MEDECINS SANS FRONTIERES
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WEEKLY UPDATE

MSF AUSTRALIA
MSF NEW ZEALAND

MSF Australia is a member of the Operational Centre Paris Group

27 June 2019

Libya: "Healthwise, it was a disaster" in detention centres

MSF staff report catastrophic medical situation in Libya's Zintan and Gharya detention centres

- At least 22 people have died in Libya's detention centres from suspected tuberculosis and other diseases since September 2018
- Hundreds of people in need of international protection and registered with UNHCR as asylum seekers or refugees have been left stranded
- An average of two to three people have died as a result of conditions in the detention centres each month since September 2018

MSF staff who were recently granted access to two detention centres in Libya found a catastrophic medical situation among the people detained there.

The situation in Zintan and Gharyan detention centres – located in the Nafusa Mountains south of Tripoli – is consistent with reports, later confirmed by UN agencies, that at least 22 people have died there from suspected tuberculosis and other diseases since September 2018.

Hundreds of people in need of international protection and registered with UNHCR as asylum seekers or refugees have been left stranded in Zintan and Gharyan detention centres for months – and in some cases for years – with virtually no assistance.

As a result of conditions in the detention centres, an average of two to three people have died there each month since September 2018.

MSF staff made their first visit to Zintan detention centre in May. They found some 900 people detained there, 700 of them in an overcrowded hangar with four barely functioning toilets, no shower and only sporadic access to water, which was not suitable for drinking.

"Healthwise, it was a disaster," says Julien Raickman, MSF head of mission in Libya. "A tuberculosis outbreak has likely been raging for months in the detention centre. The situation was so critical that we immediately arranged lifesaving referrals to hospital during our initial visits."

In total, MSF staff arranged 16 referrals to hospital between 25 May and 19 June. They also distributed supplies of food, powdered milk, blankets and hygiene items. Having been granted access to Zintan detention centre by Libya's Department for Combatting Illegal Migration (DCIM), we are now scaling up our medical and humanitarian response.

Medical consultations and referrals are still ongoing and MSF staff are working on repairing the water supply system.

Earlier this year, some 50 of the detainees in the poorest health were transferred from Zintan to Gharyan detention centre, located 100 kilometres to the northeast and on the frontline of the current conflict between the Libyan Government of National Accord (GNA) and the Libyan National Army (LNA).

With heavy fighting taking place nearby, the situation for the 29 detainees who remain in Gharyan is particularly hazardous. The area can be inaccessible to ambulances because of the fighting, making it difficult to organise lifesaving referrals to hospital when needed.

Read the full story here.

Refugees and migrants detained in a detention centre in Libya, September 2018 © Sara Creta/MSF

Contents

Field Updates.................... 02
Departures and Returns.......... 02
Media and Web................... 10
Association News................ 12
Field HR........................ 13
HR.............................. 14

OCP Updates

Access Campaign

WHO adopts resolution on drug price transparency

During its annual meeting, on May 28 the WHO adopted a resolution on transparency in the drug industry (Improving the transparency of markets for medicines, vaccines and other health-related technologies). This is good news in a context where drug price secrecy is the rule, in the service of profit, and where secrecy also prevails regarding patents, the cost and results of clinical trials, and the cost of R&D in general. Prices are set neither according to a patient's ability to pay nor to a country's economic situation. This was first the case with HIV, then Hepatitis C and resistant tuberculosis, and even certain vaccines, such as PCV.

At the end of last year, MSF's Access Campaign identified transparency as a key issue to be pushed with WHO, as the pricing problem has now gone global, with access also affecting wealthy nations. In January 2019, the head of the Italian drug agency created a political opportunity and submitted a draft a resolution to the WHO's Executive Board. It was on this basis that we undertook advocacy initiatives with many countries and via publications in the media. Negotiations were extremely tense in the run-up to, and even more so, during, the World Health Assembly held from 20 to 28 May. Convinced of the necessity for transparency and dissatisfied with the asymmetry in information from laboratories, several countries (Italy, Brazil, Egypt, Eswatini, Greece, India, Kenya, Luxembourg, Malaysia, Malta, Portugal, Russia, Serbia, Slovenia, South Africa, Spain, Sri Lanka, Uganda and Andorra) co-signed the resolution. However, a few countries (Germany, Japan, Switzerland, Switzerland, USA and UK) that are home to large multinationals attempted to undermine it.

The communications initiatives undertaken by MSF and other organisation to denounce these countries' sabotage and their positions played a crucial role, and ultimately led to the adoption of the resolution. Although not ideal, it sets a new standard and an objective of transparency for all countries, and all those purchasing drugs involved in negotiations with drug companies can use it to push for more transparency. This will not become the rule overnight, but the resolution represents a serious setback for the drug industry. The drug economy's black box kept firmly under lock and key by the pharmaceutical industry must at long last be opened.

Read more here.

DRC

Update on Ebola vaccination

Since the beginning of the epidemic in August last year, there has been over 2,000 cases of Ebola in Eastern Congo (North Kivu and Ituri). Traditional methods of controlling the epidemic, including contact-tracing and early isolation of infected cases, have been very difficult as people are hiding away and refusing isolation, due to fear and misunderstanding. Around half of the newly confirmed cases are not known to be contacts, while now have statistical modeling from the WHO and the MoH which shows that about 25% of cases are not detected at all. A vaccine was deployed just after the declaration of the outbreak with a strategy intended to target people at highest risk of contracting Ebola, a combination of the vaccination of frontline workers as well as a ring strategy which was first tested in the Guinea trial. The idea was to vaccinate the contacts of confirmed cases, as well as the contacts' future contacts quickly enough for them to develop adequate immunity before they are exposed to the contact who may have already contracted the disease during their exposure with the confirmed case, but who becomes infectious only once they develop symptoms, after an incubation period.

