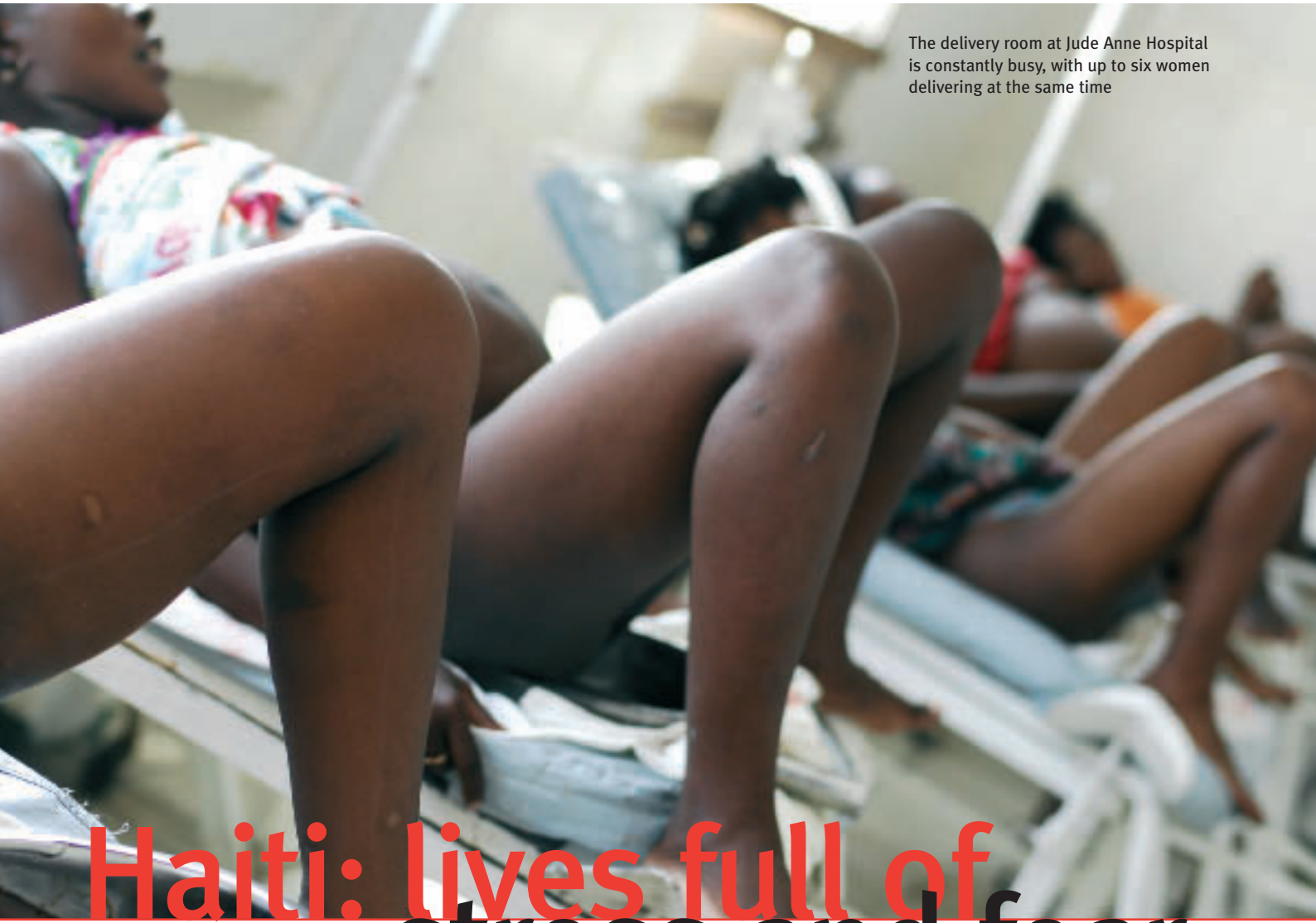
Quarterly news from Médecins Sans Frontières UK Issue nº 46 Autumn 2007

DISPATCHES

Charity no 1026588

Médecins Sans Frontières is a leading independent organisation for emergency medical aid. In over 70 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.

