MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Médecins Sans Frontières MSF (Doctors Without Borders) is a leading independent humanitarian organisation for emergency medical aid. In more than 60 countries worldwide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

# DISPATCHES

## 40 YEARS OF MSF

Maternity services in Somaliland


2009 Massive vaccination campaign in Chad

'There were no medical guidelines, no boss – you did what you thought was fit. You had to do absolutely everything yourself, so medical care was only a small part of it.

1996 Great Lakes Crisis

2003 Battling spread of TB in Abkhazia


1995 Family reunited in Bosnia

'There was a shower of bullets, and the surgeon was severely wounded. We thought it was all over. MSF was so small and frail at the time that, had we been killed, I'm not sure MSF would have survived'

Rony Brauman remembers as MSF reaches its 40th anniversary

1985 Rony Brauman treats a child in a camp on the Ethiopian border during the famine


1988 Aiding survivors of the Armenian earthquake


2002 Aiding refugees in war-torn Afghanistan


2005 Treating HIV-positive patients in Ivory Coast

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*Dispatches* is written by people working for MSF and sent out every three months to our supporters and to staff in the field. It is edited in London by Marcus Dunk.
It costs 6p to produce, 7p to package and 22p to send, using Mailsort Three, the cheapest form of post. We send it to keep you informed about our activities and about how your money is spent.
*Dispatches* gives our patients and staff a platform to speak out about the conflicts, emergencies and epidemics in which MSF works. We welcome your feedback. Please contact us by the methods listed, or email:**marcus.dunk@london.msf.org**

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## Libya
### After the battle

**Dr Gabriele Rossi, MSF emergency coordinator, describes the situation in Sirte in the days before the city was captured by forces loyal to the Libyan Transitional Council.**

**This interview was conducted on 13 October 2011.**

We are in Ibn Sina hospital, which is the main hospital in Sirte. Today we've been hearing more firing and shooting than yesterday – there is lots of noise, and the constant sound of heavy artillery. From here we can see a lot of fighters heading towards the frontline, with ammunition, armoured pick-ups and even tanks.

In the areas of Sirte we've travelled through, there are no civilians at all: all the houses are destroyed and empty. The atmosphere in the hospital is extremely heavy.

There are about 50 patients, all with trauma wounds, fractures or burns, and all in need of surgery. Most of the patients are young adults, but we also have women and children who have been injured in the fighting.

The wounds of some patients are really bad and very infected. They need urgent surgical debridement.

Ibn Sina hospital is in a very damaged state, with signs of the heavy fighting. All the patients are on the ground floor, while the first floor and the basement are taken up with about 50 people who are sheltering from the violence.

Security-wise, the hospital isn't safe. Yesterday and today, there have been a lot of fighters entering the hospital with guns, checking every patient and looking for we-don't-know-who. For our team it's not safe to stay here at night, so each evening we make the two-hour journey back to our base in Misrata.

The hospital's medical staff have been amazing – they've been truly heroic. They've worked through the intense crisis of the past few weeks and been directly exposed to violence. They've worked under shelling, under bombing, and under the threats of Gaddafi loyalists ordering them to come and treat their soldiers. They're exhausted.

When we first arrived there was a lack of medicines.

The first delivery we did was of painkillers, antibiotics for all the wound infections, plus drugs for chronic diseases.

If the situation calms down over the coming days, people will be able to access the hospital, which will receive many more patients.

That's why it's so important to ensure that everything – the staff, the medicines, the electricity and the water – is in place.

## Afghanistan
### New surgical hospital

As violent conflict continues in northern Afghanistan, MSF opened a 55-bed surgical hospital in Kunduz province on 29 August.

It provides urgent and specialised surgical care and follow-up treatment for people suffering life-threatening injuries such as gunshot wounds and injuries from bomb blasts and shrapnel. It is the only trauma centre of its kind in northern Afghanistan and is equipped with an emergency room, two operating theatres, an intensive care unit and X-ray and laboratory facilities.

"The only label we use is 'patient,'" says Dr Dorian Job, MSF's medical coordinator in Afghanistan. "Every injured person has the right to receive medical treatment, and we make no distinction between civilian and combatant."


