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RESPONDING TO COVID-19

Global Accountability Report 2

June to August 2020



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Foreword by the International President of MSF



Nine months into the COVID-19 pandemic, the sprint to respond to this global health crisis has turned into a marathon. With 250 projects in 63 countries reporting COVID-19 related activities between June and August, the pandemic has become the new reality for our patients and our staff. Our response continued to have two main pillars: confronting COVID-19 with dedicated interventions where needed and a crucial effort to maintain existing lifesaving medical services. Treating people for malaria, war wounds, or pregnancy complications, for example, were made all the more challenging by the pandemic. At the same time, high numbers of new infections and overstretched health care systems led us to deploy additional teams to support the response. Finding the right balance between these competing urgent health needs was often difficult and remains a major challenge as the novel coronavirus continues to spread in many parts of the world.

Considering the magnitude of the pandemic and the remarkable global response, MSF only plays a small part in containing the spread of the virus and protecting vulnerable populations. Nonetheless, our staff across five continents is fully dedicated to working alongside local and national response efforts to deliver the best care possible. The resilience, dedication and energy of the frontline health workers in local health structures, affected communities, and with national response teams have been a lifeline for countless people in need. They are the real COVID-19 heroes.

Despite our long history of managing health emergencies and infectious disease outbreaks, this pandemic came with new challenges and tough choices. Predicting local outbreaks, knowing where and how to intervene next, or offering critical care in low-resource health systems repeatedly gave rise to serious dilemmas and difficult decisions. As a medical humanitarian organisation, our focus is on people's urgent needs. But who needs our help first? Where can we have the biggest impact? Answering these questions became even more complex with COVID-19.

The pandemic has exacerbated pre-existing humanitarian crises and obstacles to delivering assistance. It intensified major health emergencies in countries like Yemen, Syria, Bangladesh, and Nigeria. In Greece, MSF's COVID-19 specific response was shut down by the authorities in Lesbos, and we continue to struggle to access vulnerable populations in countries like Libya and Mexico. MSF continues to prioritise assisting the most vulnerable and neglected people no matter their circumstances, whether they are fleeing conflict, imprisoned, homeless, or in long-term care.

We know that COVID-19 is affecting people globally, including our donors. This makes us even more appreciative of the extraordinary support we have received during this challenging year. Since April, our supporters have donated more than 110 million euro to our COVID-19 Crisis Fund. We have a responsibility to the thousands of people who have supported us, as well as our patients and staff, to be transparent as to how these funds were spent, what we have achieved, and where our response may have fallen short. This second report covers from June through August 2020 and complements our first accountability report released in early August. Additional reports are planned for early 2021 covering the rest of 2020, as well as a one-year review in late spring.

At the time of writing, several vaccine candidates have shown promising results and may be rolled out very soon. Currently we are assessing if and how MSF will be involved in COVID-19 vaccination activities in specific countries, but we will keep raising our voice to ensure that there is equitable distribution according to needs and vulnerability, rather than who can pay the most. In many places, misinformation, public scientific disputes, and political utilisation of the health crisis have eroded trust in science, research and medical staff. This affects all medical practitioners including MSF staff, and there is an urgent need to gain that trust back. At MSF, we believe that community trust needs to be earned by providing high-quality medical care, and that is exactly what we intend to do.

Dr Christos Christou

International President of Médecins Sans Frontières

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Executive Summary: The persistent fight against COVID-19

The COVID-19 global health crisis continues to hold the world firmly in its grip. In many countries around the world, the initial emergency response has turned into a sustained effort to contain recurring waves of infections, putting a relentless strain on healthcare systems, economies, and social life. From June to August, Médecins Sans Frontières (MSF) continued to respond to the pandemic through its existing programmes, as well as dedicated COVID-19 interventions in more than 250 projects in 63 countries.

The operational focus of MSF's COVID-19 response remained unchanged. From hard-hit areas to conflict and crisis settings, MSF sought to reach vulnerable populations who were at risk of being left behind, delivering medical care and other assistance to remote communities, people on the move, the homeless, and elderly people living in long-term care facilities. In treatment centres and health facilities across five continents, MSF worked alongside local healthcare workers, strengthening infection prevention and control measures to protect staff, patients and caregivers alike. MSF teams also worked hard to keep other essential health services open and increasingly integrated COVID-19 related activities into regular projects.

Treating patients, supporting hospitals, and reaching vulnerable communities

Globally, MSF provided technical, training, or material support to more than 600 health facilities from June through August. In an additional 138 hospitals and treatment centres, MSF medical teams treated COVID-19 patients and set up or managed more than 3,300 dedicated beds. More than 48,000 COVID-19 related outpatient consultations and over 30,000 tests were conducted in MSF-supported health facilities and treatment centres worldwide. Just over 7,700 patients required hospitalisation, and 2,793 patients showing severe symptoms and requiring intensive care. More than half of MSF-supported hospitals and COVID-19 treatment facilities were in Africa, followed by the Americas, Asia, and the Middle East. MSF teams also worked in 132 nursing homes and 125 facilities housing migrants, refugees, and homeless people, a majority of which are located in the Americas and Europe. Most of MSF's dedicated COVID-19 operations in Europe ended in late May.

Reaching out to communities, addressing misinformation and fears about COVID-19, while bringing activities closer to vulnerable groups remained a cornerstone of MSF's response. MSF outreach teams held more than 350,000 health promotion and community awareness sessions on COVID-19, including door-to-door, phone, and social

media campaigns. MSF also distributed more than 2.2 million masks, protective clothing and hygiene items to communities, displaced and migrant populations, and health facilities from June through August.

Despite MSF's comparatively small contribution to the enormous global pandemic response, COVID-19 presented extraordinary and novel challenges to MSF's ability to deliver medical and humanitarian assistance. MSF teams faced major uncertainties and dilemmas, spanning from protecting staff and medical personnel, treating COVID-19 patients, and keeping MSF projects and essential healthcare services running. At the same time, the pandemic exposed health systems' pre-existing weaknesses, exacerbated ongoing humanitarian crises, and put vulnerable populations at particular risk.

Access issues and supply shortages

Geographical, political, and conflict-related access barriers posed major obstacles to MSF's COVID-19 and other activities, from remote communities in the Amazonas region to the wars in Yemen and Syria, to the refugee and migrant camps Greece and the detention centres in Libya. In some areas, mobile technologies and social media offered some alternatives to reach people despite lockdown measures, border closures, and travel restrictions. Delivering medical assistance in remote areas and crisis settings, however, could be exceedingly resource-intensive and was often delayed. The global shortage of medical and personal protective equipment had particularly damaging effects in some low-resource and conflict settings, including Bangladesh, Syria and Yemen, where MSF teams were forced to close urgently needed medical facilities to protect healthcare workers. In several countries with major MSF operations, the lack of protective gear fuelled healthcare workers' fears of contracting the disease and contributed to shortages of qualified medical personnel. In allocating and transporting crucial medical supplies amid widespread simultaneous needs and a massively disrupted global transportation network, MSF faced extremely complex and difficult logistical challenges.

Offering the best care at the right time

A new virus with little understood transmission paths and very limited treatment options, COVID-19 repeatedly caused unexpected regional spikes and sudden surges in patients requiring specialised care. As a result, choosing where to intervene next and when to scale isolation and treatment capacities involved a great deal of uncertainty. Some activities such as MSF's response in the Brazilian Amazonas region or in Ecuador were able to be operational only as COVID-19 cases were already decreasing. Meanwhile, several MSF-built

treatment centres in Africa and in India saw far fewer patients than expected. Repeated shortages of oxygen, supplies for respiratory support, vital medications, and qualified staff complicated the provision of appropriate care for COVID-19 patients. Offering the best and latest treatments available was equally challenging, with new and often conflicting evidence on transmission and treatment options being published at a staggering rate. In places where MSF ran intensive care units, such as in Venezuela and Yemen, the focus on highly specialised care sometimes came at the price of having limited impact on triage, screening and essential primary health care.

The long shadow of the pandemic

From the very beginning of the pandemic, a primary objective for MSF's COVID-19 response was keeping facilities open and continuing urgently needed healthcare. MSF had to make tough choices about which of its existing medical services could add dedicated COVID-19 treatment capacity, which of its projects were a priority to continue, and which activities had to be suspended to reduce transmission risks and protect staff. In some countries, such as Eswatini, South Africa and Zimbabwe, expanding community-centred activities and home-based care proved a viable alternative, and could be effectively supported with mobile technologies and phone counselling. Nevertheless, MSF had to reduce or adapt activities in many countries, or temporarily close health facilities due to quarantine measures.

Despite these efforts to ensure continuity of care, COVID-19 has increased existing public health problems and further weakened already fragile health systems in many low and middle-income countries where MSF works. In Afghanistan, Pakistan, Sudan, Syria, and many other countries, high case numbers among healthcare workers led to clinics and hospitals having to close, leaving large, often vulnerable populations without access to care. Lockdown measures further complicated access to care, while fears of contracting the disease at a health facility were exacerbated by rumours and misinformation. As a result, many people decided against or delayed seeking care, often with potentially devastating health consequences.

The new normal of responding to the pandemic

Facing these challenges head on required extraordinary support from staffing coordinators, and procurement and supply specialists, at MSF offices all over the world. With most commercial flights still suspended until the end of July, MSF staff relied on humanitarian charter flights to reach projects around the world. More than 1,400 MSF staff were able to depart for international projects from June to August. Despite limited transportation capacity on international flights, global supply shortages, and extra import restrictions, MSF supply centres packed close to 30 million items for the global COVID-19 response, including personal protective equipment, medical devices, medication, testing material, and specialised laboratory equipment. Items earmarked for COVID-19 preparedness and direct response activities made up about 44 percent of packed supplies for MSF operations globally. More than two-thirds of these items were shipped to MSF

operations in humanitarian crisis settings with limited local procurement opportunities.

By the end of August, fundraising teams from 35 MSF offices had raised just under 110 million euro for the COVID-19 Crisis Fund created in March, which aims to raise 150 million euro to pay for the substantial additional costs of both its new COVID-19 interventions and the impact of the pandemic on its ongoing projects. For the period from January to the end of August, the COVID-19 Crisis Fund allocated an estimated 76.7 million euro for actual expenses. Human resources and medical activities in MSF projects together accounted for more than 70% of estimated actual expenses, followed by logistics and sanitation (8%), office costs (8%), and travel and accommodation (6%).

Continued response and looking beyond 2020

In countries where the pandemic continues to put health systems under major strain, such as Brazil and Iraq, MSF continues to operate dedicated COVID-19 treatment and isolation facilities and supports medical facilities and healthcare workers. In light of new waves of infections and high patient numbers, MSF has recently launched or reactivated activities in Belgium, Czech Republic, France, Indonesia, Italy, Jordan, Kyrgyzstan, Lebanon, South Africa, Switzerland and Ukraine.

While efficacious vaccines for COVID-19 now appear within reach, MSF remains concerned about the continued obstacles of ensuring equitable access to COVID-19 vaccines, treatments, and diagnostics. While welcoming the launch of the Access to COVID-19 Tools (ACT) Accelerator and its COVID-19 Vaccine Global Access (COVAX) Facility, MSF has repeatedly called for no patents or profiteering on drugs, tests, or vaccines used in the COVID-19 pandemic, and for governments to suspend and override patents to ensure availability, reduce prices, and save more lives. As the global health crisis continues to amplify and deepen existing inequalities and access issues, both political initiative and realistic implementation plans are needed to guarantee access to vaccines, treatments, and diagnostics for all.

This second accountability report continues the series launched with the first report released in August, covering the period from March to May, and will be continued with additional reports in 2021.

MSF and the pandemic: a timeline

29

MSF opens a COVID-19 treatment centre in Venezuela.

MSF welcomes the WHO Solidarity Call to Action to share COVID-19 technology and intellectual property, and calls on governments to adopt enforceable measures ensuring equal access for all.

MSF opens two COVID-19 treatment centres for COVID-19 patients in Reynosa and Matamoros, Tamaulipas state, Mexico.



June

2

MSF teams running the only COVID-19 treatment centre in the city of Aden, Yemen, report alarming numbers of severe COVID-19 patients, high death tolls, and a shortage of ventilators and oxygen concentrators.



MSF warns of a looming humanitarian catastrophe in Libya, where escalating armed conflicts and the arrival of COVID-19 have created a crisis within a crisis.

After six weeks of construction, the MSF COVID-19 treatment centre in Niamey, Niger opens its doors.

3

MSF urges world leaders and pharmaceutical companies to sell future COVID-19 vaccines at cost price, as Gavi, the Vaccine Alliance, announces the launch of the COVAX facility, a global financing mechanism to attract industry to scale up vaccine manufacturing and procure vaccines for low and middle-income countries.

4

MSF raises an alert over the spread of COVID-19 in Haiti, and extends the capacity of its treatment centre in Port-au-Prince to 45 beds.

9

At the High-Level Panel organised by the Humanitarian Affairs Segment of the Economic and Social Council of the UN (ECOSOC), MSF's international president Christos Christou calls for global equitable access to COVID-19 treatments and vaccines.

12

In Khayelitsha, South Africa, MSF opens a 60-bed field hospital for moderate to severe COVID-19 patients to support the local hospital.



13

MSF starts treating COVID-19 patients in a hospital annex in Tegucigalpa, the capital of Honduras.



17

MSF alerts of the deteriorating health situation in Brazil and expands its activities as COVID-19 infections in the country surpass one million cases and 50,000 deaths.



19

MSF opens a 100-bed COVID-19 field hospital within a stadium in Patna, Bihar state, north eastern India.

23

In the United States, MSF starts running COVID-19 health education and training on infection prevention and control measures in nursing homes in the Midwestern state of Michigan.

8

MSF warns of an increasing number of people dying of COVID-19 in the metropolitan area of San Salvador, the capital of El Salvador.



9

In Yemen, MSF reports a widespread fear of COVID-19 preventing people from seeking medical care in its treatment centres in Sana'a and Aden.

July

14

In Belgium, MSF publishes its recommendations to improve protection and care in nursing and retirement homes.

16

MSF urges Greece to lift restrictions and evacuate vulnerable people from the prolonged lockdown measures for refugees stuck on the Greek islands.



23

WHO reports more than 10,000 health workers in 40 countries across Africa have been infected with COVID-19.

28

MSF calls out diagnostics company Cepheid for charging four times more than necessary for its COVID-19 test.

30

Local authorities force MSF to close its COVID-19 isolation centre in Moria on Lesbos, Greece.



August

4

A powerful explosion in a port warehouse near central Beirut, Lebanon, kills more than 100 people and injures close to 5,000, putting additional strain on hospitals treating the increasing COVID-19 cases.

5

MSF's COVID-19 field hospital in Khayelitsha, South Africa, closes after two months and nearly 250 admissions, as the outbreak response shifts to the east of the country.

9

In northern Iraq, MSF warns of aggravated humanitarian and mental health conditions due to COVID-19 confinement measures in the Yazidi community.



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MSF publishes the first of three COVID-19 accountability reports, detailing activities, income and spending on its pandemic response.

15

With a six-person MSF team on board, the Sea-Watch 4 vessel heads for international waters to the north coast of Libya, after EU member states had curtailed search and rescue activities using COVID-19 related public health concerns to prohibit lifesaving operations.

18

MSF publishes a report highlighting the unacceptable neglect of the elderly in nursing homes in Spain, urging the Spanish government to improve its response.



19

Following a sharp increase in COVID-19 cases in Puerto Rico, MSF further expands its response on the island.



27

MSF warns of the knock-on impact of the COVID-19 pandemic on other health services in northeast Syria, where some 700,000 people are displaced from their homes.

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MSF's global COVID-19 response from June-August



Brazil © Diego Baravelli/MSF

Introduction

From the last days of May into June, global COVID-19 cases continued to increase rapidly, reaching six million at the end of May and passing seven million only seven days later. By the end of August, the global number of confirmed cases had reached more than 25 million, and 859,846 COVID-19 associated deaths had been reported.¹

While the rapid spread of COVID-19 had put Europe's advanced health systems under enormous strain from March to May, the epicentre of the COVID-19 pandemic now shifted to the Americas. Several countries in North, Central and South America saw sharp increases in COVID-19 cases from early June, with daily confirmed cases reaching more than 78,000 in the United States and more than 69,000 in Brazil in late July. High COVID-19 numbers were also reported from India with 78,000 daily cases in late August, South Africa with over 13,000 daily cases in late July, and Russia with over 9,000 daily cases from early June.

