

NEO FOR NAMIBIA HELPING BABIES SURVIVE



AUTHORS

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MISSION REPORT

Mission 2026–2

May 4 to June 2, 2026

NEO FOR NAMIBIA
HELPING BABIES SURVIVE

www.neo-for-namibia.org

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1. INTRODUCTION

This was the 26th mission of a NEO FOR NAMIBIA – Helping Babies Survive Team, lasting from May 4 to June 2, 2026. It was conducted by Prof. Thomas M. Berger, MD, his wife Sabine Berger, RN, her niece, Lea Bürge, EN, and driver and assistant, Isaak Boois.

Arriving from Johannesburg at Husea Kutako International Airport in Windhoek late in the evening on May 5, 2026, last minute VISA arrangements for Sabine Berger and an e-VISA for Lea Bürge allowed the Swiss team members to pass through immigration without difficulties. Earlier that day, a provisional VISA and work permit had been received by e-mail and printed out during the team's stopover at Oliver Tambo International Airport in Johannesburg. Similarly, VAT exemption had been obtained the same day, and customs clearance of donated goods proceeded without undue delays.

After a one-night-stay in Windhoek, the Swiss team members left for Rundu on May 6, 2026, following meetings with Mr. Lawrence Siyanga and Mrs. Mekondjo Haufiku from the Ministry of Health and Social Services (MoHSS) to get updates on pending administrative issues (i.e., Memorandum of Agreement (MoA), approval of the Vayu® bubbleCPAP project). They arrived in Rundu on May 7, 2026, on Sabine Berger's 50th birthday!

Isaak Boois had to stay in Windhoek to wait for the completion of Sabine Berger's VISA and work permit approval (basically transferring the data from the temporary permit into her passport) and pick up soap and paper towels from Taurus Maintenance Products for the two hospitals in Rundu and Katima. Unfortunately, despite multiple interventions, the Ministry of Home Affairs did not complete the VISA approval as promised, and Isaak Boois could only head up north almost two weeks later than anticipated; therefore, his travel plans had to be adjusted multiple times.

Prof. Thomas M. Berger, Sabine Berger and Lea Bürge spent a total of 16 full days at the two hospitals in the Kavango East and Zambezi regions of Namibia (Rundu Intermediate Hospital: 7+4 days, Katima State Hospital: 5 days). Stays at Riverdance Lodge and Camp Kwando allowed them to recover from their strenuous and sometimes emotionally challenging work at the hospitals (see below). On May 27, 2026, they headed south, and arrived in Windhoek on May 29, 2026, after traveling through the Etosha National Park and a two-night-stay at the Etosha Oberland Lodge (Fig. 1).

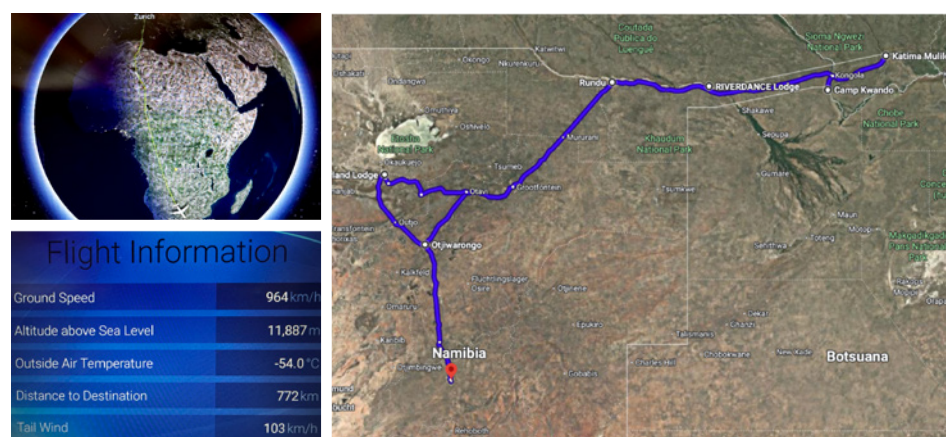


Fig. 1. The mission team members flew across the African continent and covered more than 3'000 km by car in Namibia.

Finally, on June 1, 2026, the Swiss team departed to Switzerland on board of the first Edelweiss direct flight from Windhoek to Zurich, arriving on June 2, 2026, thus completing their 30-day-mission.

2. MAIN MISSION GOALS

The main goals of the 26th mission of NEO FOR NAMIBIA – Helping Babies Survive were:

- To reassess the quality of perinatal care at both Rundu Intermediate Hospital and Katima State Hospital
- To update inventories of donated equipment to plan future donations
- To oversee the distribution of the NGO's largest donation yet (monitoring equipment, incubators, resuscitation units, X-ray view boxes)
- To introduce a handheld ultrasound scanner (Clarius C7) to allow for point of care ultrasound (POCUS) examinations
- To finalize and possibly sign a Memorandum of Agreement (MoA)
- To make final arrangements for the introduction of the Vayu® bubbleCPAP device and the Vayu® blender system in Namibia

3. HOSPITALS VISITED

3.1 Rundu Intermediate Hospital

3.1.1 Overall impression

During their visit, the team was satisfied by the overall quality of care but also observed deficiencies that will have to be addressed without delays. The unit was less clean than in the past. Hand disinfectants were not readily available at the bedside, and paper towels were out of stock. The staff toilet was broken, and often there was no water in the unit. The patient rooms were clogged with equipment that was not used.

A lack of strong leadership was apparent both among nursing and physician staff; if this situation cannot be corrected rapidly, the quality of patient care will likely decline resulting in worse outcomes of sick babies.

These concerns were discussed with the Prem Unit's leaders, Dr. Isha Kamara, MD, Cecilia Ndepavali, RN, and Natalia Murongo, RN.

