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RESPONDING TO COVID-19

Global Accountability Report 1

March to May 2020

MEDECINS SANS FRONTIERES

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1 Foreword by the International President of MSF


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In a mere few months, COVID-19 has grown into a global health crisis, pushing some of the world's most advanced and well-resourced healthcare systems to the brink of collapse. Working in more than 70 countries including the world's most fragile conflict and crisis settings, many of Médecins Sans Frontières' (MSF) humanitarian medical projects already battled limited access to care and missing resources on daily basis. It quickly became clear that many of our programmes would not have the capacity to safely receive and care for COVID-19 patients, while maintaining life-saving care they provided before the pandemic.

MSF's earliest COVID-19 interventions took place in Hong Kong and several Asian countries, responding to the outbreak even before it was declared a global pandemic. As our teams quickly jumped into scaling up preparedness measures and adapting our medical activities across five continents, COVID-19 had already led to a full-scale health emergency in Europe. In several European countries and the US, MSF for the first time in its history lent its expertise to medical staff and caretakers in hospitals, retirement homes, migrant reception facilities, homeless shelters or prisons. With the protection of vulnerable populations and healthcare workers amongst our top priorities, we alerted on the lack of care in European retirement homes, the level of exposure of people in squalid refugee camps on the Greek islands, and the negative impact of US border closure and deportation policies. MSF also called for solidarity amongst European states in sharing essential medication and protective equipment.

Global lockdown measures and interrupted transportation networks, as well as shortages of medical supplies, also tested our logistics and supply systems, human resource management, and financial resourcing. It is thanks to the tremendous effort and innovative thinking of our teams around the world that MSF managed to keep sending urgently needed staff and supplies to some of the hardest hit countries, source essential material and medication, and rapidly raise some of the urgently needed funds to include COVID-19 preparedness and response into our projects. Our gratitude also goes to our donors, who have empowered our teams to globally respond to this pandemic and continue MSF's humanitarian mission and life-saving work.

By documenting the first phase of MSF's global COVID-19 response from the beginning of the year through May, we want to provide a transparent picture of our interventions, reflect on some of the major challenges we faced, and share our best practices in fighting this pandemic. We commit to reporting regularly on our activities related to the pandemic in the months to come.

As we look back on our initial response, the pandemic continues to have grave impact globally, including in low-resource and crisis settings. At the time of writing, MSF teams are scaling activities in countries that are experiencing rising trends of COVID-19 transmissions and deaths, such as in Ecuador, India, Pakistan and Yemen, among others.

Dr Christos Christou

International President of Médecins Sans Frontières

2 Introduction: MSF and COVID-19

The COVID-19 pandemic is an unprecedented health crisis of global scale. Since early 2020, it has put tremendous strain on healthcare systems, disrupted economies, and halted large parts of social life in many countries around the world. In a race against the fast spreading virus and rapidly increasing patient numbers, Médecins Sans Frontières (MSF) scaled-up its global response from early January, committing substantial resources to both developing dedicated COVID-19 projects and maintaining essential healthcare in its existing programmes.

In countries where robust health systems exist, MSF's operational focus is in offering its expertise in handling complex emergencies and advising on public health approaches, taking pressure off overstretched health facilities, ensuring healthcare workers are protected, and caring for vulnerable populations. In conflict zones, in humanitarian crises and in low-resource settings with fragile health systems, MSF's priority is to ensure medical teams are able to provide live-saving care and safely manage potential COVID-19 patients. MSF's focus also is on maintaining or adapting crucial medical activities such as treatment for HIV and tuberculosis patients, measles vaccination campaigns, malaria prevention, and the fight against other infectious disease outbreaks such as cholera or Ebola.

In March, MSF created the COVID-19 Crisis Fund, to raise urgently needed funds for both its dedicated COVID-19 programmes and to mitigate potential severe impact on existing health services. The fund seeks to raise 150 million euros, which will be used to cover direct and indirect costs related to COVID-19 over the course of 2020 and 2021. By late July, just over 99 million euros had been raised.

This report is the first in a series of accountability reports and operational snapshots offering insight into MSF's global COVID-19 response, highlighting activities and outcomes, documenting expenditures, and shedding light on challenges faced in accessing and supplying communities with essential medicines and supplies.

Covering the period from March to May 2020 and tracing some earlier activities back to the beginning of the year, this report provides an account of how MSF projects around the globe have shifted gears to accelerate outbreak preparedness and adapt their projects in response to the COVID-19 pandemic (see Chapter 4). The fifth chapter looks at key data from MSF activities in Europe – the epicentre of the pandemic from March to late May. Chapter six then discusses MSF's approach in managing the major staffing, logistics, supply, and financial challenges of responding to COVID-19.

The second report on MSF's global COVID-19 response is scheduled for publication in October and will cover activities from June to August. A third report will be released in early 2021, reviewing the remaining months of the year.

3 MSF and the pandemic: a timeline

January

27

In Hong Kong, MSF launches its first dedicated 2019-nCoV activity, offering health education to asylum seekers, refugees, and cleaning personnel.

February

7

MSF teams undertake infection prevention and control trainings for 2019-nCoV response teams in hospitals in Cambodia and Papua New Guinea.



11

WHO assigns the novel coronavirus disease its official name: COVID-19.

14

MSF dispatches 4.5 tons of protective equipment to the Wuhan Jinyintan Hospital and to Hong Kong.



March

8

MSF launches its first COVID-19 operations in Lombardy and Marche, Italy, treating patients, and improving infection prevention & control measures in four hospitals and several retirement homes.



12

MSF calls for the immediate evacuation of refugees in camps on the Greek islands over COVID-19 fears.

15

The European Commission implements restrictions on exporting personal protective equipment (PPE), directly affecting the MSF supply process. MSF urges solidarity in the use of PPE among governments in Europe.

Photos: © MSF - Davide Arcuri

March

17

In Madrid and Catalonia, Spain, MSF sets up three treatment centres for COVID-19 patient with mild symptoms and starts supporting retirement homes.



18

MSF starts its COVID-19 response in Paris and surrounding areas, France, deploying a mobile clinic supporting migrant communities and people experiencing homelessness.



24

In Flanders, Belgium, MSF starts supporting hospitals, retirement homes and homeless shelters with dedicated hygiene, sanitation and isolation measures.

In Abidjan and Bouake, Ivory Coast, MSF supports the Ministry of Health in running a transit centre for treating and testing suspect COVID-19 patients.

MSF launches the COVID-19 Crisis Fund, looking to raise 150 million euros for the emergency response.



27

In Switzerland, MSF dispatches staff to a hospital in Geneva.

In Syria, takes up COVID-19 emergency preparedness measures in the Al Hol camp and Hasakeh National Hospital.

In the main hospital of Khartoum, Sudan, MSF starts supporting COVID-19 activities.

In Venezuela, MSF advises on COVID-19 protocols and offers health promotion sessions on hygiene and prevention measures.

MSF calls on governments and pharmaceutical industry for no patents or profiteering on drugs, tests, or vaccines used for the COVID-19 pandemic.



29

In Spain, MSF launches a phone hotline and a dedicated COVID-19 website for civil and medical authorities and health professionals.



Photos: © Benjamin Matuszenski - MSF - Olmo Calvo - Omar Haj Kadour/MSF - MSF

March

31

In Brussels, Belgium, MSF opens a COVID-19 treatment centre for refugees and migrants.

In France, MSF dispatches additional support staff to health structures.



April

1

MSF starts COVID-19 support to hospitals in Bagdad and Mosul, Iraq.

2

MSF takes up COVID-19 activities in São Paulo, Brazil.

3

In the Netherlands, MSF supports counselling and stress management for hospital staff caring for COVID-19 patients.

In Brussels, Belgium MSF teams start delivering infection prevention and control measures and mental health support to 138 nursing homes.

MSF starts COVID-19 screening in Lower Dir, Pakistan.



7

MSF USA supports infection prevention and control in Manhattan and the Bronx through the provision of handwashing stations.



In Harare, Zimbabwe, MSF starts supporting COVID-19 case management, upgrading a health facility with isolation capacity to 164 beds.

In Afghanistan, MSF starts supporting one part of a hospital in Herat, and the Afghanistan-Japan referral hospital in Kabul.



MSF calls on the Spanish government to urgently improve care for elderly patients.

Photos: © Kristof Vadino - Nasir Ghafoor - Spencer Platt/Getty Images - Laura Mc Andrew/MSF

April

9

MSF responds to COVID-19 at a hospital in Zahle, Lebanon.



10

In Reims, France, MSF deploys a temporary hospital tent.





MSF urges Yemeni authorities to grant access for humanitarian supplies and staff.

16

MSF launches COVID-19 activities in Yaoundé and the Far North Region in Cameroon.

20

In Haberstadt, Germany, MSF supports a refugee reception centre.

24

MSF starts responding to COVID-19 in the United Kingdom, supporting nursing and logistics at a London hospital.



30

In Conakry, Guinea, MSF transforms its former Ebola treatment centres to care for patients with mild symptoms of COVID-19.



Photos: © MSF - Agnes Varraine Leca/MSF

May

7

MSF teams are working in Mexico, treating moderate forms of COVID-19 in a 50-bed unit housed in a basketball stadium.



8

In Nagasaki, Japan, MSF supports the authorities with testing and treatment of the crew of the Italian-owned cruise ship Costa Atlantica.



16

MSF repurposes its burn hospital in Port-au-Prince, Haiti, to treat people with COVID-19.

22

MSF COVID-19 projects in Germany and Switzerland start to close.



25

MSF announces closure of its COVID-19 activities in Spain and Portugal.

28

In Italy, MSF projects in Marche and Lodi close down, while activities continue in Rome and Sicily.

MSF calls on the international community to support the humanitarian needs in Yemen. Numbers of confirmed or suspected COVID-19 cases rise countrywide, with hospitals in Aden already overburdened.



29

MSF opens a COVID-19 treatment centre in Venezuela.

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4 Shifting gears: MSF's global preparedness and response



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Introduction

From early 2020, the spread of COVID-19 put some of the world's most advanced and well-resourced health systems under enormous strain. To countries with already fragile health systems, the pandemic posed an additional concern. A combination of limited access to medical care in conflict zones and rural areas; a global shortage in protective equipment, essential drugs, and medical supplies; and overstretched health workers in under-resourced care facilities all threatened to impede the fight against COVID-19 and have exacerbated persisting global health crises like HIV, malaria, or measles.

With existing medical projects in more than 70 countries and longstanding experience in responding to infectious disease outbreaks in humanitarian crisis settings, MSF started implementing COVID-19 outbreak preparedness and response measures in late January 2020. These activities ranged from supporting disease surveillance and epidemiological analysis to adapting health facilities for case management, training health workers on appropriate infection prevention and control measures, supplying protective equipment, and engaging local communities with relevant public health messaging. Major efforts were made to continue and maintain the regular and emergency health services in MSF projects.

As the pandemic spread from Asia to the Middle East, Europe, the Americas and Africa, many of these early preparedness and support measures built the foundation for MSF to quickly scale-up direct COVID-19 interventions. This chapter provides a short overview and examples of COVID-19 preparedness and early response activities by MSF around the globe from the beginning of the year until May 2020. MSF's major COVID-19 interventions at the height of the pandemic in Europe, are discussed in further detail in chapter five.

Asia & Pacific

MSF's very first direct response to the novel coronavirus started in **Hong Kong** on 27th January 2020, just under a month after Chinese authorities had reported cases of an atypical pneumonia in Wuhan. An MSF team of health education specialists offered information and training sessions on handwashing and cough etiquette to refugees, asylum seekers, and cleaning personnel at heightened risk of contracting the virus and lacking access to primary healthcare. Over the course of February and March, MSF teams also ran several mental health workshops covering coping mechanisms for stress and anxiety. In mid-February, MSF dispatched 4.5 tons of urgently needed personal protective equipment to **Wuhan** and **Hong Kong**.



© MSF

A health education session on avoiding COVID-19 in Hong Kong, February 2020.

In April, similar health promotion and capacity building activities in communities and among vulnerable populations were launched in Manila and Marawi, **Philippines** and in the urban slums of Dhaka and the refugee camps of Cox's Bazar in **Bangladesh**. These countries faced shortages of qualified health care staff and access to personal protective equipment, which presented serious challenges in order to scale-up COVID-19 preparedness activities. In Penang, **Malaysia**, an MSF team supported patients diagnosed with COVID-19 among the vulnerable Rohingya and Burmese refugee communities with health messaging in the respective language, and provided mental health and psychological assistance over the phone.