We now have data to show that the vaccine is not only safe but is also effective. We cannot say that it is 100% protective against Ebola, and we know that no vaccine is 100% effective, but we have seen that mortality is almost zero amongst people who receive the vaccine at least 10 days before developing Ebola symptoms. Unfortunately, while this is an effective

Departures & Returns

Start of mission

- **Cushla Coffey**, Epidemiology Activity Manager, South Sudan

End of mission

- **Neville Kelly,** Fleet Manager, South Sudan
- **Geraldine Dyer,** Mental Health Activity Manager, Bangladesh
- **Jeanne Vidal,** Mission Technical Referent, Afghanistan
- **Tien Dinh**, Project Pharmacy Manager, Palestine

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FIELD UPDATES

vaccine, the vaccination strategy is not working today as it relies on contact-tracing. With this increase in cases over the last 10 months, the spread of the epidemic over a very large and densely-populated area and the difficulties with insecurity, we are not optimistic at all that this ring vaccination strategy would ever be feasible.

While people move between health facilities and resist being identified, we see more and more people moving in the same zone of transmission (between Beni, Butembo, Katwa and Kayna), meaning that the population living in these areas are at the highest risk of being exposed to the virus. Despite some rumors about the vaccine being responsible of spreading Ebola, recent engagement surveys show that a majority of people living in these hotspots of transmission still request access to the vaccine, and many people complain that they are not entitled to vaccination via the ring strategy.

We have been working with various actors, including the London School of Tropical Medicine and Hygiene, to review this vaccination strategy and try to better protect more people who are at highest risk of contracting Ebola, which means ensuring a better vaccination coverage by switching from the ring strategy to a geographical strategy targeting the zones at highest risk of transmission. For that we will need a bigger supply of vaccines as we are not entirely confident of the supply of the current vaccine (the only one used so far).

There is a second vaccine manufactured by Johnson & Johnson that was being developed since the West Africa epidemic, which is similar but is a two-dose vaccine (the intention of the second dose is to act as a booster to prolong the duration of immunity). This vaccine was trialed in phase-two trials and has safety data, but it was not yet used during an epidemic.

There are 1.5 million two-dose regimes of this vaccine available and manufacturing is ongoing. Discussions about the best use of the two vaccines have been ongoing for several weeks with the London School, Epicentre, the WHO, the MoH and the IRNB in DRC. Together with the London School, MSF OCP and Epicentre propose to deploy both vaccines in the zone of epidemic transmission with the first vaccine continuing to be used via the ring strategy, while the second vaccine will be offered in fixed sites with a community engagement and communication strategy to inform people living in these high-risk communities about the access to the second vaccine, allowing them the choice to be vaccinated if they wish. As this vaccine is still under trial, we proposed a clinical trial protocol to vaccinate one million people in the zone of Ebola transmission in partnership with the Congolese authorities, and we are currently waiting for feedback from the ethical boards.

Read more.

Kenya

Results of the Ndhiwa HIV Impact in Population Survey (NHIPS 2) by Stephen Wangiala, Deputy MedCo

In late 2012, MSF conducted a study to assess the burden of HIV in Ndhiwa sub-county, in Homa Bay County, south-western Kenya. The study, called Ndhiwa HIV Impact in Population Survey (NHIPS) was carried out to measure the incidence of HIV, population Viral Load and program coverage to provide baseline information prior to a joint MSF-MoH intervention.

The HIV prevalence was estimated at 26% for the County of Homabay (according to NASCOP), and the MSF study put the figure at 24% for Ndhiwa Sub-County. MSF's initial presence in Ndhiwa was through multiple HIV/TB outreaches – the initial intention of these outreaches was to provide 'mentorship' or 'technical support' to decentralized facilities in Ndhiwa. In a 2012 facility assessment, these attempts were documented as a failure and the ambition to implement a different approach emerged.

In 2014, MSF started activities to support decentralization in Ndhiwa following the results of the NHIPS. The objective was to implement effective evidence-based models of care and prevention, with the main aims of testing as many people as possible for HIV, and improving adherence to ARVs by those living with HIV to the point of having undetectable viral load; and to reduce the rates of new infections through the implementation and scale up of complementary preventive measures. A total of 104,292 people were tested between mid-2014 and mid-2018, with 1,367 testing positive. By December 2018, 16,618 patients were on ART in the facilities where we worked. A key element of the project was to have a population-based survey as a baseline and repeat this after several years of implementing.

In 2018, we thus conducted a second survey (NHIPS 2) to assess the impact of our implementation since 2014. The survey showed successful results in all of the parameters tested, including the awareness of HIV which moved from 59.4% in 2012 to 93.4% in 2018, and the viral suppression, which moved from 39.7% in 2012 to 88.3% in 2018. The prevalence dropped from 24% to 17%, and the incidence of 1.9% to 0.7% between 2012 and 2018.

Somalia

Head of mission Jocelyne Madrilene provides update on an epidemic of diarrhoea in the Togdheer region, Somaliland

There has been an epidemic of diarrhoea in the Togdheer region since 27 May. Over 1,700 cases have already been recorded, with children under the age of five years the worst affected. So far, no deaths have been reported. We are awaiting the results of

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samples sent to the laboratory in Hargeisa. Three organisations have made donations of ringer lactate and sanitation equipment. The MoH has asked us for an assessment of the situation and 3 staff deployed to the area have spent the past two days in Burao hospital. We also have the MoH's authorisation to import cholera vaccines if necessary. The last epidemic, during which 12,000 cases of cholera were recorded, was in 2017.

