



# MSF Switzerland Activity Report 2013

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

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

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

MSF is a non-profit organisation founded in Paris, France, by doctors and journalists in 1971. Today, MSF is a worldwide movement of 23 associations and an international office in Geneva, Switzerland, which provides coordination, information and support to the MSF Movement, and implements international projects and initiatives as requested. All of the associations are independent legal entities, registered under the laws of the countries in which they are based. Each association elects its own board of directors and president. They are united by a shared commitment to the MSF Charter and principles. The highest authority of the MSF Movement is the International General Assembly, which meets yearly.

The movement has five operational centres – MSF France, MSF Belgium, MSF Switzerland, MSF Holland and MSF Spain – which directly manage the missions. The partner sections contribute to the action of MSF through their recruitment efforts and by collecting funds, information and providing medical and operational support.

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**This Activity Report takes the place of the Performance Report. It was prepared in accordance with the provisions of the Swiss GAAP, FER/RPC 21.**

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## BEYOND MEDICAL AID, HOW CAN CIVILIAN POPULATIONS WHO ARE VICTIMS OF VIOLENCE BE PROTECTED?



Abiy Tamrat,  
President of MSF Switzerland

In the first months of 2014, MSF has been facing a growing number of conflicts which are resulting in tragic consequences for civilian populations, and exposing our field teams to a level of violence not seen in years. Already present in Syria to respond to medical needs brought about by a merciless war, in December teams were urgently deployed to the Central African Republic (CAR) and to neighbouring countries to treat the wounded and assist refugees. At the same time, a civil war broke out in South Sudan, resulting in thousands of wounded and displacing more than one million people. The worst may be yet to come as the risk of a serious food crisis increases during the rainy season.

In all these countries, numerous field volunteers have been shocked by a violence that spares no-one. Patients were hunted down in hospitals, and sometimes summarily executed there. Our MSF colleagues who are being held against their will in the Democratic Republic of Congo (DRC) are direct victims of this violence and MSF works tirelessly to ensure their release.



Bruno Jochum,  
General Director of MSF Switzerland

Powerless in addressing the causes of these events, our teams are constantly confronted with critical decisions, as they cannot cover all needs and, most importantly, are unable to protect victims. Today, two findings stand out.

First, be it in the Central African Republic or in South Sudan, the UN-led international aid system has not managed to address the needs of the majority of affected civilians within an acceptable time frame, owing to a slow mobilisation capacity. Multiple bureaucratic hurdles imposed by donor and host states have been hampering efficient actions. Being independent, MSF has often been the only organisation to intervene rapidly, together with a handful of other actors. However, we are increasingly concerned to find ourselves alone in emergency action. The response capacity of public agencies in epidemics such as measles, cholera and meningitis keeps on weakening. Even with a virus as dangerous as Ebola, currently affecting Guinea and Liberia, no international public health mechanism is in place for treating the sick. While our medical expertise proves to be truly meaningful in such situations, we are questioning the substitutive role that we are required to take on now and – in all likelihood – increasingly so in the future.

Second, 20 years after the Rwandan genocide that shocked the entire world and the Srebrenica massacre within a United Nations protected enclave, what progress has been achieved in terms of protection of civilian populations in the worst situations? While it is encouraging that the United Nations opened their bases in South Sudan – failing however to fully meet their obligation of assistance – our experiences in Syria, Darfur and in the Central African Republic all indicate that there has been no real breakthrough; states have collectively failed to live up to their responsibilities vis-à-vis the world's most exposed populations. Against this backdrop MSF is confronted with an unresolved dilemma, widely debated internally: should we opt for describing violence and thereby trigger actions that protect civilians? Or should we openly call for coercive interventions in extreme situations?

Despite these difficulties, we will continue to provide emergency medical assistance to those in need as long as it is necessary, and remain committed at all levels. Our care makes a real difference for the numerous people who benefit from it. Thanks to all of you for commitment and constant support, which allow us to act.

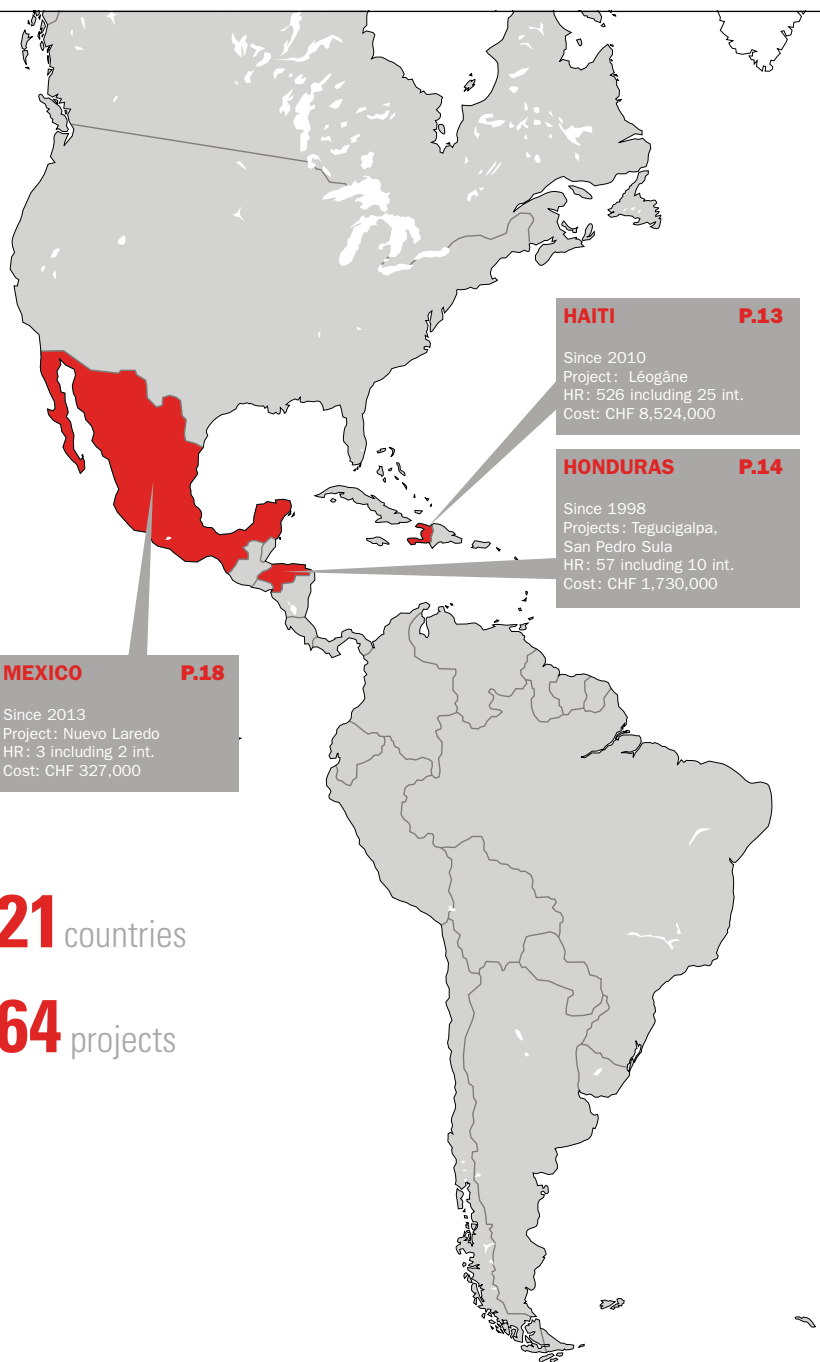
Abiy Tamrat,  
President of MSF Switzerland

Bruno Jochum,  
General Director of MSF Switzerland

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**21** countries  
**64** projects



**Sudan: MSF responds to a yellow fever epidemic in Darfur.**

**JANUARY**



© Aurélie Lachant/MSF

**APRIL**

**Iraq: MSF intensifies activity in the Domeez camp, following an influx of refugees.**



© Asia Kambal/MSF

**Honduras: Response to an outbreak of dengue fever.**

**JULY**

**JAN 2013**

**Mozambique: Emergency intervention following flooding in Gaza province.**

**Lebanon: MSF denounces insufficient aid for Syrian refugees.**

**FEBRUARY**

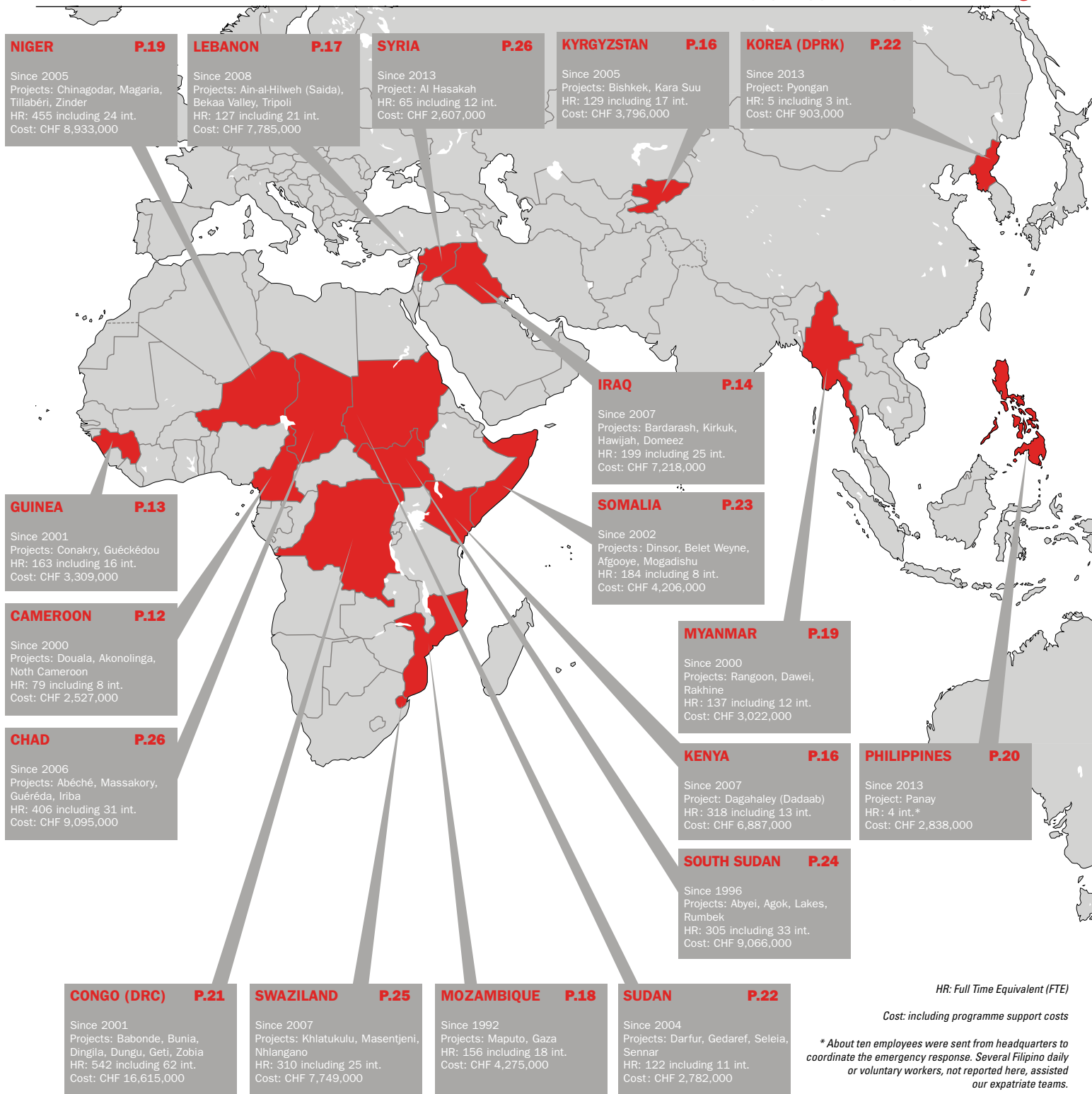


© Julien Rey/MSF

**Sudan: MSF vaccinates more than 306,000 people against measles in Al-Gedaref.**

**JUNE**

**Niger: MSF adopted seasonal malaria chemoprevention (SMC) for children aged three months to five years.**

**AUGUST**

**Somalia: MSF decides to leave the country and shuts down all programmes.**



© Tristan Pfund

**NOVEMBER**

**Philippines: Emergency response to bring aid relief to those devastated by typhoon Haiyan.**



© Hugues Robert/MSF

**SEPTEMBER**

**Iraq: After the border with Syria reopened, 60,000 refugees arrived over the period of several weeks. MSF responds to their medical needs.**

**DRC: MSF strengthens medical initiatives in Geti to help those displaced by the fighting.**



© Laurence Hoenig/MSF

**DECEMBER**

**South Sudan: Emergency intervention to bring aid to those displaced by violence.**

**DEC 2013**

## 2013 IN REVIEW

In 2013, MSF Switzerland carried out 64 medical projects in 21 countries affected by armed conflicts, population displacement, epidemic outbreaks and natural disasters. It also responded to crises in the areas of neglected diseases, mother and child health, and HIV/AIDS and TB.