Initial capacity building on preparedness and appropriate infection prevention and control measures took place in MSF projects treating hepatitis C in **Cambodia**, and a tuberculosis programme in Port Moresby, **Papua New Guinea**, in early March. These hands-on training sessions covered practical aspects from stocking the right medical supplies and correctly wearing personal protective equipment, to setting up triage points and treating COVID-19 patients in dedicated isolation wards. Similar training sessions were held in March and April in three Cambodian provinces at the border to Thailand, and in Banten, **Indonesia**, in combination with training on providing mental health support.



© MSF

A training for hospital staff in Phnom Penh, Cambodia, on the correct use of personal protective equipment.

In **Afghanistan**, MSF provided support to a 50-bed ward at a hospital in Herat, and an isolation ward at Boost hospital in Lashkar Gah in mid-April. At the Afghanistan-Japanese COVID-19 referral hospital in Kabul, MSF supported infection prevention and control measures and ran a series of trainings for local health staff. After the attack on MSF's maternity in the city's Dasht-e-Barchi district in May, the support to the the Kabul COVID-19 referral centre was halted for security reasons.

In **Pakistan**, MSF ran a 24-bed isolation ward for patients with mild and moderate cases of COVID-19 from early April, in Timergara. MSF screened over 105,000 people, admitted over 130 patients to the isolation ward, and referred 87 people to other facilities from March to May, and ran almost 400 health sessions with the local community. In Balochistan province, MSF staff supported the isolation ward at Killa Abdullah District hospital, running additional trainings on water and sanitation and providing logistical advice.

After initially offering epidemiological support to local health authorities in a district of Tokyo, **Japan**, an MSF medical team directly responded to the COVID-19 outbreak among crewmembers of the Costa Atlantica cruise ship in Nagasaki in April. A medical doctor, two nurses and a project manager helped assess and refer 149 out of 623 staff on board who tested positive for COVID-19.

Alongside its preparedness and response activities, MSF put substantial efforts in maintaining or adjusting urgently needed primary or specialized healthcare services. In **Cambodia**, MSF's hepatitis C activities had to be put on hold in both Phnom Penh and Battambang.

In **Pakistan**, hepatitis C patients at an MSF project in Machar received a larger batch of drugs in an effort to reduce physical contact at the clinic. The treatment of patients with the severe skin condition cutaneous leishmaniasis also had to be suspended in the northwestern Khyber Pakhtunkhwa province and in the southwestern Balochistan province. In Kandahar, **Afghanistan**, MSF has scaled back its programme on drug sensitive tuberculosis over concerns of health risks for staff, but has been able to continue treatment for drug-resistant tuberculosis patients.

Middle East & Northern Africa

From mid-March, several MSF projects launched COVID-19 preparedness activities in hospitals and communities across the northern regions of **Syria**. At the Al-Hassakeh National Hospital in northeast Syria, MSF provided trainings on disease surveillance, and focused on setting up triage systems and improving patient flow. In April, MSF started running a 48-bed isolation ward at the same hospital. Trainings on infection prevention and control were also held at six hospitals in northwest Syria.

Multiple health promotion sessions were conducted in camps and settlements in northwest Syria. In Al-Hol and Deir Hassan camps, as well as the informal settlements in Azaz, MSF conducted specific vulnerability mapping exercises and ran several campaigns focused on infection prevention through self- isolation and shielding. In the Deir Hassan camp, MSF distributed hygiene kits with soap in most of the camps where mobile clinics were organized, including a big distribution to more than 6,800 families in mid-April in Deir Hassan camp.



MSF distributed special hygiene kits including soap, bleach, washing powder and information leaflets on COVID-19 in the Deir Hassan camp, Syria.

In **Yemen**, MSF put in place essential infection prevention and control measures and treated hundreds of patients suffering from COVID-19 in a country whose health system has collapsed after five years of war. In early April, MSF supported the construction of a COVID-19 isolation and treatment facility at the Al-Amal hospital in Aden, opening its doors later in the month. On May 6, MSF took over the management of the centre. After a sharp increase in suspect and confirmed cases, MSF's COVID-19 treatment centre in Aden exceeded its capacity in the early weeks of May, and MSF teams had to turn away patients in urgent need of care. Because of the high numbers of patients in the city, MSF took over the management of a second COVID-19 treatment centre, based at Al Gamhuriah hospital, in late May. The situation proved equally critical in Sana'a, where MSF together with the Ministry of Health has been treating patients with COVID-19 in Al-Kuwait hospital's Intensive Care Unit. MSF also provided support and treated patients at the Heikh Zayyed hospital.

In other parts of northern Yemen, MSF set up screening points and several isolation units at Abs Hospital and Al Jambouri Hospital in the Hajjah Governorate, as well as treatment centres for moderate cases of COVID-19 in Haydan and Khamer. In Hodeidah, Taiz, and the In Ibb governorate, MSF opened additional treatment facilities, and trained several hundred local health workers on hygiene and infection prevention and control.

In **Iraq**, 62 dedicated beds were made available for COVID-19 patients at MSF's postoperative care centre in Mosul, and MSF provided technical support to a major reference hospital in Baghdad. In **Lebanon**, 60 beds prepared to receive COVID-19 patients at MSF's elective surgery and wound care programme in Bar Elias, while the paediatric project in Zahle supported COVID-19 triage over the course of April. MSF also set up and managed an isolation facility at the UN's care centre for Palestinian refugees in Siblin.

Several large-scale health promotion activities were organised in South Beirut and the Bekaa Valley in **Lebanon**, targeting food distributors, taxi drivers, and security forces who have regular community contact, as well as the migrant community and female domestic workers in particular. In Hebron, **Palestine**, MSF set up a hotline offering remote mental health counselling to COVID-19 patients, their families, and medical first responders. In several detention centres throughout **Libya**, MSF teams worked with migrants, refugees, and guards to disseminate health messaging, distribute soap and cloth masks, and install handwashing points.

From early preparedness activities to direct case management, MSF operations in the Middle East and Northern Africa faced severe access and supply challenges. In early April, MSF urged **Yemeni** authorities to facilitate access to humanitarian supplies and allow staff into the country, after requests for medical supplies to WHO and China could not be met. Lacking personal protective equipment and masks, several health facilities in Aden and Sana'a refused to admit patients with symptoms that could be linked to COVID-19, in turn increasing the number of patients seeking treatment at MSF's COVID-19 treatment centres. In May, MSF managed to send 46 tonnes of urgently needed medical supplies and 15 staff into Erbil, Iraq, from where they could be transported to northeast **Syria**.

At the end of March, two cargo planes carrying an inflatable 50-bed treatment unit and an international team of medical and intensive care specialists arrived in Tehran, **Iran**. Their purpose was to extend treatment capacities at Amin Hospital in Isfahan. Despite pre-existing agreement with the Iranian authorities for the intervention, approval for setting up the treatment unit was revoked a few days later, and after a few weeks the mobile treatment unit was re-directed to Afghanistan.



© Jacob Burns/ MSF

In early April, MSF opened the first dedicated COVID-19 treatment centre in Aden, Yemen.

Africa

The first patients testing positive for COVID-19 in sub-Saharan Africa were reported in late February and early March, and were observed with great concern over the possibility of a high number of unreported cases and limited capacity to isolate and care for COVID-19 patients, especially intensive care, due to fragile health systems in countries across the continent.



© MSF

In **Côte d'Ivoire**, MSF worked alongside health authorities at a transit centre in Abidjan to screen travellers from Europe, Asia and the Middle East. In early April, MSF logisticians and medical staff set up a 60-bed treatment centre in Grand Bassam, for patients with COVID-19 displaying moderate symptoms treating over 250 patients in April and May. In Bouaké, Côte d'Ivoire's second biggest city as well as a transportation hub, MSF ran several trainings for water and sanitation activities and deployed a 10-bed COVID-19 treatment centre at the University Hospital.

In neighbouring **Burkina Faso**, MSF projects started implementing specific water, sanitation and hygiene measures and dedicated COVID-19 trainings from mid-April in Djibo, Kaya and Barsalogho in the north, and the city of Fada in the east. In the southern city of Bobo-Dioulasso, MSF built a COVID-19 treatment centre in late April, gradually expanding to installing 50 beds and an oxygen production unit capable of supplying oxygen to dozens of people at once. In mid-May, MSF opened a second treatment centre with 50 beds in the capital, Ouagadougou.

In **Niger**, MSF's initial response to COVID-19 started in early April in its 450-bed paediatric hospital in Magaria, adapting the triage system for patient reception. A 50-bed treatment centre was constructed in Niamey shortly after, in the vicinity of the Hôpital National Lamord.

In **Mali**, MSF initiated trainings on infection prevention and control, led outreach activities for contact tracing, and supported patient management in Bamako, Ansongo, Mopti, and Gao. A treatment centre at MSF's existing oncology programme at Point G hospital was amongst the first MSF projects to manage COVID-19 patients outside of Europe, and gradually expanded its capacity to care for up to 100 patients alongside the Ministry of Health. In Niono, MSF set up water points for handwashing at the referral hospital and in several health centres. In Tominian, on the border with Burkina Faso, an isolation tent was installed, but later destroyed during fighting in the area.


© Tom Casey /MSF

In Guinea, Liberia, and Sierra Leone, three countries still recovering from an outbreak of the Ebola virus between 2014-2016, MSF ran several large training and health promotion campaigns, and supported health authorities with contact tracing and COVID-19 case management.



© Lamine Keita/MSF

A family in Bamako receives washable masks and soap distributed by MSF to protect themselves from the coronavirus.

In Conakry, **Guinea**, MSF rehabilitated one of its former Ebola treatment centres that had been handed to the Ministry of Health, and transformed it into a COVID-19 isolation and care centre to accommodate 75 stable or mild patients. In Kouroussa, MSF also supported setting up a 12-bed isolation ward in the prefectural hospital.

In **Sierra Leone**, MSF reinforced contact tracing in Tonkolili, Bombali, and Kenema districts, where it also refurbished a Lassa Fever isolation unit at Kenema government hospital to receive COVID-19 patients in mid-May. In the capital, Freetown, MSF technicians installed the wastewater management system, triage zones and a donning and doffing area for staffs' protective gear at a 120-bed COVID-19 treatment centre.

In **Liberia**, between April and May, MSF health promotion teams reached more than 78,000 households in four of Monrovia's most vulnerable neighbourhoods. Outreach teams delivered messaging around hygiene protocols, and distributed soap. Additionally, MSF teams provided technical support to the COVID-19 treatment facilities run by the Ministry of Health.

Additional health promotion activities and trainings on infection prevention and control measures were implemented at the National Hospital Simão Mendes in **Guinea Bissau**, and at the Hôpital Dalal Jamm in Dakar, **Senegal** from early April. In **Nigeria**, MSF installed handwashing points and isolation areas in local communities and the camps for internally displaced persons. Several testing and isolation centres were also set up in the states of Borno and Ebonyi. Starting in May, MSF carried out seasonal malaria chemoprophylaxis in informal settlements hosting more than 40,000 people in Maiduguri, reducing malaria prevalence at a time when people are frightened to seek healthcare because of COVID-19.

In central Africa, COVID-19 preparedness and response activities commenced in March in Cameroon and the Democratic Republic of the Congo. In **Cameroon**, MSF started supporting several hospitals in the capital, Yaoundé, in Douala, and in Maroua and Mora in the northern region- by setting up COVID-19 isolation centres and treatment facilities, and running staff trainings.

In the **Democratic Republic of the Congo**, MSF in March launched staff trainings in its health facilities and emergency programmes, covering COVID-19 infection prevention, isolation, patient management. In the country's capital, Kinshasa, epicentre of the outbreak in DRC, MSF mobile teams supported 50 health structures in four health zones, equipping them with masks and handwashing stations and training medical staff. MSF also supported Saint Joseph hospital in Kinshasa's Limete neighbourhood with running a 40-bed treatment centre for patients with mild to moderate COVID-19 symptoms. In the provinces of Ituri, North Kivu and South Kivu, where the country's latest and biggest Ebola outbreak was just declared over in June, MSF set up isolation centres and laboratories at its health structures and in camps with displaced persons. Several Ebola treatment facilities, including a major centre in Goma, were repurposed to receive suspect and confirmed



© Franck Ngonga/ MSF

A medical team member consults a patient at the COVID-19 treatment unit set up by MSF at Saint-Joseph hospital in Kinshasa, DRC.

COVID-19 patients. In Goma and Kinshasa, MSF initiated large-scale production of cloth masks locally with over 20 workshops, to help prevent transmissions outside of hospitals.

In its 13 MSF projects in the **Central African Republic**, MSF continued to provide urgent healthcare and immunization activities while COVID-19 triage systems and isolation wards were implemented in all facilities in April. In Bangui, MSF built a dedicated COVID-19 treatment centre with an initial capacity of 10 beds. Despite the pandemic and lockdown measures causing great fear in communities across the country, MSF managed to run several measles vaccination campaigns in Paoua, Carnot, Baboua Abba, Bangassou Ouanga-Gambo, and Bossangoa between March and May, vaccinating close to 300,000 children. Targeted health promotion and initiatives to counter misinformation and rumours accompanied these vaccination campaigns.