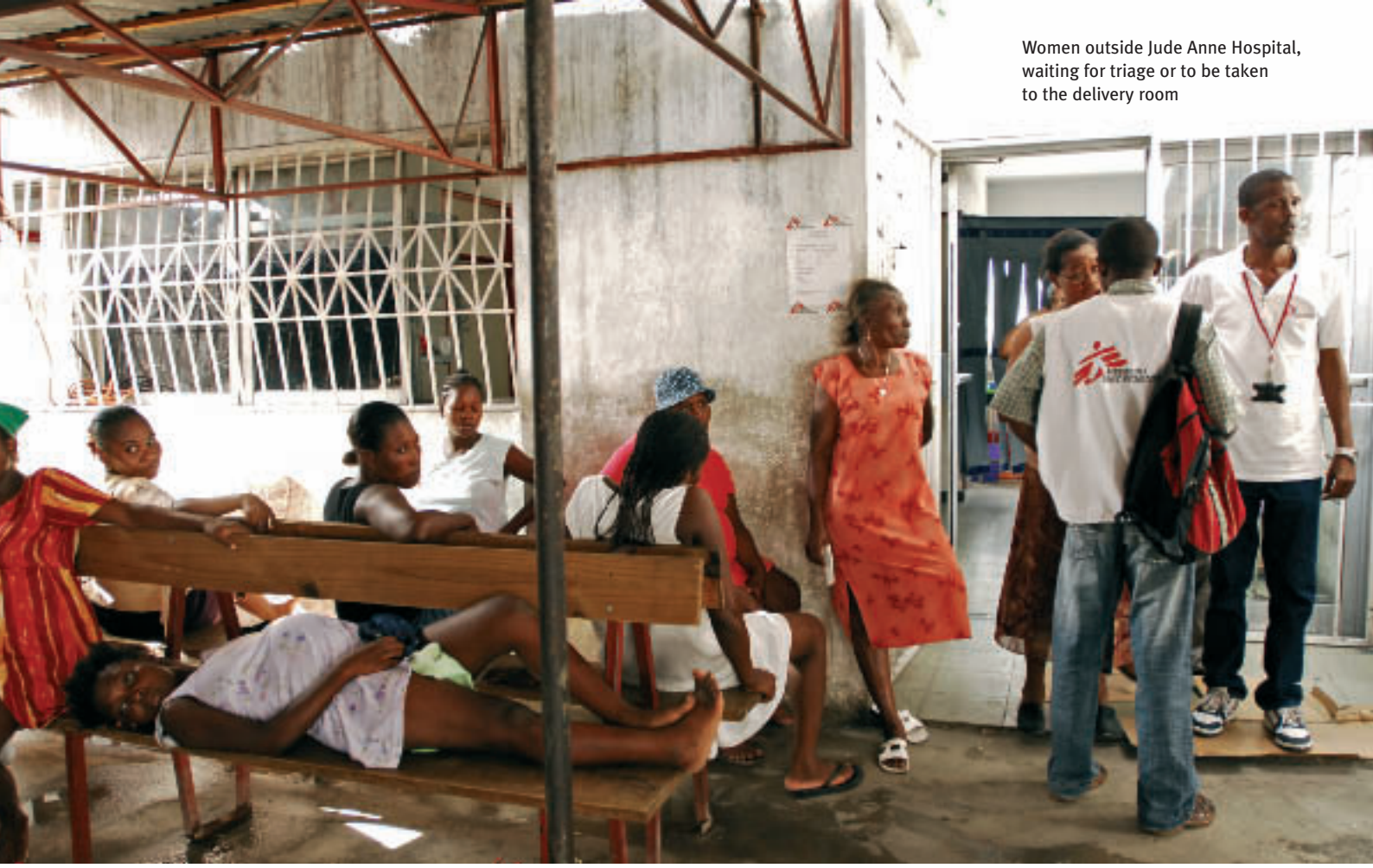


The delivery room at Jude Anne Hospital is constantly busy, with up to six women delivering at the same time

Haiti: lives full of stress and fear

When MSF started providing free maternal care at Jude Anne Hospital 18 months ago, the team, composed mainly of Haitian staff, expected to deliver about 300 babies a month. By last September, they found themselves dealing with more than four times that number: about one baby every half an hour. It was an undeniable sign of the desperate need for affordable emergency obstetric care in Haiti, which has the highest maternal death rate in the western hemisphere.

MSF took over the management of Jude Anne Hospital specifically to help women from the most violent and poorest neighbourhoods of Port-au-Prince, Haiti's beleaguered capital, where gang violence and brutality are rife. Doctors generally don't visit the deprived, violent areas as the risk of violence and kidnapping is too great.



Women outside Jude Anne Hospital, waiting for triage or to be taken to the delivery room

Nelly's story is typical of the women who crowd the entrance to the Jude Anne hospital every day. She lives in Bel Air, one of the most dangerous areas in Port au Prince. Her sister died last year when she was hit by a stray bullet. Nelly lives in a house made of corrugated metal sheets with ten other family members. Even the police are reluctant to enter the area. The gangs are in charge here.

After an extremely stressful labour, Nelly's daughter Patricia was delivered by emergency caesarean section performed by MSF surgeons:

"My contractions had been going on for some time and I felt like it was time, but the baby wouldn't come. She was too big. I couldn't take it anymore."

"It was already late," continues her husband, Patrick. "We wanted to go to the hospital but we didn't dare go out into the street. There is regularly shooting in our neighbourhood. We're used to the violence but at night it is too dangerous to go out."

The couple had had to wait until it was light before coming to Jude Anne and Nelly's medical care was only just in time.

Many maternal deaths are caused by eclampsia: an increase in blood pressure that leads to convulsions and the sudden death of both the mother and her unborn baby. If eclampsia is diagnosed in time, the mother and child can survive if the mother receives treatment and the baby is delivered by caesarean section.

The MSF medical teams at the hospital feel overwhelmed at times by the sheer number of births. The most difficult part of their work is being unable to save the lives of mothers who arrive at the hospital too late.

"It's like a factory," says Sarah Senbeto, a midwife. "So many women come here. We almost can't keep up with it. It's especially busy at night. The majority of our patients run a high health risk: they are pregnant with twins, they have pre-eclampsia and other problems. Sadly enough, we can only help a small portion of the women in Port au Prince. We can only save those who make it this far."