The present section showcases some of the positive results achieved in 2013. It also highlights a number of challenges that our teams faced when implementing projects in the field.

### KEY ACHIEVEMENTS

#### First seasonal malaria chemoprevention campaign

A first in Niger, from July to November 2013 MSF organised a distribution of preventive anti-malarial drugs for children aged three months to five years. Called seasonal malaria chemoprevention (SMC), this approach was recommended in 2012 by the World Health Organization (WHO) for specific settings, and approved by Niger's authorities in 2013 with a view to reducing mortality in children during seasonal malaria peaks. MSF directly implemented this activity, in collaboration with the Ministry of Health (MoH).

During four months, anti-malarial drugs were distributed by MSF Switzerland teams in six health zones of Magaria district, and by three other MSF sections in the Maradi and Tahoua regions. In Magaria, the SMC campaign targeted over 100,000 children. Treatment consisted of three doses taken over three days; children took one dose at the distribution site, and two others at home over the following two days. Children were thereby protected for one month, and the treatment was renewed on a monthly basis over a period of four months.

The success of this distribution campaign and its acceptance by the population is largely due to the endorsement of traditional authorities and their involvement in sensitisation and mobilisation activities. A 'capitalisation' study conducted by MSF showed excellent results in terms of coverage and adherence to treatment. It complemented other investigations that had already demonstrated the impact of SMC in reducing the incidence of simple and severe malaria.

#### Treatment of non-communicable chronic diseases in humanitarian emergency settings

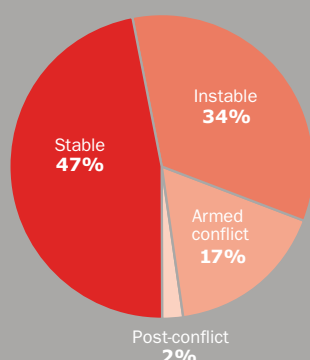
As a medical humanitarian organisation, MSF traditionally operates in emergency contexts predominantly affected by infectious diseases. In Lebanon and Iraq, however, our teams are seeing a growing number of Syrian refugees suffering from chronic diseases, such as diabetes, hypertension and asthma. MSF's expertise in treating these diseases is little developed; we therefore had to innovate and adapt diagnostic and treatment protocols designed for Europe and North America, in order to provide adequate treatment for patients. To address these challenges, MSF organised a workshop in Beirut in September 2013, bringing together teams working in Lebanon and Iraq as well as several specialists. As one of the rare humanitarian organisations treating patients affected by non-communicable chronic diseases, MSF has been developing field manuals for diagnosis and treatment of these pathologies in humanitarian emergency settings.

In 2013, 12,300 consultations for non-communicable chronic diseases were carried out by MSF teams in health facilities in Tripoli and the Bekaa Valley in Lebanon, and in Domeez refugee camp in northern Iraq.

#### Decentralisation of HIV and tuberculosis (TB) care in Swaziland

In 2013, MSF carried out an evaluation of its programme aimed at curbing the dual HIV/AIDS and TB epidemic in Swaziland. The study demonstrated that the operational strategy – decentralisation of care from regional and district hospitals to basic healthcare clinics and community level – greatly improved access to diagnosis and treatment for the population and patient follow-up. In 2012, the majority of individuals in the Shiselweni region had access to healthcare services they needed, an important increase as only 17 per cent had access when the MSF intervention began in 2007. The continuous improvement of antiretroviral treatments, as well as better treatment for

Programme costs per context



Programme costs per continent



**1,568,578**  
outpatient consultations

**65,798**  
admitted patients

**144,623**  
antenatal consultations

**15,504**  
deliveries

**311,247**

malaria cases treated

**18,252**

children admitted to inpatient feeding programme

**36,318**

children admitted to outpatient feeding programme

**60,867**

HIV patients on ARV treatment

**4,732**

TB patients

**9,743**

surgical procedures

**28,850**

individual mental health consultations

**382**

mental health group consultations

**1,033,502**

measles vaccinations

**1,507**

cholera cases treated

TB – including its multidrug-resistant form – and opportunistic infections, strongly contributed to reducing mortality in the region during the same period.

This project shows that the number of new TB cases has diminished thanks to an increase in the number of people started on treatment and also due to improvements in medical care. The number of new HIV cases seems to follow the same trend. These findings indicate that the co-epidemic can be contained.

## CHALLENGES

### Emergency response: MSF too often finds itself alone

In 2013, the MSF rapid reaction capacity proved to be successful in a series of humanitarian crises resulting from armed violence such as in South Sudan, large scale epidemics such as measles in the Democratic Republic of Congo (DRC) or natural disaster as in the Philippines. However, these achievements should not hide the other side of the coin: MSF is often one of the rare actors, if not the only one, able to provide a swift humanitarian response to large-scale emergency situations. Indeed MSF's 'loneliness' in emergency situations significantly impacts its humanitarian response, both in scope and nature.

In terms of scope, MSF is in no position to fully cover the medical needs arising in any crisis, and is therefore forced to make tough decisions on where to intervene and what to forego. For instance, the rapid deterioration of the situation in the Central African Republic (CAR) and in South Sudan in late 2013 quickly overstretched the human, financial and logistical resources of the organisation. Field teams therefore had to focus on areas where the MSF added value was highest, and where logistical means were available.

With regard to the nature of emergency interventions, the absence or lack of actors drives MSF to take over basic public health actions (e.g. mosquito net distribution, vaccinations) and to fill gaps in crucial non-medical sectors (food, water, sanitation, etc) that should be covered by others. The expanding range of activities that MSF has to undertake in emergency settings, in turn, prevents the organisation from concentrating on specialist areas and from developing operations in additional locations. Although not a new phenomenon, the lack of actors has become particularly problematic in sudden onset crises, most recently in CAR.

### Adapting approaches in middle-income countries

Over the last few years, MSF has invested significantly in assisting populations plagued by armed violence or conflict in middle-income countries, mainly in the Middle East and in Central America. Launching medical activities in such settings has proved to be challenging in many respects. It notably required MSF to adapt practices it had developed in the more 'classical' contexts of lower-income economies, where health systems are much less developed, or almost nonexistent.

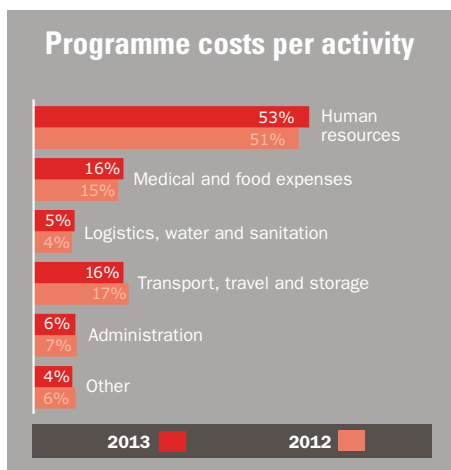
Field teams have actually been confronted with three specific obstacles in middle-income countries. First, unlike low-income settings, rules and regulations governing public health and medical practice are generally in place, with authorities capable of applying them. This forced MSF to adapt its regular treatment protocols and to abide by a variety of local norms (e.g. expatriate staff's license to practice medicine, requirement to hire specialist doctors as opposed to generalist practitioners, impossibility of importing generic medicines, etc).

Second, in these settings our support is mostly needed for specialised care, and the attention to basic, yet essential paramedical activities is often neglected. For instance, MSF teams found difficulties in ensuring hygiene standards in health facilities. Third, middle-income countries generally have a large pool of qualified and experienced medical and non-medical professionals. To bring a new added value, MSF must therefore provide well-trained and highly experienced staff. To address these challenges and others, a study carried out in 2013 identified lessons learned and suggested a number of solutions that could be explored to improve interventions in middle-income countries. Proposals include adapting the traditional MSF approach and activities to better cover specific needs, developing appropriate assessment tools, and formalising the chronic diseases treatment strategy.

### War zones: restricted access

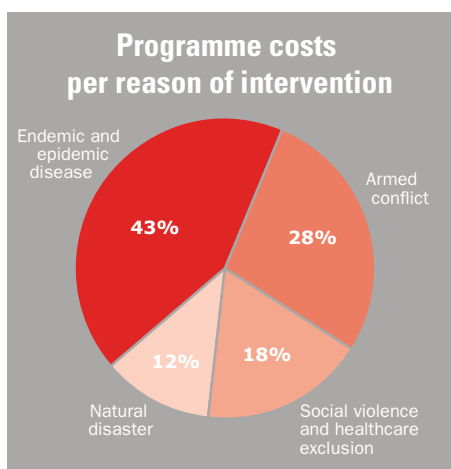
Access to zones of armed conflict continuously represented a challenge for MSF in several locations around the globe. In Sudan's Darfur region, the decade-old conflict took a new turn in 2013 with an upsurge of violence among Arab militias. Largely underreported by the media, the crisis has not been adequately addressed by international aid actors. With several hundreds additional displaced civilians and growing humanitarian needs, MSF strived to intervene; but in spite of an existing technical agreement on West Darfur signed with Khartoum authorities, it failed to obtain access to areas affected by conflict.

Similar constraints were experienced in the Horn of Africa region. The need to adapt modes of intervention in Somalia had reached such an extent that MSF decided to withdraw from the country after over 20 years of continuous presence. The insufficient acceptance of all warring parties and communities to allow the provision of medical assistance, and the unparalleled levels of risk and dire working conditions, forced MSF to stop its operations. MSF however remained committed to assisting Somalis in Kenya's refugee camp. In Dadaab camp though the modus operandi had to be significantly modified to deal with the security situation. Among others, constraints have included the limitation of visits by international staff.



### OUTLOOK 2014

Emergency response may well be the hallmark of 2014. As these lines are being written, our teams are addressing humanitarian crises related to conflicts in South Sudan, Syria and the Central African Republic. Efforts are also deployed in West Africa to contain an Ebola epidemic.



With a total budget of CHF 170 millions and according to priorities defined by the operational policy, MSF Switzerland will continue to respond to medical needs in context of war, displacements of population or repression. It will address the high mortality rate affecting children both with preventive strategies and care, and will continue to fight against HIV/AIDS and tuberculosis epidemics.

Jean-Clément Cabrol,  
Director of Operations

Annick Antierens,  
Deputy Medical Director

# THE YEAR IN PICTURES

**Response to typhoon Haiyan: intersectional collaboration to offer help.** All five sections of MSF intervened in the Philippines. Over a period of three months, MSF's emergency teams provided 96,000 outpatient consultations, admitted 2,200 people to hospital, carried out 588 major surgical procedures, assisted at 846 births and distributed 99,000 relief items, including shelter kits, tents, mosquito nets, hygiene kits and cooking utensils. In total, more than 10 cargo planes worth of medical and logistical supplies (more than 1,000 tonnes of material) were brought into the Philippines during the initial weeks after the typhoon. Nearly 900 people worked for MSF in the Philippines from November 2013 to January 2014.



