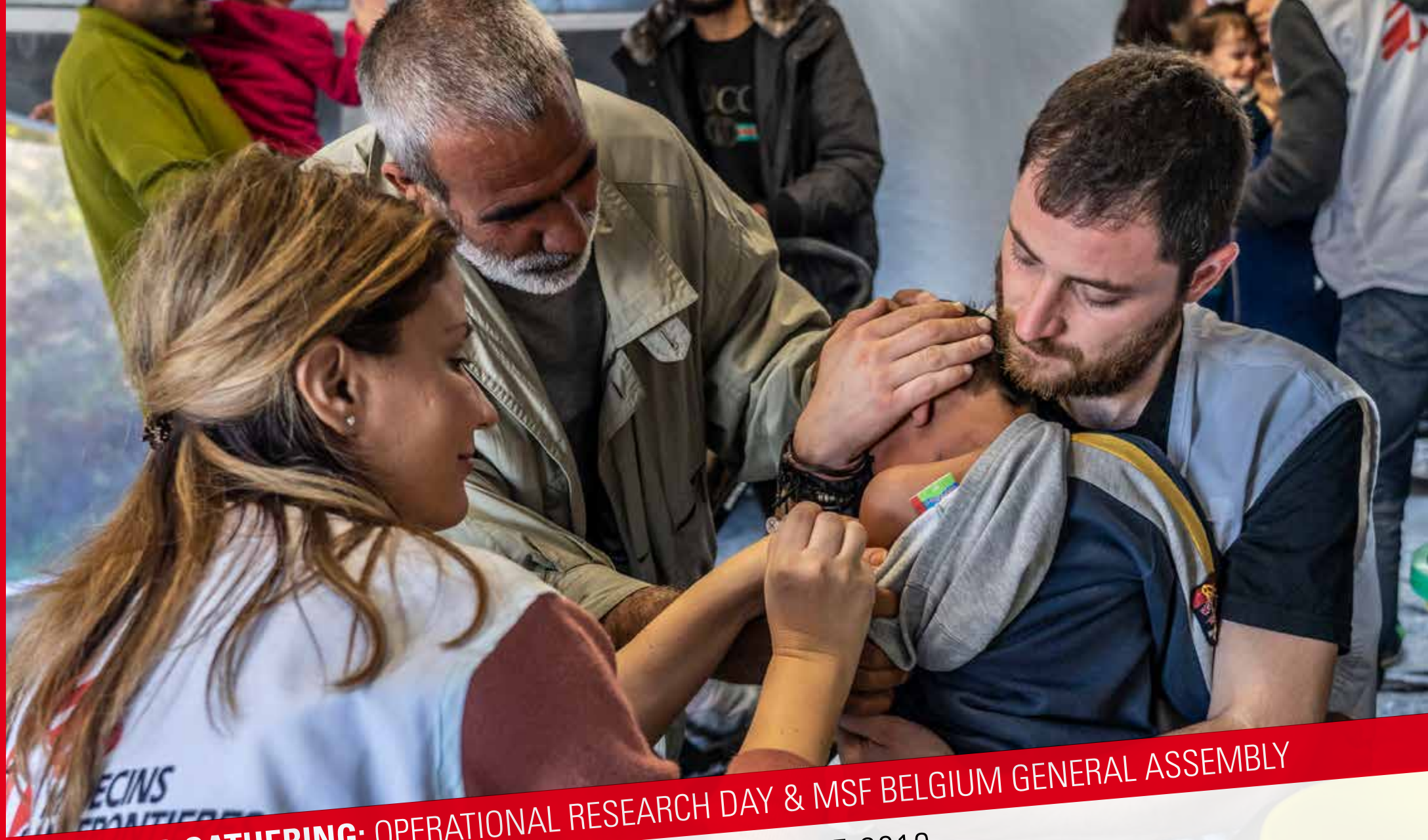

OCB GATHERING: OPERATIONAL RESEARCH DAY & MSF BELGIUM GENERAL ASSEMBLY

BRUSSELS, 31 MAY & 1 JUNE 2019

MSF Operational Centre Brussels

OR DAY 2019: SCIENTIFIC COMMITTEE

Marc Biot, Bertrand Draguez, Petros Isaakidis, Christina Psarra, Samuel Sieber, Sebastian Spencer

ORGANIZING TEAM 2019

OCB GATHERING: OPERATIONAL RESEARCH DAY / MSF BELGIUM GENERAL ASSEMBLY
Souad Aïnèche, Maria Diaz Garcia, Sophie Guillaumie, Petros Isaakidis, Lydia Linna, Christina Psarra, Samuel Sieber, Göran Svedin

TABLE OF CONTENTS

Foreword 3

Agenda 4

OR Day Abstracts
Slot 1: The Right Care for Victims of Violence 6

Slot 2: New and Persisting Challenges in HIV and TB Care 10

Slot 3: From Operational Research to Policy and Practice Change 14

Speakers and Chairs 18

MSF Field Research 24

Practical Information 25

Notes 26

Cover photo:
Vaccination campaign for migrant children on Lesvos Island, Greece. Due to the terrible living conditions, including the lack of basic sanitation, severe overcrowding, and extremely limited access to healthcare, children are particularly vulnerable to illness. © Anna Pantelia/MSF

FOREWORD

Dear friends,

It is my pleasure to invite you to the Annual Gathering of the Operational Centre Brussels (OCB), MSF Belgium General Assembly, and to our 8th OCB Operational Research Day in our offices in Brussels.

8th OCB Operational Research Day | 31 May

With the support of LuxOR and SAMU, we will be presenting innovative new operational research during this day. We often work in very difficult situations, and we need strong data, analysis, and publications to share what we do with partners and donors and to support our accountability and our advocacy efforts.

This year we will have three exciting thematic slots. The first slot will focus on the right care for victims of violence, the second slot will feature new and persisting challenges in HIV and TB care, and the last slot will be dedicated to moving from operational research to policy and practice change.

Finally, access to essential medicines remains a problem worldwide. Directly after the OR Day, a debate with the Access Campaign will explore whether we can campaign on medical issues outside of our social mission.

MSF OCB Gathering / MSF-B General Assembly | 31 May and 1 June

Starting right after the discussion with the Access Campaign, this year's MSF OCB Gathering will be filled with interesting debates, motions, and voting. Our discussions will be led by three main topics:

The field recentralization project: How to shift decision-making closer to the field? How far do we want to go, what are the risks, what kind of accountability do we want?

