Quarterly news from Médecins Sans Frontières UK Issue no 50 Autumn 2008

# DISPATCHES

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**Médecins Sans Frontières is a leading independent humanitarian organisation for emergency medical aid. In over 60 countries world-wide, 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.**

# Gonaïves
## a submerged town

People trying to dry their possessions in the aftermath of the storms in Gonaïves.
© Eduardo Munoz/REUTERS [2008] Haiti

"It's a mess – it's not a town any more, it's really a mess," **says an exhausted Max Cosci, head of MSF's emergency response to the massive flooding in Gonaïves.** "There was one man who died before my eyes because he was diabetic; the flood had washed away all his medicines and so he couldn't take his insulin. His neighbours called us, but when we arrived he was already in a coma and it was too late for us to do anything – he just died. It's dreadful, and it's happening all around."

1-3 Haiti
4 Darfur
6 Pakistan
8 Ethiopia

Between 25th August and 1st September, Hurricane Gustav, Tropical Storm Hanna and Hurricane Ike battered Haiti in quick succession. MSF sent an emergency team including medical staff and water and sanitation experts to Gonaïves, a town in the north of Haiti that had been particularly badly hit.

Head of Mission Max Cosci describes the situation they found:

# Gonaïves a submerged town

"Around 200,000 people live in Gonaïves and about 80 percent of the town has been submerged; only a small part has remained dry. A big part of town has completely gone, and one of the rivers has broken its banks and is constantly flushing water through the town, so there's at least half a metre of water everywhere. It's still raining here, and it just takes an hour of heavy rain to increase the flood level rapidly.

"Most of the houses here are small shacks with corrugated iron roofs and they've been totally flooded – the latest estimate suggests there are 60,000 people who cannot live in their homes. All the bridges have collapsed around the town and the roads into Gonaïves are impassable – even big vehicles with caterpillar tracks can't get through. So for more than three weeks the only way to get there has been by helicopter or boat.

"I was in the helicopter when we arrived on the first day. We found an ambulance that was still functioning and searched the town for a dry place to set up a clinic or a hospital or somewhere where we could provide medical care for the people who needed it. It seemed like we were the only doctors in town. We could find no Haitian doctors at all. While we were looking for a suitable place, people started coming to us with their friends and family who had been injured in the storm. They were opening the doors of the ambulance and just putting in children with their heads cracked open and people with arms or legs broken and lots of people with bleeding wounds.

"The first place we found was Rabouteau hospital. It's the only functioning medical facility apart from a small suburban health clinic that's 5km out of town. Our first job was to create a space with hygienic conditions so we could have somewhere to do surgery. On the first day we did 110 consultations and carried out 16 surgical procedures. And then in the following days we started doing mobile clinics as well,  in the main shelters where people had gathered together. But there are around 140 or 150 principal shelters where people are living, so it's not easy to reach all of them – and people move from one place to another, so we don't always know where people are. It's very complicated.

"One of these shelters is the university. There's a huge concentration of people inside and even living on the roof – probably 120 families – and they have nothing. So we are providing them with food and water and one of our mobile clinics goes there regularly to provide medical treatment. The people here urgently need to find a better place to live, but are frightened that if they leave, someone

"It's depressing, but we're doing our best. I'm in the capital to collect the latest plane load of material. Tomorrow I'll be taking it up to Gonaïves and we'll continue doing what we can."



Even before these storms, healthcare in Haiti was in crisis. Read

right
Lionel, a 22-year-old carpenter, brought his newborn son to the Rabouteau health centre after spending five days on the roof of his house

far right
A team brings medical treatment to one of the many 'shelters' in Gonaives

below left
Waiting for consultations at MSF's clinic in Rabouteau hospital

below
A consultation in Rabouteau, freshly painted by MSF to make it a hygienic environment

All images © Francois Servranckx/MSF

will break into their house and steal their remaining possessions – or worse, that someone will occupy the house and they will lose their home. So nobody wants to go too far away. They prefer to live in the town, near their house, even if it means living in cramped, unhygienic conditions.