Uganda

Head of mission Jordan Wiley reports on Ebola cases on border with Congo

On 11/06/19, Uganda's Ministry of Health reported Ebola cases in the country. At 9pm on the same day, the Ministry asked for MSF's help with managing the situation. As of the time of writing, no further cases have been confirmed in the country. Those who had the disease were a North Kivu family who attended a funeral in the Beni area and then crossed the border to Bwera. Presenting haemorrhagic fever symptoms, they were examined in a health facility in Uganda and then transferred to an Ebola treatment unit. three confirmed cases have now died, two in the Bwera treatment centre and one during transfer (the two countries have an agreement concerning the repatriation to DRC of confirmed and suspect cases). More than 100 of the family's official contacts have been traced and are being monitored by the Ministry of Health and WHO. It should be noted that, of the 600 alerts registered since the epidemic first broke out in DRC last August, up until now none have been confirmed. Uganda is accustomed to epidemics of haemorrhagic fevers, which include Ebola, as over the past 20 years there have been nine, with the biggest dating back to 2001 when over 400 cases were recorded.

From the time the outbreak began in DRC, MSF has been actively involved in preparing the emergency response. This includes providing the logistics for setting up isolation and Ebola Treatment Units and training of personnel. We are particularly vigilant regarding the Bwera border point crossed every week by 25,000 people for the customary/trading purposes. An emergency team of around 300 Ugandan reservists who have experience with haemorrhagic fevers, such as Marburg, is also on standby. Other organisations we are in contact with and with whom we have organised training over the past year are also mobilised. eight staff members are now on their way to Kasese to monitor contact cases. Over 4,400 people, most of them front-line personnel, have been vaccinated in the area between DRC and Uganda, and MSF is ready to step in to support the Ministry of Health should it wish to extend vaccination coverage.

OCG Updates

DRC

Emergencies

We still have four ongoing emergencies in DRC: IDPs crisis, measles outbreak, malaria peak and Ebola outbreak. We have had a total of eight confirmed cases of Ebola in Bunia and Komanda, and two of them in the last 24 hours. These two cases come from two different chains of transmission.

Tensions within some communities have happened in the last week including today around the clinic of Salama. Good news is the DPS (MoH) and local authorities seem open to innovative approaches to put in place a decentralized management of cases for transit and are sensitive to a non-coercive approach.

Following the request of the MoH to transform the transit centre into an ETC, we have started the construction of a 10-bed confirmed unit that should be functional next week. Experimental drugs will be available. MSF has approached WHO; it seems we are all interested in pushing for a measles vaccination in Ebola active areas, which would mean for example in Bunia, if validated by the MoH, a vaccination in the IDP camps and would enable a containment strategy for measles outbreak.

Simultaneous violent attacks on the three axes north of Bunia happened in the last week, with hundreds of people killed. We are speaking of thousands of people displaced in the area of Drodro, where insecurity remains too high to access, and 10'000 in Bunia. The major problem for us today is to access these areas. But today, the team is taking advantage of the lull in the health zone of Nizi, where we support several IDP camps to assess the damage caused by the numerous attacks.

In order to respond to the massive influx of people in Bunia town, the KERE (Kisangani Emergency Response) has started an intervention in the two spontaneous IDP sites with PHC in two health centres, treatment of complicated cases of Measles in the hospital (25 beds and already 18 cases admitted), supply to water, and NFI distribution. Along the lake, we also have one team intervening in two camps.

Kyrgyzstan

In our project in Kadamjay, we received the official authorization to deploy our strategy of screening and treatment of cervical cancer at rural level. This is good news.

Somalia

Our team went to Bardera and Afmadow to assess the situation. We also visited Kismayo the regional capital to discuss our

intervention. There is a lot of pressure from the authorities for us to setup an ITFC.

Tanzania

We are preparing an intervention to support the MoH technically in responding to cholera outbreak, notably regarding patient flow and IPC in the structures in place.

OCA Updates

Afghanistan

Training rural health workers in Lashkar Gah

A program has been started to train healthcare workers from the rural areas, mainly opposition controlled, around Laskhar Gah, Helmand. MSF has been trying to work outside of Laskhar Gah, but often for security reasons it is difficult for us to move around ourselves. While some services are available in those areas, often there is poor quality and insufficient quantity of skilled health workers. Last year we tried to work in Musa Qala in collaboration with the NGO BRAC but we didn't manage to set up a successful program. Hence now we are piloting, also in collaboration with BRAC, facilitation of rural health workers training in the Laskhar Gah Boost Hospital in order to develop the capacity for early detection and management of common diseases so as to reduce the progression and complication of illnesses.

On June 10 2019, MSF started the training of the first batch comprising 5 female MDs and 13 midwives; they received sessions on identification, management and referral of obstetric complications and complicated deliveries, rational uses of oxytocin, identification and management of GBV, importance of breastfeeding. The next batch will be male staff (nurses, MDs, surgeons and anesthetists). The training is fully supported by MSF and the selection of trainees is done by BRAC. After the training the health workers will return to their respective clinics to continue to provide health care and improve quality.

DRC

Ebola

Without active transmission in Goma at the moment, the emergency project, which is embedded in the regular DRC North Kivu, is a preventative intervention, involving the construction of a CTE (Ebola Treatment Centre), screening activities in a MoH managed CTE and furthermore focuses on two main components of engagement with authorities and communities. Health promotion by the Congolese Ministry of Health is usually done by the so-called Relais Communitaire, a person dedicated to inform about 50 households on health practices. These people are currently often not being paid by the MoH, resulting into a frustrated workforce and a gap in Ebola information reaching the communities in Goma. The link with the further up north regions around Beni, where active transmission is taking place, are mainly linked to a population that has direct ties to Goma. With families in Goma and up north, the movement of these families between the regions makes it highly likely that Ebola could reach Goma. Parts of the communities in and around Munigi, an area in the north of Goma, as the communities in the north of North Kivu, do not believe Ebola exists, moreover it is believed to be a made up disease being used as a tool by the Congolese government to regain control over the population and to make money off of it. Ebola being a trendy topic, a lot of funding actually does come into DRC, to which 90% so far has been unaccounted for.

