MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

SCIENTIFIC DAYS

MSF SCIENTIFIC DAY SOUTHERN AFRICA

9 JUNE 2016

Reviewers

We would like to thank the MSF Scientific Days editorial reviewing teams drawn from across MSF, Epicentre, *PLOS Medicine*, *The Lancet Global Health*, *The Lancet Infectious Diseases*, *BioMed Central* and the *London School of Hygiene and Tropical Medicine (LSHTM)*. We are very grateful for the time and effort of the reviewers.

Reviewing team for MSF Scientific Day Southern Africa, 9 June – Medical Research

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Topic Leads

We would like to thank our MSF topic leads who helped to ensure that high quality, relevant abstracts were submitted from across the organisation. Carmen Martinez (mental health), Gustavo Fernandez (migrant health), and Rupa Kanapathipillai (drug-resistant infections).

Sponsors

Front cover photo: *An MSF nurse tests a sex worker for HIV in her single room located on the Beira 'corridor', Mozambique, 2014. Credit: Gianluigi Guercia/AFP.* Design by *Design for development.*

Welcome to MSF Scientific Day Southern Africa 2016

Launched in 2004 in London, MSF Scientific Days aim to connect audiences – across countries, organisations, specialties, and disciplines – to promote debate and exchange around the evidence underpinning our medical humanitarian operations. Valuable exchanges with partner organisations, medical and policy audiences help guide our field operations, influence policy and ultimately improve the quality of care for our patients.

MSF field teams are asked to submit abstracts that reflect operational research being conducted across a range of medical specialities. All abstracts must have both local and MSF ethical approval to be accepted. Final selection is made by Editorial Committees comprised of academics, researchers and medical practitioners.

MSF Scientific Day Southern Africa was held for the first time last year in Harare, Zimbabwe where MSF staff, Zimbabwean researchers and Ministry of Health colleagues came together to share the challenges faced in the fields of HIV, sexual and reproductive health and Ebola. This year, MSF Scientific Days have taken place in London, New Delhi and today in South Africa, as we share with you the successes and challenges brought to us by our field teams over the last year.

Abstract sessions will include a focus on HIV, examining how MSF's work is looking towards the ambitious 90-90-90 UNAIDS targets through implementation of 'start all' and differentiated models of ART delivery. Healthcare for women forms the second theme, looking at the challenges of providing treatment services for sexual and gender based violence along with the field realities of how, still in 2016, women have limited access to maternity services. Finally a look to what's new in infectious diseases with meningitis outbreaks in Nigeria, new drugs for hepatitis C and the use of mobile applications for improved antibiotic prescribing.

While the content of today's meeting seeks to highlight the work of MSF within the Southern African region, we hope that the discussions will allow reflections on the global reach of MSF's work. Our panel discussion on migrant healthcare aims to link MSF's response to the ongoing 'migrant crisis' in Europe with the realities confronting us in sub-Saharan Africa.

MSF Scientific Day Southern Africa 2016 is the result of a large collaborative effort – not least from the Editorial Committees who reviewed the 150 plus abstracts submitted, the MSF UK Manson Unit team who have supported our plans, our sponsors who have helped promote the event and the MSF Southern Africa Office. We are very grateful for the help of all involved.

We hope that you enjoy the meeting and welcome your participation during the discussions. This day will contribute to raising awareness of the plight of vulnerable populations that MSF serves which we hope will improve the quality of their medical care.

Finally, please complete your feedback forms to allow us to keep improving this event.

Regards,

MSF Scientific Day Southern Africa Steering Committee

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SCIENTIFIC DAYS

An MSF counsellor explains to a community member how HIV is prevented and treated, 2015.
Credit: Yasuhiko Okuno/MSF

MSF SCIENTIFIC DAY SOUTHERN AFRICA 2016

Registration opens at 8.00

Opening 9.00 – 9.30

Opening remarks: Helen Bygrave, Southern Africa Medical Unit (SAMU)

Welcome and Introduction: Professor Martin Veller, Dean of the Faculty of Health Sciences, University of Witwatersrand

SESSION 1 REACHING 90-90-90: WHAT DOES MSF HAVE TO SAY?

9.30 – 11.00 Panel chair: Professor Ashraf Coovadia,
Principal Specialist, Dept of Paediatrics and Child Health, Rahima Moosa Mother and Child Hospital, University of the Witwatersrand

Early access to antiretroviral therapy (ART) in Swaziland: 6-month treatment outcomes and patient experiences. *Velibanti Dlamini*

Reaching 90-90-90: the role of community antiretroviral therapy (ART) groups in Mozambique. *Viola Nunes*

Implementation of routine viral load monitoring: a multisite cascade analysis. *Dhodo Munyaradzi*

A way out of directly observed therapy(DOT): Community approaches to Self-Administered Treatment for Rifampicin Resistant Tuberculosis. *Buci Beko*

11.00 – 11.30 **Morning Break**

SESSION 2 CONFRONTING WOMEN'S HEALTH CHALLENGES

11.30 – 13.00 Panel chair: Samantha Khan-Gillmore, Programme Manager: Human Resources for Health, Rural Health Advocacy Project (RHAP)

Community-based testing strategies among sex workers in the transport corridor in Mozambique. *Humberto Jassitene*

Sexual violence and rape in Rustenburg implications for service provision and prevention. *Sarah Jane Steele*

