Quarterly news from Médecins Sans Frontières UK Issue nº 49 Summer 2008

DISPATCHES

Charity no 1026588

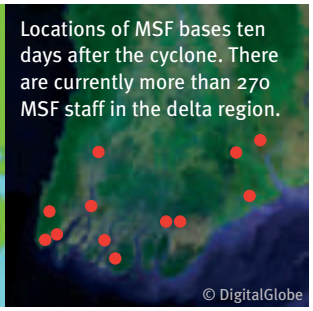
Médecins Sans Frontières is a leading independent humanitarian organisation for emergency medical aid. In over 60 countries world-wide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

Still living in an ocean of mud

"I've become a mother again," says a grandmother in a remote village, clutching a small child. "My whole family is gone – the only ones left are me and this baby girl."

Survivors of Cyclone Nargis sheltering in a buddhist temple in Pyapon.

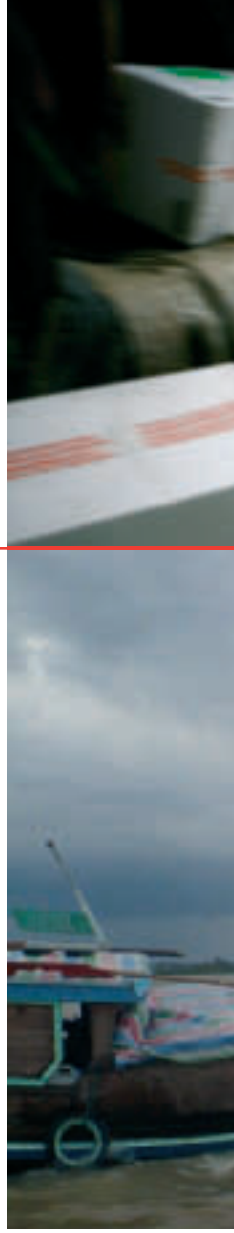
This grandmother's story barely hints at what tens of thousands of people are facing in the aftermath of Cyclone Nargis, which struck Myanmar's Irrawaddy Delta region on May 3. All over the delta, people watched helplessly as family and neighbours were swept away, houses were demolished, food supplies ruined, and wells swamped with saltwater and mud. Although it is now more than two months after the storm, tens of thousands of people still have insufficient food and only rudimentary shelter, not to mention a terrible emotional burden of grief.



Locations of MSF bases ten days after the cyclone. There are currently more than 270 MSF staff in the delta region.

To date MSF has distributed more than 940 tons of supplies, including:

- 2.6 million kilos of rice
- 618,000 kilos of beans
- 202,000 litres of oil
- 186,500 plastic sheets for temporary shelter
- 183,000 mosquito nets
- 10,000 bars of soap



Still living in an ocean of mud

Drawing staff and material from existing HIV and malaria programmes in other parts of the country, MSF rushed hundreds of tons of food, shelter and medical aid to the delta in the days following the storm. The scale of destruction, however, was beyond anything MSF's Burmese staff had previously dealt with. Normally a team of experienced disaster specialists would have flown in to co-ordinate the massive relief effort. But, although the Burmese authorities allowed MSF to import relief material by plane, no foreign staff were allowed to travel in the delta region for the first three weeks of the crisis. This left 250 of MSF's Burmese staff working round the clock for weeks without the support and the technical expertise of their international colleagues. Medics used to running busy but orderly clinics were confronted with the chaotic logistical nightmare of delivering a massive and urgent aid response to remote villages in small boats, with virtually all communication networks down.