Women have often waited for hours at other hospitals but have received no help because they cannot afford to pay for medical care. The fee for giving birth at a public hospital is completely unaffordable for a poor family, particularly for unemployed women living in the slums.

Sonja went to the General Hospital when her contractions started.

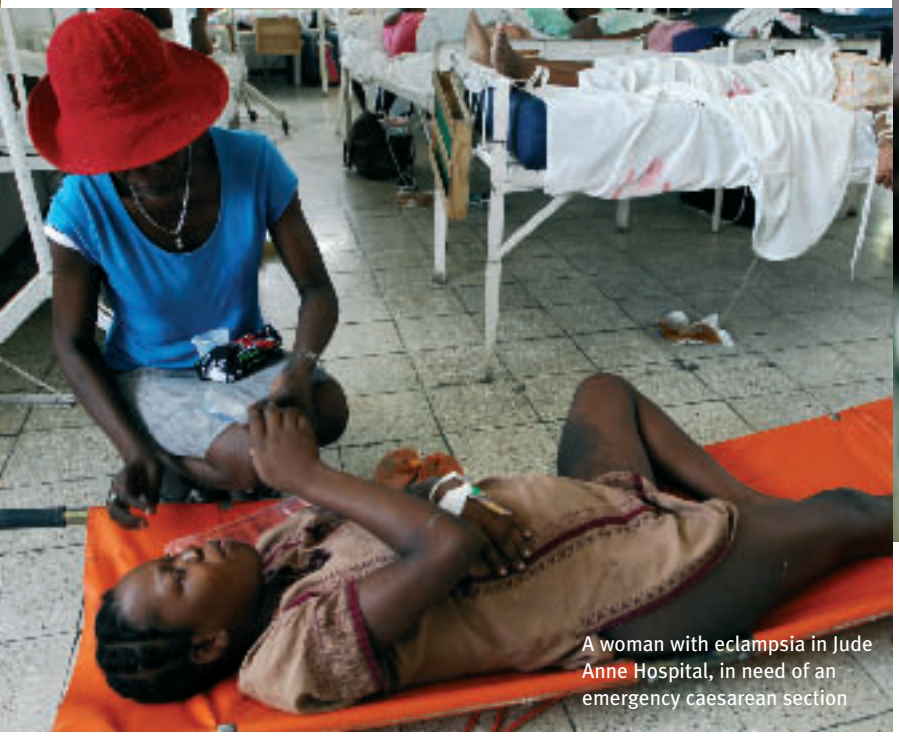
"I waited for more than three hours in that other hospital, standing in the hallway. I was in a lot of pain, I was losing blood and I was spitting up blood too. No one even looked at me. Then they came to ask me for money and I don't have any."

Raising awareness of MSF's Jude Ann Hospital in one of Port-au-Prince's slum districts

By the time she finally arrived at Jude Anne, where care is free, her baby was tired of waiting. She gave birth to her child right outside the hospital's entrance.

MSF staff have learnt from experience that women living in the gang-controlled slums of Port-au-Prince are particularly likely to be exposed to violence. An expectant mother might get caught in the crossfire of a fight between armed groups, or might experience psychological trauma. She could be sexually assaulted by a family member, a neighbour, a gang member or other assailant.

In an environment where such sustained chronic violence marginalizes people and prevents women from reaching care, it is essential to identify pregnant mothers who are potentially at risk. A team of MSF outreach workers therefore regularly visits the slums of Port-au-Prince. They teach expectant mothers how to look for signs such as bleeding or unusual headaches (a symptom of pre-eclampsia) that might require emergency care. They sing songs in Creole and play games to communicate their message to attentive audiences. A year ago, MSF also started a programme to help prevent the transmission of HIV/AIDS from mother to child at birth by testing women for HIV and transferring those who are positive to a hospital that will provide medicine to protect the unborn baby.



A woman with eclampsia in Jude Anne Hospital, in need of an emergency caesarean section

Since MSF opened Jude Anne hospital, more than 10,000 babies have been delivered. On the top floor lie the young mothers with their newborn babies. These are the women who have survived. You might expect to see only happy faces but the opposite is true. Most of the mothers are exhausted and are worried about their babies. The mortality rate for children under age five is incredibly high. Catherine has just given birth to twins. It was her tenth delivery. From the nine previous births, only five children remain alive.

"All the mothers have stories that are very moving," says Oliver Schulz, who worked for MSF in Haiti. "It's very hard to discharge the mothers from the hospital. I've been to the slums and I know what they are going back to: nothing."

Some, at least, manage to find hope.

"Our lives are full of stress and fear," say Nelly and Patrick,"but the birth of Patricia is a ray of light. She will bring us happiness."