Mothers screening for malnutrition by MUAC is non-inferior to community health workers: results from a large-scale pragmatic trial in rural Niger. *Ali Ouattara*

A steep mountain to climb: Addressing Lesotho's maternal mortality through free comprehensive family planning and maternal health care? *Sandra Sedlmaier-Outtara*

13.00 – 14.00 **Lunch**

SESSION 3 RESPONDING TO THE CRISIS: PROVIDING HEALTHCARE TO MIGRANTS AND REFUGEES

14.00 – 15.00 Panel Chair: Jacob Van Garderen, Lawyers for Human Rights

The European Crisis - Humanitarian responses to the protection gap. *Aurelie Ponthieu*

The importance of trained cultural mediators to help build trust and facilitate information sharing. *Emilie Venables*

Followed by panel debate chaired by Jacob van Garderen, Lawyers for Human Rights

SESSION 4 INFECTIOUS DISEASES: NEW STRAINS, NEW DRUGS, NEW APPS

15.00 – 16.15 Panel Chair: Lucille Bloomberg, Deputy-Director, National Institute for Communicable Diseases (NICD), National Health Laboratory Service (NHLS)

Invasive meningococcal meningitis sero-group C outbreak in northwest Nigeria, 2015: third consecutive outbreak of a new strain. *Uadiale Kennedy*

Introduction of Direct Acting Antivirals for Hepatitis C (HCV) in a primary care clinic in Karachi, Pakistan. *Helen Bygrave*

MSFecare: an electronic algorithm to improve antibiotic prescription in the management of childhood illness in primary health care. *Anna Righetti*

16:15 – 16:30 **Closing remarks**
Dr Tom Ellman, Director, MSF Southern Africa Medical Unit (SAMU)

SESSION 1

REACHING 90-90-90: WHAT DOES MSF HAVE TO SAY?

A patient receives his viral load result in Gutu, Zimbabwe, 2015. Credit: MSF

Early access to antiretroviral therapy (ART) in Swaziland: 6-month treatment outcomes and patient experiences

*Shona Horter[1,2], Bernhard Kerschberger[1], Alison Wringe[2], Inoussa Zabsonre[1], **Velibanti Dlamini**[1], Sikhathele Mazibuko[3], David Etoori[1], Roger Teck[4,5], Serge Kabore[1], Mpumelelo Ndlangamandla[1], Barbara Rusch[4], Iza Ciglenecki[4]

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Introduction
WHO now recommends antiretroviral therapy (ART) for people living with HIV (PLHIV), at any CD4 count ("test and treat", T&T), following evidence of associated health benefits and reduced transmission. Swaziland is one of the first countries to pilot T&T for all adults diagnosed with HIV under routine programme conditions. We assessed 6-month treatment outcomes and patient experiences from this pilot.

Methods
A prospective cohort of non-pregnant PLHIV (≥16 years) were enrolled in Oct 2014-Apr 2015 and followed until unfavourable outcome, transfer-out, or database closure (Sept 2015). Participants were recruited purposively from the pilot cohort for qualitative interview, including those with a range of treatment-taking experiences (eg those who had initiated and not initiated ART). 15 in-depth interviews were conducted to examine PLHIV decision-making regarding early ART initiation. Data were analysed thematically using coding, with Nvivo 11. 6-month retention on ART was estimated by Kaplan-Meier plots; adjusted Cox proportional hazard models were used to assess predictors of the composite unfavourable outcome (death/lost to follow-up).

Ethics
Ethics approval was obtained from the Swaziland Ethics Committee (SEC) and MSF Ethics Review Board (ERB).

Results
625 patients initiated ART; 280 (44.8%) had a CD4 count ≤349 cells/mm3 and 182 (29.1%) ≥500. "Asymptomatic" interview participants described embodied signs of HIV, which warned of imminent health deterioration and spurred a desire for early ART. Participants wanted to maintain a hidden HIV status through avoiding development of symptoms but also feared exposure when accessing HIV services, anticipating stigma. Participants described the need to "obey" the "law" of health services, demonstrating subservience in their relationships with providers. Some felt unable to refuse T&T, having limited autonomy over the decision to initiate ART. Of those on ART (625), 6-month retention was 86.6% (95%CI 83.9-89.2), and was higher for CD4 350-499 (89.2%; 95%CI 83.1-93.1) and ≥500 (90.0%; 84.6-93.6) than ≤349 (83.5%; 78.6-87.4) (p=0.05). The unfavourable outcome was less likely with higher CD4 levels and more likely with same-day ART initiation (adjusted hazard ratio 1.68, 95%CI 1.02-2.79; p<0.05).

Conclusion
Some PLHIV were motivated by anticipated health benefits from earlier ART initiation; however, discourses of stigma remained pervasive. Hierarchical practitioner-patient relationships can cause patients to follow health advice due to lack of perceived choice. Retention appeared better in patients with a higher CD4 count at initiation while it was decreased in patients with same-day ART initiation. How earlier initiation of treatment will influence ongoing adherence and retention is unknown. These findings are important for considerations for future adoption of T&T approaches.

Conflicts of interest
None declared.