## Congo DRC
### Health post history

**Jennifer Turnbull, a paediatric emergency doctor, is working in Mweso in the Democratic Republic of Congo.**

All around me mist is settling between the mountains. The sky has darkened and the quiet chatter of the villagers is punctuated by sudden bursts of thunder. In front of me is a terrified five-year-old boy sitting on his father's lap with a 2cm gash in his cheek. I am back in the village of Ihula with our mobile clinic. I'm kneeling in the dirt, preparing to stitch the boy's face.

As I approach with a syringe, I explain in my best (read terrible!) Swahili that I'm sorry, this will hurt and he has to hold his son very tight. As I inject him, the boy gets a leg free and kicks my shoulder and then my shin.

"Nice try, kid," I think, "but I already got you. In a minute you'll feel nothing and then you'll thank me." An elderly local woman pitches in to hold the boy's legs. Kneeling again, I get to work. Only three stitches in the end. He'll come back next week to get them taken out.

I go back to check on the 19-month-old boy who had been scalded with hot water four days before. His right side, about 15 per cent of his body, had been burned.

His mother had applied toothpaste to his burns, and they have become infected; now he has a fever and pneumonia. We set up IV fluids and give him antibiotics and painkillers.

I spend the next half hour sitting on a dirt floor, slowly cleaning and removing the thick layer of toothpaste. He lies there listlessly, a combination of the painkiller and his serious infection. We have to bring this patient and his mother to the hospital.

Other than the weekly mobile clinic, the closest healthcare is a four to five hour walk away. That's why MSF is building a health post here, to give these people permanent access to free healthcare 24/7. As we look at the large wooden structure that will soon see women delivering babies, children treated for malnutrition and people treated for various ailments, our nurse explains that we are witnessing history. Healthcare has never been this accessible here before.

The child with the burns is doing well in our hospital. I will be back in Ihula soon, when we may even see our first patients in the new health post.

## Kenya
### Two MSF staff abducted

On 13 October, two Spanish MSF staff members, Blanca Thiebaut (right) and Montserrat Serra (far right), were abducted at gunpoint from Dadaab refugee camp in Kenya.

"MSF is currently engaging with all relevant actors to seek the safe and swift release of our colleagues and any use of force could endanger this," says José Antonio Bastos, president of MSF in Spain. "We want to strongly distance ourselves from any military or other armed activities related to this case."

MSF is continuing to provide assistance in Kenya, Somalia, Ethiopia and Djibouti to people affected by the current crisis, but has temporarily suspended activities in Ifo 2 camp, Dadaab, where the abduction took place. Staff at MSF's two health posts in Ifo 2 had been providing basic healthcare, vaccinations for children and care for pregnant women, as well as referring people to the hospital that MSF runs in nearby Dagahaley camp.

"We are deeply concerned about the fate of our two colleagues. MSF is committed to continue providing healthcare to the Somali population in and outside Somalia," says Bastos, "but the level of assistance is being deeply impacted by such attacks."



Number of MSF-assisted births in DRC in 2010 **19,200**

**118,200** Number of patient consultations conducted by MSF in Afghanistan in 2010

# How a golden blanket helped to save Nasib, ‘the lucky one’

**In Somaliland, women are 128 times more likely to die in childbirth than they are in the UK. Josie Emslie visited the tiny east African state where she saw MSF doctors trying to change those odds – and save the life of a mother and her baby girl**

As our plane touches down at the airstrip in Hargeisa, the capital of Somaliland, the first things I notice are goats and camels wandering across the runway. I’d read somewhere that Somaliland is proud of its livestock exports (which form the backbone of the economy), so I’m hoping for all our sakes these prized beasts watch out.

No harm. They scatter in the nick of time and we land safely. About the size of England and Wales, Somaliland is a self-declared autonomous region of Somalia with a population of 3.5 million.

It’s a 45-minute flight in our small plane to the city of Burco where MSF is working in a hospital alongside the Ministry of Health. It’s 3pm and the hospital is hectic. Yasmin, a young, pregnant woman, is convulsing in a hospital bed.

Holding her down and examining her, gynaecologist Dr Patricia Lledo looks worried. “It looks like eclampsia,” she says. “We need to get her to surgery.”