MSF IN HAITI

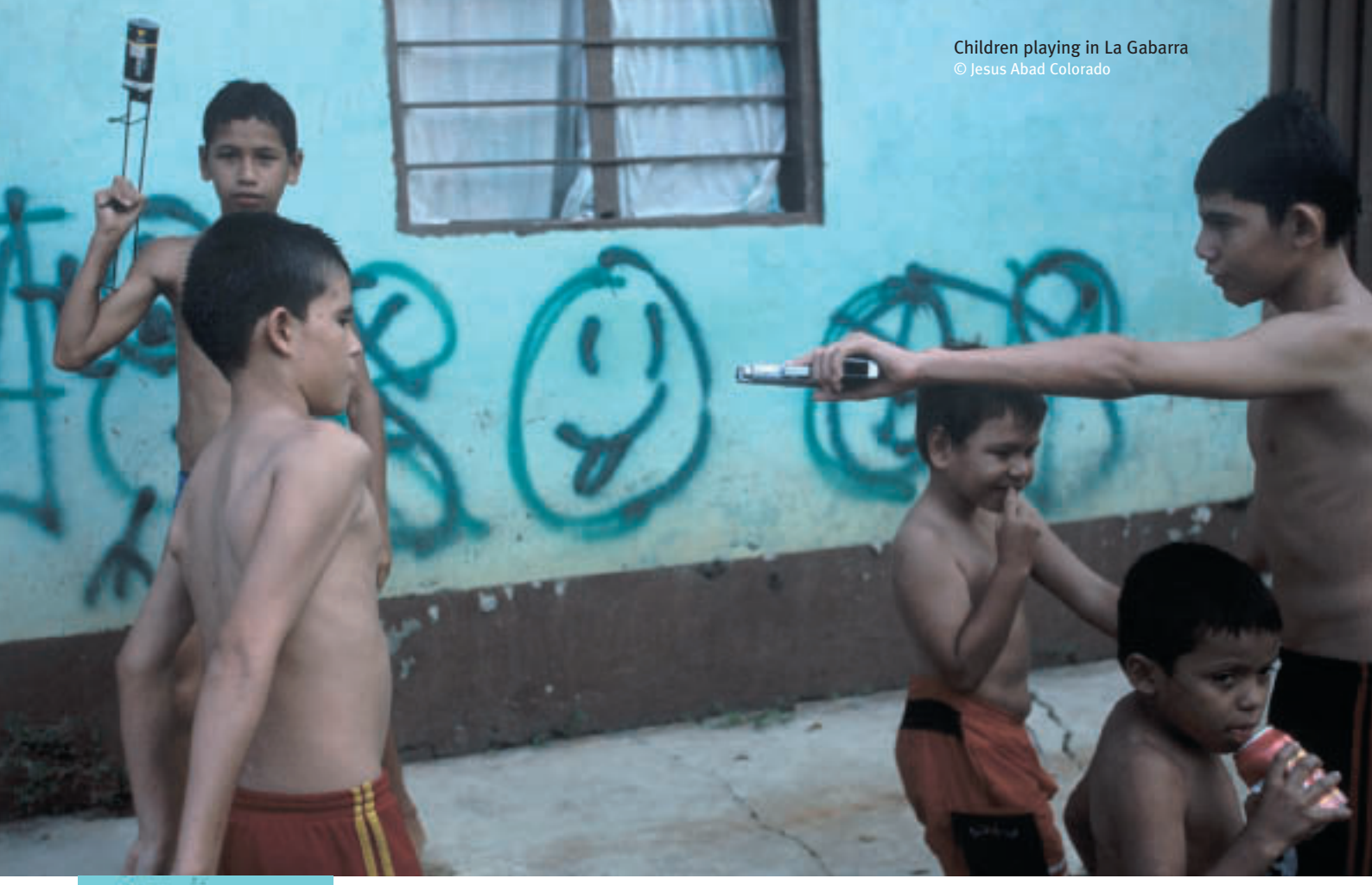
The regular outbursts of violence that plague Haiti, particularly Port-au-Prince, often go unnoticed by the outside world. Despite elections in 2006 and the presence since April 2004 of a United Nations stabilization mission, kidnappings, rape, organised crime and confrontations between armed groups and UN forces are still common occurrences.

United Nations figures show that 630 women die per 100,000 deliveries in Haiti. That's 50 times higher than the rate in the UK.

Since MSF opened the Jude Ann hospital last year, our teams have delivered about a fifth of all babies in Port-au-Prince. The need for emergency obstetric care is clearly enormous. As well as continuing our work helping the most vulnerable women, MSF is currently lobbying the government of Haiti and the international community to prioritise improving maternal care in the country.

New born child at Jude Anne Hospital

"It was already too late. We wanted to go to the hospital but we didn't dare go out into the street. There is regularly shooting in our neighbourhood. We're used to the violence, but at night it is too dangerous to go out"



Children playing in La Gabarra
© Jesus Abad Colorado

Colombia is in its fifth decade of violent conflict between guerrillas, organized criminal groups and government forces. Massacres, selective killings and intimidation have become an inescapable part of everyday life for millions of Colombians. The numbers are reaching unprecedented levels: over 3 million people displaced since 1995 and one of the world's highest homicide rates.

Living amidst violence

Control of strategic areas is at the heart of the conflict between left-wing revolutionaries, right-wing paramilitaries, organized criminals, narco-traffickers and the government. Civilians are caught in the middle of armed struggles to wrest control over coca-rich plantations, drug profits and regions with valuable resources such as coal or oil. Organised crime has reached into every corner of society and people are forced to become unwilling informants under the threat of violence or even summary executions. "You don't know who your neighbour is," says a man living in a rural community. "People keep silent in order to survive ...Many have died for calling things the way they are; many have disappeared for knowing too much..."