Reaching 90-90-90: the role of community antiretroviral therapy (ART) groups in Mozambique

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Presented by **Viola Nunes** MSF, Tete, Mozambique

Introduction
The UNAIDS 90-90-90 targets are that by 2020: 90% of HIV-positive people should know their status; 90% of HIV-positive people who know their status should be on antiretroviral therapy (ART); and 90% of people on ART should achieve virological suppression. Community ART groups (CAGs) are groups of patients who collect ART drugs for each other. CAGs, self-formed by patients in Tete, Mozambique since 2008, have been shown to support scale up of ART, reduce the burden for patients and facilities, and increase patient retention. Other potential impacts of CAGs (promoting testing, linkage to care, viral load [VL] uptake, and adherence) were explored in Changara, Mozambique.

Methods
A retrospective analysis was performed of: routine, community-based, HIV-testing data from July 2012 to Dec 2014; and virological outcomes of patients receiving ART for >6 months from Dec 2013 to Dec 2015. HIV prevalence and linkage outcomes were stratified by referral method: immediate CAG family member; other CAG contact (non-immediate family member or neighbour); and non-CAG contact. VL coverage and outcomes were stratified by CAG or non-CAG membership.

Ethics
This retrospective study met the criteria of the MSF Ethics Review Board for exemption from ethics review.

Results
16,750 people were tested, including 9192 (55%) identified via CAG contacts. Overall, the HIV positivity rate was 5%. CAG family members had higher positivity compared with other CAG and non-CAG contacts (combined) among adults (18% [108/608] vs. 6% [600/10869]; p<0.01) and children (4% [41/994] vs. 1% [40/3741]; p<0.01). No significant differences in positivity were observed between 'other CAG contacts' and 'non-CAG contacts'. Linkage to care was high (77%; 597/772) among all groups, no significant differences were observed between referral methods. Linkage within 6 months was achieved for 84% of children (<15 years) who tested positive, 75% of youth (15-24 years), and 78% of adults (≥25 years). VL coverage was higher among CAG than non-CAG patients (77% [1688/2182] vs. 52% [708/1354]; p<0.01). Overall 39% (946/2396) had VL ≥1000 copies/mL, with no significant difference in proportion with elevated VL by CAG status.

Conclusion
Index case testing of CAG members including relatives and extended family and friends is a simple way to identify a high-risk population. High linkage to care was observed; while no significant difference was observed by referral method, a reduction in stigma within the community may, arguably, have indirectly resulted from the long-term CAG presence. CAGs facilitated improved VL coverage, although VL results are worryingly high, mirroring other sites in Mozambique, regardless of CAG status, providing no evidence that CAGs have improved adherence in this context. Further work is necessary to maximise the benefit of differentiated ART delivery models across the 90-90-90 targets.

Conflicts of interest
None declared.

Implementation of routine viral load monitoring: a multisite cascade analysis

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Introduction
WHO has recommended routine viral load (VL) testing to monitor antiretroviral therapy (ART) since 2013. From 2012, routine VL testing was introduced in MSF projects in Lesotho, Malawi, Mozambique, and Zimbabwe. All districts, except one (Changara), were rural settings where ART had been extensively decentralised to primary care clinics. VL is performed annually in all sites except Malawi (2-yearly). Human resource constraints are less common in Zimbabwe and, apart from Malawi, all sites were previously monitoring patients with 6-monthly CD4 counts. To assess programmatic implementation of routine VL, we did an analysis to assess performance at each step of the VL algorithm.

Methods
We did analyses between Jan and Nov 2015 across six districts in four countries. We used reviews of clinical and laboratory records of representative samples of patients to determine how each step of the routine VL algorithm (coverage of VL, uptake of enhanced adherence counselling (EAC), repeat VL testing [within 2-9 months], suppression after EAC, and appropriate switch to second-line ART) was implemented within a defined period according to local guidelines. Results were presented to programme staff and barriers for implementation identified.

Ethics
This study was approved by the MSF Ethics Review Board UNITAID protocol.

Results
24,263 patients eligible for VL were included in the analysis. Coverage of routine VL ranged from 32% to 91%. The proportion with VL>1000 copies/mL was as low as 9% (385/4266) in Malawi compared with 40% (767/1919) in Mozambique. Rates of documented enhanced adherence were similar across sites (57-70%). The chance of a patient having a repeat VL performed after a counselling intervention was as low as 23% (176/767) in Mozambique and at best 68% (412/606) in Zimbabwe. In all sites, less than half (22-46%) of patients whose VL was repeated showed suppression. Switches to second-line therapy after a persistently raised VL according to local guidelines ranged from 10% to 38%.

Conclusion
At international level, there is substantial investment in supporting the scale-up of routine VL with much of this attention and funding focused on laboratory considerations. This analysis showed limited compliance with a routine VL algorithm based on WHO recommendations. Scale-up of VL monitoring must address human resource constraints and implement plans for provision of second-line therapy in sites where ART care has been decentralised.

Conflicts of interest
None declared.

A Way out of Directly Observed Therapy (DOT): Community approaches to Self-Administered Treatment for Rifampicin Resistant Tuberculosis

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Introduction
Daily directly observed therapy (DOT) is recommended for rifampicin-resistant tuberculosis (RR-TB) patients throughout the course of treatment. This can negatively impact adherence during the continuation phase when patients have clinically improved. Daily DOT also places a considerable burden on health care services. We assessed the impact of a self-administered treatment (SAT) intervention in a South African township with high rates of RR-TB/HIV co-infection.