**‘There are no specialised doctors in the country because of the conflict. This used to be known as the “hospital of death”.’**

**Dr Patricia Lledo**

This is not good news for Yasmin. She’s already lost four babies and she and her husband are pinning their hopes on this fifth pregnancy. She’s 30 weeks in. As the operating theatre is prepared, Argentinean surgeon Andrés begins to scrub up.

Six months ago, Yasmin would have had nowhere to go. The maternity ward here was barely functioning, due to a lack of staff, drugs and equipment. Even in such poor conditions, patients were still expected to pay for what treatment they did receive.

With a maternal mortality rate of 1,047 per 100,000 (compared to 8.2 in the UK), Somaliland is one of the worst places in the world to give birth. What these figures mean is that if you’re a mother giving birth in Somaliland, you’re 128 times more likely to die while doing so than if you were in the UK.

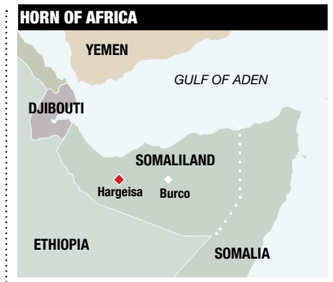
“Basically, there are no specialised doctors in the country because of the years of conflict,” says Dr Patricia. “This hospital used to be known as the ‘hospital of death’.”

Since MSF took over the maternity ward in March,the mortality rate has rapidly fallen.

We get news that the emergency caesarean is successful, and Yasmin’s baby is brought out alive. The downside: she’s tiny, just 1.2 kg — and is rushed to the hospital’s new neonatal ward. Here, Dr Sohur Mire is in charge. She examines the baby and looks concerned. “Her temperature is dropping – we need to warm her up.” Running to the cupboard, she comes back with a sheet of gold foil, like marathon runners use, and wraps the tiny baby in it.

The baby is placed in the incubator and Dr Sohur inserts an IV line, a glucose drip and oxygen. Now, the waiting game begins.

**Clockwise from above: Dr Sohur Mire tends to a baby at the maternity hospital in Burco; Yasmin, who gave birth to Nasib at 30 weeks; A child in a makeshift cradle. Left, Dr Patricia Lledo with a patient.** All photographs: © Josie Emslie/MSF, 2011




For Dr Sohur, working here is the fulfilment of a lifetime’s ambition. Originally from the region, she and her family fled as refugees when civil war broke out in 1991.

She trained as a doctor at Kings College London and worked at Lewisham Hospital in south London. It means a lot to her to be here with MSF.

“Being a refugee myself, I’ve always known about the lifesaving work MSF does here,” she says. “MSF was always a source of inspiration to me during my years of education, so it’s a real privilege to be here working for them.”

**‘MSF was always a source of inspiration to me during my education, so it’s a real privilege to be back here working for them.’**

**Dr Sohur Mire**

Slowly, the baby’s condition begins to improve and, by day four, she is breathing on her own. Her grandmother, who has stayed in the hospital all week, begins to feed her small amounts of her mother’s expressed milk.

Dr Sohur looks at the baby and gives a beaming smile. “The best thing is treating babies who are seriously ill and seeing them recover,” she says. “These are the moments you live for.”

Meanwhile, Yasmin has recovered well from her caesarean and is sitting up in bed, anxious yet hopeful about her daughter’s chances. Even in the UK, this baby’s chances of survival would have been low without specialised care. But thanks to the fantastic medical team here, she’s proving to be quite the fighter.

Yasmin smiles at me. “We’ve decided on what to call her. We’ll name her Nasib – ‘the lucky one’.”

# Welcome to Dadaab, the world's biggest refugee camp

In February 2011, cartoonists Andrea Caprez and Christoph Schuler travelled to the Dadaab refugee camp, on the Kenyan-Somali border. Their story describes the living conditions of the refugees in the camp. Since their visit in February, the situation has deteriorated. The drought and fighting have forced more than 100,000 new refugees into the already overpopulated camps in Dadaab. Today, Dadaab accomodates more than 450,000 people, making it the largest refugee camp in the world. MSF runs a busy general hospital and seven health posts in Dagahaley camp.

To see the full version of this illustrated story, go to msf.org.uk/outofsomalia.show

Today 26 families arrive, having made their way through the arid desert on foot or in the backs of trucks.