During the team's two stays at Rundu Intermediate Hospital, the patient census was around 25, but some babies were extremely ill and required invasive mechanical ventilation, often with unfavorable outcomes. Sadly, the team had to witness four deaths:

- Preterm infant (birth weight 1'770 g) with hydocolpos due to vaginal atresia, complicated by small bowel perforation (died on postoperative day 4, see below)
- Term infant (birth weight 4'360 g) with HIE III (cause not recorded)
- Near-term infant (birth weight 2'400 g) with HIE III (cause not recorded)
- Preterm infant (birth weight 900 g) died 24 hours after having been extubated to CPAP with an FiO₂ of 30 % (the likely cause remained undetermined)

3.1.2 Invasive mechanical ventilation – ongoing concerns

The Prem Unit has two EVE TR neo ventilators donated by NEO FOR NAMIBIA – Helping Babies Survive. They were now mostly used in a pressure-control mode with pressure-regulated volume control (PRVC). Most nurses and many doctors (interns and even medical officers) do not fully understand how the machines should be used. The Fisher & Paykel MR850 heaters and humidifiers were frequently turned off because of apparent excessive humidification and condensation leading to water accumulation at the y-piece of the patient circuit and malfunctioning of the flow sensor. More training both for the ventilators and the humidifiers are urgently needed (Fig. 2).

Fig. 2. Invasive mechanical ventilation remains challenging: knowledge gaps, equipment malfunction (heater & humidifiers) and unreliable availability of X-ray imaging put patients at risk.



A Mindray SV300 ventilator is borrowed from high care when both EVE TR neo machines are in use; as noted previously, appropriate training for this machine has never been provided. It is used without humidification because its heater and humidifier is broken. Obviously, training and supervision of less experienced staff must be intensified to avoid patient harm.

3.1.3 Equipment maintenance and storage space

The Cuban medical engineer, Leonardo Sandalio Sánchez de la Cruz, continues to do his best to maintain and repair medical equipment donated by NEO FOR NAMIBIA – Helping Babies Survive. He will play an important role in the installation of the donated monitors (incl. changing all the power plugs, safe fixation of the larger screens). He will also have to fit high pressure adapters to the GE Panda resuscitation unit's gas hoses, so they fit the wall gas outlets (see below).

As outlined above, equipment that is not used must be stored outside of the patient rooms to improve working conditions. To this end, broken machines and equipment that is no longer used and its consumables must be removed from currently available storage rooms.

Searching for potential storage room solutions, the mission team noted that significant effort will have to be put into this project as it will not only concern the Prem Unit rooms but will involve the utilization of rooms in other buildings (Fig. 3–5).

Fig. 3. Lack of practical and organizational skills are still omnipresent (left: oddly installed flow meters; right: countless keys are kept for no purpose)

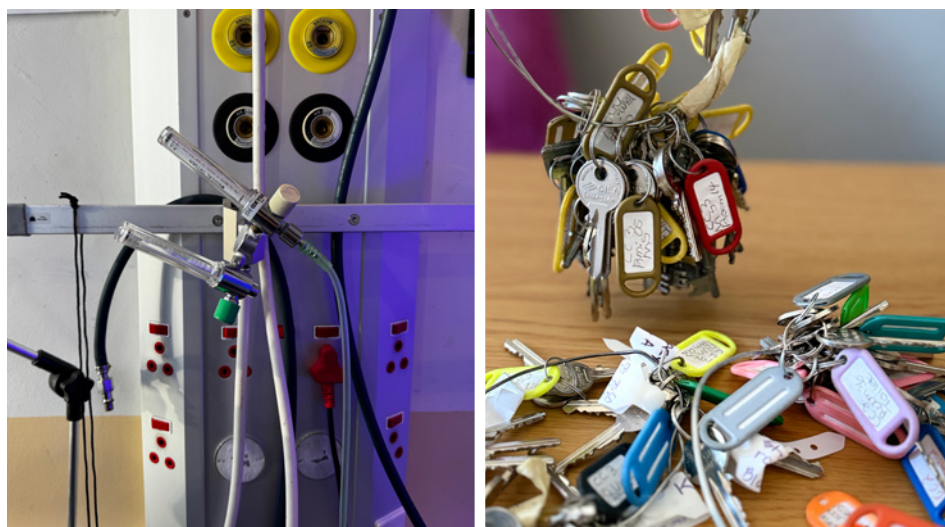


Fig. 4. The equipment graveyards (left, bottom right) at Rundu Intermediate Hospital are growing; the main storage room (top right) is cluttered and not well organized.



Fig. 5. While trying to find storage space for medical equipment, Prof. Thomas M. Berger came across a litter of kittens hidden in a cardboard box in a cupboard in an empty room in the women's shelter.

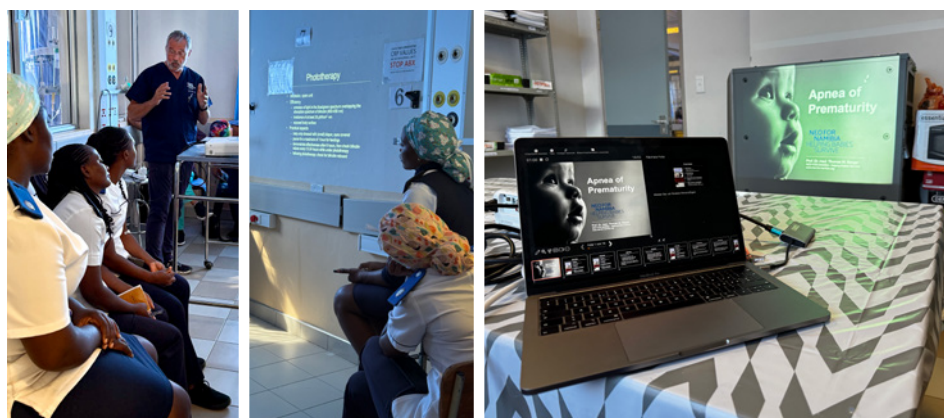


3.1.4 Lectures and teaching sessions

Prof. Thomas M. Berger was able to give formal lectures to new interns and medical officers (08:00–09:00 o'clock) and nurses (14:00–15:00 o'clock) on the following topics (Fig. 6):