Victor Garcia, head of an MSF team in Catatumbo, currently one of Colombia's most conflict prone regions, describes a visit to a remote health clinic:

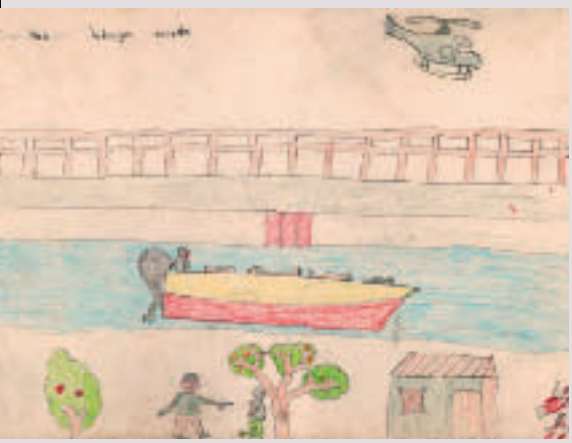
"Today we're going to a health clinic in Caricachabokira, a protected indigenous area. There are no other aid organisations working here, the 'health post' has no doctor or nurse and we have found that many people here are living spread out across small villages without any sort of medical care.

"We take the mud road to La Gabarra village on the banks of the river, where the Bari, the indigenous inhabitants, should be waiting to take us by boat to their territory. La Gabarra is a community that has been and continues to be heavily affected by the violence in this strategic border region near Venezuela. On arrival, it is clear that something is happening. Nobody sees, hears or says anything, as though the whole world were blind, deaf or dumb. But one morning, large and sinister numbers appear, sprayed on house walls. Those numbers mark the houses where paramilitaries were living that are now vacant following a de-mobilisation process...

A legacy of fear

The persistent and very real threat in regions such as Catatumbo leaves people facing rural insecurity or urban poverty. Hundreds of thousands of people make the choice to flee their homes and seek refuge from the violence, settling in urban slums that have spread on the outskirts of almost every city across Colombia. Increases in violence, alcohol and substance abuse and domestic and sexual violence can be directly linked to the breakdown of the social fabric associated with the flight from violence into displacement.

Nowhere are the mental health effects more clearly seen than through the experience of children, where fear takes recognizable form in their drawings. Boys and girls in MSF programmes usually incorporate elements associated with the conflict in their artwork, like weaponry, combat helicopters, or depictions of massacres. MSF staff have seen images of canoes loaded with lifeless bodies and figures on bended knees in front of a gun pleading for their lives.



© Juan Carlos Tomasi

Many people report feeling fear and anxiety, and react to it with insomnia, muscular tension, sweating, dizziness, palpitations, vertigo, or gastric problems. "My kids live in constant fear," says a displaced mother, living in an urban slum. "When shooting starts, the girl holds her aunt's leg and both kids start screaming, they go crazy. The thing is that the bullets pierce through the house, there are holes everywhere. My boy has nightmares and I don't know what to do."

While many displaced people live their entire lives in the slums, some eventually return to what remains of their homes. People living in these so-called 'communities of return' face a difficult mental journey to rebuild their lives. Return is seen as an escape from the slums, but also entails a plunge back into the insecurity and the 'ghosts' of the past and many returnees view the future with uncertainty.

In all MSF's teams in Colombia, alongside basic health care, there are mental health services. Often these involve group sessions, encouraging the community to support one another and creating opportunities for people to speak more freely to each other about their experiences. For people who do not respond well to group sessions, MSF provides personal counselling.

Judith Rosales, a Colombian psychologist at an MSF clinic in a Bogotá slum, explains how she works with traumatised children: "You teach them to use metaphors to make a comparison with reality, creating a parallel fiction where they can tell the truth about what happened. Little by little, they go back to that reality through the narrative technique of telling a story in first person, as if they were the main character. In this way, they are the centre of the story. It helps them move past the traumatic experience to rebuild their lives."

Currently psychological and psychiatric consultations are not available in most of the country. Even in regional capitals with established hospitals mental health care is virtually non-existent. In 2005 MSF opened a clinic offering free psychosocial services in the provincial capital of Sincelejo, in the North West of Colombia. Previously there had been only one psychiatrist and one psychologist working for the Ministry of Health, responsible for the needs of more than 850,000 people. The needs are massive and growing, and MSF cannot sure up all the cracks in the country's mental health care situation; the Colombian government and other agencies must provide more assistance for the victims of four decades of conflict.

"We were taken somewhere and they started to threaten us and talk about chainsaws. We left only with the clothes we were wearing; we walked all night and part of the day, and the kids asking for food"

Mother from a rural community

"We fuel up, load the equipment onto the Bari's boats and head upstream. The river flows dirty and turbid. Every time I travel on it, I imagine that it's even dirtier underneath because of all the bodies that were thrown into it during the big massacres of 2002 when groups were fighting for control of the waterways. But the river does not see, hear or say anything. It flows in silence as we advance against the current.