Other sensitivities as cultural or traditional practices will also have to be taken into account to ensure communities in and around Goma are well informed on the symptoms of Ebola and which actions to undertake when they receive a patient in their health clinics or if the symptoms show on a family member. For example, a person falling ill, sometimes retreat to a chambre de priere, where a doctor or healer 'cures' the patient with a highly interactive practice, including a lot of touching. These practices are a fair example of a direct negative and big impact on the community, if it would involve an (unrecognized) Ebola patient and shows how health promotion and community engagement is key for the preventative project.

Haiti

Continued Instability

Continued instability in Haiti following official report end of May implicating current President in embezzlement of Venezuela fuel subsidies causing further political, social and economic turmoil in a country already severely affected since July 2018 riots linked to announcement of fuel price increases that were later reversed. Opposition parties continue to push the population to protest in the streets resulting in significant disruption of daily life in the capital Port-au-Prince as well as several other cities across the country. Calls to protest over the next few days continue.

Libya

DR-TB

The Libyan mission started in 2018 drugs sensitive TB treatment for 164 migrants in detention in Tripoli. With access to GenXpert now available, also MDRTB cases are now diagnosed in Tripoli. Since three weeks, two migrants with MDRTB, among them a 14 year old child, have started ambulatory short course therapy MDRTB treatment in one of the detention centres MSF works.Circumstances (access to detention centres, transfers, repatriation,

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crossing the Mediterranean) and current context (fighting, conflict) in Tripoli are very difficult and challenging and not 100 % optimal for treating TB. However no TB treatment would mean continuation of transmission of TB and DRTB.

Nigeria

Our project coordinator who just returned from Nigeria presented about the shelter project in Benue. In this State there's the 'Middle belt crisis', also known as 'farmers vs. herders' conflict, a long-term situation which has escalated in the last few years with a ban on open grazing coming into effect in 2017. The ban prevents hundreds of tribes from the Northern part of the country to come to the Benue state. Thus, since Jan 2018, tension has been rising, with growing rate of displacement and mortality. Currently there are around 40,000 displaced people located in 10 camps around the town, with only two international aid organizations in place (MSF and ICRC). Most other actors came from the UN agencies; however they also left once the fund expired in February this year.

We worked in several IDP camps, one of which is called Mbawa IDP camp. This used to be an unofficial camp due to lack of attention from the State, and has been growing rapidly since last year. When MSF started working with this camp in June 2018, there were around 2,800 people. The number has increased to currently 3,550 people, accounting for around 1,200 families surviving in poor conditions. With the rainy season approaching which presented a high flooding risk, we decided that we had to take measure to protect and improve the lives of the displaced people in this area. We came up with the idea of building (on elevated sand-filled and tarpaulin-covered ground) specially-designed shelters adapted to the natural condition there.

The project was an impressive effort of coordination with various stakeholders involved, as well as a five-week timeline to finish 1,300 tents and 650 structures. The construction process itself was another massive orchestrated effect with the health promoters working closely with the community as well as the logistic team and WatSan team to make sure everything was in the right place at the right time. The project which will be finished in two-week time has been a success. It was the first time that a project of building shelter took place in Nigeria.

Update 21.06: Attacks Against civilians

Continued attacks against civilians and lack of sufficient humanitarian assistance is what Benue (at the border of Cameroon), Zamfara and Sokoto regions where MSF OCA runs operations in Nigeria have in common. The overall trend that is seen in the region comes down to:

- Impact of developments in the Sahel with intensifying attacks from extremist groups.
- Overall increased violent attacks and criminality, with insufficient accountability for these attacks.
- Increased concerns about the health situation (especially in the North West, which was already problematic to begin with).
- Climate crisis / environmental degradation impact, presenting migratory herders moving to more southern areas, where they can graze their cattle. This however, increases tensions over available land with farmers, who need it for farming.

The affected population in North West and Middle Belt regions continues to live in fear. In Benue, although attacks now seem to happen at a smaller scale, people are still getting killed when they try to go back to their village. In the North West, the violent attacks by armed men or armed gangs push people out of their villages – individuals or entire communities are attacked, some people are killed, sometimes they are kidnapped, or they are robbed. The nature of the attacks are extremely violent. Latest estimates indicate 38,000 displaced in Zamfara, and 12,000 displaced in Sokoto. The main humanitarian needs reported by the displaced populations are primarily healthcare, shelter, food, water and sanitation.

To date, there is insufficient accountability for crimes that are committed, lack of public order and police presence and little protection of the civilians by the state. We are advocating for humanitarian assistance to be scaled up, but are facing challenges: in the North West, security is the major obstacle, but in the Middle Belt, we see that funding and willingness to respond is a big issue. In our advocacy, we also have to navigate that Nigeria is the richest country in Africa, but it has the highest number of people living in poverty in the world.

Somalia/Somaliland

Our team based in Hargeisa on MDR-TB program wants to respond to a report of possible cholera in Burao. We are looking at possibility to support our team members working in intersectional projects in Somalia/Somaliland.

OCB Updates

Belgium/Niger

A few years ago OCB used to have a project called Ithaca (Information on Treatment and Healthcare Accessibility in Countries of Origin) aiming at gathering and providing information on availability and accessibility of health care in countries where MSF was present. The project closed in 2010 but we continue to regularly receive

FIELD UPDATES

requests from lawyers, social workers and judges assessing the right to stay of undocumented migrants on medical and humanitarian grounds. Accessing verified and field-based information is extremely difficult so MSF has a clear added value in many instances.