Panay, 2013. © Laurence Hoenig/MSF



Carles, 2013. © Laurence Hoenig/MSF



Carles, 2013. © Laurence Hoenig/MSF



Carles, 2013. © Laurence Hoenig/MSF



Roxas, 2013. © Laurence Hoenig/MSF



North Gigante, 2013. © Laurence Hoenig/MSF

**Critical aid for Syrian refugees.** MSF Switzerland has provided assistance to Syrian refugees in Lebanon and Iraq for more than two years. More than a million people are registered or are awaiting registration with the UN Refugee Agency (UNHCR) in this region. The lack of lodging, food and health services becomes more acute with each new arrival. The humanitarian response is far from adequate and Lebanon is struggling to accommodate the volume of refugees.

In the Domeez refugee camp in Iraq, MSF teams provide basic medical healthcare and mental health consultations to refugees. MSF is also working to improve sanitation and water in the camp.

In Lebanon, the refugees' medical needs continue to increase. MSF provides aid in the Bekaa Valley, in Tripoli in the north and in Saïda, where the majority of Palestinians from Syria have gathered. MSF provides general medical care, treatment for severe and chronic illnesses, vaccinations, maternal healthcare and mental healthcare. Teams also distribute essential relief supplies.





Arsaal, Lebanon, 2013. © Jonathan Fontaine



Arsaal, Lebanon, 2013. © Pierre-Yves Bernard/MSF



Domeez, Iraq, 2013. © Pierre-Yves Bernard/MSF



Balbek, Lebanon, 2013. © Pierre-Yves Bernard/MSF



Domeez, Iraq, 2013. © Julien Rey/MSF

**A decade of action in Orientale province.** This year marks 10 years of MSF intervention in the northeast of the Democratic Republic of Congo (DRC), where we have constantly adapted our activities to best meet the emergency needs of the population. We have provided surgery for war wounds, mental healthcare, basic healthcare, support for displaced people, treatment for sexual violence victims, response to epidemics, support for the paediatric services, treatment for HIV-positive patients, and treatment for sleeping sickness.

**Results:** more than one million consultations; 120,000 hospitalisations; 38,000 surgical procedures. Nearly 12,000 sexual violence victims also received medical, psychological, socio-economic and legal support.





Bobagala, 2013. © Tristan Pfund



Bobagala, 2013. © Tristan Pfund

## ACTIVITIES BY COUNTRY



230 patients with chronic lesions were treated by MSF in Akonolinga in 2013. © Tristan Pfund

## CAMEROON

### The evolution of treatment for HIV/AIDS and Buruli ulcer

Cameroon is one of the most stable countries in West Africa, but its population suffers from poverty and the health system struggles to meet the country's needs. MSF is focused in Cameroon on treating Buruli ulcer, a neglected disease that results in lesions and physical deformities, and fighting HIV/AIDS.

Buruli ulcer is a tropical disease that has been detected in several areas of the country, in particular along the Nyong River, which encircles the town of Akonolinga. MSF has been working in this area since 2002. We constructed a ward within the hospital specifically to treat Buruli ulcer patients and more than 1,200 have received treatment there to date. The treatment for this chronic skin infection is to bind or operate on the wounds, administer antibiotics and conduct physiotherapy to reduce muscle stiffness. MSF also carries out information sessions in the district to explain the disease to local communities.

Since the project began, MSF has noted a progressive decline in the number of Buruli cases. Of the 230 patients admitted for chronic lesions in 2013, only 50 were confirmed to have Buruli. During a screening programme that MSF teams conducted in primary schools, only five cases were diagnosed out of 24,000 children tested. As a result, MSF decided to transfer all Buruli activities to the Ministry of Health. During 10 years of medical and operational research, MSF has ensured that treatment for this disease has evolved. Treatment is now available not only at the hospital, but also in health centres peripheral to Akonolinga. MSF has highlighted that the prevalence of HIV is three times higher in patients suffering from chronic lesions and has offered systematic screening for Buruli patients since 2008.

In Douala, MSF stepped back from the HIV/AIDS project in Nylon hospital in

April 2013. MSF's objectives had been met and the Ministry of Health had adopted new protocols ensuring more efficient treatment is available and that patients that develop drug-resistant HIV/AIDS can receive second-line antiretroviral drugs.

Following flooding in September 2012, MSF intervened in Maga and in Kousséri. Teams provided a total of 3,000 consultations for malaria, respiratory infections and diarrhoea.

**Reasons for intervention:** Endemic/epidemic disease, natural disaster

**Main activities:** Neglected disease, HIV/AIDS

**Emergency intervention:** Natural disaster

**In the country since:** 2000

**Human resources (FTE):** 79 staff including 8 international staff

**Cost for 2013:** CHF 2,527,000

# GUINEA

## Fighting malaria in a hyper-endemic region

More than half of the population of Guinea live below the poverty line: for the majority of Guineans, living conditions are poor and they cannot rely on access to basic social services. In 2013, after three years of delay, the first legislative elections finally took place. This political step, as well as the cancellation of two thirds of the national debt, should now enable the government to finance essential services such as education and healthcare. In the meantime, the region is prone to a number of diseases and therefore MSF conducts epidemiological monitoring and remains prepared to respond to any emergency.

Malaria is still the main cause of death among the most vulnerable groups, in particular pregnant women and young children. MSF has continued to focus efforts on fighting this

disease. In Guéckédou, MSF provides continuous medical training to staff and ensures the provision of cost-free treatment for malaria. In order to improve access to medical health-care, a network of voluntary community health workers screen for malaria in the villages. They provide treatment to patients and refer serious cases to health centres. Nearly 92,000 cases of malaria were treated this way during the year.

After a handover phase, the Matam-Conakry project was transferred to the Ministry of Health in June 2013. MSF had been providing support in the capital's hospital for five years, ensuring children aged five and under, as well as pregnant and breast-feeding women, had cost-free access to healthcare. During the first six months of 2013, nearly 14,000 paediatric

consultations were provided and 100 patients were admitted. More than 8,600 antenatal consultations were also given.

In July, a team was sent to Nzérékoré following inter-ethnic confrontations in the town. MSF sent staff and medical supplies to the hospital, as the fighting caused several hundred people to be killed or wounded.

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

**Main activities:** Malaria, reproductive health

**In the country since:** 2001

**Human resources (FTE):** 163 staff including 16 international staff

**Cost for 2013:** CHF 3,309,000

# HAITI

## Strengthening the capacity of local healthcare facilities



MSF intervened in Haiti following the 2010 earthquake and remains to provide medical healthcare during the reconstruction period. © Tristan Pfund

In Haiti, 80 per cent of the 10 million inhabitants do not have access to medical care either due to lack of means, or because there are no health facilities nearby offering quality care at an affordable rate. The 190,000 inhabitants of Léogâne had no hospital even prior to the earthquake of January 2010 that destroyed more than 80 per cent of the city. Following the quake, MSF provided emergency first-aid to those in need. Afterwards teams stayed during the reconstruction period to provide medical assistance. A prefabricated hospital made from containers with 160 beds was installed in October 2010 to treat medical emergencies and paediatric, surgical, gynaecological and obstetric patients.

Over time, the maternity department has proven to be the most in demand unit at

Chatuley hospital. In 2013, MSF teams registered more than 500 births here each month. Fifteen per cent of births required a caesarean section. Léogâne is in an area with dangerous roads and the surgical teams also operated on numerous victims of traffic accidents.

As the 'container' hospital was only a temporary structure, this year MSF started to identify partners to take over the medical work. MSF is committed to strengthening the capacity of local healthcare facilities so that the existing healthcare structures, which today lack specialised medical personnel, will be able to offer the range of care that a district hospital should: mother and child healthcare, paediatrics, first-aid, surgery, etc. Since October 2013, women with uncomplicated pregnancies are referred to alternative medical centres in the

town for their pregnancy care. Patients requiring orthopaedic surgery are transferred to hospitals in Port-au-Prince.

In parallel, MSF continues to lobby the Ministry of Health for cholera cases to be treated within the public health system as the cholera treatment centre run by MSF teams in Chatuley, which is specialised in treating pregnant women with cholera, will close in 2014.

**Reason for intervention:** Natural disaster

**Main activity:** Hospital care

**In the country since:** 2010

**Human resources (FTE):** 526 staff including 25 international staff

**Cost for 2013:** CHF 8,524,000



# HONDURAS

## Treating victims of physical and sexual violence

Although Honduras is not at war, record levels of violence are still being reported.

In 2013, the homicide rate was 80 per 100,000 inhabitants; this is one hundred times that of Switzerland. The violence stems from gangs and drug traffickers who have turned the country into one of the main transit zones for cocaine in South America. The whole country is impacted and the public health system is completely overwhelmed. In addition, shortages of medical supplies and strikes by medical personnel have multiplied.

MSF intervened in Honduras to help improve access to medical and psychological care for victims of physical and sexual violence. The medical implications of this level of violence are under-estimated and the country has no specific protocol for dealing with affected patients.

MSF focuses on three main areas. In Tegucigalpa, mobile units reach out to

treat people living on the streets and who are those most exposed to the violence. Doctors and social workers provide direct care and organise the transfer of patients to health facilities supported by MSF. In 2013, more than 3,100 were referred.

Our teams help to identify victims of violence and to ensure they receive appropriate care in four MSF-run health centres. A total of 725 patients suffering from sexual violence received medical treatment and 890 other victims of violence received psychological support.

MSF also provided assistance in the emergency department at Escuela hospital, with the aim of improving access to healthcare at all levels of the health system. There is only one public hospital in Tegucigalpa and it is overwhelmed. An MSF team has identified potential areas for improvement, notably in the triage of wounded patients and in the recovery room. These

recommendations will be put into practice in 2014.

From July to November, MSF provided support in the Mario Catarino Rivas hospital in San Pedro Sula during an epidemic of dengue fever. MSF ran the paediatric department and trained Honduran staff in the treatment of adults with dengue. In total, more than 600 children and adolescents aged 16 and under received treatment.

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

**Main activities:** Medical care for victims of violence, hospital care

**Emergency intervention:** Dengue outbreak

**In the country since:** 1998

**Human resources (FTE):** 57 staff including 10 international staff

**Cost for 2013:** CHF 1,730,000



MSF provides medical and psychological healthcare to the victims of physical and sexual violence in Honduras. © Edu Ponces/RUIDO Photo

# IRAQ

## Providing care for vulnerable refugees and communities in Kirkuk and Dohuk

MSF's work in Iraq is concentrated in the north of the country. In the Kirkuk Governorate, an area affected by violence and sectarian tension, MSF supports the neonatal department of Kirkuk hospital as well as the emergency department of Hawijah hospital. In the northeast, in Dohuk province, MSF provides medical assistance to Syrian refugees escaping conflict in their home country; more than 210,000 were living in Iraq at the end of 2013.

MSF works in the only health centre in the Domeez refugee camp, not far from Dohuk. Medical teams provided more than 133,000 consultations in 2013, which equates to nearly 2,500 consultations each week. The medical conditions observed stem mainly from the refugees' poor living conditions.

The camp was initially set up for 27,000 refugees, but today houses 45,000. There is insufficient shelter for everyone and the majority of newly arrived Syrians must share tents, blankets, mattresses and food. Overpopulation and overcrowding increase the risk of communicable diseases spreading and MSF teams have had to respond to epidemics, notably of hepatitis A and measles. In April 2013, after several cases of measles had been diagnosed, MSF vaccinated 19,000 children to prevent the epidemic from spreading.

With the Syrian conflict intensifying, the refugees' situation is not set to improve. In 2013, the Iraqi border was closed periodically resulting in unprecedented inflows of refugees each time it reopened. For example, in August more

than 60,000 people arrived in the space of a couple of weeks. The Syrians travelled by foot and reached Iraq exhausted and dehydrated. MSF opened a medical centre in Kandala, at the border, to provide treatment and water as they arrived.