"Beginning early the next day, the sick from neighbouring communities begin to arrive at the clinic. Our free services include vaccinations and medical, nursing and psychosocial consultations. On the second day of the clinic, from the health post we can clearly see two combat helicopters. They bombard some target a few kilometres away. We can hear the bombs and the shots, and we can see the smoke. At one point, we can see an anti-aircraft missile fired from the ground that one of the helicopters narrowly dodges. It is a fight between the soldiers and the guerrilla forces. Meanwhile, the Bari are at their activities (fishing, hunting in the woods, collecting cacao or firewood) – of the patients who come to the clinic only one comments on the nearby attack, saying she thinks the smoke that can be seen is from her house.

"Five days later, we have treated over 700 patients and the Bari accompany us back in their boats. In La Gabarra, the four MSF off-road vehicles are waiting, and again there is the muddy road. We get stuck, we get unstuck and we press on. Deep down, that is our rhythm here."

The Rohingyas are a Muslim minority from the border region between Bangladesh and Rakhine State in western Myanmar (formerly Burma). Their accounts of life in Myanmar include severe human rights abuses: restrictions on movement and on marriage; forced labour; land and assets confiscation; violence; and arbitrary arrest.

Caught between a crocodile and a snake

In 1992 more than a quarter of a million Rohingyas fled from Myanmar to Bangladesh. But two years later, without any clear change in the situation in Myanmar, the Bangladeshi authorities and the UN started mass repatriations. In Bangladesh, the Rohingyas are now considered unwelcome economic migrants, but in Myanmar they face continued harassment and abuses and are denied the right to nationality. "As a Rohingya," says a 19-year old refugee in Bangladesh, "I feel caught between a crocodile and a snake."

In Myanmar

Many Rohingya Muslims in Rakhine State have great difficulty getting any sort of health care. Not only are they unable to afford the cost of health services, but travel restrictions and fees imposed by the government mean they are often effectively confined to their villages, so cannot go to the towns and provincial capital for treatment.

MSF works in over 15 clinics in Northern Rakhine State, focusing primarily on the diagnosis and treatment of malaria. The teams, largely made up of Burmese and Rohingya staff, also travel out to remote villages on a regular basis to bring treatment to those who are not able to travel to a clinic.

Rakhine State is one of MSF's largest malaria programmes; in 2006 over 450,000 patients were tested and 210,000 treated for malaria. Malnutrition, tuberculosis and HIV/AIDS care and treatment are also provided for free in the clinics.

Bill Baylis worked in the MSF clinic in Sittwe, Rakhine State's provincial capital, in 2006 and 2007: "During my time we expanded from one building to four. This expansion was due to increasing numbers of severely and acutely malnourished children and an increase in malaria cases. Almost all the patients we saw were Muslims. This may be because the Muslims faced some obstructions to attending the government hospitals, but money was probably the crucial factor – the Muslims are generally poor and our clinic was free. I imagine that if MSF left, no one would treat the Muslims."

In Bangladesh

Today, those Rohingyas who cross the border into Bangladesh still find themselves with nowhere to go. Although the UN set up camps to accommodate the influx of refugees in 1992, all but two are now closed. Bangladesh is not a signatory to the international refugee convention and therefore Rohingyas arriving since 1994 cannot seek the protective status of a refugee.

The two official refugee camps house about 26,000 people and MSF runs a busy 20-bed inpatient unit in each. The Rohingyas in these camps arrived before the government stopped new refugee registrations, and therefore are better off than their unregistered compatriots. Even so, their lives are confined within the boundaries of the camps and, unable to work outside the camps, they depend on aid to survive.

For the unregistered Rohingyas scattered across the southeast corner of Bangladesh, life is even harder. Some have never moved from the place where they landed after fleeing Myanmar. MSF runs weekly visits to Shalampur beach, reaching the converted storeroom that serves as a clinic by driving along the sand at low water to avoid bandit activity on the roads. A Rohingya woman who has survived for 14 years on the beach with her family explains her plight: "We came to Bangladesh because the Burmese army took our land, our cows and everything we had. If I go back after all this time, they will put me in jail or shoot me. Here at least they do not say anything."

Seven thousand more Rohingyas have congregated at a place called Tal in a makeshift camp, squeezed onto a 30-meter wide sliver of land between a river and the main trunk road. Two-meter by three-meter shelters house up to twelve people, built on a base of mud that needs to be continually replaced to prevent them collapsing into the water. River water comes into many shelters at high tide and in the rainy season nearly eight out of ten shelters are flooded. Food and clean drinking water are scarce and there is an average of about 40 people sharing each latrine. These conditions have led to a need for humanitarian and medical assistance.

The shelters in Tal camp house up to 12 people and are built on mud bases to raise them above the high tide level.

© Eddy Van Wessel

MSF runs a free clinic near Tal, where the most common health problems are respiratory tract infections, probably linked to overcrowding and exposure to cold and damp. The appalling sanitary conditions in the camp mean that there are also many patients suffering from diarrhoea or worms. Many Rohingya men work in the fishing industry or look for work in the Chittagong Hill Tracts district usually staying away for long periods; some never return. The women, left with no resources, often have to rely on another family, beg or engage in prostitution to keep their family alive. The children who come to MSF's clinic suffering from malnutrition are often from such fatherless families.

The Government of Bangladesh has recently expressed the intention to move the people from Tal camp onto another piece of land; but, as for most of the Rohingyas in Bangladesh, their status and their future remain uncertain.

