



MSF Switzerland  
Activity Report  
2014

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 30 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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## IMPRESSUM

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Thomas Nierle,  
President of MSF Switzerland

Looking back at 2014, one can only emphasize the extraordinary level of simultaneous crises this year, and the growing number of people facing acute needs. MSF mobilised its teams once again in an environment where slow and inadequate response was unfortunately largely predominant. While conflict spread significantly in the Middle East, in South Sudan, in northeast Nigeria and in Ukraine, an Ebola epidemic of historic proportions broke out in West Africa, deeply impacting Guinea, Sierra Leone and Liberia.

In the face of these tragedies, insufficient effective assistance combined with closed border policies by European countries, added to the vulnerability of many seeking refuge. The drowning in the Mediterranean of thousands of people hoping for a better life is one of the terrible consequences of the lack of human solidarity we have glimpsed this year.

In many countries, the most vulnerable populations are being sealed off from any significant assistance, usually due to direct political decisions but also due to levels of violence. This is the case in many regions of Syria and Iraq – due to the positioning of the Syrian government and to the rise of the Islamic State organisation as a military and political force – in northern Sudan, in Eritrea and North Korea. For millions of people, the lack of aid is combined with an absence of witnesses.



Bruno Jochum,  
General Director of MSF Switzerland

While the situation on the ground and our own choices have pushed us to focus more on emergency medical assistance and the security of our teams, we need, more than ever, to maintain some distance so that we can look at our practices objectively and have sufficient space to think critically about our role, our opportunities and our limits. In particular we need to look at the impact the work we are doing is having on the people we are aiming to assist. The ability to ally both action and reflection is one of the most valuable features of MSF as a humanitarian association and it ought to be precious preserved and developed.

Many of the trends our teams observe in the field – including the wide gap between emergency needs and the capacities of response, the bureaucratic practice of aid, the lack of action in the face of an international public health crises like Ebola – should lead MSF to even stronger positioning towards external actors and encourage us to confront and move beyond our own traditional limitations. Which responsibilities do we want to affirm in the future and with which capabilities? Which medical assistance do we want to aim at in the coming years? How can we improve our ability to work in highly insecure contexts where radical non-state armed groups are present? These are some of the questions we will have to answer when working on our strategic choices for the coming years.

The price paid by our staff in the field has been very heavy this year and to mention just the most critical events: 14 MSF staff members died after becoming infected with Ebola while dedicating themselves to the response; three colleagues from Amsterdam Operational Centre were murdered by an armed group in Boguila, Central African Republic. In Syria, 13 staff of the Belgian section were abducted in January and the five international ones were kept for several months before being released; finally, three of our colleagues from MSF France have been missing in the Democratic Republic of Congo since July 2012. We pay tribute to and remember each of them.

Thousands of other MSF staff at large have worked their hardest, in stressful conditions, to try and alleviate the suffering of those most in need, and these people deserve the association's full recognition and support.

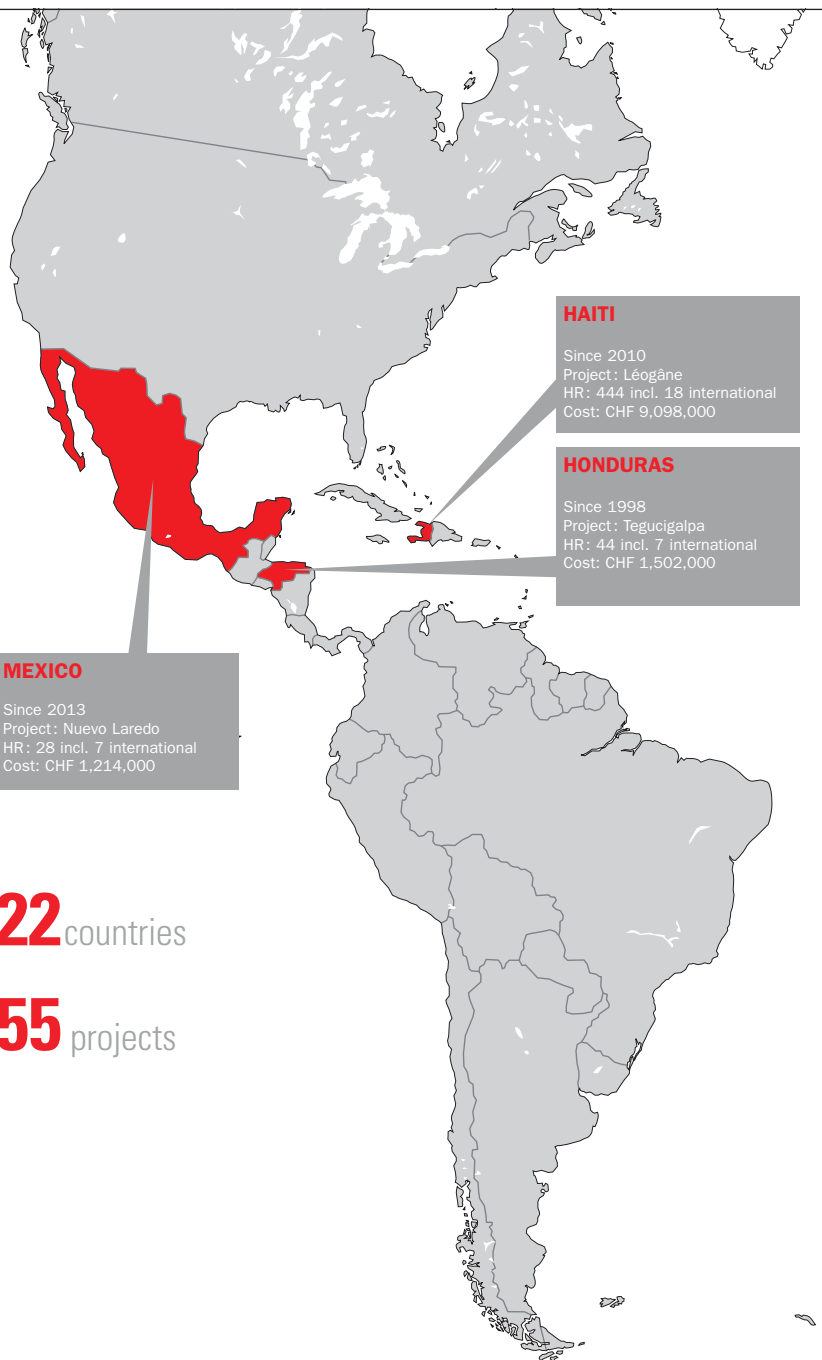
We would also like to thank each of you for your constant commitment and support, without which our work would not be possible. You enable us to make a real difference in the lives of our patients.

Thomas Nierle,  
President of MSF Switzerland

Bruno Jochum,  
General Director of MSF Switzerland

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**22** countries

**55** projects

JANUARY

South Sudan: Emergency intervention for displaced people in Minkaman.

MARCH

Guinea: The Ebola epidemic is officially declared and MSF open the first management centre in Guéckédou.



©Helmut Wachter/13photo

JUNE

Iraq: Adapting our programmes to respond to the needs of the civilians displaced by the movement of the Islamic State militants.

JAN 2014

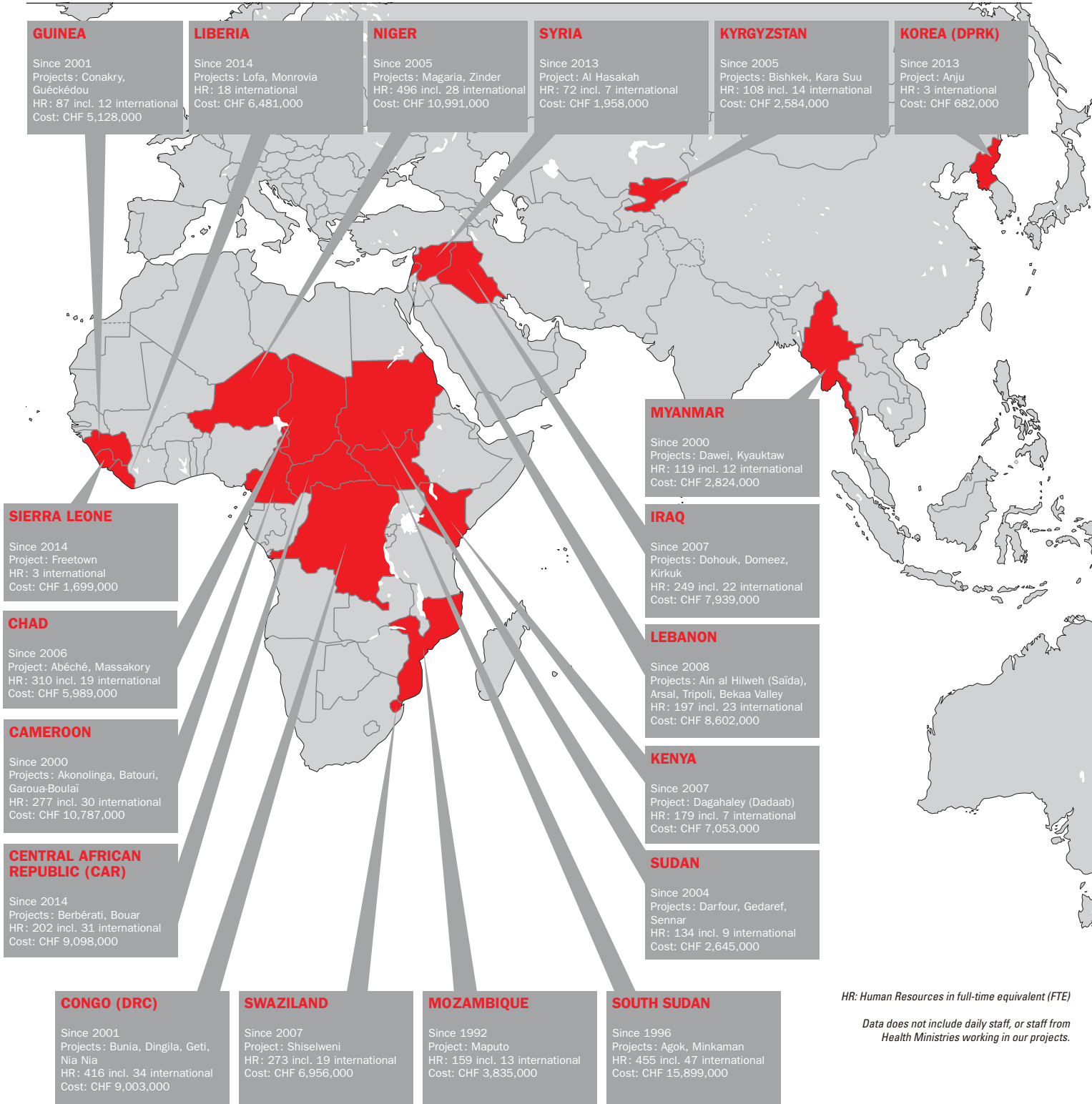
CAR: Intervention in Berbérati and Bouar at the height of the fighting and setting up programmes for refugees in Cameroon.

Myanmar: Mobile clinics in Rakhine state are stopped following attacks on international organisations.

DRC: Intervention following an upsurge of violence in Nia Nia.

Kyrgyzstan: Handing over our TB programme in Bishkek prison.

MAY



HR: Human Resources in full-time equivalent (FTE)

Data does not include daily staff, or staff from Health Ministries working in our projects.

**JULY**

**Chad:** Seasonal malaria chemoprevention campaign in Massakory region.



© Favlia Escobio /MSF

**SEPTEMBER**

**Ebola:** The MSF president addresses the United Nations for the governments to take their responsibility in front of this unprecedented epidemic.



© Sylvain Cherkau/Cosmos

**DEC 2014**

**Ebola:** The epidemic in West Africa is spiraling out of control and state of emergency is declared in Guinea, Liberia and Sierra Leone.