The changing regional pattern and rapid increase of new COVID-19 cases led MSF to adapt and rescale its global response in several continents. In hard-hit countries in South America, the United States, India, and South Africa, dedicated COVID-19 activities were underway by late May or rapidly scaled-up from June to August. In several crisis- and conflict-affected settings, including Bangladesh, the Democratic Republic of the Congo, Iraq, South Sudan, Venezuela and Yemen, MSF-supported hospitals, treatment

centres, and community-based activities offered urgently needed care for COVID-19 patients as well as other essential health services.

In countries with lower COVID-19 case numbers, MSF focused on outbreak preparedness such as implementing COVID-19 infection prevention and control measures, and on maintaining regular healthcare and emergency services. At the same time, many projects worldwide developed their capacity to safely receive COVID-19 patients and expanded community or home-based activities aiming to reduce the risk of transmission for patients and staff. In Europe, most of MSF's dedicated COVID-19 projects had closed by early June, and cases continued to decrease over the summer.

In the three months from June to August, over 250 MSF projects in 63 countries reported dedicated COVID-19 activities. Globally, MSF teams were present in 602 health facilities, implementing COVID-19 infection prevention and control measures, improving triage and patient flow, and offering training and health promotion activities. MSF directly treated COVID-19 patients in an additional 138 hospitals and treatment centres and set up or managed more than 3,300 dedicated beds in five continents, about half of them in African countries. In addition, 132 nursing homes and 125 reception facilities for migrants, refugees, and homeless people received support from MSF, a majority of them located in the Americas and Europe.



Training on disinfecting hospital materials for health professionals at the regional hospital in Tefé, Brazil. © Diego Baravelli/MSF

¹All historical COVID-19 country and regional case numbers in this report are taken from the MSF/Epicentre COVID-19 Epi dashboard using data published by the European Centre for Disease Prevention and Control and the Center for Systems Science and Engineering at Johns Hopkins University.

More than 48,000 COVID-19 related outpatient consultations and over 30,000 tests were conducted in MSF-supported health facilities and treatment centres worldwide. Close to 7,800 patients required hospitalisation, and 2,793 patients developed or presented with severe symptoms and required intensive care. Over 70% of all MSF projects with COVID-19 activities included a mental health component, offering psychosocial support for patients, health workers, or community members.

Globally, MSF outreach teams held more than 350,000 health promotion and community awareness sessions on COVID-19, including door-to-door, phone and social media campaigns. MSF also distributed more than 2.2 million masks, protective clothing and hygiene items to health facilities and communities from June to August.



A patient at MSF's fever clinic in Mumbai, India is getting tested for COVID-19. © Abhinav Chatterjee/MSF

THE AMERICAS



USA

55 Retirement and nursing homes
22 Health facilities receiving COVID-19 technical, training or material support
36,000 Items of protective equipment distributed

HAITI

2 Health facilities receiving COVID-19 technical, training or material support
1 Health facility with medical support for COVID-19 patients
255 OPD consultations
230 IPD admissions
5,038 Health promotion sessions

VENEZUELA

39 Supported health facilities
3,942 OPD consultations
805 IPD admissions
87,692 items of protective equipment distributed

MEXICO

14 Health facilities receiving COVID-19 technical, training or material support
228 IPD consultations
269 Health promotion sessions

ECUADOR

17 Health facilities receiving COVID-19 technical, training or material support
2 Health facilities with medical support for COVID-19 patients
18 Retirement and nursing homes

BRAZIL

30 Health facilities receiving COVID-19 technical, training or material support
19 Health facilities with medical support for COVID-19 patients
5,222 OPD admissions
611 IPD admissions
99 Severe patients
31 supported reception and sheltering facilities for migrants, refugees and the homeless



38

MSF projects with COVID-19 activities



157

Health facilities with COVID-19 technical, training or material support



33

Health facilities with medical support for COVID-19 patients



16,600

COVID-19 related health promotion sessions



128,800

COVID-19 protective equipment and masks distributed

The Americas



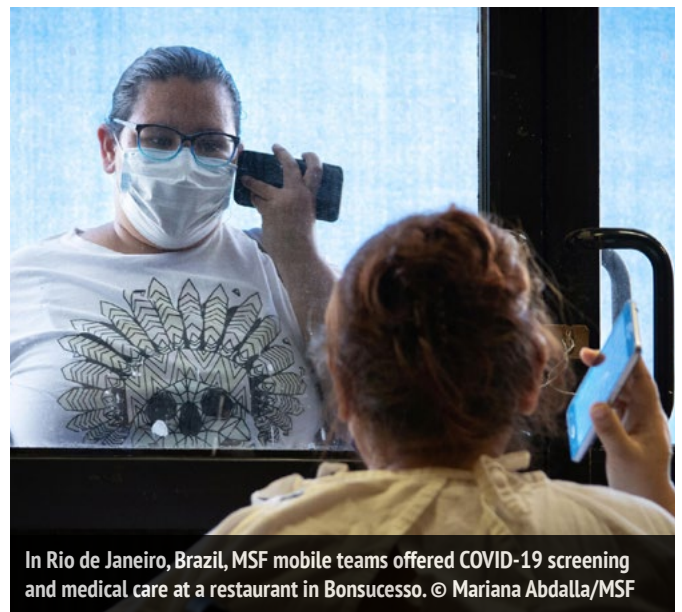
In Rio de Janeiro, Brazil, MSF mobile teams offered COVID-19 screening and medical care at a restaurant in Bonsucesso. © Mariana Abdalla/MSF

At the end of May, the World Health Organisation officially announced the epicentre of the COVID-19 pandemic had moved from Europe to the Americas, with the United States of America, Brazil and Colombia all reporting over 100,000 new weekly cases. MSF consequently increased its COVID-19 activities in the region, with several projects relocating operations to reach affected communities, and new emergency projects starting up in an effort to keep pace with the fast-spreading pandemic.

In **Brazil**, MSF treated COVID-19 patients in 19 hospitals and supported an additional 30 health facilities with tailored infection prevention and control and health promotion activities in Manaus, Rio de Janeiro, São Paulo, Boa Vista, as well as several remote, hard-to-reach areas, including São Gabriel da Cachoeira and Tefé. MSF medical staff conducted over 5,000 patient consultations, of which over 3,000 were held in Rio de Janeiro. In hospitals in São Paulo, Manaus, and the State of Mato Grosso, MSF ran treatment centres and intensive care units, admitting over 600 COVID-19 patients and treating over 90 with severe symptoms. In Manaus, the capital city of Amazonas State, as well as in the Roraima State and São Paulo, MSF continued to assist 16 retirement homes and over 30 shelters for migrants and people experiencing homelessness.

In late May, MSF opened a COVID-19 centre and intensive care unit in a hospital in Caracas, **Venezuela**, where the political and socio-economic crisis has crippled the health system. Despite persistent access and supply challenges,

additional projects were set up in Amazonas, Anzoátegui, Bolívar, Sucre and Táchira, which provided medical supplies and strengthened triage, diagnosis and infection control in health facilities. Overall, MSF supported 39 health facilities and four hospitals with dedicated COVID-19 treatment centres in Venezuela, conducting close to 4,000 outpatient consultations and admitting more than 800 patients for inpatient care, as well as 490 patients with severe symptoms. In addition, MSF projects in Venezuela held more than 9,000 health promotion sessions and distributed 88,000 items of protective equipment.



In Rio de Janeiro, Brazil, MSF mobile teams offered COVID-19 screening and medical care at a restaurant in Bonsucesso. © Mariana Abdalla/MSF



Artists pose in front of the health education mural they painted for MSF in the Santurce neighborhood of San Juan, Puerto Rico. © Gabriella N. Báez/MSF

In **Ecuador** and **Peru**, MSF set up dedicated COVID-19 operations in May and June. In Ecuador's capital Quito and the city of Guayaquil, MSF teams worked in a treatment centre supporting palliative care, and in 18 nursing homes. Responding to the alarming public health situation in the Amazon region of Peru, MSF teams supported 13 remote health structures with training and donations in the Datem del Marañón province, and another 10 facilities in Condorcanqui province. MSF additionally treated severely ill patients in the hospitals of Tarapoto, Huánuco and Tingo María.

In **Honduras'** capital of Tegucigalpa, MSF treated 124 severe COVID-19 patients in an adapted treatment centre supporting the metropolitan health system. In **El Salvador**, MSF deployed mobile clinics in the communities of San Salvador and Soyapango, providing health committees and community leaders with over 600 health promotion sessions.

In two COVID-19 centres in Matamoros and Reynosa on the northern border of **Mexico**, and in the regional hospital of Tijuana, MSF treated over 200 patients with severe COVID-19 symptoms. An additional 14 hospitals in Guerrero and Acapulco states and 55 shelters for migrants and asylum seekers all over Mexico received trainings and technical support from MSF teams.

Responding to a spike in COVID-19 cases in **Haiti** in May and early June, MSF set up triage zones and isolation units in two health structures in Port-à-Piment and Port-Salut, and converted its burns hospital in Port-au-Prince into a COVID-19 treatment centre. Until mid-August, 333 medical consultations were held at the centre, and 192 patients admitted with severe COVID-19 symptoms. With case numbers declining from July, the facility could be reconverted in August. More than 5,000 community

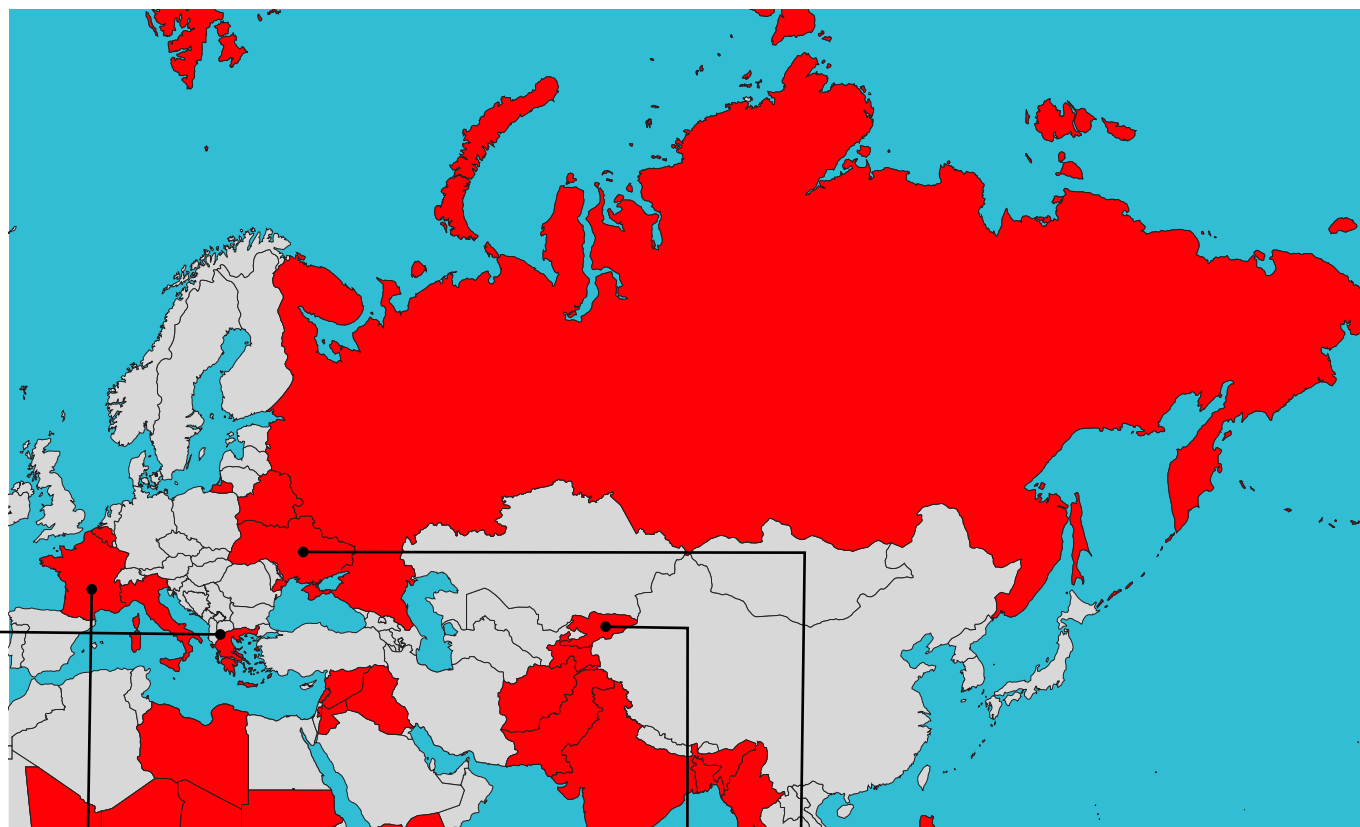
awareness and mobilisation activities were led by MSF from June to August in Haiti, focusing on prevention measures and timely admissions of COVID-19 patients.

In the midwestern state of Michigan in the **United States**, MSF provided dedicated hands-on support, technical advice, and training on infection prevention and control measures in 55 long-term care facilities from late May, where COVID-19 had taken a heavy toll on residents and health workers alike. In August, the same infection control training and wellness support model was offered to nursing homes in Texas. In **Puerto Rico**, MSF provided primary care consultations in homes and clinics to people with no access to medical services. The team supported 22 health facilities across the island and helped distribute over 30,000 items of protective equipment, as well as offering hand hygiene and COVID-19 health education workshops to high-risk groups across the island.



A nurse attends a patient in intensive care at MSF's Drouillard COVID-19 treatment centre in Cite Soleil, Port-au-Prince, Haiti. © Lunos Saint Brave/MSF

EUROPE & CENTRAL ASIA



FRANCE

- 1** Health facility receiving COVID-19 technical, training or material support
- 185** OPD consultations
- 20** Retirement homes supported
- 2** Refugee camps, migrant centres or homeless shelters supported

GREECE

- 2** Health facilities with medical support for COVID-19 patients
- 10,808** OPD consultations
- 1,702** Health promotion sessions
- 2** Supported reception and sheltering facilities for migrants, refugees and the homeless

UKRAINE

- 11** Health facilities receiving COVID-19 technical, training or material support
- 426** OPD consultations
- 518** Health promotion sessions
- 2** Retirement and nursing homes

KYRGYZSTAN

- 1** Health facility with medical support for COVID-19 patients
- 5,338** Health promotion sessions



17

MSF projects with COVID-19 activities



25

Health facilities with COVID-19 technical, training or material support



3

Health facilities with medical support for COVID-19 patients



7,700

COVID-19 related health promotion sessions



24,200

COVID-19 protective equipment and masks distributed

Europe & Central Asia

With the closure of its major COVID-19 emergency operations in hospitals, nursing homes and vulnerable communities in Italy, Spain, Belgium, France and Switzerland, most of MSF's dedicated COVID-19 programmes in Europe ended in late May. In several European and Central Asian countries, however, existing MSF projects continued to screen and treat COVID-19 patients and offered technical advice and hands-on support to health workers and vulnerable groups.

In **Kyrgyzstan**, MSF worked with the Ministry of Health to offer technical advice, support health promotion initiatives, and improve infection prevention in four main hospitals in Kadamjay. In August, MSF teams treated COVID-19 patients with mild and moderate symptoms through home-based care and supported a COVID-19 phone helpline in the Chuy region. More than 5,300 health promotion sessions were led by MSF, and 4,500 masks were distributed to vulnerable patients with pre-existing health complications. In **Tajikistan** and **Uzbekistan**, MSF focused on maintaining its major tuberculosis and HIV-programmes, advising on treatment of patients with tuberculosis and COVID-19 co-infections, as well as supporting infection control and health messaging in primary healthcare centres and treatment facilities.