Burmese ethnic minorities in need of help

The Rohingyas are not the only minority group in Myanmar facing hardship. All Myanmar's five neighbouring countries have Burmese refugees. Of these countries, only one – China – is a signatory to the international refugee convention; the others are Bangladesh, India, Laos and Thailand. Like the Rohingyas in Bangladesh, many other Burmese refugees face enormous difficulties simply surviving in countries that do not recognise their status.

As is the case for many Rohingyas, the majority of these ethnic minority refugees have fled Myanmar illegally and cannot go back to their village of origin for fear of being imprisoned by the authorities. A Rohingya man tells of his two brothers who went back to Myanmar to see their parents: "Before they could see them, they were put in jail. Why? Because they were living in Bangladesh." It is an impossible choice – return and face imprisonment or try to settle on otherwise unwanted patches of land in country that gives you no status. MSF and other organisations can try to keep these groups alive by providing basic health care, nutritional services, safe drinking water and sanitation facilities. But such actions do not solve the problem. As Frido Herinckx, MSF's Head of Mission in Bangaldesh, says: "Alternatives have to be offered or negotiated. Nobody should have to live like this."

MSF UK volunteers currently in the field

Bangladesh Chris Hall *LOGISTICAL COORDINATOR* Claire Jones *DOCTOR* Kolja Stille *DOCTOR* Burundi Anna Halford *FIELD COORDINATOR* Cambodia Christopher Peskett *NURSE* Catherine Dalrymple *WATER & SANITATION EXPERT* Central African Republic Christopher Pritchard *LOGISTICIAN* Colin Beckworth *NURSE* James Pallett *DOCTOR* Chad Alexis Gallagher *HR & ADMINISTRATIVE COORDINATOR* Andrew Mews *LOGISTICIAN* Andrew Noden *DOCTOR* Christophe Hodder *LOGISTICIAN* Emily Bell *LOGISTICAL ADMINISTRATOR* Iesha Singh *PROJECT COORDINATOR* Grant Anthony *WATER & SANITATION EXPERT* Neil Fletcher *DOCTOR* Paula Brennan *PROJECT COORDINATOR* Colombia April Baller *DOCTOR* Caroline Brant *PROJECT COORDINATOR* Julia Parker *INFORMATION, EDUCATION & COMMUNICATION OFFICER* Simon Midgley *MENTAL HEALTH SPECIALIST* DRC Adam Thomas *PROJECT COORDINATOR* Alice Thomas *NURSE* Danielle Ferris *LOGISTICAL ADMINISTRATOR* Gail Leeder *FINANCIAL CONTROLLER* Henry Gray *WATER & SANITATION EXPERT* Ike Omambala *LOGISTICIAN* Matthew Arnold *WATER & SANITATION EXPERT* Nicola Fenn *NURSE* Nitisha Nababsing *DOCTOR* Katy Peters *NURSE* Ethiopia Karen Kennedy *LOGISTICIAN* Marjolein Jongepier *CAMPAIGNER* Rosemary Davis *NURSE* Tom White *HEAD OF MISSION* Simon Buckley *FINANCIAL CONTROLLER* Joanna Knight *LOGISTICAL ADMINISTRATOR* Haiti Sophie Tilt *LOGISTICIAN* Tuppin Scrace *ANAESTHETIST* India Hilary Evans *DOCTOR* Joanna Cox *MEDICAL COORDINATOR* Simon Woods *LOGISTICIAN* Orla Condren *NURSE* Iran Rachael Craven *ANAESTHETIST* Jordan Sarwat Al-Attas *MEDICAL COORDINATOR* Eric Stobbaerts *PROJECT COORDINATOR* Maria Siemer *LOGISTICAL ADMINISTRATOR* David Cremoux *HEAD OF MISSION* Kenya Susan Sandars *REGIONAL INFORMATION OFFICER* Liberia Kartik Chandaria *DOCTOR* Annas Alamudi *ADMINISTRATOR* Foday Kargbo *FINANCIAL CONTROLLER* Malawi Bibiana Angarita *BIOMEDICAL SCIENTIST* Bryn Button *LOGISTICAL COORDINATOR* Claire Hughes *LOGISTICIAN* Margaret Othigo *BIOMEDICAL SCIENTIST* Myanmar Anna Wilkins *DOCTOR* Helen Bygrave *DOCTOR* Sarah Hichens *DOCTOR* Georgina Russell *DOCTOR* Johannah Wegerdt *EPIDEMIOLOGIST* Maria Doyle *NURSE* Michael Patmore *BIOMEDICAL SCIENTIST* Sabina Ilyas *DOCTOR* Nepal Simon Heuberger *PROJECT COORDINATOR* Nigeria David Cook *LOGISTICIAN* Jacqui Tong *HEAD OF MISSION* Erik Gorter *LOGISTICIAN* Russia Solveig Hamilton *MEDICAL COORDINATOR* Valerie Powell *MEDICAL COORDINATOR* Somalia Chris Lockyear *LOGISTICIAN* Colin McIlreavy *PROJECT COORDINATOR* Declan Overton *LOGISTICIAN* Joan Wilson Assistant *MEDICAL COORDINATOR* Robin Aherne *LOGISTICIAN* Samuel Crawley *LOGISTICIAN* Sarah Quinnell *MIDWIFE* Tom Quinn *HEAD OF MISSION* Leanne Sellers *NURSE* Paul Critchley *PROJECT COORDINATOR* Paul McMaster *SURGEON* South Africa Nathan Ford *MEDICAL UNIT COORDINATOR* Alessandra Vilas Boas *COMMUNICATIONS DIRECTOR* Sudan Alvaro Dominguez *NURSE* Anna Greenham *DOCTOR* Annabelle Williams *ASSISTANT HEAD OF MISSION* Emily Russell *LOGISTICIAN* Kathleen MacEwan *NURSE* Philippa Millard *NURSE* Ross Duffy *PROJECT COORDINATOR* Stephen Cooper *PROJECT COORDINATOR* Vicky Treacy *NURSE* Kenneth Lavelle *PROJECT COORDINATOR* Patricia Drain *NURSE* Sheila Ravindran *MENTAL HEALTH SPECIALIST* Siama Latif *DOCTOR* Tracy Crawford *ASSISTANT MEDICAL COORDINATOR* Aisa Fraser *NURSE* Anna Hess *NURSE* Anna Kent *NURSE* Boris Stringer *PROJECT COORDINATOR* Felicity Tucker *NURSE* Helen Austin *FIELD COORDINATOR* Joanne Booth *NURSE* Neil Brennan *WATER & SANITATION EXPERT* Nicole Hendriksen *NURSE* Rupert Miller *ASSISTANT HEAD OF MISSION* Sarah Maynard *LOGISTICAL ADMINISTRATOR* Brigitte Daubeny *COUNTRY ADMINISTRATOR* Sri Lanka Susan Lowery *ANAESTHETIST* Terri Morris *FIELD COORDINATOR* Jonathan Henry *PROJECT COORDINATOR* Thailand David Wilson *DOCTOR* Paul Cawthorne *PROJECT COORDINATOR* Turkmenistan Gemma Davies *LOGISTICAL ADMINISTRATOR* Uganda Alison Jones *MEDICAL TEAM LEADER* Vivienne Monaghan *NURSE* Uzbekistan Jonathan Polonsky *EPIDEMIOLOGIST* Yemen William Baylis *LOGISTICAL ADMINISTRATOR* Zambia Karen Bevan-Mogg *DOCTOR* Peter Camp *LOGISTICIAN* Zimbabwe Daniel Williamson *LOGISTICIAN* Lily Cummins *NURSE* Stephen Hide *HEAD OF MISSION*

