extensive medical or psychological care are referred to MSF-supported health centres.

In addition to providing direct medical care to the victims of violence, MSF also provides training and mentoring to medical staff from the Health Ministry to help change the way

victims receive care. By documenting the extent of the needs and lobbying authorities and donors, MSF aims to put in place medical protocols to address the situation.

Reason for intervention: Social violence/ healthcare exclusion

Main activity: Medical care for victims of violence

In the country since: 1998

Human resources (FTE): 34 staff including 7 international staff

Cost for 2012: CHF 1,124,000



In Honduras, violence seriously impacts public health and access to medical treatment is very limited for the poorest communities. © Spencer Platt/Getty Images

IRAQ

Medical treatment for Syrian refugees and for the population of Iraqi Kurdistan

After years of war, violence and economic sanctions, Iraq is now dealing with an influx of refugees fleeing the conflict in Syria. In 2012, more than 67,000 people crossed the border to settle in Iraq and this number continues to grow as the conflict worsens.

MSF has been working in Domeez refugee camp, near the town of Dohuk, since April 2012 where it manages a clinic providing primary healthcare in collaboration with the Department of Public Health. MSF is the main provider of health services in the camp, and the teams provide medical consultations, mental healthcare and training for local staff.

In 2012, 40,000 consultations were held treating a range of medical problems caused, for the most part, by refugees' poor living conditions. Emergencies are referred to Dohuk hospital.

In addition to medical work, MSF has also distributed hygiene kits and ensured that drinking water and sanitation are maintained at acceptable standards in the camp.

The majority of refugees in Domeez arrived in Iraq without possessions, having had to leave everything behind in Syria. The Kurdish authorities are granting them renewable resident permits for a period of six months, which enables them to find employment, usually as day labourers. Some of those who have been in Domeez for a while have started to build extensions to their shelters or have opened small shops in the camp. However, there is a shocking lack of shelters for new arrivals, the majority of whom have to share tents, blankets, mattresses and even food with other families.

In December 2012, in the town of Kirkuk, 200 km north of Baghdad, MSF concluded its project to support the dialysis services at Kirkuk public hospital and transferred its focus to the neonatal service. MSF had been managing the public hospital's dialysis service since June 2010. Over two years, the number

of patients increased five-fold, and at the end of 2012, there were 100 patients on treatment. MSF's surgical team also completed 30 vascular operations on patients with terminal renal failure. In addition, they provided technical and medical training to the hospital's staff to improve sterilisation processes, prevent the spread of infection and to better manage the hospital's pharmacy.

In Hawijah, 50 km south of Kirkuk, MSF is assisting the hospital's emergency service, working with local teams to provide 24-hour care to residents of the town, which is politically isolated and subject to regular outbreaks of violence. Each month the team carried out nearly 300 surgical operations.

Reason for intervention: Armed conflict, endemic/epidemic disease

Main activities: Medical care for victims of violence, hospital

In the country since: 2007

Human resources (FTE): 98 staff including 14 international staff

Cost for 2012: CHF 3,252,000



At the end of 2012, the Domeez camp sheltered 35,000 Syrian refugees. © Pierre-Yves Bernard/MSF



The situation in the Dadaab camps remains unacceptable and, without significant changes being made, the cycle of health crises followed by periods of relative calm risks continuing indefinitely. © Lynsey Addario/VII

KENYA

The Dadaab camps are in the midst of a new humanitarian crisis

Since 2009, MSF has provided medical care in Dagahaley, one of the five refugee camps in Dadaab, in Kenya's northeastern province. These camps house the largest concentration of refugees in the world. 2011 was a critical year for the camps and was marked by a massive influx of Somalis fleeing drought and violence. In 2012, the situation has remained extremely concerning.

Whereas in 2011 nearly 200,000 new arrivals were registered, the population of the camps appears to have stabilised at around 500,000 occupants in 2012. However, these figures may not be accurate, as new arrivals have not been registered since October 2011. Overpopulation and ill-adapted infrastructure in the camps remain the most critical issues, resulting in numerous epidemics breaking out in 2012, including outbreaks of cholera and hepatitis E.

The majority of international organisations have had to scale back their involvement

in Dadaab due to a deteriorating security situation since the autumn of 2011. MSF has nevertheless managed to continue to provide vital emergency care in Dagahaley camp, where it operates a 200-bed hospital as well as four health centres. Half of the hospital beds are reserved for children suffering from acute malnutrition. During 2012, 2,870 malnourished children were admitted as inpatients, 1,345 babies were delivered and 2,230 surgical operations were performed.

The four health centres provide basic health-care, antenatal care for pregnant women, and mental healthcare for refugees traumatised by their experiences in Somalia or suffering from depression as they struggle to see a way out of their current situation. On average, 700 psychological consultations took place each month, while MSF teams provided an average of 14,000 general medical consultations each month.

In 2012, MSF spoke out on several occasions about the severe shortages of aid in the Dadaab camps, as well as about the complete

lack of opportunities available to the refugees, some of whom have been in the camps for the past 20 years. Following the humanitarian crisis of 2011, levels of malnutrition and mortality have returned to pre-crisis levels. However, the situation in the camps remains unacceptable and, without significant change, the cycle of crises followed by periods of relative calm is set to continue.

In December 2012, MSF's centre for treating the neglected disease of kala azar was handed over to Kenyan health authorities. MSF had run the centre in Kacheliba, in the west of the country, since 2006. In 2012, 500 people were treated for kala azar, with a success rate of more than 98 percent.

Reason for intervention: Armed conflict, endemic/epidemic disease

Main activities: Hospital, neglected tropical disease

In the country since: 2007

Human resources (FTE): 338 staff including 15 international staff

Cost for 2012: CHF 8,348,000

KYRGYZSTAN

Improving access to treatment for multidrug-resistant tuberculosis

Kyrgyzstan is one of the 27 countries suffering from high levels of multidrug-resistant tuberculosis (MDR-TB), which is now a major public health issue. Most of the population have only limited access to diagnostics and treatment, due to a lack of resources and weaknesses in prevention programmes.

In February 2012, MSF launched a pilot project to decentralise care for patients with TB and MDR-TB in the Kara-Suu district of Osh province.

The disease is particularly prevalent in this region and waiting lists for treatment are long. Many people die before even receiving their medication.

MSF's patient-centred approach favours outpatient care, with patients completing the often long and painful treatment at home, with the support of their families. Patients are admitted to hospital for short periods only when clinically necessary.

In 2012, MSF teams provided medical and psychosocial care to almost 60 patients. They also renovated the TB care centre in Kara-Suu to meet international standards for infection control.

MSF also works within the prison system in the capital, Bishkek, to diagnose and care for patients with TB and MDR-TB. The medical team also helps former prisoners to complete their treatment, ensuring they receive psychosocial support and food aid

where necessary. In 2012, MSF diagnosed 276 cases of TB in Bishkek's prisons and put 250 people on treatment. The remaining 26 are still undergoing testing to identify their drug-resistance profile.