- Fetal physiology and pathophysiological aspects of neonatal resuscitation
- Interpretation of chest X-rays
- Intubation and invasive mechanical ventilation
- Neonatal jaundice and practical aspects of phototherapy
- Apnea of prematurity
- Neonatal sepsis (focus on biomarker-guided antibiotic therapy)
- Periparturient asphyxia and hypoxic-ischemic encephalopathy (HIE)
- Neonatal cerebral ultrasound examination (physicians only)

Fig. 6. Lectures for the nurses were given in the Prem Unit (left and middle: patient room; right: staff kitchen) to allow for as many nurses as possible to attend.



3.1.5 Point of Care Ultrasound (POCUS) examination

Ultrasound allows non-invasive examination of the neonatal brain. With adequate equipment, it can be done at the bedside (i.e., ultrasound at the point of care, thus abbreviated POCUS). This is possible because there are several acoustic windows in the baby's skull (particularly the anterior fontanel) that allow the sound waves to travel to the brain.

NEO FOR NAMIBIA – Helping Babies Survive has purchased a suitable device (Clarius C7), and Prof. Thomas M. Berger started to train local physicians in its use (Fig. 7–9).

Fig. 7. Basics of neonatal head ultrasound:
A) acoustic windows (AF: anterior fontanel);
B) ventricular system; C) standard views through the AF.

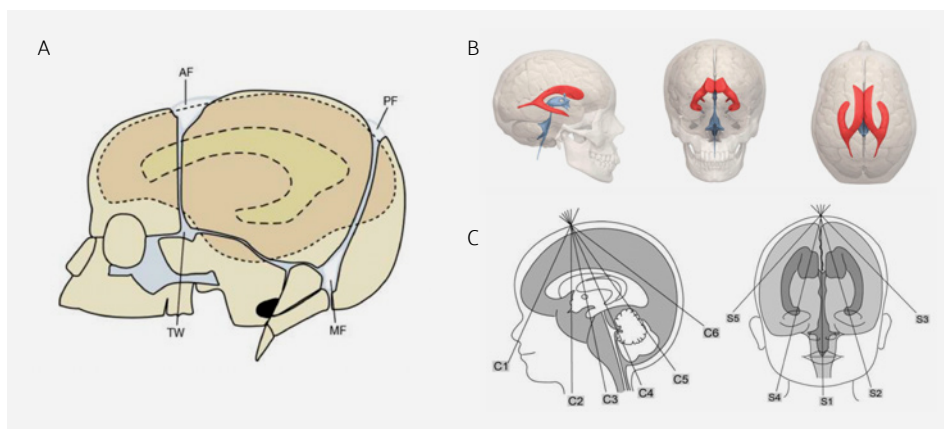
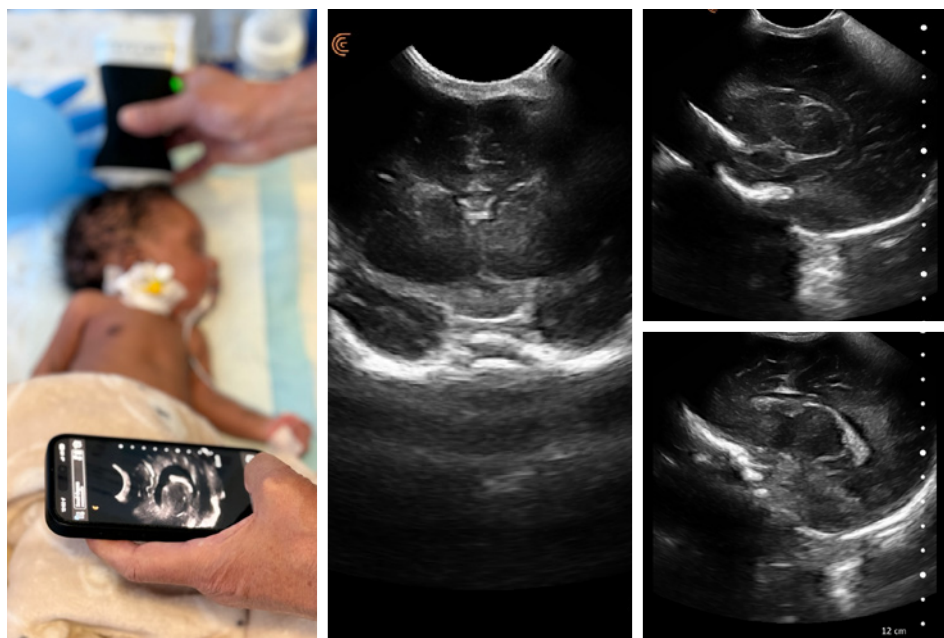


Fig. 8. Bedside teaching of the Clarius C7 POCUS scanner: Prof. Thomas M. Berger and Dr. Isha Kamara examine the brain of a baby with late-onset sepsis and possible meningitis.



Fig. 9. The Clarius C7 POCUS device is easy to use and provides excellent image quality.



3.1.6 Prem Unit statistics

As always, relevant statistical data was abstracted from the Prem Unit's admission book.

From January 1 to April 30, 2026, 248 babies were admitted to the Prem Unit (190 inborn, 58 outborn). Over the same four-month-time period, there were 22 deaths (overall mortality rate 8.9%). Of these, 11 were inborn infants (mortality rate 5.8%) and 11 were outborn infants (mortality rate 19.0%).

