



OCB GATHERING: OPERATIONAL RESEARCH DAY / MSF BELGIUM GENERAL ASSEMBLY
BRUSSELS, 1 & 2 JUNE 2018

OR DAY 2018: SCIENTIFIC COMMITTEE

ORGANISING TEAM 2018

TABLE OF CONTENTS

Bertrand Draguez, Sebastian Spencer, Walter Kizito, Bart Janssens, Petros Isaakidis

**OCB GATHERING: OPERATIONAL RESEARCH DAY / MSF BELGIUM GENERAL ASSEMBLY
Maria Diaz Garcia, Souad Aineche, Sophie Guillaumie, Veerle Hermans, Samuel Sieber**

Foreword	3
Agenda	4
OR Day Abstracts	
Slot 1: The Paradox of survival: "I prefer dying fast than dying slowly"; pain, disease and life in limbo	6
Slot 2: Sex, Drugs & Prisons; working for the unwanted, the untested, the untreated and the "unsuppressed"	10
Slot 3: Viruses, bacteria & parasites; sensitive, resistant and emerging	14
Slot 4: Panel discussion: Who pays? User fees making a comeback...	18
Speakers and Chairs	19
MSF Field Research	24
Practical Information	25
Notes	26

Cover photo:

Nurse and midwife Furaha Bazikanya examines a young pregnant woman in one of the two consultation spaces at a mobile clinic in the village of Kier, South Sudan. © Frederic NOY/MSF

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 seventh OCB Operational Research Day in our offices in Brussels.

7th OCB Operational Research Day | 1 June

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, supporting our accountability and our advocacy efforts.

This year we will have four exciting thematic slots, focusing on beneficiaries' needs and their perception of assistance, on neglected populations, and on infectious and non-communicable diseases. A debate on the alarming attempts to reintroduce user fees will conclude the OR Day.

MSF OCB Gathering / MSF-B General Assembly | 1 and 2 June

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

How to make our employee charter more explicit to address issues related to harassment and abuse?

Our Employee Charter clearly states that "MSF employees shall not tolerate any behavior that exploits the vulnerability of others, in the broadest sense (economic, social, etc.)". **Does everyone in the room understand this rule correctly?** MSF wants to continuously improve how we prevent, detect and manage harassment and abuse within our organization and several steps have already been taken.

Embedded humanitarianism: Is it justified to "cosy up" with the coalition in Iraq and Nigeria?

In Iraq or Nigeria, armed groups like ISIS and Boko Haram reject dialogue with humanitarians. These organizations are also considered terrorist by the states opposing them. This places MSF in a counter-terrorism framework when operating in the zones controlled by the Iraqi and Nigerian armies. De facto, MSF relies on the protection of these armies for the staff and health structures it runs. With the presence of protective armed forces around MSF structures and operations, do we need to address the challenges of an **"embedded humanitarianism"**?

Nursing care, are we enough equipped to provide good nursing care to patients?

Great efforts have been made to strengthen nursing care throughout the MSF-movement, and dedicated new tools have been developed in the medical world to support nursing staff. **But are we sufficiently equipped today to ensure sustainable nursing care practices?** And have we done enough for our field staff to support them in the dilemma of providing care to patients with limited resources?

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, JUNE 1

OPERATIONAL RESEARCH DAY

MASTER OF CEREMONIES

Tony Reid

09.00 OPENING REMARKS

Bertrand Draguez

09.15 Slot 1: The paradox of survival: "I prefer dying fast than dying slowly"; pain, disease and life in limbo

Chairs: Alice Bloomfield and Aurélie Ponthieu

Pain and musculoskeletal complications post sexual violence – an added value of physiotherapy in the rehabilitation of victims of sexual violence? - [Engy Sawah](#)

"I prefer dying fast than dying slowly" – How institutional abuse worsens the mental health of stranded Syrian, Afghan and Congolese migrants on Lesbos Island - [Christos Eleftherakos](#)

"I feel like I am less than other people": Self-perceived vulnerabilities of male migrants travelling alone on their journey to Europe - [Jovana Arsenijevic](#)

Life in limbo – holistic provision of mental health and psychosocial support to asylum seekers in destination countries in Europe - [Jenny Gustafsson](#)

11.00 COFFEE BREAK

11.30 Slot 2: Sex, drugs & prisons; working for the unwanted, the untested, the untreated and the "unsuppressed"
Chairs: Daniela Belen Garone and Marc Biot

Improving TB case finding in Malawian prisons: implementation of systematic screening - [Reinaldo Ortuno Gutierrez](#)

Characteristics and outcomes of HIV-infected patients admitted for inpatient care to a rural district hospital in Nsanje, Malawi - [Pier Francesco Giorgetti](#)

Provision of oral pre-exposure prophylaxis for female sex workers and men who have sex with men in Beira, Mozambique - [José Carlos Beirão](#)

Improving pediatric TB diagnosis in North Kivu, DR Congo, by targeted Gene Xpert on gastric aspirates - [Daan Van Brusselen](#)

13.00 LUNCH

14.00 Slot 3: Viruses, bacteria & parasites; sensitive, resistant and emerging

Chairs: Johan van Griensven and Ernestina Repetto

Malaria in Cambodia (a synthesis of research findings) - [Martin De Smet](#)

Field evaluation of Joachim clinical score and rapid diagnostic test for paediatric bacterial pharyngitis in a refugee camp, Beirut, Lebanon - [Chantal Lakis](#)

Household disinfection kits distribution during the 2014-2015 Ebola epidemic in Monrovia, Liberia: The MSF experience - [Peter Maes](#)

Late breaker: Care for Syrian refugees with Diabetes in a crisis context: The MSF experience in the Levant - [Krystel Moussally](#)

15.30 Slot 4: Panel discussion: Who pays? User fees making a comeback...

Chair: Wim Van Damme

16.20 CLOSING REMARKS

[Sebastian Spencer](#)

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 and answers

21.00 DINNER AND DRINKS

23.30 END

AGENDA

SATURDAY, JUNE 2

OCB GATHERING & MSF BELGIUM GENERAL ASSEMBLY

09.30 WELCOME

10.00 MSF-B Vice-President report
MSF-B Motions
IGA Reps feedback

10.45 BREAK

11.15 Debate:

How to make our employee charter more explicit to address issues related to harassment and abuse?

13.00 LUNCH

14.00 Group debates:

Embedded humanitarianism:
Is it justified to cosy up with the coalition in Iraq and Nigeria?

Nursing care, are we sufficiently equipped to provide good nursing care to patient?

16.00 BREAK – CLOSURE OF THE VOTE BOXES

16.30 2018 and 2017 feedback

19.30 Closure and voting results

20.00 APÉRO

20.30 DINNER

22.00 PARTY!

SLOT 1

THE PARADOX OF SURVIVAL: "I PREFER DYING FAST THAN DYING SLOWLY"; PAIN, DISEASE AND LIFE IN LIMBO

Pain and musculoskeletal complications post sexual violence – an added value of physiotherapy in the rehabilitation of victims of sexual violence?