In MSF projects across East Africa, COVID-19 preparedness and infection prevention and control measures accelerated in March and April. In **Sudan**, MSF worked with the World Health Organization (WHO) and the Sudanese health authorities to provide trainings to key medical staff of 90 major hospitals in Khartoum. At the Omdurman Teaching Hospital, 60 permanent MSF staff members supported the emergency department. With significantly increasing case numbers and strict confinement measures, fewer health workers were able to perform their duties at the hospitals over the month of April. As a response to this, MSF shifted its prevention and health promotion activities towards more community-based work all over the country.

Despite persisting security and access issues, MSF in **South Sudan** assisted the Ministry of Health with the training of healthcare workers in infection prevention and control measures and triage for symptoms compatible with COVID-19. In Juba, MSF's water and sanitation specialists installed handwashing points in different locations of the city and started to set up and manage several smaller COVID-19 isolation and treatment facilities in Agok, Old Fangak, and Yei. In the Bentiu Protection of Civilians camp, which provides shelter to more than 130,000 displaced people, the first confirmed COVID-19 case was treated at the MSF health facility in May.

Worried about the precarious and crowded living conditions at the Nduta refugee camp in northwest **Tanzania**, MSF called for urgent support from the international community in mid-April. MSF invested in raising awareness on hygiene protocols and best health practices during the COVID-19 pandemic; built four triage and isolation areas at each of the four MSF-run health clinics, and a main isolation centre at the MSF hospital. In **Somalia** and **Somaliland**, MSF coordinated with health authorities to prepare for the arrival of COVID-19, and offered infection prevention and control trainings for health workers. Health assessment and preparedness activities also took place in **Burundi**, in MSF's projects in Bujumbura and Kinyinya.

In **Kenya**, from early April, MSF teamed up with authorities and the local Red Cross to increase



© Gabriele François Casini/MSF

MSF staff demonstrating the correct use of masks during an infection prevention and control training in Juba, South Sudan.

ambulance services for both COVID-19 patients and other emergencies in Nairobi, with emergency calls sharply increasing in April. Health awareness campaigns, case management and infection prevention trainings were gradually rolled out over the course of April and May in several health facilities in Nairobi, Kiambu, Garissa and Mombasa Counties. Regular HIV activities and specialized care for victims of sexual violence had to be reduced or reorganized at the onset of the pandemic but could be largely maintained by offering psychological support over the phone and providing patients with larger quantities of antiretroviral drugs.



© Franck Ngonga/ MSF

In **South Africa**, MSF redirected existing project staff from four location to COVID-19 responses in Gauteng, KwaZulu-Natal and Western Cape provinces in March. The responses included developing and disseminating health promotion materials, and protecting healthcare facilities through screening triage points outside of the facilities. MSF teams also installed triage tents and handwashing points at several hospitals and community health centres in Eshowe and Rustenburg in May, and built a 60-bed field hospital in Khayelitsha, near Cape Town, receiving COVID-19 patients from 1st June. While all of major HIV/TB programmes were able to organize home-based drug refills in sufficient quantities, MSF expressed concern over the fact that 50% less patients had been diagnosed with drug resistant tuberculosis and 60% less HIV-tests had been conducted in the country during lockdown measures.

In **Zimbabwe**, MSF started supporting COVID-19 case management at the central hospital in the capital of Harare from April, upgrading available isolation facilities to 164 beds. In health centres and community health clubs all around the city, MSF trained more than 415 healthcare workers on COVID-19 case management, testing, surveillance, and safe sanitation and hygiene practices. In **Eswatini**, MSF staff advised on improving triage and zoning in several health facilities and have been participating in the technical advisory group to the Ministry of Health since April.

In **Malawi**, MSF improved infection prevention and control measures in early May, and helped adapt patient flow and consultation zones in the Nsanje district hospital where MSF has a programme treating patients with advanced HIV, its projects at Chichiri and Maula prisons. At its project in southern Malawi, MSF developed tailored messaging and measures to prevent COVID-19 transmission among female sex workers and in the community. In **Mozambique**, MSF supported health authorities in April and May in Maputo and Cabo Delgado with scaling up health promotion, surveillance and case referral, using several existing community health clubs around MSF-supported water points.

Europe & Central Asia

In mid-March, the WHO announced Europe had become the new epicentre of the COVID-19 pandemic, with more reported cases and deaths than the rest of the world combined, apart from China. As some of Western Europe's most advanced health systems started to buckle under the enormous pressure, MSF intervened in several hospitals, retirement homes and reception centres for migrants, refugees and homeless people across the continent, leveraging its substantive experience in managing emergencies and infectious disease outbreaks. In existing MSF projects in southern and eastern Europe and central Asia, MSF staff led preparedness activities to strengthen infection prevention and control capacities and maintain essential primary care for vulnerable populations.

In **Italy, Spain, Portugal, France, Belgium, and Switzerland**, MSF teams in mid-March started treating COVID-19 patients in major hospitals, temporary health centres and mobile clinics; supported shielding and isolation capacities in hundreds of retirement homes, and worked with vulnerable migrant, refugee, homeless and prisoner groups to provide crucial care, protective measures, and health messaging. This work at the heart at the epicentre of the global pandemic from March to May is discussed in detail and presented with key project, medical, supply and financial data in the next section.

A multitude of strategic advice, practical support and capacity building activities were provided to hospitals, health professionals and community workers in western and northern European countries. In mid-March, an experienced MSF emergency coordinator took an advisory role to the management team of the Bærum Hospital near Oslo, **Norway**, situated in one of the clusters of the COVID-19 outbreak. In the **Netherlands**, members of the MSF staff health unit offered psycho-social and mental health support to overworked health workers by supporting one hospital's psychologist, and running several trainings and webinars. MSF also matched some of its experienced field staff to several medical institutions and nursing homes in need of additional personnel following the outbreak of COVID-19.

From mid-April, for the first-time ever, MSF engaged in healthcare activities in the **United Kingdom**. MSF partnered with University College Hospital, on the Homeless Sector Plan, to care for London's homeless population by converting a hotel to a COVID-19 care facility. Support was also provided to the St. John's Ambulance charity organisation in England, and Safetynet, an organisation facilitating self-isolation and testing capacities in **Ireland**.

In **Germany**, an MSF psychologist and two medical staff took up participatory health education and mental health support at a refugee reception facility in late April, where a local COVID-19 outbreak affected nearly 700 people.

In **Greece** from mid-March, MSF called for the evacuation of high-risk patients with chronic diseases and elderly people from the camps on the Greek islands, where more than 30,000 people lived in overcrowded tents or containers with limited access to running water and sanitation services. In mid-April, Greek authorities made the announcement to move more than 2,000 people to hotels and other accommodations on the Greek mainland as a preventive measure. Working in camps in Lesbos and Samos, MSF teams increased health messaging, water and sanitation services and the delivery of protective equipment, and recruited additional medical, paramedical, and support staff. In May, MSF started operating a 40-bed inpatient medical unit for patients with COVID-19 symptoms near the Moria reception and identification centre.



© Anna Pantelia/MSF

In Lesbos, MSF teams have started to operate an inpatient medical unit near Moria camp, for patients who present symptoms similar to COVID-19.

In **Ukraine**, MSF started supporting the Ministry of Health with contact tracing, home-based care, and health messaging, in Mariinka, targeting patients with mild COVID-19 symptoms and preventing further strain on hospitals. In the Zhytomyr region, MSF's programme for multiple drug-resistant tuberculosis (MDR-TB) was adapted, to continuously enrol patients in an all-oral short treatment regimen and to provide health education and mental health support by phone for patients and healthcare workers. Several trainings on the correct use of protective equipment, infection prevention and control, patient triage, screening and isolation, as well as waste management were provided to four Ministry of Health facilities and an elderly home in the region, in April.

Ensuring continuity of care for tuberculosis patients and strengthening local COVID-19 preparedness and response mechanisms was also MSF's focus in several eastern European and central Asian countries. In **Belarus**, the MSF team in Minsk maintained the regular tuberculosis programme, and donated personal protective equipment to a prison hospital in Orsha and a pulmonology reference centre in Minsk. In **Russia**, an MSF-supported dispensary for tuberculosis drugs in the northern city of Arkhangelsk was transformed into a COVID-19 testing site. In its tuberculosis, HIV, and environmental health programmes in **Kyrgyzstan**, **Tajikistan** and **Uzbekistan**, MSF teams supported the diagnosis, treatment and contact tracing for suspect COVID-19 patients from late April and collaborated on the development of national guidelines for treating co-infections with COVID-19.

The Americas

The COVID-19 pandemic reached South America in late February with the first confirmed case reported in Brazil and had spread over the entire continent by early April. On 22nd May the WHO officially declared that the epicentre of the pandemic had shifted to South America. While most of MSF's COVID-19 activities evolved around existing project presence, several new operations had to be set up across the continent.

In late March, MSF 's COVID-19 operations in **Brazil** started with three exploratory missions in São Paulo, Rio de Janeiro, and Minas Gerais, to assess the needs of people facing homelessness, migrants, elderly communities, and drug users. In early April, MSF's migrant health project for Venezuelan refugees in Boa Vista urgently scaled up isolation and treatment facilities after several patients were confirmed with COVID-19. In Rio de Janeiro, MSF supported the Ministry of Health with setting up a 200-bed COVID-19 hospital and with engagement activities in several communities around the same time. During May, MSF started working in 15 health facilities in all of Brazil, directly managing nearly 170 beds for COVID-19 patients, holding over 1,500 outpatient consultations, and admitting 274 patients to clinics for stationary care.



© Mariana Abdalla

Focused on people experiencing homelessness, MSF carried out health promotion activities and basic consultations in Vaz Lobo, Rio de Janeiro.

From 20th April, MSF expanded health education, screening, triage and the monitoring of suspected cases in several government-run structures for migrants and people facing homelessness in São Paulo, and took up two isolation centres with 140 beds. From May, MSF teams in Manaus trained local health professionals and took over a 12-bed intensive care unit and a 36-bed patient ward in the 28 de Agosto hospital. As the pandemic spread, MSF set up health facilities in more remote rural and indigenous populations in the area of São Gabriel da Cachoeira and Tefé.

In **Venezuela**, MSF was able to begin an emergency intervention in Caracas in mid-April, despite access challenges. MSF rehabilitated the infrastructure at the Pérez de León II hospital, adapted the patient flow, established triage and isolation capacities, and trained staff to receive COVID-19 patients.

From mid-April, MSF took up triage and the treatment of patients with respiratory symptoms at Tibú hospital in the north and in Tumaco in **Colombia**, and provided technical advice and mental health services in hospitals in Arauca. A small MSF team also assisted health centres and nursing homes in **Ecuador** with implementing COVID-19 infection prevention and control measures. In **Argentina**, in the provinces of Buenos Aires and Córdoba, MSF extended its technical support and advice to several health authorities, helping to design protocols, patient flow, and infection prevention and control measures in health structures and homes for the elderly.

Across Central America, MSF launched several smaller COVID-19 activities over the course of May. In **Guatemala**, MSF set up triage in three public health centres, and provided mental health counselling to health workers. In **Honduras**, the MSF mental health project in Tegucigalpa shifted its services to consultations via phone, internet and social networks. MSF's sexual and reproductive health clinic and only maternity in the region of Choloma, was able to stay open by zoning appropriate triage and isolation areas. In **El Salvador**, MSF teams offered psychosocial care in quarantined deportation centres, incorporating infection prevention measures into their ongoing individual and group activities, and expanded ambulance services.

In late March and early April, MSF reorganised its Emergency Centre in the Martissant neighbourhood of Port-au-Prince in **Haiti**, allowing for the isolation and referral of COVID-19 suspected patients. In the city's Drouillard area, MSF opened a COVID-19 field hospital on May 16th, which had received more than 150 patients by the end of the month. Teams additionally carried out health promotion campaigns in communities and via public media, as well as several training initiatives targeting health workers and community leaders.

In **Mexico**, at the beginning of April MSF called for the closure of migrant detention centres in light of the pandemic, while stepping up its response in migrant shelters and camps in Matamoros and Reynosa, along the U.S. border. In early May, MSF teams installed an auxiliary hospital unit in a basketball stadium in Tijuana, offering treatment to non-critical COVID-19 patients, and assumed management of an extension unit for intensive care at a local hospital with 50 beds and respiratory support.



© Sergio Ortiz/MSF

In Mexico, MSF set up a COVID-19 treatment centre in a basketball arena in Tijuana.

