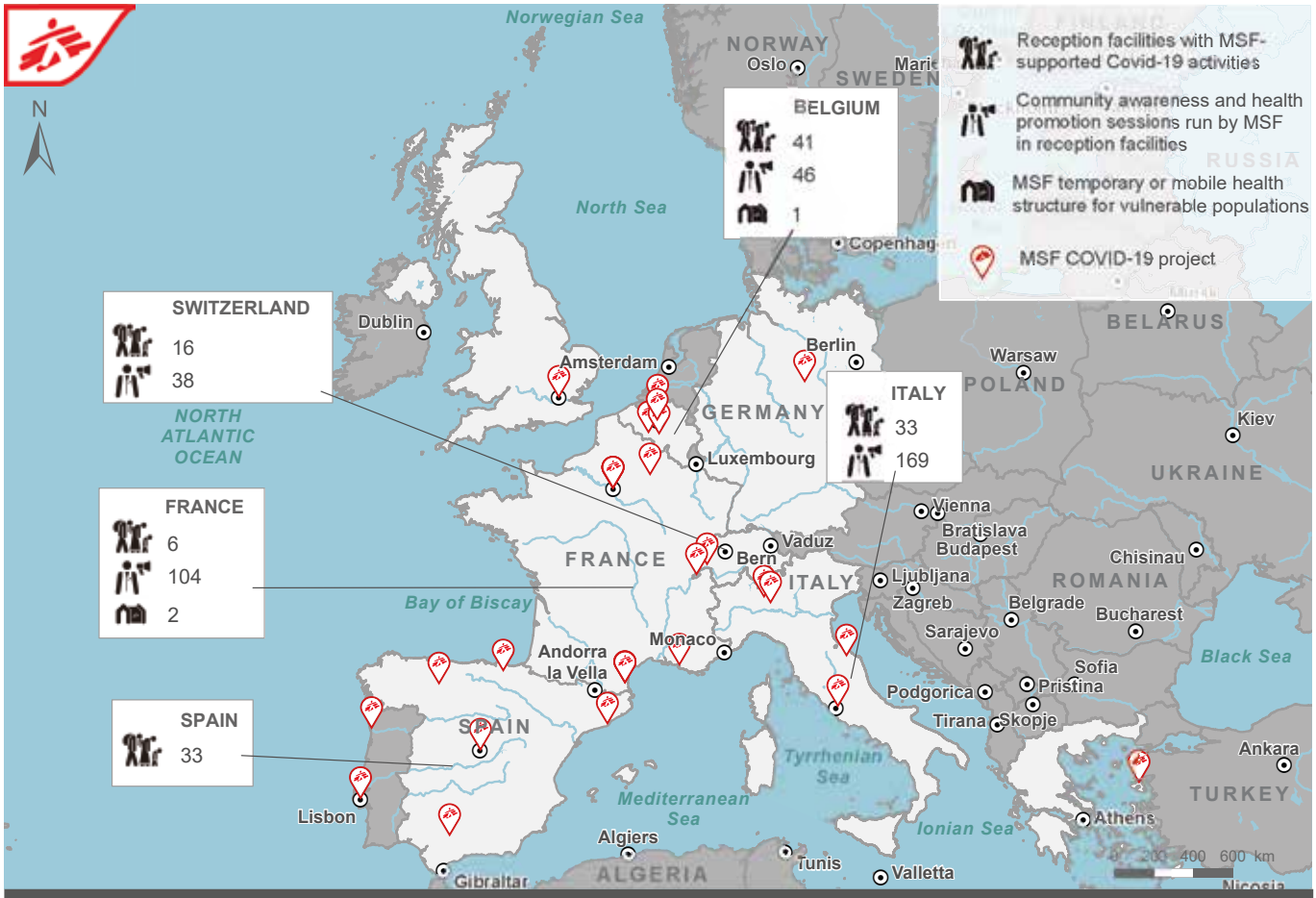
Based in Geneva, **Switzerland**, an MSF logistician and a sanitation-and-hygiene specialist worked in two retirement homes in the neighbouring French region of Haute Savoie. There, they implemented appropriate isolation and hygiene measures for residents, staff, and visitors.

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

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



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

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

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

© Benjamin Matuszenski

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

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

Pierre Mendiharat, Deputy Operations Director, MSF operational centre Paris

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

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


© Kristof Vadino

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

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

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

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

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


© Nora Teyjouni/MSF

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

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

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

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

© Smriti Singh/MSF

Introduction

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

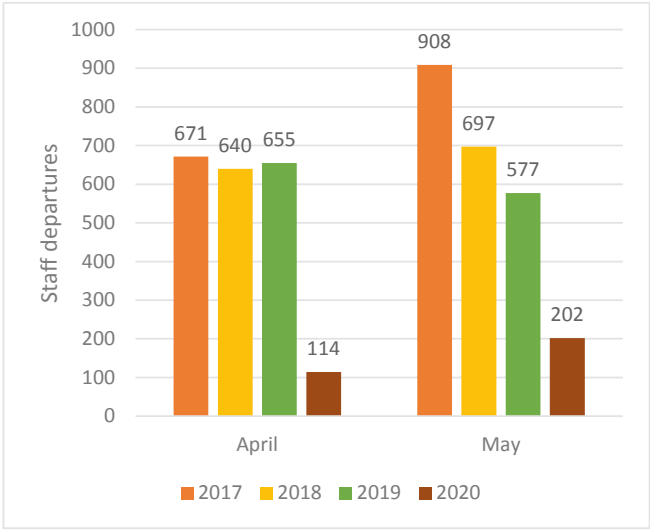
This chapter features key information illustrating what it meant to run an international humanitarian medical organisation amidst a global public health emergency. It also highlights some of the extraordinary efforts made by MSF human resources, supply and logistics specialists, and fundraising teams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