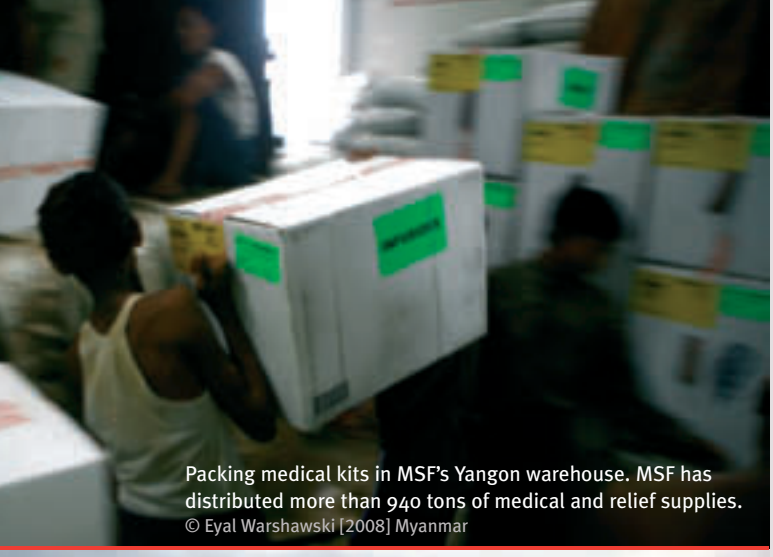
MSF medics have carried out more than 30,000 medical consultations throughout the delta.
© Robert Genest [2008] Myanmar

Dr. Myae* was one of the first aid workers to reach Hangyi, in the far southwest of the delta. "Everyone on our team sees more than 200 patients a day," he wrote in his diary. "There are confused people still searching for their families, children who have lost their parents, parents who have watched their children drown. In the evenings, I sit with my colleagues and everyone tells what they've heard and seen during the day. It is difficult for everyone. We are all tired and we sleep poorly. One of my colleagues told me that she couldn't get the stench of the dead bodies out of her nose. The smells, the images and the people's stories together form an overwhelming picture. I feel myself blocking it out. Tonight I went outside for a moment, I didn't want to hear anything anymore..."

Because of the relentless and extremely disturbing nature of the work, MSF has set up a system of rotating staff so that people get a break every two or three weeks. Before going into the delta, staff are matched with a 'buddy' so they can share the burden of what they are witnessing. On return to Yangon, there are trained counsellors that any MSF staff member can speak to. Kim*, a 26-year-old Burmese nurse, returned to Yangon after three weeks in the delta and explained what she had seen: "I was surprised because, although I didn't arrive until two weeks after the cyclone, there were still a lot of dead bodies that smell really bad. There were so many, especially lots of children. The problem was that people had to survive – they have to rebuild their homes and find clean water and food – so they are not interested in clearing away the dead bodies; there is still too much to do. I saw quite a lot of people showering in water that had bodies floating in it, but luckily they know not to drink that water.

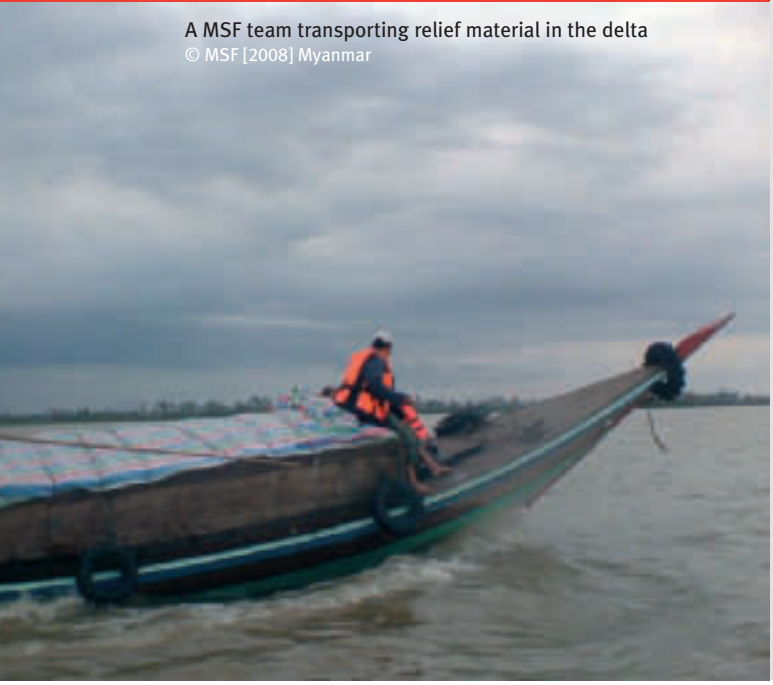
"We travelled to villages in two teams. When we arrived in a village we had three jobs to do. First we'd assess how many people lived there and what they needed. Then we'd find a place, such as a school, where we could distribute food and shelter material. After that we'd start medical consultations. The problem was, there were too many people, so we had to prioritize treating under fives first. We would assess people's nutritional status, assess for diarrhoea and check their wounds. A lot of people had badly infected wounds because they hadn't been able to clean them properly.