The organisation is also lobbying at both local and national levels to ensure better care for TB sufferers in prison in order to significantly reduce the prevalence of this disease within the penitentiary system.

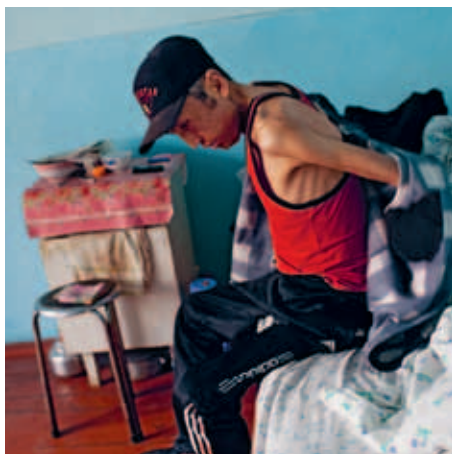
Reason for intervention: Endemic/epidemic disease, social violence/healthcare exclusion

Main activity: Tuberculosis

In the country since: 2005

Human resources (FTE): 117 staff including 18 international staff

Cost for 2012: CHF 3,805,000



In Kyrgyzstan, MSF encourages outpatient treatment so that, at home and supported by their family, patients follow through more easily with their extremely long and painful anti-tuberculosis treatment. © Vincent Tremeau

LEBANON

The country is faced with a massive influx of refugees from Syria

Since the conflict in Syria began in 2011, Lebanon has hosted tens of thousands of refugees fleeing the fighting. According to the UN's Refugee Agency (UNHCR) there were fewer than 10,000 refugees at the beginning of 2012, whereas 12 months later, the reported number of Syrian refugees in Lebanon was above 130,000. As the violence has intensified in Syria, the exodus of refugees has accelerated. Tens of thousands of refugees are also thought to be in the country without having been officially registered.

MSF has been active in Lebanon since 2006 and launched a significant aid programme in 2011 in the north and in the Bekaa Valley, the poorest regions in the country.

Many refugees have been taken in by friends, relatives or local communities, while others have found refuge in public buildings and abandoned properties.

MSF provides primary healthcare and mental healthcare to all those who need it, irrespective of their nationality. In Lebanon, our patients are a mixture of Syrians, Lebanese who had settled in Syria, Palestinian refugees who were being hosted in Syria, local communities struggling to cope with the sudden influx of people, and Lebanese displaced within their country because of tensions along the border.

In June and December 2012, MSF conducted two studies on living conditions for refugees. In December, more than half of those interviewed, whether officially registered or not,

were housed in substandard conditions, living in garages, farms or in unfinished buildings. These shelters offered barely any protection against the elements. The medical situation had also obviously deteriorated since the June study, with half of those questioned – chronically ill patients in particular – stating that they could not afford the treatments they needed.

In 2012, MSF provided more than 16,920 consultations in the Bekaa Valley. More than 520 patients were treated for chronic illnesses. Between March and December, 650 people received individual psychological consultations as part of the mental health programme. In the run-up to winter, MSF distributed more than 20,000 relief items including blankets, hygiene kits and fuel for heating.



At the end of 2012, Lebanon housed more than 130,000 Syrian refugees in makeshift camps, public buildings and abandoned houses. © Michael Goldfarb/MSF

Also during 2012, MSF gave more than 5,130 consultations at two hospitals in Tripoli, the second largest city in the country, which shelters more than 50,000 Syrian refugees and is the scene of heated sectarian tensions. More than 610 patients were admitted to the chronic illness programme and nearly 990 to the mental health programme. The team diagnosed and treated a significant percentage of the serious cases including patients suffering from urinary and respiratory infections, illnesses indicative of their poor living conditions.

MSF also offers psychological care to Palestinian refugees. Forced into exile by the creation of the State of Israel in 1948, more than 400,000 are living in Lebanon, the majority in over-populated camps. They depend upon international aid and the law restricts them from a number of professions. The lack of opportunities and the precarious living conditions weigh on their mental health. An MSF team is working at two clinics and a hospital in Ein el-Hilweh, the largest Palestinian camp located on the outskirts of Sidon. In 2012,

the team admitted more than 950 patients. Victims of sexual violence also receive treatment and psychological care. Another project providing psychological support in Burj el-Barajneh camp in Beirut was transferred to partners of MSF in December 2012. Over four years, MSF provided psychological care to 2,220 patients.

Reason for intervention: Armed conflict, social violence/healthcare exclusion

Main activities: Medical care for victims of violence, mental health

In the country since: 2008

Human resources (FTE): 81 staff including 18 international staff

Cost for 2012: CHF 6,025,000

CONDITIONAL AID FOR REFUGEES

In 2012, millions of people were forced to leave their homes as a result of violence or natural disasters. They settled in makeshift camps and abandoned buildings, in deserts and in towns. Despite the diversity of their situations, these people all have one thing in common: they received only the minimum emergency aid.

Even more seriously, having left everything behind, they have had to wait to be registered before receiving assistance. In Lebanon, MSF has observed a clear deterioration in the humanitarian situation as a result of delays in registration. In the Dadaab camps in eastern Kenya, where nearly 500,000 Somalis are housed, authorities have suspended all registration of new arrivals. While refugees arriving in neighbouring countries are granted refugee status, guaranteeing them a certain level of protection. As soon as they attempt to enter a third country, particularly if it is in Europe, they are considered illegal immigrants with no right to assistance.

Whether in Lebanon, Kenya or Niger, MSF provides treatment to those who need it, irrespective of their legal status.

MOZAMBIQUE

Focusing care on patients with complicated HIV/AIDS

Mozambique has been dealing with a major HIV/AIDS epidemic for many years. In this southern African country of more than 23 million people, some 11.5% of the adult population (aged 15-49) are believed to be HIV-positive. More than half of those needing triple therapy do not yet receive it, despite the aim of the Ministry of Health to speed up access to antiretroviral (ARV) medication and ensure universal coverage.

MSF has been treating HIV-positive people in the capital, Maputo, since 2001. The initial programme to provide treatment and to prevent the spread of the virus has evolved in parallel with the country's own strategies to fight the pandemic.

As a result, we have gradually pulled back from providing first-line treatment to focus on complicated cases.

MSF medical teams work in the Alto Mae day clinic and in five other clinics, all located in the Chamanculo area, to treat HIV-positive patients co-infected with particularly aggressive and hard-to-treat opportunistic infections, such as cryptococcal meningitis and Kaposi's sarcoma. They also care for HIV-positive patients suffering depression or experiencing serious side effect from the ARV drugs, as well as for others for whom the treatments are not working.

Much work remains to be done in caring for HIV-positive children and in particular to prevent mother-to-child transmission of the virus. According to recent scientific

studies, the use of ARV drugs can reduce the risk of transmission to less than five percent. MSF is considering the preventive measure of systematically providing ARV drugs to all HIV-positive pregnant women in order to drastically reduce the number of children born with the virus, a strategy that would also help protect the women's partners.