Introduction

Sexual violence is a devastating problem worldwide, with a major impact on the medical and psychological wellbeing of its survivors. The standardized MSF package of care for sexual violence consists of specialized medical care, mental health, and increasingly, socio-legal support. In one MSF project in the MENA region, a component of physiotherapy was integrated for the rehabilitation of patients with chronic pain, musculoskeletal dysfunctions, and gynaecological and functional complications. Physiotherapy interventions included individual patient care, group sessions, and perinatal care for women who were pregnant during or after the sexual violence. Information on the prevalence of musculoskeletal consequences for victims of sexual violence remains scarce, and the possible added value of integrating physiotherapy into the standardized MSF package of care for sexual violence rehabilitation remains undocumented. We therefore conducted a study to assess the patterns of musculoskeletal complications and chronic pain in patients who experienced sexual violence, and the functional recovery achieved during physiotherapy.

Methods

A retrospective analysis of routinely collected data from an MSF programme offering care for victims of sexual violence, from December 2014 to March 2018.

Results

240 cases receiving physiotherapy as part of their treatment for sexual violence were included. Most were female (81%), with a median age of 32. The main musculoskeletal complications following sexual violence were fractures (11%) and joint dislocations (2%). Seventy-eight percent of all sexual violence patients in the physiotherapy programme experienced chronic pain; most suffered from back pain (56%), neck pain (9%), and general pain (3%). Pain was assessed using a 10-point Visual Analogue Scale (VAS). A mean reduction of 2.1 points on the VAS scale between the first and last physiotherapy session was observed ($p < 0.001$).

Conclusion

Musculoskeletal complaints among victims of sexual violence were not uncommon, and more than three out of four patients suffered from pain. Introduction of physiotherapy for such cases appeared to reduce the pain considerably. Programmes offering care for sexual violence are urged to consider including a component of physiotherapy to their package of care. A limitation of the study was its retrospective nature, which did not allow the assessment of a number of additional key indicators. Further studies should assess how physiotherapy affects aspects of care such as psychological recovery, remediation of incontinence, and overall quality of life among victims of sexual violence.

Presenter: Engy Sawah

<engysawah@gmail.com>

Engy Sawah

Mohamed A. Ahmed

Rafael Van den Bergh

THE PARADOX OF SURVIVAL: "I PREFER DYING FAST THAN DYING SLOWLY"; PAIN, DISEASE AND LIFE IN LIMBO

"I prefer dying fast than dying slowly" – How institutional abuse worsens the mental health of stranded Syrian, Afghan and Congolese migrants on Lesbos Island

Background

In 2015 and early 2016, close to one million migrants transited through Greece on their way to Western Europe. In early 2016, the closure of the "Balkan-route" and the EU-Turkey deal led to a drastic reduction in the flow of migrants arriving on the Greek islands. The islands became open detention centers, where people would spend months or years under the constant fear of being returned to Turkey. Syrians were generally granted refugee status in Greece and those arriving before March 20th 2016 had the option of being relocated to other European countries. Afghans had some chance of being granted asylum in Greece, yet most migrants from the Democratic Republic of Congo were refused asylum. In a clinic run by *Médecins Sans Frontières* on Lesbos Island, psychologists observed a deterioration in the mental health of migrants. In order to understand the mental health needs for this stranded population, it was essential to explore how, and through what factors, their mental health on Lesbos Island has been affected due to the EU-Turkey deal.

Methods

This was a qualitative study in which eight interviews with service providers and 12 focus group discussions with male and female Syrian, Afghan and Congolese migrants in two refugee camps on Lesbos Island were conducted. Thematic content analysis was manually conducted and the triangulation of findings was undertaken to enhance the interpretation of data.

Results

Three main themes were identified: 1) Institutional abuse, 2) Continuous Traumatic Stress (CTS) and 3) Lack of or inefficient MH services. Institutional abuse was expressed as inhumane living conditions, lack of information to make future decisions, humiliation and depersonalization. This led to CTS that was expressed through being in a state of permanent emergency without protective measures. Delays in appointments, lack of psychiatric care and differences in mental health perceptions highlighted the inadequacy or inefficiency of mental health services.

Conclusion

The EU-Turkey deal reduced migrant flows at a very high price. Decongestion of the camps and the elimination of institutional abuse are urgently needed to reduce CTS and improve the mental health status of migrants.

Presenter: Christos Eleftherakos
<celeftherakos@gmail.com>

Christos Eleftherakos
Wilma van den Boogaard
Declan Barry
Nathalie Severy
Ioanna Kotsioni
Louise Roland-Gosseli

THE PARADOX OF SURVIVAL: "I PREFER DYING FAST THAN DYING SLOWLY"; PAIN, DISEASE AND LIFE IN LIMBO

Presenter: Jovana Arsenijevic

<jarsenijevic@gmail.com>

Jovana Arsenijevic
Doris Burtscher
Aurelie Ponthieu
Nathalie Severy
Andrea Contenta
Stephane Moissaing
Stefano Argenziano
Federica Zamatto
Rony Zachariah
Engy Ali
Emilie Venables

"I feel like I am less than other people": Self-perceived vulnerabilities of male migrants travelling alone on their journey to Europe

Background

During 2015 and early 2016, an unprecedented flow of around 800,000 migrants crossed the Balkans towards Western Europe. The EU-Turkey deal left thousands of people trapped on Greek islands and in the Balkans. MSF has been present in Serbia since 2014 providing medical and mental health services. In the migration response, male migrants are perceived as being less vulnerable than other migrants and are often not prioritised. This study was conducted to explore self-perceptions of vulnerabilities of male migrants travelling alone.

Methods

This was an exploratory qualitative research study conducted in 2017. Twenty-four in-depth interviews, two group interviews and participant observation were conducted with male migrants in Belgrade, Serbia. Data was thematically analysed and manually coded. Codes were generated and main themes extracted.

Results

Male migrants traveling alone face the cumulative vulnerability of various traumatic events and migration-related contextual circumstances. Three main themes emerged: their ongoing desperate journey, the better treatment of 'traditionally' vulnerable sub-groups, and the impact of continuous stress on mental health. Deterrence measures imposed for border control purposes in the form of push-backs, expulsions, cross-border violence, detention, degrading, inhumane treatment and humiliation amplified the psychological distress. Feelings of hopelessness, desperation, lack of self-value and self-esteem were predominantly reported. 'Traditionally vulnerable' populations were perceived to have received better treatment from smugglers, border state authorities, governmental officials, civil society and international organizations throughout the journey.

Conclusion

The devastating experiences of male migrants travelling alone; precarious living conditions; continuous exposure to violence, humiliating and degrading treatment; as well as the better treatment offered to other groups of migrants, like women and children, resulted in a perceived neglect of the needs of men in the humanitarian response. In a context where needs are unmet and people's dignity and health is at risk, specific strategies should be developed to be more inclusive for young men in the assistance and protection offered, in particular related to exposure to violence.