"It's very hard work in the delta and my family is quite worried about me. But I'm happy to be going back because I really want to help the people living there."



Packing medical kits in MSF's Yangon warehouse. MSF has distributed more than 940 tons of medical and relief supplies.
© Eyal Warshawski [2008] Myanmar

A MSF team transporting relief material in the delta
© MSF [2008] Myanmar



"We heard a lot of stories about the cyclone. Apparently the sky went red and they heard a very loud noise. The rain and the wind started at the same time and the water levels rose to 12 feet high, so the villages near the river were completely overwhelmed. One father who could swim tied string around the wrists of all his children, so that they would not be separated or swept away. But the cyclone went on for too long, and he couldn't swim any longer. Afterwards they found the whole family drowned, tied to one another by the string."

Kim*, a 26-year-old Burmese nurse

Although the situation in the Irrawaddy Delta is now less visible in the world's media, thousands are living in appalling circumstances and still require basic emergency aid – food, clean water, shelter and basic health care including psychological support. On June 6, more than a month after the storm, project coordinator Emmanuel Goue returned from a remote village in the south of the delta: "A giant wave during the cyclone simply flattened the area. We estimate there are 21,000 people here, including children and elderly, who live in the middle of nowhere, in an ocean of mud. Everything has been broken and they have not seen any aid for one month."

Besides the lack of food and clean drinking water, people are experiencing great psychological trauma. Kaz de Jong, an MSF mental health expert, describes a worrying situation: "In areas that have been more heavily affected people stare at you with empty faces, their natural coping mechanisms obliterated and communities broken apart. I spoke to one woman who explained that she was thankful for the food being delivered but asked if we could also find her the motivation to eat it." Basing specially trained counsellors in the areas with the worst destruction needs to start now, but at the same time keeping people alive must be a priority.

With most of the local boats destroyed during the storm, getting food, shelter and medical aid to where it is needed is extremely hard. "With a disaster on this scale you are constantly faced with dilemmas," explains emergency co-ordinator Vincent Hoedt. "You could be aiming to reach four villages in a day, but you might come across very sick people who take longer to treat. So you have to risk missing the tide and not being able to deliver the aid to everyone, or alternatively leaving without treating the patients properly. We have had problems getting all the supplies we need at times. You have to choose between leaving without essentials such as plastic sheeting, or leaving with everything but making people wait longer for food. Our staff face these kinds of dilemma everyday."

"Be it food, clean water, shelter or health care, the basic needs of people living in the Irrawaddy Delta remain paramount," says Joe Belliveau, MSF's operations manager for Myanmar. "People are especially vulnerable right now, having lost their loved ones, homes and livelihoods, on top of which the rainy season has begun. So the delivery of aid remains vital. Our teams are continuing to work on providing clean water but, as other organisations step up their efforts, particularly in food distributions, MSF has started shifting the emphasis of its programmes. Now we can really focus on delivering health and psychosocial care."

*names changed

Find out the latest on MSF's cyclone response at **www.msf.org.uk/cyclone**

"My job is to fight against malaria and help treat our children. Malaria has been our major problem in this community before now. But with this box we will be able to drive malaria away, even from here."