Despite the repeated ceasefire violations in the Donetsk region of **Ukraine**, MSF continued to run a mobile clinic that provided screening and home-based care to over 420 suspect and mild-symptom COVID-19 patients, helping to

prevent health facilities from being overwhelmed. In the region of Zhytomyr, MSF staff trained health workers and offered psychological support to staff and patients in 10 health facilities and via a phone hotline.

In **Belarus**, MSF continued its efforts to maintain its regular drug-resistant tuberculosis programme amidst ongoing political demonstrations. The team donated over 16,500 masks and protective equipment items to a prison hospital and visited the inpatient departments of several tuberculosis hospitals in Minsk and Volkovichi with medical and patient support teams. At the end of July, MSF began distributing food packages and hygiene kits to multidrug-resistant tuberculosis patients in the northern city of Arkhangelsk, in **Russia**.

On the islands of Lesbos and Samos in **Greece**, more than 30,000 asylum seekers and migrants remained confined in camps and reception centres without access to general healthcare or sufficient sanitation services. While no COVID-19 infections were officially confirmed in the camps at the time, MSF projects on both islands continued health messaging, water and sanitation services and distribution of personal protective equipment. In addition to its regular clinic on Lesbos, MSF operated an inpatient isolation and treatment unit for patients with COVID-19 symptoms near the Moria reception and identification centre. The two clinics, along with mobile outreach teams, examined more than 10,800 patients, and 57 patients with suspected COVID-19 were isolated. At the end of July, the



A COVID-19 health information session in Aydarken, Kyrgyzstan. © MSF



Nurses are discussing with unaccompanied minors in a camp set up by MSF in the 11th arrondissement of Paris in June 2020. © Nicolas Guyonnet/MSF

COVID-19 treatment centre was forced to close after local authorities imposed fines with potential criminal charges related to urban planning regulations.

In **Italy**, an MSF team joined local health authorities in Palermo to respond to a COVID-19 outbreak in four shelters hosting 700 migrants. In the southeast of Rome, MSF helped establish a health surveillance system for COVID-19 in several informal settlements. There, the team also treated confirmed patients with mild symptoms in a transformed hotel facility and carried out more than 100 health promotion sessions.

In **France**, MSF teams continued providing care and COVID-19 health messaging to people living on the streets or in camps in the Île-de-France region, a population recently found prone to COVID-19 infection rates as high as 94 percent due to poor living conditions.² In July and August, MSF teams conducted 185 consultations with people living in precarious conditions and referred six patients with COVID-19 symptoms. MSF also offered psychological care and facilitated stress management trainings in 20 retirement homes in the region.

MSF's dedicated COVID-19 shelter and treatment facility for vulnerable migrants and homeless people in Brussels, **Belgium**, closed its doors in early June. A mobile team continued to support care homes in July and August, improving protective measures, organisation of care, and psychosocial support for residents and staff. MSF led a

qualitative research study on the mental wellbeing of residents of care homes and issued recommendations to health authorities and the regional parliament on how to improve mental healthcare.

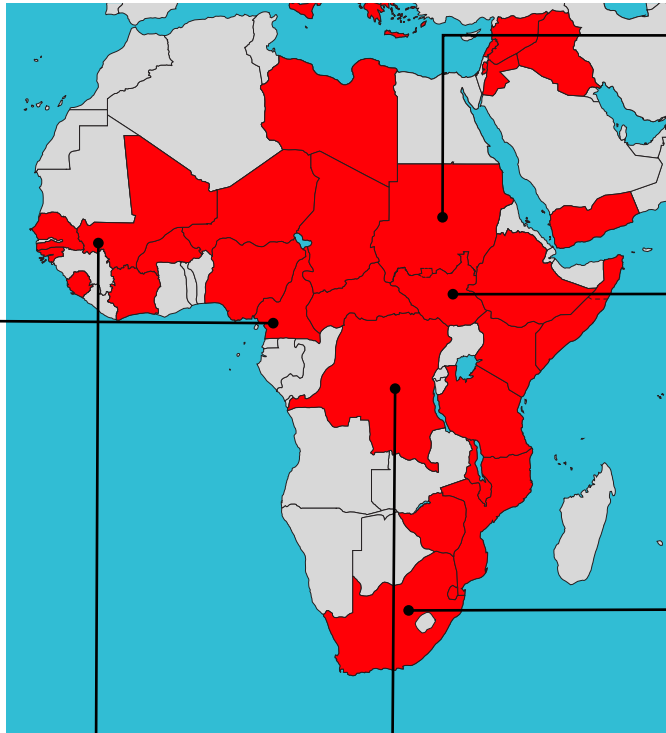
In late August in **Spain**, MSF published a report highlighting severe issues in the national response to COVID-19 in nursing homes across the country.



An MSF mobile team prepares to test healthcare workers for COVID-19 in Eastern Ukraine. © Katerina Stepanina/MSF

² <https://www.msf.org/high-coronavirus-covid-19-rates-found-amongst-people-living-hardship-paris>

AFRICA



SUDAN

27 Health facilities receiving COVID-19 technical, training or material support
3 Health facilities with medical support for COVID-19 patients
5,739 Health promotion sessions

SOUTH SUDAN

7 Health facilities with medical support for COVID-19 patient
896 OPD consultations
320 IPD admissions
2,997 Health promotion sessions

SOUTH AFRICA

21 Health facilities receiving COVID-19 technical, training or material support
4 Health facilities with medical support for COVID-19 patient
238 IPD admissions

MALI

26 Health facilities receiving COVID-19 technical, training or material support
1 Health facility with medical support for COVID-19 patient
1,766 OPD consultations
16,713 Health promotion sessions

DEMOCRATIC REPUBLIC OF CONGO

64 Health facilities receiving COVID-19 technical, training or material support
11,708 Health promotion sessions
62,854 Items of protective equipment distributed

CAMEROON

29 Health facilities receiving COVID-19 technical, training or material support
3 Health facilities with medical support for COVID-19 patient
2,539 Health promotion sessions



118

MSF projects with COVID-19 activities



351

Health facilities with COVID-19 technical, training or material support



70

Health facilities with medical support for COVID-19 patients



147,200

COVID-19 related health promotion sessions



1,489,100

COVID-19 protective equipment and masks distributed

Africa



An MSF medical team await patients in the screening and testing tent outside the District Hospital at Mongolwane in KwaZulu-Natal, South Africa.
© Chris Allan/MSF

Most African countries continued to report relatively low case numbers from June to August. Nonetheless, the pandemic posed a severe threat to healthcare systems across the continent, with reports of more than 10,000 doctors and health workers infected at work.³ To prepare for COVID-19 patients and ensure the continuity of regular healthcare programmes, MSF had rapidly instituted preparedness measures in all of its projects in Africa back in March and April. Thanks to this early implementation of infection prevention and control standards and the provision of protective equipment for staff, most regular MSF projects were able to keep their doors open, providing essential healthcare to vulnerable populations, and treating COVID-19 patients when necessary.

A rapid surge in COVID-19 infections was reported in **South Africa's** Western Cape province beginning in June, with nearly 15,000 active cases and 1,500 deaths reported by the middle of the month. In the township of Khayelitsha in Cape Town, MSF opened a COVID-19 field hospital with 60 beds and oxygen concentrators at the beginning of June, which functioned as a referral facility for the overwhelmed district hospital. The field hospital admitted close to 250 patients in two months, treating 89 patients with severe symptoms. As the COVID-19 infection rate slowed in the Western Cape in late-July, it surged elsewhere in the country, and MSF was able to react by deploying staff and equipment from the Khayelitsha Field Hospital to support struggling district hospitals in South Africa's Eastern Cape and KwaZulu-Natal provinces. In

Gauteng, KwaZulu-Natal and Western Cape provinces, MSF staff additionally assisted health authorities with contact tracing and delivering COVID-19 information, conducting more than 600 health promotion sessions. In Eshowe, MSF established 35 medicine pick-up points in communities to reduce non-essential visits to healthcare facilities for people living with HIV, TB and non-communicable diseases like diabetes.

In the **Kingdom of Eswatini**, MSF worked alongside the Ministry of Health to implement infection prevention and control and triage in 11 health facilities. MSF staff directly supported tuberculosis patients with video-observed therapy, and held more than 200 health education sessions. In **Mozambique**, MSF helped 15 hospitals and health centres improve patient flow and triage systems, and installed COVID-19 isolation and treatment facilities in the COVID-19 referral hospital in Maputo, as well as in health structures in Pemba and Beira.

In **Zimbabwe's** capital Harare, a team of environmental health and sanitation specialists screened suspected cases in a COVID-19 community isolation centre. MSF conducted trainings and health promotion, distributed masks and soap, and installed handwashing stations in seven additional health facilities and 55 local community health clubs. In Mutare and Chipinge in western Zimbabwe, MSF implemented COVID-19 infection prevention measures in six health facilities that are part of its existing non-communicable disease programmes. At Southern Africa's

³ <https://www.afro.who.int/news/over-10-000-health-workers-africa-infected-covid-19>

busiest border post in Beitbridge, MSF helped to improve flow and triage systems and supported COVID-19 screening, sample collection, and referral. In the Gutu district in southern Zimbabwe, MSF raised awareness of COVID-19 in health facilities and set up screening tents and hand washing points at the gates of the two main hospitals.

In Nsanje District Hospital in **Malawi**, where MSF is running a project for patients with advanced HIV disease, a treatment centre for severe COVID-19 cases was setup in a hospital. While continuing a project that provided care to female sex workers in Neno, Dedza and Nsanje districts, MSF adapted its health messaging and installed handwashing stations to prevent COVID-19 transmission in the community. MSF teams also worked at the Chichiri prison, screening for COVID-19 at the entry and continuing to provide medical services.

In Nduta refugee camp in northern **Tanzania**, MSF continued to provide the only available healthcare for an estimated 75,000 Burundian refugees. The team ran the triage areas at four health clinics and the main isolation centre at the MSF hospital constructed earlier in the year. Only 12 confirmed patients had to be admitted to the facility, of which eight presented with severe symptoms. MSF staff distributed more than 109,000 masks and hygiene items, and conducted close to 1,600 health promotion sessions on preventing COVID-19 transmission. In **Kenya**, MSF provided medical and technical support to two clinics and four health centres in Mombasa County, and conducted over 9,000 thematic health promotion sessions. Teams also improved triage and managed patient waiting areas in two referral hospitals in Homa



Staff tending to a patient with a hand injury in the Mathare slums of Nairobi, where MSF has been supporting emergency care for COVID-19 & other patients. © Paul Odongo/MSF

Bay and the Mathare and Kibera slums of Nairobi. In Embu County, MSF worked with the Ministry of Health to improve infection prevention and control in 11 health facilities and a level 5 hospital.

In **Somalia and Somaliland**, the already fragile health system was quickly overburdened with implementing infection prevention and managing COVID-19 patients. As a result, routine immunisation and nutrition programmes, along with other regular healthcare services, had to be reduced. MSF supported hygiene and preventive measures and offered trainings for healthcare workers in 15 health structures in Baidoa, Mudug, and South Jubaland. In the Gambella region of **Ethiopia**, MSF set up two COVID-19 isolation centres in the Kule and Tierkidi camps for South Sudanese refugees in June. A second team worked at the COVID-19 triage and temporary isolation centre at Gambella Hospital, where more than 200 confirmed



In Mutare, Zimbabwe, MSF continued its nurse-led care programme for hypertension and diabetes patients after implementing infection prevention measures in six health facilities. © Tsvangirayi Mukwazhi/MSF



A biotechnologist registers and codes samples of COVID-19 suspected cases in the National Public Health Laboratory (NPHL) in Juba, South Sudan.
©MSF/Tetiana Gaviuk

patients were admitted. In Abdurafi, Addis Ababa, and the Somali Region to the East, regular MSF projects supported by a mobile team delivered technical and training support to 15 additional health facilities.

In **South Sudan**, COVID-19 cases gradually increased from June to August, including in existing MSF projects in Yambio, Agok, Yei, Lankien, Bentiu, Western Equatoria, and Malakal. In Juba, MSF teams led community assessments and installed handwashing points, while providing training and technical support to the Ministry of Health, the National Public Health Laboratory and the local teaching hospital. MSF examined close to 900 suspected COVID-19 patients in the country, hospitalised over 300 confirmed patients, and treated 54 patients with severe symptoms in seven MSF-operated hospitals and health centres across the country. In addition, nearly 3,000 health promotion sessions were organised by MSF in South Sudan.

With the aim of maintaining or reopening essential healthcare services and restoring confidence among health workers in **Sudan**, MSF supported patient screening, triage, and isolation in three main public hospitals in Khartoum and in a health facility in White Nile state. Trainings, infection prevention and control, and donations of more than 33,000 items of protective equipment were provided to 27 health facilities in South Kordofan, White Nile, and the cities of Al-Fashir and Omdurman.

In the **Democratic Republic of the Congo**, the COVID-19 pandemic threatened to exacerbate several other pressing health emergencies, including the world's largest measles epidemic and an Ebola outbreak in Equateur province. MSF supported 60 hospitals and health centres with COVID-19 infection prevention and control measures, protective equipment, and technical training, while continuing to run its regular programmes. MSF medical

teams directly treated over 270 confirmed COVID-19 patients, with 64 patients requiring intensive care, in 20 health structures in Kinshasa, Lubumbashi, and North and South Kivu provinces. Ongoing MSF projects and dedicated COVID-19 operations together ran more than 11,700 awareness and health promotion sessions in communities to improve acceptance of COVID-19 prevention measures, such as handwashing and contact tracing.

MSF built a COVID-19 treatment centre in Bangui, the capital of **Central African Republic**, in June, which remained on standby due to low numbers of severe COVID-19 cases. In MSF-supported hospitals in Batangafo, Kabo, Bambari, and Bossangoa, dedicated screening and isolation facilities accommodated some 400 patient consultations and 50 admissions of confirmed COVID-19 patients. Community outreach teams visited more than 28,000 Bangui households to deliver COVID-19 health information, and nine other projects conducted over 13,000 health promotion sessions across the country. In Bangui and Bangassou, MSF completed emergency measles vaccination campaigns with accompanying health messaging on COVID-19.

Cameroon was among the African countries with higher COVID-19 case numbers, while insecurity and violence limited access to healthcare in the western and Far North regions. Most cases were reported in Yaoundé, the capital city, where MSF treated moderate patients at Djoungolo hospital. In 29 hospitals in the Central, Northwest, Southwest, and Far North regions, MSF teams set up isolation and treatment wards, supplied oxygen and essential medical equipment, and trained healthcare staff. More than 2,300 health promotion activities were organised all over the country, targeting displaced people and communities affected by violence via health workers and nurses, as well as radio messages.

In **Nigeria's** Borno state, over a decade of armed conflict has left more than two million people internally displaced, vulnerable to malnutrition and outbreaks of malaria, measles and cholera, and in need of humanitarian assistance. In addition to its regular projects MSF implemented infection prevention and control measures at its paediatric hospital and therapeutic feeding centre in Maiduguri, and provided technical support and supplies to the city's COVID-19 isolation centre.

In the towns of Gwoza and Pulka, MSF prepared beds for COVID-19 patients while also offering comprehensive primary and secondary healthcare. In the states of Ebonyi, Zamafara and Benue, MSF supported a COVID-19 testing centre and a treatment facility, conducted a large community sensitisation campaign, and installed water points. At its two projects for internally displaced people in Zamfara and Benue states, and the Lassa fever project in Ebony state, MSF medical teams conducted more than 1,000 consultations for suspected COVID-19 patients, and admitted close to 100 confirmed cases for treatment to its facilities. In Sokoto state, MSF handed over a renovated 32-bed isolation centre in May, while support to primary healthcare was extended to Kano state in June as several healthcare structures had closed due to COVID-19.