**AUGUST**

**Syria:** Mobile clinics for displaced people at the Iraqi border.

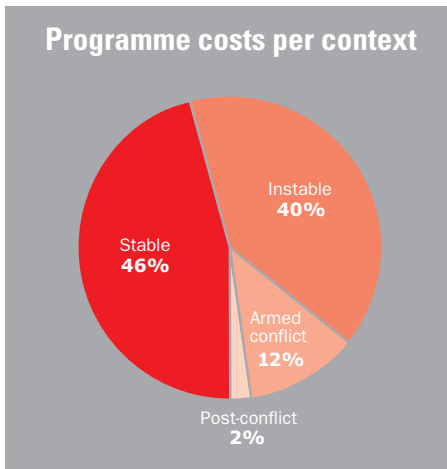


© Martin Zingg/MSF

**DECEMBER**

**Liberia:** Closure of the Ebola management centre in Foya, 42 days after the release of the last patient.

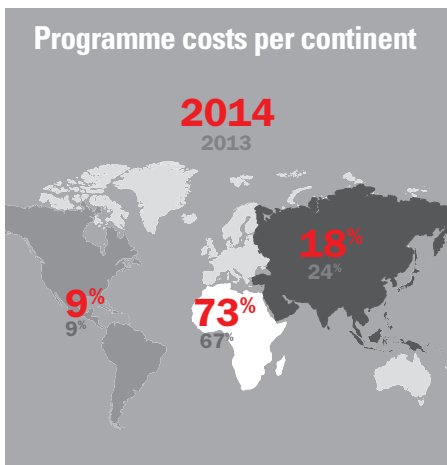
## 2014 IN REVIEW



Responding to a large number of concurrent crises, MSF had to work actively on all fronts in 2014: from massacres in the Central African Republic, to the historic Ebola epidemic in West Africa, not forgetting the continued war in Syria and regional destabilisation in the Middle East caused by the rise of the Islamic State (IS) organisation in Iraq. In a climate where relief responses by aid organisations are proving inadequate, MSF questioned its role and its limits more than ever before. This year, MSF Switzerland carried out, 55 medical projects in 22 countries.

### EBOLA: PUSHED BEYOND OUR LIMITS<sup>1</sup>

In March 2014, in order to tackle the Ebola epidemic that started in Guinea and spread rapidly to Liberia and Sierra Leone, MSF Switzerland and the Brussels Operational Centre set up a joint medical project of unprecedented scale. During the year more than 1,300 international staff members from all MSF sections and 4,000 national staff were deployed to West Africa. They cared for nearly 5,000 people suffering from Ebola. More than 2,300 were cured and could return home, each of them being celebrated as a true victory over the disease.



This Ebola epidemic was the most deadly in history. More than 24,000 people were infected by the virus and more than 10,000 died, including 500 health workers, of whom 14 were MSF members. Ebola has destroyed lives and families, left deep scars, and ripped at the social and economic fabric of Guinea, Liberia and Sierra Leone.

The extent of this catastrophe, and the slow response of the international community, pushed MSF beyond its limits. Unable to meet the level of need, teams focused most of their resources on taking care of patients within Ebola centres. We had to go beyond maximum capacity, turning 40-bed centres into centres with hundreds of beds. Based on experience, we adapted the construction of our structures, for example by installing Plexiglas walls that enabled patients, their families and carers to see each other without having to change into personal protection suits.

MSF also led information and health awareness campaigns within communities. We encouraged the development of drugs and vaccines, and ran clinical trials in several of our centres. We also provided training to transfer expertise to hundreds of health professionals, both within MSF and other organisations.

However, during the most critical periods, our teams were not able to take all the action needed to tackle the epidemic fully, such as following up with those who had been in contact with infected individuals or ensuring that safe burials were carried out. We were also not able to admit all patients nor, sometimes, to provide adequate care.

As soon as the epidemic started to spread uncontrollably, MSF alerted the international community; however, our organisation was the only one on the ground for far too long. What is clear is that no-one was prepared for the nightmarish spread and magnitude of this Ebola epidemic. Its exceptional nature demonstrated the inefficiency and slow pace of health systems and of international relief aid in response to emergencies. Operational practices swiftly showed their weaknesses, while inadequate funding and severe lack of co-ordination between all parties resulted in thousands of deaths.

**1,260,893**  
outpatient consultations

**73,500**  
admitted patients

**129,080**  
antenatal consultations

**24,799**  
deliveries

<sup>1</sup> MSF's analysis of the global response to Ebola, published one year after the epidemic outbreak: [www.msf.ch/ebola\\_1year](http://www.msf.ch/ebola_1year)

**239,582**

malaria cases treated

**20,494**

children admitted to inpatient feeding programme

**38,009**

children admitted to outpatient feeding programme

**44,348**

HIV patients on ARV treatment

**3,209**

TB patients

**229**

DR-TB patients

**9,245**

surgical procedures

**29,264**

individual mental health consultations

**4,001**

mental health group consultations

**522,368**

children vaccinated against measles

**THE MIDDLE EAST: HOW TO REACH THE POPULATIONS MOST IN NEED?**

As Syria enters its fifth year of conflict, the war continues to be defined by brutal violence that targets civilians and fighters indiscriminately. Eleven million people have had to flee their homes, and although 7.6 million remain displaced in Syria, nearly four million have sought refuge in neighbouring Iraq, Lebanon, Turkey and Jordan.

With the impacted countries' health systems failing, providing medical assistance to these populations is a major challenge. MSF is held back from developing the necessary medical activities in Syria by violence and insecurity, attacks on medical infrastructure and personnel, as well as by the lack of government authorisation to operate in the country. MSF Switzerland has nonetheless developed several support projects for refugees in neighbouring countries and is present in Al Malykiah (Derek), in the east of Syria.

The emergence of a "transnational" conflict, following the rise of the Islamic State organisation in Iraq, represents a critical evolution in the situation for the whole region. MSF has adapted its approach to deal with the constant changes of situation. Responding to the population movements, we have provided aid through mobile clinics to people in Kirkuk, Tikrit and Dohuk. However, our teams cannot reach those who are living on the frontline, or those displaced in Sunni areas. They remain inaccessible.

Faced with constantly increasing needs, MSF continues to negotiate with Damascus and with radical groups for access to civilian populations, an access which is required under international humanitarian law. We have yet to obtain a minimum guarantee of safety for our teams.

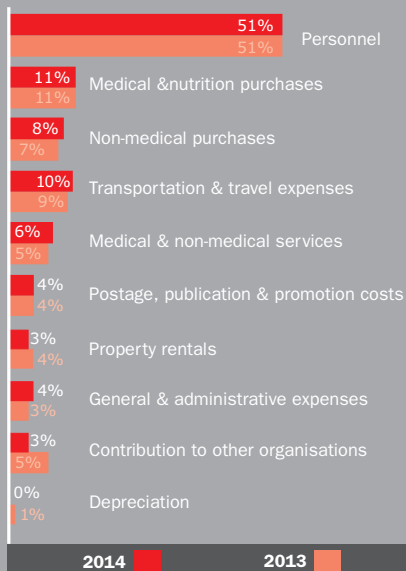
**THE CENTRAL AFRICAN REPUBLIC: MSF'S PRESENCE AT THE HEIGHT OF CONFLICT**

The start of 2014 saw massacres in the Central African Republic (CAR) that killed nearly 5,000 people, wounded tens of thousands and displaced nearly 800,000. Although used to working in war situations, our teams were shocked by the level of violence, the relentless killings and the mutilations they were faced with in CAR.

At the height of the massacres, MSF Switzerland opened projects in Berbérati and Bouar, to help reinforce the activities of other MSF sections that were already present in the country. Very reactive to the situation, our organisation quickly deployed the necessary resources. In total, more than 20 projects were run by the MSF movement in CAR, as well as aid programmes for refugees in neighbouring countries, notably Cameroon.

Once again, MSF was one of the only organisations to intervene on the frontline, and the devastating consequences of the violence were exacerbated by the absence of significant international aid. Humanitarian assistance had been insufficient in Bangui and practically non-existent outside the capital. The international community failed dramatically to protect the Central African population.

### Programme costs per type



### South Sudan: Support for displaced people in Minkaman

In January 2014, MSF launched an emergency intervention to aid displaced populations in the Awerial region. Fleeing the violent confrontations in Bor, hundreds of South Sudanese were crossing the Nile each day to seek refuge in the makeshift camp of Minkaman, on the other side. There were 57,000 people there at the beginning of the year, but this increased to 95,000 by June.

MSF was one of the first aid agencies present and offered primary medical, nutritional and mental healthcare to the displaced. Our teams also organised significant vaccination campaigns against measles, meningitis and cholera. As the prevalence of diarrhoeal diseases was high in the camp, MSF also set up sanitation activities.

In October 2014, by which time numerous other medical organisations were also providing assistance, MSF withdrew from the Minkaman camp as the displaced were receiving the aid they required and the zone was now relatively secure.

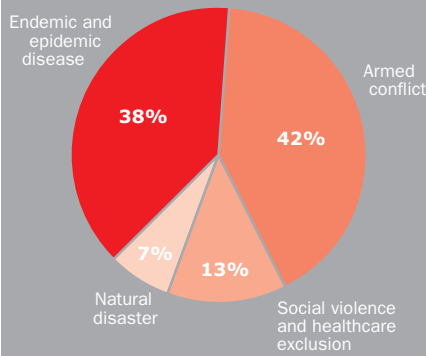
### OUTLOOK FOR 2015

Despite political constraints and the increasing lack of access in some regions, MSF continues to reinvent itself to bring aid to civilian populations in need, and strives to find a balance between benefiting our patients and putting our teams at risk.

Responding to epidemics and crisis situations is our key operational objective. As a result, at the beginning of 2015 changing circumstances led to our intervention in Ukraine, where conflict is taking an extremely high toll on human life and people's mental health. We also opened projects in Cameroon and Chad, in response to population displacements due to Boko Haram attacks in Nigeria.

MSF continues to make progress on fundamental projects such as improving medical practice in the field, updating our medical monitoring systems and improving skill-set and knowledge management. We will continue to invest in the fight against drug-resistant tuberculosis, HIV/AIDS and hepatitis C, areas for which operational research projects are being developed. We will also make a significant investment in women's and child's health, tackling chronic diseases and fighting malnutrition.

### Programme costs per reason of intervention



Dr Jean-Clément Cabrol,  
Director of Operations

Dr Micaela Serafini,  
Medical Director



# 2014 IN PICTURES

Iraq moves from one war to another. After decades of war, any hope of peace for Iraq was crushed in the early summer of 2014. Conflict flared up in the region as Islamic State militants took over Mosul and an international coalition triggered intense resistance. More than two million Iraqis fled their homes and many civilians find themselves trapped on the frontline. Others were able to reach the region of Iraqi Kurdistan – which also host a large number of Syrian refugees – and the Al Anbar and Kirkuk governorates. Displaced Iraqis are now living in unfinished buildings where conditions are deplorable. MSF provides them with treatment via mobile clinics.





**Violence reigns.** The Central African Republic (CAR) plunged into chaos following the Séléka coup in 2013. This predominantly Muslim rebel coalition committed unprecedented atrocities against the majority Christian civilian population. The “anti-balaka” militia group then carried out revenge attacks against Muslims, committing terrible atrocities themselves. The conflict rapidly degenerated into extraordinary violence, causing at least 5,000 deaths, tens of thousands of wounded, and resulting in the displacement of more than 800,000 people within CAR and towards Chad, Cameroon and the Democratic Republic of Congo. In July 2014, the warring parties signed an agreement to end the hostilities, but sporadic violence continues, and the country remains divided.

Since December 2013, MSF has doubled medical relief aid to CAR and to neighbouring countries, in response to the situation. Across all sections of MSF, more than 20 projects were run in the country in 2014, as well as five additional projects to aid refugees in neighbouring countries.



Mpoko airport, Bangui, CAR, 2014. © Sven Torfinn



Bangui, CAR, 2013. © Camille Lenage/Polaris



Bangui, CAR, 2014. © Pierre Terdjman/Cosmos





CAR, 2013. © Marcus Bleasdale/VI



Garoua-Boulai, Cameroon, 2014. © Laurence Hoenig/MSF



Berbérati, CAR, 2014. © Yann Libessart/MSF



Berbérati, CAR, 2014. © Ricardo Garcia



Gbitti, Cameroon, 2014. © Daniel Barney



**An epidemic of historic scale.** The Ebola epidemic that struck West Africa in 2014, was one of unprecedented scale both in terms of its geographic spread, and in the resulting number of cases and deaths. In less than one year, more than 24,000 people became infected and more than 10,000 died from the virus. The MSF movement responded to this major health crisis from day one and set up an exceptionally large medical relief project due to the inaction of other organisations. More than 1,300 international staff and 4,000 national staff treated nearly 5,000 people with Ebola in the last year.