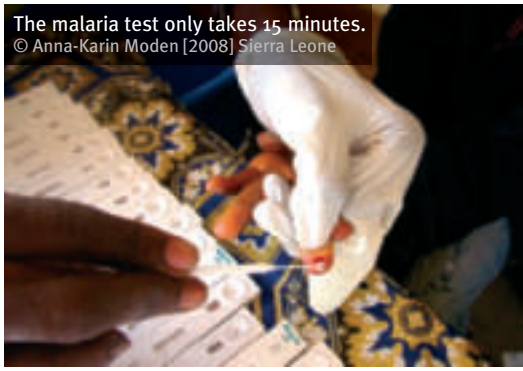
Mohammed Amara, Community Health Volunteer

"I live in Tongo, and I have travelled 40 miles to come here," says Fudia Janneh, a young mother sitting in the MSF waiting room at Gondama, in southern Sierra Leone. "My child is sick, so I took her to the clinic in Tongo three times but each time I had to pay and the fever is still there. My sister advised me to come here. I was told that the health care in this clinic is free."

Fudia's two-year-old daughter Sebatu has malaria, a disease that is endemic in Sierra Leone. One in four children in the country die before reaching their fifth birthday, and in the majority of cases the cause is malaria.

But malaria is easy to detect and, if caught early enough, easy to treat. Rapid Diagnostic Tests exist that are simple to use, give fast results, and require little training and no microscopes or laboratory. And there is no secret about the best treatment for malaria in Africa today; Artemisinin-based combination therapy (ACT) can cure malaria in three days and has minimal side effects.

So if the diagnostic tools and effective treatment exist, why are so many people still suffering and dying from malaria in Sierra Leone?


The malaria test only takes 15 minutes.
© Anna-Karin Moden [2008] Sierra Leone

"One of the problems is that transport and roads are very bad and people often have to walk several miles to reach a rural health post or clinic," says David Curtis, head of mission for MSF in Sierra Leone. "Some villages are completely cut off during the rainy season, and even when people do manage to reach the health post, they cannot always be sure that the nurse will be there because there is also a shortage of health staff.

Community Health Volunteers "I am happy because

ABOUT MALARIA

People catch the deadly malaria parasite from infected Anopheles mosquitos. There are different types of malaria parasite – the most dangerous, and by far the most common in Sierra Leone, is *plasmodium falciparum*.

Malaria symptoms appear about 9 to 14 days after the infectious mosquito bite. Typically, malaria produces fever, headache, vomiting and other flu-like symptoms. In severe cases children can suffer from convulsions, severe anaemia, and – if they survive – can suffer from blindness or speech disorders. Pregnant women have a lowered immune response and so are also particularly vulnerable. If treatment is not administered using drugs that are effective against the parasite, the disease can rapidly become life-threatening.

Joseph Tucker

My name is Joseph Tucker. I am 38 years old and I am a farmer. I have four children and we live in Bandajuma Village. I was appointed by my community to be a Community Health Volunteer because I am well known by everyone in my community, and I met the criteria of being able to read and write, being reliable and honest. I received training from MSF, where I learnt about malaria, how to diagnose it and treat it. Then, three weeks ago, our community was given a health kit, containing the diagnostic tools and ACTs so I could start my role of volunteer.

Normally I see patients between 7am and 10am every day and then I go to work in my field. If there are very serious patients that need to be seen during the day, then I come back from my field and treat them.

In my village there are 145 children under the age of five and four pregnant women. Forty three of the children and pregnant women I tested in the last three weeks were malaria positive. Before this time, they would have had to walk three miles to reach the nearest clinic to get treated. Now, we even have people coming to our village from other villages because they know we have the tools to treat malaria.

Malaria is a very dangerous problem in our community and I am very happy to be a volunteer because I am saving lives.