We come across a young man spreading out in the dust the few possessions he has managed to bring with him from Somalia.

His wife and their two children huddle in the sparse shade of a tree with spindly leaves.

It doesn't take long to build a shelter – provided you have some wood.

An iron bar is used to make holes in the ground, into which thin branches are inserted.

The branches are bent towards the centre and bound together...

... and covered with cloth, plastic bags and empty maize sacks.

A teenager in a dusty T-shirt complains that although there is water in the camp, there is nowhere near enough for him to wash himself and his clothes regularly. He is ashamed to stand before us in dirty clothes, he tells us sadly; this is not what he is used to.

Everyone knows Abu, and Abu knows everyone. He is the local assistant of the MSF field coordinator.

Abu is approached every few minutes for advice or help. This time it is a woman who wants to call his attention to a newly-arrived family with health problems. A rasping cough is heard from within the tent.

Rukiyah, the mother of the ten-strong family, can hardly breathe. Many of the refugees suffer from breathing difficulties because the air is always filled with fine dust.

Abu decides to drive Rukiyah ...

and six of her children to MSF's hospital.

A doctor sees Rukiyah and the children immediately and checks their health. They are all exhausted after their recent journey from Somalia. But luckily the children have no serious health problems. Rukiyah has a respiratory tract infection, and is kept in hospital. Within a couple of days she is well enough to rejoin her family.

# ‘You had to do absolutely everything yourself’

**Rony Brauman is a French doctor. He joined MSF when it was run from a single room, and went on to work in refugee camps and amidst famines and wars, narrowly escaping with his life. As president of MSF from 1982 to 1994, he helped shape it into the organisation it is today. Forty years after it was created, Rony Brauman looks back at the organisation’s early years.**

Dr Rony Bauman working in Ethiopia in 1985, during the time of the famine Photograph: © Sebastião Salgado / Amazonas images

Photographs © Hans Jurgen Burkard; D.R.; MSF; Chris Hondros/Getty Images

An MSF health worker talks to a soldier in Angola in 1999; the MSF charter is signed in Paris in December 1971

A surgical team after treating a patient during the Lebanese civil war in 1979; a wounded patient in Ethiopia in 1985

Smuggling medicines into Afghanistan in 1984; a girl injured in the Liberian civil war in 2003 is rushed to an MSF clinic

The first time I stepped into MSF’s office in Paris, there was one part-time secretary, Christiane, and that was it. It was the mid-70s, and after five years of political activism, I had finally graduated from medical school. I’d always wanted to be a doctor, to be involved in the magic of treating and healing people, and had a very mythical idea of what medical work was all about.

At the time, only the Church and the government sent doctors to work abroad. I didn’t want to work for either, so MSF, being neither political nor religious, was very attractive for a young doctor like me. MSF motivated me to resume my studies and work late into the night, learning about surgery and tropical and emergency medicine so that I would be prepared for all kinds of situations.

MSF was still a tiny organisation – it had 10 or 12 doctors and nurses working in various places in Africa and Asia – and they didn’t even know where everyone was. One very loyal and hard-working doctor had been sent to Zaire and then had been completely forgotten. Eight months later she came back to Paris asking why none of her letters had been answered.

Then it was my turn. I was sent to Thailand, to set up a hospital in a refugee camp near the Cambodian border, and after six months I found myself with no resources whatsoever, not a penny in my pocket. The refugees were feeding me because I didn’t have the money to feed myself. I had just enough gasoline in my car to make it back to Bangkok. When I got back to Paris, MSF organised for me to do a lecture tour in the north and east of France so I could gather

**‘One loyal and hard-working doctor had been sent to Zaire and then had been completely forgotten. Eight months later she came back to Paris asking why none of her letters had been answered’**

enough money to keep the hospital running for another six months. But in a way I enjoyed the experience: there was no hierarchy, no medical guidelines, no boss – you did what you thought was fit. You had to do absolutely everything yourself, so medical care was only a small part of it. That was the way it worked at the time – but it couldn’t continue like that.