Leading causes of death were complications of prematurity (n=9) with a high rate of pulmonary hemorrhages (n=3), neonatal sepsis (n=5), and congenital malformations (n=5: esophageal atresia, omphalocele, brain atrophy and club feet, suspected congenital heart disease).

The quality of these statistical analyses remains limited because the outcome of babies transferred to Windhoek for tertiary care (often patients with suspected congenital

heart disease) is frequently unknown. In addition, causes and circumstances of deaths often remain ill-defined.

After more than ten years of support by NEO FOR NAMIBIA – Helping Babies Survive, it was interesting to analyze mortality rates over time (for the entire period, complete data was only available for inborn babies). Prior to our first interventions (mostly training on basic neonatal care, provision of pulse oximetry monitors), the mortality rate of sick babies admitted to the hospital's Prem Unit was 14.8 % (range 11.4 – 18.6 %). In 2016, it decreased to 11.0%. The most dramatic decrease of mortality rate was seen when CPAP was introduced (Pumani® bubbleCPAP in 2017, MTTs Dolphin® bCPAP in 2019) and surfactant replacement therapy became available (in 2019). By 2020, the mortality rate had decreased to less than 8.0 %. Invasive mechanical ventilation was introduced in 2019 (EVE® TR neo), likely benefitting some of the sickest patients; its effect on overall mortality rate, however, remained limited. Over the past three years, mortality rates decreased only slightly from 7.9 % in 2021 to 6.9 % in 2025 (Fig. 10).

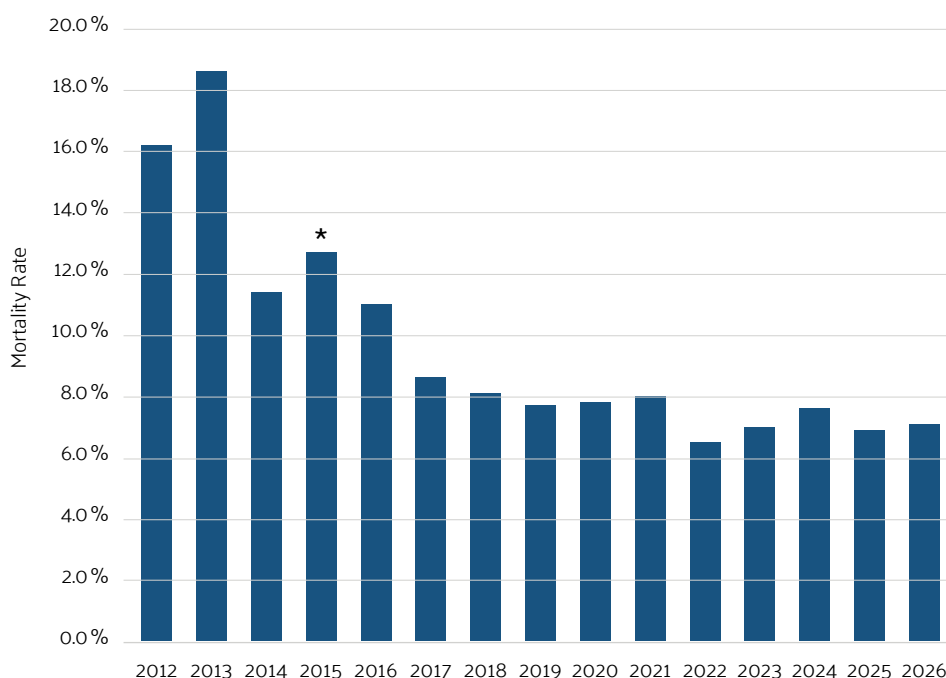


Fig. 10. Mortality rate of inborn infants at Rundu Intermediate Hospital over the past 15 years (asterisk: first visit of the founders of NEO FOR NAMIBIA – Helping Babies Survive).

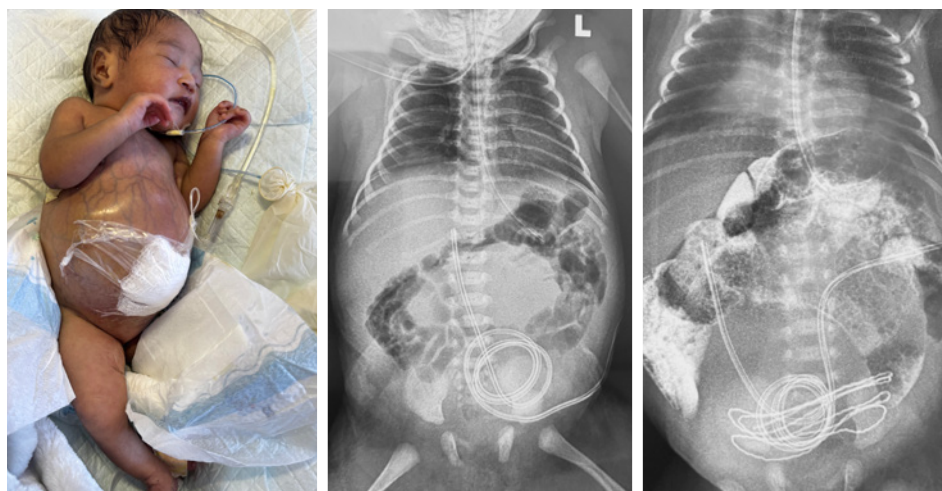
3.1.7 Case observations (Rundu Intermediate Hospital)

Pediatric surgery and pediatric anesthesia had only recently become available at Rundu Intermediate Hospital (in 2025). Long and risky transfers to Windhoek can now be avoided in some but not all cases. For example, abdominal surgery (e.g., correction of abdominal wall defects, intestinal atresias) can be performed, whereas neurosurgical interventions (e.g., ventriculoperitoneal shunt placement for hydrocephalus) or cardiac surgery are not possible.