"I've had malaria many times before, so I know what it's like," says Kadie, in MSF's clinic in Gondama. "You can feel it in your head, in your neck, in your joints. Your whole body is aching". Like most people in malaria endemic areas, Kadie has developed a partial immunity to the disease. But this time she is pregnant with her third child, and her pregnancy has reduced her immunity. Without proper treatment, the malaria could affect her baby, potentially causing a spontaneous abortion. Because of this increased vulnerability to malaria among pregnant women, they are one of MSF's primary concerns in Sierra Leone
© Francesco Zizola [2008] Sierra Leone

I am saving lives"

"In the rural areas especially, people are very poor and they don't have the money to pay for health care," continues Curtis. "So even if the ACT treatment is handed out for free in the Ministry of Health clinics, people still cannot afford the registration fees, the doctor's consultation, the cost of other drugs that they might need..."

These obstacles can be deadly for young children; if they don't get treatment within 24 to 48 hours, they face a serious risk of developing severe malaria and dying from it.

In the southern districts of Bo and Pujehun, MSF is trying to overcome these obstacles by bringing malaria treatment closer to people living in remote areas. The team has started a new Community Malaria Programme in villages that are more than three miles away from a rural health post.

Each community chooses two people to be their Community Health Volunteers, who are then trained by MSF in how to diagnose and treat cases of malaria. Once the volunteers have been trained, a ceremony takes place where MSF hands over to the whole village a 'community health kit', containing the Rapid Diagnostic Tests and the ACT treatment. With the training and the kit, the volunteers are able to diagnose and treat simple malaria cases in children under five and pregnant women, the two groups most at risk. Every month, the volunteers get together with MSF staff and share their reports on how many people have been treated and discuss any problems or questions they might have.

Alpha Kappia's first patient is Jabbie Mansaray. The test strip shows that she has malaria.
© Anna-Karin Moden [2008] Sierra Leone

Just five minutes after the official hand-over of the kit to two newly trained volunteers in the village of Fayama Malen, their first patient arrives. Jabbie Mansarey is two years old and has a fever. Alpha Kappia, one of the volunteers, dons a pair of sterile gloves and pricks the tip of Jabbie's finger. She winces as Alpha squeezes a small droplet of blood onto the plastic testing strip. After fifteen minutes, Alpha holds up the strip, which has two clear lines showing that Jabbie has malaria. Fortunately Alpha and his fellow volunteer, Mohammed Amara, know how to give the three-day course of ACT treatment, which should cure Jabbie and is administered free. And Jabbie's mother will not have to carry her daughter all the way to the health post, where she it is likely she would have to pay for a consultation.

See more of Alpha and his Community Health Worker colleagues at **www.msf.org.uk/malaria_video**

Following the outbreaks of violence in Johannesburg, around 1,500 people have sought shelter at this police station in the city centre, where MSF has set up a clinic. They sleep on concrete floors or on the grass, outside in the cold.

No sanctuary in South Africa

In Cleveland police station, on the outskirts of Johannesburg, a young couple share their horrific story with Adrienne Carter, a MSF Psychologist. Having fled the Congo after seeing Mai Mai rebels murder their family, the couple settled in South Africa hoping to build a better life. This dream was shattered in May when widespread violence against immigrants broke out in South Africa. Several men attacked the couple in their home – beat the husband, stole all their belongings and raped the wife. Terrified, she waited a whole week before even daring to go to hospital for treatment.

This couple are just two of an estimated 80,000[1] people who have fled their homes after brutal violence against African immigrants erupted in townships around Johannesburg on May 11 and quickly spread across parts of Gauteng, Western Cape, and KwaZulu Natal provinces. Tens of thousands of people quickly sought refuge at police stations and community halls. In the historically volatile township of Thokoza in Johannesburg, one 40-year-old Zimbabwean man who had been attacked in his home explained how he felt:

"The reason I came to South Africa is because of fear – I came looking for asylum, but South Africa has also neglected us. Everyone is failing to protect us. I just want to find a safe and peaceful place to live. It seems like South Africa can't accommodate Zimbabweans anymore. Again, I have no food and clothes. I am back in the same situation that I was in, in Zimbabwe."