Things changed: we began to provide support to our staff in the field, and to pay our doctors wages. We drew up lists of essential drugs, established guidelines and brought in logisticians and water and sanitation experts; we began to network with researchers, academics and specialists such as nutritionists. I was involved in the first trial for a new malnutrition treatment, in the form of foil-packed tablets of ready-to-use food, suitable for tropical conditions. In the event, the tablets that the manufacturer sent out were not suitable – the composition was wrong and the taste was unacceptable – so they ended up in a warehouse, tons of them, and I ate them myself – after all, there wasn’t much else to eat.

We decided to focus on war, and displaced people, and found ourselves working more and more in refugee camps. In the camps we could start from scratch, and bring services that were badly needed, and which no else was ready to bring. The refugee camps of Somalia, Thailand, Central America and South Africa were where we built our knowledge and skills, and forged the methods that MSF still uses today.

We learnt lessons along the way. In the summer of 1980 I went to Uganda on an exploratory mission. The country was in a state of anarchy, with armed groups fighting each other without any visible political purpose. At the same time, a severe famine was developing in the arid north-east of the country.

By the time I arrived, about 10,000 people had already died. Just stepping out of the house in the morning was nightmarish – there were dead bodies all along the dust road, and people were incredibly emaciated and on the verge of death. The worst thing was that no one recognised it as a famine. In the capital I’d been assured by officials that the problem had already been solved and everyone was as well-fed as in a French restaurant. I decided to go to see for myself, and what I found was a real life-saving emergency. It showed me that official papers and statistics should not be trusted too much – to see with your own eyes is absolutely key.

Only once did I think MSF itself might not make it. I was in Chad, with a surgeon and an anaesthetist, and we were caught up in an ambush. There was a shower of bullets, and the surgeon was hit and severely wounded. For several minutes we thought it was all over for the three of us. MSF was so small and frail at the time that, had we been killed, I’m not sure MSF would have survived.

But luckily enough that didn’t happen, and MSF grew, in size and reputation, becoming far bigger than anyone had ever expected. By

**‘The refugee camps of Somalia, Thailand, Central America and South Africa were where we built our knowledge and skills, and forged the methods that MSF still uses today’**

the end of the 1980s, there were 100 people working full-time in the Paris headquarters. Humanitarian aid and human rights were becoming extremely popular, there was real momentum, and we had incredible support from the public – despite our reputation for being controversial.

There’s no doubt that, as the world continues to change, MSF will have to adjust, and that in 40 years’ time, it won’t be the same organisation as the MSF we know now. My generation – growing up in the 60s and 70s – had a very different outlook from the generation growing up today. But I’m convinced that the deeper motivations of those who join MSF – the expectations and the desire to help people – remain fundamentally the same.



Number of outpatient consultations conducted by MSF in 2010 **7 million**

**58,326** Number of surgical procedures conducted by MSF in 2010

# A long-distance revolution in training doctors

**What happens when the junior doctors you're supervising work hundreds of miles away in a country that is too dangerous for outsiders to travel to? That's the dilemma MSF faces in parts of Somalia, where our MSF Somali clinical staff run an important district hospital in the town of Guri El, in the south central part of the country.**

**To overcome these difficulties, MSF is piloting a revolutionary new approach to medical treatment — telemedicine. Using portable webcams and a satellite link, senior MSF specialist doctors based in Kenya help staff in Somalia diagnose difficult cases and provide expertise and support to isolated and overwhelmed staff, all in real time.**

**Lindsey Mackenzie sat in on one of these groundbreaking consultations in Nairobi, Kenya.**

● We're sitting in a small office in Nairobi when news arrives that the paediatric ward of our hospital in Guri El is overflowing with patients.

● Dr Abdisalan, a Kenyan Somali paediatrician, leans over his desk towards the computer monitor, where he can see Dr Osoble in Guri El examining a little boy carried by his father. The boy, Omar (pictured above), looks about ten, but is actually 13. He is thin, obviously malnourished and barely has the energy to move. His chest is rising and falling rapidly as he struggles to breathe normally. He weighs only 22kg (3 stone 6lbs).

● With Dr Abdisalan guiding, Dr Osoble carries out an examination, checking Omar's central nervous system and taking note of the stiffness in the child's neck. "We're looking at malnutrition and pneumonia, and what seems to be meningitis," says Dr Abdisalan. On screen, we see Dr Osoble nod. Both doctors suspect Omar also has TB. The decision is made to stabilise him before he is transferred to the main MSF hospital in Galcayo. This will be a difficult journey as the rains have started and the 250km journey will be on mud roads. As the camera moves round from Omar to his father (above), we see just how thin he is too. Dr Osoble is instructed to make sure he also receives therapeutic food.