Methods
Community supported SAT for patients in the continuation phase was initiated progressively in five MSF-supported clinics from January 2012 – December 2014. Patients were assessed for SAT eligibility by clinicians based on previous adherence record and clinical condition. SAT patients were assigned a weekly community treatment supporter, and attended the clinic monthly to monitor treatment progress and collect medication. Additionally, SAT patients received a specialized counseling session by a trained MSF RR-TB counselor who focuses on medication identification, management of adverse events, and strategies for boosting adherence. All RR-TB patients still receiving treatment at the end of the intensive phase within the SAT clinics (SAT phase) were compared to patients in the same five clinics from January 2010 through July 2013 when DOT was the prevailing model of care (DOT phase). Descriptive statistics and chi squared tests were conducted to assess differences in 12 month treatment outcomes.

Results
One hundred and eighty two patients (74% HIV infected) entered the continuation phase during the SAT phase and 122 patients (71% HIV infected) during the DOT phase. Due to phased implementation 92/182 (51%) patients were considered for SAT. Eighty two (89%) were enrolled; reasons for exclusion included adherence concerns (n= 6), location of home (n=2), treatment failure (n=1) or other (n=1). Three of the 82 (3.7%) patients enrolled in SAT returned to clinic DOT due to adherence concerns. There was no differences in the frequency of patients still on treatment 12 months post treatment initiation, excluding those lost, died or failed during the intensive phase and/or those transferred out during treatment, in the SAT (149/173, 86%) versus DOT (92/112, 82%) phases of the clinics (p=0.36).

Conclusion
Data from this non-randomized comparison suggests that structured SAT does not lead to a reduction in the proportion of patients retained in care 12 months post treatment initiation. This intervention should be considered for wider implementation in order to decrease the burden on patients and health facilities.

Conflicts of interest
None declared.

SESSION 2

CONFRONTING WOMEN'S HEALTH CHALLENGES

A mother measures her child's arm for signs of malnutrition using a four-colour MUAC (Mid-Upper Arm Circumference) bracelet in Mirriah, Niger.
Credit: Sylvain Cherkaoui/Cosmos

Community-based testing strategies among sex workers in the transport corridor in Mozambique

Erica Simons[1], Tom Ellman[2], Ruggero Giuliani[1], Christine Bimansha[1], Lucia O'Connell[1], Emilie Venables[2], **Humberto Jassitene**[1], Carla das Dores T.P. Mosse Lázaro[3], Mulassua Jose Simango[3]

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Background
The MSF Corridor project aims to implement a comprehensive intervention for sex workers (SW) along the transport corridor in Mozambique and Malawi. The community-based model incorporates outreach services, HIV testing and counseling, condom distribution, quarterly follow-up testing for HIV negative SW, and access to STI and HIV care. Sex worker peer educators (SWPE) play an important role in supporting outreach activities, health education and linkage to care. This analysis describes testing, retesting and seroconversion among SWs in Tete and Sofala, Mozambique and explores SWPE perspectives on their role.

Methods
Retrospective analysis of routinely collected data included SWs enrolled in the outreach program between January 2014 and June 2015. The proportion HIV positive among SWs who initially tested between January 2014 and June 2015, and the proportion of those initially negative who retested within 6 months was assessed. Seroconversion was determined among those who retested within 6 months. Participant and non-participant observations were conducted during SWPE outreach activities in four project sites, along with nine in-depth interviews and two focus group discussions.

Ethics
The study was approved by the London School of Hygiene and Tropical Medicine Research Ethics Committee.

Results
1461 female SWs were enrolled in Tete, with a median age at first contact of 28 years [23-32]. Among 1008 SWs tested, the HIV positivity at initial test was 48%. Of an additional 384 who had previously tested but were not tested within the program prior to July 2015, 67% reported a positive HIV status. Overall HIV positivity rate was approximately 59%; 40%, 64%, and 78% among SWs < 25 years, 25-34 years and ≥35 years, respectively. 40% of SWs initially HIV negative retested within 6 months and 7 (3%) seroconverted (median time: 136 days). Of 349 SWs enrolled in Sofala with a median age at first contact of 27 [23-31], 52% were positive overall; 44%, 51%, and 77% among SWs < 25 years, 25-34 years and ≥35 years, respectively. Of 148 who tested negative, 49% retested within 6 months and 7 (10%) seroconverted (median time: 85 days). SWPEs described their ability to reach out to their peers, to engage new and 'informal' SWs with health-care services including HIV testing. Challenges included experiencing prejudice and being undervalued by non-SWs on the team.

Conclusion
Despite stigma and mobility challenges, the majority of SWs contacted agreed to be tested. Among those negative, almost half retested within 6 months. However retention for retesting remains a major challenge. HIV prevalence and apparent incidence demonstrate the extreme risk among this group and importance of community strategies to access testing, treatment and prevention, including PREP. SWPEs have a key role in developing trust among their peers and supported the uptake of testing and re-testing. Greater efforts are needed to develop their role within SW programs.

Conflicts of interest
None declared.

Sexual violence and rape in Rustenburg implications for service provision and prevention

Amir Shroufi[1], Gilles Van Cutsem[1], ***Sarah Jane Steele**[1], Kim Phillips[1], Andrew Mews[1], Julia Hill[1], Patricia Mazuru[1], Ania Łuczyńska[1],Kristal Duncan[1]

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Introduction
Rustenburg Municipality (population 550,000) is one of Africa's fastest growing cities, and as South Africa's platinum mining capital, attracts many migrant workers. Bojanala district, in which Rustenburg is situated, has an HIV prevalence of 35% among antenatal women; the prevalence of rape has not previously been reported. HIV transmission is higher during forced sex (particularly child sexual abuse) than consensual sex; hence transmission is exacerbated in settings with concurrent epidemics of HIV and rape. Here we quantify the prevalence of sexual violence and rape in Rustenburg.