Since December 2007, MSF teams had been working to provide care to Zimbabweans seeking refuge in South Africa and had established clinics in the Central Methodist church in Johannesburg and around the town of Musina on the border with Zimbabwe. They very quickly responded to the peak in violence by providing direct medical aid to victims, including treatment for gunshot wounds and caring for victims of rape, as well as ensuring that patients were referred to, and treated by, local hospitals.

The South African authorities seem to have been caught unawares by the sudden violence and their response was initially slow. For three weeks terrified people remained in limbo in the police stations and community halls as the authorities determined what should be done. During this time overcrowded conditions and poor hygiene quickly led to health problems and MSF medics treated people for diarrhoea, respiratory infections and stress related illnesses.

Finally, at the beginning of June, the government started moving people into tented camps but these were often poorly-chosen sites with unsuitable living conditions. Above all, they did not provide the safety that people so desperately needed. "We witnessed families being separated and heard numerous reports of intimidation by security companies sub-contracted to 'protect' the displaced," explained Rachel Cohen, head of mission for MSF in South Africa. "People are telling us they feel trapped with nowhere to turn to, and that everyone is failing to protect them – including the UN's refugee agency."

"Hygiene and sanitation conditions in the camps are still inadequate, temperatures are plummeting at night, and the tents are not meant for this kind of weather," said Philippe Havet, who co-ordinates MSF's emergency response.

"Almost half of our medical consultations are for respiratory diseases, which can be linked to the cold. In addition, our patients continuously express anxiety about their safety and security."

Find out more about the conditions these people face

Today, three MSF teams rotate between six camps in Johannesburg and one in Pretoria ensuring basic care is available to those in need. On the other side of the country, in Cape Town's Khayelitsha township, another mobile medical team is supporting the local health officials in providing basic health care for the displaced. Since the beginning of the troubles, MSF medics have carried out more than 6,000 consultations for people affected by the violence.

Many of the people targeted by this wave of violence came to South Africa precisely because they were fleeing political unrest in their home countries. Mental health support is therefore an essential part of the package of care, and MSF has incorporated mental health activities into the work of the medical teams, organising both individual and group counselling.

"Many of our patients, including Zimbabweans and Congolese, have been re-traumatised by the violence and displacement in South Africa," says MSF nurse Bianca Tolboom. "In addition to living in harsh conditions, they are living in fear and their main concern is what to do next. Will they go back to their homes in South Africa where they may be attacked again? Will they go back to the countries they fled in the first place? It is an impossible choice, and for the moment, they are literally left in the cold."

Conducting medical consultations for refugees who have gathered in Cleveland police station.
© Benedicte Kurzen [2008] Johannesburg

MSF started caring for vulnerable Zimbabweans in South Africa back in 2007. Crisis in their own country had led many[2] to cross into South Africa seeking safety and a way to support their families. Very few are granted official refugee status – many are too afraid or unable even to apply and consequently live without papers - which makes them very vulnerable to abuse and exploitation. Without refugee status, the Zimbabweans in South Africa live in apprehension that at any time they can be deported. They are right to be afraid.

On June 28, just one day after the latest run-off election in Zimbabwe, MSF teams in Musina were shocked to discover that over 400 people, including 15 children, had been abruptly deported back to Zimbabwe by South African authorities. Such practice is in violation of international as well as South African laws, which guarantee the right to seek asylum and the help they need.

In such a climate of fear, violence and distrust of authorities, MSF's role is more vital than ever. "MSF is not here to substitute the responsibility of the government but rather to fill any vital gaps that may exist," explains Havet. "People are very afraid and many distrust the aid coming through South African authorities. This makes MSF's intervention as an independent organisation critical."