Like so many others in Somalia, Omar's family are pastoralists whose goats have died due to the drought. Each day they travel four hours just to collect water.

● Even though hundreds of miles separate them, it's clear that Dr Abdisalan and Dr Osoble have developed a strong working relationship.

"It's been wonderful to see how successful this approach has been in terms of improving the quality of care for patients, picking up on conditions that might have been missed and reducing mortality," says Dr Abdisalan. "But what's equally important is the way it has enabled us to show solidarity with our colleagues in the field. They know we care about what they're doing, we support them medically and they are learning all the time. I'm also learning – I get to see things I would not normally see here in Nairobi."

**Above, Dr Abdisalan consults in the case of baby Mohammed, who was treated for meningitis and pneumonia after a videolinked consultation** All photographs: © Lindsey Mackenzie/MSF, 2011

**'I've found it exciting and helpful to have the support and to be able to learn and make better diagnoses.'**

**Dr Osoble**

● Five-month-old Mohammed is being held by his mother. When we first saw him a couple of days ago, he lay listless in his mother's arms, suffering from a high fever and convulsions.

His grandfather and uncle were the traditional healers in their village, and his family had taken him to them when he fell ill. Little white burn marks cover his chest, a result of the traditional healing practice.

After his condition worsened, his parents paid for a lift to the MSF hospital in Guri El, where Dr Osoble was able to diagnose him with meningitis and pneumonia. "It's a good diagnosis and it saved this child's life," Dr Abdisalan reassures Dr Osoble. We're just checking up on Mohammed today, and it's clear his condition has improved. He no longer has a fever, the convulsions have stopped and the stiffness in his neck is improving. He cries during the consultation, but that's a good sign.

He will stay in the hospital for another ten days. His mother tells us that she'll always bring her sick children to the MSF hospital in future.

● When the telemedicine trial started a year ago, nine out of ten diagnoses were being corrected. Today it's fallen to approximately five out of ten, which are usually the most difficult cases on the ward.

"The improvement in the doctor's knowledge has been really visible," smiles Dr Abdisalan. "Initially we would have to ask them to do basic tests, but now they'll have already done the basics before they consult us.

**'The doctors are more prepared and confident... the diagnoses they're making are correct and we're just supporting them in the terms of treatment.'**

**Dr Abdisalan**

They're more prepared and confident. Over time, we're discovering the diagnoses they're making are correct and we're just supporting them in terms of treatment."

"Being part of the telemedicine trial has helped me a lot," says Dr Osoble. "I have found it exciting and helpful to have the support and to be able to learn and make better diagnoses. When it first started, only one doctor in the hospital was going to take part. But soon, we all wanted to take part."

● At 3.30, the consultations end. Dr Osoble and Dr Abdisalan share a quick joke and then Dr Osoble is off to do ward rounds and check the emergency patients. There is still work to be done.