The refugees' mental health is also a priority for MSF's psychologists and psychotherapists, who have noted that symptoms have worsened compared to the previous year. In 2012, seven per cent of patients in the Domeez refugee camp had severe psychiatric disorders. This number has doubled in 2013, reaching 15 per cent.

New arrivals have been exposed to multiple traumas: they have witnessed violence or have been directly threatened; they have often lost members of their family or their homes. In



In the Domeez refugee camps, MSF teams provide approximately 2,500 medical consultations each week. © Julien Rey/MSF

addition, the lack of certainty about their future has an enormous impact on their psychological wellbeing. Last year, MSF provided over 60 mental health consultations each week.

Despite the general reduction in violence in Iraq, the Kirkuk Governorate remains a disputed territory subject to sectarian violence. On 19 April 2013, demonstrations in Hawijah, led by the Sunni community, deteriorated into open conflict with the Iraqi army and resulted in 53 deaths. The population's access to aid is hampered by violence and insecurity.

MSF has supported the neonatal department in Kirkuk hospital since the beginning of 2013. By providing training and direction, the teams bring technical expertise that will help the hospital to improve the quality of newborn care.

In Hawijah, MSF surgeons and anaesthetists support the hospital's emergency department which has a critical shortage of medical personnel. Together with local staff they carried out more than 300 surgical procedures per month in 2013.

**Reasons for intervention:** Armed conflict, social violence/healthcare exclusion

**Main activity:** Hospital care

**Emergency intervention:** Medical care for refugees

**In the country since:** 2007

**Human resources (FTE):** 199 staff including 25 international staff

**Cost for 2013:** CHF 7,218,000

### Susan's story – a Syrian refugee in Domeez

On 25 November 2013, Susan gave birth to twins in the Domeez refugee camp. She had arrived in Iraq the year before, at the end of winter, and had joined her husband who had fled from Syria at the start of the war to avoid forced recruitment into the army. They live with her brother's family in a part of the camp with brick buildings. A stove barely heats their living area where they also sleep. The roof is made of metal sheeting that her husband installed.

As she was pregnant with twins, it was planned for Susan to have the babies delivered in Dohuk hospital where all medical emergencies are sent. When the contractions started she called for an ambulance but it did not arrive in time. Her family called for the MSF midwife based in the camp to come. The birth was difficult and Susan lost a significant amount of blood. "If the midwife had not come, I would be dead," she said. The twins are called Arian and Vasterk. Baby Arian became ill due to the constant fumes from the heating, the cold and the difficult living conditions. He has a fever, asthma and is coughing. Teams from the MSF medical centre are providing him with treatment.

# KENYA

## Making humanitarian aid the priority in the Dadaab camps

In 2013, Kenya took in more than 625,000 refugees, of whom 483,390 had come from Somalia. The majority are housed in the six Dadaab refugee camps. These camps form the third largest city in Somalia, by number of inhabitants. Living conditions are extremely challenging. In August 2013, an MSF-led team found that half of the refugees interviewed did not have the means to keep their houses dry during the rainy season. One in ten said they did not have access to proper sanitation.

MSF provides medical healthcare to the 105,000 inhabitants of the Dagahaley camp, one of the six Dadaab camps. The teams run a 100-bed hospital and four health centres, from which over 215,600 outpatient consultations were provided during the year. In addition, 9,000 patients were hospitalised and 2,600 children were born in the maternity ward.

Although levels of severe malnutrition were not critical in 2013, the refugees' health continues to be gravely impacted by malnutrition. Reflecting this, more than half of the hospital beds were reserved for children suffering from malnutrition. More than 1,000 malnourished children required intensive care treatment in the hospital and 2,400 others received outpatient care. The MSF teams in Dagahaley hospital also provide treatment for HIV/AIDS and for tuberculosis. They conduct emergency surgical procedures and provide mental health consultations.

Due to the growing deterioration in security since the autumn of 2011, the majority of international organisations have had to reduce their activity in the Dadaab camps. Poor maintenance and lack of investment, with regard to hygiene and shelter in particular, are causing serious health issues and increase the risk of epidemics occurring. In January 2013,

MSF treated 2,350 cases of water-born diarrhoea, 900 more cases than last year.

Although MSF has continued to provide medical support in Dagahaley, we cannot guarantee a permanent presence of international staff. Whilst programmes were set out in 2013 to anticipate the voluntary return of hundreds of thousands of Somali refugees to their country, MSF continues to lobby authorities to ensure that this process is not at the expense of aid that will still be required for those remaining in the camps.

**Reason for intervention:** Armed conflict

**Main activity:** Medical care for refugees

**In the country since:** 2007

**Human resources (FTE):** 318 staff including 13 international staff

**Cost for 2013:** CHF 6,887,000

# KYRGYZSTAN

## Combatting tuberculosis – the new face of an old disease



Tuberculosis is one of the main public health issues in Kyrgyzstan. © Vincent Tremeau



Tuberculosis (TB) is one of the main public health issues in Kyrgyzstan. There are 9.4 million new cases and 1.7 million deaths declared each year, making TB one of the most deadly diseases in the developing world. The resurgence of TB has been dramatic and drug-resistant strains of the disease are spreading. In 2013, MSF launched a global campaign for better detection and treatment of drug-resistant tuberculosis.

MSF has worked in a Bishkek prison since 2006, where around 9,500 inmates are held. Cases of TB are 25 times higher in Kyrgyz prisoners than in the general population and the death rate is 60 times higher. Since the project began, MSF has provided more than 2,800 TB patients with treatment. We also provide treatment for chronic illnesses and screen and vaccinate for hepatitis

B. We follow up with former inmates that have TB, to encourage them to continue treatment once they have been released. In 2013, 170 inmates were receiving treatment in Bishkek.

In Osh, in the south of Kyrgyzstan, MSF supports the Kara Suu hospital, where more than 100 patients with multi-drug resistant tuberculosis were admitted this year alone. MSF tests patients for HIV, hepatitis B, hepatitis C and sexually transmitted diseases, since co-infections are common. In addition to providing direct healthcare services, MSF is responsible for the hospital's laboratory – where we identify drug-resistant forms of TB – and for the pharmacy and the treatment rooms. MSF, with the help of local healthcare providers, also offers an outpatient service so that

people can receive treatment at home. This pioneering form of treatment encourages patients to adhere to the full term of medication, as they are supported by their families and can continue daily life. As a result, hospitalisation is only required for patients with multidrug-resistant and extensively drug-resistant forms of the disease. We offer psychosocial support and help to both the patients and their families.

**Reason for intervention:** Endemic/epidemic disease

**Main activity:** TB

**In the country since:** 2005

**Human resources (FTE):** 129 staff including 17 international staff

**Cost for 2013:** CHF 3,796,000

# LEBANON

## Healthcare to meet Syrian refugees' needs

Since the Syrian civil war began in March 2011, Lebanon has taken in nearly one million refugees. The country is struggling to absorb this influx, having only four million inhabitants itself, and there are serious consequences on Lebanese society as a result: economic growth has declined; poverty and unemployment have increased; public services are overwhelmed; and political tensions have multiplied.

In 2013, MSF increased humanitarian efforts in various regions of the country. In the Bekaa Valley, the main point of entry for those fleeing Syria, the number of refugees continues to increase and reached 300,000 at the end of December. Access to housing remains one of the key issues and new arrivals live mainly in tents or in unfinished buildings. MSF provides basic and reproductive healthcare from four clinics. The teams also provide treatment for chronic illnesses such as hypertension and diabetes, which are very common in Syrian patients. MSF typically intervenes in emergency situations concerning infectious diseases but in order to respond to this specific situation, the organisation has had to adapt healthcare protocols that were initially developed to deal with chronic diseases in Europe and North America.

In 2013, the teams provided nearly 50,000 medical consultations in the Bekaa Valley, of which nearly 9,000 were for chronic illnesses. As winter loomed, we also distributed blankets, stoves and vouchers for fuel.

In Tripoli, where more than 50,000 Syrians are housed, MSF provides free healthcare to refugees, as well as to the Lebanese communities of Jabal Mohsen and Bab al-Tabbaneh. These two areas are opposed in a sectarian conflict that has been going on for several decades, but which has intensified during the past two years, mirroring the war in Syria. MSF works in the city hospital and in three health clinics. From here teams provide consultations in basic and reproductive healthcare, routine vaccinations and treatment for chronic illnesses. During the year, more than 40,000 medical consultations were completed. In order to focus resources where they are most urgently needed, MSF transferred its mental healthcare work to another international organisation in September 2013. MSF's psychologists provided more than 1,300 consultations before handing over the project.

The Ain al-Hilweh refugee camp in Saida is the largest in Lebanon. It was set up in 1948 and

houses 75,000 Palestinians. 40,000 more have since joined them, having fled camps in Syria where they were living. The new arrivals live with host families, rent rooms or settle in collective housing. Living conditions are difficult in the over-populated camp and mental healthcare needs have increased, as many refugees coming from Syria have seen members of their families killed or their homes burnt to the ground. Some have also been tortured.

MSF psychologists provided nearly 5,000 consultations in 2013. One third of the 800 newly enrolled patients had fled from Syria. In addition, over the year MSF strengthened the range of healthcare offered in the camp, taking charge of basic healthcare.

**Reason for intervention:** Social violence/ healthcare exclusion

**Main activity:** Medical care for refugees

**Emergency intervention:** Medical care for refugees

**In the country since:** 2008

**Human resources (FTE):** 127 staff including 21 international staff

**Cost for 2013:** CHF 7,785,000



Access to housing remains a major issue for Syrian refugees in Lebanon. New arrivals live mainly in tents or in unfinished buildings. © Aurélie Lachant/MSF

# MEXICO

## Managing the medical implications of violence

Mexico has the highest per capita income in Latin America; however, social and economic inequality is high. Rural areas are often neglected and are subjected to seasonal epidemics and poverty-related diseases such as Chagas disease, tuberculosis and cholera.

During the last 10 years, violence due to the war against drug trafficking and in-fighting between cartels has increased. It is estimated that 50,000 to 100,000 people were killed between 2006 and 2012. The violence is impacting every state institution and is causing the government to prioritise investment in internal security, to maintain order, at the expense of the health sector. The health system is overwhelmed and struggles to support the needs of the population.

In 2013, MSF set up a project in Nuevo Laredo, on the Texan border, which is the main commercial crossing point – both legal and illegal – into the United States. The town's inhabitants are at the forefront of the fighting between cartels wanting to control the region. MSF's objective is to strengthen the capacity of the hospital's emergency department, in particular by improving their triage system and transferring patients to the appropriate facility or department.

In parallel, MSF is lobbying the authorities to improve management of medical emergencies in situations where the level of violence threatens the local healthcare systems. A strong political will is needed to manage the medical implications of violence on the population.

MSF teams also remain ready to respond to emergency situations arising from the frequent natural phenomena of hurricanes, tropical storms and earthquakes, as well as to epidemics.

**Reason for intervention:** Social violence/ healthcare exclusion

**Main activity:** Hospital care

**In the country since:** 2013

**Human resources (FTE):** 3 staff including 2 international staff

**Cost for 2013:** CHF 327,000

# MOZAMBIQUE

## Adapting treatment for HIV/AIDS and complications from opportunistic infections



In January 2013, MSF launched an emergency intervention in Chokwe, which had been devastated by flooding. © MSF



Despite the political, economic and administrative reforms undertaken during the past decade, Mozambique is still faced with an extensive HIV/AIDS epidemic, food insecurity and natural disasters. There has been progress in the national response to the HIV/AIDS epidemic, but 53 per cent of HIV-positive people still have no access to antiretroviral drugs. We estimate that 1.6 million adults are living with the virus and it causes 40 per cent of the deaths in the country.

MSF works in collaboration with the Ministry of Health to provide patients with HIV/AIDS and tuberculosis access to complete and quality healthcare. MSF is developing adapted care by simplifying treatments, decentralising the follow-up of patients and influencing public health policy. In addition, MSF is developing services for the prevention of

mother-to-child transmission (PMTCT) by supporting option B+. This involves treating all pregnant women with antiretroviral drugs to prevent the virus' transmission from mother to child. It also aims to protect the long-term health of mothers, of any future babies, as well as HIV-negative partners.