[1] *United Nations High Commissioner for Refugees (UNHCR) figures*

[2] It's impossible to know for sure how many Zimbweans are currently in South Africa but it's estimated to be close to 1.5 million (source: Human Rights Watch)

at **www.msf.org.uk/southafrica_slideshow**

MSF UK volunteers currently in the field

Bangladesh Emily Russell *LOGISTICIAN* Julie Syvret *FINANCIAL CONTROLLER* Bolivia Thomas Ellman *HEAD OF MISSION* CAR Anat Aharoni *PROJECT COORDINATOR* Dominic Deville *LOGISTICAL ADMINISTRATOR* Kathleen MacEwan *NURSE* Mark Scott-Fleming *DOCTOR* Chad Simon Barrett *DOCTOR* Simon Brown *LOGISTICIAN* Sophie Sabatier *PROJECT COORDINATOR* Colombia David Cook *LOGISTICAL ADMINISTRATOR* Sally Tillett *NURSE* DRC Cokie Van Der Velde *LOGISTICIAN* Alexis Gallagher *LOGISTICAL ADMINISTRATOR* Anna Halford *PROJECT COORDINATOR* Christophe Hodder *PROJECT COORDINATOR* Gina Bark *HEAD OF MISSION* Kathryn Johnstone *HUMAN RESOURCES OFFICER* Sarah Harvey *LOGISTICAL ADMINISTRATOR* Simon Wright *FINANCIAL CONTROLLER* Sophie Tilt *LOGISTICIAN* Ethiopia Alvaro Dominguez *NURSE* Angela Cave *NURSE* Anna Greenham *DOCTOR* Bruce Russell *PROJECT COORDINATOR* Gareth Walker *LOGISTICIAN* Jill Mowbray *NURSE* Katarzyna Russell *MIDWIFE* Lily Cummins *NURSE* Sanjay Joshi *LOGISTICAL ADMINISTRATOR* Guatemala Alison Jones *MEDICAL COORDINATOR* Haiti Georgina Brown *MIDWIFE* James Pallett *DOCTOR* India Adam Thomas *PROJECT COORDINATOR* Alice Thomas *NURSE* David Sweeney *LOGISTICAL ADMINISTRATOR* Jacob Stringer *HEAD OF MISSION* Joanna Cox *MEDICAL COORDINATOR* Maria Dominguez *DOCTOR* Mike Patmore *LAB TECHNICIAN* Orla Condren *NURSE* Pawan Donaldson *PROJECT COORDINATOR* Jordan Colin McIlreavy *HEAD OF MISSION* Maria Siemer *LOGISTICAL ADMINISTRATOR* Kenya Danielle Ferris *PROJECT COORDINATOR* Lucy Pamment *NURSE* Susan Sandars *REGIONAL INFORMATION OFFICER* Liberia Foday Kargbo *FINANCIAL CONTROLLER* Jane Metz *DOCTOR* Myanmar Emily Bell *LOGISTICAL ADMINISTRATOR* Luke Arend *DEPUTY HEAD OF MISSION* Paula Brennan *PROJECT COORDINATOR* Roger Anthony *WATER & SANITATION EXPERT* Nepal Dawn Taylor *PROJECT COORDINATOR* Pakistan Chris Lockyear *HEAD OF MISSION* Hannah Denton *MENTAL HEALTH SPECIALIST* Philippa Farrugia *DOCTOR* Palestine Fran Miller *MENTAL HEALTH SPECIALIST* Russia Valerie Powell *MEDICAL COORDINATOR* Sierra Leone Sophie Dunkley *EPIDEMIOLOGIST* Somalia Duncan Bell *DEPUTY HEAD OF MISSION* Kenneth Lavelle *HEAD OF MISSION* Tom Quinn *HEAD OF MISSION* South Africa Louise Knight *EPIDEMIOLOGIST* Nathan Ford *HEAD OF MISSION* Sudan Aisa Fraser *NURSE* Catherine McGarva *MENTAL HEALTH SPECIALIST* Dan Williamson *LOGISTICAL ADMINISTRATOR* Emily Goodwin *LOGISTICAL ADMINISTRATOR* Felix Over *MEDICAL COORDINATOR* Freda Graf *NURSE* Gaelle Tavernier *PROJECT COORDINATOR* Gill Ross *DOCTOR* Jane-Ann McKenna *FINANCIAL CONTROLLER* Jose Hulsenbek *DEPUTY HEAD OF MISSION* Kirsten Brown *DOCTOR* Laura Rinchey *DOCTOR* Maria Doyle *NURSE* Sarah Maynard *LOGISTICAL ADMINISTRATOR* Simon Tyler *LOGISTICAL ADMINISTRATOR* Andrea Hewitt *FINANCIAL CONTROLLER* Andrew Dennis *NURSE* Ed Ramsay *WATER & SANITATION EXPERT* Malcolm Townsend *LOGISTICAL COORDINATOR* Peter Camp *LOGISTICIAN* Philippa Millard *PROJECT COORDINATOR* Boris Stringer *DEPUTY HEAD OF MISSION* Stephen Flanagan *NURSE* Sri Lanka Mesfin Senbeto *SURGEON* Natalie Thurtle *DOCTOR* Sarah Quinnell *MIDWIFE* Thailand David Wilson *DOCTOR* Paul Cawthorne *REGIONAL CAMPAIGN OFFICER* Uganda Alison Criado-Perez *NURSE* Harriet Cochrane *PROJECT COORDINATOR* Samantha Perkins *MIDWIFE* Yemen Cristian Ghilardi *PROJECT COORDINATOR* Zimbabwe Andrew Mews *LOGISTICAL COORDINATOR*