Methods
In this cluster randomized household survey, fieldworkers collected information from women aged 18-49 on their experience of rape, as well as associated behaviours and attitudes. The characteristics of the study population and prevalence of rape (forced sex or sexual acts) are described.

Ethics
This study was approved by the University of Cape Town Ethics Review Board and MSF Ethics Review Board.

Results
The average age of participants (n=890) was 32 years and 44% had completed secondary school or higher. The majority of women grew-up in South Africa; however, 62% grew-up in a rural area/village outside of the Rustenburg Municipality. Life-time prevalence of rape was 33%, with 10% experiencing at least one rape by a known sexual partner, and 8% experiencing at least one rape by a non-sexual partner before the age of 15 years. The reported incidence of rape was 53 per 1000 person years.

Conclusion
We report an extremely high prevalence of sexual violence, including among children, in the platinum belt of Rustenburg. This includes rape by partners and non-partners, making women vulnerable to mental and physical trauma, and HIV acquisition. In South Africa there is a coordinated HIV response, however there is urgent need for a coordinated, patient centred response to sexual violence. Strengthening the links between legal, medical and psycho-social services for sexual violence should be central to this response.

Conflicts of interest
None declared.

Mothers screening for malnutrition by MUAC is non-inferior to community health workers: results from a large-scale pragmatic trial in rural Niger

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Presented by **Ali Ouattara,** ALIMA, Dakar, Senegal

Introduction
Community health workers (CHWs) commonly screen for acute malnutrition in the community by assessing mid-upper arm circumference (MUAC) on children aged 6-59 months. MUAC is a simple screening tool that has been shown to be a better predictor of mortality in acutely malnourished children than other practicable anthropometric indicators; and empowering mothers by training them to screen for malnutrition by MUAC and checking for oedema has been shown to be a promising approach. This study compared, under programme conditions, mothers and CHWs in screening for severe acute malnutrition (SAM) with colour-banded MUAC tapes.

Methods
This pragmatic interventional, non-randomised efficacy study took place in two health zones of Niger's Mirriah District from May 2013 to April 2014. Mothers in Dogo (mothers zone) were trained to screen children in their household, and CHWs in Takieta (CHWs zone) were trained to screen children in the community for malnutrition by MUAC colour-coded class and to check for oedema. We conducted exhaustive coverage surveys quarterly, and relevant data were collected routinely in the health and nutrition programme. We did an efficacy and cost analysis of each screening strategy.

Ethics
The National Consultative Ethics Committee of Niger's Ministry of Public Health approved the study protocol.

Results
12,893 mothers were trained in the mothers zone and 36 CHWs in the CHWs zone; point coverage (proportion of children with MUAC <115 mm or oedema who were effectively supported) was similar in both zones at the end of the study (35% [26/74] mothers zone vs 32% [11/34] CHWs zone; p=0.7772).The rate of MUAC agreement (compared with health centre agents) was higher in the mothers zone (75.4% [721/956] vs 40.1% [221/551]; p<0.0001) and cases were detected earlier, with median MUAC at admission for those enrolled by MUAC <115 mm estimated to be 1.56 mm (95%CI 0.65-1.87) higher using a smoothed bootstrap procedure. Children in the mothers zone were much less likely to need inpatient care, both at admission and during treatment, with the most pronounced difference at admission for those enrolled by MUAC <115 mm (0.7% [4/569] vs 7.8% [32/413]; risk ratio 0.09 [95%CI 0.03-0.25]; p<0.0001). Training of mothers required higher up-front costs, but overall costs were much lower ($8,600 vs $21,980 USD).

Conclusion
Mothers were not inferior to CHWs in screening for malnutrition at a substantially lower cost. Children in the mothers zone were admitted at an earlier stage of SAM and needed fewer hospital admissions. Making mothers the focal point of screening strategies in this way should be included in malnutrition treatment programmes globally.

Conflicts of interest
None declared.

A steep mountain to climb: Addressing Lesotho's maternal mortality through free comprehensive family planning and maternal health care?

Aline Aurore Niyibizi[1], Sarah Jane Steele[1], Gilles Van Cutsem[1], Malehlohonolo Kuleile[1], Kananelo Kabeli[1], Innocent Muleya[1], **Sandra Sedlmeir-Ouattara**[1], Jesper Hildebrandt-Brix[1], Andrew Mews[1], Quentin Baglione[2], *Amir Shroufi[1]

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Introduction
Lesotho has one of the highest maternal mortality rates in the world due to HIV and poor access to skilled maternal health services. Hospital fees for delivery represent a major barrier to maternal health service utilization. In addition to transport and accommodation costs incurred a normal vaginal delivery costs an average of 165 Malotis and a C-section 410 Malotis. Unsafe abortion is estimated by UNDP to be responsible for 20% of maternal mortality making it the second most common cause of maternal mortality in the country. In addition, due to the high numbers of clinics (40%) supported by The Christian Health Association of Lesotho (CHAL) many clinics are not able to provide family planning services, including provision of condoms. This study aims to examine the uptake of obstetric and family planning services following introduction of Free Maternal Care (FMC) in a district hospital in Lesotho.