The quality of care: How to ensure our staff has the right skills to perform difficult clinical procedures? Are we too ambitious in our program objectives? Do we have too many projects, or are they too complex?

Emergency deployment: Are we still able to deploy emergency responses, taking into consideration the constraints we are facing internally and externally?

We look forward to seeing you for these two days at Rue de l'Arbre Bénit, Brussels.

Bertrand Draguez
President MSF Operational Centre Brussels

AGENDA

FRIDAY, 31 MAY

OPERATIONAL RESEARCH DAY

MASTERS OF CEREMONIES
Christina Psarra and Samuel Sieber

09:15 INTRODUCTORY VIDEO & OPENING REMARKS
Sebastian Spencer, Bertrand Draguez

09:30 Slot 1: The Right Care for Victims of Violence
Chairs: Séverine Caluwaerts and Reem Mussa

"My mind is not like before": Psychosocial rehabilitation of refugee victims of torture and other forms of ill-treatment in Athens - Christina Popontopoulou

"What about men and boys?" Access to care and type of assault suffered among male victims of sexual violence, a multicentric study of MSF programs in seven countries in Africa - Anaïs Broban

"Better dead than being mocked": Unwanted pregnancy and abortion, an anthropological study on perceptions and attitude. Mweso, Mambasa and Lulingu, DRC 2018 - Doris Burtscher

Research Initiative: Migration History Tool: An innovative way to collect information from people on the move - Juan-Carlos Cubides

11:00 COFFEE BREAK*

11:30 Slot 2: New and Persisting Challenges in HIV and TB Care
Chairs: Daniela Belen Garone and Nathan Ford

High levels of HIV-1 drug resistance pre-treatment and with first-line ART failure in Mozambique - Valentina Carnimeo

Very poor short- and medium-term patient outcomes amongst critically ill patients hospitalized for HIV in Guinea, Conakry - Kassi Nanan-N'Zeth

Responding to the substance use challenge in rifampicin-resistant tuberculosis: Preliminary outcomes of a primary health care substance use management model in Khayelitsha, South Africa - Laura Triviño-Duran

Research Initiative: MSF KwaZulu-Natal, South Africa: Bending the Curves of HIV & TB: 2011-2018 - Ellie FordKamara

13:00 LUNCH

14:00 Slot 3: From Operational Research to Policy and Practice Change
Olumide Ogundahunsi and Bjørn Nissen

An innovative water, sanitation and hygiene toolkit to fight cholera and typhoid fever: The road to change in Harare, Zimbabwe - Danish Malik

Diphtheria anti-toxin administration, outcomes, and safety in response to a diphtheria outbreak in Cox's Bazar, Bangladesh - Nell Eisenberg

Reasons for sub-optimal vaccination coverage in urban settings in Conakry, Republic of Guinea: "When you welcome well, you vaccinate well" - Julita Gil Cuesta

Research Initiative: Measurement properties of an Activity Independence Measure for Trauma (AIM-T) patients in humanitarian settings - Bérangère Gohy

15:30 CLOSING REMARKS
Sebastian Spencer

15:45 Access Campaign Debate
Can we campaign on medical issues outside of our social mission?

OCB GATHERING & MSF BELGIUM GENERAL ASSEMBLY

16:30 WELCOME

17:00 OPENING
President's report
Financial & HR reports
Questions and answers to the Board and Voting

19:00 DRINK AND SNACKS

19:30 Candidates to the OCB-Board & MSF-B Board
Presentation - Questions & Answers

21:00 DINNER AND DRINKS

23:30 END

*Poster presentation "Voices from the Field: The Impact of Mentoring on MSF" will take place throughout the day - Holly Bennett

AGENDA

SATURDAY, 1 JUNE

OCB GATHERING & MSF BELGIUM GENERAL ASSEMBLY

09:30 **WELCOME**

10:00 **MSF-B Vice-President's report**
MSF-B Motions
IGA Reps feedback

10:45 **BREAK**

11:15 **Debate:**
Field recentralization project: How to shift decision-making closer to the field? How far do we want to go, what are the risks, what kind of accountability do we want?

13:00 **LUNCH**

14:00 **Group debates:**
The quality of care:
How to ensure our staff has the right skills to perform difficult clinical procedures? Are we too ambitious in our program objectives? Do we have too many projects, or are they too complex?

Emergency deployment:
Are we still able to deploy emergency response, taking into consideration the constraints we are facing internally and externally?

16:00 **BREAK – CLOSURE OF THE VOTE BOXES**

16:30 **2019 OCB motions and 2018 feedback**

19:30 **Closure and voting results**
20:00 **APÉRO**

20:30 **DINNER**

22:00 **PARTY!**

SLOT 1

THE RIGHT CARE FOR VICTIMS OF VIOLENCE

"My mind is not like before": Psychosocial rehabilitation of refugee victims of torture and other forms of ill-treatment in Athens

Presenter: Christina Popontopoulou
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Introduction
The dual trauma of being a victim of torture as well as a refugee is related to a myriad of losses, human rights violations, and other dimensions of suffering linked to torture experienced pre-migration, as well as different forms of violence experienced during and after migration.

Methods
The goal was to present three case studies to explore culturally-informed perspectives on trauma among victims of torture and track trajectories of psychosocial rehabilitation in relation to environmental factors. The case studies are part of a larger qualitative study of asylum seekers and refugees in a center for victims of torture in Athens, managed by Médecins Sans Frontières and Babel in collaboration with the Greek Council for Refugees, which follows beneficiaries, their care providers, and community representatives and leaders.

Results
Key themes emerging include the substantial psychological impact of current material realities of migrant victims of torture as they adapt to their new environment and engage in rehabilitation. Delayed asylum trials, poor living conditions and unemployment have a substantial impact on posttraumatic symptoms that in turn influence psychosocial rehabilitation. Personal, social, and cultural resources emerged as having a mediating effect.

Conclusions
The results highlight the significant impact of the political, legal, and sociocultural environment on psychosocial rehabilitation. Practical implications for interventions are to ensure holistic, interdisciplinary, and culturally sensitive care which includes a focus on environmental factors affecting resilience, and with a dynamic focus on the totality of the individual over isolated pathologies.