In 2012, MSF monitored the ARV treatment of more than 21,500 HIV-positive patients in Chamanculo.

Reason for intervention: Endemic/epidemic disease

Main activity: HIV/AIDS

In the country since: 1992

Human resources (FTE): 164 staff including 20 international staff

Cost for 2012: CHF 4,236,000



In Dawei, in the Tanintharyi region, MSF's clinic provides a complete treatment for patients with HIV/AIDS and tuberculosis. © Ron Haviv/VII

MYANMAR

Despite political reform, the medical situation remains critical

Myanmar has experienced political and economic reform during the past two years. In March 2011, the junta that had ruled the country for nearly 50 years dissolved, giving way to a new "civil government", made up of former members of the military. The transition towards democratic governance is taking place step-by-step, including elections in April 2012 where the opposition party, led by Aung San Suu Kyi, won the majority of contested seats.

Half a century of military dictatorship in Myanmar has severely impacted the country's economy, and its population remains extremely poor. Despite the constantly evolving situation, medical and humanitarian needs continue to be largely ignored by

the authorities. Less than one percent of the national budget is allocated to health, compared to 23 percent to the army.

In Myanmar, 15,000 to 20,000 HIV-positive people die each year from opportunistic infections and more than 9,300 new cases of drug-resistant tuberculosis are detected. In Dawei, in Tanintharyi region, patients with HIV/AIDS and tuberculosis (TB) can receive complete, integrated treatment at MSF's clinic. During 2012, in Dawei, MSF provided antiretroviral (ARV) treatment to more than 2,600 HIV-positive patients and started treating 466 people with TB.

MSF also provides primary healthcare in local communities. Malaria is one of the main causes of death in Myanmar. To prevent the spread of this disease, MSF teams gave out

impregnated mosquito nets treated with insecticide to villagers, treated more than 3,400 patients with malaria and held nearly 57,330 medical consultations in Dawei.

In the capital, Yangon, MSF worked in Insein prison. The bad conditions in which prisoners are held and the lack of healthcare available leaves prisoners vulnerable to a multitude of health problems. In 2012, MSF provided ARV treatment to over 240 prisoners and treated 79 prisoners for TB.

Reason for intervention: Endemic/epidemic disease, social violence/healthcare exclusion

Main activities: HIV/AIDS, tuberculosis

In the country since: 2000

Human resources (FTE): 131 staff including 10 international staff

Cost for 2012: CHF 2,674,000



The level of severe malnutrition in Niger, at 14.8% nationally, is above the emergency threshold set by the World Health Organization (WHO). © Julie Rémy/MSF

NIGER

Dealing with chronic food insecurity

Niger is predominantly desert and, like the rest of the Sahel region, is subject to recurrent food crises. Country-wide, the malnutrition rate stands at 14.8%, above the emergency threshold set by the WHO. In 2012, the weather and the political and economic situation combined to bring about even greater levels of poverty while decreasing people's access to healthcare and already scarce food resources. The cost of food staples rose, the early rainy season caused malaria cases to shoot up, and more than 50,000 Malian refugees sought shelter in the north of Niger, all of which put pressure on an already suffering population.

MSF provided emergency treatment to malnourished children aged five and under in the Zinder and Magaria regions. To help relieve overstretched local health services, MSF set up outpatient services to increase the number of patients that could be treated. Teams distributed ready-to-use therapeutic food at six feeding centres to 16,770 malnourished children. This treatment can easily be administered by the children's mother or father, and avoids patients being systematically admitted to the hospital. Only those children whose conditions worsened, or who were suffering from additional illnesses, were referred to hospital for treatment.

MSF runs two inpatient feeding centres in hospitals to treat children with severe malnutrition and medical complications: one in the national hospital of Zinder and the second in the district hospital of Magaria.

In 2012 the teams treated 9,950 children as inpatients, and also provided training for local staff on running the centres, which MSF has begun to hand back to the Ministry of Health.

Community health workers trained by MSF went from one village to another to provide early screening for child malnutrition and other illnesses. The health workers used MUAC bands to measure children's mid upper arm circumference as a means of assessing their level of malnutrition, and screened a total of 113,130 children.

At the same time, they educated the local population on the three childhood illnesses that cause the highest levels of child mortality in Niger: respiratory infections, diarrhoea and malaria.

In 2012, the seasonal peak in malnutrition (from August to September) coincided with a spike in malaria. These two illnesses converge in a vicious cycle: malnutrition weakens the immune system, making it harder to recover from malaria, whilst malaria triggers

anaemia, diarrhoea and vomiting, which in turn increase malnutrition. In order to deal with this emergency, MSF temporarily opened two additional inpatient centres in Chare Zamna and Dungass. Some 750 children received treatment in Dungass.

MSF also responded in Tillabéri, in the north of Niger, where nearly 50,000 Malian refugees had fled to escape fighting in their country. Living conditions in this desert area are desperate. Whilst villagers provided lodging to some of the refugees, the majority set up makeshift camps on the outskirts of villages. MSF provided the refugees, and the villagers hosting them, with primary and secondary medical care. Logistical teams also assisted with sanitation at the camps, installing showers and toilets.

In June, a cholera epidemic broke out in Tillabéri. MSF set up two cholera treatment centres, as well as rehydration points, and treated some 1,200 patients.

Reason for intervention: Armed conflict, endemic/epidemic disease

Main activities: Nutrition, paediatric care

In the country since: 2005

Human resources (FTE): 398 staff including 23 international staff

Cost for 2012: CHF 10,235,000

DEMOCRATIC REPUBLIC OF CONGO

Dealing with repeated epidemics in 2012

2012 was once again a violent year for Democratic Republic of Congo (DRC), with hundreds of thousands of people displaced from their homes by fighting between rebels and the army.

Despite the presence of armed groups, Orientale province, where MSF has worked since 2001, was generally spared from the fighting. However, the region was hit by repeated epidemics, which had a massive impact due to regional instability, failures in the health system and low vaccination rates. In 2012, MSF responded to epidemics of cholera, malaria and measles. Orientale province, in the northeast of DRC, is twelve times the size of Switzerland, and the majority of the population live in isolated villages with no access to healthcare. During the epidemics, reaching these cut-off communities was particularly challenging.

At the beginning of 2012, cases of cholera were identified on the shores of Lake Albert in the Ituri region. An MSF team set up a cholera treatment centre with 50 beds in the town of Kasenyi, as well as several treatment and rehydration units in nearby areas. In total, MSF treated 1,160 patients.

Although malaria is endemic to DRC, in 2012 in Orientale province there was a significant increase in the mortality rate and the number of serious cases requiring hospitalisation and blood transfusions. From June 2012, teams set up healthcare units, including intensive care units, throughout the province, restocked health centres with equipment and materials, where needed, and organised the transfer of the most seriously ill patients. MSF treated more than 58,000 people between June and September; some 3,500 of them were admitted to hospital, mainly children under the age of five.