Conakry, Guinea, 2014. © Julien Rey/MSF



Kailahun, Sierra Leone, 2014. © Sylvain Cherkouki/Cosmos



Conakry, Guinea, 2014. © Julien Rey/MSF



Monrovia, Liberia, 2014. © John Moore/Getty Images



Foya, Liberia, 2014. © Martin Zingg/MSF



Foya, Liberia, 2014. © Martin Zingg/MSF





Paynesville, Liberia, 2014. © John Moore/Getty Images



Liberia, 2014. © Fernando Calero/MSF



# ACTIVITIES BY COUNTRY



In 2014, 135,000 Central Africans sought refuge in Cameroon. MSF provided them medical, psychological and nutritional care. © Laurence Hoenig/MSF

## CAMEROON

### Response to an influx of refugees from Central African Republic (CAR)

Intercommunal conflict in CAR caused hundreds of thousands of people to seek refuge in Cameroon and other countries in 2014. Some 9,000 arrived in Cameroon during a 10-day period in February alone, and by the end of the year, an estimated 135,000 were in the country.

In January, MSF began to support the Ministry of Public Health by providing medical, psychological and nutritional support to refugees at sites in Garoua-Boulai, Gado-Badzéré, Gbiti and Batouri. The majority of patients were suffering from malnutrition, malaria and respiratory infections. Medical care, primarily maternity services and healthcare for children up to the age of 15, was also offered to host communities and MSF helped with vaccination campaigns.

In Garoua-Boulai, a small border city where many refugees crossed into Cameroon, MSF teams conducted medical consultations, distributed relief items and worked on sanitation and water supply at the Pont Bascule transit site. The water and sanitation activities were handed over to the NGO Solidarité Internationale in October. Another team continues to work at the district hospital and provided about

1,000 outpatient consultations per week last year. At the Protestant hospital, MSF supports a therapeutic feeding centre and in 2014 increased the bed capacity to 100 to accommodate more children with severe malnutrition.

From February to October, MSF ran a health centre at Gado-Badzéré camp, about 25 kilometres from Garoua-Boulai. There was an outpatient feeding centre and a space designated for individual and group psychosocial counselling sessions. MSF also carried out water and sanitation activities in the camp, undertook epidemiological surveillance and implemented an early response to a cholera outbreak.

In March, MSF began working in Gbiti, another border town where more than 20,000 refugees have been registered. MSF conducted about 1,000 medical consultations per week, supplied water, and built latrines and showers at a makeshift camp. Two mobile teams provided medical care to small pockets of refugees in the area. Patients requiring more intensive care were referred by MSF to hospitals in Batouri or Bertoua. MSF also supported Batouri district hospital

in the management of patients with severe, complicated malnutrition, and increased capacity to 100 beds.

In June, MSF handed over the Buruli ulcer pavilion in Akonolinga to the Ministry of Health. This project had opened in response to the high number of people in the area affected by Buruli, a chronic and destructive skin infection. Laboratory diagnosis, antibiotics, wound dressing, surgery and physiotherapy were provided. Some 1,432 patients have been treated since the project began in 2002, and 43,000 people have benefited from awareness activities. The University Hospital of Geneva, Switzerland, will continue training Cameroonian medical students in chronic wound treatment and care, including for Buruli ulcer.

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

**Main activity:** Neglected disease

**Emergency intervention:** Medical care for refugees

**In the country since:** 2000

**Human resources (FTE):** 277 staff including 30 international staff

**Cost for 2014:** CHF 10,787,000

# GUINEA

## Frontline response to the Ebola virus

In March 2014, an Ebola epidemic broke out for the first time in Guinea. The epicentre was in Guéckédou, in Forest Guinea, where MSF Switzerland had been running a malaria treatment project since 2010. The regular project teams, together with infectious disease experts, immediately began the construction of a management centre and took in patients straight after the official epidemic declaration. From then on, Geneva and Brussels Operational Centres launched a joint intervention to tackle the largest Ebola epidemic in history.

MSF has many years of experience responding to haemorrhagic fever outbreaks and recognised early on, given the wide geographical spread of the virus, that this would be an epidemic of unprecedented scale. New management centres were quickly opened in Guinea, in particular in the capital Conakry. The Donka centre, initially set up with 40 beds, grew to nearly double that capacity. Very quickly, training sessions were set up for local Ministry of Health teams, as well as other organisations, on treating patients in a highly contagious environment. In total, more than 3,700 potential patients were cared for by MSF in Guinea. Analysis confirmed that 1,700 had the Ebola virus and of those, 800 survived.

In the months that followed, MSF also ran clinical trials in two centres in Guinea. Additional research projects are planned for 2015, in collaboration with the Ministry of Health, in particular vaccination programmes.

Given the size of this global crisis, MSF called for other aid organisations to support the intervention from the outset and also asked the international community to take responsibility and intervene. However, foreign governments initially limited aid to the financing or construction of centres, leaving local authorities and non-governmental organisations to manage treatment. Weaknesses in infection control, in follow-up for those who had been in contact with the virus, and in community awareness campaigns were major challenges faced by teams on the ground.

The malaria project in Guéckédou, which had been temporarily halted in March, was officially closed in August. Until the project closed, MSF had continued to work with the Ministry of Health and had supported the district hospital, seven health centres and 13 clinics. MSF ensured that anti-malaria treatments would continue to be supplied to the local health centres, as malaria remains the main cause of death in Guinea, in particular among pregnant women and children under five.

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

**Main activity:** Malaria

**Emergency intervention:** Ebola epidemic

**In the country since:** 2001

**Human resources (FTE):** 87 staff including 12 international staff

**Cost for 2014:** CHF 5,128,000 (of which 3 million for the Ebola response)

### Safiadou's story\*

*In Conakry, MSF employed former patients who had survived Ebola to run community awareness programmes and to offer moral support to patients. These people were invaluable, as they are living proof that Ebola can be beaten.*

When Safiadou entered the Ebola management centre in Conakry in March 2014 she was feverish and had a very bad headache. Six members of her family successively joined her, all suffering from the mysterious, rapidly spreading disease that had just arrived in Conakry.

Safiadou explains that throughout her treatment she did not know what disease she was suffering from. "I just did not think about it. I just knew that I wanted to get out alive," she says. "If I had known, I am not sure that I would have made it."

She stayed in the management centre for a total 13 days, tortured by diarrhoea and violent vomiting. She and two other family members were the only ones to survive.

Several months later, when MSF teams asked her to work directly with patients, Safiadou immediately accepted. "At the beginning it was really hard. I re-lived it all again and felt such pain," she explains with a slight smile.

But Safiadou lifts her gaze, "I forced myself to continue, as it is my civic duty to give hope to other patients." Despite everything, Safiadou asked to remain anonymous to avoid the negative stigma associated with Ebola.

\*Names have been altered





# HAITI

## Progressively reducing activities in Léogâne

For the past four years, MSF has managed a container hospital in Léogâne, to the west of the capital Port-au-Prince. This temporary hospital was set up immediately after the massive 2010 earthquake to provide emergency first aid to the wounded and had an initial bed capacity of 160. In the following years, the hospital gradually expanded its community healthcare services to offer primary healthcare, maternity care and surgical interventions for the significant number of road accident victims in the region.

Chatuley hospital, opened during the crisis, was never intended to replace local healthcare structures on a long-term basis and it will be officially closed at the end of August 2015. As a result, MSF has begun to progressively

transfer activities to other organisations and has worked to strengthen local healthcare providers to ensure quality healthcare will remain in place. Since November 2014, the hospital has only provided emergency paediatric, neonatal, obstetrics, and gynaecology services. It has reduced its capacity to 40 beds. Local healthcare teams now manage uncomplicated pregnancies and births. In 2014, MSF teams provided 6,200 prenatal consultations and assisted 3,300 births. Over 1,400 surgical procedures were also carried out.

The cholera treatment centre adjoining the hospital, which is managed by MSF and specialises in treating pregnant women with the disease, was also closed in March 2014.

Three additional MSF sections run projects in other locations in Haiti, where the vast majority of the population has limited access to healthcare. Throughout the year, MSF has continued to lobby the Ministry of Health and local officials for a better access to care for people suffering from cholera and with reproductive health issues.

**Reason for intervention:** Natural disaster

**Main activity:** Hospital care

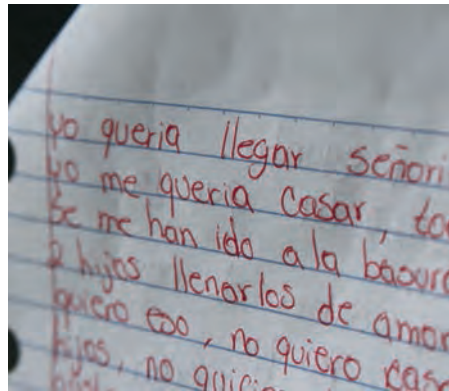
**In the country since:** 2010

**Human resources (FTE):** 444 staff including 18 international staff

**Cost for 2014:** CHF 9,098,000

# HONDURAS

## Treatment to people affected by violence and victims of sexual violence



The priority service provides medical and psychological care to victims of violence and sexual violence. © Delmer Membreno

Honduras has experienced years of political, economic and social instability and as a consequence has become overrun with criminal activity. Tegucigalpa, the capital, is one of the world's most violent cities, and murder, abduction and rape are day-to-day realities for many inhabitants.

MSF developed a *servicio prioritario* or priority service in collaboration with the Health Ministry in Tegucigalpa, offering emergency medical and psychological attention to victims of violence, including sexual violence. Comprehensive healthcare services are lacking for those who are able to overcome fear of retaliation and seek help. The priority service, where everything is provided in one place and is confidential and free, is offered at two health centres and in Tegucigalpa's main hospital. As many people, especially young women and girls, do

not know that this help exists, MSF's health promotion teams focus on sensitisation and outreach activities to spread the word, and consequently the number of victims of sexual violence seeking assistance within 72 hours increased this year. In 2014, MSF treated 700 victims of violence, including 560 victims of sexual violence, and carried out 1,800 mental health consultations.

Medical treatment for rape includes post-exposure prophylaxis to prevent HIV infection and provide protection against other sexually transmitted infections, hepatitis B and tetanus. The mental healthcare includes counselling and psychological first aid. The emergency contraceptive pill, however, has been banned in Honduras since 2009. A debate was initiated in 2014 in the Honduran Congress to change the policy on emergency contraception, and it

continues today. MSF has taken part in the discussions and has highlighted the psychological and medical consequences of pregnancy as a result of sexual assault.

As there are currently no guidelines in place for the treatment of victims of sexual violence in Honduras, MSF is pushing for the Health Ministry to implement a national protocol.

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

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

**In the country since:** 1998

**Human resources (FTE):** 44 staff including 7 international staff

**Cost for 2014:** CHF 1,502,000





MSF has constantly adapted to the evolving situation in order to provide essential services to the displaced. Mobile clinics were organised in Dohuk and Kirkuk governorates. © Gabrielle Klein/MSF

## IRAQ

### Adapting to a volatile security situation

In June 2014, following the fall of Mosul to the organisation Islamic State (IS) and Sunni opposition, Iraq was thrust into a new war and millions of Iraqis were forced to flee their homes. The extent and the violence of the confrontations triggered several waves of displacement, which according to official estimates affected more than two million people in 2014.

In addition, thousands of people are living in opposition-controlled areas, which are bombed on a daily basis by Iraqi army planes and those of the international coalition. These civilians receive virtually no humanitarian assistance.

MSF has constantly adapted to the evolving situation in order to provide essential services to the displaced. As the security conditions deteriorated in June 2014, MSF suspended its support programme for Hawijah hospital and instead started to provide medical support and distribute emergency aid in Kirkuk, Dohuk, Al Anbar and Baghdad governorates.

Aid is mainly provided from mobile clinics, comprised of doctors, nurses and mental healthcare specialists, who move around the region. In addition to primary healthcare, there is a particular focus on reproductive health,

paediatrics and the treatment of chronic illnesses such as diabetes.