"One of the big problems is that all the lavatories have been washed away and we cannot dig new latrines because the ground is too waterlogged. There's one small part of town that's dry enough to dig, but of course people will not cross the entire town to go to the toilet. So most people are defecating and urinating in and around the shelters – in some of them the smell is terrible.

"But by far the worst thing is that people have no water to drink. The water table is contaminated and most of the wells are not working. I have seen people starting to drink the dirty water. They filter it with their clothes, which gets rid of some of the mud, but this water that people are drinking is still brown and it's contaminated with excrement, urine, dead bodies of animals floating around. People are living right on the limit of what is possible. A lot of women are developing genital infections because they're walking around in this dirty water, which can be very serious for pregnant women. And we're starting to see things that really worry us, like bloody diarrhoea, which could be the first sign of an epidemic in town.

"We're doing what we can to provide clean water. We have pumps, generators, pipes, big water bladders; we've flown in about half a million euros' worth of water and sanitation equipment from Europe so far. There are several wells, like the one at our base, that are providing a good rate of water flow. We pump the water into a 'bladder', a huge sterile plastic sac, treat it with chlorine, and transport it by truck to where it is needed in town. If you keep these pumps and chlorination going day and night, you can produce a lot of drinking water – we're producing about 150,000 litres a day. But getting the water where it's needed is a logistical nightmare.

> "People are living their lives in dirty water. But if you keep the pumps and chlorination going day and night, you can produce a lot of drinking water - we're producing about 150,000 litres a day."

"It's not just Gonaïves – lots of smaller towns and villages have been flooded and roads everywhere have been cut, so people have been going without food. And the health centres that have not been damaged have run out of medicines and supplies. We have been making kits of essential drugs that we have been delivering by helicopter to health centres that are cut off. Then at least they can continue to function.

"But it's in Gonaïves that the situation is really bad, because it's built in a depression below sea level, at the confluence of three rivers. When the hurricane hit, the tide rose and the sea swamped part of the town; and at the same time the waters from the rivers swept into the town from the north. So the town was completely flooded. I don't know whether people really understand that they are living somewhere that's not a good place to live. This is not the first flood here. In 2004, 3,000 people in Gonaïves died in another big flood – 3,000 dead! And this is the third time the town has been flooded this year. The hospital had only just been expensively repaired after being knocked out by floodwater for the third time. You cannot just move a town of 200,000 people to somewhere else, but you can be sure it will happen again, maybe not next year, but in two or three years' time. It's depressing, but we're doing our best. I'm in the capital to collect the latest plane load of material. Tomorrow I'll be taking it up to Gonaïves and we'll continue doing what we can."

MSF's report on how this is particularly serious for pregnant women at **www.msf.org.uk/perilous_journey**

# Mental healthcare in

**Musa was chained naked to a tree stump for five years as an 'act of love'. In Darfur, as in many regions of the world where treatment for psychiatric illness is seldom understood, protecting a man from injuring himself and others can push families to drastic measures. If they kept him bound, Musa's parents reasoned, they could feed him. They could give him water. He would stay alive.**

Mental health is a significant medical issue, especially in places where people suffer from violence or are living through extreme danger. In 2007, MSF conducted nearly 126,500 individual counselling sessions and more than 34,500 group sessions around the world. But treating severely disturbed people remains a challenge for MSF teams, given the complexity of managing psychiatric drugs and medication in emergency situations, especially when violence and trauma is ongoing and it is therefore difficult to guarantee continuity of care.