In the **United States**, MSF partnered with local service organisations in New York to improve sanitation and hygiene in soup kitchens and supportive housing, while donating over 80 handwashing stations placed in key locations across the city and running over 80 health promotion sessions. In Florida, MSF worked with partner organisations and the Department of Health to run a public health education campaign. MSF also ran mobile virtual clinics to provide COVID-19 testing and remote medical consultations targeting an estimated 15,000-20,0000 migrant farmworkers continuing to work during the pandemic with minimal access to healthcare.

In Michigan, MSF launched a support programme for care homes, providing on-site support to improve infection prevention and control practices, and ran mental health workshops for frontline staff to address the high levels of stress and grief. In New Mexico and Arizona, an MSF teams worked with local officials and healthcare workers from the Navajo Nation and Pueblo peoples, addressing needs related to COVID-19 for indigenous communities.

MSF staff in **Puerto Rico**, distributed essential supplies such as face shields, hygiene kits, and more than 10,000 masks to healthcare facilities and vulnerable community groups on the island.

In **Canada**, MSF teams conducted several infection prevention and control assessments- in shelters in Toronto for people facing homelessness, and in long-term care facilities in Montreal- providing recommendations to improve the overall safety of staff and patients.



© Taimy Alvarez/MSF

The team at a joint mobile COVID-19 testing clinic for area farmworkers in Immokalee, Florida.

5 At the heart of the pandemic: MSF's response in Europe



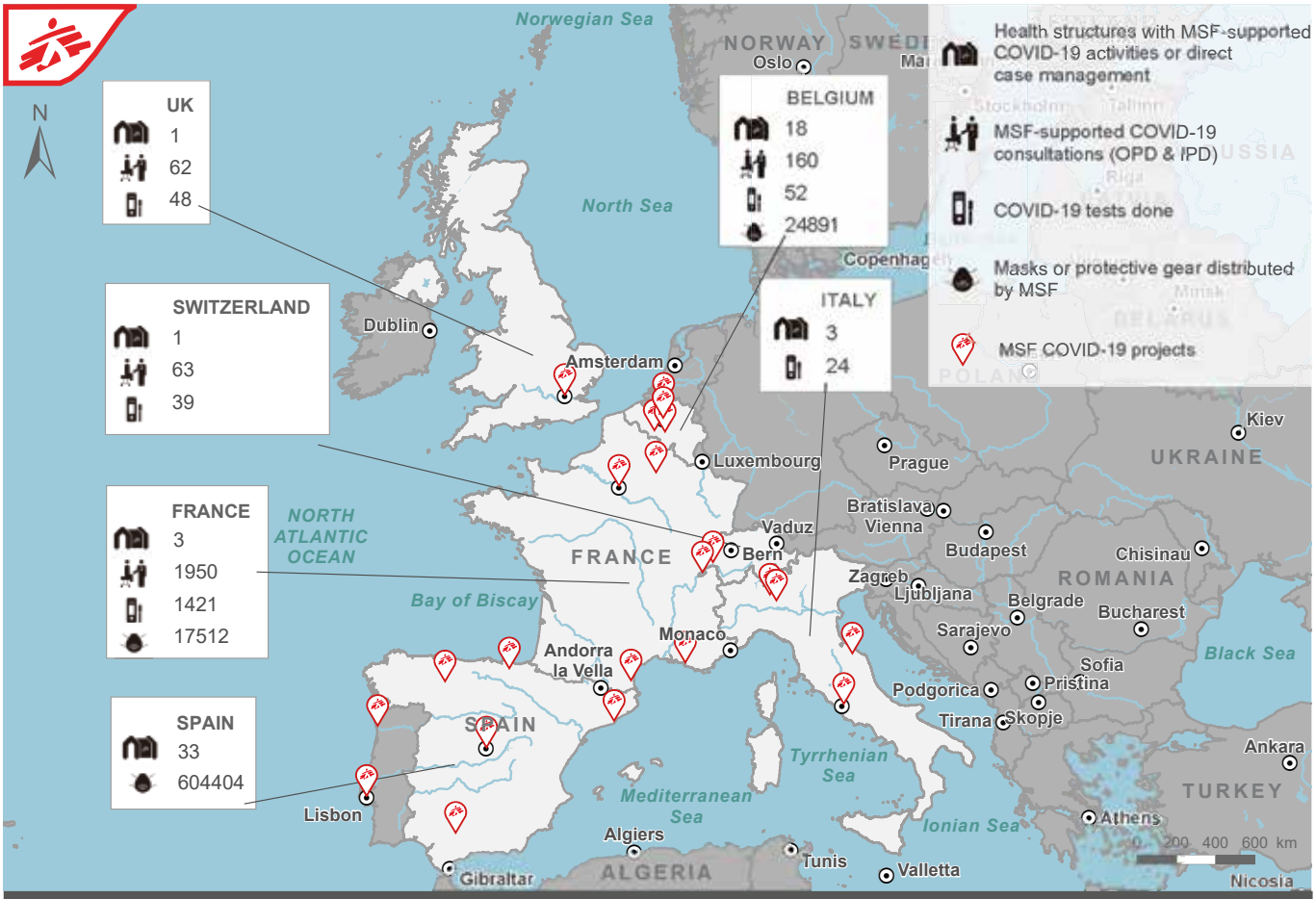
© Nora Teylouni/MSF

Introduction

As the epicentre of the COVID-19 pandemic shifted to Europe, its well-resourced health systems fell under unprecedented pressure. MSF lent its expertise in managing public health emergencies and controlling infectious disease outbreaks to hospitals, health care facilities and vulnerable groups across the continent.

Beginning in March, MSF launched major COVID-19 interventions in Italy, Spain, Belgium and France. All of these European operations included projects assisting hospitals and primary health care facilities, supporting retirement and nursing homes, and providing protection and care to vulnerable groups in reception facilities, refugee camps, homeless shelters, and prisons.

Strengthening hospital capacity and supporting patient management



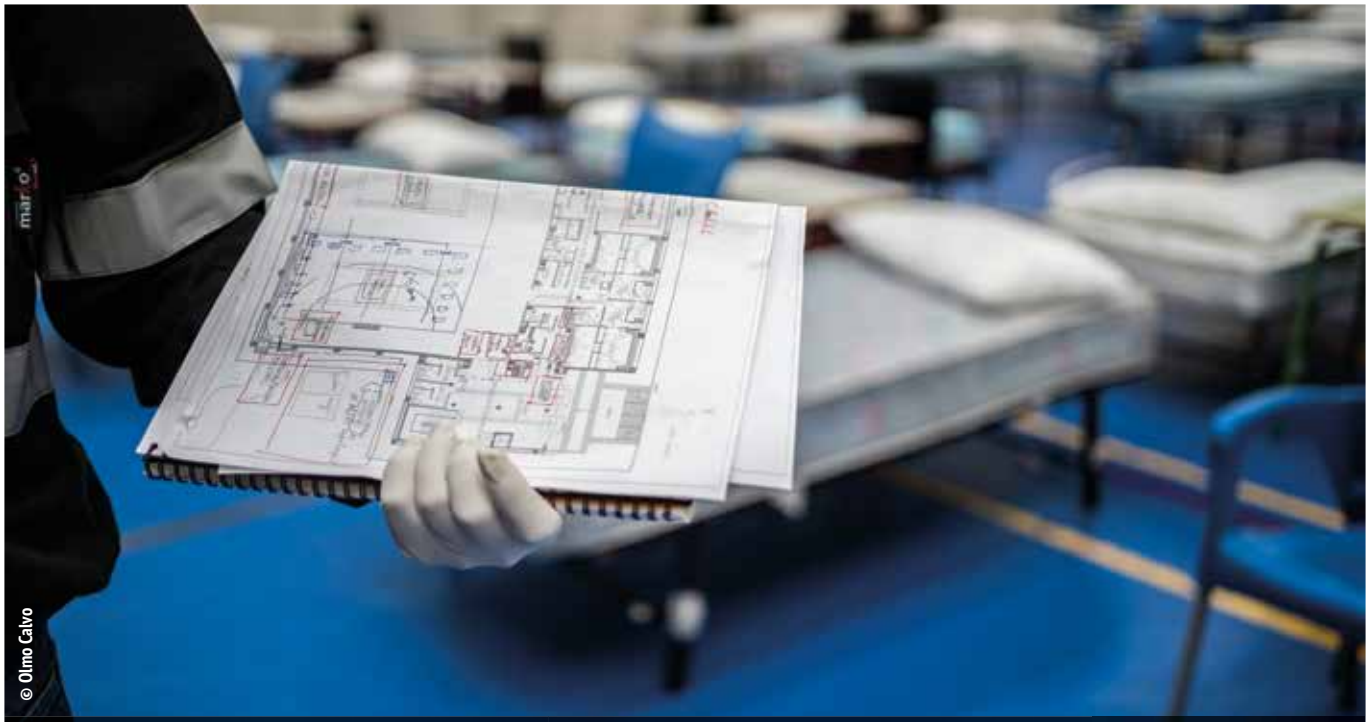
MSF support to hospitals and health facilities in Europe.

Smaller COVID-19 operations with one or two of these programme components were set up in Portugal, the United Kingdom, and Switzerland. In several other European countries, MSF provided short-term strategic advice on infection prevention and control, and offered mental health counselling to medical staff and patients (see Chapter 4 for an overview). This chapter features the major COVID-19 interventions at the height of the pandemic in Europe from March to May, along with key operational and medical data.

MSF's support to hospitals in Europe started on 8th March in three hospitals in Lombardy, Italy, one of the regions hardest hit by the COVID-19 pandemic.

Three MSF medical teams made up of 34 doctors, nurses, hygiene experts and emergency coordinators worked alongside hospital staff to set up triage zones, improve patient flow and establish donning and doffing procedures for personal protective equipment. In Lodi, MSF doctors worked in the intensive care unit and the emergency room of one hospital to support the hospital's overstretched medical team.

By late March, with over 3,500 health workers in **Italy** having tested positive for COVID-19,MSF's operational priority focused on protecting health workers and other hospital personnel. In addition to implementing strict infection prevention and control measures, MSF



A temporary hospitalisation unit was installed by MSF in a sports complex in Leganes, Spain.

offered mental health counselling and introduced stress management techniques for health professionals and patients' families.

> *"With all that the hospital staff had do to care for the patients, they had little time to think about themselves. We helped them to fight the pandemic safely, so they were able continue their work taking care of all patients."*



Carlotta Berutto, nurse and MSF project coordinator, Codogno

MSF also extended its support beyond health facilities, training emergency response personnel and caregivers in crucial hygiene and shielding principles at retirement homes, migrant dormitories, volunteer centres and police stations. Further, MSF teams worked with networks of family doctors and general practitioners to disseminate important health information and strengthen early detection and alert mechanisms for suspect cases, aiming to reduce the number of patients in need of hospitalization.

In mid-March, major MSF COVID-19 emergency operations launched in **Spain**. In Madrid and Barcelona, MSF worked alongside health authorities and hospital staff to plan and design 30 hospitalisation units and set up four more, helping to decongest emergency departments during the most critical phase of the pandemic. These temporary hospitalisation units were located inside hospitals or in nearby sports complexes or hotels, and provided over 4,000 additional beds. Across its operations in Spanish health facilities, retirement homes and reception facilities, MSF distributed more than 300,000 gloves, gowns, and other protective gear, as well as more than 60,000 masks.

MSF specialists also advised on the design and implementation of the decongestion structures and patient flow of the four main hospitals in the Barcelona metropolitan area, and in central Catalonia. In other regions, MSF teams trained healthcare staff and cleaning personnel on infection prevention and control, and operated a phone hotline and COVID-19 website for government and medical authorities and health professionals.

Also in late March, MSF was asked to support several hospitals in **Belgium**. Health facilities in Flanders and Wallonia were facing high numbers of COVID-19 patients and related deaths, yet had insufficient infection prevention and control measures in place, lacked protective equipment, and reported high levels of distress among staff. During March and April, MSF teams worked in seven hospitals in Flanders and two in Wallonia to train and support staff to prevent the virus' spread in these health facilities.

In Mons, an MSF team of five medics and three logisticians trained staff in the use of personal protective equipment and infection control techniques, and advised on how to adapt the hospital's capacity modelling based on different outbreak scenarios. In Antwerp, MSF set up washing zones in three hospitals where protective aprons could be cleaned and disinfected. In Lier and Sint Truiden, MSF teams worked in two health units with 60 beds to care for recovering COVID-19 patients. Targeted psychosocial support and mental health counselling for health workers and hospital staff complemented these MSF interventions in Belgian hospitals.