3.1.7.1 Hydrocolpos

This near-term female baby was referred to Rundu Intermediate Hospital because of massive abdominal distension (Fig. 11). Conventional X-ray examinations without and with contrast revealed a midline mass.

Fig. 11. Term baby with abdominal distension, increased abdominal venous markings (left) and evidence of an abdominal mass on X-rays (middle, right).



Initially, it was planned to refer the baby to Oshakati Intermediate Hospital for a CT scan of the abdomen to define the pathology more clearly (the CT scanner at Rundu Intermediate Hospital was broken); however, the patient deteriorated within a couple of days and was therefore taken to the operating room for exploratory surgery. Intraoperatively, the surgeon (Dr. Shapaka) found a fluid-filled vagina (hydrocolpos) and a small bowel perforation. Fluid from the hydrocolpos was aspirated, and the perforated ileum was repaired with a wedge resection and primary anastomosis (Fig. 12).

Fig. 12. Surgical notes: Operation findings (left top), procedure done (left bottom) and post-operative plan (right).

PROCEDURE AND FINDINGS ANESTHESIA TYPE: GA & Local Anesthesia PREOPERATIVE DIAGNOSIS: Intra Abdominal Mass dx Hydrocolpos POSTOPERATIVE DIAGNOSIS: Hydrocolpos with Bilateral Ovarian Cysts ANTIBIOTIC PROPHYLAXIS: Yes/No PATIENT POSITION: Supine SKIN/SITE PREOPERATION (SOLUTION): Betadine + Alcohol in Tincture INCISION: Sub-umbilical Transverse OPERATION FINDINGS (Include Illustration): Enteric fluid - fascia		TISSUE SENT FOR HISTOLOGY: Yes ☐ ESTIMATED BLOOD LOSS: 50 ml SWAB, NEEDLE, INSTRUMENT, BLADE/SCREW COUNT: CORRECT ☒ INCORRECT ☐ IF NOT CORRECT, COMMENT:
PROCEDURE DONE (Include Illustration): ① Thorough abdominal exploration ② Aspiration of the Hydrocolpos ③ Excision of Bilateral Ovarian cysts ④ Wedge resection of the perforation on the ileum ⑤ Adhesiolysis ⑥ Exploration of the Vagina ⑦ ~ 50.5 ml of fluid aspirated COMPLICATIONS: None CLOSURE: Abdominal Fascia - 3.0 Vicryl Subcut - 4.0		POST-OPERATIVE PLAN: ① Transfer to prem Unit ② Keep on Vent ③ Keep NPO for the next 72h ④ Daily wound dressing with Betadine solution ⑤ Added Metronidazole 12mg Paracetamol 20mg Shapaka SURGEON/MEDICAL OFFICER

The initial postoperative course was uncomplicated; however, on the morning of the fourth postoperative day, the baby was found to have no respiratory effort and no reaction to painful stimuli. The fontanel was tense but point of care ultrasound (POCUS) of the head showed only some ventricular dilatation but no hemorrhage.

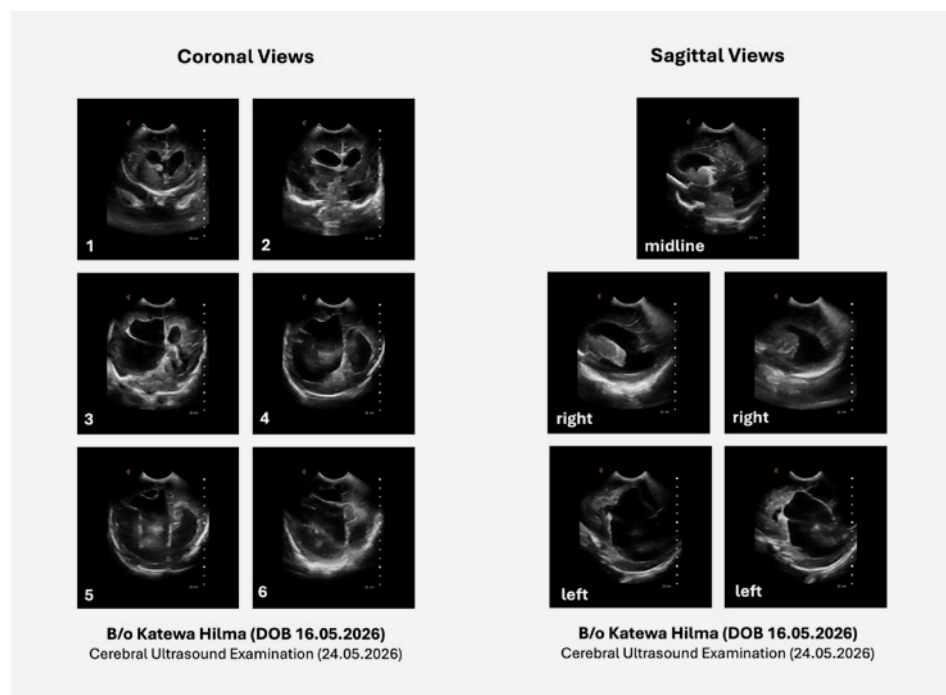
The patient demised two days later while still being ventilated (the surgeons felt uncomfortable to extubate the baby and provide palliative care only).

3.1.7.2 Congenital hydrocephalus

Prof. Thomas M. Berger was asked to review this term baby that had been born at term and was found to have a large head. Thus far, no imaging study had been done (ultrasound not readily available, CT scanner broken).

With the help of a handheld US scanner (see below), a likely diagnosis of posthemorrhagic hydrocephalus with porencephalic cyst was made (Fig. 13). When the images were shared with specialists in Switzerland, the possibility of hydrocephalus secondary to a suprasellar cyst was mentioned. At the time of this writing, the further course and final outcome of this patient remained unknown.