Musa's home, Kalma Camp, is one such place. With a population of more than 90,000 people who have fled their villages, it is one of Darfur's largest camps for displaced people. Five years of living in constant fear of arson, killings, rape and looting is more than most could bear. The pressure of living in Kalma Camp was highlighted most recently on August 28, when the ever-present tension exploded in open violence. At least 65 patients were admitted into MSF's clinic, more than half of them women and children. The team managed to secure safe passage to transfer the most severely wounded to the hospital in Nyala, the regional capital, at the same time as organising MSF's own evacuation from the camp.

The constant low-level violence and sporadic outbreaks of very real life-threatening danger have made the burden heavier on Musa's family. "Violence does not only cause pain in the body but also pain in the heart," explains MSF mental health advisor Kaz de Jong. "Survival in emergencies depends not only on physical fitness but also the mental condition of the people. For example, we have seen people in therapeutic feeding centres not wanting to eat because they do not see a reason for living."

MSF began providing basic healthcare in Kalma Camp in early 2004 and by 2006 had added a mental health programme to help those experiencing violence-related stress, adjustment problems, psychosis, anxiety and a host of other burdens. Amal Hashim Algack, a Khartoum-trained psychologist, was involved in the earliest days of training a dozen of the camp's inhabitants to become outreach workers and psychosocial caregivers. The central idea was, and still is, to offer workshops that help people recognize in themselves and in others the symptoms of psychological stress. The next goal is to give families support as they strengthen their own remarkable coping skills. People who are more deeply disturbed can seek therapy for themselves or their family at the MSF clinic.

"It was a big effort to change the minds of these people, for them to believe in mental health treatment," Algack says. "Most will just say it's devils in people's minds." That is what Musa's parents believed. They first tried a traditional healer who attempted to expel the demons by inscribing a piece of paper with verses and dipping it

One of the many torched villages in the region around Kalma Camp
© Sven Torfinn [2007] Darfur

## Neuroleptic drug therapy in emergency situations

MSF medical doctors prescribe neuroleptic drugs in order to restore a minimum level of human function for patients with acute psychiatric symptoms, such as psychosis, extreme anxiety and an inability to get any rest or sleep. Counselling is essential before and during drug therapy, not least to explain to the family how they can help and that the patient has a disease that can be medically treated. Whenever it is necessary and possible MSF will start a patient on drug therapy, because this can quickly restore a patient's functioning, and enhances their likelihood of survival. Drugs that can be sourced in the country are used, so that the treatment can continue even if MSF is forced to withdraw. Even so, if insecurity means that MSF is likely to evacuate at short notice, it could be inappropriate to start a course of therapy and many MSF medical doctors face this dilemma week-in, week-out.

# Darfur

"Now he is a man again. He's smart and can function with the help of the medication."

Psychologist Amal Hashim Algack talks to Musa
© Avril Benoit/MSF [2008] Darfur

The chains from which Musa was freed after five years
© Avril Benoit/MSF [2008] Darfur

"Everybody who saw Musa cried, even the MSF drivers."

into a glass of water until the ink seeped out. Musa then drank the blackened liquid, but time and again the treatment failed.

A relative of Musa's, who knew about the MSF mental health programme and was impressed by its positive results, invited the organisation to try its methods on the young man chained up on the far reaches of the sprawling camp.

"He was like an animal," Algack shudders. "His hands and feet were chained together to that stump, amidst the stench of years of excrement and urine. He was aggressive towards everyone – beating his father and mother when they came near."

The MSF counsellors urged Musa's parents to release him into their care. The father doubted their methods, and wanted to see a different traditional healer. After five sessions with the family, Algack was finally permitted to talk to Musa. These sessions went on for months. The MSF team would come back day after day, filled with sorrow at the young man's situation, watching him struggle against the chains. "We even cried," Algack admits. "Everybody who saw Musa cried, even the MSF drivers."

Over the course of seven months Algack and her team persisted. There were three failed attempts when Musa's parents relented and unchained him. Every time, he turned extremely violent. By January 2007, MSF's mental health programme started including prescription medication, and this made all the difference to someone in Musa's condition. Within a month on neuroleptic drug therapy, Musa was freed. The counselling finally began to take effect.