THE RIGHT CARE FOR VICTIMS OF VIOLENCE

"What about men and boys?" Access to care and type of assault suffered among male victims of sexual violence, a multi-centric study of MSF programs in seven countries in Africa

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Philip Owiti
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Eva De Plecker

Introduction
Often neglected, male-directed sexual violence (SV) has recently gained recognition as a significant issue. However, male victims have fewer access points for care, due to stigma and lack of program adaptation, and their characteristics remain poorly understood and recognized. For several years, MSF has systematically documented characteristics of presentation to care of all victims arriving at its SV clinics in different contexts across Africa, providing a unique opportunity to examine ways of improving males' access to SV care. The objective of this study was to document the challenge of males in accessing SV care, and to describe key differences of male versus female victims of SV, to strengthen the awareness of frontline workers towards this relatively neglected population.

Methods
This was a multi-centric cross-sectional study using routine program data from 11 MSF programs in 7 countries in Africa, between 2011 and 2017.

Results
A total of 13,550 cases of SV, including 1009 against males (7.5%), accessed MSF SV clinics between 2011 and 2017. Children (<13yrs) represented 34% of male patients. Overall, patients presenting to clinics providing integrated care (medical and psychological) for victims of violence were more frequently male (odds ratio 3.3, 95%CI 2.4-4.6), as compared to stand-alone SV clinics or clinics integrated into maternal and child health units, where disclosure upon admission was necessary. Different SV patterns appeared between younger and older males presenting for care. While children and adolescents were more often assaulted by known civilians, without physical violence, adults more often endured violent assault, perpetrated by authority figures. Though most cases in migratory zones were adults, the proportions of children and adolescents in this setting were also significant. Limitations included selection bias, as victims who did not present for care were missed, and difficult accounting of the impact of local contexts.

Conclusions
The setup of SV services is a key factor to encourage more males, particularly adults, to access SV care. Disclosure of SV events remains challenging, especially for males; however, once disclosed, adherence to care was similar between genders. SV projects need to consider awareness activities tailored to child, adolescent, and adult male SV victims, and should anticipate the need for adequate medical capacity, notably psychological care with appropriately trained attendants able to treat all ages and genders, to improve both access to and care for male victims of SV.

"Better dead than being mocked": Unwanted pregnancy and abortion, an anthropological study on perceptions and attitude. Mweso, Mambasa, and Lulingu, DRC 2018

Presenter: Doris Burtscher
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Introduction
Unwanted pregnancy and unsafe abortion contribute significantly to the burden of ill health, maternal suffering, and death in the Democratic Republic of the Congo (DRC). A qualitative study was conducted to improve understanding of vulnerabilities of females with health care needs related to unwanted pregnancy and abortions, health-seeking behavior, and barriers for accessing health care.

Methods
Data was collected in three different areas in DRC, using in-depth individual interviews (124), group discussions (36), and observations. Respondents were purposively selected with the help of MSF team members. All interviews were recorded. Transcriptions were screened for relevant information, manually coded, and analyzed, inspired by qualitative content analysis. Methodological triangulation of findings enhanced the interpretation of data.

Results
Perceptions and attitudes towards abortion vary across the three study areas. In North Kivu, abortions are seen as morally reprehensible, contrary to widespread practice of abortion. In Ituri, many see abortions as an appropriate solution for reducing maternal mortality, whereas health professionals are hindered in providing adequate medical care due to legal constraints. In South Kivu, people are primarily opposed to abortion, whereas some tolerance exists towards breastfeeding women. The main reasons for women to abort are related to stigma and shame, socio-demographics and finances, as well as transactional sex or rape. Contrary to the prevailing critical narrative on abortion, the study highlights a significant demand in all three study sites.

Conclusions
Women lack decision-making power regarding their sexuality, in and outside of marriage. The reasons for females to abort reflect traditional values, difficult living conditions, and socio-economic constraints. The Lega proverb "Better dead than being mocked" shows that females would rather risk dying through an unsafe abortion than staying pregnant and being mocked for their unwanted pregnancy.

THE RIGHT CARE FOR VICTIMS OF VIOLENCE

Migration History Tool: An innovative way to collect information from people on the move

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Nuni Jorgensen
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Introduction

Using their knowledge and experience regarding the complexities surrounding health conditions of mobile populations, their variation from context to context, and the limitations that standard surveys have to capture and correlate information on multiple migratory moves, BRAMU has developed the Migration History Tool (MHT) to collect intricate data on migrant populations and establish its connections to a specific time and place.

Methods

After researching the methodologies and tools in the field of migration studies, we found the Life History Calendar (LHC) technique the most suitable for our purposes, as it relates different events of a person's life and associates them to specific timeframes and locations. The vertical dimension details the aspects to be investigated, whereas the horizontal dimension is divided in the places where the person has gone through. Because there was no program specifically designed for LHC research, we are in the process of developing an interactive and flexible data collection software integrated with mapping.

Results

MSF TIC is the sponsor of our project and we are now at the development stage; the tool will be tested for the first implementation in Beitbridge, Zimbabwe. Operationally, the main outcomes will potentially include reorientation of project objectives by identifying latent health needs that are not being addressed; indication of community engagement strategies through the analysis of migrant's health seeking behavior; recognition of key populations that may be particularly vulnerable and should receive deeper attention; suggestion of new attention points at specific points of the route; and refinement of advocacy strategies through a better understanding of difficulties in health access and rights violations against migrants.

Conclusions

The Migration History Tool is a tool projected to trace migratory routes in contexts of multiple and rapid moves, and relating routes to migrants' health conditions in unstable settings, situations in which traditional questionnaires are often unsuitable.

SLOT 2

NEW AND PERSISTING CHALLENGES IN HIV AND TB CARE

High levels of HIV-1 drug resistance pre-treatment and with first-line ART failure in Mozambique

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Introduction
Since 2013, MSF has supported viral load (VL) scale-up in rural and urban Mozambique where programmatic data showed high rate of HIV-1 virological failure (VF, VL≥1,000 HIV-1 RNA copies/mL). The extent of acquired drug resistance (ADR) to first-line antiretroviral therapy (ART) and pre-treatment drug resistance (PDR) was unclear in this phenomenon. We aimed to estimate the proportion of VF and HIV drug resistance (HIVDR) among patients receiving first-line ART for more than 6 months and the level of PDR among HIV-patients (re-) initiating ART in both settings. We present combined findings of two studies on high level of pre-treatment HIV-1 drug resistance in a rural and an urban setting in Mozambique, and on high level of HIV-1 drug resistance among patients with first-line ART failure in three health facilities in Tete province and Maputo city, Mozambique.