THE PARADOX OF SURVIVAL: "I PREFER DYING FAST THAN DYING SLOWLY"; PAIN, DISEASE AND LIFE IN LIMBO

Life in limbo – holistic provision of mental health and psychosocial support to asylum seekers in destination countries in Europe

Background

Many European countries struggle to provide adequate psychosocial care for asylum seekers, with priority often placed on specialised mental health care for severe cases, rather than preventative approaches. In Sweden and Belgium, MSF has initiated a new, holistic model of intervention for mental health and psychosocial support for asylum seekers and staff involved in the care for asylum seekers, including screening and detection of mental health conditions; counselling; provision of psychoeducation group sessions; provision of psychological first aid (PFA); and capacity building among asylum centre/healthcare staff.

Methods

This was a mixed methods study, relying on a quantitative analysis of routine programme data generated in four asylum centres in Skaraborg, Sweden, including a baseline survey on health information, healthcare utilisation, and quality of life; and a series of qualitative interviews with asylum seekers and asylum centre staff.

Results

A total of 219 screenings, 123 in-depth assessments, 209 counselling follow-up sessions (including PFA by counsellors), and more than 200 phone follow-up sessions were conducted. Additionally, 642 asylum seekers received PFA sessions by lay workers (cultural mediators), and 1301 individuals participated in group activities.

Out of all individuals screened by MSF, 164 (75%) reported receiving a health screening at arrival in Sweden, but only 44 (20%) had undergone a mental health screening. The severity of the mental health conditions was found to be considerably higher among individuals residing in Sweden >2 years. Overall, 61% of individuals undergoing screening and 85% of individuals undergoing an assessment were referred on to another service/actor (medical care, mental health care, psychoeducation, recreational activities, or cultural briefings).

Interviews with asylum seekers and staff clearly identified the need to talk: the strong need of the asylum seeker population to be listened to and to be taken into consideration seemed to be met by MSF's openness and organised activities.

Conclusions

The MSF holistic model of intervention seems to address a number of gaps in care for mental health in the Swedish asylum system, including the lack of early screening/identification, the challenge of access to required services, and the difficulty of simply finding someone to listen and talk to about the ordeals of migration. While the intervention holds promise, it also reveals how the asylum system does not manage to provide a conducive environment for mental recovery, and indeed may contribute to further deterioration of mental health conditions among the asylum seeker population.

Presenter: Jenny Gustafsson

<jenny.gustafsson@lakareutangranser.se>

Jenny Gustafsson

Gaia Quaranta

Rafael Van den Bergh

Umberto Pellecchia

Niklas Bergstrand

Rosa Crestani

Tomas Thiels

SLOT 2

SEX, DRUGS & PRISONS; WORKING FOR THE UNWANTED, THE UNTESTED, THE UNTREATED AND THE "UNSUPPRESSED"

Presenter: Reinaldo Ortuño Gutierrez
<MSFOCB-Blantyre-MedCo@brussels.msf.org>

Reinaldo Ortuño Gutierrez
Altynay Shigayeva
Caroline Aluda
Dyson Henderson
Kumbukani Chawinga
Eric Goemaere
Petros Isaakidis
Lawrence Chiwaula

Improving tuberculosis case finding in Malawian prisons: implementation of systematic screening

Introduction

Maula and Chichiri, two central prisons in Malawi, currently hold 2770 and 1870 inmates respectively, over 340% of their intended capacities. In 2014, MSF introduced a comprehensive package within these prisons, using measures on entry, during their stay and exit to prevent, screen, diagnose and treat HIV and tuberculosis (TB), and other health conditions. Since 2015 interventions for patients with presumptive TB have included symptomatic screening followed by MTB/RIF GeneXpert and/or sputum microscopy. In 2017 MSF, working together with Challenge TB, carried out a mass campaign using digital X-ray as an additional screening tool. This study aims to assess how TB case finding changed between 2014 and 2017, and to determine factors associated with developing TB disease whilst in prison.

Methods

We carried out a retrospective analysis of routinely collected data from 2014 to 2017. Case notification rate was calculated for new cases (self-reported as never previously treated). To determine the person-time at-risk, we used a sum of monthly inmate count excluding time on TB treatment for incident cases. We used a 3 month cut-off to separate prevalent cases on entry from incident cases. We applied multivariate logistic regression to assess factors associated with development of TB.

Results

Between 2014 and 2017, TB case notification per 100 000 population increased from 921 to 4621 in Chichiri, and from 430 to 3346 in Maula. For the 468 TB cases seen, 464 (99%) were males, median age was 32 years (IQR; 26-38), 213 (46%) were TB/HIV+, and 81/386 (21%) had BMI<18.5. Sixty-three (13.5%) had extrapulmonary TB, 376/468 patients were diagnosed >3 months after entering prison. Risk of developing TB was significantly associated with being HIV+ (aOR=3.8, 95% CI; 2.9-5.2, p<.0001), BMI<18.5 (aOR=2.0, 95% CI; 1.4 – 2.8, p<.0001), and being incarcerated for >1 year (aOR=7.1, 95% CI; 4.7-10.6, p<.0001). Of the 468 TB cases detected, treatment was provided for all.

Conclusion

Systematic TB screening (including digital X-rays) has likely lead to an important increase in case finding in Malawi prisons between 2014 and 2017. As prisons remain a high risk setting for acquiring or developing TB disease, we suggest that systematic screening may be expanded country-wide and preventive therapy for eligible prisoners should be considered to prevent development of TB.

**SEX, DRUGS & PRISONS; WORKING
FOR THE UNWANTED, THE UNTESTED,
THE UNTREATED AND THE "UNSUPPRESSED"**

Characteristics and outcomes of HIV-infected patients admitted for inpatient care to a rural district hospital in Nsanje, Malawi

Background

MSF has supported the District Health Office of Nsanje, Malawi in strengthening HIV and TB services since 2011. In May 2016, in response to high in-hospital mortality among HIV and TB patients, a surveillance system was set up at Nsanje District Hospital (NDH) to monitor HIV- and TB-related admissions and related cause of death. In this report, we describe the characteristics and outcomes of HIV positive adults >15 years old admitted to NDH from 1 May 2016=31 December 2017.

Methods

In-hospital surveillance was based on retrospective review of medical records. Data on prior ART history was collected from ART facilities. Categorical variables were compared using Chi-square test. Factors associated with in-hospital death were assessed using multivariate logistic regression. Advanced HIV disease was defined as CD4<200 or having WHO stage III/IV clinical conditions.