Musa, now 33, works with his father, weaving straw mats that they sell in Nyala, 15km away. "Now he is a man again," Algack reflects. "He's smart and can function with the help of the medication."

Families throughout Darfur still depend on a massive humanitarian effort to stabilise people's physical health and nutritional status. But the teams working in the camps know that there are also multiple layers of torment that MSF is committed to alleviating. It took drug therapy to trigger Musa's positive response to the home visits and counselling. For most, however, community education workshops give people the information they need to regain some sense of control over their emotions, their behaviour, their stress levels and their ability to function despite day after day of traumatic experiences in the camp.

The mud drying in extreme temperatures after Cyclone Yemyin devastated parts of Balochistan
© MSF [2007] Pakistan

# "Tears of joy and happiness"

## MSF starts working in Balochistan

For several years MSF teams in Pakistan have been running clinics and health centres in the regions bordering Afghanistan, where insecurity has had a serious impact on healthcare. But it has become clear that there are other rural areas in Pakistan where many people are finding it hard or impossible to get medical treatment that they can afford. This is particularly true of eastern Balochistan province, which has some of the most neglected healthcare in the country. Life here is harsh, with cold winters and dry, blistering hot summers. There are steep barren mountains in the north of the province and desert plains in the south that slope down to the Indus valley. "We have been trying to work in East Balochistan on a permanent basis for several years now," says Chris Lockyear, MSF's head of mission in Pakistan. "Our new programme in Jaffarabad district hopes to address some of the very great needs."

In June last year, Cyclone Yemyin brought widespread flooding to Balochistan. "I was part of a big MSF team that came here to the town of Usta Muhammad," says Dr Ahmed Bilal. "We started working in an area that was very hard to reach, and when we got there we saw how terrible the conditions were. Whole villages were destroyed and we started up treatment centres under the open sky. We treated about 3,000 people in two weeks. When we heard that in one area children were dying of diarrhoea, we very quickly did some 'rapid tests', which confirmed that it was cholera. The MSF base in Islamabad immediately sent down cholera kits and logistical materials and we set up six cholera treatment centres. We treated more than 300 children. Before our arrival four children had died of cholera, but after we set up the treatment centres there were no deaths.

"I remember the conditions being very, very bad – nothing to drink, nothing to eat. We covered the whole of that difficult area and the regional officials really appreciated the work of MSF - they said that MSF were right on the frontline, the first to get there in these terrible conditions.

"Working in the floods, we saw how bad the general health situation is here. I have been working with MSF for more than three years and I have seen many places, and I really think that East Balochistan is an area in great need. The land is some of the richest in Balochistan, but most of it is owned by landlords and the majority of people work as daily labourers. They often cannot pay for good food for themselves or their children. The mothers are often very malnourished and when they are breastfeeding, they have no proper food to give their babies. And sewage gets into the drinking water channels, which people are using for drinking, for cooking, for everything. The number of cases of diarrhoea, typhoid and hepatitis is very high and when they get diarrhoea, the children quickly become malnourished.

"In July this year we did a rapid nutritional survey and we found high rates of malnutrition in this district. So we agreed with the authorities that we should start a nutrition programme. We are working in the main regional hospital, an old 40-bed hospital that was built in 1944. It is in very bad condition, and we have been offered a separate ward that we are repairing. It is always busy and people come from far away, from all over the region. They know that there are new doctors in the hospital, 'doctors for weak children' they call us, and if people have a malnourished child at home they bring them to our programme."