In Niamey, the epicentre of the COVID-19 pandemic in **Niger**, the MSF-built treatment and isolation centre received 31 patients in June and July. With case numbers decreasing in the country, the facility was handed over to the Ministry of Health in August. Through its projects in Zinder, Diffa, Tillabéry and Agadez, MSF offered technical support and training to 15 health structures, conducted screening and patient management in seven hospitals,

and delivered health information to over 170,000 people via door-to-door visits and phone calls. In **Chad**, MSF donated a central oxygen concentrator to launch a new COVID-19 project at the Farcha referral hospital in N'Djamena, which admitted 41 patients in July and August.

In **Burkina Faso**, the pandemic threatened to further exacerbate the rapidly deteriorating humanitarian crisis that has displaced large numbers of people since 2019. Yet only low case numbers were reported in June and July, leading MSF to end its intervention in Bobo-Dioulasso and gradually hand over the COVID-19 treatment centres in Ouagadougou and Fada to the Ministry of Health. Trainings for healthcare workers on safe triage, infection control, and case management continued in 13 health facilities.

Across **Mali**, MSF strengthened hygiene standards and set up isolation areas in 26 health centres and hospitals, and reached health workers, patients, and communities with more than 16,000 health promotion sessions. In the COVID-19 treatment unit operated jointly with the Ministry of Health at the Point G Hospital in Bamako, MSF staff supported more than 1,600 outpatient consultations, treated nearly 200 confirmed patients, and rehabilitated the hospital's oxygen network. At the end of August, management of the unit was handed back to the local health authorities. In **Côte d'Ivoire**, MSF distributed more than a million locally produced cloth masks at three supported isolation centres in Abidjan, Bouaké, and Gran Bassam.

In Conakry, **Guinea**, MSF had rehabilitated the Nongo Epidemic Treatment Centre, which was built by MSF



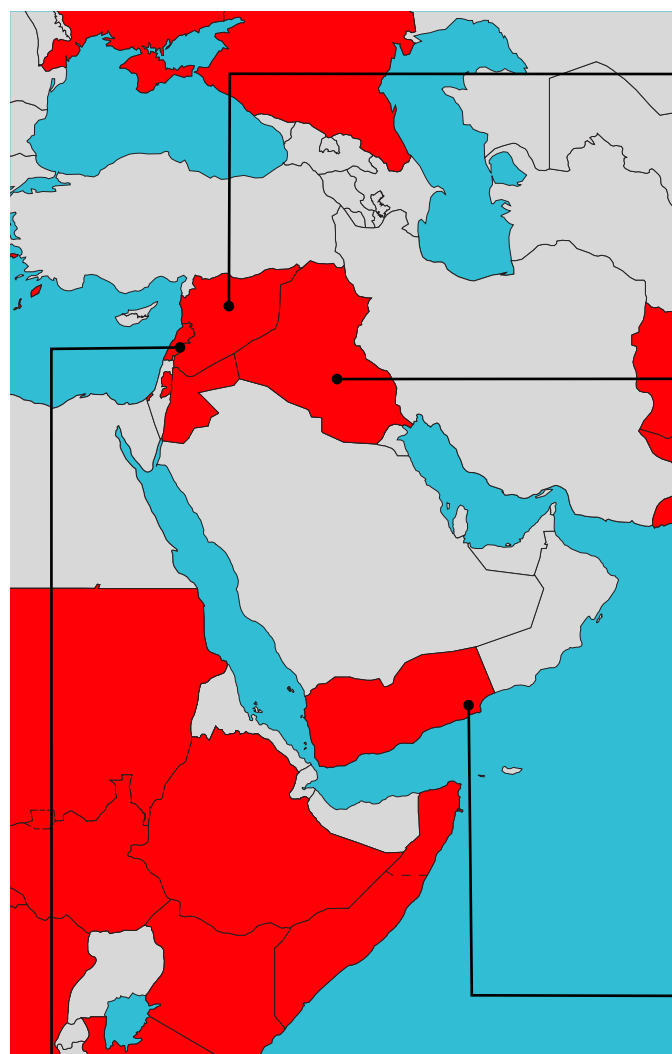
Maiduguri, Nigeria, MSF continued to offer free medical care including intensive paediatric care for malaria patients. © MSF/Stefan Pejovic



during the 2014/2015 Ebola outbreak, to receive COVID-19 patients earlier this year. MSF admitted 122 confirmed patients from June to early August, while offering training and technical support to an additional 23 health facilities in the area. In **Sierra Leone**, MSF participated in the case management and surveillance activities of the national Emergency Operations Centres in the Kenema, Tonkolili and Bombali districts, and organised large health promotion campaigns. MSF teams also worked with community health workers to deliver COVID-19 prevention messages and distribute hygiene articles in a Freetown slum. Training on safely managing COVID-19 patients and health promotion activities and trainings continued at the National Hospital Simão Mendes in **Guinea Bissau**, and at the Hôpital Dalal Jamm in Dakar, **Senegal**.



MIDDLE EAST & NORTHERN AFRICA



SYRIA

15 Health facilities receiving COVID-19 technical, training or material support
2 Health facilities with medical support for COVID-19 patients
823 Health promotion sessions

IRAQ

13 Health facilities receiving COVID-19 technical, training or material support
4 Health facilities with medical support for COVID-19 patients
826 IPD consultations
17,609 Health promotion sessions

YEMEN

8 Facilities with patient management
238 Beds managed
4,918 OPD consultations
1,263 IPD admissions
708 Severe patients

LEBANON

11 Health facilities receiving COVID-19 technical, training or material support
2 Health facilities with medical support for COVID-19 patients
10,290 Health promotion sessions
112 OPD consultations



43

MSF projects with COVID-19 activities



48

Health facilities with COVID-19 technical, training or material support



16

Health facilities with medical support for COVID-19 patients



38,300

COVID-19 related health promotion sessions



50,700

COVID-19 protective equipment and masks distributed

Middle East & Northern Africa

Two major humanitarian crises in Yemen and Syria, as well as prolonged conflicts, civil unrest and political transition in several countries have left a staggering number of people displaced and vulnerable in the Middle East and Northern Africa. Across the region, increasing numbers of COVID-19 infections put additional pressure on already weakened health systems, and threatened to have devastating consequences for large numbers of people living in camps, makeshift settlements, and detention centres.

More than five years of war have shattered the health system in **Yemen**, and a partial land, sea, and air blockade continues to hinder humanitarian access to the country. Due to a lack of testing capacity and the reluctance of some health authorities to declare cases, the true scale of the COVID-19 outbreak in Yemen remains unknown. Beginning in early May, MSF teams running a COVID-19 treatment centre in Aden and working in the intensive care unit and large inpatient departments of a hospital in Sana'a reported alarming numbers of severe COVID-19 patients, high death tolls, and shortages of ventilators, basic equipment, and medications. In June, MSF teams opened a second treatment centre in Aden and later intervened at a second hospital in Sana'a. More than 1,000 patients were admitted to these four health facilities with more than 600 patients requiring respiratory support or intensive care. Many sought treatment too late over

fear of the virus or limited access to care, and more than 300 patients reportedly died from May and August. At its projects in Saada, Hajjah, Hodeidah, and Ibb, MSF helped set up screening points and isolation capacity for patients and held trainings on infection prevention and case management. In all, MSF medical teams conducted close to 5,000 outpatient consultations and MSF supply centres packed and shipped more than 2.3 million items of COVID-19 medical and laboratory equipment, protective gear, and medications to Yemen. With fewer patients requiring care in Aden, MSF handed over its treatment centres in July and at the end of August. In Sana'a, where cases fell throughout the summer, MSF ended its two interventions in the city by the beginning of September.

In **Jordan**, MSF finished construction of a COVID-19 treatment centre at the Zaatari camp for Syrian refugees, which remained on standby until receiving its first patients in October. In the West Bank of **Palestine**, MSF distributed hygiene kits to affected households and offered psychological support through a hotline for COVID-19 patients, their families, and medical personnel. In the district of Hebron, MSF provided technical support to the main hospital treating COVID-19 patients, as well as two other health facilities. In MSF's mental healthcare project in Cairo, **Egypt**, the team organised 200 health promotion sessions on COVID-19.



A nurse working at the MSF-supported Sheikh Zayed COVID-19 centre in Sana'a, Yemen. © MSF/Maya Abu Ata



In several displaced camps in Idlib governorate and North Aleppo in North-West Syria, MSF distributed hygiene kits. © MSF

MSF led major health promotion campaigns on COVID-19 infection prevention and shielding across **Lebanon**, with more than 10,000 sessions conducted in vulnerable communities from June to August. MSF's surgery and wound care hospital in Bar Elias was equipped to admit and treat COVID-19 patients, and several screening tents were set up to triage children outside the Elias Hraoui Governmental Hospital in the Beqaa Valley. In Siblin in the south of Lebanon, MSF supported the transformation of a training centre of the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) into an isolation site for vulnerable people unable to isolate at home due to overcrowded living conditions. An MSF medical response team also supported the Ministry of Public Health with its COVID-19 testing strategy across Lebanon. In early August, MSF responded to the devastating explosion in a port warehouse near central Beirut, donating relief items, supporting hospitals with wound care, and offering mental healthcare.

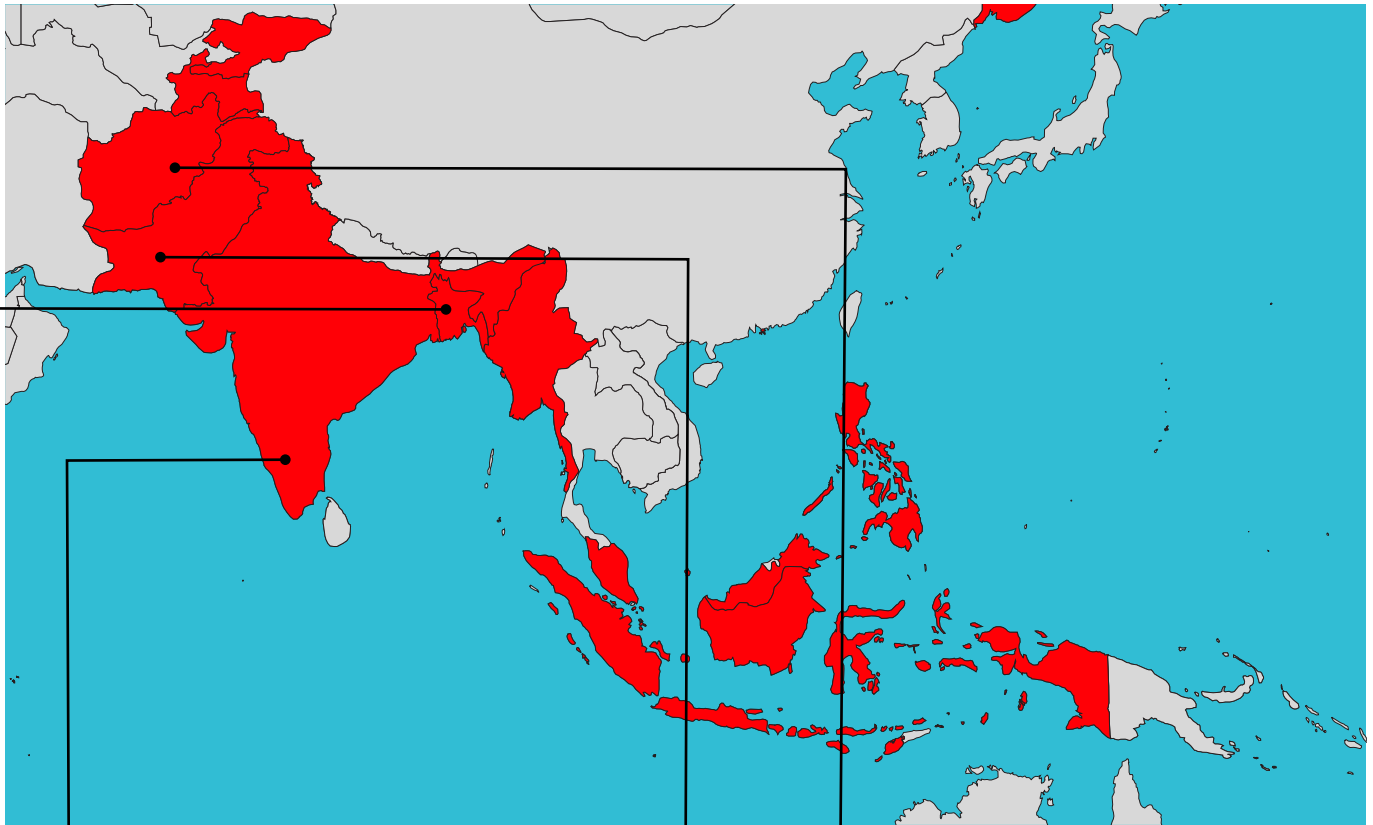
By the end of August, the COVID-19 pandemic had turned into a full-scale health emergency in **Iraq**, with up to 4,000 new cases being reported daily. In Baghdad, one of the worst-hit areas of the country, MSF supported the respiratory care unit of Al Kindi hospital, treating 95 patients and providing medical training to staff. MSF's post-operative care centre in Mosul, which had been transformed into a COVID-19 facility earlier in the year, admitted and treated more than 700 mostly mild and moderate COVID-19 cases. Technical support and trainings on infection control were also offered to several local health facilities in Erbil and Dohuk, and in the Laylan camp in the Kirkuk governorate.

In war-torn **Syria**, MSF participated in the COVID-19 humanitarian taskforce led by local health authorities, helped renovate a 48-bed isolation ward in Hassakeh

National Hospital, and supported the only dedicated COVID-19 hospital in Hassakeh city in the northeast. At Al Hol camp, where the first COVID-19 cases were confirmed in early August, MSF teams identified 1,900 particularly vulnerable people living with non-communicable diseases such as diabetes, hypertension, asthma, or heart conditions, and provided them with basic medication, soap, and other essential items. MSF staff conducted 500 health promotion sessions in the camp, where more than 70,000 people have sought refuge. In the northwest, MSF reinforced its team at the COVID-19 treatment centre of the Idlib National Hospital, after the first cases were confirmed in the area in early July. Another 12 health facilities were supported near the internally displaced camps in several areas in northwest Syria, including in North Aleppo and Idlib governorates, where MSF also conducted a large-scale distribution of hygiene products to displaced families.

In **Libya**, COVID-19 curfew and lockdown measures in early June on top of continued armed conflict further reduced the already limited access of migrants and refugees to basic healthcare and essential services. In detention centres in Tripoli, Khoms, Zliten, Zintan, and Zuwara, MSF teams offered first aid and primary healthcare to migrants and refugees, ran a tuberculosis program in Misrata and Tripoli, and led COVID-19-related trainings for medical staff in all project locations. In mid-August, the Sea-Watch 4 **search and rescue** vessel headed for international waters near the north coast of Libya with a six-person MSF team on board, after member states of the European Union had curtailed search and rescue activities using COVID-19 related public health concerns to prohibit lifesaving operations. In late September, after having rescued 354 people at sea, the ship was detained in Palermo by Italian port authorities.

ASIA & PACIFIC



INDIA

7 Health facilities receiving COVID-19 technical, training or material support
2 Health facilities with medical support for COVID-19 patients
904 OPD consultations
299 IPD admissions

AFGHANISTAN

3 Health facilities receiving COVID-19 technical, training or material support
4 Health facilities with medical support for COVID-19 patients
7,537 OPD consultations
2,789 Health promotion sessions

BANGLADESH

8 Health facilities with medical support for COVID-19 patients
3,124 OPD consultations
132,000 Door to door sessions
288,590 Items of protective equipment distributed

PAKISTAN

1 Health facility with medical support for COVID-19 patients
4645 OPD consultations
1612 Health promotion sessions
231,070 Items of protective equipment distributed



34

MSF projects with COVID-19 activities



21

Health facilities with COVID-19 technical, training or material support



16

Health facilities with medical support for COVID-19 patients



143,300

COVID-19 related Health promotion sessions



575,700

COVID-19 protective equipment and masks distributed

Asia & Pacific

While most Asian countries continued to transition out of their initial COVID-19 emergency response phase, increasingly high COVID-19 cases were reported in Southern Asia in June, and in the Pacific region in July and August.