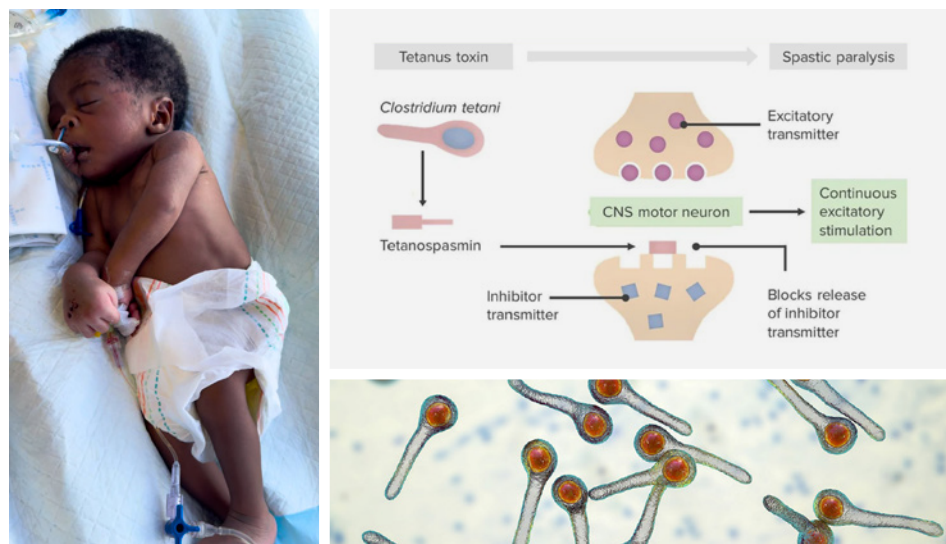
Fig. 13. POCUS imaging of a baby with congenital hydrocephalus: posthemorrhagic hydrocephalus with porencephalic cyst (DDx: hydrocephalus secondary to suprasellar cyst).



3.1.7.3 Neonatal tetanus

This baby was born at home (in a village in Angola, across the Kavango river) and admitted to the Prem Unit with apparent epileptic seizures. As no first line seizure medication was available (phenobarbital, phenytoin), the baby was treated with a midazolam drip. Due to apnea spells, the baby had to be intubated (Fig. 14).

Fig. 14. Newborn baby with neonatal tetanus (left); tetanus bacteria (bottom right) produce a toxin (tetanospasmin) that blocks the release of inhibitory transmitters (top right), leading to continuous excitatory stimulation and spasms.



Ultimately it was noted that the baby reacted to various stimuli (light, noise, touch) with violent spasms, and a presumptive diagnosis of neonatal tetanus was made by Dr. Isha Kamara. Fortunately, the baby survived and was discharged home.

Tetanus, known colloquially as “lockjaw”, predominantly affects the world’s poorest and weakest. The infectious disease is caused by a bacterium that releases a nerve-damaging toxin when it penetrates under the skin. Births in particular can be life-threatening: both non-immunized mothers and their newborn infants can become infected with tetanus if delivery takes place in unsanitary conditions. Without treatment, the disease is fatal in almost every case. Even in hospitals, up to 60 percent of infected babies die. Neonatal tetanus is one of the leading causes of death among newborns, claiming the lives of more than 18’000 children under the age of five each year (source: www.unicef.ch).

3.1.8 Next steps

NEO FOR NAMIBIA – Helping Babies Survive will continue to support Rundu Intermediate Hospital, provided adequate funding can be secured. As mentioned in previous reports, ownership of the program will have to be transferred to the hospital in the not-too-distant future (time frame: 3–5 years). The NGO’s support will focus on the supply of relevant consumables and occasional replacement of equipment that has reached end-of-life and can no longer be repaired.

3.2 Katima State Hospital

During their short stay in Katima (four days), the mission team was able to abstract statistical data (see below), to update the neonatology unit’s inventory list and to give a lecture on neonatal resuscitation to doctors and midwives in the obstetrical unit (Fig. 15).

Fig. 15. A lecture on neonatal resuscitation was given in the labor and delivery ward and was well attended by doctors and nurses.



The quality of neonatal care continues to be very good given ongoing structural and staffing restrictions (Fig. 16). As mentioned in previous reports, training and supervision of junior staff must be improved to ensure a safe environment for sick babies.

Fig. 16. Syringe feeding of a preterm baby.



3.2.1 Warm knitwear for babies from Switzerland

With winter approaching, keeping babies warm becomes increasingly challenging, both in the neonatology unit and in the villages. The mission team was once again able to bring a large amount of knitted hats and socks for babies (handcrafted by Sabine Berger's mother Pia Meier, Martha Sigrist, a retired pediatric nurse, and Margrith Mäder, a retired midwife from Switzerland) (Fig. 17).

Fig. 17. Always keeping babies warm: knitted hats and socks are welcome (they are used in the unit and given to mothers when their babies are discharged).



3.2.2 Statistics DR and Prem Unit

In the first four months of 2026, there were a total of 1'163 deliveries, resulting in 1'300 live births and 15 stillbirths. The Cesarean section rate continued to be low at 11.8%. Over the same period, 189 babies were admitted to the Neonatology Unit. Overall, there were 7 deaths (overall mortality rate 3.7%). Birthweight-specific mortality rates were as follows: <1'000 g: 2/6 (33.3%); 1'000 – 1'500 g: 1/19 (5.3%); 1'501 – 2'500 g: 0/65 (0.0%); > 2'500 g: 4/99 (4.0%). These results are truly amazing with overall and birthweight-specific mortality rates reaching an all-time low.

3.2.3 Next steps

Given the success, NEO FOR NAMIBIA – Helping Babies Survive is highly motivated to continue to support Katima State Hospital, provided adequate funding can be secured. As for Rundu Intermediate Hospital, ownership of the program will have to be transferred to the hospital in the not-too-distant future (time frame: 3–5 years).