MSF provides specialised healthcare in the capital Maputo. Our teams prescribe and hand out second- and third-line antiretroviral drugs when patients no longer respond to their initial treatment. They also treat opportunistic infections and complications such as Kaposi's sarcoma, cervical cancer or co-morbidities, in particular multidrug-resistant tuberculosis. In total, more than 27,000 patients received antiretroviral drugs in 2013 thanks to MSF.

In January, strong rains caused flooding in southern Africa. Mozambique was the worst affected country, with more than 250,000 people displaced, according to authorities. MSF intervened in and around Chokwe town, where the main hospital was submerged in water and mud and no longer functioned. MSF teams got activities running again, whilst ensuring continuity of care. MSF had provided over 23,000 consultations prior to April 2013.

**Reasons for intervention:** Endemic/epidemic disease, natural disaster

**Main activities:** HIV/AIDS, TB

**Emergency intervention:** Natural disaster

**In the country since:** 1992

**Human resources (FTE):** 156 staff including 18 international staff

**Cost for 2013:** CHF 4,275,000

# MYANMAR

## Treating vulnerable communities in Rakhine and Tanintharyi

Despite the recent opening up of Myanmar and its transition from military rule to democracy, the population still lacks basic human rights and suffers from decades of authoritarian rule. There is a high prevalence of infectious diseases in the country and access to medical healthcare is insufficient.

In Rakhine state, the situation between Buddhists and Rohingya Muslims remains very tense. Tens of thousands of people lost their homes during the tensions between the two communities in 2012. Today, those displaced still live in makeshift camps without access to healthcare, drinking water or essential supplies. MSF organises mobile clinics in the town of Kyauktaw and offers basic healthcare to the most vulnerable, irrespective of religion. In 2013, teams provided more than 7,000 consultations.

In addition, the HIV/AIDS and tuberculosis (TB) epidemics are causing a major public health emergency in Myanmar. Every year 15,000–20,000 individuals infected with AIDS die from opportunistic infections and more than 9,300 new cases of drug-resistant tuberculosis are detected. MSF has been one of the main providers of healthcare in the Tanintharyi region since 2000. New NGOs have taken over basic healthcare, which enabled our teams to withdraw from this activity in 2013 and to focus their efforts on HIV/AIDS and TB. This year, nearly 500 new HIV-positive patients received antiretroviral (ARV) medication. 3,200 existing patients already receive tri-therapy from MSF. Two hundred new patients also started treatment for TB.

At the end of December 2013, MSF teams were able to close the Insein prison project in

Yangon. The aim of this project was to integrate treatment for HIV/AIDS and TB into the general framework of medical care for all prisoners. MSF played a central role in convincing the government to provide specific treatment to prisoners. Since the beginning of the programme in October 2010, MSF has started 450 HIV-positive patients on ARV treatment and has worked to prevent and treat opportunistic infections, including 180 cases of TB.

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

**Main activity:** HIV/AIDS

**Emergency intervention:** Medical care for victims of violence

**In the country since:** 2000

**Human resources (FTE):** 137 staff including 12 international staff

**Cost for 2013:** CHF 3,022,000

# NIGER

## Prevent the deadly combination of malaria and malnutrition in young children



During the annual peak in malnutrition, MSF admits up to 150 children to hospital each day. © David Di Lorenzo/MSF



The nutritional situation in Niger worsened in 2013 and global malnutrition levels exceeded the emergency threshold set by the World Health Organisation (WHO). In Zinder and Magaria hospitals, two locations where MSF treats infant malnutrition, teams saw a considerable increase in the number of patients admitted. Nearly 13,000 malnourished children were hospitalised in a serious condition this year, up to 150 per day at peak times, and 19,000 received outpatient care in health centres.

In Niger, the seasonal peak in malnutrition coincides with the seasonal peak in malaria. The combination of these two illnesses is extremely dangerous, as malnutrition weakens children's immune systems, making it harder for them to fight off illness. Malaria causes anaemia, diarrhoea and vomiting, which in turn increases malnutrition. In 2013, MSF launched

a malaria prevention strategy to combat this deadly combination of illnesses. For the first time in Niger, MSF adopted seasonal malaria chemoprevention (SMC), targeting more than 100,000 children aged three months to five years in Magaria district. MSF teams also used this as an opportunity to screen each child for malnutrition.

In December, after three years of preparation, training and local capacity improvements, we handed back the nutritional rehabilitation centre in Zinder to the Ministry of Health. MSF will continue to provide backup support during seasonal malnutrition peaks.

MSF continued to support Malian refugees in two camps in the Tillabéry region, in the north of Niger, who had fled the conflict that broke out in Mali during 2012. This year, teams

provided more than 57,500 consultations, assisted 360 births and vaccinated thousands of children against measles. In May, MSF also responded to two cholera epidemics. Once the emergency had abated, MSF transferred our projects to other international organisations that had newly arrived to bring relief aid to the refugees.

**Reasons for intervention:** Armed conflict, endemic/epidemic disease

**Main activities:** Malnutrition and paediatric care

**Emergency interventions:** Malnutrition crisis, cholera outbreak, malaria outbreak, medical care for refugees

**In the country since:** 2005

**Human resources (FTE):** 455 staff including 24 international staff

**Cost for 2013:** CHF 8,933,000

# PHILIPPINES

## Emergency relief for typhoon victims

MSF provided emergency relief to disaster-stricken communities following the typhoon that struck the Philippines on 8 November 2013. According to official figures, typhoon Haiyan caused more than 6,000 deaths and displaced more than four million people. MSF Switzerland's teams were immediately active on the ground in the days following the disaster and brought relief aid to Panay and its surrounding islands, where 70 to 80 per cent of buildings had been destroyed by the typhoon.

Despite logistical hurdles, MSF teams concentrated efforts on health centres in the most remote areas. MSF organised mobile clinics on boats in order to reach villages on the islands that had yet to receive any help, and provided populations with medical consultations close to home. In Estancia, we rented a barge to enable teams to get close to the coast. Teams then used traditional boats to navigate between villages and more than 12,500 consultations were provided during three months.

MSF teams immediately integrated a mental health unit into the project to provide survivors

with psychological care. MSF psychologists provided more than 3,300 individual consultations and group therapy sessions in hospitals and clinics.

In order to help those who had lost everything in the disaster, MSF also distributed drinking water, food for 50,000 families, shelter, 10,000 hygiene kits and essential aid items. We organised vaccination campaigns against measles and polio on the islands, to protect 15,000 and 4,500 children respectively.

In the port of Estancia, a barge several hundred metres from the shore became detached. It crashed into the shore causing an oil slick and toxic emissions which threatened shoreline populations. MSF and other aid organisations set up a temporary camp to shelter more than 1,000 displaced people.

**Reason for intervention:** Natural disaster

**Main activity:** Natural disaster

**In the country since:** 2013

**Human resources (FTE):** 4 international staff\*

**Cost for 2013:** CHF 2,838,000

\* About ten employees were sent from headquarters to coordinate the emergency response. Several Filipino daily or voluntary workers, not reported here, assisted our expatriate teams.

### Cindy's story

*Cindy is a nurse in Estancia, a small town in the north-east of Panay Island, in the Philippines.*

"When we were alerted that the typhoon was arriving, I warned my family that I would help disaster victims in any way I could. I was stuck for four hours in the evacuation centre. The wind was so strong it ripped off the roof from the gymnasium opposite. When we could finally go out, the ground was strewn with trees and bits of roofing, aluminium leaves were still flying about.

We sutured numerous people, wounded by falling objects. There was no electricity in the centre and we worked all night by candlelight. I was so relieved to see my mother and brother were safe when they came to find me the next morning.

I am very sad for those who have lost relatives, friends and homes. Some will not have the means to survive: fishermen have lost their boats; farmers have lost their harvests. I know I am very lucky to be alive and to be able to help those in need."

*Cindy worked for MSF for several days after the typhoon struck, providing treatment in some of the most remote islands. For three months, teams went from village to village to help as many people as possible.*



MSF organised mobile clinics on boats in order to reach villages on islands that had not yet received relief aid. © Laurence Hoenig/MSF

# DEMOCRATIC REPUBLIC OF CONGO

Conflicts, epidemics and neglected diseases in the east of Congo



In Orientale province, MSF facilitates access to medical healthcare for those impacted by fighting and epidemics. © Tristan Pfund

Years of conflict and inadequacies in the health system have restricted access to medical care for the Congolese population. MSF is active in Orientale province, bringing humanitarian aid to the most vulnerable populations, in particular those impacted by conflict and by epidemics. Given the high number of emergencies in the region, a special team has taken charge of epidemiological surveillance and can respond in just a matter of hours.

In August, violent clashes for territorial control broke out in Ituri district between the government's Armed Forces of the Democratic Republic of Congo (DRC) and the local Front for Patriotic Resistance of Ituri. More than 100,000 people were forced to flee their homes as a result of the fighting. MSF immediately strengthened activities in Geti to help the displaced people. Teams treated water supplies, handed out plastic sheeting, blankets, soap and mosquito nets. MSF also set up two additional medical clinics near to the camps. We took charge of the surgical and maternity services in Geti hospital,

where MSF has run the intensive care and paediatric services since 2009, and operated on nearly 400 patients, of whom a quarter had bullet and knife wounds. We also preventatively vaccinated more than 42,000 children against measles.

Even though measles epidemics have occurred in DRC in the past, MSF is concerned by the increasingly virulent reoccurrence of the disease since 2010. The extent of the spread of disease was such that we provided an emergency response in 2013, specifically in Bas-Uélé where we vaccinated nearly 190,000 children and treated close to 30,000 patients.

In Ganga-Dingila and Ango, MSF runs a project to combat sleeping sickness: a neglected disease that is almost always fatal if left untreated. Mobile laboratories were set up in the villages in order to diagnose and treat patients with the disease. More than 73,000 people were screened in 2013 and more than 1,300 received treatment. Screening and treatment procedures for

this neglected disease are dated and inconvenient for patients. In the near future, rapid testing and oral treatment should significantly improve this. MSF is collaborating with the Drugs for Neglected Diseases initiative (DNDi), which is currently running clinical trials for sleeping sickness.

Although MSF will continue to work with SOFEPADI (Female Unity for Peace and Overall Development), a local NGO specialised in treating victims of sexual violence in Bunia, we will no longer provide financial help after 2013.

**Reasons for intervention:** Armed conflict, endemic/epidemic disease

**Main activities:** Neglected disease, emergency and paediatric care

**Emergency interventions:** Malnutrition crisis, measles outbreak, malaria outbreak, medical care for victims of violence

**In the country since:** 2001

**Human resources (FTE):** 542 staff including 62 international staff

**Cost for 2013:** CHF 16,615,000

# DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

After developing a common agreement with the government, MSF opened a programme in May

The collapse of the Soviet Union in the early 1990s meant that DPRK no longer benefited from regular assistance from its close ally. Moreover, international embargoes and UN sanctions, together with adverse climatic conditions, have resulted in insufficient energy supplies, chronic food insecurity and deteriorating services in all the areas, including medical care. In general, healthcare facilities are in need of continuous support. Drug shortages are common, traditional medicine (Koryo) is widely practised and disposable medical materials are reused.

However, medical assistance is not considered a top priority and most aid is steered toward self-sufficient food production, food aid and disease prevention strategies. Only a few international aid organisations are present in the country, and these face restrictions on their movements and on free access to patients.

In this unique context, MSF has employed an adapted approach. After a long absence in DPRK, MSF started working in the country again in 2012. From the beginning of 2013, MSF teams started to visit DPRK on a regular basis to upgrade some medical practices related to mother and child health in the district hospital of Anju, South Pyongan province. A memorandum of understanding was signed in May, outlining the framework of the collaboration between the government and MSF, and MSF's activities in the country.