Methods
Two cross-sectional studies were conducted between October 2017 and October 2018 in MSF-supported health centers (HC) (ADR survey: 1 HC in Maputo, 2 HCs in Tete District; PDR survey: 1 in Maputo, 7 in Tete) among patients aged ≥ 18 years. VL was quantified and drug resistance test (DRT) realized if VL ≥1,000. HIV DR was defined as low, intermediate, or high level resistance (StanfordHIVdb). PDR was reported as the proportion of non-nucleoside reverse transcriptase inhibitor (NNRTI) resistance.

Results
ADR: among 1,113 participants (57.5% in Maputo, median age 42 years, 67.7% female), 11% (95CI% 9.4-13.2) had VF. Among these, 91.2% (N=114, CI95% 84.7-95.5) had any HIVDR, 73.6% (95CI% 65.0-81.0) had any nucleoside reverse transcriptase inhibitors (NRTI) resistance, and 89.6% had any NNRTI DR.PDR: among 735 participants (39% in Maputo, median age 34 years, 55% female, 12.7% ART-pre-exposed), 525 (71.4%) had VL>1,000 and DRT available, of these 25.9% (95CI% 22.2-29.9) had NNRTI resistance (55% among those pre-exposed to ART).

Conclusions
Viral suppression on first-line ART was high, but among VF, most were on a failing regimen. The level of PDR among ART-initiators exceeded 10% threshold, and about one quarter of patients would initiate ART with an ineffective first-line regimen. Surveillance at national level is needed as well as non-NNRTI first-line ART for initiation.

Very poor short- and medium-term patient outcomes amongst critically ill patients hospitalized for HIV in Conakry, Guinea

Presenter: Kassi Nanan-N'Zeth
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Introduction
Optimal management of critically ill patients with HIV infection or patients with advanced HIV disease during and after hospitalization is critical for their survival. This study describes characteristics and outcomes during hospitalization and six months after hospital discharge of patients with HIV infection hospitalized at Unité des Soins Formation et Recherche in Conakry, Guinea between August 2017 and April 2018.

Methods
A retrospective observational cohort study using routine clinical data of all patients admitted during the period was performed. Baseline characteristics, and short- and medium-term outcomes were described using proportions and chi-squared tests.

Results
A total of 401 patients were hospitalized for the first time during the study period. 230 (57%) were female, median age was 26 (IQR: 28-45), 237 (60%) were on ART, and median CD4 cell count at admission was 64 cells/mm3. 268 patients had HIV RNA VL at admission; of these, 185 (70%) had documented VL>1000copies/mL. Of 306 patients with adherence documentation, 97 (32%) had documented treatment interruption. 270 (67%) presented with symptoms lasting >2 weeks before admission. 143 (36%) patients died during hospitalization, and of these, 18 (13%) died within the first 48 hours of admission. The net mortality at >48h after admission was 31%. Regarding clinical presentation at admission, 84 (21%) patients presented severe anemia, 127 (32%) signs of central nervous system (CNS) involvement, and 137 (34%) severe malnutrition. Tuberculosis in any form or localization constituted 35% of all final discharge diagnoses and 34% of documented mortality causes. Other diagnoses were of neurological origin (107, 27%), other respiratory infections (57, 14%), and NCDs (43, 11%). A total of 194 of the 258 patients discharged (75%) from the hospital could be traced for follow-up six months after hospitalization. Of these, 35 (18%) died after hospitalization, 57 (29%) were lost-to-follow-up, 5 (3%) transferred, and 97 (50%) alive and active in care. 59% (N=57) of all lost-to-follow-up occurred immediately after discharge. Amongst post-hospitalization deaths, tuberculosis constituted 47% of recorded diagnosis, and neurological conditions 21%. 89/194 (46%) patients were readmitted at least once within 6 months after discharge of first hospitalization.

Conclusions
One in three critically ill patients with HIV infection admitted in the hospital in Conakry died during hospitalization, at least one in two patients died or were lost-to-follow-up post-discharge and at least one in two was readmitted at least once. While most deaths were attributed to TB, strategies to strengthen care, management, and follow-up of those patients during and after hospitalization should be explored to improve survival and retention in care.

Responding to the substance use challenge in rifampicin-resistant tuberculosis: Preliminary outcomes of a primary health care substance use management model in Khayelitsha, South Africa

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Introduction
Substance use (SU) is associated with poor rifampicin-resistant tuberculosis (RR-TB) treatment outcomes. In 2017, Médecins Sans Frontières and the Department of Health integrated screening, brief intervention and referral to treatment (SBIRT) into the RR-TB treatment program in primary health care clinics. Here we describe early experiences of the use of this model, which incorporates motivational interviewing.

Methods
This was an observational cohort of patients with RR-TB who were screened for SU between October 2017 and May 2019 in Khayelitsha, South Africa. Screening was conducted using the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) and the Alcohol Use Disorders Identification Test (AUDIT). Patients who scored moderate- or high-risk were referred to a SU support group; those with moderate- or high-risk alcohol use and considered eligible by a clinician, were offered naltrexone treatment. Here we describe the number of patients screened, their risk category, and the number of patients started on naltrexone.

Results
One hundred nine RR-TB patients were screened for SU; 53 (49%) were females and the median age was 36 years (interquartile range [IQR] 29-45); 81 (74%) were HIV co-infected. Ninety-eight (90%) patients reported SU, with 17/62 (27%) using ≥ one substance; 44/62 (71%) scored moderate or high-risk for ≥ one substance. Overall, patients reported using the following SU: 92/98 (94%) alcohol, 49/98 (50%) tobacco, 17/98 (17%) cannabis, 3/98 (3%) methamphetamines, and 1/98 (1%) cocaine. Twenty-two (32%) of the 69 moderate- or high-risk patients attended the support group at least once. Of the 92 that reported alcohol use, 39 (42%), 18 (20%), and 35 (38%) scored low-, moderate-, and high-risk, respectively. Of the 53 patients that scored moderate- or high-risk, 50/53 (94%) received a brief intervention and 19/36 (53%) initiated naltrexone.

Conclusions
Moderate and high-risk substance use was common among the RR-TB patients screened; alcohol was the most common substance reported. Integrating SBIRT, pharmacotherapy, and support groups into primary health RR-TB care could be beneficial.