Find out how

The team is seeing increasing numbers of patients by the day and one of the biggest challenges is making sure that patients continue their treatment after the first visit to the hospital. "Having outreach workers who can visit people at home is very important because some people find it hard to come back for check-ups and to collect their next ration of therapeutic food," says Aleem Shah, MSF's programmes officer for this region of Pakistan. "People here are very poor and most cannot pay for transport. Ninety percent of mothers in this area work as daily labourers, mostly in the brick kilns, mixing clay to make mud-bricks, or in the rice fields. They have to work 8 to 10 hours, in temperatures up to 50 degrees in July, and if they do not work a full day they do not get paid. So it is very hard to find the time to come to the hospital. They want to come, and they do come when they can, but often it is simply impossible, so we need to go out to their homes."

Dr Bilal with one of the patients at the new Usta Muhammad programme
© MSF [2008] Pakistan

Gaining acceptance is also a challenge when starting to work in a new area. "A mother had brought her 2-year-old baby from a long way away by donkey cart," continues Shah. "The baby was severely malnourished so we had to give the child special therapeutic food rich in vitamins and minerals. The first time the mother had come alone, but when she brought her baby back for a check-up, her mother and mother-in-law came as well. The baby was doing much better already, and there were tears in all their eyes. The baby had vitamin A deficiency, probably since birth, and was blind. They explained that he used to just lie there limp, but now he is getting a bit more active, showing signs of liveliness. I saw tears of joy and happiness running down the mother's face. This is the best thing, better than words, and it makes me feel that what we are doing is really worthwhile. Since this family went back to their village, we have had thirty more patients from this area, so it is clear that MSF is getting well known."

For now MSF has started with a nutrition programme, but Dr Bilal suggests that MSF will need to do more in the future: "Tuberculosis is common; there is a lot of hepatitis; people's general health condition is very bad; there's almost no awareness about health education; maternal mortality is very high; and there are no c-sections in this district – women who have a complicated pregnancy are referred to a hospital 200km away, but people are too poor to get to other cities. Healthcare in this area is completely neglected. For the people in and around Usta Muhammad I think there is a great need for MSF to do more."

MSF chooses where to work at **www.msf.org.uk/reasons**

# MSF UK volunteers currently in the field

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**Editor:**
Robin Meldrum

**For more information, contact:**
MSF UK
67-74 Saffron Hill
London EC1N 8QX
Tel: 0207 404 6600
Fax: 0207 404 4466

**E-mail:**
uk.fundraising@london.msf.org

**Website:**
www.msf.org.uk

English Charity Reg No. 1026588

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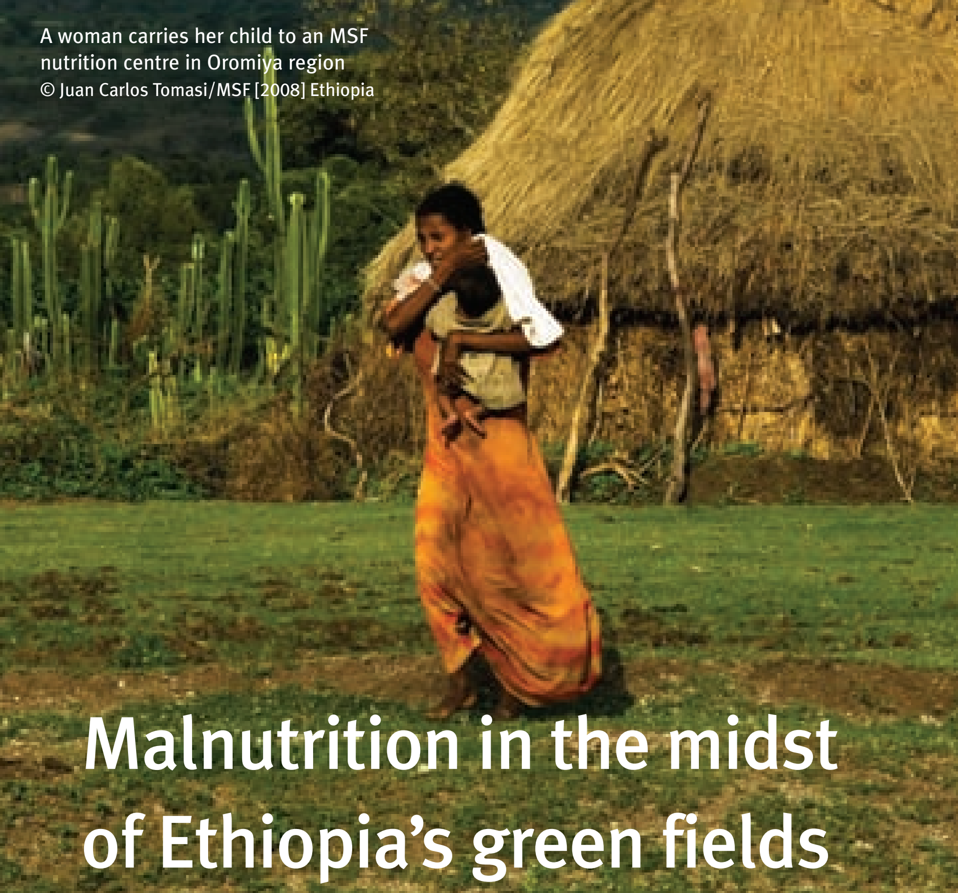