Results

734 patients were admitted during the study period: 75/734 (10.2%) were re-admitted at least once. Average length of stay was 7 days (IQR; 4-14). 367 (50%) were male, median age was 37 years old (IQR; 30-45). Sixteen percent (n=118) were diagnosed with HIV during hospitalization, and 83.9% (n=616) were admitted with a known HIV positive status. Prior ART history was verified for 496/616 patients with a known HIV positive status. A further 120 patients self-reported being on ART. Out of these 496, 62.5% (n=310) were on ART >6 months and 37.5% (n=186)<6 months. 71/496 (14%) were known to have interrupted treatment. Of 734 patients 331 had a CD4 count. The median CD4 was 151 cells/mm³ (IQR: 56-338.5), 57% (189/331) had CD4<200 cells/mm³. On presentation, 519 (71%) met advanced HIV disease criteria. Clinical conditions included pulmonary TB (n=135), extrapulmonary TB (n=106), recurrent pneumonia (n=152), meningitis including cryptococcal (n=73), pneumocystic pneumonia (n=11), Kaposi sarcoma (n=20), esophageal candidiasis (n=38), toxoplasmosis (n=13), chronic diarrhea (n=13) and cervical cancer (n=9). Advanced HIV disease was 73% (451/616) amongst those who were known to be HIV positive and 58% (68/118) in newly diagnosed patients. In-hospital mortality was 29.4% (216/734), 68/216 (31.4%) died ≤ 48 hours of admission. Factors associated with in hospital mortality were advanced HIV disease (aOR=1.85; 95% CI, 1.25 to 2.86; p=0.002), male gender (aOR=1.44, 95% CI, 1.04 to 2.01; p=0.02), and aged ≥45 (aOR=1.69; 95% CI, 1.09 to 2.53, p=0.03).

Conclusion

Despite Malawi's success in scaling up HIV services for reaching the 90-90-90 targets, in-hospital HIV-related mortality remains high in Nsanje. The implementation of a new model of care, rapid assessment unit for HIV patients, would likely be the key element to reduce mortality, through timely and intensive investigations and early treatments initiation. The intervention has to run in parallel with an intensified identification of patients with advanced HIV at peripheral level (decentralization of screening package) and increased switch to second line ART regimes.

Presenter: Pier F. Giorgetti

<MSFOCB-Nsanje-SeniorMD@brussels.msf.org>

Pier F. Giorgetti

Altynay Shigayeva

Blessings Kapumba

Reinaldo Ortuno Gutierrez

Eric Goemaere

Rosie Burton

Alphonsina C. Ndembera

Alexander Chijuwu

SEX, DRUGS & PRISONS; WORKING FOR THE UNWANTED, THE UNTESTED, THE UNTREATED AND THE "UNSUPPRESSED"

Provision of oral pre-exposure prophylaxis for female sex workers and men who have sex with men in Beira, Mozambique

Introduction

MSF began providing outreach HIV prevention, testing and treatment services to Female Sex Workers (FSW), Men who have Sex with Men (MSM) and truck drivers along the trucking corridor leading from Beira to Tete, Mozambique, in 2013. In 2016, a pilot mixed methods study was implemented to evaluate the feasibility, acceptability and demand for oral pre-exposure prophylaxis (PrEP) among female sex workers (FSW) and men who have sex with men (MSM).

Methods

All FSW and MSM attending HIV services in Beira between March 2016 and December 2017 were invited to participate in the study by community counselors and peer-educators. We provide descriptive statistics and proportions at contact, screening, enrollment and retention in PrEP. Reasons for drop-out and loss to follow up were collected and tabulated. Convenience sampling was used to select FSWs (who did not want to participate, who dropped out and who were still enrolled), peer-educators and MSF staff for the qualitative component, in which two focus group discussions (FGD) and 32 interviews were conducted. Interviews and FGDs were transcribed, thematically analyzed and coded using NVivo.

Results

252 FSW and 58 MSM were offered PrEP. 184 (73%) FSW and 58 (100%) MSM accepted to be screened, from which 169 (92%) FSW and 54 (93%) MSM were eligible for the study. We recruited 119 (70%) FSW and 42 (78%) MSM. Mean participant age was 24 years (SD=6). Among 81 not included, 6% were HIV positive, and 5% were pregnant. Fifty FSW and 11 MSM did not return to the clinic after confirming eligibility. Overall retention rates in PrEP at month 1, 3, 6, 9 and 12 were 73% (117/161); 49% (79/161); 40% (46/115); 29% (24/84); and 25% (14/56), respectively. Higher dropout rates were observed among FSW (79/119; 66%) as compared to MSM (24/42; 57%). Main reasons for withdrawal were change of residence (53%) and lack of awareness about their risk of HIV infection (11%). One HIV seroconversion was observed, after 6 months of PrEP, in a FSW. Reasons why participants were taking PrEP included for '*protection*', as an '*insurance policy*' if a condom breaks, lack of trust in male partners and perceiving themselves to be at risk of HIV. Reported side-effects and travel were reasons for '*dropping out*'. FSWs were concerned about the risk of stigmatisation.

Conclusions

Preliminary results showed a high demand and uptake of PrEP amongst a high-risk mobile population. Despite the acceptability of PrEP, dropout rates after initiation were high and mostly related to changing residence or not perceiving themselves to be at risk of infection. Qualitative analyses revealed challenges with integrating PrEP whilst travelling and stigmatisation. A study is ongoing to ascertain adherence impact to incidence and to better understand association between mobility, risk perception and appropriate PrEP use.

Presenter: José Carlos Beirão

<msfocb-beira-Ormanager@brussels.msf.org>

José Carlos Beirão

Ivan Alejandro Pulido Tarquino

Sarala Nicholas

Ana Torrens

Emilie Venables

Gianluca Ferrario

Ruggero Giuliani

Tom Ellman

**SEX, DRUGS & PRISONS; WORKING
FOR THE UNWANTED, THE UNTESTED,
THE UNTREATED AND THE "UNSUPPRESSED"**

Presenter: Daan Van Brusselen

<daan.vanbrusselen@ugent.be>

Daan Van Brusselen

Erica Simons

Tony Luendo

Jimmy Ngowa

Nadine Neema Mitutso

Delphine Habarugira

Zakari Moluh

Mieke Steenssens

Hilde Vochten

Lucien Ngabo

Petros Isaakidis

Gabriella Ferlazzo

Improving paediatric TB diagnosis in North Kivu, DR Congo, by targeted Gene Xpert on gastric aspirate

Background

According to WHO estimates the incidence of tuberculosis (TB) in the Democratic Republic of Congo (DRC) is 323/100,000. A context of civil conflict, displaced populations and mining activities suggests a higher regional incidence in North Kivu. Médecins Sans Frontières (MSF) supports the General Reference Hospital of Masisi, North Kivu, covering a population of 520,000, including a high number of malnourished children. Twenty-five percent of the current TB cohort in Masisi are children. HIV prevalence is less than 1%. In the summer of 2017, Gene X-pert testing on gastric aspirates (GA) was introduced and utilisation of the MSF paediatric TB diagnostic algorithm was reinforced.

Methods

We performed a retrospective review of TB diagnosis and treatment in children admitted to paediatrics and the inpatient therapeutic feeding centre (ITFC) comparing the last 6 month periods of 2016 and 2017. Targeted GA and the reinforced MSF paediatric TB diagnostic algorithm were used in 2017.