In February a team travelled to DPRK to start updating the medical knowledge of staff by providing training. The first module covered was 'Management of dehydration and shock among children', and then in June the team returned to complete the second training module, 'Life support in obstetric services'. In October, the third module on

'Management of malnutrition, respiratory and neurological diseases among children' was completed.

The drugs and medical items related to the modules were provided during each visit, as well as food for the hospitalised patients, their care givers and the hospital staff. Follow-up monitoring and supervision was provided during field visits.

**Reason for intervention:** Social violence/ healthcare exclusion

**Main activity:** Medical training

**In the country since:** 2013

**Human resources (FTE):** 5 staff including 3 international staff

**Cost for 2013:** CHF 903,000

## SUDAN

Emergency situations and victims of conflict



In 2013, MSF responded to several epidemics in Sudan, provided treatment for kala azar and set up a reproductive health programme. © Asia Kambal/MSF

The Sudanese population has little access to medical healthcare, in particular in states such as Darfur and South-Kordofan where there is unrest. International humanitarian organisations continue to struggle to reach certain areas of the country and it is difficult to provide a rapid and adequate response to the populations in need.

In January, MSF continued to assist the Sudanese Ministry of Health in responding to a yellow fever epidemic that had broken out in Darfur at the end of 2012. Approximately 459,000 adults and children aged nine months and above were vaccinated. The teams also treated a total of 250 patients. MSF maintained a presence in three health centres near to the town of Al Geneina in case an emergency intervention was required.

Since 2010, MSF has been treating patients with kala azar (visceral leishmaniasis) in a

treatment centre in Gedaref state. In 2013, more than 450 patients received treatment in Tabarak Allah hospital. MSF teams also train local staff in Sennar state to diagnose and treat this neglected disease. It can manifest itself as a simple skin rash but can result in severe organ failure.

In July 2013, MSF diversified its activities in Tabarak Allah hospital and started a reproductive health programme. Teams manage obstetric emergencies 24/7, provide antenatal consultations to pregnant women and follow-up appointments for young post-partum mothers. MSF also refurbished and re-equipped the hospital's maternity ward and operating room.

Between March and May 2013, MSF's emergency teams responded to a measles epidemic that broke out in five communities in Gedaref state. More than 306,000 people were vaccinated and

nearly 900 received treatment. Teams also used this as an opportunity to screen 56,000 children for malnutrition.

Finally, MSF provided an emergency intervention following floods that affected more than 150,000 people in August. Teams handed out more than 228,000 litres of drinking water and provided nearly 600 medical consultations in Sharag Alniel, in the north of Khartoum state.

**Reasons for intervention:** Armed conflict, endemic/epidemic disease

**Main activities:** Neglected disease, reproductive health

**Emergency interventions:** Yellow fever outbreak, medical care for victims of violence

**In the country since:** 2004

**Human resources (FTE):** 122 staff including 11 international staff

**Cost for 2013:** CHF 2,782,000

# SOMALIA

## MSF forced to leave

In August 2013, MSF left Somalia, closing all medical programmes in the country. MSF has worked in Somalia since 1991, when the state collapsed and civil war broke out. After 22 years of conflict, violence remains a daily occurrence, the health system is dysfunctional and a large proportion of the population live in poverty.

The decision to pull out of the country was one of the hardest in the history of MSF. Armed groups and civilian leaders tolerated and supported the violent attacks against MSF and we were no longer able to ensure the minimum level of security required to continue our medical work in Somalia.

The withdrawal followed a long series of attacks against MSF staff, most recently the killing of two staff members in Mogadishu in December 2011, followed by the early release of their convicted killer, and the kidnapping of two volunteer workers from the Dadaab refugee camps in Kenya, who were held for 21 months in the south of Somalia and freed in July 2013.

Before the programmes were shut down, MSF Switzerland's teams were working in the capital city Mogadishu, where a paediatric hospital had been opened in 2011 to cope with the influx of displaced people fleeing drought, violence and the lack of medical healthcare in southern and central Somalia. During the first half of 2013, more than 3,000 children were treated under the outpatient nutrition programme, and 820 severely malnourished children had to be hospitalised. An additional 740 children received treatment in hospital for illnesses such as measles and acute diarrhoea.

In Afgooye, off the main highway to the capital, MSF supported a local community hospital. This health facility is the only one serving the inhabitants of Afgooye and the 180 surrounding villages. In 2013, MSF teams assisted with 950 births here. The teams provided nearly 11,400 medical consultations and 740 patients were admitted to hospital.

In Dinsor, in Bay province, our teams ran a 100-bed hospital and provided basic, obstetric

and nutritional healthcare, as well as treatment for tuberculosis (TB) and kala azar. More than 16,200 outpatient medical consultations were given prior to August 2013, and 1,220 patients were hospitalised. In addition, teams assisted with 650 births and admitted 170 new patients to the TB programme.

While MSF remains committed to addressing these tremendous needs through medical care and humanitarian assistance, all actors in Somalia must demonstrate through their actions a willingness and ability to facilitate the provision of humanitarian assistance to the Somali people and respect for the safety of the humanitarian aid workers who care for them.

**Reason for intervention:** Armed conflict

**Main activities:** Hospital care, medical care for displaced people

**In the country since:** 2002

**Human resources (FTE):** 184 staff including 8 international staff

**Cost for 2013:** CHF 4,206,000



# SOUTH SUDAN

Providing aid in an unstable region



In South Sudan, three quarters of the population do not have access to medical healthcare. © Jake Simkin/MSF

Multiple crises are evolving in South Sudan. Three quarters of South Sudanese do not have access to basic medical healthcare and 80 per cent of health facilities are run by non-governmental organisations. Despite officially declaring independence in July 2011, fighting continues in border areas and thousands of people have been displaced by the violence.

On 15 December, clashes broke out in Juba, the capital, between forces faithful to the president Salva Kiir and insurgents supporting the former vice-president Riek Machar. By the end of the month, fighting had spread to many areas of the country in particular to Bor, the capital of Jonglei state, in the centre of the South Sudan. More than 70,000 people, mainly women and children, fled the city and gathered around Aweril on the other side of the Nile in Lakes state. MSF's emergency team intervened in Mingkaman several days after the displaced people first set up camp.

MSF currently operates two clinics from which teams provide consultations, predominantly obstetric, and distribute medication. Our other priorities are to distribute drinking water to the displaced people and to provide preventative vaccinations against measles, cholera, polio and meningitis. MSF is one of the only medical aid providers in the camp. We are concerned that the dire living and hygiene conditions are increasing the risk of epidemics.

In November, before the arrival of the displaced individuals, MSF launched a mass vaccination campaign against measles in Jonglei. In the first round, 41,000 children aged between six months and five years were vaccinated.

In Agok in the North, MSF manages the only hospital that serves the Abyei region – a disputed territory with Sudan – and offers a reproductive and neonatal healthcare programme.

In September, in order to improve the quality of care, we constructed a new maternity building. MSF teams in the hospital also conduct emergency surgeries and run paediatric and nutritional therapy programmes. In addition, the hospital is the main HIV/AIDS and tuberculosis treatment centre for the region. Mobile clinics also visit remote local populations and provide consultations or refer patients to Agok hospital.

**Reasons for intervention:** Armed conflict, endemic/epidemic disease

**Main activity:** Hospital care

**Emergency intervention:** Medical care for displaced people

**In the country since:** 1996

**Human resources (FTE):** 305 staff including 33 international staff

**Cost for 2013:** CHF 9,066,000

## Mary Aluer's story – a midwife from Bor, who is now a refugee in Minkamann

*When fighting broke out in Bor, Mary was working in the hospital.*

"We knew there was fighting in Juba, but eventually it came to Bor too. It was total chaos. I can hardly remember what day it was. We heard gunshots near to the hospital and everyone started to run. Even the patients fled. Everyone panicked. Everyone scattered not knowing whether to hide or flee..."

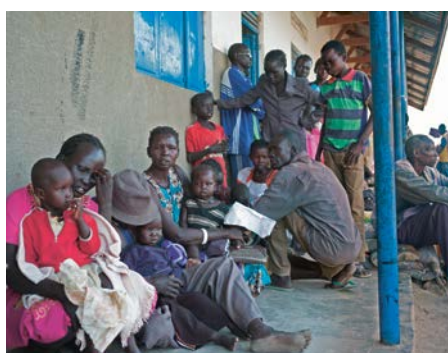
We heard people dying outside, so we headed for the bush, hoping things would calm down. But the

fighting kept going. So we went to the banks of the Nile and waited for a boat to take us up to the other side, where there was no fighting. There were bodies floating in the river, sometimes those of children.

When I arrived in Minkamann, there were loads of people who had taken refuge there already. So many women and children! The day after I arrived I came across a woman giving birth under a tree,

with her three children crying around her. I looked for somewhere more private to help her deliver her baby safely. This was not unusual. Many women give birth here in similar conditions.

I was not able to find my family before I left Bor. I did not have time. I have not received any news from them since and I just hope they were also able to escape."



In December, more than 70,000 people fled the conflict in Bor and gathered on the other side of the Nile in Minkamann. © Jake Simkin/MSF

## SWAZILAND

### Decentralising care: treating HIV/AIDS in the community

Public health in Swaziland clearly improved during the 1980's, in line with economic growth in the country. Sadly, this trend has been largely reversed by the HIV/AIDS and tuberculosis (TB) epidemics, which have reduced life expectancy from 60 to 39 years in less than ten years. MSF has operated in the Shiselweni region since 2007. It has taken six years to decentralise treatment for HIV/AIDS and TB from the cities to the most remote villages. Now, every person has access to the medical services that they require.

MSF is working on the prevention of opportunistic infections, which are often fatal to HIV-positive patients, and also to ensure that treatment is adhered to. We offer essential psychosocial support for those undergoing a lifetime of treatment. In total, more than 17,200 HIV/AIDS patients were receiving first-line antiretroviral treatment in

2013, of whom eight per cent were children under 16.

Since our intervention began, MSF's strategy has been to treat HIV/AIDS and TB simultaneously. In 2013, we took on 850 TB patients. We pay particular attention to drug-resistant cases. This year 185 patients were admitted to the 30-bed treatment centre which was built in 2011 by MSF in Nhlengano. Patients who are unable to attend clinics on a daily basis receive decentralised care, including prescribed injections each day by members of the community.

In order to increase access to laboratory testing for TB, mini-labs have been set up in primary healthcare clinics. Samples for diagnosing drug-resistant TB across the Shiselweni region are now sent to Nhlengano for testing.

MSF has rolled out a preventative programme for mother-to-child transmission of HIV/AIDS (PMTCT B+), under which pregnant women are pro-actively tested and offered antiretroviral drugs early in their pregnancy. The aim is not only to prevent transmission of the virus from mother to child, but also to ensure the mothers' long-term health and to protect any future babies from being infected, as well as HIV-negative partners.

More than 300 women underwent treatment following their antenatal consultations in 2013.

**Reason for intervention:** Endemic/epidemic disease

**Main activities:** HIV/AIDS, TB

**In the country since:** 2007

**Human resources (FTE):** 310 staff including 25 international staff

**Cost for 2013:** CHF 7,749,000

# SYRIA

## Emergency medical aid

Syria is in ruins after three years of extreme violence. Entire towns and villages have been destroyed by war, including hospitals and health clinics. Emergency healthcare needs continue to accumulate: there is no maternity healthcare; no vaccinations are available; patients with burns, chronic illnesses, gunshot and shrapnel wounds are left untreated. The health system, which operated well prior to the conflict, has been completely wiped out in certain areas. Millions of Syrians have no other choice than to turn to makeshift clinics in cellars and houses to obtain limited healthcare.

An MSF team has been supporting the accident and emergency department of

a hospital in Al-Hasakah Province, in the northeast of Syria, since July 2013. Between September and December, 160 patients received emergency care there.

In addition, MSF helped local staff put contingency plans in place to deal with the influx of wounded. We also donated medicines.