In **Afghanistan**, MSF conducted more than 5,000 outpatient consultations at the regional hospital in Herat and admitted 130 patients to a 32-bed COVID-19 treatment centre opened in June. In Lashkar Gah and Kandahar, MSF strengthened screening and referrals in three hospitals with dedicated COVID-19 facilities and at a provincial tuberculosis centre, and distributed more than 22,000 pieces of protective equipment. In Kunduz, MSF organised trainings for health care staff and donated protective equipment to the regional hospital.

In **Pakistan**, MSF expanded its COVID-19 isolation ward at the District Headquarters Hospital in Timergara to 24 beds in June, screening an average of 1,350 people for symptoms every day. From June to August, the team conducted more than 4,500 consultations with suspected cases, and admitted 103 patients to the facility. At the end of August, the centre's capacity could be reduced from 30 to 14 beds due to the downward trend in cases. In the province of Balochistan, MSF helped set up an isolation unit with 32 beds at the Killa Abdullah New Hospital in Chaman. More than 1,000 health promotion sessions were organised across MSF projects in the Balochistan and Khyber Pakhtunkhwa provinces and in the city of Karachi, and more than 230,000 masks and protective equipment items were distributed.

A steady increase of COVID-19 cases beginning in June led to an urgent demand for isolation facilities and beds



People are screened at a triage point set up by MSF at Herat Regional Hospital, western Afghanistan. © Laura Mc Andrew/MSF

with oxygen supply in **India**. MSF opened a 100-bed temporary treatment centre in a sports complex in Patna, the capital of Bihar state, and admitted more than 250 patients. In Mumbai, MSF ran intense health education activities, scaled up COVID-19 trainings for its drug-resistant tuberculosis and HIV project staff, and conducted more than 800 consultations for suspected COVID-19 at its fever clinic and at a local hospital. MSF's programme for victims of sexual violence in New Delhi and its clinic for HIV patients in Manipur remained open, but saw fewer patients due to continued lockdown measures.

Nearly one million Rohingya refugees live in overcrowded, unsanitary conditions in Cox's Bazar, **Bangladesh**, in the world's largest refugee camp. The first COVID-19 cases among the refugee population were confirmed in mid-May, but case numbers remained relatively low over the summer months. Across 10 medical facilities, MSF built isolation wards, consulted more than 3,000 patients with COVID-19 symptoms and other healthcare needs, and



In Cox's Bazar, Bangladesh, MSF built isolation wards in ten medical facilities in the world's largest refugee camp. © Hasnat Sohan/MSF



An MSF team distributing COVID-19 information leaflets in Marawi City, Philippines. Chika © Suefuji/MSF

admitted about 330 confirmed COVID-19 patients to two dedicated treatment centres. MSF teams carried out major door-to-door COVID-19 health promotion campaigns, reaching more than 130,000 families in the camps. In the Kamrangirchar urban slum of Dhaka, MSF reduced regular activities to focus resources on its main clinic.

In **Myanmar**, MSF held technical trainings and more than 5,000 health promotion sessions in health facilities and communities in the states of Kachin and Shan, the city of Maungdaw, and the displaced camps in Sittwe. In the state of Penang, **Malaysia**, MSF teams offered mental healthcare and COVID-19 health education to migrants and refugees in different languages, including Rohingya and Burmese, as well as a translation service in hospitals. MSF also advocated for a more inclusive COVID-19 response and called on the government to halt targeting migrants and refugees in immigration raids that risk spreading the virus in detention centres. Reacting to a sudden surge in COVID-19 cases in **Hong Kong**, MSF expanded its emergency response from health education to providing emergency shelter and basic medical consultations to people experiencing homelessness.

In **Indonesia**, MSF teams worked at three health facilities in Jakarta and Banten Province, conducting workshops and trainings for community health workers who treat suspected COVID-19 cases and observe home isolation. In Manila City in the **Philippines**, an MSF medical team started working in the COVID-19 ward and onsite test laboratory of San Lazaro Hospital operated by the Ministry of Health, admitting more than 330 confirmed patients and processing close to 30,000 tests for analysis. In four additional health centres in Manila's poor neighbourhoods, MSF set-up handwashing points and distributed quarantine kits. In Marawi City, an MSF team distributed leaflets with health information and trained the contact tracing teams of the city's health office.



Briefing on correct use of protective gear at MSF's COVID-19 treatment centre in Patna, India. © Garvit Nangia/MSF

5

Old barriers & new frontiers: Major challenges in MSF's COVID-19 response



India © Abhinav Chatterjee/MSF

Introduction

With dedicated activities in more than 80 countries since the beginning of the pandemic, MSF's global COVID-19 response ranges from medical assistance in conflict zones and in low- and middle-income countries to supporting some of the world's most advanced healthcare systems. While this global health emergency presented extraordinary and novel challenges, it also exposed many health systems' pre-existing weaknesses, exacerbated ongoing humanitarian crises, and put some vulnerable populations at particular risk. In its response to COVID-19, MSF teams intervened in new areas, while facing long-standing obstacles in delivering care.

While MSF supported hundreds of health facilities and local authorities with implementing safe infection

prevention and control measures, MSF COVID-19 activities in most countries made a relatively small contribution to the major emergency response led jointly by local, national, and global actors. The programme and patient figures presented in Chapter 4 offer a snapshot of this work, but only partially capture the uncertainties and dilemmas MSF teams faced, spanning from protecting medical personnel and other staff, treating COVID-19 patients, and keeping MSF projects and essential healthcare services running. This chapter uses specific country and project examples to take a closer look at some of these major challenges of fighting COVID-19 on a global scale.

Reaching vulnerable populations



MSF and local health staff leaving the primary healthcare boat at a community on lake Mirini, in Brazil's Amazonas State. © Diego Baravelli/MSF

Working in crisis and conflict settings, and remote and rural areas, MSF is regularly confronted with geographical and political barriers that limit access to people in need of medical assistance. The rapid spread of the COVID-19 pandemic accompanied by lockdown measures, border closures and travel restrictions exacerbated these challenges globally. Over fears of uncontrollable COVID-19 transmission, some national governments sealed off entire regions and communities, and deprived vulnerable refugees and migrants, homeless people, the elderly, and indigenous communities of access to essential services. At the same time, COVID-19 created an urgent need for more specialised medical services in remote places with limited healthcare options, often in

regions with no nearby MSF projects from which to launch additional operations.

In **Brazil**, reports of a catastrophic health situation in the vast and sparsely populated Amazonas state in May led MSF to shift its centre of operations from coastal cities to areas along the Amazon River. One of the hardest-hit towns was Tefé, reachable only by a two- to three-day boat journey from the state capital, Manaus.

The local hospital had been overrun by patients and dealt with very high numbers of COVID-19 related deaths during a first wave, yet case numbers were declining by the time MSF arrived onsite. MSF trained staff at the

overburdened local hospital on infection control and the management of severe patients in a looming second wave. Later, an MSF infection-control team spent two weeks on a primary healthcare boat, offering medical services to small communities further up river. More than 400 kilometres to the northwest, in the municipality of São Gabriel da Cachoeira, on the banks of the Negro river, another MSF team set up a care centre for patients with moderate and severe cases of COVID-19. To facilitate access to the mostly indigenous population, the facility incorporated the use of traditional medicines and accommodated visits from spiritual leaders using personal protective equipment.

Upstream of the Amazon River, in neighbouring **Peru**, MSF was struggling to overcome similar geographical and logistical barriers. An exploratory mission in June had found strong evidence of active transmission in indigenous communities in the three large regions of Loreto, Ucayali, and San Martín, and recommended setting up activities in proximity to these communities to minimise referrals and avoid lengthy evacuations by boat. With a small international team of only six staff, the MSF intervention in July and August had to prioritise one of the three regions, and supported 13 health facilities in Datem del Marañón, a province of over 46,000 square kilometres and a population of 50,000 people. An international order of medical and protective equipment took 10 days to prepare and ship, yet required another 23 days to be cleared for import and transported to the project sites. As MSF was missing a valid commercial registration in Peru, no local agreements or work contracts could be signed and no property rented, further limiting the project's reach. A second MSF team working in Condorcanqui province was facing similar challenges in reaching communities in remote areas.

For MSF health promotion and community outreach teams in many countries, lockdown and confinement measures initially threatened direct contact with patients, their families and vulnerable communities. Together with qualitative assessments, the daily exchange with patients and affected communities is fundamental to understanding the sociocultural context, community perceptions, and practices, and to tailoring MSF interventions to specific health needs. By adopting safe hygiene and distancing measures, most regular health promotion activities could be continued with major COVID-19 health promotion activities in Bangladesh, Cameroon, Central African Republic, Iraq, Lebanon, and Mali, among other countries.

The pandemic, however, also presented an opportunity to accelerate the use of mobile communication technologies and social media to reach and interact with a wider digital audience. Building on the experience of successful digital health promotion campaigns in South Africa and Zimbabwe in 2018 and 2019, MSF increased digital campaigns with COVID-19 health and hygiene messaging using popular social networks and messaging apps in several countries. In Mosul, **Iraq**, for example, a rapid qualitative assessment conducted in April had highlighted gaps in COVID-19 awareness, as well as common



myths and misconceptions, and provided evidence that promoting prevention measures would have a positive impact in the city. From late July to the end of August, MSF launched a digital campaign focusing on infection prevention and the de-stigmatisation of COVID-19 patients on two popular social networks, reaching close to one million people, amid lockdown and curfew measures. By monitoring and facilitating comments and discussions on these channels, the digital health promotion team gained a better understanding of patients' needs, and was able to directly counter misinformation, such as sharing a facemask among several people, or ineffective self-medication with antibiotics.

In northeast **Syria**, nearly half a million people in Hassakeh province were cut off from water during frequent disconnections and disruptions to Al-Halouk water station for weeks at a time. A reliable source of safe water is essential, and even more so in a pandemic, and threatened to have catastrophic consequences in the face of increasing COVID-19 cases in the region. With no access to Al-Halouk, MSF supported the local authorities with a water station in the north of Hassakeh city, able to cover 30 percent of the region's water needs at full capacity.

In **Greece**, MSF's COVID-19 response was expelled from the Moria reception centre for migrants and refugees on the island of Lesbos. At the end of July, authorities forced MSF to close the COVID-19 isolation centre near Moria over urban planning regulations, leaving more than 15,000 people living in overcrowded and unhygienic conditions without treatment and isolation capacity. Receiving and treating patients with suspect COVID-19 since early May, the MSF-run isolation centre had been a major pillar of the emergency preparedness plan set out by the Minister of Migration, and was the only place on Lesbos that provided isolation and care for people displaying COVID-19 symptoms.

In **Libya**, the COVID-19 pandemic, together with the escalating armed conflict, led to movement restrictions and further hindered access to the 1,500 refugees, asylum seekers and migrants held in overcrowded detention centres. For them, and the hundreds of thousands of refugees and migrants living in informal urban settlements without access to care, taking to the dangerous Mediterranean Sea remained as the only way out of Libya, as borders closed, and all evacuation and resettlement activities were suspended.

A shortage of personnel, medical supplies, and protective equipment



The global shortage of medical and personal protective equipment needed to respond to COVID-19 posed challenges in countries around the globe, but had particularly dramatic effects in low-resource and conflict settings. Some health systems faced near complete stock-outs of surgical masks and protective gowns, and were missing essential medical equipment, such as oxygen concentrators and accessories for respiratory support. In several countries with major MSF operations, the lack of protective gear fuelled healthcare workers' fears of contracting the disease and contributed to shortages of qualified medical personnel. MSF allocated the existing medical and protective equipment available in its warehouses to the projects that needed them the most. Amid a disrupted global transportation network, allocating and transporting the supplies was a complex and extremely difficult logistical challenge.

Virtually all medical supplies and protective equipment for MSF's projects in **Yemen** had to be flown into the country using dedicated charter flights, or through purchasing transportation capacity on the few cargo planes able to land. A full cargo plane carrying 32 metric tonnes of medical and protective equipment reached Aden from MSF's Logistics hub in Dubai in May, followed by another two flights carrying 45 metric tonnes in June. Personal protective equipment, such as surgical masks and gowns, oxygen concentrators and other supplies for respiratory support made up the biggest proportion of delivered cargo, supplying MSF's COVID-19 treatment and

intensive care units in Sana'a and Aden. Additional smaller shipments were sent to Yemen using humanitarian cargo flights or private transportation companies, but often took a long time to be negotiated, cleared for transport, and released from customs. Close to six million medical items were packed in MSF supply centres and shipped to Yemen from June to August; more than 2.3 million of which were used for in dedicated COVID-19 interventions.

Delivery of international medical supplies to northern **Syria** presented major challenges prior to the pandemic and was further complicated by COVID-19. Beginning in May, deliveries were complicated even further due to new customs regulations and export blockades, including embargos on exporting personal protective equipment and essential medical supplies. Supply routes from Iraq remained largely blocked for humanitarian goods, while channelling protective equipment through Jordan was only possible for items originating from Asia, of which not all passed medical quality standards. Consequently, there were constant shortages of specialised protective gear, often presenting MSF with serious ethical dilemmas. Could medical and personal protective equipment of possibly substandard quality be donated without putting health workers at risk? Would urgently needed health facilities need to be closed, further limiting the scarcely available care?

In MSF's extensive projects in the Rohingya refugee camps in the Cox's Bazar district of **Bangladesh**, the

pandemic led to major human resource gaps and staffing challenges. The limited access for humanitarian workers combined with lockdown measures and strict travel restrictions meant only very few international staff could reach or leave Bangladesh. At the same time, more than 30 local health workers who were working in MSF-supported clinics were summoned to Dhaka or other regions to support Bangladesh's national COVID-19 response. Others struggled to reach MSF projects because of local lockdown measures. Several regular MSF projects had to be closed, or activities reduced due to staff shortages. As protocols for the use of personal protective equipment continued to change, and Bangladesh faced countrywide shortages of these items, MSF had to make difficult decisions as to whether available protection was sufficient to maintain quality of care and protect patients and staff in its clinics. Aiming to reduce transmission risks in the densely populated camps, MSF decided to start large-scale distributions of cloth masks even before their protective effect had been fully proven. Refugees fearing

infection or isolation from their families led patients to delay seeking care, especially alarming when several pregnant women with complications presented late at MSF maternity wards.

MSF also managed to send major cargo deliveries of protective and medical equipment to supply projects in Burkina Faso, the Democratic Republic of the Congo, Mali, South Sudan, and Sudan in Africa, to Venezuela in South America, and to Iraq in the Middle East. In some places, such as Lebanon, Mozambique, Tanzania, and Peru, lengthy custom procedures further delayed the delivery of humanitarian supplies. In some places where COVID-19 numbers were lower than expected, such as Burkina Faso and the Central African Republic, excess protective equipment was stored in MSF health facilities to ensure continuity of care and strengthen preparedness, reallocated to other MSF projects in the region, or donated to partners and other health structures.

Responding to COVID-19 in the right place, at the right time

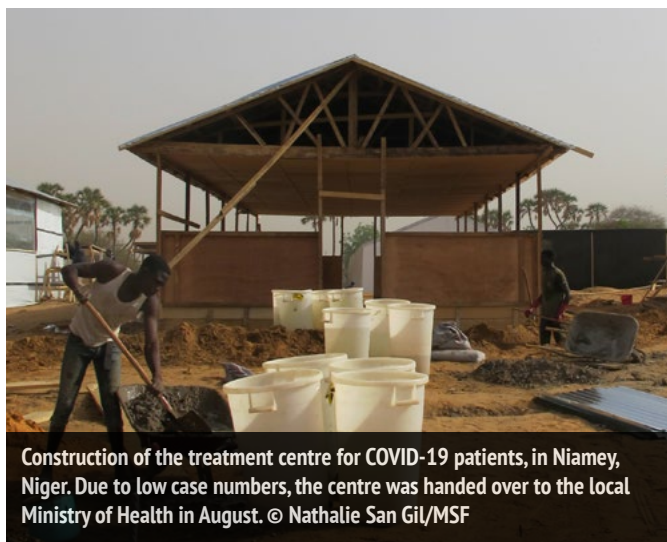
From the early days of the pandemic, MSF's global COVID-19 response focused on protecting healthcare workers, preserving lifesaving and essential medical services, and reaching vulnerable populations with tailored and timely COVID-19 interventions. This last objective, however, often proved challenging. A new virus with little understood transmission paths, COVID-19 repeatedly caused unexpected regional spikes and sudden surges and decreases in patients requiring specialised care. Choosing where to intervene next and when to scale isolation and treatment capacity therefore always involved a great deal of uncertainty.