Staff travel and human resources

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

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

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



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

© Quentin Bruno/Brassage Photographique

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

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

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

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

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

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

Supply and logistics

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

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

© Julien Dewarichet/MSF

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

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

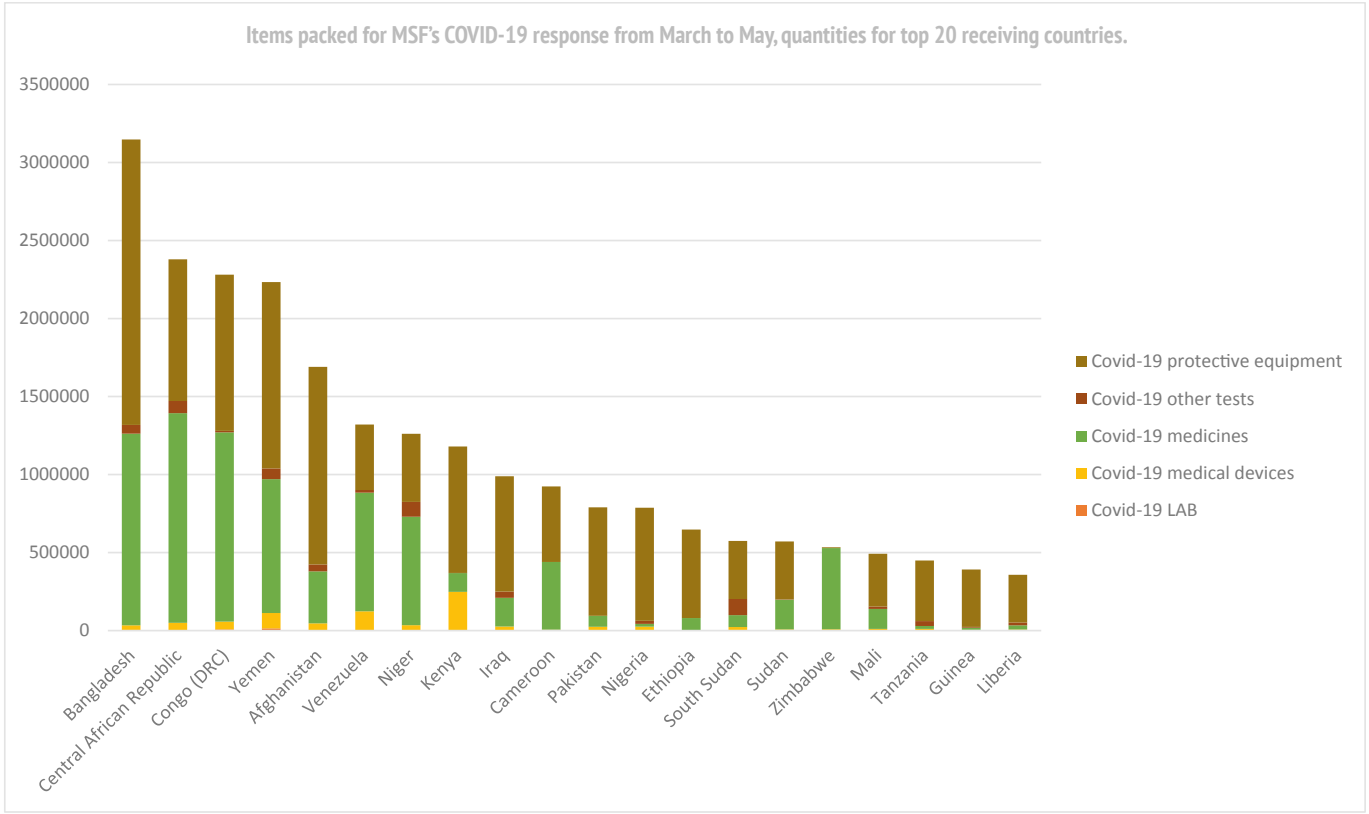
MSF researched and procured oxygen delivery devices and treatment equipment such as ventilators, oxygen concentrators, and four large-scale oxygen generators, which rapidly were in severe global shortage.