In Kirkuk city, MSF operates mobile clinics which provide healthcare to six locations. Twenty thousand blankets and 2,200 hygiene kits were distributed to displaced families. Despite the security problems, it is possible to work in the city; however, MSF is the only international organisation present. Several times during the year, MSF called for other aid organisations to strengthen their presence in areas of Iraq where the most vulnerable displaced people can be reached, including Kirkuk. MSF has been working in the city since 2010. In February 2014, MSF handed over support of the neonatal service at the general hospital to the Ministry of Health and, following escalating violence in June, re-directed activities to respond to the most urgent medical needs.

At the same time, MSF also rapidly increased activities in Dohuk to deal with the influx of displaced people. In addition to the support programme for Syrian refugees in the Domeez camp, MSF set up mobile clinics for nearly 20,000 people living on construction sites or in unofficial camps. Teams also handed out 1,045 hygiene kits and renovated latrines and showers in unfinished housing projects in Dabin.

In Domeez, MSF continued to provide round the clock medical services from the camp's sole health centre, as well as referring emergency patients to Dohuk hospital; activities we have performed since 2012. The camp had been set up to accommodate 27,000 people, but today is home to 60,000 Syrian refugees. Responding to the increasing number of births, MSF opened a maternity centre within the camp in August 2014 and 570 babies have since been born there.

Despite the huge needs of the displaced Iraqis and the Syrian refugees, international aid is still largely insufficient due to the difficult security situation. Delivering aid in Iraq will remain a priority for MSF in 2015.

**Reason 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):** 249 staff including 22 international staff

**Cost for 2014:** CHF 7,939,000

# KENYA

## Insufficient aid for Somali refugees

Kenya is home to one of the largest populations of refugees in the world. In the Dadaab camps, on the Somali border, more than 350,000 refugees live in extremely difficult conditions and some have been there for nearly 25 years. During recent years, the threat of kidnapping, theft and sexual attack has increased, making daily life for the refugees even harder. This deterioration in security conditions has also restricted humanitarian organisations from providing adequate aid.

For these reasons, MSF can no longer guarantee a permanent presence of international staff on the ground in Kenya and experienced national staff manage the hospital and the four health centres in Dagahaley, one of the five Dadaab camps. There are on average more than 1,000 admissions registered each month in the hospital and the intensive therapeutic feeding centre, as well as 16,000 outpatient

and mental health consultations provided by MSF in the camp.

The 100-bed hospital provides general medical treatment and emergency surgery, as well as obstetrics and gynaecology, neonatal and paediatric services. Severely malnourished children are admitted into the nutritional programme. The majority receive outpatient treatment and only children with an additional pathology, such as a respiratory infection or oedemas, are hospitalised. MSF also provides refugees with treatment for HIV/AIDS and tuberculosis.

In 2013, MSF set up a palliative treatment programme to help alleviate end of life suffering. This programme has now evolved to also provide home-based treatment to patients with chronic illnesses.

In March 2014, a tri-partite agreement was signed between the United Nations and the Kenyan and Somali governments, to facilitate the voluntary return of Somali refugees. MSF strongly reiterated our concern for the Dagahaley camp inhabitants when this was signed. An MSF-led inquiry showed that four out of five refugees questioned did not want to return to Somalia and our teams fear that the repatriation process will be at the expense of aid for those that decide to stay in Kenya, aid that is already insufficient.

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

**Main activity:** Medical care for refugees

**In the country since:** 2007

**Human resources (FTE):** 179 staff including 7 international staff

**Cost for 2014:** CHF 7,053,000

# KYRGYZSTAN

## A better access to TB treatments



Tuberculosis is one of the main health issues in Kyrgyzstan. © Pierre-Yves Bernard/MSF

One in four patients newly diagnosed with tuberculosis (TB) in Kyrgyzstan has a multidrug-resistant strain of the disease. This means they do not respond to standard first-line drugs and need more intensive treatment. However, medical services for TB have been centralised and are largely focused on treatment in hospitals only. Consequently people have difficulty accessing medical care, particularly in rural areas.

MSF is the only international organisation actively engaged in the direct clinical implementation of drug-resistant TB (DR-TB) programmes in Kyrgyzstan. In Kara-Suu district, Osh province, where TB rates are among the highest in the country, MSF focuses on outpatient care to limit the amount of time a patient spends in hospital. The programme aims to influence health policy and has succeeded in introducing this decentralised approach to DR-TB treatment

as a key strategy for the Kyrgyzstan Ministry of Health in the coming years.

For patients with severe TB, MSF continued to diagnose and treat patients in Kara-Suu hospital, which has 80 beds, including an isolation ward for those with multidrug-resistant TB. MSF provides support in the pharmacy and laboratory, and also assists with the management of the hospital's waste, water and infection control.

Many patients have received prior treatment for TB, and more than two-thirds of them have developed drug resistance because treatment has been interrupted or they have had difficulty in adhering to it. As part of its comprehensive package of care, MSF provides psychosocial support to help people sustain and complete their arduous drug regimens.

In 2006, MSF began to develop a programme providing TB diagnosis and treatment for inmates at a prison in Bishkek. The project was handed over to the International Committee of the Red Cross, the Health Ministry and prison authorities in 2014, as management of TB in the prison sector had improved enough to justify MSF's exit. MSF had enrolled and treated more than 3,000 patients over the last eight years.

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

**Main activity:** TB

**In the country since:** 2005

**Human resources (FTE):** 108 staff including 14 international staff

**Cost for 2014:** CHF 2,584,000



# LEBANON

## Increasing relief aid for refugees

Lebanon currently holds the world record for the most refugees per inhabitant. More than 1.2 million refugees are officially registered, representing one quarter of the population. The country is struggling to meet their needs and receives insufficient aid from the international community. In 2014, Lebanon was forced to cross its borders, leaving only a trickle of refugees able to enter the country. As the war in Syria intensifies, it is in turn becoming much harder for refugees to flee persecution in their country.

Although the Syrian conflict began four years ago, the living conditions for the refugees in Lebanon have not improved and their access to medical care remains insufficient. Thousands of families live in unacceptable conditions, exposed to the elements in make-shift camps, scattered throughout the country.

Since 2011, MSF has been constantly increasing the level of urgent humanitarian aid we provide to Syrian refugees, to Palestinians who have fled Syria and to vulnerable Lebanese. MSF conducts medical work in Tripoli, in the Bekaa Valley and in Saida in the

south. We provide free medical treatment, including for chronic illnesses, as well as offering family planning sessions, antenatal and postnatal care and preventative treatments such as vaccinations. In Arsal, in the Bekaa Valley, MSF opened a maternity service at the beginning of 2014 to meet the specific needs of refugees. We also integrated mental health care into all MSF projects, given the growing requirement for this. In the Ain-al-Hilweh camp, for example, MSF provided more than 4,800 psychological and psychiatric consultations to Palestinian refugees in 2014.

The extremely difficult living conditions negatively impact the health of refugees, and diarrhoea and respiratory infections are the main illnesses treated by our doctors. When necessary, our teams also distribute emergency supplies such as blanket and hygiene kits to help refugees during the harsh winters.

MSF regularly calls for donors and agencies to increase levels of aid provided to refugees in Lebanon, but their huge needs have yet to be met.

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

**Main activity:** Medical care for refugees

**Emergency intervention:** Medical care for refugees

**In the country since:** 2008

**Human resources (FTE):** 197 staff including 23 international staff

**Cost for 2014:** CHF 8,602,000

### Samira's story\*

*A Syrian refugee in the Bekaa Valley*

"We fled the war in Syria and since then have lived in a miserable, cold garage. My 15 year old daughter suffers now from anorexia and has nightmares about the night the bombs destroyed our village. My husband lost his hearing and without international aid we would have nothing to eat. My mother-in-law lives with us. She is old and has diabetes. MSF teams in Baalbek treat her, but with the refugee food hand-outs that we receive in the camp and that is not adapted for diabetics, I do not know how we'll manage. I am not sure if she will survive."

Samira and her family are refugees living in the Bekaa Valley in Lebanon. Like 400,000 other Syrians, their living conditions are deplorable, in particular during the winter months when there is snow, fog and sub-zero temperatures and they do not have the means to keep warm.

\*Names have been altered



# LIBERIA

Fighting the Ebola epidemic in the hardest hit country



In Foya, 400 of the nearly 700 admissions were confirmed Ebola cases; 154 patients survived and could be discharged, while 252 died of the disease. © Caroline Van Nespen/MSF

When Liberia reported its first cases of the Ebola virus in March 2014, the health system was in no way prepared to deal with what would become the largest Ebola epidemic in history. The health infrastructure was still suffering from the consequences of the long civil war and despite 10 years of reconstruction, there was a severe lack of health resources.

The first cases of Ebola were reported in Liberia's northern county Lofa, just across the border from the epicenter in Guinea, and in the capital Monrovia. One of the MSF teams in Guinea was dispatched to Liberia to set up isolation wards and train healthcare workers on how to tackle the virus. Only 12 cases were reported in 10 days and by mid-May, the situation seemed to be under control. However, it rapidly worsened in late June, when the hitherto hidden outbreak in Sierra Leone had a knock-on effect in neighbouring countries. The virus exploded across Guinea, Sierra Leone and Liberia, with the epidemic spiralling out of control. In August, while the Belgium section of MSF was fighting the epidemic in Monrovia, MSF Switzerland continued working in the 100-bed Ebola management centre in Foya in Lofa county, where the teams were faced with daily influxes of patients. Between August and December, 400 of the nearly 700 admissions were confirmed Ebola cases; 154 patients survived and could be discharged, while 252 died of the disease.

Despite huge efforts, the MSF teams were simply overwhelmed by the number of patients,

while at the same time desperately lacking in staff and resources. Ebola is a double tragedy as the virus takes the lives of not only the patients but also the very people who are working hard to contain it. In Liberia alone, 179 local health workers have passed away since the outbreak of the epidemic, among them six of our MSF colleagues. Furthermore, the teams not only had to deal with the patient overload but also with the population's fear, denial and misinformation, as Liberia had never before had an Ebola outbreak. Soon it became evident that MSF had to adopt a comprehensive and transparent approach if the virus was to be contained. Apart from isolating and caring for patients, MSF knew from past experience that it had to get involved in activities within the communities, including raising awareness among the population, providing psychological care, and organising safe burials and disease surveillance activities. Behavioural changes in Lofa county resulted in a rapid decrease in virus transmission. In December, the centre in Foya closed after the county was officially declared Ebola-free.

One of the unseen consequences of this historic outbreak is the major impact it had on the general public health system. Indeed, with many hospitals and clinics across the country shut down, people with diseases such as malaria and diarrhoea were left untreated. Redemption Hospital, the only hospital in the capital Monrovia providing free medical care to a catchment population of approximately 90,000 people closed entirely in October. In order to allow the hospital to reopen for regular

inpatient services, MSF opened a transit unit for the triage of suspected Ebola patients.

Following the overwhelming number of Ebola cases in Liberia between August and October, there was a sharp decline in the numbers reported towards the end of the year. Patient numbers in MSF facilities dwindled significantly and, at the end of 2014, Liberia reported the least number of cases among the three worst affected countries.

However, it is important to remain vigilant and ready to act immediately and comprehensively if any new cases are reported. Indeed, in March 2015 a patient tested positive for Ebola in MSF's transit centre in Redemption Hospital. Apart from treating new patients, MSF teams also provide support to Ebola survivors who often suffer from medical complications or from mental health problems after they have been cured. At the same time, non-Ebola health needs in Liberia are an urgent priority that must be addressed, as the already fragile public health system collapsed in the wake of the Ebola epidemic.

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

**Emergency intervention:** Ebola epidemic

**In the country since:** 2014

**Human resources (FTE):** 18 international staff\*

**Cost for 2014:** CHF 6,481,000

\* The daily workers who assisted our expatriate teams are not reported here.



# MEXICO

## Improving emergency hospital care

The town of Nuevo Laredo, on the banks of the Rio Grande at the American border, is being fought over by drug cartels. For nearly 15 years, inhabitants have been subject to levels of violence that are equal to those faced by civilians in times of war. As well as living under the daily threat of extortion, kidnapping and physical violence, it is difficult for residents to access healthcare. Over-population and rapid growth have put the town's infrastructure under strain. Almost 150,000 economic migrants, en route to the United States have arrived in the town, which already has 400,000 official residents. Public services are overwhelmed.