© Pablo Garrigos/MSF

In early April, MSF and the Henri-Mondor Hospital in Créteil, a suburb of Paris, **France**, jointly opened a twelve-bed care unit for convalescent intensive care patients, and dispatched a doctor and ten nurses to manage the ward until mid-May. In Reims, MSF set up an inflatable tent at the University Hospital to increase the capacity of the intensive care unit. In mid-April, MSF opened a COVID-19 diagnostic and counselling centre in support of the Malpassé health facility in Marseille, France, where a quarter of the population is living below the poverty line. Together, the projects in Paris, and Marseille conducted over 1,300 COVID-19 tests in France.

Continuing a long-standing collaboration with the Hôpitaux Universitaires de Genève in **Switzerland**, three MSF mobile teams with a doctor and a nurse each joined the hospital's outreach units, visiting people without medical insurance and offering home-based care. One MSF staff member also worked in the hospital's intensive care unit. From mid-March to mid-April, the mobile teams supported over 60 inpatient admissions and performed 39 COVID-19 tests. In mid-April, MSF medical teams also started working at the COVID-19 care centre in a converted hotel facility in London, **United Kingdom**, managing 40 beds and holding 60 patient consultations.

"Hospitals in Belgium did not need MSF to provide quality care. But what we offered is our expertise on how to organise a hospital and how to organise the flow of patients to prevent further infections."



Meinie Nicolai, nurse and MSF general director, MSF Belgium


© Agnès Varraine Leca/MSF

Across Europe, MSF teams worked in over 60 hospitals and health facilities from March to May, treated more than 2,000 patients in outpatient consultations and admitted more than than 200 patients for inpatient care, conducted 1,584 COVID-19 tests, and distributed over 640,000 masks, protective equipment and basic relief items. At COVID-19 interventions in health facilities in Italy, Spain, Belgium, France, and Switzerland, as well as hospitals in Norway, Netherlands, Greece, and Ukraine, MSF teams were welcomed as a knowledgeable and experienced partner in preventing and controlling COVID-19 infections. In many countries, MSF was able to rely on a network of former staff, board members and supporters working in health care to facilitate support requests and early involvement of MSF teams.

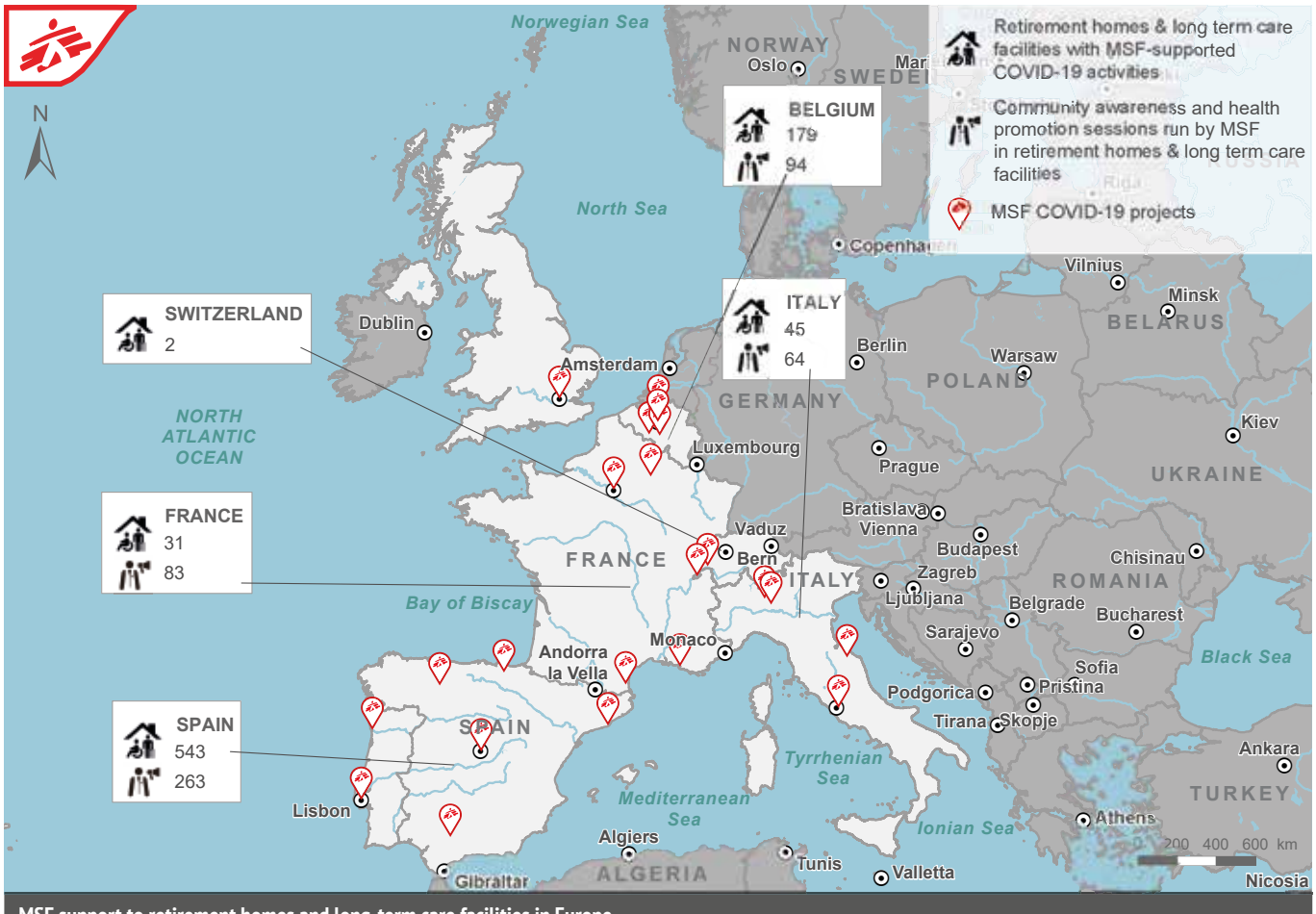
During the critical phases when intensive care and treatment capacities were overloaded in Italy, Spain, France and Belgium, MSF teams stepped in and worked alongside medical staff, set up triage and isolation zones, and opened additional facilities to decongest emergency rooms and treat patients with mild or moderate symptoms. A major part of MSF's support to European hospitals consisted of training medical professionals and hospital personnel on prevention measures and the correct use of personal protective equipment. When hospitals were able to handle their patient caseloads on their own, MSF directed its support towards filling critical gaps in care, including for vulnerable groups, or tailored mental health and psychosocial support to health workers, patients and families.

"One thing that particularly struck me about this extraordinary experience of working at the ICU in Geneva is the loneliness of the patients.
The healthcare staff, nurses, doctors, are the only link between patients and their families."

Katherine Zimmerman, MSF Geneva HQ staff



Supporting residents and staff in retirement homes and long-term care facilities



MSF support to retirement homes and long-term care facilities in Europe.

The health crisis in several European countries took a major toll on retirement homes and long-term care facilities, where a substantial proportion of COVID-19-related deaths in Europe was recorded among elderly people and those with pre-existing medical conditions. In many of these care facilities in Italy, Spain, Portugal, France, and Belgium, staff lacked appropriate training, equipment, and medical support to protect themselves and residents from an infectious disease outbreak. Strict confinement and shielding measures, grief over lost residents, and a fear of unwillingly spreading the virus caused additional distress and trauma among staff of these facilities.

In **Italy**, targeted support to retirement homes was part of MSF's overall strategy to relieve pressure on the overstretched healthcare system and protect healthcare workers. Simultaneously with its engagement in hospitals in early March, MSF received requests for support from retirement homes in Lombardy and Marche. In both regions, retirement homes experienced mortality rates of up to 30%, while over half of their staff were absent due to confinement measures and fear.

In the province of Lodi, where most retirement homes are run privately, MSF assisted two elderly homes and a hospice for terminally-ill patients. In Marche, media reports of MSF's support to long-term care facilities led to a wave of similar requests, and MSF intervened in 39 homes during April and May, adapting isolation and shielding measures, establishing referral protocols for suspected COVID-19 patients, and training caregivers and cleaning personnel. MSF also identified the need for mental health support of staff and ran sessions on stress management.


© Amna Suriyyath/MSF

While their colleagues were working at hospitals and temporary clinics, MSF teams in **Spain** started advising the management teams and caregivers of nursing homes with risk assessment and implementation of hygiene and protection measures in late March. When presence onsite was not possible, these trainings took place on virtual platforms. From March to April, MSF teams in Madrid, Catalonia, the Basque country, Castilla y Leon, Andalusia, and Asturias supported 543 retirement homes and


© Vincenzo Livieri/MSF

"As a society, we will need to have a good think about why the priority in this pandemic has been hospitals and other medical facilities, and why barely a thought has been given to the most vulnerable."



Dr Ximena di Lollo, MSF care home coordinator, Spain and Portugal

thousands of health professionals and caregivers with tailored face-to-face and remote trainings.

Yet little outbreak preparedness, a lack of epidemiological surveillance, inadequate infection prevention and control, missing resources for primary and palliative care, and an increased workload for staff led to a drastic deterioration of the health situation among residents of many Spanish nursing homes.

In early April, MSF issued an urgent call on Spanish health authorities to allocate additional resources and ensure that care for elderly patients is appropriate and compassionate, and allows for dignified farewells with families.

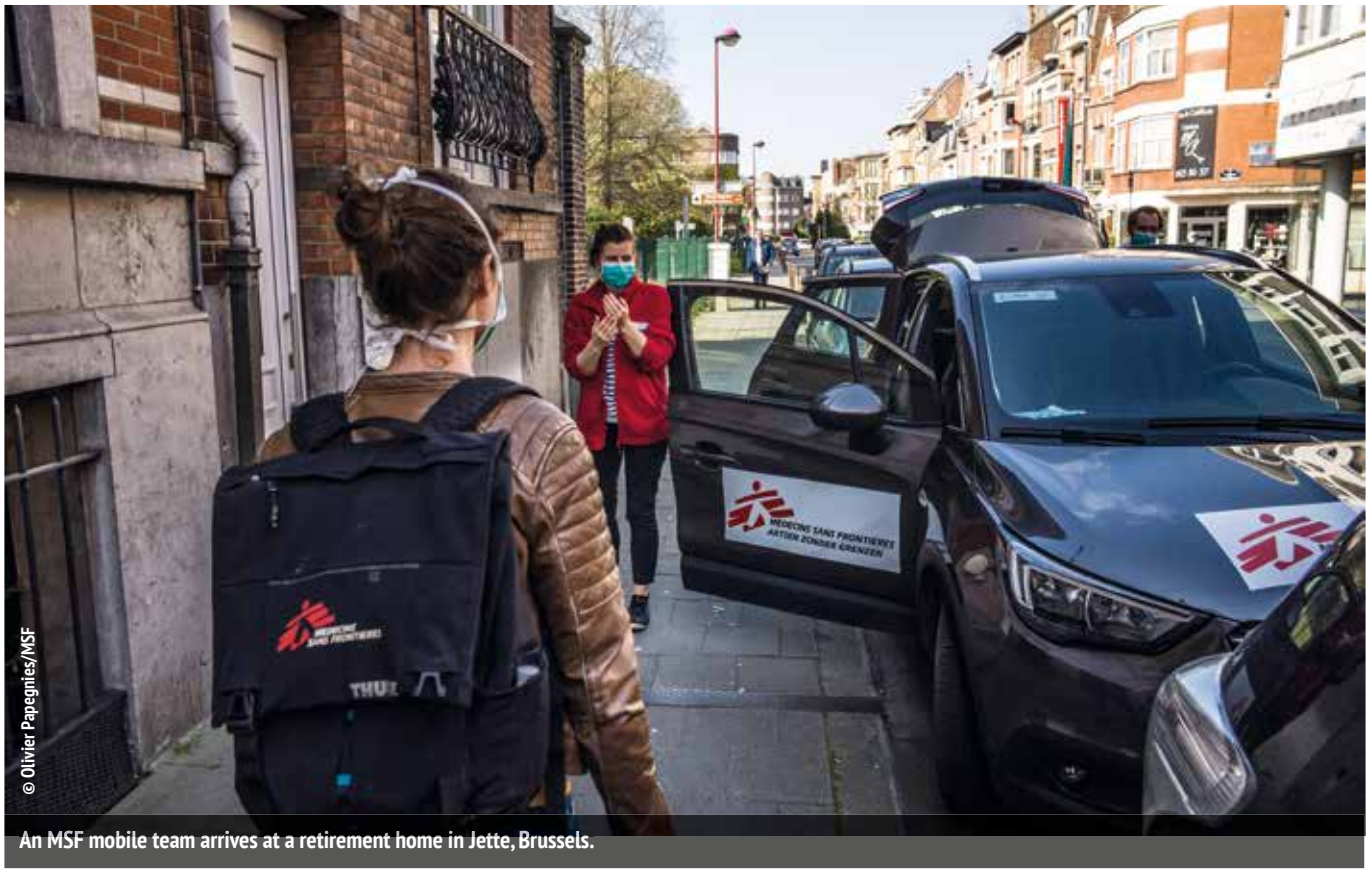
In **Belgium**, the situation in retirement homes was equally alarming, and MSF started shifting its activities from hospitals to these long-term care facilities in early April. Nine MSF mobile teams, each with a nurse and health promoter, visited 174 retirement homes in Brussels, Wallonia and Flanders. These teams assessed local facilities and preparedness measures, often identifying a lack of knowledge of basic hygiene rules and safety and treatment protocols, as well as shortages of personnel and protective equipment. After developing tailored recommendations for each facility, MSF returned to the retirement homes with infection prevention and control recommendations and to conduct staff trainings.