In **Brazil**, the rapid tests used by many health agencies impeded the work of epidemiologists trying to follow the course of the outbreak. As these tests detect antibodies to the coronavirus, which take 14 days on average to appear in infected humans, they provided an outdated picture of infections and transmission rates. The sheer size of the country, with major urban centres and remote, hard-to-reach areas, further impeded the identification of

major outbreaks in time for MSF to prepare an adequate medical response. When MSF arrived in Manaus and finally received permission from health authorities to take over the intensive care unit and patient ward at the 28 de Agosto hospital in May, the initial peak of cases had already passed, and the virus had spread to other communities along the Amazonas River. More than 80 patients were admitted and treated at the ward in May and June, and infection control measures and trainings were expanded at the hospital. MSF's response, however, would have been more effective if launched sooner.

MSF's initial COVID-19 response in **Ecuador** faced similar delays and timing issues linked to weak epidemiological surveillance and limited testing capacity. While the health system in the city of Guayaquil was already overwhelmed by mid-March, MSF did not receive a request from health authorities to plan an intervention until early April. With no permanent project in Ecuador and few staff available locally, it took MSF until mid-May to launch activities to reduce transmission in health facilities, communal centres, and vulnerable communities. In early July, assessments for a second project in the hard-hit province of Esmeraldas were deprioritised in favour of an intervention in the capital, Quito, where cases were only beginning to rise. There, MSF's training, material, and psychosocial support at the temporary treatment centre promised to have a much bigger impact for patients, families, and health workers.

Lower than expected case numbers in several African countries presented MSF teams with a different challenge. In Burkina Faso and Niger, two West African countries affected by several humanitarian emergencies, the impact of escalating conflict, food insecurity and COVID-19 threatened to be catastrophic. The first cases and local transmission were reported in March in **Burkina Faso** in the capital, Ouagadougou, with local health facilities lacking the necessary material, training, and qualified staff



Construction of the treatment centre for COVID-19 patients, in Niamey, Niger. Due to low case numbers, the centre was handed over to the local Ministry of Health in August. © Nathalie San Gil/MSF



A nurse screening a patient at a shelter in Manaus, Brazil, where MSF's response delivered urgently needed support to the health system. © MSF

to respond to a bigger outbreak. Thus, MSF decided to extend an existing structure into a COVID-19 treatment centre next to a Ministry of Health-run facility, supporting screening, treatment, and referral of suspected patients. The necessary supplies and extra staff arrived in April, and the facility was set up and operational by mid-May. Already by late May, however, it became clear that fewer COVID-19 cases than expected required treatment. Over the course of June and July, only 34 patients were admitted to the centre, and MSF was able to extend its material and training support to additional health centres in the area. At the end of July, the treatment centre was fully handed over to the Ministry of Health.

Similarly, construction of MSF's COVID-19 treatment centre in Niamey, **Niger** started in mid-April amid worrying case numbers being reported in an area with only limited treatment capacity. The centre opened its doors at the beginning of June. While up to 600 patients could have been admitted and treated with oxygen therapy at the 50-bed facility, only 31 patients required care over the course of June and July, and the centre was handed over to the neighbouring hospital at the end of August.

MSF's COVID-19 treatment centre in Bihar State in **India** had been setup in collaboration with health authorities in June to provide urgently needed treatment capacity for patients with mild and moderate symptoms and support the overwhelmed Patna district government hospitals. Shortly after opening the 100-bed facility, the state health department however started to discharge asymptomatic and mild cases to home isolation, and MSF had no option to admit patients with light symptoms directly. This led to much fewer patients being admitted than the facility and medical team could have handled. By September, the referral mechanism had improved, yet patient numbers were already decreasing and the local health facilities were able to admit patients to their facilities again.

The delays in reaching vulnerable populations and effectively responding to increasing case numbers in South America, as well as the lower-than-expected number of patients in West Africa or in India, are just two examples of how MSF's operational decisions were affected by the little understood transmission patterns of the virus, and the need for operational flexibility and adaptability.

Providing the best care and latest treatment with limited resources



In Caracas, Venezuela, MSF faced regular resource restraints and logistical challenges. © MSF

Although MSF has a long history of managing health emergencies and infectious disease outbreaks, responding to the rapid, global spread of a novel virus that causes severe respiratory illness came with unprecedented challenges in providing safe, quality care. New and often conflicting evidence on COVID-19 transmission and treatment options were published at a staggering rate and required careful review by MSF medical staff and technical referents before they could be implemented at MSF health facilities.

The little understood transmission patterns of the virus led to prolonged uncertainty on minimum safety standards for surgical masks and protective gowns for health workers, for example, and contributed to global shortages of these items. Different infection prevention and control protocols circulated at MSF projects over several months, prioritising specific cleaning solutions over more readily available alcohol and chlorine in some healthcare facilities. The global rush to trial hydroxychloroquine as a promising prophylaxis and treatment for COVID-19 led to its limited adoption in some MSF activities, yet had to be ended a few months later as several large studies showed it was not effective. For clinical case management, new scientific evidence and increasing practical experience brought significant improvements, such as awake prone positioning of patients, early use of corticosteroids, and a preference for non-invasive breathing support in low-resource settings.

Keeping track of the fast-evolving body of new evidence was especially difficult for projects providing critical care in humanitarian crisis settings, with the latest medical guidelines and treatment protocols often requiring specialised medical equipment and extensive training. Setting up three MSF-run COVID-19 treatment centres and providing intensive care in Sanaa and Aden in **Yemen** posed major challenges from the onset. In all three centres, critical medications, supplies for respiratory support, and oxygen were missing or in short supply. Further, not all health facilities had enough qualified doctors, nurses, physiotherapists, pharmacists, and social workers available. No centralised oxygen supply was available, so teams developed a solution with a two cylinder-setup to avoid patients being deprived of oxygen while a cylinder was changed. With very few intensive care beds available, many critically ill patients remained in regular wards and received oxygen therapy without ventilation. Combined with awake prone positioning, this double oxygen set-up successfully treated several patients. In the intensive care units, critical care concepts that typically require years of training, such as non-invasive and invasive ventilation management, invasive ventilation using intubation, and intubated prone positioning were successfully taught and implemented.

The MSF-team running the COVID-19 intensive care unit at the Ana Francisca Pérez de León II hospital in northeast Caracas, **Venezuela** faced resource restraints and logistical challenges. MSF started to support the



An MSF team prepares to move a patient requiring critical care to a new intensive care unit at the COVID-19 treatment centre in Aden. Jacob Burns/MSF

hospital to provide critical care because there were not enough referral facilities for patients with severe symptoms, and MSF had no other primary healthcare projects in the city. As international staff had no access to the country, an adaptive project set-up with remote programme support for field staff was implemented. Working at this specialised level of care, however, meant that MSF was not present in communities and local health centres to improve early care, identify patients in need of additional treatment, and adequately plan for intensive care capacities. At the same time, the intensive care unit lacked qualified staff and equipment. While the hospital managed to treat or refer more than 90 percent of patients, the mortality rate in the intensive care unit was high. End-of-life care remained largely unavailable, with nationwide shortages of essential medicines, as a result of the recent political and humanitarian crisis. National clinical protocols changed almost monthly in Venezuela and included off-label uses of repurposed medications whose therapeutic value for treating COVID-19 was disputed.

At the eight-bed intensive care station in the Tide Setúbal Municipal hospital in São Paulo, **Brazil**, MSF led a series of multi-disciplinary trainings to improve staff capacity and integrate the latest findings into daily patient management. This included immediate assessment of critically ill patients, improved fluid balance control to reduce the number of patients that developed renal failure, changes to nutrition protocols, and a reorganisation of staffing rounds, including nursing, rehabilitation, and technical staff. By introducing checklists for staff briefings, patient safety and intensive care, as well as facilitating interdisciplinary exchange in the ward and faster referrals of critically ill patients to the intensive care unit, the team was able to substantially improve treatment outcomes.

Continuing essential health care in the pandemic



An MSF nurse preparing a transfusion at the newborn unit of MSF's hospital in Peshawar, which suspended its activities for six weeks after a team member tested positive for COVID-19 in April. © MSF/Nasir Ghafoor

Maintaining urgently needed primary or specialised healthcare and keeping MSF facilities open wherever possible were key objectives for MSF's COVID-19 response from the beginning. In many countries, COVID-19 not only threatened to overburden fragile health systems, but to disrupt essential health services¹ and crucial medical activities, such as treatment for HIV and tuberculosis, measles vaccination campaigns, malaria prevention, and efforts against outbreaks of cholera and Ebola.

Rapidly adopting new infection prevention and control protocols allowed most MSF projects to continue key services, but maintaining existing operations often came at a price. MSF had to make tough choices about which existing medical services could be scaled up to add dedicated COVID-19 treatment facilities, and which activities had to be suspended to reduce transmission risks and protect staff. Planned projects that had not yet started activities were mostly put on hold, including plans for major constructions of new hospitals in Afghanistan, Sierra Leone and Yemen. In some contexts, expanding community-centred activities and home-based care proved a viable alternative, and could be supported with telemedicine, phone counselling or digital health promotion, using social media. Despite these efforts, in many countries MSF had to reduce activities – often at a cost to patients needing medical assistance and support.

At the MSF-supported District Headquarter Hospital in Timergara, **Pakistan**, more than 200 health workers had to either isolate or quarantine between April and June

because of suspected or confirmed COVID-19 cases. The remaining staff kept services running by managing double-shifts and with support from additional health workers. MSF's women's hospital in Peshawar, however, had to suspend its activities for six-weeks after a team member tested positive in April. A small unit for emergency deliveries kept running, but existing and new patients were referred to a public hospital, until the patient flow at the hospital could be reorganised. In Karachi, south Pakistan, the team at MSF's hepatitis C clinic reduced its direct patient contact to two-days a week to lessen the risk of transmission and provided most patients with medication to last up to three months. In March and April, MSF had to completely suspend its treatment centres for cutaneous leishmaniasis, a skin infection transmitted by sand flies, in Peshawar, Bannu and Quetta, but was able relaunch activities in July and August.

In **South Africa**, where around 7.7 million people live with HIV and an estimated 301,000 people have active tuberculosis, continuing care and improving protection for people living with chronic illness and compromised immune systems were a priority. In Eshowe in KwaZulu-Natal province, MSF dispensed medication for stable patients with chronic conditions at easy-to-reach pick-up points, relying on a network of 12 healthcare hubs. In August, four additional hubs and 21 pick-up points were set up in schools, churches, and shelters. To reduce COVID-19 related fear and stigma at health facilities, MSF assisted the Department of Health to establish helpdesks and triage points outside clinics, which included health

¹ In key informant survey among 105 countries, the World Health Organization in August reported nearly all countries reported disruptions of essential health services. Cf. https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2020.1



Community members at a newly opened medication pick-up point for HIV and TB services in rural KwaZulu-Natal, South Africa. © Chris Allan

workers trained to identify the subtle differences in symptoms of COVID-19 and tuberculosis patients. In neighbouring **Eswatini**, where high HIV and tuberculosis prevalence led to similar concerns for high-risk patients, MSF expanded its community-based model of care that was started several years ago. To protect patients with multidrug-resistant tuberculosis, the MSF team introduced video observed therapy, allowing patients to record themselves using a smartphone when taking their medication, rather than being directly observed by a health worker or a community member. The video is sent to a healthcare worker who ensures the correct medication was taken and addresses patients' questions either by phone or by a home visit. In combination with the novel video observation technology, a small mobile clinic provided medical check-ups and delivered food and medicines to tuberculosis patients' homes, while HIV patients received six-month refills of antiretroviral treatment and phone consultations.

In several African countries, including the **Democratic Republic of the Congo**, MSF teams were able to continue measles vaccination campaigns with approval from health authorities, taking extra precautions to reduce transmission risks. In May and June, MSF teams set up vaccination sites taking necessary precautions, including longer, single file waiting lines, and instructing families to keep a safe distance from each other. These precautions were taken even though there had been no COVID-19 cases recorded in the area. Most of the churches, schools and shelters that served as vaccination sites offered ample space to safely separate registration and vaccination, and vaccination teams were equipped with masks and personal protective equipment. Extensive health promotion activities accompanied all of MSF's measles vaccination campaigns during the pandemic, to address rumours and fears of COVID-19 transmission risks in communities. Measles prevention and treatment remained a priority for MSF in several countries.

In the area of Batangafo in neighbouring **Central African Republic**, MSF distributed preventative medicines for malaria – the number one cause of death of children in the country. In August, at the beginning of the rainy season, an awareness campaign with the help of community leaders and local radio announcements was launched. The campaign was followed with door-to-door distributions of the medicines with delivery teams following strict protective measures. Although this required additional time and resources, this approach avoided the risk of large gatherings at distribution sites, limiting the risk of COVID-19 transmission. Similar campaigns to prevent Malaria were organised in other African countries.

Additional pressure on fragile health systems

Despite these efforts to ensure continuity of care, COVID-19 exacerbated existing public health problems and complicated delivery of humanitarian assistance in many low and middle-income countries where MSF operates. Fragile health systems threatened to collapse under the pressure of a major outbreak with large numbers of patients requiring specialised care. In some countries, high infection rates among healthcare staff caused entire hospitals to close, leaving large, often vulnerable populations without access to care. Lockdown measures further complicated access to care, while fears of contracting COVID-19 at health facilities led people to delay seeking care, often with devastating health consequences.

Nearly a decade of conflict in **Syria** has devastated the health system and the humanitarian needs remain enormous. More than six million people are estimated to be internally displaced, many living in camps and makeshift shelters with limited or no access to health care and other essential services. MSF works in northeast and northwest Syria, where the extent of the COVID-19 pandemic is largely unknown, with limited testing capacity and health services, and lack of access to many

areas. Even isolated reports of cases repeatedly forced remaining health services to close, due to insufficient personal protective equipment.

In northeast Syria, around 700,000 people are displaced, most of them almost entirely dependent on humanitarian assistance. A spike in infection rates among health workers and related quarantine measures for them and their contacts further impacted on the fragile health system. In August, health authorities were forced to introduce new regulations prohibiting health staff from working in more than one clinic. Several health facilities, already working at reduced capacity, had to close completely, and some health workers reported being too scared to go to work. In Al-Hol camp, where more than 65,000 people live, the majority of them women and children, 9 out of 24 primary healthcare clinics had to close between May and July. In one week in August seven children under five-years-old died in the camp, as their mothers desperately searched for an open clinic. By late August, just five facilities remained operational, including an MSF clinic that had reopened in late July, and saw more than 1,000 patients in one month.



At Al-Hol Camp in northeast Syria, a majority of clinics had to close between May and July. © Ricardo García Vilanova

For the four million people living in northwest Syria, only nine dedicated COVID-19 hospitals and 36 small isolation and treatment centres were available as of early November. In northwest Syria, MSF had to reduce its mobile clinics in several camps because of increased infection and transmission risks and lack of protective equipment.

In **Yemen**, widespread fear of contracting COVID-19 in a health facility or of being stigmatised in case of a positive test result deterred people from seeking medical care. This resulted in COVID-19 patients with severe symptoms arriving late to MSF's treatment centres in Aden and Sana'a, but also impeded other healthcare services. In an MSF-supported hospital in Abs, for example, admissions at the paediatric ward dropped by a staggering 40 percent between May and August compared to the same period last year, while the inpatient therapeutic feeding centre for severely malnourished children had a sharp increase in admissions starting in late August. Similar increases were reported from MSF's inpatient therapeutic feeding centres in Diffa, Niger, and Douentza, Mali.