Since October, measles has also been wreaking havoc amongst the region's children, already weakened by the malaria epidemic. With the Congolese health system struggling to cope, MSF launched another emergency response and has been fighting against the clock to reduce the number of deaths by providing free healthcare to the maximum number of patients. Although an epidemic had been officially declared, treatment was not available for free, health facilities faced

significant shortages of essential supplies, and there was a shocking lack of qualified staff. Between October and December, MSF treated more than 12,700 measles patients and vaccinated 226,000 children in several affected areas.

In December 2012, having noted a drop in the number of violence victims, MSF withdrew from Dungu hospital in the Haut-Uélé district where we had been providing support in the emergency room and operating theatre. However, we increased our presence in Gety hospital in Ituri district, where there is recurrent fighting between armed groups and government soldiers, with many people displaced from their homes as a result.

MSF is running an emergency room and an intensive care unit in Gety hospital, to which 830 people, mainly children, were admitted in 2012. In the neighbouring town of Bunia, MSF has continued to provide support to a Congolese NGO that looks after female victims of sexual violence.

Finally, MSF has continued its work fighting sleeping sickness (human African trypanosomiasis) in the districts of Bas-Uélé and Haut-Uélé. Some three-quarters of all cases of this neglected disease are believed to be concentrated in DRC. In 2012, MSF teams worked with the Ministry of Health towards eradicating this disease. Some 60,000 inhabitants were tested in the Ganga-Dingila and Ango areas, of whom 1,075 were found to be infected and received treatment. In the city of Doruma, MSF has handed the treatment of sleeping sickness back to the Congolese authorities, since the number of cases has dropped below emergency levels.

Reason for intervention: Armed conflict, endemic/epidemic disease, social violence/healthcare exclusion

Main activities: Tropical medicine, neglected tropical disease

In the country since: 2001

Human resources (FTE): 461 staff including 55 international staff

Cost for 2012: CHF 14,075,000



In the north east of the DRC, reaching the most isolated populations is a massive logistical challenge. © Aurélie Lachant/MSF, Tristan Pfund



ONGOING EMERGENCY SITUATION

Democratic Republic of Congo (DRC) is a desert when it comes to healthcare. Over the years, there has been little investment in healthcare in this huge country. Currently it is struggling to recover from years of war, while its eastern regions remain far from stable. Hundreds of thousands of children have never been vaccinated, in particular against measles – a vaccine that is both cheap and effective.

The health system in DRC is completely overwhelmed by the needs of the population. The existing health centres are short of drugs and qualified staff, who are often not paid for their work. The situation is complicated by many regions being cut off by non-existent or impassable roads. People commonly have to walk for days to reach the nearest public health centre.

Finally, healthcare in DRC is not free of charge. This is catastrophic for the majority of the population who live below the poverty line and simply cannot afford to pay for healthcare. These factors help to explain why easily treatable diseases like measles can wreak such havoc, and why MSF has to respond to emergencies in DRC on such a regular basis.



In DRC, repeated epidemics have placed huge pressure on children's health. © Tristan Pfund

THE DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

Emergency response following flooding

In the summer of 2012, North Korea was faced by a serious humanitarian crisis after torrential rains caused flooding and landslides over more than 650 km². According to official reports from North Korea, 169 people died in the floods, 400 people disappeared and 212,200 were displaced from their homes.

An MSF team of two travelled to North Korea to evaluate needs at 13 health facilities in the capital, Pyongyang, and in the rural communities to the north.

As a result of their findings, MSF provided essential medicines and general medical supplies to the hospitals and health centres, distributed essential items such as blankets, bottled water and plastic sheeting to nearly 1,000 families and brought in 25 tons of rice.

The Democratic People's Republic of Korea, a country which has undergone very few changes over the past 30 years, is one of the most politically isolated states in the world.

Reason for intervention: Natural disaster

Main activity: Medical care for victims of natural disasters

Human resources (FTE):
2 international staff

Cost for 2012: CHF 867,000

SOMALIA

The humanitarian situation remains appalling

More than two decades after civil war broke out, Somalia is still torn apart by fighting and its population subject to indiscriminate violence. In 2012, the country appointed a new president and government. However, despite a partial retreat by the insurgents, the country remains divided and the majority of Somalis live in terrible conditions.

The health system has effectively been shut down since 1991 following the fall of the Siad Barre regime. There is a heightened risk of epidemics as vaccination rates are low, and there continue to be massive movements of people within the country. Access to drinking water is often scarce and sanitary conditions are poor, all of which contribute to the deplorable humanitarian situation. International aid also remains insufficient due to regional insecurity and a lack of access granted by the warring parties.



Our two colleagues, Montserrat Serra and Blanca Thiebaut, kidnapped in October 2011 from a refugee camp in Dadaab in Kenya, are still being held in Somalia. All sections of MSF have decided to suspend new projects in the country, with the exception of emergency interventions, until our colleagues have been released.

Despite these difficulties, MSF has continued to provide essential healthcare to Somalis in 2012. In Mogadishu, MSF was able to strengthen its 60-bed paediatric hospital opened at the height of the humanitarian crisis in summer 2011. Some 1,430 children received treatment in 2012, the majority suffering from severe acute malnutrition and measles. A further 6,310 malnourished children received treatment at the hospital's mobile clinics.

Outside the capital, MSF has been providing medical supplies to a community hospital in the Afgooye corridor, the only hospital in an area with one of the largest concentrations of displaced people in the world. In late 2012,

MSF teams also implemented a number of emergency responses in Afgooye, screening 1,530 children under five for malnutrition. One out of four was malnourished and was provided treatment. Teams also vaccinated 380 children against measles, polio or tetanus.

In Dinsor, almost 1,900 patients were admitted to MSF's hospital in 2012. The medical team assisted at 1,055 births and provided 36,040 ambulatory consultations. The hospital has 60 beds, and also has an inpatient therapeutic feeding centre with 40 beds.

In December 2012, MSF transferred its project at Belet Weyne hospital to local authorities. During the year, 9,830 people were admitted as inpatients, including 155 with war wounds.

Reason for intervention: Armed conflict

Main activities: Hospital, nutrition

In the country since: 2002

Human resources (FTE): 420 staff including 8 international staff

Cost for 2012: CHF 5,499,000



In Mogadishu, MSF has opened a paediatric hospital that mainly treats children suffering from malnutrition. © Mike Woodman/MSF



SUDAN

The country has been hit by a series of epidemics

Since South Sudan gained independence in 2011, the economic situation in Sudan has weakened and levels of investment in health services have decreased. Rural communities have been hit the hardest, and many people in the countryside struggle to afford medical care.

In 2012, MSF responded to a number of emergency health situations. In August, flooding in Al-Gedaref state caused 35,000 people to be displaced from their homes. An MSF team distributed basic provisions to homeless families, including plastic sheeting to construct shelters, and built showers and toilet facilities. MSF also trained local

medical staff in recognising and treating acute watery diarrhoea, which is common during flooding.