Although medical personnel are often competent and sufficient in number, the admissions service in public hospitals cannot cope with the numbers of patients and the influx of wounded exceeds the capacity of the emergency

department. This is having a major impact on mortality rates in the town's hospitals.

In February 2014, MSF set up a pilot project in Nuevo Laredo general hospital, which is the only hospital to offer free treatment to the town's poorest inhabitants. Working with Tamaulipas state authorities, MSF sought to improve the medical response to the violence by offering its expertise in dealing with crisis situations. MSF provided support by standardising healthcare protocols and reorganising amongst other, the emergency service. The organization also provided medical supplies.

MSF advised emergency service personnel on how to ensure patients benefit from better treatment as soon as they enter the hospital. MSF teams have concentrated on triage methods, enabling staff to determine the level of severity of a patient's condition and to

prioritise admissions accordingly. Eight months after the programme started, there have been notable improvements in patient flow.

At the end of the year, MSF extended this support to another hospital in the region that faced similar challenges. The Reynosa project, 250 kilometres further south, is providing support to the public hospital, in a town with more than one million inhabitants.

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

**Main activity:** Hospital care

**In the country since:** 2013

**Human resources (FTE):** 28 staff including 7 international staff

**Cost for 2014:** CHF 1,214,000

# MOZAMBIQUE

## Growth in preventative strategies and innovative treatment for HIV/AIDS



In Mozambique, MSF is concentrating on expanding specialised and adapted care for HIV patients with medical complications or those suffering from particularly serious opportunistic diseases.  
© Fernando Fidelis/MSF et Sarah-Eve Hammond/MSF

Official efforts have enabled significant progress in the fight against HIV/AIDS in Mozambique. However, this country still has one of the highest rates of HIV/AIDS in the world. Each year, the virus causes more than 70,000 deaths and 100,000 new infections. Despite improvements in patient treatment, more than one in two HIV-positive patients still does not have access to antiretroviral (ARV) treatment.

MSF remains very active in the fight against this epidemic. At the end of June 2014, MSF was providing ARV treatment to 27,800 people, of whom 423 were children under five. In collaboration with local authorities, MSF has gradually stopped providing direct first-line medical treatment to patients and is, instead, concentrating on expanding specialised and adapted care for people with medical complications or

those suffering from particularly serious opportunistic diseases such as multi-drug resistant tuberculosis (MDR-TB) or Kaposi's sarcoma, a type of cancer that causes painful skin lesions.

Accordingly, MSF treated more than 2,440 HIV/AIDS patients with additional virus-related complications in the Alto-Maé referral centre in Maputo. Over 450 patients were treated for Kaposi's sarcoma and 40 were treated for MDR-TB. In five MSF-supported health centres in the Chamanculo district, our focus this year centred on early diagnosis of infantile TB.

Finally, in Chamanculo hospital, MSF worked with the local health authorities to prevent virus transmissions between HIV-positive mothers and their children, under which all HIV-positive pregnant women receive life-long ARV treatment, irrespective of their CD4 count.

In collaboration with the Ministry of Health, MSF has continued to promote innovative approaches this year that centre on simplifying patient follow-up, as well as transferring certain treatment processes to non-medical personnel. The organisation's objective is to remain at the forefront of the fight against the HIV epidemic, and to enable the thousands of people deprived of treatment to gain access.

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

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

**In the country since:** 1992

**Human resources (FTE):** 159 staff including 13 international staff

**Cost for 2014:** CHF 3,835,000

# MYANMAR

## Ensuring marginalised communities have access to treatment

Despite political reforms carried out by the Myanmar government during the last few years, access to medical treatment remains very limited, in particular for marginalised populations and for certain ethnic groups. MSF's presence, providing free healthcare in different regions of the country, is necessary given the high prevalence of infectious disease and the number of displaced people.

In 2014, MSF intervened in Rakhine State, where violent conflict was taking place between Buddhists and Muslims. Large numbers of the Muslim Rohingya community were displaced and living in refugee camps, with no access to healthcare. MSF set up mobile clinics to provide medical treatment to the population of Kyauktaw Commune, both Buddhist and Muslim, but these had to be shut down at the end of March following attacks against international humanitarian aid

organisations. MSF remains deeply concerned for the population of Kyauktaw who have extremely limited access to primary medical healthcare, hospital treatment and routine vaccinations.

In Dawei, in the Tanintharyi region, MSF's clinic continues to treat patients with HIV/AIDS and tuberculosis (TB). MSF has more than 3,000 patients on tri-therapy and nearly 200 taking TB drugs, and is one of the main healthcare providers in the region. In 2014, new hope emerged for patients suffering from cytomegalovirus (CMV); a virus that attacks the retinas of patients with weakened immune systems, and in particular, those infected with HIV. Without treatment, patients can lose their sight. After years of negotiations with the pharmaceutical company Roche, MSF has finally been able to use valganciclovir in its Dawei clinic, an oral drug that has been available in

high-income countries since 2001. As a result, this has replaced painful ocular injections, which were the core treatment to date.

At the end of 2014, MSF had also extended activities in the region to support three HIV testing centres and to provide psychological support to marginalised groups such as sex workers, migrants and men who have sex with men.

**Reason 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):** 119 staff including 12 international staff

**Cost for 2014:** CHF 2,824,000



MSF provides medical care for HIV and TB patients. © Eddy McCall/MSF et Kaung Htet

# NIGER

## Innovative strategy to tackle both malaria and malnutrition

In 2014, the people of Niger, and in particular the most vulnerable, once again suffered chronic food shortages with nearly one in every two children affected by malnutrition.

In Magaria hospital, in the south of Niger, MSF teams provided medical and nutritional treatment to more than 7,000 children with severe, acute malnutrition. They also provided paediatric services to 4,100 hospitalised children. Nearly 20,200 less seriously affected patients received outpatient nutritional care, and teams provided 113,300 medical consultations via 13 MSF-supported health centres.

This year the management of the nutritional centre in Zinder was handed over to the local health authorities. They had full management of the centre during quieter periods and

MSF only intervened to provide support at peak times.

From July to October, MSF set up a seasonal malaria chemoprevention programme, targeting more than 120,000 children under the age of five in the Zinder region. This is a critical time of year for Nigeriens, as food stocks are depleted and malaria is at its seasonal peak. The combination of malnutrition and malaria is particularly dangerous for young children. MSF teams included vaccination campaigns in their preventative strategy, to protect children from potentially life-threatening but avoidable diseases. Finally, MSF sent community workers into villages in these areas to encourage parents to take their children to drug distribution points and to raise wider awareness within communities.

This is the second year in which MSF's combined therapeutic and preventative strategy has been used in the Zinder region and it has shown very encouraging results. MSF has started to collaborate with local authorities to roll out this strategy nationally. In parallel, we continue to urge the government to improve the treatment of malnutrition in local health structures.

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

**Main activity:** Malnutrition, paediatric care

**In the country since:** 2005

**Human resources (FTE):** 496 staff including 28 international staff

**Cost for 2014:** CHF 10,991,000



# CENTRAL AFRICAN REPUBLIC

Providing emergency medical care in an extremely violent conflict situation

The Central African Republic (CAR) has been in chaos since December 2013 when the Séléka, a predominantly Muslim rebel coalition group, staged a coup that resulted in unprecedented atrocities against the non-Muslim civilian population. The “anti-balaka”, a majority Christian militia group, attacked Muslims in reprisal and in the space of a few months the conflict degenerated into an exceptionally violent civil war, causing the death of nearly 5,000 people, wounding tens of thousands and resulting in the displacement of more than 800,000 Central Africans. More than 90 per cent of the Muslims who were living in the west of the country fled to Chad, Cameroon and the Democratic Republic of Congo to escape the violence.

Already present on the ground before the conflict erupted, MSF teams quickly set up new activities to reinforce the failing of the non-existent health system. The healthcare situation in CAR, a sparsely populated country ten times the size of Switzerland, is catastrophic. Access to medical care is limited and costly. There are few qualified personnel and recurrent medical supply issues. All the more since many medical centres were abandoned and were looted by armed gangs during the conflict.

From January 2014, MSF Switzerland worked in the Berbérati regional university hospital, in the west of the country, where teams treated conflict victims and provided medical aid to the displaced and to pregnant women, children and adolescents under the age of 15. MSF teams conducted surgical interventions, provided post-operative care and also managed the maternity and paediatric services. More than 3,000 surgical interventions took place and 2,400 births were assisted during the year. Nearly 8,000 patients were hospitalised by MSF. From July, the levels of violence settled down and our team were also able to provide support to five health centres in nearby villages. The main pathologies observed during consultations were malnutrition, malaria, respiratory infections and measles. MSF was also providing targeted women’s health consultations.

Some of the displaced Muslims in Berbérati found refuge in a church, and have been there since March. There were initially more than 2,000, but now only 400 men, women and children remain, living in tents or outbuildings in the church grounds. MSF teams visit once or twice a week to provide consultations. More than 42,000 consultations took place in Berbérati in 2014.

Between January and April, at the height of the conflict, MSF Switzerland also intervened temporarily in Bouar, to provide emergency medical treatment to victims of the violence. MSF also provided consultations to 8,500 Muslim refugees in the Bouar mosque. Our teams carried out more than 240 surgical operations and treated 1,600 people in the emergency room during this time.

Following numerous security incidents, MSF withdrew teams from several locations in CAR. One incident took place in Boguila in the north, where on 26 April 2014, 19 civilians, including three MSF staff members, were killed during a targeted attack on a hospital that MSF supports.

**Reason for intervention:** Armed conflict

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

**In the country since:** 2014

**Human resources (FTE):** 202 staff including 31 international staff

**Cost for 2014:** CHF 9,098,000



A MSF doctor look after an epileptic patient in Berbérati hospital. © Yann Libessart/MSF



# DEMOCRATIC REPUBLIC OF CONGO

Helping victims of violence and treating sleeping sickness



In 2014, MSF screened 30,747 people for sleeping sickness, and found 78 cases. © Marizilda Cruppe

For years, the Democratic Republic of Congo (DRC) has been in a state of unrest. Persistent conflict in its eastern provinces and instability in other regions have led to recurrent humanitarian crises and outbreaks of disease. Since 2003, MSF has been continually working in the province Orientale, focusing on assisting civilians who have been affected by violence, including sexual violence, and supporting populations who do not have access to healthcare.

In 2014, the Pool Urgence Bunia (PUB) acted on a total of 71 alerts in the Bas Uélé, Haut Uélé and the Ituri districts. This pool was put in place to reduce mortality and morbidity linked to emergency situations such as population displacement and disease and epidemic outbreaks. One of the alerts that was investigated in 2014 led to an intervention in Nia Nia, a small town in Ituri district, as MSF responded to an exceptional peak of violence in April, related to the mining of gold and diamonds in this area. Thousands of

people fled their villages in order to escape the constant threat of abduction and violence by different groups of armed poachers. Between May and early July, MSF teams provided 3,600 medical consultations and offered psychological support and counselling to victims of violence, including those subjected to sexual violence and torture.

In Geti, people continued to suffer the effects of confrontation between armed groups. MSF provided medical assistance to the displaced and to the local population, with a particular focus on women and on children under five. At Geti hospital, MSF managed the emergency and intensive care wards, mother and child health services, blood transfusions and the hospital laboratory. In parallel, the logistics team also constructed a new paediatric and neonatology ward, which had previously been located in a tent.

In Dingila, a town in Bas Uélé district, MSF closed its project focusing on the

screening and treatment of human African trypanosomiasis, also known as sleeping sickness. This decision was based on the significant decrease in the number of new cases, and many of the areas in the Dingila, Zobia and south Ango region previously identified as high prevalence zones had been screened two or three times. In 2014, our teams screened 30,747 people, and found 78 cases of sleeping sickness.

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

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

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

**In the country since:** 2001

**Human resources (FTE):** 416 staff including 34 international staff

**Cost for 2014:** CHF 9,003,000

# DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA

**Negotiations are underway to establish new projects**

The population of the Democratic People's Republic of Korea (DPRK) is affected by frequent food shortages, and health facilities are not regularly maintained and lack medical equipment and supplies. Only a handful of international NGOs are permitted to work in the country, and their activities are closely controlled.