DISPATCHES is a quarterly publication designed to keep our supporters updated on the work of Médecins Sans Frontières.

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MSF is currently the only humanitarian NGO offering health service in Shangyl Tobaya camp, North Darfur

Darfur: the suffering continues

The crisis in Darfur first started appearing in international headlines at the end of 2003. Kenny Gluck, MSF's Head of Mission in North Darfur, still sees the situation as a crisis: "We hear that the international aid response for Darfur has been massive, and maybe it has. But four years into the conflict, in some areas you still see rising levels of malnutrition. That's not an acceptable situation."

The past four years have seen a dramatic change in the situation in Darfur. It is over a year now since the signing of the May 2006 Darfur Peace Agreement and in the meantime various armed factions, both rebel and pro-government, have splintered and are turning their weapons on each other. The violence is less intense than in 2003 and 2004, but everyday insecurity is still shocking and villages continue to be attacked and raided; civilians continue to be killed.

Over the past year a sharp increase in attacks on aid workers has limited the scope of humanitarian activity, cutting off hundreds of thousands from any assistance. MSF has had to reduce the number of locations where it works: either because fighting forced teams to evacuate; or because we were attacked in our compounds; or because of general insecurity on the roads. Despite the difficulties, MSF teams continue to do whatever they can to assist the people of Darfur.

"We are trying to use helicopters to run clinics in several mountainous areas that are under the control of one rebel faction or another," explains Gluck. "Unfortunately the fact that we can only get to these areas by helicopter severely limits our ability to transfer patients who need further treatment; but we think at the moment it would be simply too dangerous to get there by car. While travel outside the camps is limited, we are trying to ensure that the people in the camps survive this horrible experience until they feel it is safe for them to go home."

Novartis update

On 6 August, MSF was delighted to learn of the landmark decision in India to uphold the country's Patents Act in the face of a legal challenge by drugs company Novartis. Last December, MSF launched an international petition to ask the pharmaceutical giant to drop the case. We were concerned that, if Novartis won, India might dry up as a vital source of affordable medicines for people in developing countries. The Court's decision to reject Novartis's claims now makes Indian patents on desperately needed medicines less likely.

420,000 people in six continents signed the petition, which was handed over to the Novartis headquarters in Basel. A huge thank you to everyone who added their voice, and helped preserve India's role as 'the pharmacy of the developing world'.

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How to make a donation

If you would like to support MSF further, you can make a donation by:

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Please quote your supporter number (located on the top right hand side of the letter) and name and address when making a donation.

Why *Dispatches*?

Dispatches is written by people in MSF and sent every three months to our supporters and volunteers in the field. 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 donors, informed on how your money is spent and what our latest activities are.

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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