As an example, a few months ago MSF was requested to issue a written testimony on the access and availability of certain molecules and medical exams in Niger by the Cour du Travail de Liege (Belgium). Thanks to the valuable information provided by the OCP mission there, we just learnt that a Nigerien man suffering from a serious disease and who was already detained in a pre-removal centre, was allowed to stay by the Court and will receive financial and medical assistance. This is why it is very important that when we receive such requests we offer an adequate and coherent response. Please email Aurélie in the Analysis Department if you receive such requests for information by clicking here.

CAR

In Bangui's PK5, following the death of the main active armed group leader, Force, we have been monitoring reconstitution and constellation of armed (auto defense) groups; this week, a GA of 14 auto-defense armed groups active in that area, have appointed a new leader (also called Force). Bangui SRH project is actualizing their risk assessment and following this up in light of the agenda-setting by all armed groups taking place in CAR, including in Bangui, under the Khartoum peace agreement and with 2020 elections coming closer.

DRC

Following the outbreak declaration by the Ministry of Health and several meetings with MoH, UNICEF and others, the Measles Emergency Pool (Pool d'Urgences Rougeole) will kick off next week 24th of June with a focus on the areas in Mai Ndombe province along the Kasaï River.

In the meantime, the Emergency Pool Congo (PUC – Pool d'Urgences Congo) will focus on the areas with the highest mortality rates in former Equateur Province (current Tshuapa and Mongala provinces). Meanwhile, we continue efforts to conclude on the joint MSF request to import measles vaccines.

Greece

Ahead of the visit of the UN Committee Against Torture (UNCAT) to Greece and the revision of the Greek report at the UNCAT session in July, MSF has decided to submit an alternative report to the UNCAT on the situation faced by victims of torture in Greece.

The report focuses on the lack of adequate identification, referral to care, safety, access to specialised and comprehensive services, and access to medical legal report for victims of torture in Greece.

MSF does not often report to UN Human Rights bodies but our perspective on this topic in Greece being quite unique we agreed that it was an opportunity to put pressure on the Government and raise awareness about the systemic failures to identify, protect and provide adequate care to victims of torture. As part of the Expert by Experience project, a group of patients-advocates in Greece have also submitted their concerns to the Committee, independently from MSF.

Guinea

In Guinea, we witness a rise in measles cases since the begin of 2019. In the first 18 weeks of 2019, there were 1.247 suspected cases of which 519 were confirmed – an increase compared to the same period in 2018. The cases are widely distributed: 27 districts out of 38 have at least one confirmed measles case. In Conakry, measles cases concentrate in the commune of Matoto. We therefore started supporting a health center there 10 days ago and collect data since then. Last week, we recorded 83 measles cases. None is confirmed as the government decided to stop laboratory confirmation of cases.

At this point, there is no decision from MSF or the authorities to call for a vaccination campaign (no outbreak declaration yet), but we will continue supporting Matoto health center for one month and see if further action is needed. Our last massive measles vaccination campaign in Guinea was in 2017. In 2019, we noticed that 80% of measles cases were non-vaccinated children, indicating limitation of EPI even in Conakry. Emmanuel Lampaert (CO) is in Geneva today where he is meeting the Global Fund country teams for Guinea, CAR and DRC. They will mostly discuss HIV financing and priorities in those countries.

In Kouroussa, we are getting the results of the multi-antigen survey we started in February. This survey aims at capturing the coverage of our December 2018 measles vaccination campaign as well as the general coverage of EPI in Kouroussa, in order to provide recommendations for the remaining two years of this four-year project. The results of this survey are positive: our measles intervention indicate a 95% coverage while the EPI outcomes are better than expected, especially for children between 11 to 23 month as 78% of these have completed vaccination according to the calendar. We still have to look at the details of the whole report but overall, these results seem to indicate that supporting primary health care without putting a heavy focus on vaccination gives interesting results in terms of vaccination coverage, as this 11-23 month cohort corresponds to the moment we started the Kouroussa project.

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Haiti

Alberto and Marc are back from a visit to Haiti, where they could witness a very tense and worrying situation, marked by an increased level of violence in Port-au-Prince. The situation looks very bad, with few signs of hope given the current political stalemate and the catastrophic economic climate. All indicators are flashing red and analyzes show that the situation today is much worse than in 2017, with total lack of vision and political stability, aggravated by the decline in purchase power of Haitians following the devaluation of the currency. The country does not currently have a functioning government or Senate - and the budget for 2019 has still not been voted. Many civils servants have not been paid for months, including doctors and police officers.

Since 9 June, there have been daily demonstrations in the provinces and in Port-au-Prince, leading to several injuries and deaths. Numerous barricades have been erected and shops, schools, offices and institutions close early or remain closed. The protesters demand the departure of President Jovenel Moise after he was cited in a report of the Supreme Audit Office about a corruption case. Panic and stress of the population, our staff and our patients are palpable as several violent episodes occurred last week: the police opened fire on students; there were heavy clashes between two armed groups in Martissant; there were lootings and burning barricades in the streets; and an MSF OCP car was damaged by a group of people who threw stones at it – while probably not targeted as “MSF”, this episode is a sign that our logo/image does not totally protect us in the current climate.

This situation obviously affects MSF teams. Our emergency stabilization center in Martissant received 16 gunshot wound patients between 10 and 17 June. Since many public health structures do not work properly anymore, the team struggles to find adequate structures to refer those patients. OCB has an emergency plan (plan catastrophe) ready allowing us to re-activate emergency care within 48 hours in Tabarre facility (closed now) with a limited medical team to treat wounded patients. Since the closure of tabarre, Port-au-Prince suffers from a gap in trauma care capacity, as MOH has not developed trauma capacity despite their willingness and promises to do so following OCB’s August 17’ decision to close Tabarre. In this light, we also have to find solutions to increase referrals from Martissant to other health structures, and we are looking at how we can strengthen links with health structures around it.