In June 2014, MSF completed a project in Anju district, South Pyongan province, aimed at increasing the capacity of medical services for the local population, primarily through staff training and donations of drugs and supplies. MSF's modular approach focused on mother and child healthcare, including specific training

on management of diarrhoea, respiratory and neurological diseases, malnutrition among children, and life-saving obstetric procedures. As well as training medical personnel, the MSF team visited the paediatric and maternity wards of the local hospital, examining patients and assessing the implementation of training modules. MSF also supplied the medical equipment and drugs related to training topics, along with food for patients, caregivers and staff. Through the project MSF provided direct care for 250 patients and indirect support for 3,000 people.

At the end of October MSF began exploring the feasibility of activities in other locations. The

team visited the county hospital in Sukchon in South Pyongan and Kim Man Yu hospital in Pyongyang and was negotiating with the government at year end to launch further programmes. In December, two Ministry of Health staff attended Ebola training offered by MSF in Geneva.

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

**Main activity:** Medical training

**In the country since:** 2013

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

**Cost for 2014:** CHF 682,000

# SIERRA LEONE

**Unprecedented mobilisation of resources to fight Ebola**



The MSF movement launched several emergency interventions in Sierra Leone, as the epidemic started to spread. © Anna Surinyach/MSF

The Ebola outbreak that struck West Africa this year was an epidemic of unprecedented scale. Sierra Leone was one of the worst hit countries, with more than 8,000 registered cases. The epidemic started at the end of May in the eastern regions of Sierra Leone. The MSF movement launched several emergency interventions in the country, as the epidemic started to spread. From June onwards, MSF set up a management centre for patients in Kailahun, the first district to have been impacted by the virus. Given the influx of patients, MSF increased capacity from 32 to 80 beds at the height of the epidemic. As well as treating patients, teams concentrated their efforts on raising awareness within the community. Maternity services were also provided to pregnant patients infected with the virus. In total, 1,200 patients were admitted in Kailahun and 860 were confirmed as having Ebola.

Other teams opened centres near the town of Bo, which thanks to its central location was easily accessible from all over the country. Another management centre was set up in the overpopulated capital Freetown, where the spread of Ebola had long been out of control. In addition, an epidemiological monitoring network was put into place to identify new cases quickly and to convey public health messages.

At the beginning of December, when medical facilities in Freetown had become completely overwhelmed, MSF opened a 100-bed management centre that had individual rooms for suspected cases, Plexiglas corridors to allow better supervision of patients and an intensive care department. From the 10 to 31 December, 135 people were admitted to the centre, and 70 were confirmed as having Ebola.

The epidemic destroyed the Sierra Leonean health system and as a result, an incalculable number of people died this year from diseases that had no link to Ebola. Towards the end of the year, MSF distributed anti-malaria medication to 1.5 million inhabitants of Freetown. The objective was to reduce the number of cases of malaria, the most deadly disease in the country, but also its impact on the Ebola management centres.

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

**Emergency intervention:** Ebola epidemic

**In the country since:** 2014

**Human resources (FTE):** 3 international staff\*

**Cost for 2014:** CHF 1,699,000

\* The daily workers who assisted our expatriate teams are not reported here.



# SUDAN

## Treating a neglected disease and responding to emergencies

MSF's work in Sudan remains much needed because of the country's weak health infrastructure and the difficulties faced by people trying to access medical care, especially those affected by conflict. In addition to a deteriorating economic situation, internal armed struggles continued to multiply in Sudan and accessing the populations in need in the country is a growing challenge for MSF. The conflict in Darfur intensified in 2014, where nearly 450,000 people were newly displaced this year.

MSF is currently running medical activities in two states: Gedaref and West Darfur. In Gedaref, MSF is providing treatment for kala azar in the Tabarak Allah hospital as well as reproductive healthcare services (maternity, ante- and postnatal care). Kala azar, also known as visceral leishmaniasis, is spread by the bite of certain types of sandfly and is almost always fatal if left untreated. Sudan is one of the eight most affected countries in the world. In 2014,

400 patients with kala azar received treatment in Tabarak Allah hospital and 3,200 patients were screened for the disease, of which 12 per cent were admitted for treatment. At the beginning of the year, MSF organised a huge training session in the neighboring state of Sennar on diagnosis and treatment of kala azar. It was attended by nearly 600 medical staff.

In West Darfur state, MSF runs a primary health-care centre for the local population of Kereneq, as well as for people fleeing the violence of central Darfur. Preventive activities such as epidemiological surveillance are carried out. However, our teams had immense difficulties to assist victims of violence, humanitarian space in Sudan being extremely reduced.

Since Sudan is a transit country for pilgrims from Western Africa travelling to Mecca, Ebola preparedness and training was given to more than 100 Ministry of Health staff. The Sudan

Emergency Response Project (SERP) carried out several emergency interventions throughout the year, including large scale treatment for skin diseases (scabies and Tinea Capitis or scalp ringworm) in Gedaref state.

A short term flood intervention was also carried out in Mafaza, during which a total of 50,000 litres of drinking water were distributed. Mobile clinics were conducted over two days in two villages.

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

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

**Emergency intervention:** Flood, medical care for victims of violence

**In the country since:** 2004

**Human resources (FTE):** 134 staff including 9 international staff

**Cost for 2014:** CHF 2,645,000

# SOUTH SUDAN

## Emergency medical relief aid



MSF intervened to help the 80,000 people who fled violence in Bor and sought refuge in Minkaman. © David Di Lorenzo/MSF

A severe humanitarian crisis is taking place in South Sudan. In December 2013, fighting broke out between forces faithful to the president Salva Kiir and insurgents supporting the former vice-president Riek Machar and as a result more than one and a half million people have been displaced. The generalised violence, combined with a substantial lack of health infrastructure, is having a significant impact on the population's health, in particular that of women and children. In light of the increasing risk of epidemics and the high mortality rate in the country, MSF has multiplied relief efforts in order to respond as quickly as possible to any emergency medical needs.

In January 2014, the organisation intervened to help 80,000 people fleeing violence in Bor, who sought refuge on the other side of the Nile in the temporary Minkaman camp. MSF was one of the first organisations present and provided medical healthcare to the displaced up until October 2014, when we withdraw from the region as the medical requirements in the

camp were now covered by numerous other organisations who had arrived in the meantime. During 10 months, MSF teams conducted more than 51,700 outpatient medical consultations, provided surgical services and treatment for mother and child, supplied medicines and distributed drinking water. They also carried out preventative vaccination campaigns against measles, cholera, polio and meningitis and set up mental healthcare activities.

In the north, MSF offered primary healthcare and hospital treatment in Agok. In 2014, more than 6,600 patients were admitted to the MSF-managed hospital, and nearly 640 were children suffering from severe, acute malnutrition and associated pathologies such as diarrhoea or respiratory infection. Our teams gave 30,000 outpatient consultations and assisted 1,600 births. In addition, they remained primed to respond to any emergency situation that might arise. In April, MSF transferred primary healthcare treatment to the humanitarian organisation GOAL and concentrated resources

on providing hospital treatment. The mobile clinics used to treat remote populations were also stopped due to the insecurity east of Agok. The surgical team treated nearly 400 war wounded during this time.

In April, following an outbreak of measles in the Lakes region, MSF launched a vaccination campaign to stop the spread of the disease. The situation in South Sudan was very unstable throughout 2014 and remains a concern in 2015. MSF is ready to respond to any new emergency situation in South Sudan.

**Reason 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):** 455 staff including 47 international staff

**Cost for 2014:** CHF 15,899,000

# SWAZILAND

Progress accelerates due to preventative strategies



The success of the decentralisation of HIV and TB services is due particularly to the support given by local communities, as well as the delegation of certain responsibilities to 'expert-patients'. © Sven Torfinn

The HIV/AIDS rate is extremely high in Swaziland, a small landlocked country in southern Africa. Around 31 per cent of sexually-active adults are infected with the virus and 80 per cent of patients with tuberculosis (TB) also have HIV/AIDS. MSF is collaborating with the Ministry of Health to respond to this double epidemic, which is decimating the population.

Teams are intervening in Shiselweni, a rural area that is particularly impacted by HIV/AIDS and TB. For the past six years, MSF and the Ministry of Health have set up innovative strategies to help slowly tackle these diseases, responsible for tens of thousands of deaths. The programmes work by decentralising treatment for HIV and TB, taking it from regional hospitals to primary healthcare clinics, and by providing treatment for HIV and TB in the same consultation space. This avoids patients having to travel long distances, improves patient adherence to treatment and enables to diagnose and treat more people. MSF teams working in 22 local clinics and three specialised centres (Nhlangano, Hlatikulu and Matsanjeni) treat patients and also focus on the control and prevention of

opportunistic infections. In 2014, more than 12,300 patients received antiretroviral (ARV) therapy and 900 patients with drug-resistant tuberculosis were treated.

Following the success of the pilot programme for preventing mother-to-child transmission of HIV, PTMC option B+, set up by MSF two years ago, the Ministry of Health has decided to roll the programme out throughout the country this year. This programme offers HIV-positive pregnant women immediate and lifetime ARV treatment to prevent the transmission of the virus to their child, to keep them healthy and to protect HIV-negative partners and children born as a result of future pregnancies.

This strategy of "treatment as prevention" entails a second stage, which was launched last October. This stage will enable all HIV-positive children and adults in the Shiselweni region to access early ARV treatment, independent of clinical or immunological criteria. By systematically putting all HIV-positive patients on ARVs, the teams hope patients will stay healthy longer and that this will therefore reduce the risk of HIV transmission and its impact on communities.

The success of the decentralisation of HIV and TB services is due particularly to the support given by local communities, as well as the delegation of certain responsibilities to 'expert-patients': patients with HIV/AIDS who diligently follow treatment and who show a motivation to support their peers. This year, 'expert-patients' led more than 3,200 community health education sessions and mobilised more than 137,000 community members to support HIV diagnostic efforts in their area.

In parallel, MSF invested in laboratory technologies, specifically in viral load testing used to monitor patients' responses to ARV treatment. In addition, teams now have access to GeneXpert, the most advanced technology, as well as to the 22 regional clinics' mini-laboratories, to diagnose drug-resistant TB.

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

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

**In the country since:** 2007

**Human resources (FTE):** 273 staff including 19 international staff

**Cost for 2014:** CHF 6,956,000



# SYRIA

## Humanitarian action hampered by generalised and targeted violence

With the brutal conflict showing no signs of resolution, the plight of the Syrian people continues to worsen. By the end of 2014, half of the population had fled to neighbouring countries or had been displaced within Syria, while more than 200,000 people had been killed. Inside the country, those trapped between the ever-shifting frontlines had very little access to health-care, especially as violent attacks did not spare medical facilities or personnel.

Despite the huge needs in Syria, the violence and insecurity, risk of kidnappings and assaults on medical workers, and the major constraints imposed by those involved in the conflict severely limited MSF's activities. The abduction in January 2014 of five staff members (liberated five months later) forced MSF to close several of its programmes.

In northeast Syria, MSF has supported the trauma and maternity ward of Al Malykieh (Derek) hospital in Al-Hasakah governorate since 2013. MSF supplies personnel, drugs and equipment and also provides pre- and post-operative care. In 2014, the medical team assisted 570 deliveries, and 665 patients were treated in the trauma ward. There, MSF also runs two clinics offering outpatient consultations and healthcare for mothers and children.

MSF also worked on the border with Iraq in 2014, in order to provide general healthcare as well as mother and child services to internally displaced people and the host communities. MSF supported a mass immunisation campaign targeting 15,350 people, as well as a routine vaccination campaign against polio. The border with Iraq was closed in September 2013 but it re-opened in June 2014, allowing

Syrian refugees to return. In August, tens of thousands of Iraqis also crossed the border into Syria to escape the violence in Ninewa governorate, after the Islamic State organisation took Mosul. In order to provide immediate medical assistance to the displaced population, MSF teams set up mobile clinics and health facilities in camps on both sides of the border.

The provision of medical assistance to the Syrian population remains a priority for MSF in 2015.