## MSF UK VOLUNTEERS

**Afghanistan** Patrik Kontina *Anaesthetist*; Juan de Dios Robinson *Anaesthetist;* John Gray *Logistical coordinator*
**Bahrain** Birgit Hauffe *Doctor*
**Bangladesh** Laura Smith *Surveyor;* Judith Nicholas *Midwife;* Stephen Sercombe *Financial coordinator*
**Central African Republic** Warwick Strong *Logistician;* Mark Blackford *Financial Coordinator;* William Turner *Logistician;* Bernadette Rooney *Biomedical scientist;* Melanie Child *Nurse;* Victoria Hammond *Water & Sanitation expert*
**Chad** Nicole Hart *Nurse;* Aline Sobole *Administrator*
**Colombia** Ronan O'Mhaoinigh *Financial Coordinator;* Carme Abello *Logistician;* Conor Prenderville *Logistician;* Stephen Hide *Logistical Coordinator*
**Democratic Republic of Congo** Andrew Mews *Head of Mission;* Sarah Maynard *Logistical Coordinator;* Niamh Allen *Doctor;* Orla Condren *Medical Team Leader;* Laura Gregoire *Doctor;* Julian Barber *Water & sanitation expert;* Christopher Bird *Doctor;* Robert Malies *Logistician;* Oliver McGrath *Water & sanitation expert;* Sarah Geoghegan *Doctor;* Helen Rafferty *HR coordinator*
**Egypt** Mario Stephan *Head of Mission*
**Ethiopia** Lupetu Ives Ntambwe *Epidemiologist;* Terri Anne Morris *Project coordinator;* Robert Allen *Logistician;* Emily Stenke *Doctor;* Ebbe Thingaard *Doctor;* Peter Camp *Logistician;* Alvaro Mellado Dominguez *Field coordinator;* Christopher Houston *Project Coordinator;* Susannah Woodall *Medical team leader*
**Guatemala** Maria de los Llanos Ortiz Monero *Medical coordinator*
**Haiti** Camila Garbutt *Water & Sanitation Expert;* Benjamin Le Grand *Logistician;* Elaine Badrian *Nurse;* Kiran Jobanputra *Medical coordinator*
**India** Emily Goodwin *Field Coordinator;* Sakib Burza *Medical Coordinator;* Elizabeth Harding *Project Coordinator;* Alistair Iveson *Logistician;* Colin Hermann *Logistician*
**Ivory Coast** Josie Gilday *Nurse*
**Kenya** Amanda Nayagam *Doctor*
**Kyrgyzstan** Juma Khudonazarov *Medical Team Leader*
**Lebanon** Alison Jones *Medical Coordinator*
**Liberia** Richard Kinder *Logistician;* Angelika Schott *Nurse;* Jenna Broome *Doctor;* Lewis Isaacs *Logistician*
**Mozambique** Doriana Santos *Biomedical analyst*
**Myanmar** Victoria Hawkins *Deputy Head of Mission;* Thomas How *Project Coordinator,* Pawan Donaldson *Project Coordinator;* Duncan Bell *Head of Mission;* Riccardo Donati *Logistician;* Jane Bell *Doctor;* Mya Hornsby *Financial coordinator*
**Niger** Angelica Orjuela *Logistician*
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**Sierra Leone** Daniela Stein *Nurse*
**Somaliland** Timothy Tranter *Logistical Coordinator;* Adam Thomas *Head of Mission;* Harriet Rees-Forman *Midwife;* Carole Pye *Nurse;* Lesley Wills *Midwife;* Sohur Mire *Doctor*
**South Sudan** Haydn Williams *Logistician;* Pradeep Natarajan *Anaesthetist;* Jean-Marc Jacobs *Deputy head of mission;* Louise Roland-Gosselin *Humanitarian affairs officer;* Simon Tyler *Project coordinator;* Alison Bishop *HR coordinator;* Siama Latif *Medical team leader;* Annas Alamudi *Logistician;* Danielle Wellington *Medical team leader;* Eleanor Gray *Administrator*
**Sri Lanka** Amy Hughes *Doctor;* Eleanor Hitchman *Mental Health Officer*
**Sudan** Shaun Lummis *Logistician;* Joan Hargan *Medical Team Leader;* Angela Cave *Nurse;* Katie Gatward *Nurse;* Jose Hulsenbek *Head of mission;* Kate Reid *Midwife*
**Swaziland** Ilias Pavlopoulos *Head of Mission*
**Tajikistan** Kartik Chandaria *Doctor*
**Thailand** Paul Cawthorne *Consultant*
**Uganda** Salvador Vegas Palacin *Logistician;* Deirdre Healy *Pharmacist;* Margaret Playle *Doctor*
**Uzbekistan** Yvonne Ovesson *Logistician;* Elsa Barbosa *Biomedical scientist*
**Yemen** Sarah Siobhan O'Neill *Anaesthetist*
**Zimbabwe** Tharwat Al-Attas *Deputy Medical Coordinator;* Amir Shroufi *Epidemiologist;* Paul Foreman *Head of Mission;* Kiersten Simmons *Doctor;* Johannes McGavin *Doctor;* Paul Arobmoi *Biomedical analyst*



Cost of the telemedicine equipment **£8,600**

**460,437** Number of outpatient consultations carried out by MSF in Somalia in 2010