These outreach visits gave caregivers a much-needed opportunity to voice their distress and grief following weeks of working in strict confinement, their fears of getting infected, and sadness about residents who lost their lives away from loved ones. Together with a psychologist, MSF teams offered counselling and ran group trainings on stress management, peer support techniques, and coping mechanisms. Based on its operational experience in Belgian retirement homes, MSF has started to collaborate with local partners and is advocating with Belgian health authorities to improve preparedness and response plans and create better support networks for caregivers.

"Retirement homes were asked to operate like hospitals, but not given the protective means and necessary personnel to do so. We witnessed a true humanitarian crisis in Belgian retirement homes."



Stephanie Goublomme, MSF project coordinator, Belgium



© Olivier Papegnies/MSF

An MSF mobile team arrives at a retirement home in Jette, Brussels.

More than 1,000 care home managers and staff participated in MSF webinars and received support via email and phone.

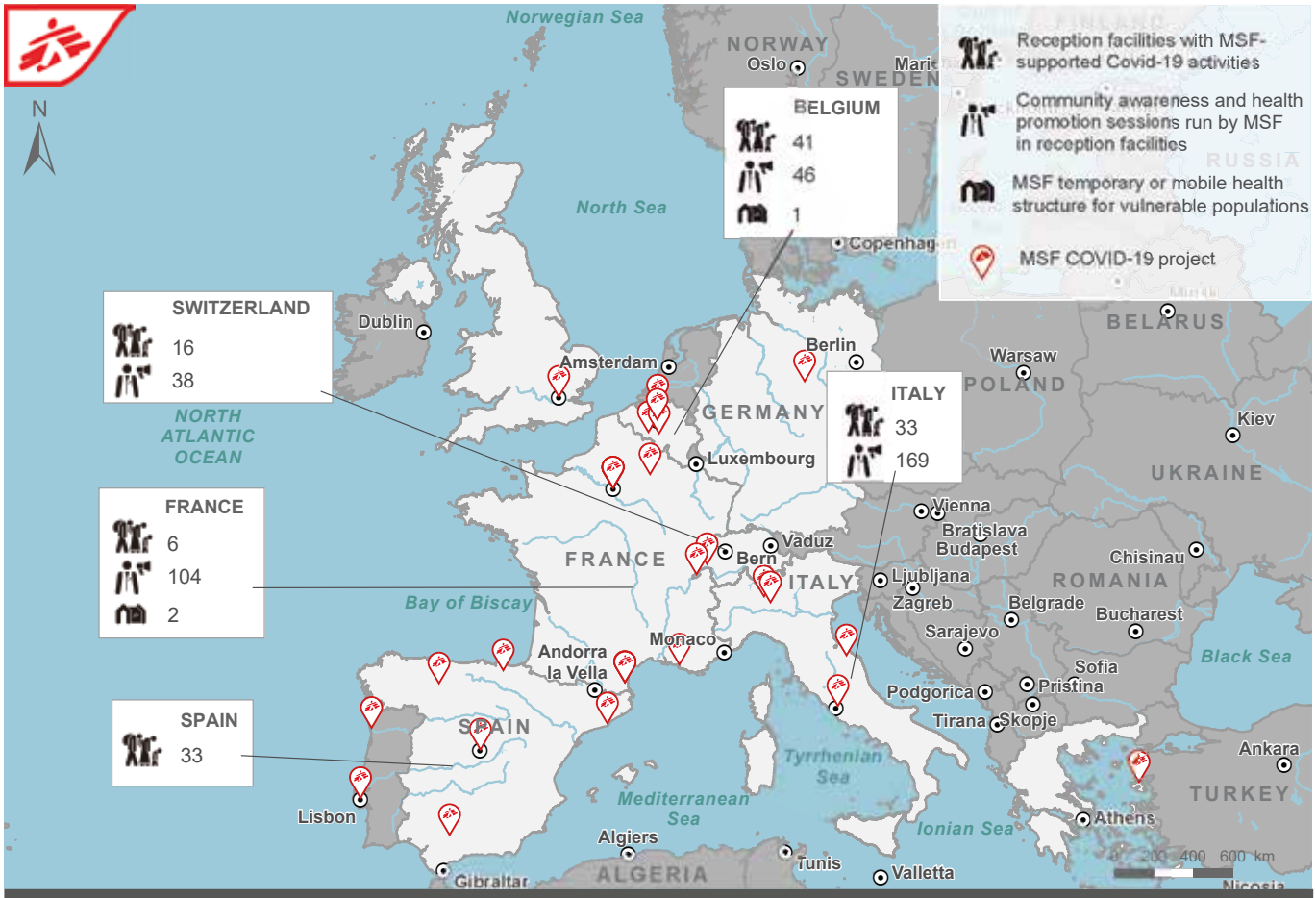
As part of its partnership with the Henri-Mondor Hospital in Créteil, **France**, MSF started visiting residential care homes for the elderly in the Ile-de-France region in the beginning of April.

Some residents had not been examined by a doctor for months. In 33 retirement homes in the Val-de-Marne department, MSF teams provided technical guidance and hands-on assistance to improve infection prevention and control measures and provided consultations to residents. MSF also supported retirement homes in Hauts-de-Seine and Seine-Saint-Denis.

Based in Geneva, **Switzerland**, an MSF logistician and a sanitation-and-hygiene specialist worked in two retirement homes in the neighbouring French region of Haute Savoie. There, they implemented appropriate isolation and hygiene measures for residents, staff, and visitors.

From March to May, MSF teams in **Europe** directly supported 795 retirement communities, nursing homes and long-term care facilities, and ran over 250 health promotion and training sessions. In Belgium and Spain, the alarming living conditions of residents during the pandemic, the lack of protective equipment and sufficient personnel, and the enormous emotional burden on caregivers led MSF to alert national authorities on several occasions in April and May. In June and July, MSF published extensive recommendations and advocated for improving preparedness, response measures, and overall care in retirement homes in both Belgium and Spain.

MSF's work in migrant and refugee centres, homeless shelters, and prisons



MSF support in migrant and refugee centres, homeless shelters, and prisons in Europe.

Complementing the support to patients, residents, and staff in hospitals and retirement homes, MSF's COVID-19 operations in Europe also provided care to vulnerable groups that are unable to self-isolate, lack access to health care, or live in precarious conditions without sanitary facilities and food. From prisoners in Milan to homeless people on the streets of Paris and undocumented migrants in Brussels, MSF teams supported national health authorities and health care providers to reach, protect, and treat those at risk of being forgotten or neglected during the COVID-19 pandemic.

In **France**, MSF's COVID-19 response started on 24 March in Paris, when over 700 migrants were evicted from a squalid encampment in the suburb of Aubervilliers and confined at gymnasiums and hotels. Following a request from the regional health agency, MSF deployed mobile medical teams to several of these facilities, conducting medical examinations and helping to identify people with COVID-19 symptoms. MSF also ran a mobile clinic near food distribution sites five days a week, where a team offered medical care to people living on the streets or in camps. Together, the mobile teams and street clinic staff held nearly 1,800 patient consultations in April and May, ran 107 health education sessions, and distributed 1,700 masks and non-food items. Several additional communal shelters reached out for support, and MSF set up a hotline staffed by nurses who directed support requests and visited several additional hostels for foreign workers to provide targeted medical support.



© Benjamin Matuszenski

MSF's mobile clinic providing treatment and COVID-19 screening in Paris.

"In the context of the coronavirus pandemic, we were particularly concerned about the fate of people in precarious situations.
If nothing was to be done to detect and isolate cases, the disease risked spreading among them rather quickly, as these people live on the margins of health services and were difficult to reach"



Pierre Mendiharat, Deputy Operations Director, MSF operational centre Paris

An estimated 250,000 people live on the streets in informal settlements, slums, vacant buildings, emergency shelters and temporary accommodations across France, with a majority living in the region of Ile-de-France around Paris. With government authorities and local health actors, MSF strongly advocated for appropriate and safe accommodations for these vulnerable groups, as gymnasiums and other large communal spaces presented a high-risk environment for inhabitants, as well as healthcare and social workers. As much as the strict lockdown measures in France allowed, MSF continued to support unaccompanied minors through its project in Paris that opened in 2017. In Perpignan, an MSF nurse helped to coordinate medical activities in a centre in the district of Saint Jacques, offering care for convalescent patients discharged from hospitals but who lacked the means for home-based care.

MSF was already running projects that provide medical and mental health support to homeless people and undocumented migrants in Brussels, **Belgium**. In early April, MSF set up a dedicated COVID-19 shelter and treatment facility at the former industrial site of Tour & Taxi, partnering with La Plateforme Citoyenne de Soutien aux Réfugiés and Samusocial.


© Kristof Vadino

Strict lockdown measures and increasingly overstretched hospitals meant these vulnerable groups had nowhere to turn to self-isolate with suspected COVID-19 symptoms. The facility opened with 50 beds, and was expanded to 104 beds later in the month, offering a place to sleep, isolation capacity, treatment for patients with mild symptoms, and referral of severe cases. By May, MSF had administered over 50 COVID-19 tests and admitted over 160 patients at the Tour & Taxi facility.

MSF teams also reached out to over 40 homeless shelters and centres for refugees, migrants, and asylum seekers in Brussels, where they ran sessions on health and hygiene and offered psychosocial support. At the Humanitarian Hub, a facility for refugees and migrants in transit supported by MSF since 2017, activities continued and included COVID-19 triage and referrals.

In mid-March, the Regional Penitentiary Health Director in the region of Lombardy **Italy**, asked MSF for technical support to contain the spread of COVID-19 inside detention facilities in the region after 13 positive cases had been reported in four prisons. After an initial assessment in the main detention centre of Milan, MSF launched a project focused on technical assistance, reorganising safe movement for inmates, building circuits for new arrivals and suspect and confirmed cases, and training prisoners, guards, and medical staff on the correct use of protective equipment. A total of 75 health promotion and instructional sessions were held in 19 prisons in Lombardy, Piemonte, and Liguria from March to May.

In Rome, MSF continued its work carrying out health promotion and medical care through a clinic at Selam Palace, a building hosting more than 500 refugees, mostly from the Horn of Africa.

In Geneva, **Switzerland**, MSF staff provided logistical and sanitation support in shelters and centres for migrants and refugees and distributed food to 1,300 families and people in need. In the neighbouring canton of Vaud, MSF ran infection prevention and health promotion trainings for staff working with the homeless population in Lausanne, Vevey and Yverdon-les-Bains, and dispatched a nurse to work with the medical and social emergency team operating in the region. In **Spain**, MSF conducted health promotion at 31 centres for people with disabilities, as well as two homeless shelters.


© Nora Teyjouni/MSF

In late April, MSF in **Germany** responded to a COVID-19 outbreak in the refugee reception centre in Halberstadt, where inadequate quarantine measures and lack of health education had led to unrest and mental health issues among inhabitants. An MSF psychologist and two health promoters deployed to the centre, where they offered mental health care and supported essential COVID-19 preventive measures.

In **Greece**, MSF provided support to the thousands of asylum seekers held in the overcrowded reception centres on the islands of Lesbos and Samos by conducting health promotion sessions, increasing the provision of water and sanitation services and scaling up activities with extra medical, paramedical and support staff. In Lesbos, MSF teams set up an inpatient medical isolation unit near Moria reception centre for patients presenting COVID-19-like symptoms, intended for the early detection and treatment of suspected or positive COVID-19 cases. In May alone, MSF received 494 patients as part of regular primary healthcare consultations, all of whom tested negative. MSF teams also supported the Greek national public health organisation with training on COVID-19 triage and case management.

In all of **Europe**, MSF supported people at risk in 129 reception facilities, shelters, makeshift camps, and prisons, conducting over 250 health promotion and training sessions from March to May. For many vulnerable and neglected groups, MSF's European COVID-19 projects were their only means to access essential care, shelter for self-isolation, or appropriate shielding. By the end of May, most of MSF's dedicated COVID-19 projects in Europe had come to a close, with some activities in Belgium continuing into June.