Al-Hasakah Province is a transit zone for anyone trying to flee to Iraq. In 2013, 150,000 Syrians crossed the border, even though it was periodically closed. In August, after three months of closure, 60,000 people crossed the border in the space of a couple of weeks. In order to bring urgently needed aid to individuals waiting on the Syrian side

of the border to enter Iraq, MSF set up a unit from which to distribute water and essential aid items. The teams also provided medical healthcare services. More than 3,000 medical consultations were given in 2013.

**Reason for intervention:** Armed conflict

**Main activity:** Hospital care

**In the country since:** 2013

**Human resources (FTE):** 65 staff including 12 international staff

**Cost for 2013:** CHF 2,607,000



Medical needs in Syria requiring urgent care continue to escalate, including treatment for bullet wounds, maternal healthcare, vaccinations, burns and chronic illnesses. © Robin Meldrum/MSF

## Zeina and her family's journey

*A report from MSF's border unit*

"We have come from Tel Brak in Syria. Seven months ago we had to flee our home as fighting had broken out in the area. Everyone in our village fled. We lived for seven months in the mountains, but we had nothing: no shelter, money or food... When we finally decided to cross the Iraqi border, it was closed and we had to stay in a school. We left as soon as we heard that the border had reopened again. We are so relieved to be in Iraq at last!"

# CHAD

## Focus on paediatrics, malnutrition and vaccinations

After years of violence, power struggles and coups, Chad is now experiencing a period of peace. However, this relative calm is threatened by heavy militarisation in the region and by the fighting in Darfur and the Central African Republic. Despite government commitment to invest in healthcare and education, the medical system still has a huge shortfall of human resources and materials. Health indicators are extremely poor, in particular for rural populations and vulnerable groups such as women, children and refugees.

In 2013, MSF had to respond to several epidemics. In July, the Massakory region was struck by a large increase in cases of malaria. MSF supports the district hospital's paediatric service in Massakory and our teams treated more than 40,000 children with malaria. In May, July and November, MSF also organised vaccination campaigns against measles in the

Guéréda, Ouaddaï and Iriba regions. In total, more than 432,000 children were vaccinated and patients received care in treatment centres that we set up.

In Massakory hospital, MSF manages paediatric emergencies, as well as malnutrition. In 2013, we provided more than 3,000 medical consultations to children aged 15 or under, and more than 1,800 were hospitalisations in the intensive nutritional rehabilitation centre. Nearly 4,000 other children, whose nutritional state was less severe, received treatment through the outpatient programme. In parallel, MSF undertook a prevention campaign against diarrhoeal diseases, which are one of the main causes of death in young children, by focusing on sanitation issues.

At the end of the year, MSF handed over the obstetric fistula programme in Abéché to the

Ministry of Health. Fistulas stem from complicated pregnancies and result in tears between the bladder and vagina or rectum. This causes incontinence, and results in social stigma. Since this project began, MSF has conducted 960 surgical procedures rehabilitating patients' urinary and faecal functions and female genital organs. MSF will continue to provide support for the first six months of 2014, to help facilitate the transfer to the government and maternal health actors.

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

**Main activities:** Malnutrition and paediatric care

**Emergency interventions:** Measles outbreak, malaria outbreak

**In the country since:** 2006

**Human resources (FTE):** 406 staff including 31 international staff

**Cost for 2013:** CHF 9,095,000

# HUMAN RESOURCES

MSF Switzerland employed 4,361 people in the field in 2013. Some 917 expatriate staff were deployed from Geneva, of whom 350 were sent on emergency interventions, in particular to Syria and the Democratic Republic of Congo. We employed 192 people in our Geneva headquarters and we plan to remain at this headcount. We also benefited from 2,031 hours of voluntary work. These voluntary contributions are not included in our operating accounts, under MSF Switzerland's accounting principles. There were more than 100 different nationalities working in our organisation this year.

We completed our review of policies and expatriate employment terms in 2013 and will implement changes from July 2014. The new policies demonstrate our understanding of the value of volunteering and of commitment to our organisation. The policies will enable us to offer long-term contracts to volunteers and for them to alternate between missions, training and rest periods. We believe that these measures will facilitate greater involvement and will keep specialised and experienced staff for the longer term, whom we need in the ever-increasingly complex situations in which we work. Recruiting and placing new personnel is a real challenge in programmes such as the fight against HIV/AIDS and tuberculosis, for which medical specialisation and professional experience are essential, or in countries where we cannot guarantee security. These policies will help us to improve living conditions for our expatriate staff (more frequent trips home, allowing families to travel together, etc.) in missions where security is a constraining factor.

In 2013, we consolidated our training programmes to help international and local staff strengthen and acquire new skills. We have considered how best to ensure gender diversification within our teams, to promote internal mobility and to re-deploy staff between missions in emergency situations. These work-streams will conclude in 2014 and will be included in MSF Switzerland's Human Resources policy.

I would like to extend heartfelt thanks to our whole "HR community": to our volunteers; to those working on the "Peer Support Network" project in Switzerland run by former MSF volunteers; to our interns, and to everyone who assists out in the field and in headquarters.

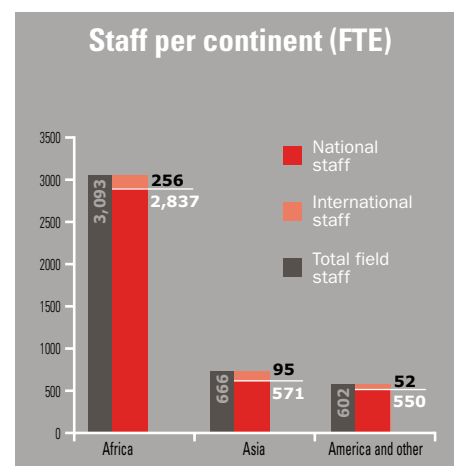
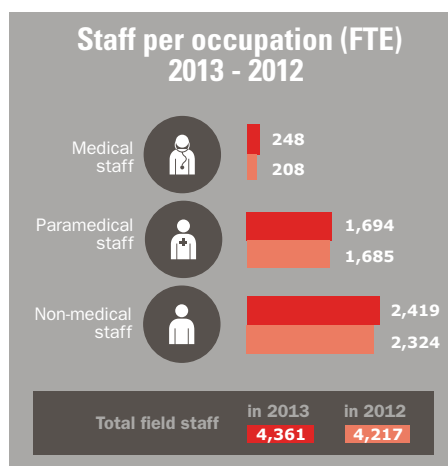
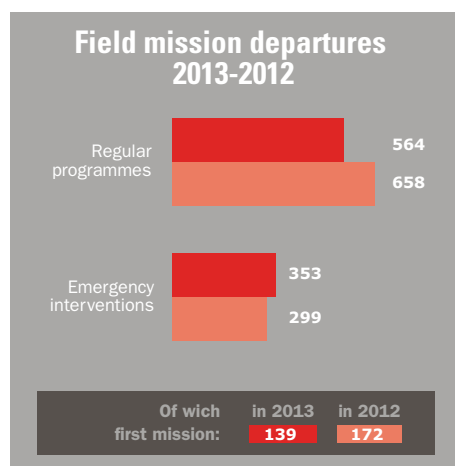
Franck Eloi, Director of Human Resources

**4,361**  
field staff

**192**  
headquarters staff

**2,031**  
hours of voluntary work

*All figures provided in this report represent full-time equivalent (FTE) positions*



# FINANCIAL RESULTS

In 2013, expenses remained stable whilst revenues increased significantly and we finished the year with a CHF 16m profit and strong cash reserves.

**Total expenses** for 2013 rose to CHF 163m. This was 3% higher than in 2012.

**Programme costs** rose 1% compared with 2012 to CHF 122m. The volume of operations has remained relatively flat during the past four years.

The budget allocated to regular projects decreased by CHF 2.5m, due to the closure of projects at the end of 2012 and the handover of our mother-and-child healthcare project in Conakry to the Guinean Ministry of Health. The budget also decreased due to the MSF movement's decision to pull out of Somalia and the security issues that now require we run our project in the Dagahaley camp for Somali refugees, in Kenya, with no permanent expatriate staff. This decrease was partially offset by new projects, in particular the paediatric healthcare project in Kirkuk, Iraq, and the medical training initiative in Anju hospital, in the Democratic People's Republic of Korea.

The budget for emergency operations increased by CHF 5m, reflecting the intensification of the Syrian crisis, for which we needed to send additional resources to respond in Lebanon, Iraq and Syria – we allocated CHF 12m to this specific crisis in 2013. This year was a significant one for emergencies: 31 interventions took place, costing CHF 30m. The main emergencies to which we responded were the measles epidemic in the Democratic Republic of Congo (DRC), Syrian refugees in Iraq and typhoon Haiyan in the Philippines.

This year, once again, we mobilised the largest number of resources in the DRC, representing CHF 17m of annual costs. This was followed by Chad, Sudan and Niger.

In line with MSF's solidarity procedures, MSF Switzerland also allocated CHF 5m to projects run by other **MSF operational centres**: CHF 4.5m to the Barcelona operational centre, which required additional financing, and CHF 0.4m to the Amsterdam operational centre's response to typhoon Haiyan.

Expenses related to our **Geneva Headquarters**, excluding fundraising, increased by CHF 2.2m (+8%), mainly due to an increase of CHF 1.9m in operational support expenses for training and strengthening the medical department and support staff on the ground. Reporting expenses increased by CHF 0.2m, primarily for communication on Syria and the Philippines. Administrative and management costs remained stable.

**Fundraising costs** also increased by CHF 0.9m (+13%) due to campaigns related to the Syrian crisis and typhoon Haiyan, as well as initiatives to acquire new financial donors.

**Contribution costs** related to the MSF International Office and MSF Switzerland's delegated offices (Prague, Seoul, Mexico) increased by CHF 1m (+31%).

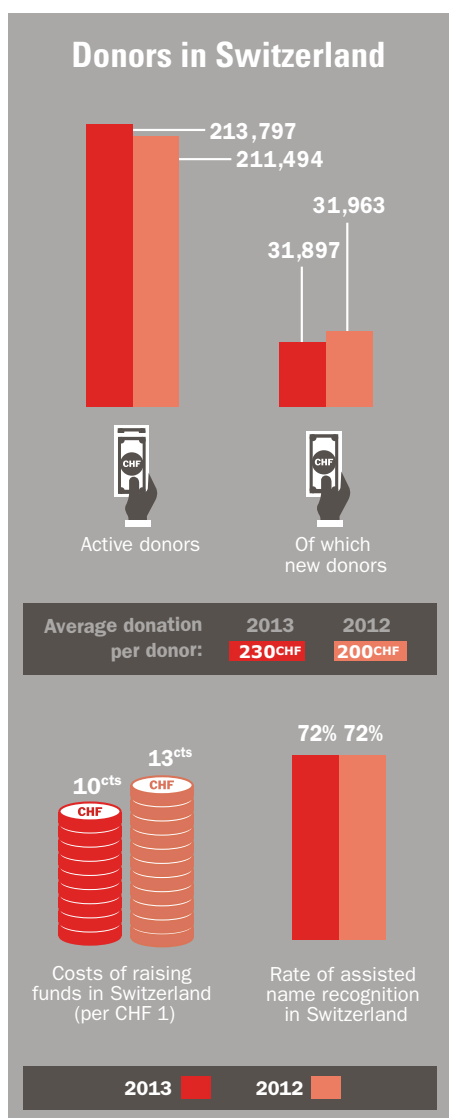
In 2013, **89% of expenses were allocated to MSF's social mission.**

**Revenues** declined by CHF 4m compared with 2012. However, if we exclude the exceptional CHF 26m donation received in 2012, we note that revenues actually increased by CHF 22m in 2013.

This increase is mainly due to **excellent fundraising results in Switzerland**, where CHF 83m was raised this year. This is a 26% increase on last year, excluding the exceptional donation in 2012, and is the largest amount of funds ever raised by MSF Switzerland. It can mainly be explained by generous donations for the Syrian and Philippine emergencies, resulting in CHF 15m of increased revenues. This was also a record year for gifts and bequests from private organisations. However, the growth of regular donors was weaker than expected and the acquisition of new funding is difficult. Had these emergencies not occurred, the number of active donors would most likely have decreased.