NEW AND PERSISTING CHALLENGES IN HIV AND TB CARE

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MSF KwaZulu-Natal, South Africa: Bending the Curves of HIV & TB: 2011-2018

Médecins Sans Frontières has been supporting the Department of Health in the sub-district of Mbongolwane and Eshowe, KwaZulu-Natal (KZN), South Africa since 2011. The prevalence of HIV in KZN was 25.8% in adults 15-49 years in 2008 and 27.9% in 2012 (national prevalence was 18.8% in 2012 and 16.9% in 2008), consistently the highest prevalence amongst all provinces in South Africa.

MSF conducted a household survey in 2013 in the project catchment area which showed the prevalence in the project area to be even higher than that of KZN, reaching 56% amongst women aged 25-29 years.

The "Bending the Curves" project has sought to implement a wide range of innovative interventions to help reduce HIV and TB incidence in line with the five-year SA National Strategic plan on HIV, STIs, and TB (2012-2016) and the UNAIDS 90/90/90 strategy. Focused primarily on the high-risk population under 29 years of age, it included community mobilization for the aggressive promotion of prevention methods of both HIV and TB, community testing and screening, linkage to care, earlier treatment, promotion of patient-centred and patient-owned treatment, faster diagnosis and treatment, and ensuring adherence and retention, providing access to both community- and facility-based options. The direction of the program was led by the survey conducted in 2013 and evaluated with a second household survey conducted in 2018, thus allowing the project to compare the 2013 and 2018 surveys.

The 2018 survey has shown a significant increase in the number of people aware of their HIV status, increasing from 76% to 90%, and the percentage of people on antiretroviral treatment increasing from 70% to 95%. Overall, the project has achieved a significant increase in the proportion of people living with HIV who are virally suppressed (from 57.4% to 83.9%).

SLOT 3

FROM OPERATIONAL RESEARCH TO POLICY AND PRACTICE CHANGE

An innovative water, sanitation and hygiene toolkit to fight cholera and typhoid fever: The road to change in Harare, Zimbabwe

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Introduction

Water is a key determinant of health, and water supply is increasingly at risk of over-demand, contamination, and pollution. Harare is such a context where high water demand and poor access to improved sanitation come together in a perfect storm, and the city is faced with recurrent outbreaks of cholera and typhoid fever. In 2015, MSF launched the "WASH as prevention" project, diagnosing boreholes in the suburbs of Budiriro and Glen View with an innovative mobile toolkit, and upgrading/rehabilitating them where necessary. In parallel, community health clubs (CHC) were established and/or reinforced in order to ensure appropriate maintenance, including chlorination, of these boreholes. A study was conducted to understand the underlying dynamics of the recurrent outbreaks and to evaluate the performance of the CHC, in order to provide direct operational guidance on the "WASH as prevention" project and to establish a strong feedback between research and practice on the ground.

Methods

Geospatial mapping of the 2016 and 2017 typhoid fever outbreaks in Budiriro and Glen View in function of borehole location was conducted. Additionally, boreholes were investigated using the mobile toolkit for contamination, structural damage, hydrogeological context, and environmental contamination.

Results

At least 4 boreholes were found to be contaminated with Salmonella spp., and a spatial association with the outbreaks of typhoid fever in 2016 and 2017 was observed. Detailed investigations using the toolkit for borehole diagnosis identified multiple potential sources of contamination, including fracturing of the local hydrogeological context, very shallow depth of the water table, poor sanitary conditions in the immediate surroundings of the boreholes, and borehole construction defects. Evaluation of both short-term and longer-term impact of the CHC is on-going and results are expected to be out in the coming months.

Conclusions

Boreholes appear to play a key role in the transmission of Salmonella spp. Many possible routes of contamination were identified, and sealing all such routes in the complex hydrogeological context of Harare may be challenging. Chlorination of borehole water is a viable short-term solution, but requires sustained support to community interventions such as CHC to maintain access to safe drinking water. The toolkit for borehole diagnosis that was used throughout this study is now being prepared for regional scale-up and will be the cornerstone of initiatives towards a comprehensive environmental health approach.

FROM OPERATIONAL RESEARCH TO POLICY AND PRACTICE CHANGE

Diphtheria anti-toxin administration, outcomes, and safety in response to a diphtheria outbreak in Cox's Bazar, Bangladesh

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Introduction
Diphtheria has re-emerged over the past several years, particularly in areas of conflict and poor vaccination coverage. There is scarce data on the administration and safety of diphtheria anti-toxin (DAT). The 2017-2018 outbreak among Rohingya refugees in Cox's Bazar Bangladesh was the largest in decades. We determined the outcomes of DAT-treated patients and described the occurrence, management, and risk factors associated with adverse reactions to DAT therapy.

Methods
We conducted a retrospective study on the OCB-managed Diphtheria Treatment Center from December 2017-September 2018. Diphtheria was diagnosed based on the MSF clinical case definition. Cases were risk-stratified into high and low-risk. High-risk patients were eligible for DAT. Dose was determined based on clinical signs and symptoms. Safety precautions were meticulously maintained, including a high clinician-to-patient staff ratio, infusion-readiness checklists, and close patient monitoring during infusions.

Conclusions
The outcomes for DAT-treated patients were excellent. There were no deaths attributed to DAT. Adverse reactions were not rare, but most reactions were mild and resolved with slowing the infusion and symptomatic therapy. DAT can be safely administered in a low-resource setting provided there is a high clinician-to-patient ratio, intensive staff training, and attention to safety precautions. Our findings show the feasibility of administering DAT at this critical care level and will be incorporated in the Clinical Diphtheria guidelines.

FROM OPERATIONAL RESEARCH TO POLICY AND PRACTICE CHANGE

"When you welcome well, you vaccinate well": Reasons for sub-optimal vaccination coverage in urban settings in Conakry, Republic of Guinea

Introduction

Quantitative surveys have identified sub-optimal vaccination coverage reached by mass vaccination campaigns (MVC) in urban settings in sub-Saharan countries. Understanding the reasons for this could help to adapt and improve future vaccination strategies. The 2018 measles outbreak in Conakry, Republic of Guinea, provided an opportunity to understand sub-optimal vaccination coverage within a MVC among participants through their perceptions and experiences.

Methods

We conducted Focus Group Discussions (FGDs) with caregivers, and key informant interviews (KII) with healthcare workers and community leaders in two communes in Conakry. Participants of vaccinated and non-vaccinated children were recruited through purposive sampling. FGDs were conducted in Susu and KIIs in French, until saturation was reached. Informed consent and ethics approval was obtained.

Conclusions

In order to increase MVC coverage, we suggest recruiting CHWs from the local community, ensuring better presentation tech-niques and language skills, and improving their training to promote comprehensive knowledge about vaccine mechanisms, and potential side effects and their management.