In Sennar state, which was also hit by flooding, MSF organised the distribution of basic provisions and set up mobile clinics to provide first aid. A number of cases of measles were diagnosed during consultations and the teams launched a vaccination campaign, vaccinating a total of 1,760 children.

At the end of the year, MSF helped the Ministry of Health to stem a yellow fever epidemic in the centre and north of Darfur by carrying out a vaccination campaign in five locations. The MSF teams also treated more than 150 patients with haemorrhagic fever.

Sudan is also a global hotspot for kala azar, a neglected disease transmitted by sandflies which is fatal if left untreated. In 2012 MSF treated kala azar sufferers in Tabarak Allah, in Al-Gedaref state, screening 3,090 people and providing treatment for 730 people with the disease. MSF also trained medical personnel in Sennar state to diagnose and treat kala azar. MSF's kala azar treatment centre in Sennar state is one of the few locations where medical research is conducted on this illness.

Reason for intervention: Endemic/epidemic disease

Main activities: Tropical medicine, neglected tropical disease

In the country since: 2004

Human resources (FTE): 121 staff including 14 international staff

Cost for 2012: CHF 3,657,000



MSF is specifically focused on children and pregnant women at its hospital in Agok. © Corinne Baker/MSF

SOUTH SUDAN

Healthcare in the contested Abyei region

The Republic of South Sudan, independent since July 2011, is one of the most underdeveloped countries in the world. The majority of the population live on less than one dollar a day and the country is severely lacking in basic social services. In 2012, fighting broke out on the border with Sudan; large numbers of people were wounded and many more were displaced from their homes. To date, a number of contentious issues remain unresolved between the North and the South, including the demarcation of the border and the sharing of oil resources – contentions which feed tensions in the region.

The Abyei region, where MSF has been working since 2006, is still contested by both states. MSF provides the population with basic

healthcare and with secondary-level care at Agok hospital, with a particular focus on children and pregnant women whose health is most at risk. In January 2012, alarming results from a nutrition survey prompted MSF to distribute ready-to-use food to 12,200 malnourished children. Teams also treated 2,760 children under five suffering from acute malnutrition and assisted at 860 births.

In 2012, MSF treated 140 tuberculosis patients at Agok hospital and started treatment for patients with HIV/AIDS. In total, 9,200 outpatient consultations were held and 2,600 patients were admitted to hospital.

Mobile clinics were organised in the remote areas of Aja Kuach, Abeimnom, Rumamer, Mabok, Mijak, Leu, Marial Achak, AkacNyel et Malual Aleu. These zones are only accessible in the dry season and the Dinka

population who live there has very little access to healthcare. In November 2012, MSF was also able to assist the nomadic Misseriya tribe north of Abyei for the first time since 2010.

In Lakes State, in the centre of South Sudan, MSF provided support in dealing with a malaria epidemic at 11 government health facilities between October and December. MSF provided antimalarial medication, rapid screening and 20,000 mosquito nets and treated more than 7,350 patients.

Reason for intervention: Armed conflict, Endemic/epidemic disease

Main activity: Hospital

In the country since: 1996

Human resources (FTE): 293 staff including 40 international staff

Cost for 2012: CHF 9,563,000

SWAZILAND

A long fight against the dual epidemic of HIV/AIDS and tuberculosis

MSF has been working in Swaziland since 2007 to fight the tragic dual epidemic of HIV/AIDS and tuberculosis (TB), which has decimated the population and is continuing to threaten future generations. Some 26% of adults (aged 15-49) are infected with HIV, while TB cases are rising fast, with approximately 1,200 new cases per 100,000 inhabitants per year. The impact of these diseases on society and the economy is huge. Swaziland has lost the most active layer of its workforce and life expectancy has plummeted from 60 years in 1997 to just 39 in 2012.

In collaboration with the Swazi Ministry of Health, MSF has decentralised care for HIV/AIDS and TB patients into the community, as well as bringing treatment for the two diseases into the same consultation area to reduce the

number of appointments that patients have to attend regularly in order to complete their treatment, which also has cost benefits.

In the Shiselweni district, in the south of the country, teams in 22 rural clinics and three health centres provide diagnostic services, treatment and care, as well as psychosocial support to help patients follow through with their treatment. At the end of 2012, more than 8,730 patients were receiving antiretroviral (ARV) treatment in the clinics and health centres supported by MSF, 2,090 of whom were new patients that year. In addition, 180 patients were receiving anti-TB drugs, 110 of them for multidrug-resistant forms of the disease.

MSF has a particular focus on the prevention of mother-to-child transmission of the HIV virus, providing 1,370 pregnant women with ARV drugs during their pregnancies to

prevent the disease being transmitted to their children. According to the latest scientific studies on this topic, taking ARV medication can reduce the risk of transmission to less than 5%.

In 2013, MSF launched a pilot project to provide ARV medication to all pregnant women irrespective of the state of their immune system, with the aim of drastically reducing the number of children born with the virus in existing or future pregnancies. This strategy will also help to protect the partners of HIV-positive women.

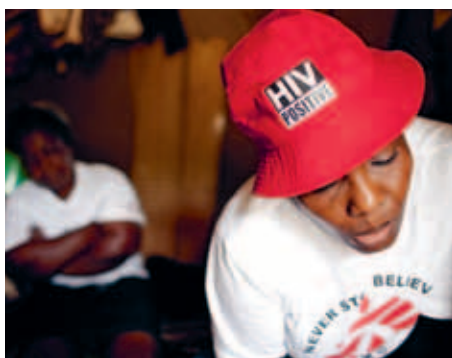
Reason for intervention: Endemic/epidemic disease

Main activities:
HIV/AIDS, tuberculosis

In the country since: 2007

Human resources (FTE): 192 staff including 23 international staff

Cost for 2012: CHF 8,387,000



In collaboration with the Swazi Ministry of Health, MSF has decentralized treatment of HIV/AIDS and tuberculosis into the local communities. © Giorgos Moutafis

CHAD

Managing malnutrition and conducting vaccination campaigns

Chad may have experienced three years of peace, but it is still one of the poorest countries on the planet. Infant and maternal mortality rates are among the world's highest, while there have been no improvements to sanitary conditions, according to the World Health Organization (WHO). Chad's health system suffers from a significant lack of human and material resources.

Within the Sahel region, which cuts a swathe across Chad, food insecurity is at chronic levels and epidemics are frequent. In this harsh environment, children are the most at risk.

MSF manages a hospital in the town of Massakory. Opened in 2010, the hospital

has up to 220 beds and provides emergency care to children up to the age of 15. In 2012, 8,532 children suffering from severe acute malnutrition and 1,068 children with malaria were treated there. A mobile nutrition service is provided from six health centres in the district so that local residents need not bring children long distances to the hospital. MSF teams have also vaccinated more than 17,000 children in the district against measles, and treated 72 children suffering from the disease.

In the spring of 2012, MSF conducted an extensive vaccination campaign to prevent an epidemic of meningitis breaking out in Massakory and the Léré commune. Some 358,850 people aged 30 and under were immunised with the new vaccine, which provides ten years of immunity,

compared to the three years' immunity of previous vaccines.