Results

In 2017, 94 GAs were performed, compared to 0 in 2016. Twelve percent (11/94) of samples were Gene Xpert positive. Sixty-eight children (3% of total exits) between 3 months and 15 years started TB treatment in the second half of 2017, compared to 19 (1% of total exits) in 2016 ($p < 0.05$). Patients with a negative Gene X-pert result, but a clearly positive result using the TB diagnostic algorithm, started treatment based on clinical criteria.

Conclusion

After the introduction of Gene X-pert for GA samples and the reinforcement of the MSF paediatric TB diagnostic algorithm, more than three times the number of children started on TB treatment than previously observed, mostly on clinical grounds. Increased awareness of clinicians, due to the frequency of positive paediatric sample results, likely played a role in the increasing TB diagnosis.

SLOT 3

VIRUSES, BACTERIA & PARASITES; SENSITIVE, RESISTANT AND EMERGING

Presenter: Martin De Smet
<martin.de.smet@brussels.msf.org>

Martin De Smet
Gabriele Rossi
Pierluigi Taffon
Lieven Vernaeve
Neil Saad
Jesse Verschuere
Mark Debackere
Chea Nguon
Nimol Khim
Didier Menard
Emilie Venables
Rafael Van den Bergh
Jean-Marie Kindermans

Malaria in Cambodia - a synthesis of research findings

Malaria elimination is a high priority for many low-endemic malaria countries, in particular with the emergence of multi-drug resistant *Plasmodium falciparum* malaria in Southeast Asia. In the Preah Vihear province of Cambodia, which has been identified as an area of high artemisinin resistance, MSF has implemented a vertical project contributing to *P. falciparum* elimination since 2014.

This project has incorporated diverse research and operational activities, including prevalence surveys; design of targeted mass treatment interventions; development of pro-active and reactive case detection strategies (including qualitative investigations on the population's perceptions of such interventions); strengthening of passive case detection and follow-up of patients after treatment; introduction of molecular diagnosis and highly sensitive rapid diagnostic testing (RDT) for (resistant) *P. falciparum*; and anthropological investigations into the interaction between health-seeking behaviour and accessing the various malaria treatment modalities in the region.

Main lessons learnt from the Preah Vihear project include the important contribution of active and reactive case detection to the identification of *P. falciparum* carriers in the region. Such strategies are well-accepted in the community, and benefit from an in-depth understanding of local transmission patterns, which help to define at-risk populations who need to be targeted for screening. Adding molecular diagnosis and, more recently, highly sensitive RDT to the screening activities appears feasible, and markedly increases the positivity rates in the various screenings. Strategies to support the national programmes in implementing such diagnostics are needed. Other initiatives that have been found to be key in contributing to *P. falciparum* elimination in this region are providing strong support to the local Village Malaria Workers, community networks, and involvement of the private sector.

Field evaluation of Joachim clinical score and rapid diagnostic test for paediatric bacterial pharyngitis in a refugee camp, Beirut, Lebanon

Introduction

Acute pharyngitis/tonsillitis, a common diagnosis in children, can be bacterial or viral of origin. Due to the difficulty in discriminating one from the other, antibiotics are often prescribed unnecessarily. In the Médecins Sans Frontières (MSF) run clinic in Shatila, a refugee camp in Beirut, Lebanon, antibiotic prescription monitoring revealed that 90% of children diagnosed with pharyngitis/tonsillitis were prescribed antibiotics. The gold standard for the diagnosis is a microbiological culture; however, in most MSF contexts the use of this method is limited by the delay in obtaining results, their quality, and the cost of the test. Hence, rapid diagnostic tests (RDT) for group A Streptococcus have been developed to increase diagnostic accuracy and reduce inappropriate antibiotic prescription. Additionally, a clinical diagnostic score, the Joachim Score (JS), has been developed as a tool to guide medication prescription in absence of RDT and/or culture. The aim of this study was to evaluate the diagnostic accuracy of the JS and *Alera*TM RDT against gold standard throat swab culture for the diagnosis of bacterial pharyngitis in children.

Methods

All patients ≤15 years diagnosed with pharyngitis/tonsillitis and not having used antibiotics in the previous five days were included in the study. Doctors administered the JS, and a research nurse performed the RDT and took a throat swab for culture. Data was entered in an Excel 2010 database and analysis was done in STATA/IC version 14.2.

Results

A total of 306 patients were enrolled from January to March 2018. Sixty-one percent (187/306) were male, with a median age of 5 years. Only 8% of cultures (24/306) were positive for group A Streptococcus. For JS, the median score was 4 [Range: 0-7]; it demonstrated a sensitivity of 71% and a specificity of 22% at a cutoff of ≥3 against the gold standard. For the RDT, 17% were positive (51/306), with a sensitivity of 71% and a specificity of 88%. Combining the JS and RDT in a diagnostic algorithm did not increase the sensitivity and specificity to an acceptable standard.

Conclusion

In relation to streptococcal pharyngitis in children, the JS was not found to have an acceptable specificity. In settings where valid diagnostic tools are difficult to obtain and where antibiotic prescription rates are high, the JS could represent an additional instrument which aids doctors' decision for prescription, but should still be used with caution.

Presenter: Chantal Lakis

<MSFOCB-Beirut-Epidemiologist@brussels.msf.org>

Chantal Lakis

Amal Chamoun

Sahar Bajis

Wilma van den Boogaard

Dolla Sarkis

Pascale Chaillet

Isabel Zuniga

Marjolein De Bruycker

Rafael Van den Bergh

Household disinfection kits distribution during the 2014-2015 Ebola epidemic in Monrovia, Liberia: The MSF experience

Background

In an unconventional attempt to slow the rise in Ebola cases in Monrovia, Liberia, MSF as a stopgap measure distributed disinfection kits in the most affected zones (mass distribution) and among those who were at a high risk of contamination (targeted distribution) including health workers, and relatives of admitted patients. This evaluation study: a) describes the contents and the distribution process of the Ebola protective kits, b) assesses whether the distributed kits were used correctly.

Methods

This was a descriptive study using operational monitoring data. Each kit contained protective gowns, gloves and masks, as well as soap, chlorine and a sprayer, along with instructions on the use and safe disposal of materials. Kits were meant to be used for care of the sick or to handle dead body fluids. The overall target population was estimated to be 65,000 households in Monrovia. In order to ensure the optimal and correct use of the kits, health promotion accompanied the distribution. Four teams performed the mass distribution using 8-15 health promoters in each event. Community leaders estimated the number kits necessary for their areas. Live demonstrations (25 minutes, max 30 participants) and movie sessions (45 minutes, max 150 participants) were organized at all distribution sites. Using structured questionnaires, phone interviews were conducted by four trained health promoters one week following the distribution. Phone interviews were attempted for all beneficiaries of the targeted distribution and 2% from the mass distribution.