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FROM OPERATIONAL RESEARCH TO POLICY AND PRACTICE CHANGE

Measurement properties of an Activity Independence Measure for Trauma (AIM-T) patients in humanitarian settings

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Introduction
Trauma is a major cause of burden to society, and even more so in crisis situations: health structures and actors are often overwhelmed and major trauma can result in long-term disabilities, affecting not only the patient, but also families and communities. To improve trauma care, improved data collection and analysis are essential to better understand the quality of care and patient outcomes. There are, however, no validated functional outcome measures for trauma patients in humanitarian settings. The Activity Independence Measure for Trauma patients (AIM-T) was designed for use in the Kunduz Trauma Center, and is composed of 20 daily activities. This tool has since been used at field level by MSF and Handicap International (HI), but aspects of validity and reliability have not yet been assessed.

Methods
An observational study with sequential cross-sectional studies, including analysis of retrospectively and prospectively collected data, is being conducted across seven MSF/HI projects to address: 1) internal redundancy and floor-and-ceiling effects; 2) content validity; and 3) construct validity, interrater reliability, and internal consistency.

Results
The study is currently ongoing. Previous results from the Kunduz Trauma Center showed a marked relevance of the score, indicating an increase in activity independence over the course of in- and outpatient physiotherapy, reaching independence levels of 79% by the time of outpatient discharge. The AIM-T showed a high capacity to discriminate between different types of patients. Routine data from six MSF projects (n=790) has allowed the identification of redundancy (correlation >90% between two items), as well as a large ceiling effect, mainly within upper limb activities. The AIM-T was reviewed and the number of activities was reduced from 20 to 11. Interviews with patients and staff are ongoing in four MSF projects to assess the content validity of the revised AIM-T across different cultures. Optimizations conducted during the study are anticipated to further refine the score, and the final output will be a cross-culturally valid, reliable, and easy-to-use AIM for trauma patients in humanitarian settings.

Conclusions
The AIM-T will set a new standard to monitor, evaluate, and report on trauma care outcomes in the field. Next steps include a gradual rollout of the validated activity independence score and extensive development of hands-on experience for health and rehabilitation actors on the ground, using on-site and remote training and practical guidance on how to use the score. It is anticipated that the study will provide the basis for reviewing and updating surgical and rehabilitation protocols in humanitarian settings. Additionally, the study will serve as a prelude to a wide analysis of the determinants of functional recovery following trauma, providing evidence of the role of physiotherapy in functional recovery in humanitarian contexts.

SPEAKERS AND CHAIRS

Anaïs Broban graduated from the Institut National des Sciences Appliquées (INSA) of Toulouse as a biochemical engineer, then from the Institut Pasteur and Conservatoire National des Arts et Métiers (CNAM) in Paris in 2014 with a specialized Master's degree in Epidemiology of Infectious Diseases. After first experiences at the Institut Pasteur in Madagascar and at Sanofi Pasteur involving vaccines for neglected diseases, she joined MSF in 2016. Anaïs has accomplished various field missions in countries including DRC and Bangladesh, and worked on subjects such as active and passive surveillance networks, surveys, and operational research. In 2018, she participated in the African SORT IT program, created to develop researchers' capacities for operational research in Africa.

Doris Burtscher holds a PhD in Medical Anthropology and works at the Vienna Evaluation Unit. Since 2001, she has worked as a medical anthropologist with MSF and has undertaken fieldwork within MSF and other NGOs in Mauritania, Kenya, Sierra Leone, Zimbabwe, Liberia, Niger, Eswatini, Lebanon, India, Chad, Iraq, Kyrgyzstan, Afghanistan, Uganda, DRC, Senegal, and Albania. Her main fields of interest are how people deal with health and illness in different contexts (HIV/AIDS, MDR TB, malnutrition, sexual and reproductive health, sexual violence, safe abortion care etc.) and health seeking behavior.

Séverine Caluwaerts is an obstetrician-gynecologist from Belgium who has been working with MSF since 2008 in different contexts (Sierra Leone, Burundi, DRC, Afghanistan, Pakistan, Niger, Central African Republic). She has been one of the gynecology referents since 2011. Her special interests include pregnancy and infectious diseases (HIV, Ebola), care for sexual violence victims, and cervical cancer screening and treatment in low-resource settings. She also continues to work as a clinician at the Institute of Tropical Medicine (ITM) in Antwerp, Belgium. She obtained a diploma in Tropical Medicine from ITM, Antwerp and a Master's in Public Health from Liverpool University.

Valentina Carnimeo is an epidemiologist with a background in biology. She earned a Master's degree in public health from Insititut Pasteur, CNAM in Paris. She joined Epicentre in 2015, working in Kenya as study coordinator and then in Paris. Before joining Epicentre, she worked with the Drugs for Neglected Diseases initiative (DNDi) on the sleeping sickness clinical trial in RDC and CAR as clinical research assistant. She has worked in different countries in Africa as a lab technician. Her research interests are HIV and viral hepatitis.

Juan-Carlos Cubides holds a Bachelor's degree in Microbiology, with specialization in the domain of Bioanalysis (University of Antioquia, Medellín, 2005), a Master's degree in Epidemiology (CES University, Medellín, 2011), and is a Tropical Medicine PhD candidate (Oswaldo Cruz Foundation, Rio de Janeiro, 2019). He joined MSF in 2010 and currently works as an epidemiologist for the Brazilian Medical Unit (BRAMU), after working in projects and management activities on various topics and contexts: HIV-TB (Malawi, Swaziland, Uganda, Kenya, Georgia and Armenia), emergency response (Sudan), and Ebola (Sierra Leone). He has experience in the domain of Public Health, with emphasis on Monitoring and Evaluation, Epidemiology, and Diagnostic Tests.

Julita Gil Cuesta is a medical doctor with a Master's in Public Health. She holds a degree as Specialist in Preventive Medicine and Public Health in Spain. She worked for the World Health Organization country office in Vietnam from 2010-2012 for Maternal, Neonatal, and Child health. She was part of the EPIET field epidemiology programme at the SSI in Copenhagen, Denmark from 2012-2014. Julita has done different missions as medical epidemiologist in Cameroon (Zerca y Lejos NGO), Bolivia (WHO), DR Congo (MSF OCA), Sierra Leone (WHO), Myanmar (CRED/UCL), and the Philippines (CRED/UCL). She joined LuxOR in February 2017 and is based in Brussels.