6 Changing the way MSF works: Human Resources, Supply and Finance during COVID-19



© Smriti Singh/MSF

Introduction

While the COVID-19 pandemic had MSF projects around the world racing to implement outbreak preparedness and ensure continuity of care, it also had an unprecedented impact on MSF's operations. For human resources, procurement and supply chain logistics, and fundraising and financial processes, the sudden lockdown measures and closure of borders, global travel and export restrictions, and an urgent need for additional supplies and funding posed enormous organisational challenges.

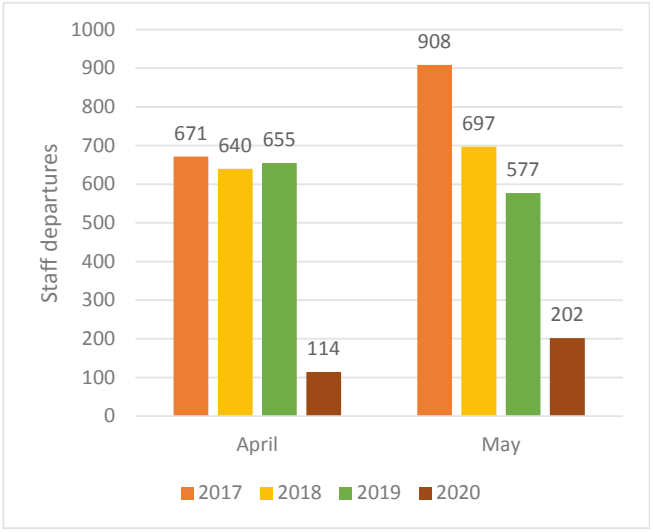
This chapter features key information illustrating what it meant to run an international humanitarian medical organisation amidst a global public health emergency. It also highlights some of the extraordinary efforts made by MSF human resources, supply and logistics specialists, and fundraising teams during the first few months of the pandemic.

Staff travel and human resources

Although over 80% of MSF's workforce is national staff hired locally, regular and reliable air transportation and unhindered access to projects located in low-resource and humanitarian crisis settings remain essential for MSF's global operations. In any given year, MSF staff originate from and move between more than 140 countries. In mid-March, international borders closed, countries imposed strict quarantine measures, and international travel came to a near-complete standstill. As a result, MSF doctors and nurses, technical specialists, and support staff could not reinforce or replace colleagues in the field, and all major supply and evacuation routes were interrupted.

The lockdowns and travel bans heavily affected immediate and upcoming departures of international MSF staff to field projects. Whereas over 650 MSF staff normally leave on an international mission each month, departures dropped to 114 in April and 202 in May.

Most travel that did occur during this period was booked on humanitarian charter flights operated by the UN, ECHO, or partner organisations, and in many cases required several additional stopovers and long travel times. By the end of May, MSF human resource and travel coordinators had successfully booked close to 150 flights on the United Nations Humanitarian Air Service operated by the World Food Programme – accounting for more than half of the UN air services' passenger volume. In addition, MSF was able to extend its presence and activities by using the few remaining flights in and out of Addis Ababa in Ethiopia and Accra in Ghana, two humanitarian travel hubs. Via these airports, a limited number of staff could be sent to or return from MSF's projects in East, Central and West Africa. Some repatriation flights for international staff were also organised directly by their respective governments.



Global MSF departure numbers in April and May, 2017-2020



© Quentin Bruno/Brassage Photographique

Due to the pandemic and travel restrictions, specialised humanitarian charter flights were among the few travel options for MSF staff.

Travel restrictions, however, directly affected the recruitment of new field staff and medical specialists with final confirmation of assignments depending on the availability of rare flights. Furthermore, some formerly eligible health professionals could no longer go to the field due to COVID-19 risk factors. Many experienced medical professionals were engaged in responding to COVID-19 in their home countries, including some staff who had dispatched to one of the dedicated COVID-19 operations in Europe, South America, or the US.

In several countries, MSF projects had to manage and mitigate substantial staff shortages, notably in humanitarian crisis settings and conflict zones such as Bangladesh, Nigeria and Yemen. In April, MSF called for Yemeni authorities to urgently allow the entrance of supplies and humanitarian staff into the country in order to facilitate a response to COVID-19.

MSF defined a set of key principles governing its HR policies and staff allocation during the COVID-19 pandemic. Operational continuity and duty of care were identified as top priorities, aiming to maintain activities in as many MSF projects as possible. At the same time, MSF committed to implementing all necessary measures to protect staff and offer support, medical treatment or evacuation when needed. Based in Norway, MSF's Mentoring & Coaching Hub offered short-term coaching to support MSF staff facing major challenges and stress in their work.

Globally, thousands of MSF staff had their regular responsibilities shifted to COVID-19 preparedness and response activities in ongoing projects or were redirected to dedicated COVID-19 interventions. Several hundred of the medical and emergency specialists needed to run MSF's COVID-19 interventions in Europe were re-tasked from their usual roles in MSF's five operational centres and in partner sections.

As in most industries, beginning in March, teleworking and video conferencing became the norm across MSF operational centres and offices around the world, and only a small number of COVID-19 taskforce members were physically present in offices at the same time. For a few field staff about to begin international missions or just having concluded their contracts, teleworking from home or mission countries offered a temporary alternative when travel was not possible.

Supply and logistics

Reliable and effective supply chain and logistics are crucial to maintaining humanitarian medical assistance around the world. However, major challenges in procuring, supplying and shipping personal protective equipment and medical supplies for COVID-19 activities began in March. With emergency preparedness and response efforts simultaneously underway in all MSF projects, and direct COVID-19 interventions launching in multiple countries, MSF supply centres saw an unprecedented demand for protective masks, gowns, goggles, and gloves, as well as for other essential medical supplies and treatments. At the same time, the rapid spread of COVID-19 quickly disrupted global production, supply chains and distribution systems. As global shortages of medical and protective items became evident, several countries including European Union Member States started restricting export and enlarging their own stocks, while lockdown measures and restrictions increasingly complicated international shipping.

To address these major challenges, MSF's supply centres and procurement teams in Bordeaux, Brussels and Amsterdam joined forces in a dedicated emergency taskforce charged with managing orders from the field, monitoring stock levels, and jointly evaluating procurement opportunities. In mid-March, the European Union added waivers for essential medical goods and humanitarian aid shipments to its export restrictions, an amendment advocated for and facilitated by MSF humanitarian representatives in Brussels.



© Julien Dewarichet/MSF

MSF supply centres, like this warehouse in Brussels, faced shortages of essential protective equipment and medical supplies to fight COVID-19.

By April, the rapid depletion of supplies and severe risk of stock ruptures led MSF pharmacists and supply specialists around the globe to expand on local purchasing solutions. In addition, MSF offices worldwide approached governments, local companies and civil society organisations in search of additional sources of personal protective equipment, especially Type N95 or FFP2 respirator masks, as well as Type IIR surgical masks. Uncertainty over the minimum standards for protective masks and gowns to protect against COVID-19, and rapidly changing recommendations from health authorities posed an additional challenge in procuring and distributing the right equipment. By May, the supply situation had improved slightly for respiratory and surgical masks, yet surgical gowns and protective gloves remained understocked.

MSF researched and procured oxygen delivery devices and treatment equipment such as ventilators, oxygen concentrators, and four large-scale oxygen generators, which rapidly were in severe global shortage.

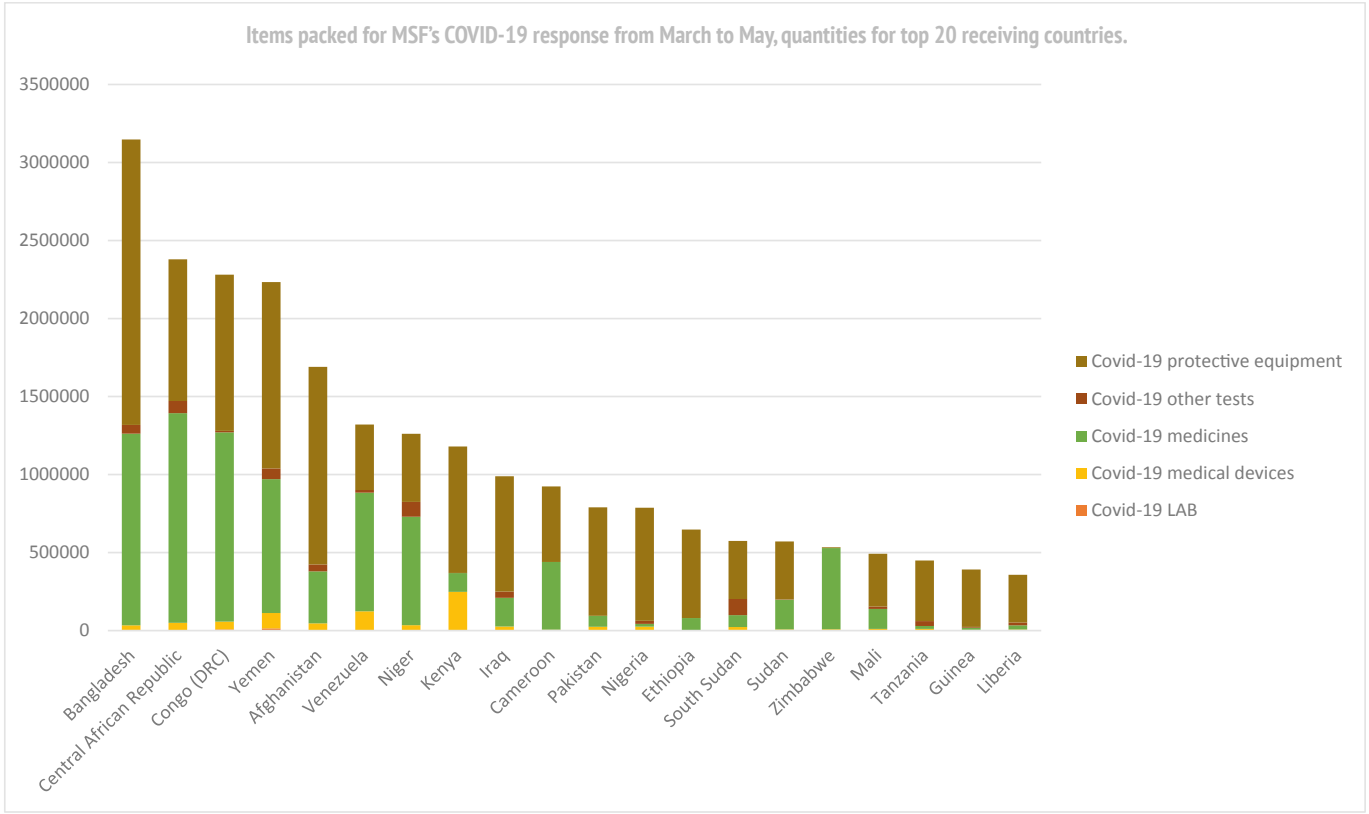
UV light disinfection devices were dispatched to more than 35 project locations to enable respirator masks to be safely reused up to four times. MSF also designed reusable hospital gowns; and in the early stages of the pandemic designed a 3D-printed headband that could be fitted with an A4-size plastic ring-binder laminate plastic sheet and be used as a face-shield.

With virtually all commercial passenger and cargo flights suspended during much of April and May, many regular transportation routes were unavailable and cargo space scarce, leaving only more expensive cargo charters as an alternative. For operations in Syria, for example, MSF managed to fly 46 tons of urgently needed medical supplies and 15 staff into Erbil, Iraq in mid-May, which were then transported to Syria by truck. To arrange this shipment, MSF staff spent several weeks of intense negotiations and planning with national authorities, supply and transportation teams, and MSF staff on the ground in Iraq and Syria.



© Pierre Crozes/MSF

MSF supply centres, like this warehouse in Brussels, faced shortages of essential protective equipment and medical supplies to fight COVID-19.



From March to May, MSF supply centres packed close to 26 million items for the global COVID-19 response, including personal protective equipment, medical devices, medication, testing material, and special laboratory equipment. More than half of these items were shipped to MSF operations in humanitarian crisis settings in Bangladesh, Central African Republic, the Democratic Republic of the Congo, Yemen, Afghanistan, and Venezuela, where local procurement opportunities and access to them are severely limited.

Overall, items earmarked for COVID-19 preparedness and direct response activities made up about a third of packed supplies for MSF operations globally. More than 50 million other items were dispatched from MSF supply centres from March to May, supplying essential non-COVID medical activities around the world.