At MSF's large maternity hospital in Khost, **Afghanistan**, where 60 to 70 daily deliveries occurred before the pandemic, daily admissions decreased to 30 to 40 a day in recent months. While an isolation ward was installed early on and included delivery rooms for pregnant women with confirmed or suspected COVID-19, the maternity hospital faced staff shortages because of quarantine measures. Some women, unable to get to the maternity hospital, gave birth at other health centres, including those supported by MSF in the region, yet others were likely forced to deliver at home with no medical assistance. At the same time, far fewer contraceptive consultations could be offered during the pandemic, possibly leading to an increase in unwanted pregnancies.

In **Honduras**, a country with no government protocol for the care of sexual and gender-based violence survivors, health authorities also did not consider sexual and reproductive healthcare as essential care during the pandemic. Beginning in March, all related services, with the exception of MSF's clinic in Choloma, were ordered to close. No longer able to conduct outreach in the community and visit smaller health centres, the team was forced to offer only limited services by phone. Similar

limitations on essential reproductive health services and family planning measures were reported from MSF projects in Colombia, Greece, Iraq, Mozambique, South Africa, and Uganda. In July, MSF called on governments and the global health community to increase access to contraception and safe abortion care during the COVID-19 pandemic.²

COVID-19 also threatened to impede food security, interrupting international and domestic food supply chains and leading to increased food prices. While only few MSF projects observed a direct link between the pandemic and malnutrition, the lower number of patients seeking care was a cause for concern. In the **Central African Republic** from June, for example, an MSF analysis found higher malnutrition rates in some areas of Bangui and Bangassou. At the same time, the project recorded lower admission rates than expected at its therapeutic feeding centres. Similarly, in **Ethiopia**, an atypical decrease in severe-acute-malnutrition was reported, while there was significant crop damage from locusts as well as shortages of essential therapeutic treatments for malnutrition.

Additional negative impacts of COVID-19 on health services are expected in other major areas as essential health, protection, sanitation, and employment programmes were put on hold or drastically reduced from the onset of the pandemic, including hundreds of mass vaccination campaigns, and malaria and nutrition programmes. Addressing and mitigating these negative impacts and restoring essential health services for already vulnerable populations remains a major concern for MSF.



With the lockdown in Honduras, most reproductive health care, including contraception, was declared as non-essential, so the MSF team had to conduct consultations by phone. © Sergio Ortiz/MSF

² Cf. <https://gh.bmj.com/content/5/7/e003175>

6

Adapting to a new normal: Human Resources, Supply, and Finance during the pandemic



Peru © MSF/Kuki Mendonça

Introduction

In the first half of the year, lockdown measures and border closures, shortages of essential supplies, and disrupted transportation routes posed major obstacles to MSF's global COVID-19 emergency response. From June through August, staffing coordinators, procurement and supply specialists, and fundraising teams at MSF continued to face extraordinary challenges: global travel and distribution routes remained largely suspended, some

medical supplies were still difficult to source, and new COVID-19 operations required additional funding. While operating direct COVID-19 interventions and continuing care at its regular projects, MSF adapted to the new normal of running an international medical humanitarian organisation during a long-lasting global pandemic of unprecedented scale.

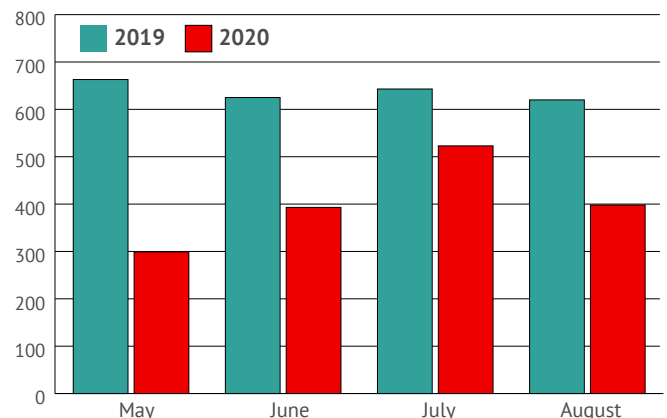
Staff travel and human resources

Through the end of July, MSF staff continued to rely heavily on humanitarian charter flights, such as the United Nation's Humanitarian Air Service (UNHAS) operated by the World Food Programme, to reach projects all over the world or to return home after completing missions. Beginning in early August, additional travel routes and commercial flights gradually became available as more and more countries lifted lockdown measures and reopened their borders.

In mid-August, however, UNHAS substantially reduced the flight services it had been running for the global COVID-19 response. As a result, booking international flights and ensuring smooth travel for MSF medical staff, technical specialists, and support personnel remained challenging even though more commercial flights were available. A majority of flight routes were only operated irregularly or with limited passenger and cargo volumes, and flights were cancelled on a regular basis. Fearing fines and damage to their reputation, airlines issued a multitude of hygiene and safety measures, while different transit airports and destination countries required passengers to produce a recent COVID-19 test result or quarantine for up to two weeks. For all countries in the European Schengen area, as well as for Nigeria and Bangladesh, visas were very difficult or impossible to obtain, further complicating travel.

Overall, international departures of MSF staff to the field increased in June and July, after having plummeted to under half of MSF's average monthly departures in May. A total of 393 MSF staff in June and 523 in July were able to leave on an international mission, the majority using UNHAS flights for at least one leg of their trip. Only 398 departures were recorded in August after several humanitarian flight routes were no longer served. Compared to 2019, departures from June through August were 30 percent lower, while costs and travel time increased due to longer routes, extra layovers, and additional costs for flight cancellations, COVID-19 testing, and accommodation in transit airports. In late July, the International Air Transport Association (IATA) estimated that global passenger traffic will not return to pre-COVID-19 levels until 2024, a year later than previously projected.⁴ At many MSF projects, the difficult travel conditions resulted in staff having to extend their time commitments,

International assignment departures



complicating handovers between staff and affecting rest and recovery periods for returning team members. To mitigate the impact of these disruptions, MSF adapted its staffing models and human resource policies. Respecting MSF's duty of care and staff wellbeing principles as much as possible, some international staff agreed to work beyond their expected return date or assumed different roles within the same region. In several countries, an increasing number of national staff filled positions usually held by international colleagues. Lessons learned from these adaptations also informed continuing discussions on how MSF's staffing and hiring policies need to evolve and operational centres are exploring how to support more local and regional recruitment, while facilitating an international and diverse workforce.

MSF offices continued to support staff in working from home, providing them with additional office equipment and continually improving teleconferencing services. In a survey conducted at 25 MSF offices in Africa, the Middle East, the Americas, and Europe in late September, more than half reported to have adapted office policies to allow for more remote work and over 80% indicated that they expect the number of staff working remotely to remain above pre-pandemic levels in the coming years. Taking care of staff's physical and mental health remained a key priority for MSF during the pandemic. Working in challenging humanitarian crisis settings, facing uncertainty about personal health risks, as well as being forced into inaction due to confinement measures

⁴ <https://www.iata.org/en/pressroom/pr/2020-07-28-02/>



Morning team meeting at the MSF-run Nablus hospital, in Mosul, Iraq. © Manhal Alkallak/MSF

led to strong, sometimes painful, moral experiences amongst some staff. MSF offices applied in-country the instructions received from the local health authorities to help protect employees, and, where necessary, put in place extra protective measures for employees and people MSF works with in its operations. Offices also offered support for employees working from home to reduce isolation

and help maintain a healthy work-life balance, including resources to manage stress and anxiety, support from staff health units, and regular check-in calls. Several MSF offices have also conducted surveys exploring how staff are coping with working from home.

Supply and logistics

Major supply shortages had dominated the first months of the pandemic as the rapid spread of COVID-19 simultaneously created an unprecedented demand for protective equipment and medical supplies, and quickly disrupted global production, supply chains and distribution systems. In many countries, strong market competition, as well as protectionist measures such as exportation bans, had healthcare providers struggling to secure a reliable supply of surgical and respirator masks, goggles, and gowns. In June, MSF publicly called for increased regulation to ensure that personal protective equipment is distributed in an equitable and transparent manner during the COVID-19 pandemic.

In addition to relying on local purchasing options, MSF's international supply centres created a joint procurement taskforce in late March, aiming to source sufficient quantities of protective equipment, as well as other essential medical supplies and medication. Over the following months, the taskforce assessed close to 600 potential suppliers for compliance with MSF quality and safety standards and identified 16 new suppliers for urgently needed surgical and respirator masks and gowns.

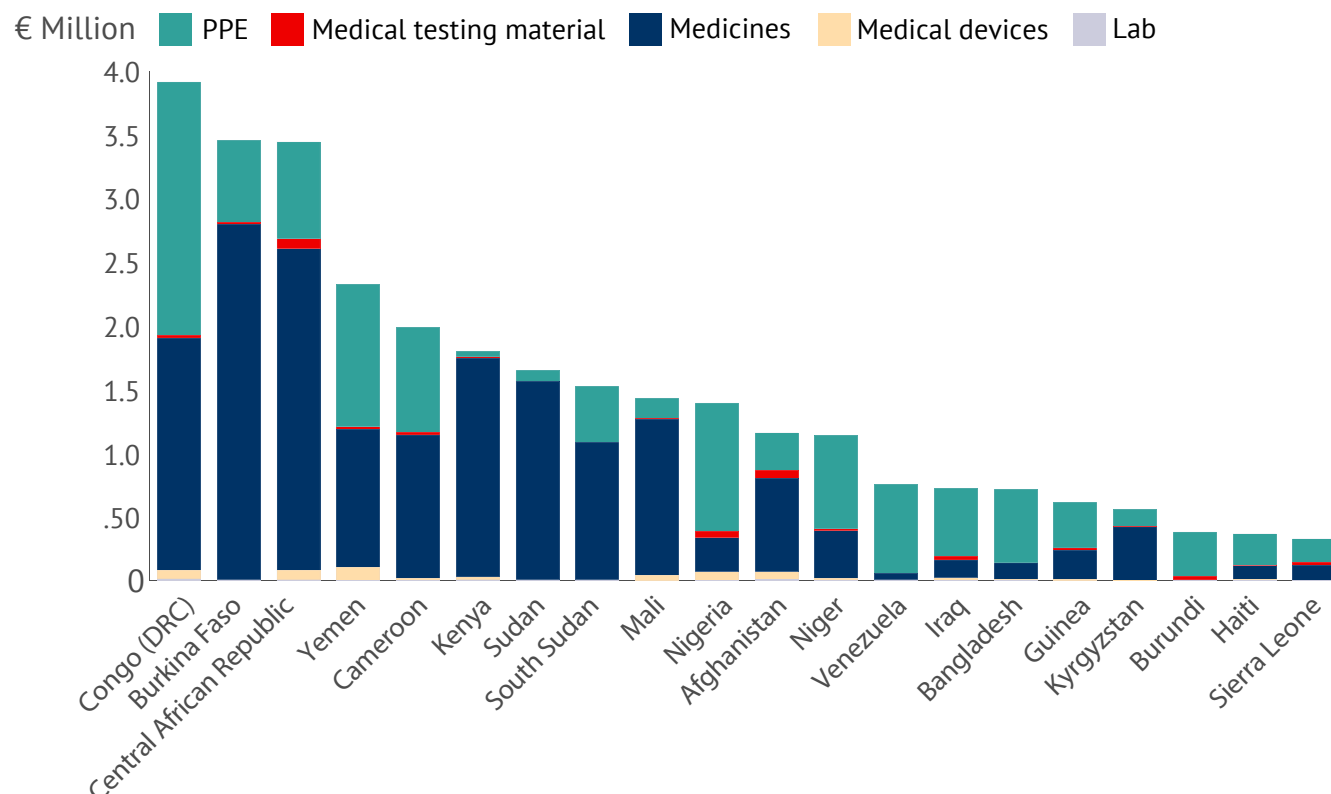
The first deliveries of newly sourced personal protective equipment arrived in May, some of which was stored at two regional hubs in Dubai and Nairobi to increase



A medical team at the MSF-supported COVID-19 treatment centre in Ibb governorate, Yemen, where MSF provided protective masks, gowns, gloves and other items. © MSF/Majd Aljunaid

operational agility and mitigate the risk of limited regional access. By June, the new suppliers were able to assure a steady flow of bigger deliveries to MSF's warehouses at its logistics and supply centres in Amsterdam, Bordeaux and Brussels. Thanks to a major donor offering their own supplier to produce protective gowns to MSF specifications, sufficient quantities could be purchased in July. The availability of surgical and respirator masks improved substantially over the summer months, yet by August, the market remained tense with

Items packed for MSF's COVID-19 response from June to August, quantities for top 20 receiving countries.



some bigger deliveries still pending final confirmation. Limited transportation capacity on international flights, insufficient access to several humanitarian crisis settings, as well as extra import restrictions due to the pandemic delayed deliveries to several countries. In Yemen, for example, securing the authorities' approval could take several weeks, with cargo awaiting departure at the airport.

From June to August, MSF supply centres packed close to 30 million items for the global COVID-19 response, including personal protective equipment, medical devices, medication, testing material, and specialised laboratory equipment. Items earmarked for COVID-19 preparedness and direct response activities made up about 44 percent of packed supplies for MSF operations globally.

More than two thirds of these items were shipped to MSF operations in humanitarian crisis settings with limited local procurement opportunities, including the Democratic Republic of the Congo, Central Africa Republic, Yemen, South Sudan, Bangladesh, and Venezuela, or to countries where MSF directly supported major COVID-19 treatment centres, such as Burkina Faso, Cameroon, and Sudan. Not all shipped COVID-19 materials were directly distributed or used. In several African countries, MSF built and stocked dedicated COVID-19 treatment centres as part of emergency preparedness measures, yet few patients required care due to lower than expected case numbers in these countries. More than 37 million other items were dispatched from MSF supply centres from June to August, supplying essential non-COVID-19 medical activities for MSF's projects worldwide.



Personal protective equipment, including masks, gloves and high-quality body protection, is being stocked at the COVID-19 treatment centre in Patna, Bihar state, India. © Garvit Nangia/MSF

Key lessons learned from overcoming global supply shortages and the logistical challenges of the COVID-19 pandemic have informed strategic discussions on how to improve early warning and risk management mechanisms, and possibly on expanding regional logistics hubs to increase supply chain agility in the long run.

Finance



In late March, MSF created a dedicated COVID-19 Crisis Fund to raise funds to pay for the substantial additional cost of both its new COVID-19 interventions and the impact of the pandemic on its ongoing projects in humanitarian settings. In April, the fund's original goal was raised from 100 million to 150 million euro as it became clear that the extraordinary operational, logistical, and resource challenges caused by the pandemic would extend beyond the year 2020.

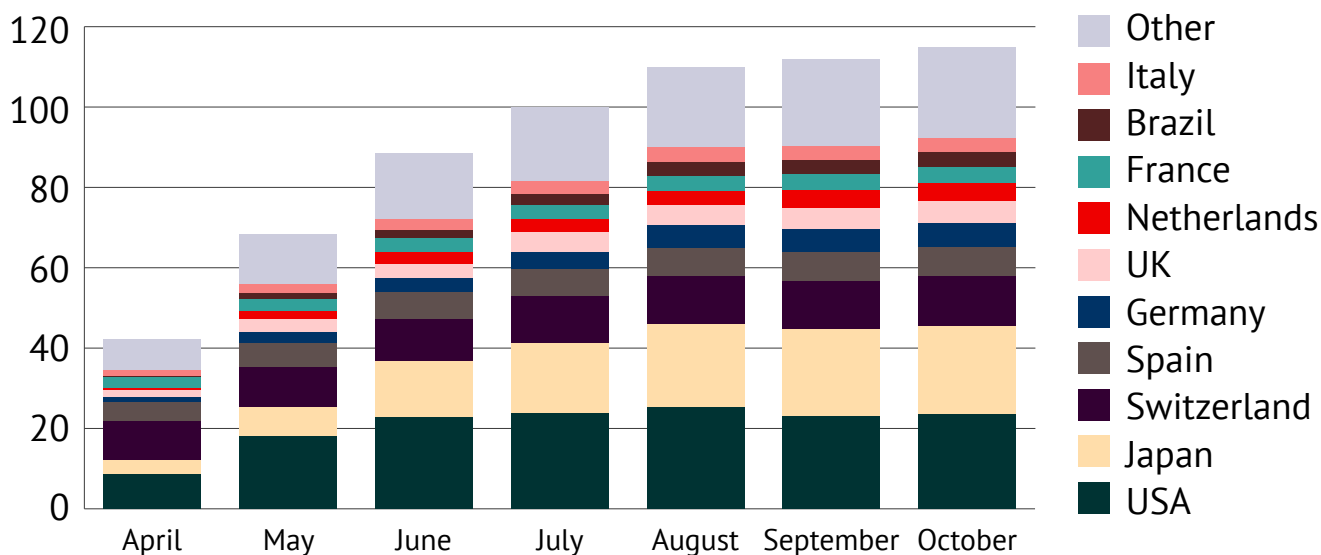
By the end of August, fundraising teams from 35 MSF offices had raised just under 110 million Euros, with the

largest contributions from private donors in the US, Japan, Switzerland, Spain, Germany and the United Kingdom. By early November, the Crisis Fund had raised over 114 million euro, reaching three-quarters of the estimated funds needed to cover the direct and indirect costs of MSF's COVID-19 response. Donations to the fund have slowed considerably since its launch in April, with fewer funds raised over the summer and autumn months.