In 2013, MSF Switzerland received CHF 70m of **funding from other MSF partner sections**, representing 40% of total income. This contribution was stable compared with 2012.

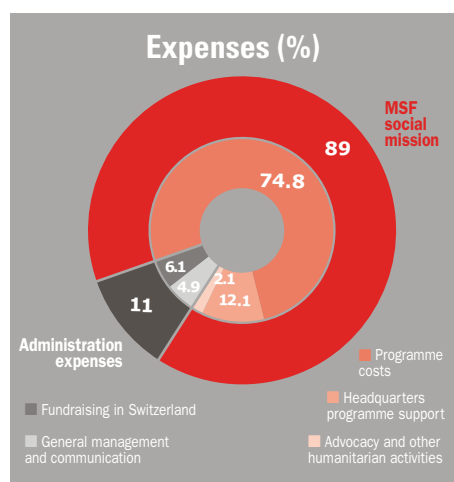
**Funding from public institutions** increased by CHF 4m in 2013, reaching CHF 22m, which was 18% higher than in 2012. We would highlight that MSF Switzerland signed a financial



Active donors are those who made at least one donation to MSF Switzerland in the year just ended. New donors are those that supported MSF Switzerland's action for the first time in the past year.

The ratio "Costs of raising funds in Switzerland" relates the total amount of funds raised during the year (including the change in deferred donations) to the total of the fundraising expenses.

The assisted name recognition rate is assessed each year by the GFS research institute; it measures the percentage of people questioned that responded "MSF" to the question: "Which NGOs on this list are you familiar with?"

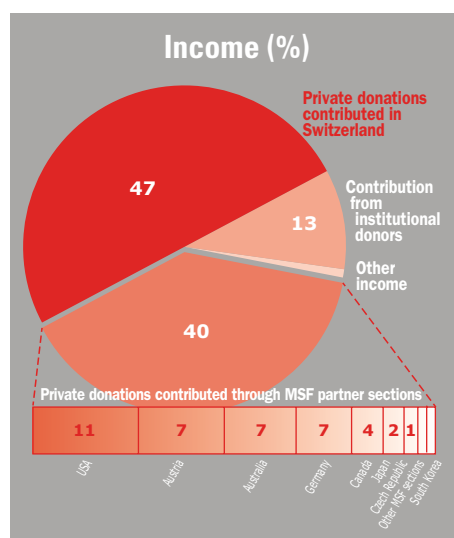


agreement for CHF 24m with SDC, The Swiss Agency for Development and Cooperation, for the 2013–2016 period.

The **dedicated fund**, set up with the 2012 exceptional donation, deferred CHF 20m of revenue for future operations. CHF 6m of the fund was used in 2013 and CHF 14m remains for future years. In addition, we received CHF 2m more than was spent in 2013 for the typhoon Haiyan response. This amount has been deferred to 2014.

MSF Switzerland closed the year with a CHF 16m **profit**, which represents a cash reserve equivalent to 7.8 months of activity. The reserves are essential to preserve our operational readiness and independence, as well as to ensure medical commitments for our patients are met, factors that define MSF Switzerland.

**We would like to thank the 213,787 donors** in Switzerland who responded to our fundraising campaigns in 2013. Thanks also to the thousands of others who finance our operations through gifts to MSF partner organisations. We would also like to thank the Communes, Cantons and Confederation of Switzerland, as well as the foreign governments that provide financing for our operations.



Geneva, 3 May 2014

Ralf de Coulon  
Treasurer

Emmanuel Flaman  
Finance Director

## EXPENSES AND REVENUES BY PROJECT FOR THE YEAR ENDING 2013

(in thousand Swiss francs)

PROJECT-ASSOCIATED EXPENSES		RESTRICTED SOURCES OF FUNDING			
PROJECTS	Total	Public sector grants	Private grants	Other revenue	Total
Cameroon	2,527	0	1,907	20	1,927
Congo (DRC)	16,615	4,975	9,088	108	14,170
Guinea	3,309	332	2,680	2	3,013
Kenya	6,887	124	6,286	2	6,412
Mozambique	4,275	0	4,035	39	4,074
Niger	8,933	2,303	5,343	2	7,648
Somalia	4,206	0	4,082	0	4,082
South Sudan	9,066	3,405	3,217	15	6,637
Sudan	2,782	651	1,434	5	2,090
Swaziland	7,749	523	5,534	29	6,086
Chad	9,095	2,460	5,499	8	7,967
Other	1,713	115	92	44	252
<b>TOTAL AFRICA</b>	<b>77,159</b>	<b>14,888</b>	<b>49,197</b>	<b>274</b>	<b>64,359</b>

PROJECT-ASSOCIATED EXPENSES		RESTRICTED SOURCES OF FUNDING			
PROJECTS	Total	Public sector grants	Private grants	Other revenue	Total
Korea (DPRK)	903	0	579	4	584
Iraq	7,218	0	6,926	11	6,936
Kyrgyzstan	3,796	0	3,445	49	3,493
Lebanon	7,785	0	7,620	100	7,719
Myanmar	3,022	914	1,741	24	2,679
Philippines	2,838	167	2,671	0	2,838
Syria	2,607	467	2,133	7	2,607
<b>TOTAL ASIA</b>	<b>28,169</b>	<b>1,548</b>	<b>25,115</b>	<b>194</b>	<b>26,857</b>
Honduras	1,730	247	957	16	1,220
Haiti	8,524	2,347	6,139	16	8,502
Other (incl. Mexico)	346	0	-46	0	46
<b>TOTAL AMERICA</b>	<b>10,600</b>	<b>2,594</b>	<b>7,143</b>	<b>32</b>	<b>9,769</b>
Others	1,451	2	402	33	433
Financing other MSF sections projects	4,732		0		0
<b>TOTAL</b>	<b>122,111</b>	<b>19,028</b>	<b>82,190</b>	<b>533</b>	<b>101,751</b>

# ACKNOWLEDGEMENTS

**We are grateful to all the donors who made the work of MSF possible in 2013. Last year, 213,787 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:**

- CARE
- CIDA – Canadian International Development Agency
- DANIDA – Danish International Development Agency
- ECHO – European Community Humanitarian aid Office
- Ministry of Foreign Affairs, Germany
- Ministry of Foreign Affairs, Norway
- Ministry of Foreign Affairs, Czech Republic
- NORAD – Norwegian Agency for Development Cooperation
- Solidarités International
- 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 foundations, organisations, companies, cantons and cities:**

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- The Swatch Group SA
- UBS Optimus Foundation
- Ville de Genève

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- Argramat SA
- Avadis Vorsorge AG
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- Baumer Electric AG
- Berner Augenklinik am Lindenhofspital
- Binder Rechtsanwälte
- Blaser Swissslube AG
- Bolliger & Mabillard
- Breitling SA
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- Büchi Labortechnik AG
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- Commune de Cologny
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- Commune de Meyrin
- Commune de Plan-les-Ouates
- Commune de Satigny
- Commune de Troinex
- Commune de Vernier
- Commune de Vevey
- Commune de Veyrier
- Compass Asset Management SA
- Consa Treuhand AG
- Couvent Ste.Ursule de Sion
- Delphin Teamwork
- DEMO Scope AG
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- Fondation Hubert Looser
- Fondation Johann et Luzia Graessli
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- Fondazione Pro Dimora
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- Gebrüder Kägi Stiftung
- Gemeinde Baar
- Gemeinde Belp
- Gemeinde Küsnacht
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- Gemeinde Nürensdorf
- Gemeinde Reinach
- Gemeinde Wallisellen
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- Hapmed AG
- Heguka Stiftung
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- Ivoclar Vivadent AG
- Jean Wander Stiftung
- Jürg Walter-Meier-Stiftung
- Kanton Aargau
- Kanton Appenzell Ausserrhoden
- Kanton Basel-Landschaft
- Kanton Graubünden
- Kanton Schaffhausen
- Kanton Thurgau
- Karelsie Stiftung
- Karlsbader Wochenenden
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- Praxis Brunnenhof
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- Projet Luciana Life
- Promotor Stiftung
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- Provisa AG
- Proxilab analyses médicales SA
- ProXit AG
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- Schiller AG
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- T2B AG

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- The Kozuki Trust
- The Tanner Trust
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- Trafag AG
- Trollship SA
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- Zurich Film Festival

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- Viola Bingler

Thank to our  
**213,787**  
donors

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

# STRUCTURE AND GOVERNANCE OF MSF SWITZERLAND

Created in 1981, Médecins Sans Frontières Switzerland is an association registered under Swiss law. It is governed by statutes, the latest version of which was published in June 2012.

The General Assembly is the supreme authority of MSF Switzerland. The General Assembly elects the members of the Board of Directors, approves the activity and financial reports as well as the financial statements, and deliberates on all matters indicated on the agenda.

## MSF Switzerland Board of Directors in 2013

- |                                    |                                     |
|------------------------------------|-------------------------------------|
| - Dr Abiy Tamrat, President        | - Dr Philippe Sudre (from May 2013) |
| - Dr Thomas Nierle, Vice President | - Nicolas Cantau                    |
| - Ralf de Coulon, Treasurer        | - Jean-Christophe Azé               |
| - Dr Slim Slama, Secretary         |                                     |
| - Olivier Antonin                  | Co-opted members:                   |
| - Dr Karin Hartmann                | - Dr Karim Laouabdia                |
| - Dr Joanne Liu (until May 2013)   | - Fiona Terry (until May 2013)      |

The Board of Directors is in charge of managing and supervising MSF Switzerland. It decides on the strategic direction, the action plan and the annual budget of the association. The Board of Directors has set up a Financial Commission, made up of Board members and experts from outside the Board. The Commission is tasked with assisting the Board of Directors in its supervision of the financial management of MSF Switzerland.

## MSF Switzerland Financial Commission in 2013

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|--|--|
| - Ralf de Coulon, MSF Switzerland Treasurer, President of the Financial Commission | - Norbert Beckhaus, MSF Germany Board Member     |
| - Dr Abiy Tamrat, MSF Switzerland President  | - Peter Lamatsch, MSF Austria Board Member       |
| - Olivier Antonin, MSF Switzerland Board Member                                    | - Hans Isler, Financial Expert (from April 2013) |

The Board of Directors appoints a General Director, who is in charge of carrying out the Board's decisions and managing MSF Switzerland. The General Director is assisted by a management team, made up of eight directors.

## MSF Switzerland Management Team in 2013

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|--|--|
| - Bruno Jochum, General Director                 | - Emmanuel Flamand, Finance Director                           |
| - Dr Jean-Clément Cabrol, Director of Operations | - Béatrice Godefroy, Deputy General Director (until June 2013) |
| - Jean-Luc Castell, Logistics Director           | - Susanna Swann, Deputy General Director (from September 2013) |
| - Dr Eric Comte, Medical Director                | - Laurent Sauveur, Communication and Fundraising Director      |
| - Thang Dao, Information Systems Director        |  |
| - Franck Eloi, Director of Human Resources       |  |

The statutory auditors elected by the General Assembly perform the yearly audit of MSF Switzerland's financial statements. Ernst & Young SA, Geneva, has been the statutory auditor since 2002. In 2013, for good practice purposes, MSF Switzerland invited bids in order to choose new statutory auditors for 2014. Their appointment will be endorsed by the General Assembly in May 2014.

## Risks assessment

Since 2008, MSF Switzerland annually assesses strategic, operational and financial risks which could affect the organisation. The assessment is led by the management team of MSF Switzerland and approved by the Financial Commission and the Board of Directors. It analyses risks related to the environment in which MSF works, internal processes, information and available data. For every identified risk, reduction measures are taken.

The analyses completed at the end of 2013 highlighted several risks in specific fields such as staff security, medical practice, management of change and development of legal framework in the countries in which we work.



## 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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