In Abéché, in the east of the country, MSF has continued to conduct operations on women with obstetric fistula, injuries resulting from childbirth that can cause incontinence. There is a particularly high occurrence of fistulas in Chad due to a lack of quality obstetric care. In 2012, 166 women had fistulas repaired by MSF's surgical team.

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

Main activities:
Hospital, nutrition, paediatric care

In the country since: 2006

Human resources (FTE): 428 staff including 36 international staff

Cost for 2012: CHF 8,848,000

HUMAN RESOURCES

Our two colleagues from MSF Spain, Montserrat Serra and Blanca Thiebaut, have now been held captive more than 500 days. On the 31st October 2011, they were taken from the Dadaab refugee camps in Kenya where MSF continues to provide medical assistance to Somali refugees. MSF does everything within its means to obtain their release and the absence of Montserrat and Blanca is a constant reminder of how vulnerable our teams are in these complex and difficult operational environments.

“To staff our operations in complex and difficult environments is a daily challenge.”

In 2012, MSF Switzerland employed nearly 4,700 people in the field, of whom more than 950 expatriated from Geneva. Even though our regular programmes remained relatively stable, we responded to a succession of medical emergencies throughout the year requiring a significant mobilization of human resources (HR) for our projects in the Democratic Republic of Congo, Niger, South Sudan, Guinea and Cameroon.

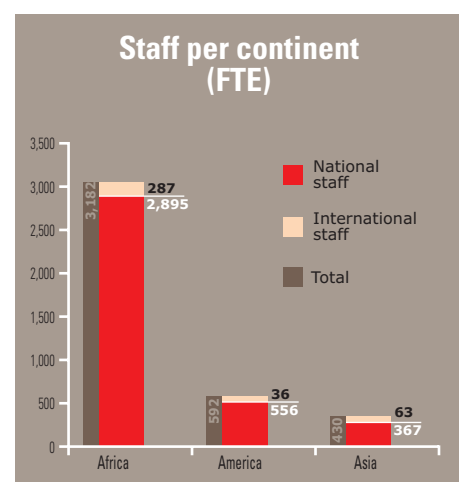
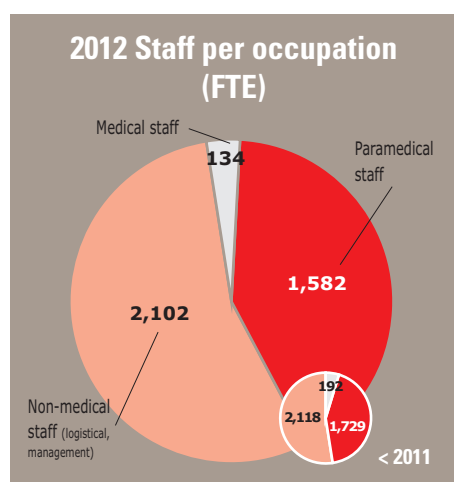
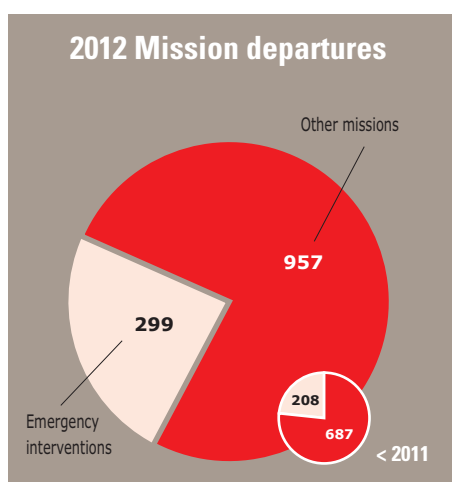
The political situation in the Sahel complicates our ability to deploy experienced teams, whether national or international, as there is significant insecurity and many nationalities are restricted from the area due to the high risk of kidnapping. As in Somalia, the difficulty to staff the medical teams in Niger endangers our capacity to maintain the quality of care in relief operations. This is a constant daily challenge for all our staff out in the field and back in head quarters.

In 2012, MSF Switzerland launched a three-year strategic plan, in which human resource issues play a central role: stabilizing coordination efforts, developing career paths and focusing on internal mobility, training and diversity are key topics we have started to tackle this year.

We also look to the international MSF movement as HR policies and tools are developed. In 2012, the new global remuneration strategy for international staff (IR 2.0) was finalized, which will be linked to our future HR management system (Symphony). Using these new tools from 2014 should, in the medium term, allow us to make the best use of our different skillsets to better serve our patients.

I offer sincere thanks to all those who have collaborated with MSF Switzerland and who made our work possible in 2012.

Franck Eloi, Director of Human Resources



FINANCIAL RESULTS FOR 2012

In 2012 MSF had an exceptional donation: MSF Switzerland was very pleased to receive an unexpected private gift of nearly CHF 26M. Prior to accepting this, we conducted full due diligence to ensure that the donation met all criteria stipulated in MSF's gift acceptance policy. This ensures that gifts originate from ethical and legal sources. In order to optimize this donation impact, have created a specific "fund" with this to finance particularly innovative or strategic medical and operational projects.

MSF Switzerland's **total expenses** increased by CHF 12M between 2011 and 2012 (+8.7%) totalling CHF 159M for 2012. Half of this growth was due to our financing of MSF Spain's programmes (CHF 5M) and our contribution towards the expansion of MSF Logistique's premises in Bordeaux (CHF1.2M). Excluding these items, the growth in expenses was CHF 6M (+4.4%). The donation to MSF Spain was made in the MSF movement's ethos of solidarity to help alleviate their significant dip in donations due to the economic crisis in Spain and it was made to specific innovative medical programmes.

Programme expenses increased by 3% in 2012 and have returned to the levels of 2010. Following the major emergency intervention in Haiti in 2010, programme expenses had slightly lowered in 2011. The level of operational costs has therefore remained relatively stable during the past three years at around CHF 115M.

The cost of regular projects increased by 4% compared with 2011, notably due to the increase in activities related to treating HIV/AIDS and tuberculosis in Swaziland and our work in the Massakory hospital in Chad.

Concerning **emergency responses**, whilst there were no major interventions, this was a dynamic year with more than twenty new projects opening. We spent CHF 24M in 2012, 3% more than in 2011. The main emergency situations responded to were the malaria epidemic in the Democratic Republic of Congo (CHF 3.3M), refugees in Niger (CHF 2.5M) and the South Sudan region (CHF 2.4M). A significant mobilization of our resources was required in the DRC in 2012, with nearly a quarter of our emergency budget being allocated to the DRC in response to the malaria, measles, cholera and malnutrition crises. Within our budget "structure" emergency projects formed 21% of our operational expenses, in line with 2011.