Results

Overall, 65,609 kits were distributed: 58,250 during mass distribution and 7,359 during targeted distribution. During mass distribution, 67 distribution events took place, with a median of 649 [IQR 344-838] kits distributed/event/team. In total, 1,386 recipients were reached by phone interview. Households from targeted distribution (non-health staff) experienced significantly more events of sickness and/or death than others after receiving the kits. Of 60 households experiencing sickness and/or death after the distribution, 56 (93%) reported using the kit. Eighty-seven percent (95%CI 74.7-93.8) reported correct use of chlorine for handwashing and 71% (95%CI 56.3-81.7) for cleaning. Nine out of ten recipients reported burning waste (93%, 95%CI 79.7-97.8). Among those households that did not experience sickness and/or death after the distribution (n=1,322), 44 % used the kit, mainly for hand washing and protection purposes.

Conclusions

In the words of MSF staff who implemented the distribution, "it was an imperfect solution for a difficult situation". At the peak of an unprecedented outbreak, the distribution of household disinfection kits was feasible and the kits were appropriately used by the majority of beneficiaries. However, the actual impact on infection rates is not known.

Presenter: Peter Maes
<peter.maes@brussels.msf.org>

Peter Maes
Engy Ali
Guido Benedetti
Rafael Van den Bergh
Anna Halford
Rosa Crestani
Luke Bawo
Moses Massaquoi

Presenter: Krystel Moussally
<MenaEpidemiologist@msf.org>

Krystel Moussally
Jeffreys Edwards
Kiran Jobanputra
Albane Sibourd-Baudry
Carla Peruzzo
Madhu Prasai
Wilma van den Boogaard
Shoaib Muhammad
Jamil Faqirzai
Chantal Lakis
Tobias Homan
Salem Shanka A.
Mounia Amrani
Philippa Boulle

Care for Syrian refugees with Diabetes in a crisis context: The MSF experience in the Levant

Introduction

MSF has been responding to the unmet health needs of displaced Syrians in the Middle Eastern North African region following the Syrian crisis in 2011. As part of its operations, MSF provides care for non-communicable diseases (NCD), including diabetes (DM), at primary level to Syrian refugees in urban and rural locations in Lebanon and Jordan. This study aimed at 1) identifying demographic and clinical characteristics of Syrian refugees affected by DM and followed in MSF clinics, 2) assessing six-month DM treatment outcomes in these patients, and 3) describing common operational challenges affecting diabetes care delivery.

Methods

This was a retrospective descriptive analysis among Syrian refugees who had received DM care in MSF clinics in Lebanon and Jordan as of 30 September 2017, using programme data. Outcomes of DM care were analyzed among patients who had been followed in the program for ≥ 6 to ≤ 12 months and had \geq two HbA1C results recorded, with a repeat HbA1C done after the first six months. We calculated means of the last two HbA1C measures recorded within 6 months. Lists of key challenges were solicited from the medical supervisors of all clinics.

Results

Among 13,118 Syrian refugees in follow-up in MSF NCD programs as of 30 September 2017, 6,923 (52.7%) were affected with DM. DM patients were predominately female (58.7%), 40 to 65 years old (67.7%), and with Type 2 DM (93.4%). Most, 90.3% (n=5,991), had DM previously diagnosed at enrollment. Proportion of DM-II patients with ≥ 2 co-morbidities at first visit was significantly higher in Lebanon (35.2%) versus Jordan (20.8%). In Lebanon, Syrians with DM had a higher first HbA1C mean (9.5%) compared to Jordan (8.5%) ($p < 0.05$). Outcome analysis, conducted on 195 eligible patients, showed a significant decrease in the second HbA1C mean compared to the first in Lebanon (1.8%) and Jordan (0.7%). The main challenges included access to affordable and continuous DM care, difficulties affording an appropriate diet, modifying lifestyle behaviors, and patient literacy.

Conclusion

Syrian refugees turn to MSF for free diabetes care, most of whom have been previously diagnosed. Good clinical outcomes can be achieved through provision of diabetes care at primary level despite challenges.

SLOT 4

PANEL DISCUSSION: WHO PAYS? USER FEES MAKING A COMEBACK...

Abstract

Since 2003 it is MSF's policy is to provide care free of charge to patients, which has led to significantly increased utilisation rates and more vulnerable people being able to access quality services. MSF also contributed also to respective policy changes at national (Liberia, Sierra Leone, Burundi, Haiti, CAR, DRC, Lesotho etc.) and international level (HIV, malaria, etc.), positioning itself clearly in the debate, using documentation of user fee problems and less damaging alternatives, advocacy and activism.

With global attention and international funding for health currently waning, an old paradigm threatens to return: poor health care for poor people. While donors' economic and geopolitical interests continue to determine aid, politics of fear dominate health priority-setting, directing aid allocations towards interventions with the intent to keep out migrants or infectious diseases with pandemic potential. For other health problems, countries are expected to mobilise resources themselves or take on loans. For many, such financing is neither realistic nor sufficient, and premature transitions away from international health funding lead to more and deeper health gaps, especially for those who need it most.

MSF teams witness how this push for rapid transition away from international health funding has brought user fees and other co-payments back in Malawi, Mozambique, Sierra Leone and Afghanistan among other countries. In many other missions, financial barriers in the public sector continue to contribute to exclusion, poverty, abuse and even detention over unpaid bills.

Many MSF health facilities are overwhelmed by patients who cannot find affordable access elsewhere because of exorbitant patient fees. Even worse, many people die before they reach health care in absence of free care – often unnoticed. Ensuring even basic continuity of access to key services becomes impossible after MSF handover, with clinics reverting to making patients pay.

The panel discussion and following debate will focus on the importance for MSF to continue service provision without patient charges, and the role MSF should play both through our medical action and our ambitions to contribute to change.

What arguments prevail for the commitment to subsidised free care within MSF's operations, as part of the humanitarian imperative, and in order to assure optimal potential impact on people's health?

How willing and prepared is MSF to push back on the current policy trends that lead to increased barriers and burdens for people in need of effective health care?

Moderator: Wim Van Damme

Severine Carillon
Emmanuel Lampaert
Mit Philips
Robert Yates

SPEAKERS AND CHAIRS



Jovana Arsenijevic holds a degree in Social Pedagogy, Masters in Public health and is a PhD candidate in Public Health (Belgrade). Since 2009, she had been working in HIV project and National TB program management in Serbia. She joined MSF in 2015 as a Liaison Officer and later Head of Mission Assistant in Northern Balkan migration mission. In 2017, she was engaged with LuxOR for Operational Research and Data Support on Migration in Europe. Currently she is working for Oxfam on migration related advocacy in the Western Balkans.



José Carlos Beirão was born in Mozambique on November 30th, 1980. He holds a degree in Veterinary Medicine, and is a candidate in Master in Public Health. He has been working in HIV and TB research projects, working in clinical research laboratory at Catholic University of Mozambique Research Center in Beira since 2011. In 2015, he went to Liberia for the Ebola response, and in 2016 to an NIH project in the USA working in the clinical research laboratory as Laboratory Manager. He joined MSF in 2016 in the Beira-Mozambique HIV project, integrating the Operational Research Team to the present.