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

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

© Pierre Crozes/MSF

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



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

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

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

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

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

Finance

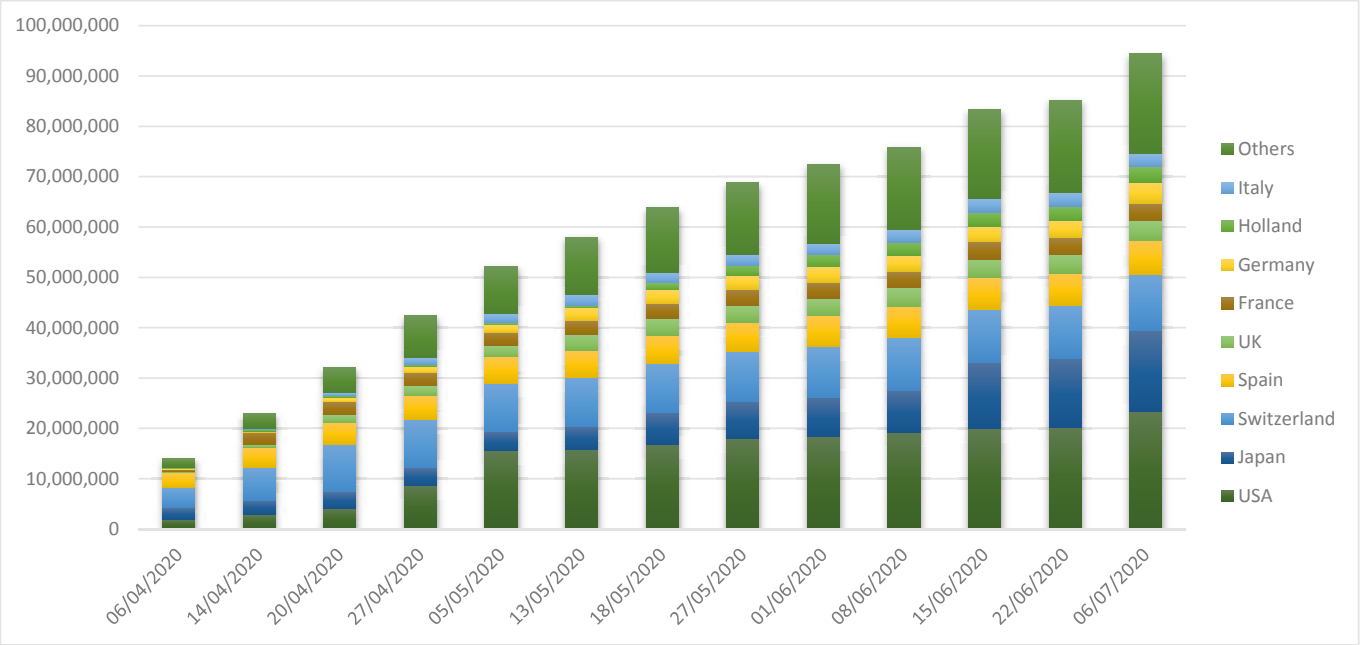
To address the unprecedented operational, logistical, and resource challenges caused by the pandemic, MSF created a dedicated COVID-19 Crisis Fund in late March. The additional funds needed for rapidly scaling outbreak preparedness measures and launching dedicated COVID-19 interventions, as well as some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

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

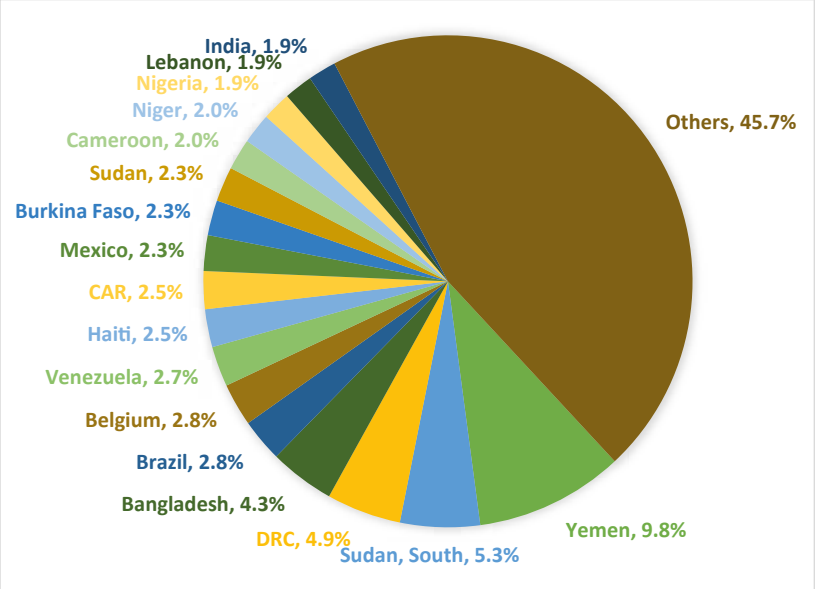
By the end of May, fundraising teams from 34 MSF offices had raised over 70 million Euros, with the US, Japan, Switzerland, Spain, and Germany among the countries with the largest contributions from donors. By late July, the crisis fund had raised just under 100 million euros, nearly two-thirds of the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

© Pablo Garrigos/MSF

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



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



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

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

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

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

© MSF

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

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

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

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

© Jakub Hein/MSF

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

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

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

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

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

The MSF Global COVID-19 Accountability Report is commissioned and published by MSF's International Office

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