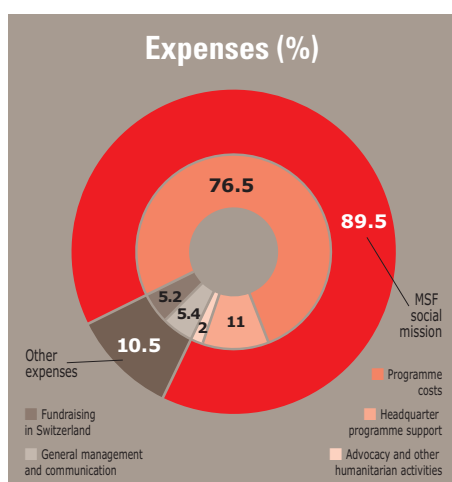
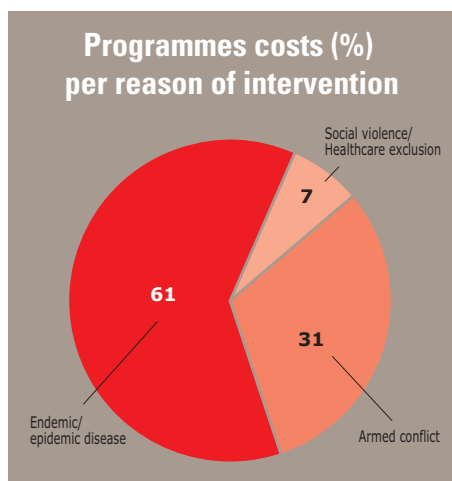
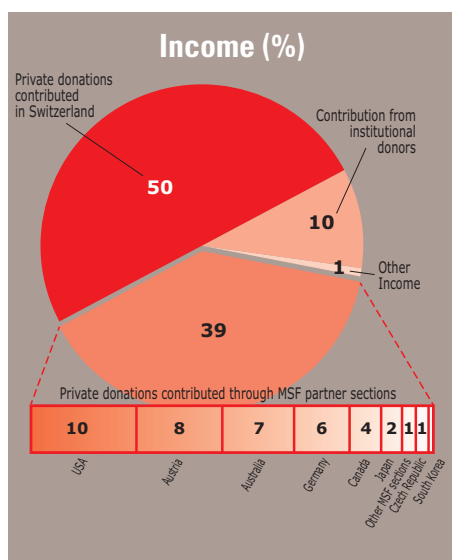
This year, 61% of our project-based expenses went towards endemic/epidemic disease and 31% to victims of armed conflict. In geographical terms, Africa still represents the most significant share of project expenses (75%); however, this year Asia moved ahead of the Americas. This can be explained by the increase in expenses for Lebanon and above all by the decrease in activities related to the Haiti programme.

Headquarter expenses increased by CHF 3M (+9%). This growth was due to the delayed adjustment to headquarter expenses for the operational support of programmes, which had grown strongly in 2010 due to the Haiti emergency. As a result, for the period 2007-2012, programme expenses increased by 61%, whilst headquarter expenses increased by 48%. MSF plans a stabilization for 2013-2014.

The share of expenses allocated to MSF's **social mission** remained stable at 89%.

MSF Switzerland's **revenues** increased by CHF 27M compared with 2011 (+18%). This increase was primarily due to the exceptional donation of CHF 26mm, but also from the growth of CHF 10M (+16%) in contributions from MSF sections that partnered with MSF Switzerland and which counterbalanced the decrease in revenues from public, institutional funds.

Donations in Switzerland from private sources, excluding the exceptional donation, were in line with those received in 2011, a year when over CHF 5M had been collected in response to the crisis in Somalia. As the media had not specifically drawn attention to any individual emergency in 2012, this stability in donations is in itself an excellent result. To achieve this we had to increase fundraising expenses by 7.5%.



“In 2012,
we spent
CHF 24M on
emergency
operations.”

MSF Switzerland received CHF 70M in donations **from partnering sections** in 2012. The contributions were CHF 10M higher than in 2011 and firmly anchor our section within the dynamics of the MSF movement.

Financing from public institutions decreased by CHF 6M in 2012 and was at CHF 19M, or 10% of revenues.

The setting up of a **dedicated fund** with the exceptional donation has deferred CHF 19M of revenues to future projects. The CHF 1.6M fund, set up in 2007 to finance the expansion of MSF Logistique, was finally used in 2012.

MSF Switzerland concluded the year with a CHF 4.4M surplus in 2012.

We would like to thank the 211,494 donors in Switzerland who responded to our requests in 2012, as well as the hundreds of thousands of others who, in the USA, Germany, Austria, Australia, Canada, Japan, Mexico, Czech Republic and in South Korea, helped finance our operations through donations to MSF partner sections.

We would also like to thank the Communes, the Cantons and the Swiss Confederation for the help they have provided to us throughout many years, as well as the foreign governments and humanitarian aid agencies who finance our operations.

Geneva, 4 May 2013
Ralf de Coulon
Treasurer

Emmanuel Flamand
Financial Director

89% OF MSF'S FINANCING IS FROM PRIVATE SOURCES

MSF Switzerland's financing is mainly sourced from private donations (89%), as well as funds from governments and public institutions (10%).

In 2012, thanks to our 211,494 donors, the majority of private donations came from Switzerland (56%). Funds also came from other countries, notably USA, Austria, Australia and Germany, through sections of MSF in these countries. Governmental donations came essentially from the European Commission (35%), the Swedish government (15%) and the Swiss Confederation (11%).

MSF's work is conducted in a manner strictly independent of all political, economic, religious or other powers. MSF does not wish in any situation to become an instrument of foreign policy for any government or group. To maintain this independence, MSF aims to raise the maximum of fundraising from private sources and seeks to limit the influence of governmental or public financing by diversification and by only soliciting funds in accordance with very specific criteria. For instance, when intervening in a complex conflict situation, in which various States are involved, we rely only on private donations to avoid any risk of confusion or potential manipulation.

MSF's decision to intervene in a crisis is based on our own evaluation of the situation. We make an independent assessment of the medical needs, gain unrestricted access to the populations affected and we directly control any aid that we supply. Private donations enable us to respond more quickly with emergency medical assistance in a crisis, even in areas far from the media's attention or from political interests.

In order to preserve this defining responsiveness we keep financial reserves aside to enable us to respond to a crisis immediately, without having to wait for fundraising. These reserves also enable us to guarantee the continued financing of our medical programmes, even when there is a decrease in donations received.

This freedom to act independently, due to our significant share of privately sourced financing, does not in any way remove our responsibility to ensure that the resources entrusted to us are used in the most efficient way. Quite the opposite, MSF is committed to making the best use of our means, to controlling directly the distribution of relief aid and to evaluating our impact on a regular basis. In addition, in order to remain transparent, MSF is committed to publishing particularly detailed, audited financials.