Considering the need of trauma care Alberto and Marc discussed with OCP to see if a common OCB/OCP project using part of the facilities in Tabarre could at one point be managed there with the involvement of the Ministry of Health. They also discussed the possibility of a transversal HR pool for trauma hospitals, allowing staff from both section to work together and easily go from one hospital to another when needed. The idea is to work ahead on how to put in place complementary approach, a common vision and how to optimize resource in Haiti between the three sections, as already developed in other countries (Afghanistan, Mozambique…).

Iraq

In Sadr City (Baghdad), our Operational Research was accepted and we’ll start our MDR-TB research soon. In Sadr City, the ER doctors attended the BASIC training last week (nurses will attend the BASIC training this week).

Nigeria

Peak season of malnutrition in Maiduguri as a cholera outbreak threatens. The 72-bed hospital is running under full capacity, an analysis is under way in order to understand if more is needed from OCB side to face the seasonal rise in malnutrition. OCB is running a preparation exercise ahead of the expected seasonal hit of cholera.

Pakistan

MSF was asked by the authorities to join an assessment by the WHO and MoH of the HIV “outbreak” in Sindh province, which got large coverage in the Pakistani media. It’s clear that the situation is serious, but the full scale of the problem is still unknown. So far, around 800 people have tested positive for HIV (82% of them under five years old) but the screening is not finished so the numbers may increase further. The infections are most probably related to poor medical practices; there are private blood banks and unlicensed clinics in the area.

It’s not yet clear what other actors will do, so it’s difficult to foresee what gaps MSF be able to fill. We need to understand better to extent of the problem, understand where we will have the biggest added value but also what will actually be feasible to do based on the needed authorisations for Visa, NoC, exceptions to our present MoU, etc to implement the proposal we will come up with. We are presently defining a chronogram that will contemplate all the questions above in order to come up with a plan of intervention.

Discussions are ongoing with the authorities and other actors on the response to the HIV outbreak in Sindh province. The Ministry of Health should take part in the programme design and invest in the programme (HR as a start and medical materials, drugs, etc) as it progresses. And we will need to have an MoU or protocol of cooperation where all parties’ obligations are stipulated, specifically when it comes to negotiations with the decision makers to ensure that MSF will be able to get the needed authorizations to be operational.

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Palestine

We received a few new patients last week in Al Awda, the hospital where OCB is running a surgery and post-operative care program.

Sahel Interdesk

This week the first Sahel interdesk meeting will take place with OCP, OCG, OCBA and OCB. In light of growing humanitarian needs across the region and revamped violence, it is paramount to reach a satisfactory level of inter-OC coordination. ISA (inter-OC Security Agreement) will also be launched under the facilitation of the international office

Sierra Leonne

The MSF Hangha hospital was officially opened on 14 June, 2019 by the Honorable Dr. Minister Professor Alpha Tejan Wurie, Minister of Health and Sanitation, Sierra Leone. From MSF OCB president Bertrand Draguez and deputy CO Gbane Mahama were present.

On March 6th, MSF welcomed the first patients in its new 63-bed hospital in Hangha town, Kenema district, south-east Sierra Leone. The country has one of the world's highest maternal and child mortality ratio; each year about 1,360 women die during or shortly after child birth. Through comprehensive support to 13 primary health units in three chiefdoms (Gorama Mende, Wandor and Nongowa) and a new hospital in Hangha, MSF aims to reinforce the district health system and reduce Sierra Leone's record-breaking levels of child and maternal morbidity and mortality.

In the first three months after it opened, 3,092 patients were triaged, of these 1,988 were seen in the emergency room, including 449 patients that were admitted to the ITFC and 253 that were admitted in the general paediatric ward, 261 patients needed admission to the paediatric intensive care unit (PICU). Out of all admissions, 23 suspected Lassa fever patients were admitted to the isolation unit, but so far all the cases have tested negative.

Deputy CO, Gbane visit to Kenema and Gorama Mende and Wandor projects. MSF relation with the MoHS local and central authorities is amicable. The hospital with a functional ER, ICU and ITFC, is seeing high number of patients since it opened on March 06 and is also operating at full stretch due to the ongoing Malaria peak-season. The team will work in the possibility to set up a 10 beds malaria unit

Gorama Mende and Wandor

Deputy CO Gbane and Catherine, Deputy medical director, visit to one of the outreach project, Punduru where we launch the ICCM approach in order to strengthen the primary health care .

South Sudan

Gumuruk

Lekwangole MSF handed over AFTC to JAM an international NGO. MSF will continue to provide support during emergencies.

Yei

Second assessment was carried out in Yaribe village/ PHCU last week, an area under SPLA-IO located 82 km from Yei and on the way to Morobo. Population are displaced in surrounding village with some medical need linked to malaria cases. Team will share the report this week with more information

OCBA Updates

No updates from OCBA this week

MEDIA AND WEBSITE

In the news

• **Gaza:** Adventurer and broadcaster Todd Sampson, from Channel 10's *Body Hack*, recently filmed with our surgical team in Gaza. The episode focuses on the ongoing human toll of the ongoing blockade and conflict in Palestine. The episode will air on Channel Ten, Tuesday 25 June at 8:45pm. Watch here.

• **Ebola in DRC:** Dr Saschy Singh who recently went on two assignments in the DRC, spoke to the ABC Perth Breakfast team last Wednesday about the complications of fighting Ebola in the Congo. Listen here.

• **Our field workers:** Australian logistician Rob Baker has been profiled in Create, Engineer Australia's members magazine, about his time working with MSF in Bangladesh and CAR and how this differs to working in the corporate world back home. Read here.