Marc Biot first worked with MSF in 1989 in Afghanistan, followed by the Philippines. In 1992, he came back to Afghanistan before joining the Operations Department in 1994, where he concentrated his focus on the Horn of Africa and Central Asia. After a Master in Public Health (1998), he was appointed as first HIV/Aids focal person in the Medical Department, to provide support for starting HIV care & treatment program in Africa, Asia and the Americas. Rich with this experience, he left to Mozambique in 2002, where he supported the beginning HIV treatment programs till 2009. After a short stay with ICAP (2009/10) in Maputo, he returned to the Operations Department at the end of 2010 to focus on the large HIV & TB treatment programs in Southern Africa & India as Operational Coordinator. Since 2018, he is the Director of Operations for MSF OCB.



Alice Bloomfield is a migration advisor for the International Committee of the Red Cross (ICRC) in the regional delegation in Paris covering part of Europe. Her work includes supporting ICRC missions and National Red Cross' work towards vulnerable migrants, especially those in immigration detention. After studying Arabic and Economics at Durham University (UK) and specializing in Middle Eastern politics and economics, she went on to do a MA in International Relations & European studies at the Institute for European and International Studies (France) and a DU in ethno-psychology. Passionate about human rights and humanitarian issues, she has worked over the last 15 years in and outside Europe with a wide range of governmental and non-governmental organizations (OFPRO, UNHCR, Handicap International, ICMC, the Odysseus network and MSF) on refugee/migrant identification and protection, empowerment and autonomy for people with disabilities and access to healthcare in emergency settings. She also regularly gives lectures on migration and asylum issues and produced a number of reports including on alternatives to immigration detention and identification of migrants in need of protection in boat arrivals.

SPEAKERS AND CHAIRS



Martin De Smet graduated as medical doctor from Ghent State University and from the Antwerp Institute of Tropical Medicine. He joined MSF in 1991 and has since worked in many countries and in different functions, in the field and in headquarters. Since 2008, Martin is the leader of MSF's Malaria Working Group. He also coordinates MSF's malaria research project in Cambodia, a context of multidrug resistance.



Christos Eleftherakos holds a degree in Psychology and two Master's degrees in Clinical Psychology and Philosophy of Mental disorders. Since 2012 he has been working with asylum seekers and migrants in Greece. He joined MSF in the summer of 2016 and worked at the MSF Victims of Torture Project (VOT) for Rehabilitation of Migrant Survivors of Torture in Athens, Greece. At the moment he is the field as assistant coordinator of the Athens VOT project.



Daniela Belen Garone 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 more than 15 years of experience in Clinical and Operational research as study coordinator and/or principal investigator and contributed with over 50 international publications and presentation in international forums. Since 2012, Daniela serves as reviewer for multiple international journals and conferences. Daniela was part of the creation of MSF Latin-American and served as Board Member of MSF Southern Africa from 2015 to 2017. Areas of specialization include simplification of care and optimization of resources in resource limited settings; an area MSF has been contributing to with sound evidence.



Pier Francesco Giorgetti is a MD, and graduated in Tropical Medicine in Italy. In 2015, he started working with the National TB program in Burkina Faso with a focus on HIV/TB coinfection and key populations. In 2016, he joined MSF and he is now working in Malawi trying to improve the management of patients advanced HIV.



Johan van Griensven is a specialist in internal medicine, with a PhD degree in biomedical sciences and a Master's degree in Epidemiology (LSHTM). He is currently professor at the Institute of Tropical Medicine in Antwerp, Belgium, where he heads the unit of HIV & neglected tropical diseases. Over the last ten years, he has been working as clinician, clinical researcher and clinical epidemiologist in Africa and Asia, including three years with MSF. His main interest is clinical research & trials on leishmaniasis and HIV coinfection, and outbreak research for (re)-emerging diseases. During the 2013-2016 Ebola outbreak in West-Africa, he lead the Ebola_Tx Consortium, which evaluated convalescent plasma against Ebola virus disease in Guinea.



Jenny Gustafsson is a nurse and PMR in various contexts (Ethiopia, India, Malta, South Sudan, Afghanistan, Serbia etc). Most recent experience with MSF was as project coordinator for the project mental health and psychosocial support to asylum seekers in Sweden 2016-2017. She is currently working with psychosocial support to refugee children in Sweden and has recently joined the board of MSF Sweden.



Reinaldo Ortuño Gutierrez is a Bolivian medical doctor with a diploma in tropical medicine and disease control that has joined MSF in 2007 as a TB/PHC MD in Somali region - Ethiopia. Since then he has worked as a mobile clinic doctor in Colombia, field coordinator in Burundi and Ivory Coast, and last as medical coordinator in Somaliland and Guinea Conakry. His expertise goes from general medicine (including chronic diseases such as HIV, TB, HTA, etc.) to nutrition, SRH, disease control and public health. He has worked in the field of HIV and TB for the last 5 years and he is since August 2015 in Malawi as Medical Coordinator.



Chantal Lakis is an epidemiologist in the Lebanon mission since 2016 with a background in medical laboratory. She has earned a master's degree in epidemiology from the American University of Beirut, and a master's in health care management from the University of Surrey in the UK. Before joining MSF she has worked in the private sector, overseeing and monitoring the overall quality of medical and nursing care, and has been a first aid volunteer and trainer with the Lebanese Red Cross for 9 years. Her research interests include antibiotics, chronic diseases and displacement.



Peter Maes has been working with MSF since 1991 in a variety of projects in Europe, Russia, South-east Asia and Sub Saharan Africa. He is a qualified bioscience engineer holding an additional master's degree in water resources engineering. Over the years he completed his education with certified training on sculpture, mechanics, vector control, epidemiology, operational research and management. He has been member of the emergency pool and is currently coordinator of the water, hygiene and sanitation unit in the MSF-OCB medical department. He is since 2005 the vector control referent of the malaria working group of MSF. Since 2006, he is also leading the water, hygiene and sanitation working group of MSF. Publications of Peter Maes focus environmental health linking water, hygiene and sanitation to infectious diseases.

SPEAKERS AND CHAIRS



Krystel Moussally is a regional epidemiologist for MSF's MENA hub based out of Beirut since 2016. She has a Doctorate in Pharmacy from Saint-Joseph University in Beirut and a Masters' in Medications and Population Health from the University of Montreal. Krystel first joined MSF in 2011 as a field epidemiologist and spent more than three years in eight projects between Africa, Asia and the Middle-East. She also has four years of experience in project coordination with UNHCR and the Lebanese Ministry of Health, project monitoring and evaluation with International Alert, and academic research in Canada. As a regional epidemiologist, Krystel has an institutional mandate and provides technical support to MSF missions in the region.