**Reason for intervention:** Armed conflict

**Emergency intervention:** Hospital care

**In the country since:** 2013

**Human resources (FTE):** 72 staff including 7 international staff

**Cost for 2014:** CHF 1,958,000

# CHAD

## Fighting child malnutrition and malaria



MSF offers nutritional and paediatric care at Massakory hospital. © MSF

In Chad, food shortages, epidemics and high infant and maternal mortality levels remain critical humanitarian issues. This year was particularly intense for MSF, as in addition to running the Massakory paediatric service, teams also responded to several epidemics and focused on strengthening preventive activities.

MSF manages the paediatric emergency department at Massakory hospital, in the Hadjer Lamis region, as well as the infant malnutrition programme. 2,600 children and adolescents under the age of 15 were admitted for treatment at the hospital and the nutritional rehabilitation centre. In addition, nearly 4,000 children received outpatient treatment.

At the end of January, measles broke out across Chad. The Massakory teams treated 245 patients and launched a vaccination campaign, immunising 69,700 children under the age of five. From the end of March, MSF also provided intensive support to several hospitals and health centres in the capital N'Djamena and treated 4,300 patients with measles.

Between August and December, when the risk of malaria was at its highest, MSF worked with the Ministry of Health to treat 33,300 confirmed malaria cases. At the same time, MSF systematically screened children for malnutrition (particularly deadly when combined with malaria) and organised treatment for those that were malnourished.

Teams also distributed insecticide-treated mosquito nets and ready-to-use food supplements.

In Abéché in the east of Chad, during the first half of the year, MSF actively supported the programme for women with obstetric fistulas, which had been transferred to the Ministry of Health at the end of 2013.

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

**Main activity:** Malnutrition, paediatric care

**Emergency intervention:** Measles outbreak

**In the country since:** 2006

**Human resources (FTE):** 310 staff including 19 international staff

**Cost for 2014:** CHF 5,989,000

# HUMAN RESOURCES

Ebola took a heavy toll on MSF teams in 2014: 28 of our colleagues contracted the disease whilst treating patients in Guinea, Sierra Leone and Liberia and 14 subsequently died. Ebola epidemics make huge demands on resources and in particular on human resources. International staff spend less time on these missions than they would typically (a maximum of six to eight weeks, instead of several months) and as a result, a much higher rotation of staff is required. Security protocols are extremely strict and working conditions are very difficult, both physically and psychologically. MSF mobilised the necessary experts for responding to this epidemic and trained hundreds of health professionals in treating Ebola, prior to their deployment. Across all sections of MSF, 1,300 international and 4,000 national staff members were deployed to fight Ebola in West Africa in 2014.

However, this extensive mobilisation of staff had consequences. Resources are not unlimited and we needed to prioritise accordingly. Missions in other equally critical crisis situations could potentially have suffered. For example, one of MSF Switzerland's largest missions in 2014 was to the Central African Republic. Ensuring we deployed a sufficient number of experienced staff to this difficult medical and security situation, whilst also intervening in Ebola, was a constant challenge.

Despite the huge pressure on our human resources, 962 volunteers went on missions in 2014 for MSF Switzerland. All year long, 415 international and 3,939 local staff provided medical treatment in 22 countries to communities that would otherwise have had no access to healthcare. Our offices in Geneva and Zurich helped teams on the ground, including 197 staff, as well as volunteers who kindly provided 2,930 hours of work. In accordance with MSF Switzerland's accounting principles, these efforts were not included in operating statements.

MSF Switzerland's Human Resources Department continued to focus on general operational improvements in 2014. Our review of remuneration policies for international staff was completed and many initiatives worked on, including a focus on diversity, internal mobility and systems upgrades.

I want to pay tribute to colleagues who died whilst working on MSF programmes in Africa and in the Middle East this year. Despite the heightened health and safety risks experienced during 2014, our staff doubled their efforts to bring adequate treatment to vulnerable populations. We thank them for making our work possible.

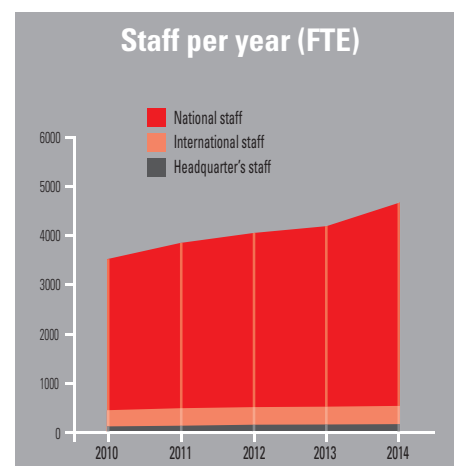
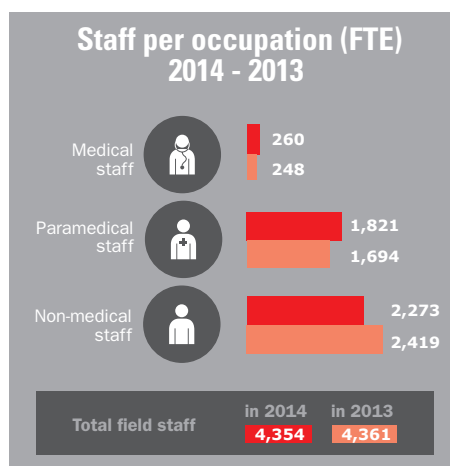
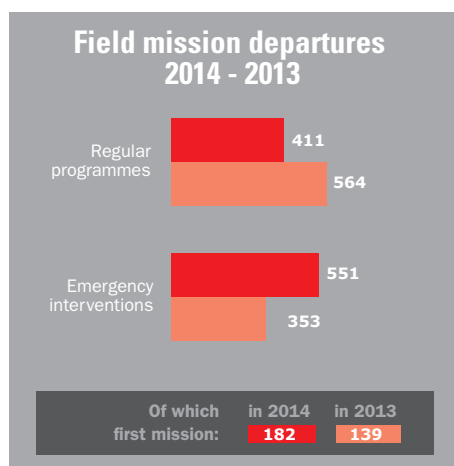
Franck Eloi, Director of Human Resources

**4,354**  
field staff

**197**  
headquarter staff

**2,930**  
voluntary hours

*All data is shown on a full-time equivalent basis.  
Data does not include daily staff, or staff from Health Ministries working in our projects.*





# FINANCIAL RESULTS

The Ebola epidemic in West Africa has had a significant impact on both income and expenditure this year. Donors provided considerable support for our fight against Ebola, resulting in an **income of CHF 201 million** (14% higher than the previous year). **Expenditure grew by 9% to CHF 178 million**. As the level of donations exceeded immediate financing needs, 2014 resulted in a surplus of CHF 23 million.

After four relatively stable years, 2014 was a year of strong operational growth (+11%) with **CHF 135 million of programme expenditure**. This growth was due primarily to emergency interventions. In total, 55 projects were implemented in 22 countries. Geographically, 73% of programme expenses were for Africa, compared with 66% in 2013; 18% of expenses were for Asia, down from 24%; and the Americas remained stable at 9%.

The budget for our regular projects increased by CHF 3 million (+3%). This included past emergency projects in Lebanon and in Iraq (Bekaa, Tripoli and Domeez), and new projects in Mexico supporting emergency services in two hospitals. We also started to run clinical trials in Niger for a new rotavirus vaccine. On the other hand, we closed the mission in Guinea, as well as other projects like Hawijah in Iraq, Bishkek in Kyrgyzstan and Akonolinga in Cameroon.

The budget for emergency operations rose to CHF 45 million, an increase of CHF 15 million or 50%. In 2014, emergencies represented a third of total operational expenditure, which is exceptional. We all have in mind the unprecedented Ebola outbreak in West Africa. The cost of this intervention in Liberia, Guinea and Sierra Leone totalled CHF 11 million. However, it was the response to the Central African Republic crisis (in the Central African Republic itself and with refugees in Cameroon) which required the greatest financial resources with CHF 18 million. Our project for displaced people in Minkaman, in South Sudan, was individually the project with the highest costs at CHF 7 million.

Finally, we continued to mobilise resources in the Middle East. We allocated a total budget of more than CHF 18 million for regular and emergency projects in Syria, Lebanon and Iraq.

**Headquarters' expenditure remained stable in 2014 at CHF 29 million**. Following four years of average annual growth of 10%, our headquarters showed an increase in expenditure of less than 2%, excluding fundraising. The latter increased by 4% to CHF 8 million.

In contrast, our contribution to the MSF International Office, as well as support to MSF entities in the Czech Republic, Mexico and South Korea, increased by 18% to CHF 5 million.

This year our expense ratio continued to be excellent, with **89% of our total expenses dedicated to MSF's social mission**, and only 6% spent on fundraising and 5% on management costs.

The Ebola epidemic in West Africa and our teams' engagement to tackle it bolstered public support for MSF. The unprecedented level of generosity made 2014 an exceptional year in terms of income. **Income totalled CHF 201 million** in 2014, an increase of 14%, of which **CHF 102 million was donated in Switzerland**, up 23% from the previous year. We received support from **more than 236,000 donors in Switzerland**: individuals' donations increased by 17%; private organisations' donations increased by 53%, due primarily to the IKEA Foundation.

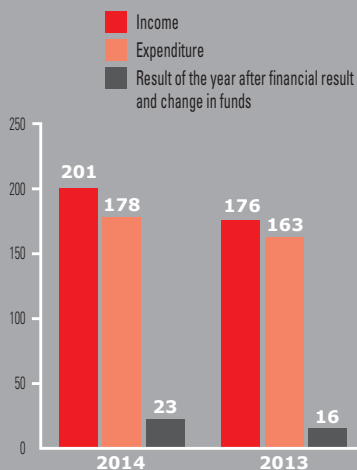
With a total of CHF 73 million, funding from MSF Switzerland's partner sections rose by 4% compared to 2013. MSF USA remains the largest contributor (CHF 22 million), followed by MSF Austria (CHF 15 million) and MSF Australia (CHF 12 million).

**Public institutional income rose to CHF 26 million**, up 15% from 2013 and in-line with programme increases. The Swiss Agency for Development and Cooperation is our largest source of public funding (CHF 8 million), followed by the European Union and the Swedish International Development Cooperation Agency.

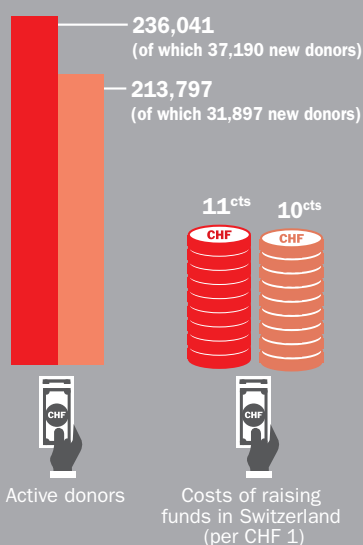
**In total, 87% of our income came from private sources (donated in Switzerland and by MSF partner sections) and 13% from public funding.**

During the 2014 financial year, exchange rate variations remained strongly contained by the action of the Swiss National Bank which maintained an exchange rate floor for the euro. As a result, we saw a marginal forex gain of CHF 700,000.

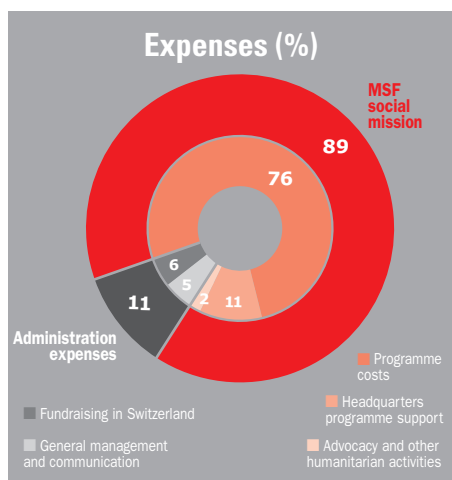
## Statement of operations (in million Swiss francs)



## Donors in Switzerland



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.