• **World Refugee Week:** The Canberra Times has published an opinion piece by Paul McPhun, Executive Director MSF Australia. In this piece, Paul reflects on the criminalisation of people on the move – and further, the criminalisation of humanitarian organisations who seek to assist them. The piece looks at MSF's work in Europe and the Mediterranean, Central and South America, and a closer look at the state of affairs in Australia.

Website and social media updates

• **Gaza:** Catch Australian orthopaedic surgeon Thomas Shaefer talking to *Body Hack* about the complex and severe wounds treated by MSF teams.

• **Yemen:** Although aerial bombardments have decreased in Yemen, Saada remains the most targeted governorate by the coalition.

• **Dr Unni Karunakara:** "In '95 I became a humanitarian worker because I saw the problems of the world and that was how I chose to address them. But now you, the young people, can choose to address them in ways I could never have imagined." Dr Karunakara, former International President of MSF, spoke to medical students at the University of Melbourne this week.

• **Iraq:** "Seven per cent of our current patients are children under 18. The three main diseases we treat are epilepsy, diabetes and asthma." Medical activity manager Britta Koelking on treating children with chronic diseases in Hawija, Iraq.

• **Guatemala:** Daniela, a transgender woman who had to flee her country to save her life, summarises the experiences of many people fleeing extreme violence and poverty in El Salvador, Guatemala,and Honduras. Watch her story here.

• **Stand with refugees:** For World Refugee Week, MSF featured video testimonies and first-hand accounts from people who have risked everything for a chance at safety - and from our staff working to provide them with medical care around the world. See our Twitter and Facebook for more.

From surviving an attack in Iraq, to rebuilding his life at an MSF hospital in Jordan, to reinventing himself again in the US, Qusay Hussein reminds us of our shared humanity. Watch the full documentary here and read his story here.

European migration policies continue to lead to more suffering and death on the Mediterranean.

• **Syria:** MSF employs mobile clinics to attend to the needs of newly displaced families in northern Syria. Watch the response here.

• **Kenya:** MSF's Lavender House in Nairobi offers a 24-hour lifeline for medical emergencies. See what a night on call is like.

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ASSOCIATION NEWS

International General Assembly

The International General Assembly will held later this week in Dublin, Ireland from **Thursday 27 June to Saturday 29 June**. The agenda includes the following discussions:

- How can MSF improve patient engagement in humanitarian medicine?
- New entities: WaCA and Colombia Branch office
- People - Defining volunteerism in MSF today
- RSA4: Goals, principles and governing mechanisms

The meeting will also discuss the motions that have been put forward, as well as the election of International Board Members and the International President. IB and IP candidates are receiving questions and comments on Fluicity. (create an MSF Fluicity account here).

The IGA will be livestreamed. Login here (user: msf / pw: asso)

MSF AGM motion

Thank you to members of the Association who contributed to the writing of the Motion that will go to the IGA later this month. Considerable support was demonstrated via the online poll.

The motion reads as follows:

"Médecins Sans Frontières' current structure of operational entities based entirely in one continent is an impediment to provision of efficient, effective and culturally appropriate medical care for our beneficiaries. The number of MSF operational entities based in Europe should therefore be rationalised, and operational entities should be opened in regions where we predominantly work."

Network meetings

Sydney

Dr Unni Karunakara, former International President is visiting Australia this week. Unni is a current Board member of MSF Holland, and former International President 2010-2013. Unni currently serves on the Board of Directors of Drugs for Neglected Diseases Initiative (DNDi) and is a Senior Fellow of the Jackson Institute for Global Affairs at Yale University.

You can meet Unni (or reconnect with Unni) at the Sydney Network meeting happening this Thursday. All MSF folk are welcome. Join us for some drinks/meal and some lively discussion.

When: Thursday 27 June, 6pm

Where: Two Wolves Cantina

RVSP: Juno Min by email or mobile:0416 577 367

Mapathon in Auckland

There is a Missing Maps Mapathon happening next week. Together with Auckland University and Engineers Without Borders NZ, we will have Jessa Pontavedra (MSF RN emergency nurse) speaking to the group.

If you want to know more about Missing Maps, visit www.missingmaps.org The event details are below. If you would like to come along and are around Auckland during the time of the event it would be wonderful if you could attend or visit for some or all of the event.

Date: 6th July 2019

Time: 9am – 3pm

Talk: Jessa is speaking at midday

Venue: Auckland University (Room venue TBC)

If you want to attend please send Nathan Dart an email. It'll be a great opportunity to network and mingle with other aspiring humanitarian workers from the Engineering and Medical faculties, and also engineering professionals within New Zealand who might be interested in knowing about MSF and what we do!

Association Coordinator

If you would like to contact Emma, she would love to hear from you.

Email: Emma.SullivanSmith@sydney.msf.org

Phone: +61 2 8570 2655

Association Facebook group: www.facebook.com/groups/MSFAAsso/

The Portal: asso.ocp.msf.org/en (username: msf/ password: asso)

ASSOCIATION & MSF COMMUNITY NEWS

Report on Harassment and Abuse at MSF

The International Office this week published new data on reported harassment and abuse at MSF.

The Intersectional Platform on Ethical Behaviour (IPOB), which brings together the behaviour units of the five OCs, has worked tirelessly to prevent and manage abuse and inappropriate behaviour in the field. While the scope of the IPOB, including the data collected, focuses on the field and does not cover complaints at headquarters, its analysis is helpful in indicating where we need to improve. The data is classified according to agreed intersectional working definitions and typologies of abuse established by the IPOB.