A woman carries her child to an MSF nutrition centre in Oromiya region
© Juan Carlos Tomasi/MSF [2008] Ethiopia

# Malnutrition in the midst of Ethiopia's green fields

"It is very difficult to 'triage' and spot the very sick, in a sea of faces, holding their arms out to you in desperation, tugging at your clothing as you try to pass among them," says Jill Mowbray, a nurse working in the village of Hadero, high up in the southern highlands of Ethiopia. Here, and in other villages where MSF has set up temporary nutrition centres, the team considers it a 'quiet day' when the crowd of people waiting for food numbers less than a thousand. But all around is greenery – pale coloured maize and darker banana leaves – and farmers are tending their crops, so why are children visibly dying of hunger?

Samuel Theodore, an MSF administrator, explains: "For five or six months there was not a drop of rain. Hunger started to set in. Some of the farmers around here managed to grow a small crop of ginger to sell to traders, but they've no food to eat. The staples have become very expensive at the market, as has fertiliser – it is simply too expensive for the farmers. Now that we've got some rainfall, the maize and other crops are growing again. But we'll have to wait until the next harvest before we see any sort of improvement."

MSF started an emergency relief operation in the southern Ethiopian regions of Oromiya and the Southern Nations, Nationalities and Peoples Region (SNNPR) in May. Confronted by rapidly escalating numbers of severely malnourished patients, the teams set up a network of around 60 temporary rural nutrition centres and five hospitalisation centres. By early September nearly 24,000 patients with severe acute malnutrition had been admitted into this nutrition programme.

So many people are coming to the centres that MSF can only provide treatment and therapeutic food for those who are in the greatest medical need. "It's very difficult to send children back home because they're not malnourished enough, when you can plainly see that they are hungry and that their whole family needs help," says Dr. David de Souza in Tunto, a village near Hadero. "A lot of them don't meet the admission criteria, but they don't understand why they'll receive nothing when they have nothing."

Although in some villages the harvest has begun, many communities are still in trouble - where the crops are growing but will not be harvested for some weeks. And in some areas the situation may still be deteriorating. MSF teams are exploring the Afar and Amar regions in the north, and the Somali region in the east of the country, where alarming rates of severe malnutrition are being reported. MSF may need to start new programmes in these areas, just as some of the temporary centres in Oromiya and SNNPR are preparing to close.

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It costs 8 pence per copy to produce and 22.5p to send, using Mailsort Three, the cheapest form of post. We send it to keep you, our supporters, informed about our latest activities and how your money is spent. Dispatches also gives our patients, staff and volunteers a voice to speak out about the conflicts, emergencies, and epidemics in which MSF works, and about the plight of those we strive to help.

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