Methods
FMC was introduced in January 2014. Utilization of delivery services from July 2012 to December 2013 compared to January 2014 to June 2015 were assessed. Information on baseline characteristics, deliveries, obstetric outcomes and referrals was collected from maternity registers. Numbers of stillbirth, maternal and neonatal mortality rates were compared before and after introduction of FMC.

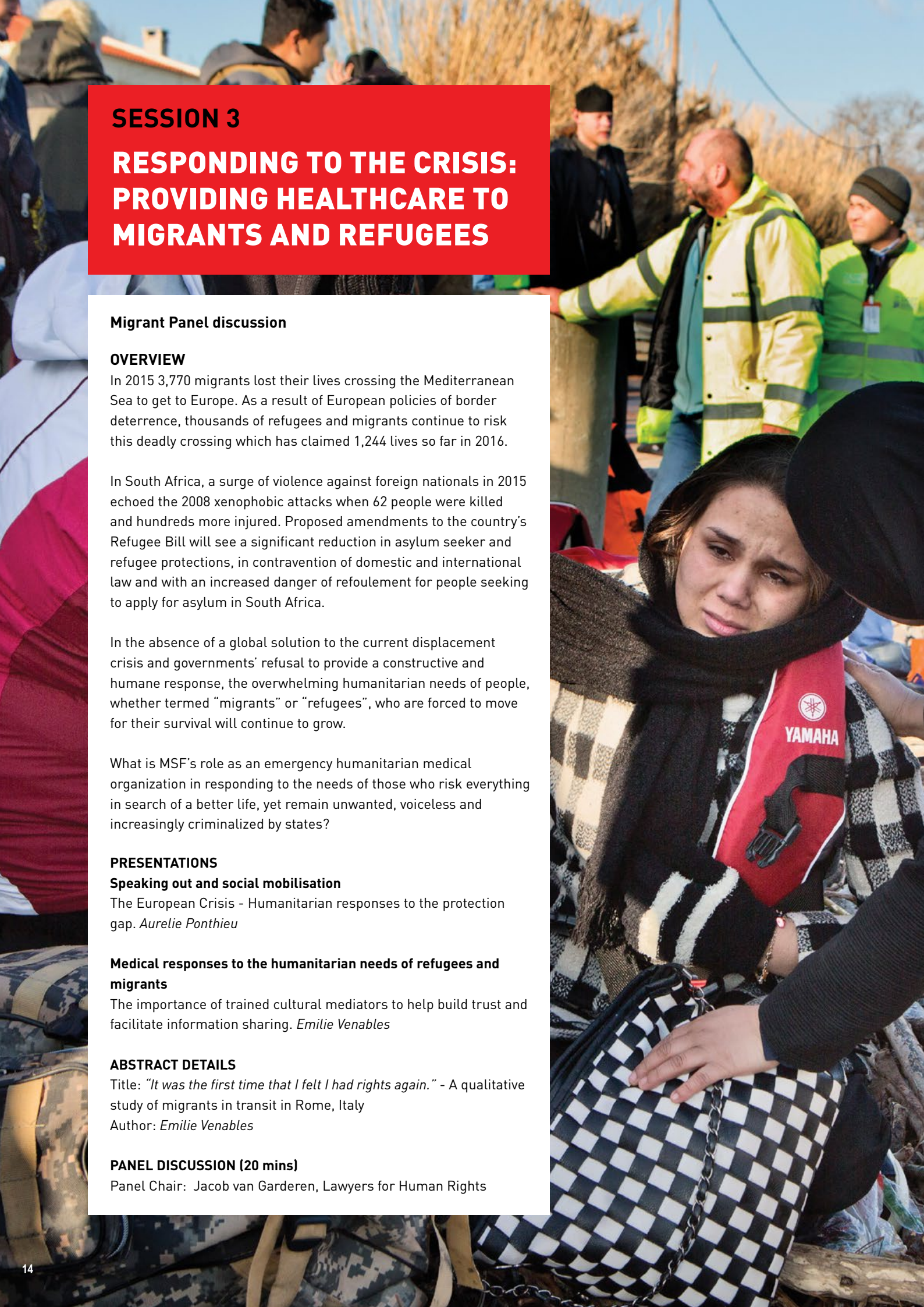
In parallel, in collaboration with the Lesotho Planned parenthood Association (LPPA) outreach family planning clinics were conducted from tents, providing injectable contraception, the contraceptive pill, implants and the IUCD. Rates of uptake from July 1, 2012 – June 30, 2015 were documented.

Ethics
The analysis used routinely-collected data and met the MSF ERB criteria for an exemption from ethics review.

Results
A total of 3782 women delivered during the study period, of which 684 (18%) were less than 19 years old. HIV prevalence was 23.7%. After the introduction of FMC, the number of hospital deliveries increased by 55% (from 1484 to 2298). Referrals from primary care clinics doubled (from 38 to 79) and referrals from secondary to tertiary hospital increased 5-fold (from 5 to 27). Maternal mortality ratios, neonatal death rates and stillbirth rates dropped respectively from 146 to 89/100,000, 5.1 to 1.3/100,000 and 26 to 19/100,000 live births. When promoted, acceptance of family planning was high, and increased from 749 initiations in 2013 to 4077 in 2014, most of which were for injectables (51%) and implants (31%).