4. LARGEST DONATION OF NEO FOR NAMIBIA – HELPING BABIES SURVIVE

After an odyssey lasting more than eight months, the largest donation of NEO FOR NAMIBIA – Helping Babies Survive arrived on board of a container ship in Walvis Bay, Namibia. Following repetitive interventions to facilitate customs clearance, the container truck arrived in Rundu on Saturday, May 23, 2026 (Fig. 18).



Fig. 18. Arrival of the container truck from Walvis Bay with donations.

With the help of some hospital employees, the mission team was able to unload the container and sort the equipment (Fig. 19, 20) over the long weekend (Monday was a public holiday: Africa Day).

- Monitoring equipment (donated by the Zuger Kantonsspital: Philips IntelliVue X2 (n=60), Philips IntelliVue MP3 with stands (n=30), Philips IntelliVue MP30 (n=10), Philips IntelliVue MP50 (n=20); donated by Anandic Switzerland: GE Dash 3000 (n=9), GE Dash 5000 (n=5))
- Resuscitation units (donated by Anandic Switzerland: GE Panda Warmer (n=2), bought from Hirslanden Klinik Cham: GE Panda Warmer (n=2))
- Incubators (donated by Anandic Switzerland: GE Giraffe Omnibed (n=2), GE Giraffe Incubator (n=3))
- X-ray view boxes (donated by the Zuger Kantonsspital (n=7))
- Accessories (bought by NEO FOR NAMIBIA – Helping Babies Survive: Li Ion Akku Philipps MP2 (n=70), charging stations with adapters (n=5), RD SET MP-05 patient cables (n=70), RD SET MP-12 patient cables (n=20))



Fig. 19. Unloading GE Panda resuscitation tables and GE incubators.



Fig. 20. More than 100 monitors have been donated and shipped to Namibia.

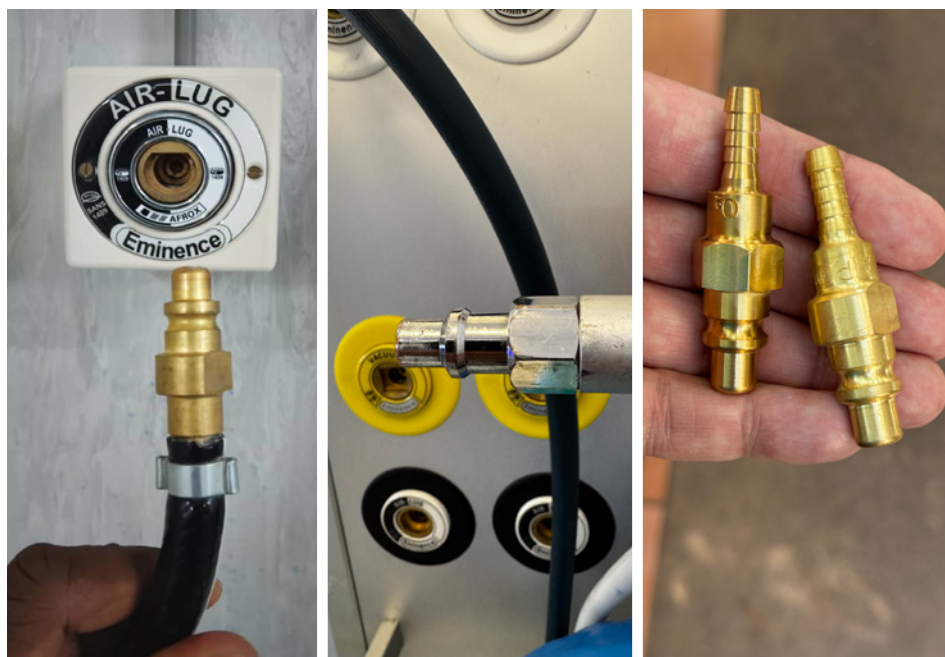
The donated goods will be used at Rundu Intermediate Hospital (roughly 2/3) and Katima State Hospital (roughly 1/3). Given the large numbers of monitors donated, not all of them will be used immediately but serve as back-up or for use on transports (see Vayu® project below) (Fig. 21).

Fig. 21. Many of the donated monitors were brought to the Prem Unit, installed and immediately used.



To operate the state-of-the-art GE Panda resuscitation units, both compressed oxygen and compressed air are required. Such wall outlets are available at Rundu Intermediate Hospital, but new adapters had to be bought from Afrox in Windhoek (of note: another Namibian supplier of medical equipment wanted to charge three times the price ultimately paid to Afrox) (Fig. 22). At Katima Hospital, no compressed air was available, and, therefore, cylinders with compressed air had to be obtained.

Fig. 22. High-pressure adapters (HPAs) for compressed air and oxygen: different standards often require change of adapters.



5. VAYU® bubbleCPAP PROJECT

With the support of Mr. Lawrence Siyanga, NEO FOR NAMIBIA – Helping Babies Survive finally received permission to introduce the Vayu® bubbleCPAP and air-oxygen blender (Fig. 23) systems to Namibia. Operation of the devices requires no electricity and only compressed oxygen because the blender system is based on the Venturi effect (Fig. 24).