ACKNOWLEDGEMENTS

**We are grateful to all the donors who made the work of MSF possible in 2012.
Last year, 211,494 people generously supported our organisation – we thank them for their trust.**

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

- CIDA – Canadian International Development Agency
- DANIDA – Danish International Development Agency
- 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
- SDC – Swiss Agency for Development and Cooperation
- SIDA – Swedish International Development Cooperation Agency
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Unicef – United Nations International Children Emergency Fund
- UNITAID
- WFP – World Food Programme

In particular, we would like to thank the following organisations:

- Canton de Genève
- Chaîne du bonheur
- Cofra Foundation
- Ferster-Stiftung
- Fondation des Fondateurs
- Fondation Rifké
- Gamorsa Stiftung
- Hilfswerk Pro Beatrice
- Hilti Foundation
- Kanton Aargau
- Lanfrosa Stiftung

- Leopold Bachmann Stiftung
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Our most sincere thanks also go to:

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- Baumer Electric AG
- Binder Rechtsanwälte
- Bolliger & Mabillard
- Breitling SA
- Büchi Labortechnik AG
- C + S AG
- Caisse de Pensions Swatch Group
- Caliqua AG
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- Commune de Cologny
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- Commune de Veyrier
- Commune du Grand-Saconnex
- Commune de Meyrin
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- Consa Treuhand AG
- Couvent Ste. Ursule de Sion
- Deepview Capital SA
- Dieter Kathmann Stiftung
- Dominikanerinnenkloster St. Peter & Paul
- Dosteba AG
- Eduran AG
- Elbro AG
- Elisabeth Nothmann Stiftung
- Evangelisch-Reformierte Kirchgemeinde Obwalden

- Exedra AG
- Fides Treasury Services Ltd
- Fondation Alfred et Eugénie Baur
- Fondation de bienfaisance de la Banque Pictet & Cie
- Fondation Hubert Looser
- Fondation Johann et Luzia Graessli
- Fondation Francis et Marie-France Minkoff
- Fondation Pierre Demaurex
- Fondazione Casal
- Fondazione Green Island
- Fondazione Pro Dimora
- Forcklabs
- Gemeinde Baar
- Gemeinde Küsnacht
- Gemeinde Meilen
- Gemeinde Muri b. Bern
- Gemeinde Nürensdorf
- Gemeinde Riehen
- Gemeinde Stäfa
- Gemeinde Wallisellen
- Gemeinde Wettingen
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- Giessenbach Stiftung
- GOM International AG
- Günther Caspar Stiftung
- Habi Druck
- Hemmann Schleiftechnik GmbH
- Huwa Finanz & Beteiligungs AG
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- Intellec AG
- Kanton Appenzell Ausserrhoden
- Kanton Basel-Landschaft
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- Kanton Luzern
- Kanton Schaffhausen
- Kanton Thurgau
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- Karlsbader Wochenenden
- Kath. Kirchgemeinde Baar
- Kirchgemeinde Vechigen
- Klinik Stephanshorn
- Labmed
- Manor AG
- Marcuard Family Office AG
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- Seedamm Plaza
- Soltop Schuppisser AG
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- Stadt Zug
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- Sternsinger Eschlikon
- Stiftung Barbara Christiane Koch
- Stiftung der Gemeinschaft der
Liebfrauenswestern
- Stiftung Fürstlicher Kommerzienrat
Guido Feger
- Stiftung Symphasis
- Storz Medical AG
- Sungard Switzerland SA
- Sunside Treuhand- und Verwaltungs AG
- Swiss Post
- Tanaca Holdings Ltd
- Testex
- The Ambassador
- The Aurora Light Foundation
- The Herrod Foundation
- The Kozuki Trust
- The Swatch Group SA
- The Tanner Trust
- Titan Software Consulting AG

- Toni Frei Metallbau AG
- Tschikali Stiftung
- Uts United Trading Service SA
- Verein Saus und Braus
- Victorinox
- Ville de Genève
- Ville de Lugano
- Ville de Vevey
- Voegeli & Wirz AG
- von Duhn Stiftung
- Vontobel-Stiftung
- VP Bank Stiftung
- Wellington Partners Advisory AG
- Yellow Bird Foundation
- ZetaVision

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- May Win
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- Nelly Humm
- Nicole Hoekstra
- Patrick Maurer
- Regula Bucher
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- Viola Bingler

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our event partners:**

- Zürich Film Festival
- Fumetto – Internationales comix –
Festival Luzern

**Finally, we would like to thank
all those who offered their time
and energy to MSF in 2012:**

- Anne Chick
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- Daniel Schilliger
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- Flavia Galletti
- Gerhard Amman
- Hélène Leherpeur
- Henry Spaeti
- Irène Serfass
- Jacqueline Leroux
- Katharina Meyer

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

THE BOARD

President

Dr 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

Dr 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

Ralf de Coulon is Director of Finance, Human Resources and Administration at DNDi (Drugs for Neglected Diseases initiative), an independent drug R&D organisation founded in 2003 with the help of MSF. DNDi's objectives are to develop drugs to address the needs of patients with the most neglected tropical diseases. Prior to this role, Ralf de Coulon worked for MSF for several years. He was elected to the Board of MSF Switzerland in May 2012.

Secretary

Dr Slim Slama is Chief Resident at the Division of International Humanitarian Medicine at Geneva University Hospitals. He is also Programme Director for the Geneva Health Forum, an international conference forum that aims to promote critical reflection on contemporary global health issues (ghf.globalhealthforum.net). Slim Slama was elected to the Board of MSF Switzerland for a period of three years in May 2012.

Members

Dr 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. She was elected to the Board of MSF Switzerland in May 2010.

Dr 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.

Nicolas Cantau has been involved in international aid, development and public health programmes for the past 20 years. He currently works as Regional Director for Eastern Europe and Central Asia for the Global Fund to Fight AIDS, Tuberculosis and Malaria. Prior to this, Nicolas Cantau worked for more than ten years for MSF. He joined the Board of MSF Switzerland in May 2012.

Jean-Christophe Azé worked for MSF Switzerland from 1991 to 2004, both in the field and at head quarters. He currently works for the World Health Organization (WHO) where he is Head of Logistics for communicable diseases. He has been a member of the Board of MSF Switzerland since May 2012.

Co-opted Members

Dr Karim Laouabdia joined MSF in 1985. He worked for several years in the field before joining the headquarters of MSF France, in Paris, as Director General from 1998 to 2003. He was responsible for the general management of the Campaign for Access to Essential Medicines from 2004 to 2006. He is currently Deputy Director General of the French Agence de la biomédecine. He was co-opted to the Board in 2011.

Fiona Terry has spent most of the last 20 years involved in humanitarian rescue operations in different parts of the world. Formerly President of Médecins Sans Frontières Australia, she is currently involved in independent research and holds a PhD in International Relations and Political Science.

THE MSF CHARTER

Médecins Sans Frontières is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honour the following principles:

Médecins Sans Frontières provides assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict. They do so irrespective of race, religion, creed or political convictions.

Médecins Sans Frontières observes neutrality and impartiality in the

name of universal medical ethics and the right to humanitarian assistance and claims full and unhindered freedom in the exercise of its functions.

Members undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, or religious powers.

As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them.



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A Syrian refugee child is being examined by MSF doctors in the emergency room of Domeez camp, in Iraq. © Pierre-Yves Bernard/MSF