SPEAKERS AND CHAIRS

Nell Eisenberg is an internist and infectious disease specialist based in New York. She received an AB from Harvard University and a MD from Columbia University in USA. Nell has worked with MSF since 2006, completing missions in: Guatemala, Kenya, India, South Sudan, Sierra Leone, Ethiopia, and Bangladesh. When not in the field, she is an Assistant Professor at Cornell Medical School and works as a Hospitalist at NewYork-Presbyterian Hospital.

Nathan Ford is a scientific officer with the Department of HIV/AIDS and Global Hepatitis Programme of the World Health Organization in Geneva, and head of WHO's Guidelines Review Committee. Prior to joining WHO in 2012, he worked with MSF for 14 years, supporting HIV programs in in southern Africa and Southeast Asia. He holds a degree in Microbiology and Virology, a Master's in Public Health and Epidemiology, and a PhD in Clinical Epidemiology. He has published over 400 peer-reviewed publications and is an editorial adviser for the WHO Bulletin and a member of the editorial boards of JAIDS, Tropical Medicine and International Health, and Conflict and Health.

Ellie FordKamara has been working in the humanitarian world since 1995, and for MSF since 1998, as Finance Coordinator, HR Coordinator (or both), Project Coordinator or Head of Mission and in locations as varied as Rwanda, DRC, Sierra Leone, South Sudan, Thailand, Cambodia, Kenya, Mozambique, and Malawi. Ellie also worked for MSF Australia as Director of Admin and Finance between 2000 and 2005. Ellie has been working in Southern Africa since 2005 and since 2015 has been the Project Coordinator for MSF OCB in KwaZulu-Natal (KZN), South Africa.

Daniela Belen Garone has been Medical Deputy Coordinator of Operations for Malawi, Mozambique, South Africa, Zimbabwe, India, Venezuela, Bolivia and Brazil since October 2018. She is an Infectious Diseases and Tropical Medicine doctor from Argentina, with 20 years of experience working in HIV/TB and MDR-TB programs. She joined MSF in 2008 and worked as a medical doctor, HIV Implementer, Project Medical Referent, and Medical Coordinator in Zimbabwe, South Sudan, Malawi, South Africa, and Mozambique. Daniela has over 15 years of experience in clinical and operational research and contributed to over 50 international publications and presentations in international forums. Since 2012, Daniela serves as reviewer for multiple international journals and conferences. She was part of the creation of MSF Latin America and served as Board Member of MSF Southern Africa, 2015-2017. Areas of specialization include simplification of care and optimization of resources in resource-limited settings, a domain to which MSF contributes sound evidence.

Bérangère Gohy has worked as a physiotherapist in several Handicap International (HI) and MSF projects, then as rehabilitation technical referent in emergency projects for HI. She is currently coordinating a joint research project with HI, MSF, and the Karolinska Institute on outcomes after trauma in humanitarian settings.

Danish Malik is specialized in Land Resources Engineering and has previously worked as a Geophysicist in the Oil and Gas sector. He joined MSF in 2015 as an Environmental Health Engineer and has worked in emergency Cholera and Typhoid responses, European Migration Response, Integrated Vector Control, and Ground Water. He is currently based in Harare, Zimbabwe, as a Regional Project Coordinator for an Environment and Health Project. The project aims to combat diarrheal outbreaks by enabling the provision of safe drinking water through the rehabilitation of dysfunctional boreholes and the drilling of new boreholes, community engagement and empowerment for sustainability and disease surveillance, urban and rural hygiene and sanitation models, capacity building on MSF's innovative WASH toolkit, operational research, advocacy, and policy change at the national level.

SPEAKERS AND CHAIRS

Reem Mussa has been working for MSF since 2017 as Humanitarian Advisor on Forced Migration. She provides support to MSF operations in terms of context analysis, positioning, and advocacy strategies. Prior to MSF, Reem was the Advocacy Director at RISE, a refugee-led organization based in Australia. Reem has worked with a range of international organizations to address issues of health, education and refugee rights with experience in North and Eastern Africa, Europe, and Australia. Reem has a Master's in Migration and Intercultural Relations from the University of Oldenburg, Germany. She completed field work on protracted urban refugees in Khartoum, the politics of asylum in Africa, and implications of European policies in collaboration with Afhad University for Women, Sudan. She has a Bachelor of Arts in Anthropology and Social Theory from the University of Melbourne and has held academic positions at the University of Melbourne teaching development and post-colonial studies.

Kassi Nanan-N'Zeth is from Côte d'Ivoire and currently works as the MSF Medical Coordinator in Conakry, Guinea. He has a Master's in Public Health (Health Systems Strategic management), as well as a Certificate in Humanitarian Practice and a Doctor's State diploma. His experience includes positions as MSF Medical Coordinator in Guinea, Central African Republic, Burundi, Mali, and Egypt. He has also participated in MSF Medical Academy (Preparation MPH for MedCos and PMRs, OCB headquarters), and has worked as PMR in Masisi DRC, expatriate MD in Guinea, Zimbabwe, and Niger, and as National staff with MSF in Côte d'Ivoire. Kassi is a co-author on "How do low-birth weight neonates fare 2 years after discharge from a low-technology neonatal care unit in a rural district hospital in Burundi? (2017)," "Emergency Obstetric Care in a Rural District of Burundi: What Are the Surgical Needs? (2017)," and "One size fits all? Standardised provision of care for survivors of sexual violence in conflict and post-conflict areas in the democratic republic of Congo (2014)."

Bjørn Nissen is the country director for MSF in Zimbabwe. He studied political science in Oslo, and has worked with Norwegian People's Aid and Food, the Agriculture Organization of the UN, and MSF. Since 2002, Bjørn has held various MSF positions as field coordinator, logistical coordinator, and country director in Sudan, Chad, India, Italy, and Pakistan, was on the board of MSF Norway and worked in the MSF offices in Norway, Italy, and India.

Olumide Ogundahunsi is a scientist in the Research Capability Strengthening unit of the Special Programme for Research and Training in Topical Diseases (TDR) at the World Health Organization, Geneva and visiting Professor of Pharmacology & Therapeutics at the University of Medical Sciences, Ondo. In 2012, he led TDR efforts to build implementation research capacity in low and middle income countries. In this role, he coordinated the development of an implementation research tool kit designed to help researchers, policy-makers and program officers identify and address system bottlenecks / implementation problems. He currently leads the Access and Delivery Partnership (ADP) project in TDR – ADP is a collaboration with the UNDP, PATH, and WHO designed to build capacity for access to and delivery of new global health technologies for NTDs and other diseases in low and middle income countries.