In 2018, 356 complaints were made in the field, up from 182 in 2017. After investigation, 134 of these complaints were confirmed as abuse or inappropriate behaviour (83 in 2017). Of the 134 confirmed cases, 78 were qualified as a form of abuse, of which 80% of the victims were women. 59 out of the 78 cases of abuse were of sexual harassment, abuse or exploitation (SAE). The other 56 confirmed cases were qualified as inappropriate behaviour. Of the total 134 confirmed cases all staff members received disciplinary measures proportional to the severity of the misbehaviour, among them 52 staff members were dismissed. 36 of them due to cases of SAE. A few complaints are still under investigation.

The data tells us that in the last year, more people used the complaint mechanisms and more cases of abuse have been detected and dealt with as a result. Greater awareness of our grievance mechanisms, more resources to support the field and to manage cases, and an improved reporting system have certainly all contributed to this improvement. Last year's internal and external discussions on sexual harassment and abuse probably also encouraged more people to sound the alert in such situations.

There is more information online here.

On the Portal

asso.ocp.msf.org/en
(login: msf ; password: asso)

[EBOLA VACCINE] Disputed Territory
How did this happen? Alain Alsalhani, CAME pharmacist, examines why the WHO's response to the Ebola epidemic in the Democratic Republic of Congo failed.

[NIGERIA] Critical Review of Borno
In 2016, the Operations Department commissioned a critical review of the operations conducted by MSF France in Borno state in northeastern Nigeria between 2015 and 2016. Interview of Isabelle Defourny, Director of Operations at MSF OCP.

[ENVIRONMENT] Avoiding greenwashing and setting priorities
What are the consequences of climate change on the health of populations? What is MSF's footprint on the environment? This paper attempts to problematise these issues from the point of view of MSF logistics.

[GAZA] Not going too far - To what extent?
How can we respond to such a large influx of patients with often devastating injuries, making medical treatment more complicated? The question will be raised at this year's General Assembly.

FIELD HR

Humanitarian Surgery in Austere Environments

Three years ago, MSF-OCB launched, with three universities based in Belgium, an inter-university certificate called "Humanitarian surgery in Austere Environments". The first edition was launched in 2017 and consisted of four sessions of three days in Brussels (hands on and case studies). .

Participants who have actively taken part in the whole program and passed the required evaluations will be issued an "Interuniversity certificate in Humanitarian surgery in austere environments", worth 10 ECTS credits (European Credit Transfer System). This certificate is in itself a valuable addition to the participant's academic records.

Key Program Benefits:

• Multi-skill training which deals with various aspects of emergency humanitarian surgery

•Teaching staff combining the expertise of field specialists with that of leading experts in trauma and obstetrical surgery

• A certificate which will enable you to possibly take part in surgical missions within the leading humanitarian NGOs

Audience is a mix of non- and humanitarian surgeons.

Subscriptions have started.

Find out more here and in the flyer attached to the Weekly Update email.

ESMT Executive Transition Program

Like last year, in 2019 MSF has a free spot in the Executive Transition Program of the German Business school, ESMT. It is a 3 sessions/one week training and the applicant has to cover only for accommodation and travel.

All the 2018 MSF participants were very positive about the quality of the training (and the school about the quality of the participants!).

The ideal candidate we are looking for is a member of a Management Team (field or HQ), in the process of transitioning to a General direction position.

Please send your applications (CV, motivation letter and application form) to Sophie Le Canu, MSF International Human Resources Coordinator, by 16 July.

You can find more details attached to the Weekly Update email.

Positions Vacant: Field

Sexual and Reproductive Health Referrent

ICRC is looking for a sexual and reproductive health referent – based in Nairobi, Kenya.The role is available as the current person (ex-MSF midwife) is leaving her position.

In emergency and non-emergency situations, the midwife guarantees access to quality reproductive health services for women in a defined geographic area, and/or ICRC supported health facilities.. She is a capacity-building interface between communities (local leaders, health staff, women's groups, etc.) and internal (ICRC) and external (Ministry of Health, NGOs, UN system, etc.) stakeholders on health-related issues, also follows specific health-related issues, such as care for victims of violence, including sexual violence, within the ICRC's institutional and Health Strategy approaches.

Click here for more information and to apply.

Positions Vacant: MSFA

For a copy of each job description including the full selection criteria, please see the MSF website.

Applications MUST address individual selection criteria. You should also write a cover letter indicating why you want to work for Médecins Sans Frontières Australia Ltd and attach a copy of your CV. Applications & enquiries to the HR Advisor, officerecruitment@sydney.msf.org.

Médecins Sans Frontières Australia is committed to creating an inclusive workplace for all our staff. We believe that a diverse team helps us better serve those most in need, and we encourage people from a wide range of backgrounds to apply, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people with disabilities.

Executive Director, MSF Australia

This is a broad, all-encompassing position with the following key role outcomes:

- Together with the Board, successfully model and encourage a culture of leadership and development across all levels of MSF Australia.
- Represent MSF Australia to government, not for profit, academic and research sectors as appropriate in Australia and New Zealand while maintaining the organisation's independence.
- Manage media as one of the primary spokespersons in conjunction with the MSF Australia President.
- Represent MSF Australia and New Zealand to the donor community, and specifically foster one on one high level donor relationships.
- Represent MSF Australia's interests and shared responsibilities with its partnerships within the MSF movement, namely the Operational Centre Paris (OCP) and Operational Centre Geneva (OCG) groups, and the South East and East Asia Pacific (SEEAP) partnership of Hong Kong, Japan and Australia.
- Set International Policy and Practice, and the allocation of resources as a voting member of the MSF International Executive Committee.
- Stewardship of finance, HR, IT, risk management fundraising.

Application process:

Beaumont Not-for-Profit has been retained to recruit this position so please direct all enquiries, or requests for a full position description, to Lisa Turner at Beaumont People.

Applications should address the requirements of the role and how your experience is relevant together with a copy of your CV.

Please submit your application here.

Applications close: 21 July 2019