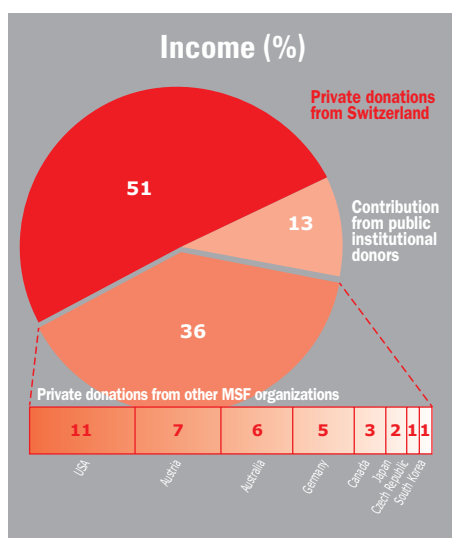
These factors resulted in a CHF 23 million surplus for 2014 and brought our **reserves to CHF 131 million**, which equate to 8.8 months of activity. This level of reserves brings with it responsibility towards our donors and also to the populations we help, and opens up new opportunities for MSF Switzerland to better fulfil its social mission.

We would like to thank all of the donors in Switzerland, as well as those in the USA, Germany, Austria, Australia, Canada, Japan, Mexico, the Czech Republic and South Korea who funded our operations through their generosity.

Geneva, 9 May 2015

Ralf de Coulon  
Treasurer

Emmanuel Flamand  
Finance Director



## EXPENSES AND REVENUES BY PROJECT

(in thousand Swiss francs)

Projects	Public funds	Private funds and other income	Total income	Expenditure 2014	Expenditure 2013
Cameroon	3,154	7,633	10,787	10,787	2,528
Guinea	1,261	3,867	5,128	5,128	3,309
Kenya	80	6,973	7,053	7,053	6,887
Liberia	1,894	4,587	6,481	6,481	0
Mozambique	700	3,135	3,835	3,835	4,276
Niger	2,300	8,691	10,991	10,991	8,932
Central African Republic	175	8,923	9,098	9,098	49
Democratic Republic of Congo	2,073	6,930	9,003	9,003	16,614
Sierra Leone	466	1,233	1,699	1,699	0
Somalia	0	0	0	0	4,206
Sudan	747	1,898	2,645	2,645	2,783
South Sudan	5,330	10,569	15,899	15,899	9,067
Swaziland	1,251	5,705	6,956	6,956	7,749
Chad	660	5,329	5,989	5,989	9,095
Other	80	1,622	1,702	1,702	1,664
<b>TOTAL AFRICA</b>	<b>20,171</b>	<b>77,095</b>	<b>97,266</b>	<b>97,266</b>	<b>77,159</b>

Projects	Public funds	Private funds and other income	Total income	Expenditure 2014	Expenditure 2013
Iraq	119	7,820	7,939	7,939	7,218
Kyrgyzstan	0	2,584	2,584	2,584	3,795
Lebanon	148	8,454	8,602	8,602	7,785
Myanmar	1,556	1,268	2,824	2,824	3,022
Philippines	0	182	182	182	2,837
Democratic People's Republic of Korea	0	682	682	682	903
Syria	0	1,958	1,958	1,958	2,609
<b>TOTAL ASIA</b>	<b>1,823</b>	<b>22,948</b>	<b>24,771</b>	<b>24,771</b>	<b>28,169</b>
Honduras	688	814	1,502	1,502	1,730
Haiti	459	8,639	9,098	9,098	8,525
Mexico	100	1,114	1,214	1,214	327
Other	0	0	0	0	18
<b>TOTAL AMERICA</b>	<b>1,247</b>	<b>10,567</b>	<b>11,814</b>	<b>11,814</b>	<b>10,600</b>
Others	0	1,319	1,319	1,319	1,451
Financing other MSF sections projects	0	325	325	325	4,732
<b>TOTAL</b>	<b>23,241</b>	<b>112,254</b>	<b>135,495</b>	<b>135,495</b>	<b>122,111</b>



# ACKNOWLEDGEMENTS

**We would like to thank all the donors who made the work of MSF possible in 2014. Last year, 236,041 people generously supported our organisation – we are very grateful for their trust.**

## **We also thank the governments, government agencies and international organisations that supported our projects:**

- DANIDA – Danish International Development Agency
- DFATD / IHA – Department of Foreign Affairs, Trade and Development, Canada
- DFID – Department for International Development, UK
- ECHO – European Community Humanitarian aid Office
- Liechtenstein government
- Ministry of Foreign Affairs, Norway
- Ministry of Foreign Affairs, Czech Republic
- SDC – Swiss Agency for Development and Cooperation
- SIDA – Swedish International Development Cooperation Agency
- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- UNHCR – The UN Refugee Agency
- Unicef – United Nations International Children Emergency Fund
- UNITAID
- WFP – World Food Programme

## **In particular, we would like to thank the following foundations, companies, cantons and cities:**

- Canton de Vaud, Département de la Santé et de l'Action Sociale
- Cartier Charitable Foundation
- Chaîne du Bonheur
- COFRA Foundation
- Coop Patenschaft für Berggebiete
- Ferster Stiftung
- Fondation Hans Wilsdorf
- Fondazione R.R. per l'aiuto umanitario
- Gebauer Stiftung
- Hilti Foundation
- IKEA Foundation
- Kanton Basel-Landschaft
- Lanfrosa Stiftung
- Leopold Bachmann Stiftung
- Linxx SA
- Medicor Foundation
- MSC - Mediterranean Shipping Company SA
- Oak Philanthropy Limited
- Panorama Trust
- Radio-Onkologiezentrum Biel-Seeland-Berner-Jura
- République et Canton de Genève
- Townley Business SA

- UBS Optimus Foundation
- Ville de Genève
- von Duhn Stiftung

## **Our most sincere thanks also go to:**

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- AgonPro AG
- Ameos Holding AG
- Ammarkt AG
- AMZ Architekten AG
- Arcanum Stiftung
- at rete ag
- Avadis Vorsorge AG
- Aperience AG
- Banca Raiffeisen Mendrisio e Val Muggio
- Bank-now AG
- Baugenossenschaft Freiblick Zürich
- Benevity Inc.
- Beratende Ingenieure Scherler AG
- Berner Augenklinik Am Lindenhofspital
- Binder Rechtsanwälte
- BlackRock Advisors (UK) Limited Dubai Branch
- Blaser Swissslube AG
- Bolliger & Mabillard
- Borer Chemie AG
- Breitling SA
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- Commune de Bardonnex
- Commune de Bellevue
- Commune de Bernex
- Commune de Chêne-Bougeries
- Commune de Collonge-Bellerive
- Commune de Cologny
- Commune de La Tour-de-Peilz
- Commune de Meyrin
- Commune de Plan-les-Ouates
- Commune de Troinex
- Commune de Versoix
- Commune de Vevey
- Commune de Veyrier
- Commune du Grand-Saconnex
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- Dema Dent
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- Dieter Kathmann Stiftung
- Elbro AG
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- Exedra AG
- FileWave Financial Services GmbH
- Fisba Optik AG
- Fondation Alfred et Eugénie Baur
- Fondation 'Avec et pour autres'
- Fondation Charitable Bienvenue
- Fondation de bienfaisance de la Banque Pictet & Cie
- Fondation Divesa
- Fondation Françoise Siegfried-Meier
- Fondation Hubert Looser
- Fondation Johann et Luzia Graessli
- Fondation McCall MacBain
- Fondation Ousseimi
- Fondation Pierre Demaurex
- Fondation pour l'aide humanitaire
- Fondation Resurgens
- Fondation Rifké
- Fondazione Casal
- Fondazione Pro Dimora
- Gebrüder Kägi Stiftung
- Gemeinde Aeugst am Albis
- Gemeinde Baar
- Gemeinde Binningen
- Gemeinde Elgg
- Gemeinde Goldach
- Gemeinde Herrliberg
- Gemeinde Küsnacht
- Gemeinde Riehen
- Gemeinde Wallisellen
- Gemeinde Wettingen
- Generation Media AG
- GFK Switzerland AG
- Giessenbach Stiftung
- GOM International AG
- Günther Caspar Stiftung
- GZ Trust
- Hackenjös Immobilien AG
- Hapmed AG
- Hatex AG
- Heguka Stiftung
- Heinis AG

- Huwa Finanz & Beteiligungs AG
- I+F Public Benefit Foundation
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- Ivoclar Vivadent AG
- Jost J. F. & Co
- Jürg Walter-Meier-Stiftung
- Kambly-Fonds für notleidende Kinder und Familien
- Kanton Appenzell AusserRHoden
- Kanton Schaffhausen
- Kanton Thurgau
- Karelsie Stiftung
- Kempf und Pfaltz Histol. Diagnostik
- Kummler + Matter AG
- Kundzutun AG
- Lanz Oensigen AG
- Looser Management AG
- Martin Nösberger Stiftung
- Mathilde Daudert Stiftung
- Musgrave Charitable Trust
- New Brain Marketing et Promotion
- Oswald Gruppe Zug AG
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- Spline AG
- Stadt Rapperswil-Jona
- Stadt Schlieren
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- Stiftung der Gemeinschaft der Liebfrauenschwester
- Stiftung Fürstlicher Kommerzienrat Guido Feger
- Stiftung Missionarische Entwicklungshilfe
- Stiftung NAK Humanitas
- Stiftung Theresianum Ingenbohl
- Stokar + Partner AG
- Stone Age Gems Ltd
- Storz Medical AG
- STOXX Limited
- Sun Store SA
- Sunside Treuhand- und Verwaltungs AG
- Swissi AG
- Tarbaca Indigo Foundation
- Tech-Insta SA
- Teletrend AG
- The Aurora Light Foundation
- The Kernco Foundation
- The Tanner Trust
- Thurgau Travel AG
- Toni Hilti Treuhand-Gesellschaft
- Treuco AG
- Tschikali Stiftung
- Twentieth Century Fox Home Entertainment
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- Weber Serneus AG
- Wellington Partners Advisory AG
- Wietlisbach Foundation
- WorldConnect AG
- Xerof Financial Services SA
- Yellow Bird Foundation
- Zweifel Pomy-Chips AG

### We would also like to thank our event partners:

- Fumetto Comix Festival
- Zurich Film Festival

### Finally, we would like to thank all those who offered their time and energy to MSF in 2014:

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- Anne Morel
- Katja Müller
- Brenda Nelson
- Thérèse Rasmussen
- Irène Serfass
- Anna Sczeniowski
- Cecile Thiery
- Jeannette Varzandeh
- Eliane Vilpert

Thank to our  
**236,041**  
 donors



# 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 2014

- Dr Thomas Nierle, President (from May 2014)
- Dr Abiy Tamrat, President (until May 2014)
- Ralf de Coulon, Treasurer
- Nicolas Cantau, Secretary (from May 2014)
- Dr Slim Slama, Secretary (until May 2014)
- Dr Philippe Sudre
- Jean-Christophe Azé
- Liza Cragg
- Dr Anne Perrocheau
- Olivier Antonin (until May 2014)
- Dr Karin Hartmann (until May 2014)
- Co-opted members:
- Dr. Karim Laouabdia
- Andreas Wigger

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 2014

- Ralf de Coulon, Treasurer of MSF Switzerland, President of the Financial Commission
- Dr Thomas Nierle, President of MSF Switzerland (from May 2014)
- Dr Abiy Tamrat, President of MSF Switzerland (until May 2014)
- Peter Lamatsch, MSF Austria Board Member
- Hans Isler, Financial Expert
- Frank Copping, MSF Canada Board Member
- Liza Cragg, MSF Switzerland Board Member (from May 2014)
- Olivier Antonin, MSF Switzerland Board Member (until May 2014)
- Norbert Beckhaus, MSF Germany Board Member (until May 2014)

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 2014

- Bruno Jochum, General Director
- Dr Jean-Clément Cabrol, Director of Operations
- Franck Eloi, Director of Human Resources
- Emmanuel Flamand, Finance Director
- Kim N'Guyen, Information Systems Director (since December 2014)
- Thang Dao, Information Systems Director (until September 2014)
- Susanna Swann, Deputy General Director
- Laurent Sauveur, Communication and Fundraising Director
- Dr Micaela Serafini, Medical Director (from March 2014)
- Dr Eric Comte, Medical Director (until May 2014)
- Mathieu Soupart, Logistics Director (from June 2014)
- Jean-Luc Castell, Logistics Director (until June 2014)

The statutory auditors elected by the General Assembly perform the yearly audit of MSF Switzerland's financial statements. PricewaterhouseCoopers SA, Geneva, has been appointed to perform this task for MSF Switzerland 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 2014 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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