Christina Popontopoulou is a clinical psychologist trained in Systemic psychotherapy with a Master's degree in IPPS Psycho-pedagogy of Inclusion and Multicultural Education. Since 2016, she has been working with Médecins Sans Frontières (MSF) in the Athens Project for migrants and refugees who have suffered torture or/and ill-treatment. She has also long experience in working in the field of drug addiction rehabilitation.

Laura Triviño-Duran is a registered nurse and a medical doctor who holds a Diploma in International Relations (CIDOB, Barcelona, Spain) and a Master's in Public Health from the London School of Hygiene and Tropical Medicine. She worked in Spain as a GP before joining MSF 13 years ago. Since then, she has worked in different countries, including Nepal, Zambia, Uganda, Lesotho, Malawi, and India, and currently works in South Africa with a strong focus on the implementation of HIV and TB programs. She now works in South Africa as Medical Coordinator.

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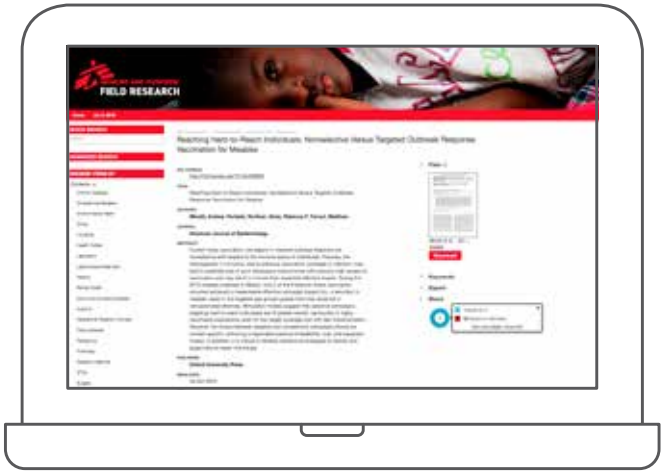

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Back cover photo: Londiwe, a young mother, gets her blood pressure taken by an MSF nurse at the Community Adherence Club at King Dinizulu Clinic in Eshowe, KwaZulu-Natal. She is among 30 stable HIV+ patients who attend the club once every two months to have their health checked and receive their ARVs. This relieves people living with HIV of the hassle of sitting in long queues for 1-on-1 visits, and reduces the strain on an already overburdened public health system.
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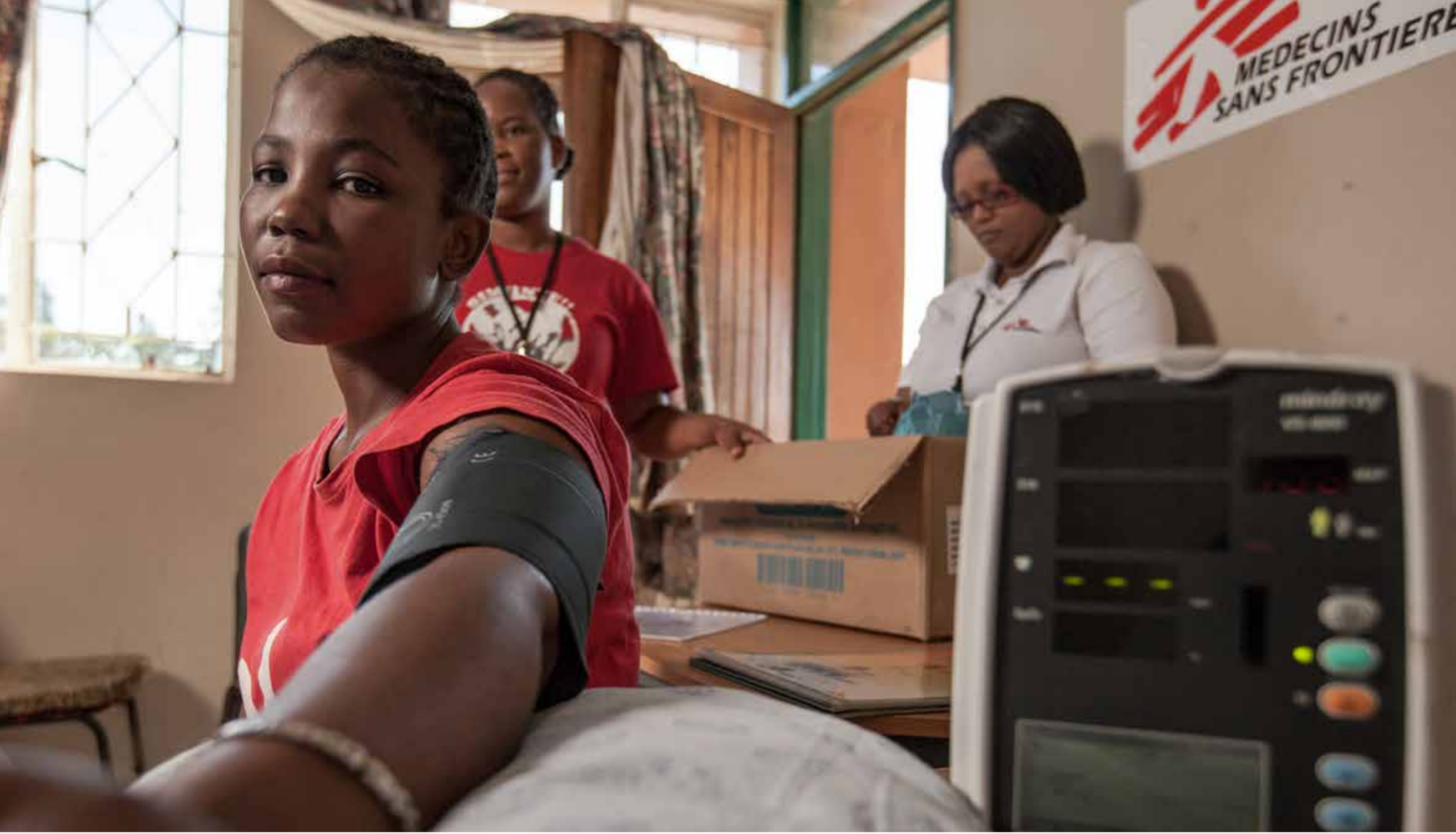

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