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

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No choice: crossing the Gulf of Aden

Most of the landings are at night
© Angel Castillo [2008] Yemen

"The smugglers were beating us from the beginning of the trip like animals. They have no mercy even if you die in front of them."

Thousands of people, like this 50-year-old Somali man from Afgoye, risk their lives every year to cross the Gulf of Aden to escape conflict, violence, drought and poverty. During 2007, almost 30,000 took the dangerous voyage to seek relative safety in Yemen. Due to the escalation of the conflict in Somalia and the food crisis in parts of the Horn of Africa, more and more people will probably join them.

In September 2007, MSF established a project on the southern coast of Yemen to provide medical, psychological and humanitarian assistance to new arrivals. A system of focal points in strategic villages along the shore serves as an alert system, allowing MSF teams to respond rapidly once a landing has been signalled.

The sea is too rough for crossing in June and August because of the monsoon. But this September, smugglers in the Somali port town of Bossaso will again start cramming up to 150 people in 26-foot boats for the three-day crossing. Most of these people are aware of the potential risks, but say that they have no choice. For them, taking the dangerous trip does not constitute an option among several, but their only survival strategy to escape violence, insecurity and destitution. "A missile had fallen on my house, killing my wife, two of my children and my mother," said a 32-year-old man from Mogadishu. "Fortunately one of my children survived, because he was not at home that moment, he was at Quranic school. After that, I decided to leave Somalia with my son."

The conditions of the crossing are atrocious. "I was in the hold," said an Ethiopian man. "It looks like a small storage room, just one metre. We were 20 people there. We suffered a lot inside, it was really very hot and we had no air. We were afraid that one of the people inside was going to die of suffocation." Passengers are usually deprived of food and water, and beatings occur on almost all boats, sometimes using rifle butts and knives. Women and children are not spared.

Arrival on the Yemeni shores is exceedingly hazardous, as the smugglers take extreme measures to avoid being detected by the Yemeni security forces. Most boats approach the shore at night, but not close, so people are forced to disembark in deep water. If passengers are afraid and refuse to jump, they are beaten and thrown into the sea. Since many people coming from the interior of Ethiopia or Somalia cannot swim, deaths from drowning are frequent.

While migrants and refugees crossing the Mediterranean into Europe have received some international attention, the tragedy in the Gulf of Aden is largely ignored. MSF has released a report that aims to raise awareness of this appalling situation. The report examines people's reasons for making this journey, the conditions of the crossing and the difficulties encountered on arrival in Yemen. It can be downloaded at www.msf.org.uk/nochoice

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If you have any questions about your support of MSF's work we would be delighted to hear from you. We would also be grateful for any comments or suggestions that you would like to make on *Dispatches*. Please feel free to contact us by:

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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 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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