Conclusion
Introduction of FMC resulted in a 55% increase in hospital based deliveries, as well as increases in referral rates and a drop in maternal, neonatal and stillbirth rates. Hospital fees for maternal care in Lesotho are a barrier to access skilled birth attendants and should be urgently removed. There is high unmet demand for family planning which if addressed would further contribute to reducing maternal mortality.

Conflicts of interest
None declared.



SESSION 3

RESPONDING TO THE CRISIS: PROVIDING HEALTHCARE TO MIGRANTS AND REFUGEES

Migrant Panel discussion

OVERVIEW

In 2015 3,770 migrants lost their lives crossing the Mediterranean Sea to get to Europe. As a result of European policies of border deterrence, thousands of refugees and migrants continue to risk this deadly crossing which has claimed 1,244 lives so far in 2016.

In South Africa, a surge of violence against foreign nationals in 2015 echoed the 2008 xenophobic attacks when 62 people were killed and hundreds more injured. Proposed amendments to the country's Refugee Bill will see a significant reduction in asylum seeker and refugee protections, in contravention of domestic and international law and with an increased danger of refoulement for people seeking to apply for asylum in South Africa.

In the absence of a global solution to the current displacement crisis and governments' refusal to provide a constructive and humane response, the overwhelming humanitarian needs of people, whether termed "migrants" or "refugees", who are forced to move for their survival will continue to grow.

What is MSF's role as an emergency humanitarian medical organization in responding to the needs of those who risk everything in search of a better life, yet remain unwanted, voiceless and increasingly criminalized by states?

PRESENTATIONS

Speaking out and social mobilisation

The European Crisis - Humanitarian responses to the protection gap. *Aurelie Ponthieu*

Medical responses to the humanitarian needs of refugees and migrants

The importance of trained cultural mediators to help build trust and facilitate information sharing. *Emilie Venables*

ABSTRACT DETAILS

Title: *"It was the first time that I felt I had rights again."* - A qualitative study of migrants in transit in Rome, Italy
Author: *Emilie Venables*

PANEL DISCUSSION (20 mins)

Panel Chair: Jacob van Garderen, Lawyers for Human Rights

“It was the first time that I felt I had rights again.” A qualitative study of migrants in transit in Rome, Italy

Emilie Venables[1], Ahmad Al Rousan[2],Caterina Spissu[2], Lilian Pizzi[2], Claudia Lodesani[2], Stefano Di Carlo[2]

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Introduction
Between July and November 2015, MSF provided psycho-social support - including individual and group counselling and information sessions - to people in transit in Rome. Transit centres are a very unique context in which to offer services, as most migrants only stay a few days before continuing their journeys through Europe, and facilities are volunteer-run meaning there is little certainty over the type and duration of services offered. This qualitative study was conducted to explore migrant health needs and how best MSF could support people in transit.

Methods
A qualitative study was conducted from August-September 2015. A total of 20 individual in-depth interviews were carried out with migrants in two MSF-supported transit centres in Rome. Participant observation was conducted in the centres to observe day-to-day activities and psycho-social support sessions with migrants. Interview data and handwritten notes from observations were transcribed and translated from Tigrinya into English before being entered into NVivo, coded and analysed.

Results
The majority of interviewees (18/20, 90%) were Eritrean. Interviewees did not view their health needs as a priority, talking instead about their need for information to assist them on their journey through Europe. Migrants were grateful of the psycho-social support they received, but were unaware that they had the right to access health-care services in Italy. Their main concerns were family reunification, receiving money, the implications of ‘forced fingerprinting’ in Italy and the next stages of their journey. Migrants were reluctant to receive long-term treatment because they did not want to remain in Italy. Cultural mediation was essential to the project, especially as Eritreans expressed their difficulties in knowing who to trust upon arrival in Italy, which left them open to exploitation.

Conclusion
It was challenging to provide psycho-social support to people in transit, particularly Eritreans who did not necessarily recognise their needs or rights to access health-care services. The study enabled the MSF team to understand the needs of refugees – information, psychological sessions and cultural mediation – in more detail, and target their activities accordingly. The research highlighted the importance of trained cultural mediators to help build trust and facilitate information sharing, and a further qualitative study is planned to explore the role of cultural mediation in more detail. One limitation is that the study was conducted over a three week period: the situation for migrants in Europe changes daily, meaning the findings of this research may need to be reviewed and adjusted accordingly before implementation.
Ethics Statement: This study or programme description met the criteria of the MSF ERB for exemption from ethics review [and this has been verified by the Medical Director or delegated representative].

Conflicts of Interest
None declared

SESSION 4

INFECTIOUS DISEASES: NEW STRAINS, NEW DRUGS, NEW APPS

MSF health staff check children for measles on the streets of Sokoto, Nigeria, after an outbreak of meningitis and measles. Credit: Olga Overbeek/MSF

Invasive meningococcal meningitis serogroup C outbreak in northwest Nigeria, 2015: third consecutive outbreak of a new strain

Jaime Chow[1], **Kennedy Uadiale**[1], Agatha Bestman[1], Charity Kamau[2], Dominique A. Caugant[3], Aminu Shehu[4], *Jane Greig[5]

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Introduction
In northwest Nigeria in 2013 and 2014, two sequential, localised outbreaks of meningitis were caused by a new strain of Neisseria meningitidis serogroup C (NmC). In 2015, an outbreak caused by the same novel NmC strain occurred over a wider geographical area, showing different characteristics from the previous outbreaks. We describe the characteristics and epidemiology of the 2015 outbreak.