Mit Philips is the coordinator of the Health Politics Team, Analysis Department for MSF in Brussels. Currently her main focus of work at MSF concerns HIV, health care in 'fragile states' and crisis, trends in global health and health systems policies, financial barriers to health care and health financing, the health workforce crisis. Mit has been on mission for MSF for 15 years in Chad, Angola, Sudan, Ethiopia, Kenya, DRC and Cambodia. She was Operations Director from 1999 to 2003. From 2003 on she worked in analysis and advocacy in MSF Brussels headquarters (Access to Care Unit, Analysis & Advocacy Unit, Analysis department). Mit has also worked as part of the team of the Health Policy and Planning Unit at the Institute of Tropical Medicine in Antwerp, Belgium, with a focus on global health policies, health in fragile states and mixed emergency-development contexts. Mit has a Masters degree in Public Health from the London School of Tropical Medicine and Hygiene in and a diploma in Tropical Medicine in Antwerp.



Aurélie Ponthieu has been working for MSF since 2006. She has been working as Humanitarian Specialist for Médecins sans Frontières in Brussels since 2011. She is the Coordinator of the Forced Migration Team in the Analysis Department since 2017. The Forced Migration Team focuses on understanding, navigating and challenging the humanitarian and medical consequences of migration and asylum policies in Europe, Northern Africa, Southern Africa and South East Asia. This includes analysing the political drivers of migration policies and their humanitarian consequences. The team provides support in terms of context analysis, positioning and advocacy strategies. She has a Master degree in Humanitarian Action/International Field legal Assistance and an LLM in International and European Law. Before working at the MSF Headquarters in Brussels, she worked in the field with MSF for five years in Niger, Sudan, Chad, Colombia and Haiti. She also worked in Liberia during the Ebola outbreak in 2014. Prior to her work with MSF, she also volunteered for other organisations in Honduras and Chile.



Ernestina Repetto is an Italian medical doctor and an infectious diseases specialist who has been working with MSF since 2012 in different contexts (Italy, South Sudan, Guinee, Democratic Republic of Congo, Bangladesh, and Papua New Guinea) as doctor, project medical referent and medical coordinator. She holds a PhD in “Appropriate Methodologies and Techniques in International Development Cooperation”. She has conducted clinical research on antibiotic resistance and HIV in Italy and operational research with MSF on migrants’ health and neglected tropical diseases. Since January 2018 she is the Antibiotic Resistance Referent based in Beirut (MENA Hub).



Engy Sawah is a specialist in physiotherapy who joined MSF in 2014 supporting a project specializing in physiotherapy management for victims of violence and ill-treatment, with a focus on sexual violence. She was born in Cairo, Egypt and graduated from the Faculty of Physiotherapy in 2009. Lately, she has been focusing her work on physiotherapy from a scientific perspective. Prior to 2014, Engy worked as a physio-therapist in ICU and outpatient clinics at the Nile Badrawy hospital. She was an internal coordinator and board member at Namaa Initiative for sustainable development in 2014 and participated in the Arab Turkish congress for social sciences in 2013.



Daan Van Brusselen, MD, is a Belgian pediatrician with a postgraduate degree in tropical medicine, who has worked in different humanitarian contexts (Ecuador, Pakistan, the Balkans, Haiti, DR Congo), mostly with MSF. Since 2014 he combines MSF missions with clinical work in Belgium and research in pediatric public health (with a focus on environmental health). He teaches tropical pediatrics at the Institute of Tropical Medicine (ITM) in Antwerp, Belgium.



PROVIDE FREE AND EASY ACCESS TO MSF RESEARCH EVIDENCE TO IMPROVE HEALTH SERVICES



OBJECTIVE

BASED ON A PRINCIPLE OF OPEN ACCESS INFORMATION TO SERVE GLOBAL HEALTH PROGRAMS

- 1 MEDICAL AND PROGRAM STAFF
- 2 HEALTH EDUCATION PROFESSIONALS
- 3 POLICY-MAKERS
- 4 JOURNALISTS



THE USERS

THE CONTENT

MSF ARTICLES PUBLISHED IN

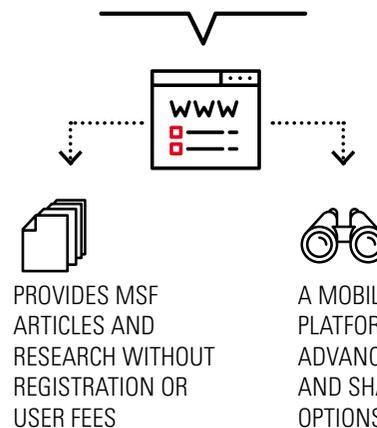


OVER **100** PEER-REVIEWED **JOURNALS**, CONFERENCE ABSTRACTS, PROGRAM DESCRIPTIONS AND RESEARCH RESOURCES

ARTICLES INCLUDE: HIV/AIDS, tuberculosis, malaria, ebola, malnutrition, hospital management, surgery, non-communicable diseases, neglected diseases, tropical diseases, pharmacy, trauma care, emergency care...

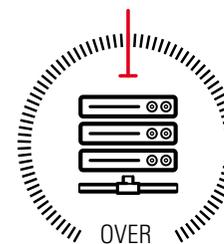
THE WEBSITE

FIELDRESEARCH.MSF.ORG



THE DATA

AVAILABLE SINCE 2010



OVER **200K** ITEMS

NEW ITEMS ADDED WEEKLY

1.2 MILLION CUMULATIVE DOWNLOADS SINCE 2010

PRACTICAL INFORMATION

REGISTRATION & FOOD

Register and book your food at
<https://www.insideocb.com/page/ocb-gathering-2018>
by 27 May 2018
FRIDAY & SATURDAY: 25 Euros (both days)

VENUE AND ACCESS

In our office, 46 rue de l'Arbre Bénit, 1050 Brussels
<http://welcomeocb.msf.be>

There are no parking spaces available.
Please use public transport.

REMOTE PARTICIPATION

Connect to orday.msf.lu and
<https://www.insideocb.com>
for online STREAMING and VOTING

A QUESTION?

or@msf.lu
asso.brussels@brussels.msf.org

CHECK THE UPDATED INFO:

OR Day details, motions,
candidates, debates,
live broadcast etc on
orday.msf.lu
www.insideocb.com



Cover photo:
*Paediatrician Layal Issa at work at the Elias Haraoui
Governmental Hospital in Zahle, Bekaa, Lebanon.*
Photo: Florian SERIEX/MSF

MSF Operational Centre Brussels (OCB)

46, rue de l'Arbre Bénit
1050 Brussels
Belgium
www.msf-azg.be

MSF Luxembourg Operational Research (LuxOR)

MSF Luxembourg
68, rue de Gasperich
L-1617 Luxembourg
Luxembourg
or.msf.lu
orday.msf.lu

MSF Southern African Medical Unit (SAMU)

Deneb House, 4th Floor
Corner Main & Browning Roads
Observatory, 7925
Cape Town, South Africa
www.samumsf.org



© Florian SEREX/MSF

All presentations, abstracts, and videos will be available at orday.msf.lu.

Booklet coordination