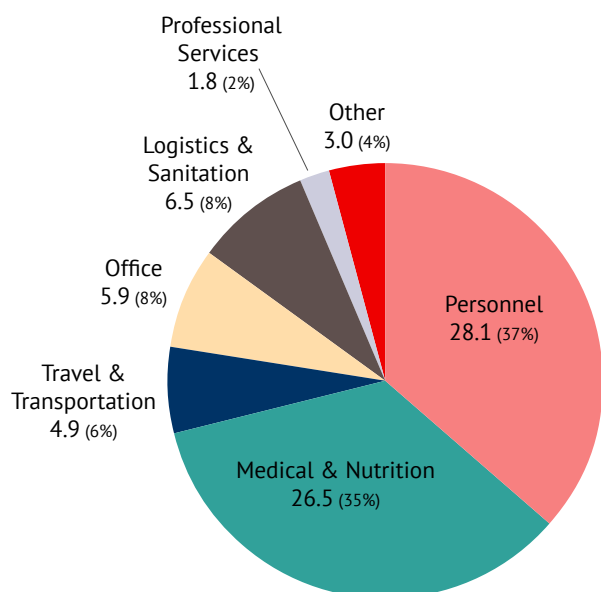
For the period from January to the end of August, the COVID-19 crisis fund allocated an estimated 76.7 million for actual expenses. Human resources and medical

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

€ Million



Estimated actual expenses by family in million euro, Jan-Aug 2020

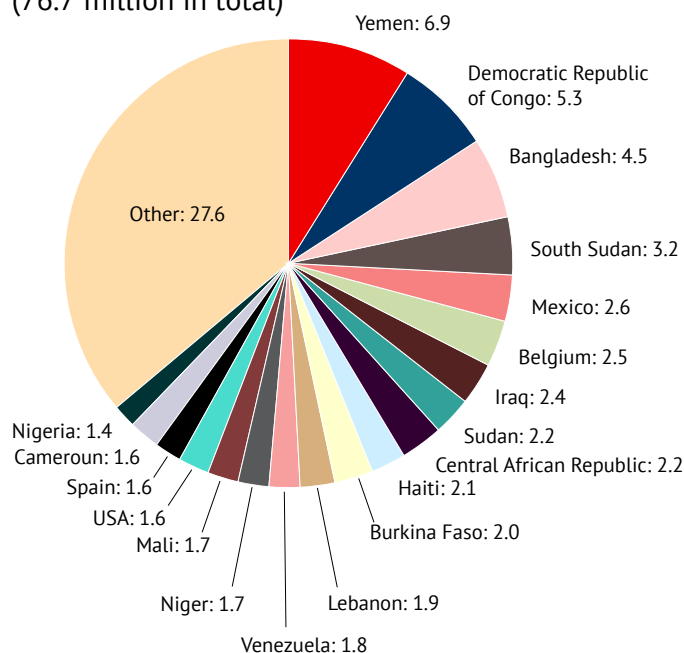


activities in MSF projects together accounted for more than 70% of estimated actual expenses,⁵ followed by logistics and sanitation (8%), office costs (8%), and travel and accommodation (6%).

A major share of expenses funded by the Crisis Fund was incurred in MSF projects in humanitarian settings and conflict zones, where resources to run and maintain COVID-19 treatment facilities, emergency medical services, and essential health care are scarce. MSF's largest and most cost-intensive operations in Yemen

⁵ Audited financial information was not yet available at the time of this report's publication. Actual cost figures are based on estimated expenditure and are still subject to corrections.

Actual expenses in million euro by country of intervention from Jan-Aug (76.7 million in total)



(9.1%), the Democratic Republic of the Congo (6.9%), Bangladesh (5.9%), and South Sudan (4.2%) accounted for more than a quarter of eligible expenses at the end of August. Countries with larger COVID-19 operations over the summer months, such as Mexico (3.4%), Iraq (3.1%), and Sudan (2.9%), or during spring such as Belgium (3.2%), the United States (2.1%) and Spain (2.1%) accounted for another sizable share of expenses. Through the end of the year, eligible expenses are projected to total 111.3 million euro, with the remaining 38.7 million forecasted for expenditure in 2021.

7

Outlook: Equitable access to COVID-19 diagnostics, treatments and vaccines



South Africa © Chris Allan



A hygiene worker at the recently opened COVID-19 treatment centre at the Zaatari camp for Syrian refugees in Jordan. © MSF/Mohammed Sanabani

As of late November, more than 55 million people globally have been confirmed to have contracted COVID-19, and over 1.3 million people reportedly have died. Despite only playing a small part in the massive global response, the pandemic remains a major challenge for both regular MSF projects, as well as its dedicated COVID-19 interventions.

In countries where the pandemic continues to put health systems under major strain, such as Brazil and Iraq, MSF continues to operate dedicated COVID-19 treatment and isolation facilities and supports medical facilities and healthcare workers. In light of new waves of infections and high patient numbers, new activities are underway, including in Belgium, Czech Republic, France, Indonesia, Italy, Jordan, Kyrgyzstan, South Africa, Switzerland and Ukraine. Some facilities built earlier in the year, such as the COVID-19 treatment centre at the Zaatari camp for Syrian refugees in Jordan, have only been activated recently in response to increasing numbers of patients in need of care. In many of the crisis and conflict settings where MSF operates, such as in Syria, Yemen, and Bangladesh, the negative impact of the pandemic casts a long shadow ahead, with countless health facilities still closed and routine medical services on hold.

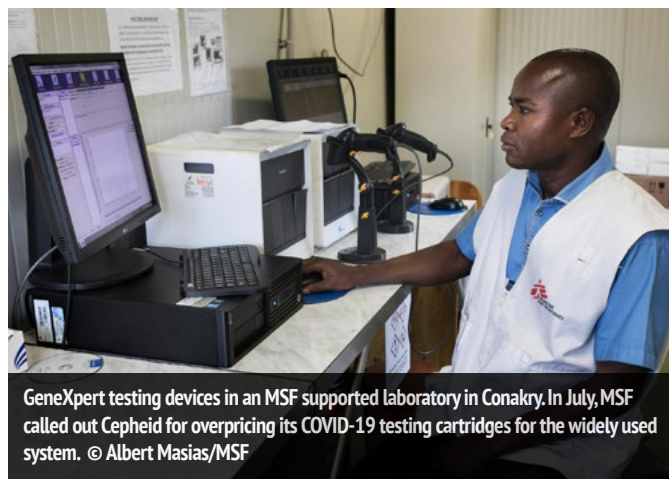
For the foreseeable future, MSF's work in the pandemic will follow the same key objectives that have guided its response from the beginning. The safety and protection of healthcare workers and medical staff remains a priority. Wherever possible, MSF is looking to preserve or rebuild lifesaving activities and other essential care and keep the doors of its projects and hospitals open for patients in need of assistance. MSF will also continue to care for the vulnerable people who are at risk of being left behind. Globally, more than 70 million refugees, asylum seekers, internally displaced people, as well as migrant workers and undocumented migrants have limited access to

care, and are especially affected by lockdown measures, curfews, and closed borders. Following its support to retirement homes and long-term care facilities in Europe and the Americas, MSF will closely monitor the evolving situation in these facilities and is ready to intervene should conditions deteriorate again.

After several manufacturers recently announced promising interim results of their phase-3 trials, COVID-19 vaccines now appear within reach. Major hurdles remain, however, to ensure equitable access to COVID-19 vaccines, treatments, and diagnostics.

From as early as March, MSF has called for no patents or profiteering on drugs, tests, or vaccines used in the COVID-19 pandemic, and for governments to suspend and override patents and other intellectual property to ensure availability, reduce prices, and save more lives. In April, the launch of the Access to COVID-19 Tools (ACT) Accelerator, a global collaboration bringing together major philanthropists and global health organisations including the World Health Organization (WHO) and Gavi, the Vaccine Alliance, was an important first step in the right direction. Yet MSF remains concerned that in the absence of binding and enforceable measures under the ACT Accelerator, the traditional pharmaceutical industry's business approach, along with nationalistic priority setting by governments, will continue to pose barriers to global equitable distribution of medical tools to prevent and treat COVID-19.

A case in point is the pricing for COVID-19 test cartridges used in GeneXpert devices, a widely used technology for testing for tuberculosis, HIV and other diseases, with an estimated 11,000 machines in use in low- and middle-income countries. In July, a series of independent cost-of-goods analyses commissioned by MSF's Access Campaign



revealed diagnostics company Cepheid is charging four times more than it should for its COVID-19 tests. Currently priced at nearly US\$20 per test, the cartridges could be sold for a profit at just US\$5. This has been disputed by Cepheid, and the Access Campaign continues discussions with the company.

Given the urgent global need for rapid, point-of-care diagnostic tests to help stem the spread of COVID-19, MSF called on Cepheid to refrain from profiteering from the pandemic and demanded for fair allocation and affordable supply of this test.

Similar pricing and access issues have been identified for the increasing number of existing medicines and therapeutics being trialled as possible treatments for COVID-19. Close to 150 therapeutics, including direct-acting antivirals and host-targeting compounds, were or remain under clinical investigation, a majority of them already approved therapies, potentially repurposed for COVID-19. Dexamethasone, a corticosteroid free of patents and produced by multiple generic producers around the world, was one of the first substances shown to reduce deaths in COVID-19 patients on mechanical ventilators and remains widely available at low cost.

For the antiviral drug remdesivir, on the other hand, the United States bought up virtually all global stocks in June after a trial had found it to reduce recovery time in some COVID-19 patients. Manufacturer Gilead priced remdesivir as high as US\$3,120 in the United States and other high-income markets, while striking several secret deals with generics manufacturers in India, Pakistan, and Egypt in May and June. These licenses, however, exclude nearly half of the world's population, including most South American countries and a number of middle-income countries with possible manufacturing capacity, such as Brazil, Russia, or China. Considering that remdesivir was developed with considerable public funding for both early-stage research and clinical trials, the drug should not remain under one company's exclusive control, and patents should be overridden to make it affordable to everyone who would benefit. In late November, the World Health Organization announced that it does not recommend using remdesivir to treat COVID-19 patients, as new evidence from the WHO Solidarity Trial did not show a positive clinical impact. The European Medicines

Agency (EMA) announced that it is evaluating the newly available data. For all therapeutics that prove effective in treating COVID-19, MSF nevertheless continues to call on governments, industry, and multilateral organisations to adopt mandatory measures that ensure full transparency of funding, licensing, cost of research and development, preclinical and clinical trial data, patent status and marketing approval information.

In early June, Gavi, the Vaccine Alliance, unveiled the COVID-19 Vaccine Global Access (COVAX) Facility, a global funding initiative that aims to raise billions to pay for increased production capacity for future COVID-19 vaccines and to secure a negotiated price and vaccine volumes for participating countries. The first agreement reached through the COVAX Facility was a US\$750 million deal with pharmaceutical company AstraZeneca on manufacturing, procurement and distribution of 300 million doses of a vaccine by the end of the year. Unlike most other leading COVID-19 vaccine candidates, manufacturing capacity for the AstraZeneca/Oxford vaccine is being scaled up by multiple independent vaccine manufacturing facilities globally, including by the Serum Institute of India, Fundação Oswaldo Cruz (Fiocruz) and mAbxience. The vaccine currently has the highest projected production capacity worldwide. This is a welcome preparatory step during a global pandemic in which supplies of any COVID-19 vaccine, once proven safe and effective, should be distributed equitably around the world.

MSF's Access Campaign bilaterally and publicly urged Gavi and governments participating in the COVAX Facility to ensure that any future COVID-19 vaccines are sold at cost, are accessible to all and that pharmaceutical corporations receiving funding are transparent in sharing research, development and production costs. In July, MSF co-signed an open letter to Gavi board members, demanding better representation of civil society and communities in the governance of the COVAX Facility.

While the recent trial results of COVID-19 vaccines have been met with global enthusiasm, there is a long road ahead to make them truly accessible globally. The ACT-Accelerator's funding gap is a staggering US\$35 billion, and only two of the \$16 billion needed for the vaccines pillar have been pledged to date. Most of the distribution mechanisms identified by the COVAX Facility rely on national infrastructures, which poses an enormous challenge for countries with weak health infrastructures. Virtually all of the 13 vaccines that currently are in phase 3 clinical trials require several doses or booster injections and need to be stored and transported in cold chain at low temperatures. These conditions make vaccination campaigns difficult to implement in many of the crises- and conflict settings where MSF works. However, the AstraZeneca/Oxford University vaccine candidate was recently announced to require cold-chain management at standard 2-8°C refrigerator temperatures. This is positive news, as it would potentially facilitate distribution in low-resource settings where the existing cold-chain equipment for storage of vaccines used in routine programmes covers this temperature range.



Similar to the measles vaccine, a majority of COVID-19 vaccines will require cold chain storage and transportation, complicating implementation in low-resource settings. © Pablo Garrigos/MSF

To facilitate allocation of COVID-19 medical products to populations that are excluded from national access mechanisms, the World Health Organization is leading an interagency process to create a humanitarian buffer of COVID-19 vaccines. This buffer will potentially include diagnostics and therapeutics, as well as the required coordination mechanism to allocate and prioritise vaccine use in humanitarian crisis settings. The buffer is planned to work in tandem with the national allocation systems developed through the COVAX Facility. How and when the necessary vaccine supply for this humanitarian buffer can be secured, however, remains uncertain. Additional access and distribution initiatives are underway at regional and national levels. MSF is following these developments closely, including in major MSF operational settings such as the Democratic Republic of the Congo and Brazil. MSF is currently assessing different scenarios to potentially support vaccination efforts and complement the implementation led by local health authorities once vaccine safety and efficacy are sufficiently proven.

Considering the substantial public investment made into the development of many vaccines and drugs, MSF has also been urging governments to demand more transparency from pharmaceutical companies on all licensing agreements, research and developments costs, and clinical trial data. While most governments and international institutions continue to rely on voluntary measures by pharmaceutical companies to ensure accessibility and affordability, MSF is concerned that they are continuing to put profits first. In a recent licensing deal between AstraZeneca and the Brazilian public research institution Fiocruz, for example, the vaccine manufacturer reserved the right to change the vaccine price as early as July 2021, irrespective of global needs. Without full transparency on such licensing agreements, governments and multilateral institutions are forced to negotiate blindly, and the public is unable to hold corporations accountable.

In a groundbreaking move, India and South Africa asked the World Trade Organization in early October to allow all countries to choose to neither grant nor enforce patents and other intellectual property related to COVID-19 drugs, vaccines, diagnostics, and other technologies for the duration of the pandemic. If approved, the proposal promises to be a game changer as it would remove intellectual property on COVID-19 medical tools and enable uninterrupted global collaboration to scale up manufacturing and supply. As the global health crisis continues to amplify and deepen existing inequalities and access issues, both political initiative and realistic implementation plans are needed to guarantee equitable access to vaccines, treatments, and diagnostics for all.



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