For the dedicated COVID-19 projects in Europe, MSF supply centres packed more than 450,000 items of personal protective gear, medical devices, medications,

testing and laboratory equipment, sending large shipments of protective gear to Belgium, Italy and France. As the epicentre of the pandemic moved to South America in May, new and existing MSF projects required supplies of COVID-19-related materials and medications. In early May, the Access to COVID-19 Tools (ACT) Accelerator was launched at a pledging conference hosted by the European Commission, France, Germany, United Kingdom, Norway and Saudi Arabia, which aimed to marshal funding for the development, production, distribution and delivery of diagnostics, therapeutics and vaccines for COVID-19. While welcoming the initiative as an important first step in fighting the pandemic, MSF's Access Campaign called for making COVID-19 medical tools global public goods in order to ensure truly equitable allocation instead of uneven distribution guided by market dynamics.

In June, a first lessons learned exercise on managing the supply and logistical challenges of the COVID-19 pandemic was conducted by MSF. In supply centres, strengthening digitalisation and compatibility of systems along the supply chain and a joint purchasing structure were identified as a major success factor. To prepare for future global shortages, diversifying supply sources and extending MSF's investment in regional supply centres and transportation hubs were proposed as promising mitigation measures.

Finance

To address the unprecedented operational, logistical, and resource challenges caused by the pandemic, MSF created a dedicated COVID-19 Crisis Fund in late March. The additional funds needed for rapidly scaling outbreak preparedness measures and launching dedicated COVID-19 interventions, as well as some regular fundraising sources declining or halting altogether, threatened to create a financial shortfall and impair MSF's outbreak response and regular projects.

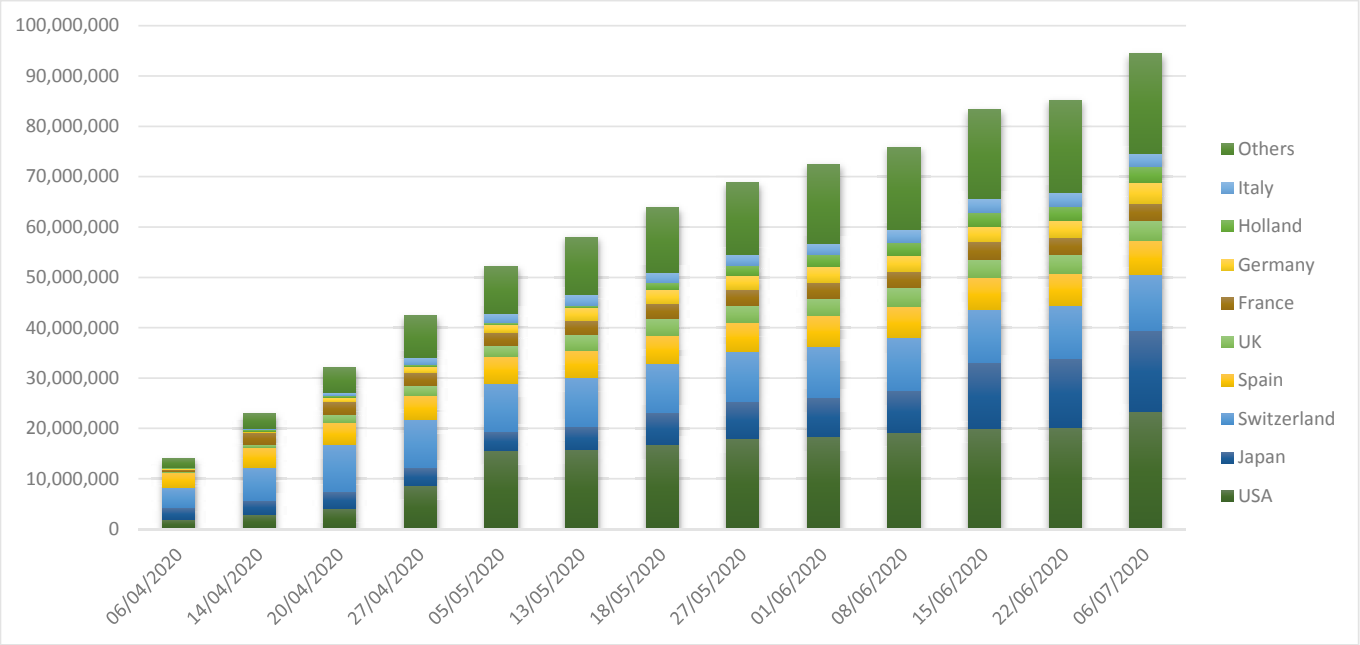
The Crisis Fund was set up to cover both direct and indirect costs of MSF's COVID-19 response. While additional funding was needed to cover dedicated COVID-19 activities, such as the emergency projects launched in Europe, the Americas and other regions, MSF was equally concerned about the impact of the pandemic on its regular projects in fragile health systems and humanitarian crisis settings. Based on early estimates, MSF originally set a goal for the COVID-19 Crisis Fund to raise 100 million euros by the end of 2021. Once it became clear that additional funds would be needed, this goal was increased to 150 million euros in April.

By the end of May, fundraising teams from 34 MSF offices had raised over 70 million Euros, with the US, Japan, Switzerland, Spain, and Germany among the countries with the largest contributions from donors. By late July, the crisis fund had raised just under 100 million euros, nearly two-thirds of the estimated funds needed to cover projected expenses.

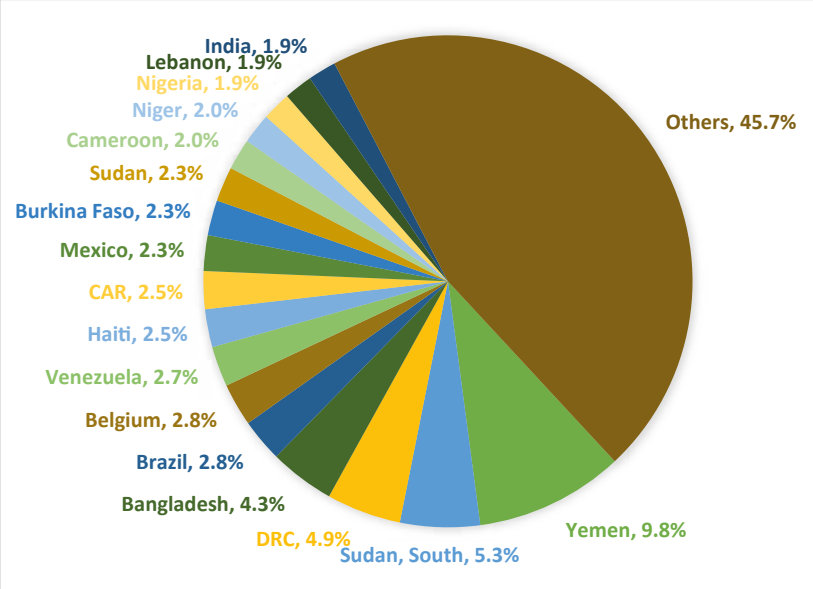


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For MSF projects like the advanced HIV care programme in Kinshasa, DRC, COVID-19 is proving to have severe operational consequences.



Evolution of contributions to MSF's COVID-19 crisis fund and countries with highest donations



Estimated expenses eligible for the COVID-19 Crisis Fund by country.

A substantial portion of expenses that will be funded by the Crisis Fund are incurred at MSF projects in humanitarian crisis settings and conflict zones, where more resources are necessary to set up, supply, run and maintain emergency medical services and provide healthcare. MSF's largest and most cost-intense operations in Yemen (9.8%), South Sudan (5.3%), the Democratic Republic of the Congo (4.9%) and Bangladesh (4.3%) account for nearly a quarter of projected eligible expenses, followed by countries with large COVID-19 interventions like Brazil (2.8%), Belgium (2.8%) and Venezuela (2.7%). Costs to ensure continuity of care or implement additional COVID-19 preparedness in major existing MSF projects such as in Haiti (2.5%), Central African Republic (2.5%), Burkina Faso (2.3%), and Sudan (2.3%) make up another major proportion of projected eligible expenses.

For MSF's major COVID-19 operations in Europe, actual expenses at the end of May added up to just over 4 million euros, yet several projects are still operational, and audited financial information is not yet available. By early July, incurred expenses eligible for the Crisis Fund were estimated at 145 million Euros.

7 Looking ahead: The impact of COVID-19 on health care in low-resource and crisis settings



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The firsts few months of responding to the COVID-19 pandemic required MSF teams around the world to rapidly mobilize and deploy complex outbreak preparedness and response measures. It took its toll on patients, communities, and staff alike. Despite unprecedented supply shortages and travel restrictions, MSF projects in many low ressource and humanitarian crisis settings succeeded to remain with existing target populations, implemented essential infection prevention and control measures, and maintained continuity of essential care.

Some remarkable initiatives allowed MSF to overcome many of the major challenges of this global public health emergency. In many places, MSF extended community-centred programming, distributed essential drugs in larger quantities to people with chronic diseases or offered home-based care, and successfully capitalized on innovative tools such as telemedicine, mental health counselling via phone or video chat, and digital health promotion campaigns using social media. Most of MSF's direct COVID-19 interventions in Western Europe – the epicentre of the global pandemic from March to May – came to a close by July as health facilities and authorities regained sufficient capacities, and the high transmission eased off.

Yet the initial sprint to adapt programmes and protect vulnerable populations has now turned into a marathon, putting persistent strain on health workers and MSF field staff already on the brink of severe fatigue and exhaustion. Moving from Asia through the Middle East and Europe, to the Americas, and to Africa, the pandemic took several unpredictable turns, producing sharp peaks in several European countries and in North and South America, alarming number of deaths in some African and Middle Eastern Countries, and fears of a second wave in Europe and Asia.

At the time of publishing this report in early August, up to 60,000 new COVID-19 infections are confirmed in the United States and in Brazil on a daily basis, threatening to bring health systems to a collapse, and putting vulnerable and neglected populations in slums, homeless shelters, and indigenous communities at severe risk. In July, the World Health Organization reported that over 10,000 health workers had been infected with COVID-19 in Africa, rendering them unable to do their job in health centres across the continent. In MSF hospitals in Yemen, more than 1,000 suspected cases have been admitted since mid-April, and case fatality rates remain at a staggering 30-50%, as patients present late due to fear, misinformation, and insufficient treatment capacity. Millions of vulnerable people in refugee or internally displaced camps in Bangladesh, Syria, Iraq, the Greek Islands, South Sudan, and Nigeria continue to live in unhygienic and precarious living conditions, with a lack of access to health care, and remain at severe risk of contracting the virus.



© Jakub Hein/MSF

Digital tools like video observed therapy for multidrug resistant patients in Eswatini play a key role in adapting MSF's programmes during the COVID-19 pandemic.



While much of world's attention lies on the direct impact of the COVID-19 pandemic, MSF has since the beginning of the outbreak urged to look at the health crisis in a broader perspective. In many of the low-resource and humanitarian crisis settings MSF works in, the indirect impact of the pandemic on primary health care is likely to be substantial. Fears of transmitting the virus have led to routine and reactive vaccination campaigns being put on hold, creating dangerous immunity gaps allowing vaccine-preventable diseases to rise. Important malnutrition and malaria programmes have equally been scaled back, leaving huge populations at risk of hunger and malaria epidemics.

Lockdowns and closed down health facilities are limiting access to primary and secondary healthcare services, particularly for communicable and non-communicable diseases, and sexual and reproductive health care. Assuming COVID-19 causes similar access disruptions as the West Africa Ebola outbreak, 1.2 million children and 57,000 mothers in low-middle income countries are estimated to be at risk in the coming months alone. In HIV-care, recent modelling estimates that a six-month complete disruption in HIV treatment could lead to more than 500,000 additional deaths from AIDS-related illnesses. From the very beginning of the pandemic, MSF has aimed to mitigate these serious knock-on effects of the COVID-19 pandemic, maintaining continuity of health care services or setting-up novel models of care where possible.

MSF has also been closely observing global health policy and drug regulation developments in the face of the COVID-19 pandemic. As a leader in global health advocacy for vulnerable and neglected communities – refugees, migrants, internally displaced and communities experiencing conflict and poverty – MSF has led several global advocacy initiatives focused on ensuring enhanced production and equitable access to any and all COVID-19 treatments or vaccines. MSF continues to call upon governments and the pharmaceutical industry to ensure the rapid and ample production of PPE, medicines and other medical tools required to fight the pandemic, as well as ensure access is based solely on need. This includes preventing patents or monopolies from limiting production or affordable access to drugs, tests and vaccines.

Ending the current pandemic will continue to require substantial resources, flexibility in adapting and transforming care, and outstanding commitment and innovation from health and humanitarian workers around the world. The contributions to MSF's COVID-19 Crisis Fund provide us with the invaluable resources to continue supporting patients, communities, and staff in our projects, while our global network of individual donors ensure we remain one of the few truly independent global medical humanitarian actors responding to this first ever modern pandemic.



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