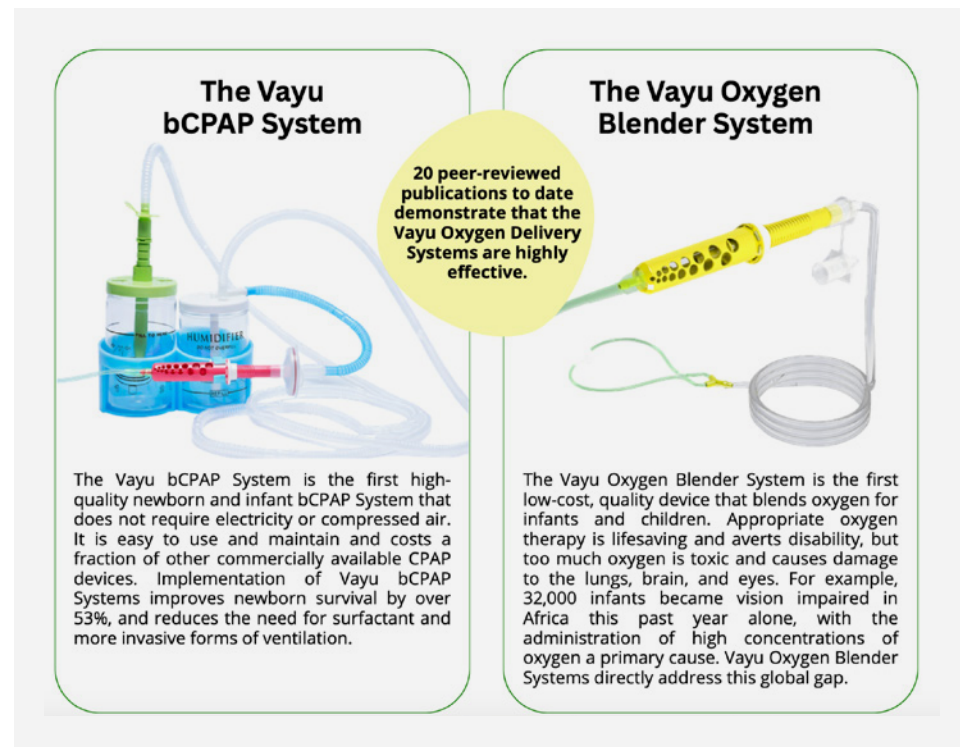


Fig. 23. Vayu® bCPAP system and the Vayu® oxygen blender system.

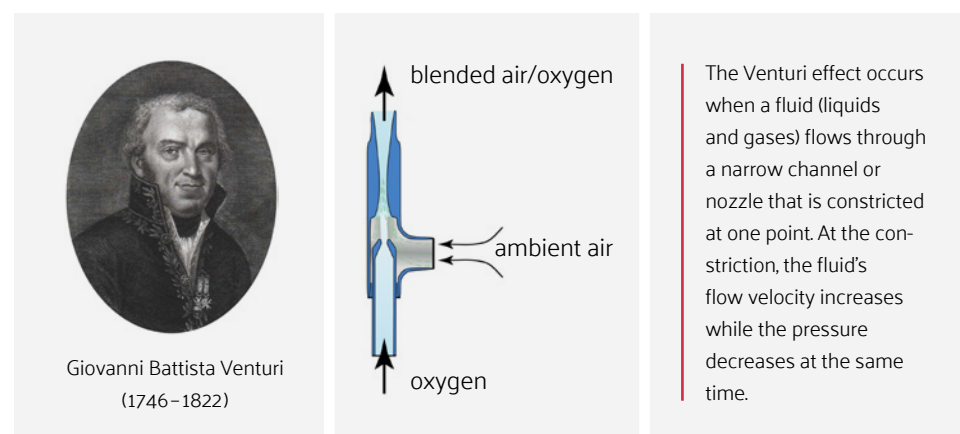


Fig. 24. The Venturi effect.

The issued letter confirming exemption from device registration has since been accepted by Vayu® Global Health Foundation in Boston. As soon as the scope of the initial training sessions can be determined, the necessary amount of equipment will be ordered.

6. IMPRESSIONS FROM THE 25TH MISSION

To conclude this report, some images will illustrate various scenes the team encountered during their one-month-trip through Namibia (Fig. 25–32). Enjoy!

Fig. 25. Evening scenery at the Kavango River.

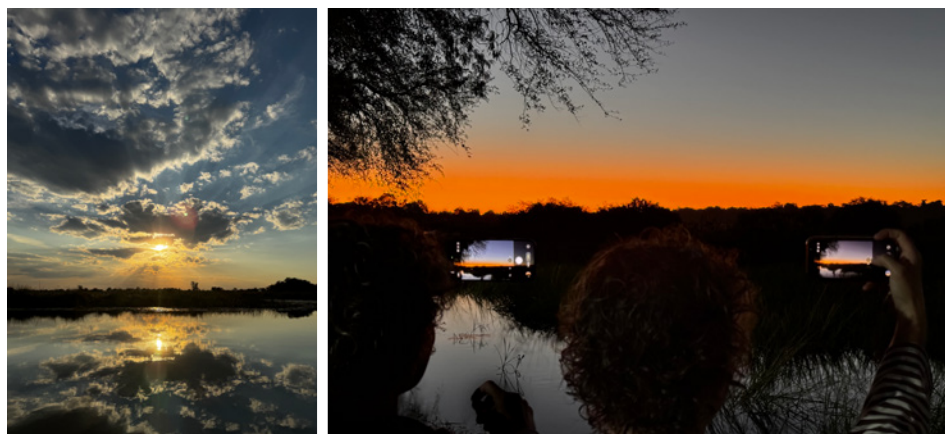


Fig. 26. African flora: angel's trumpet (left), frangipani (middle), papyrus (right).



Fig. 27. African fauna: Impala (left top and bottom), praying mantis (right).



Fig. 28. African fauna: Nile crocodile (left),
vervet monkey (right).



Fig. 29. Sports event: Kids playing with
donated tennis rackets and tennis balls
(la vie en tennis, Adligenswil, Switzerland).



Fig. 30. Sports event: Standing in line to get
water, fruit and cookies.



Fig. 31. Sports event: Happy kids following an afternoon of sports activities with food and drinks.



Fig. 32. Mission team at work (left: Lea Bürge, EN, middle: Prof. Thomas M. Berger, right: Sabine Berger, RN).



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