Methods
From 10 Feb to 8 June 2015, data on cerebrospinal meningitis (CSM) cases and deaths were recorded on standardised line-lists from case management sites supported by MSF. Cerebrospinal fluid (CSF) samples from suspected cases at the beginning of the outbreak and from suspected cases from new geographical areas throughout the outbreak were tested using rapid Pastorex® latex agglutination to determine causative serogroup. Some of these CSF samples were inoculated into Trans-Isolate medium for testing by the WHO Collaborating Centre for Reference and Research on Meningococci, Oslo. Reactive vaccination campaigns with meningococcal ACWY polysaccharide vaccine targeted affected areas.

Ethics
This retrospective study met the criteria of the MSF Ethics Review Board for exemption from ethics review.

Results
A total of 6394 (65 confirmed and 6329 probable) cases of CSM, including 321 deaths (case fatality rate 5.0%), were recorded. The cumulative attack rate was 282 cases per 100,000 population in the areas affected. The outbreak lasted 17 weeks, affecting 1039 villages in 21 local government areas in three states (Kebbi, Sokoto, Niger). Pastorex® tests were NmC positive for 65 (58%) of 113 CSF samples. Of 31 Trans-Isolate medium samples, 26 (84%) tested positive for NmC (14 through culture and 12 through PCR); all had the same rare PorA type P1.21-15,16 as isolates from the 2013 and 2014 outbreaks. All 14 culture-positive samples yielded isolates of the same genotype (ST-10217 PorA type P1.21-15,16 and FetA type F1-7). More than 222,000 targeted individuals were vaccinated relatively early in the outbreak (vaccination commenced 4 and 6 weeks after initial case detection with administrative coverage estimates of 98% and 89% in Kebbi and Sokoto, respectively).

Conclusion
The outbreak was the largest caused by NmC documented in Nigeria. Reactive vaccination in both states may have helped to curtail the epidemic. Serogroup and strain should be verified in future outbreaks of N. meningitidis to monitor for possible serogroup replacement following the success of MenAfriVac vaccination against NmA. A vaccination campaign against NmC with a long-lasting conjugate vaccine should be considered in the region.

Conflicts of interest
None declared.

Introduction of Direct Acting Antivirals for Hepatitis C (HCV) in a primary care clinic in Karachi, Pakistan

*Dmytro Donchuk[1], Yuely Capileno[2], Guglielmo Rossi[2], Ylva Bjorklund[2], Husni Mubarak Zainal[2], Rosa Auat[2], Valentina Mazzeo[2].

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Presented by **Helen Bygrave**. MSF Southern Africa Medical Unit

Introduction

The burden of hepatitis C infection in Pakistan is among the highest in the world with national HCV prevalence reported to be 4.9%. However in urban communities in Karachi the prevalence is suspected to be higher. Interferon-free treatment for chronic HCV (CHC) infection with direct acting antivirals (DAAs) could allow scale up, simplification and decentralization of treatment to these communities. Since May 2015 MSF has been supporting the diagnosis and treatment of hepatitis C, using sofosbuvir and weight-based Ribavirin in Machar Colony, Karachi, Pakistan. Treatment was initiated and followed up by general practioners in the primary care clinic. We describe initial outcomes of this programme.

Methods

Patients screened for hepatitis C and those found positive were included in the analysis. Routine demographic and clinical outcome data was collected prospectively.

Results

2539 patients were tested for HCV antibody. 719(28%) were positive and of these, 646 (89%) were found to have CHC. 176 (27%) of patients with CHC had APRI >1.0. 111 HCV genotype(GT) results were available: 99 (89%) had GT 3, 9(8%) GT1, and 3 (3%) GT2. 111 patients initiated treatment. To date, 6 patients have completed treatment, all with negative HCV RNA at completion.

Conclusions

Interim results suggest feasibility of CHC treatment with DAAs prescribed by general practitioners at a primary care clinic. Simplified diagnostic algorithms and availability of less toxic, shorter and more effective treatments has greatly facilitated access to HCV treatment in this setting. Ongoing advocacy to ensure access and price reductions for such drugs must be supported.

MSFecare: an electronic algorithm to improve antibiotic prescription in the management of childhood illness in primary health care

*Clotilde Rambaud-Althaus, **Anna Righetti**, Nicolas Peyraud, Maya Shah, Michel Quere, Micaela Serafini, Marie-Claude Bottineau

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Introduction
MSFeCARE is an electronic clinical decision support system, designed to encourage more rational use of antibiotics when diagnosing and treating childhood illnesses in children aged <5 years in primary health-care settings. We aimed to evaluate the acceptability, in terms of users' satisfaction and appropriateness, the feasibility, and the potential impact of MSFeCARE on antibiotic prescriptions in Gety, Democratic Republic of Congo.

Methods
A feasibility study for MSFeCARE was conducted in three rural health centres without internet access supported by MSF in Gety in April 2015. After 1 day of training, tablets running MSFeCARE were deployed and six consulting nurses conducted 252 paediatric consultations using the tool over a 7-day period. Acceptability and implementation were assessed through qualitative data collected by direct observation and in-depth interviews (IDI) with three users, in order to assess users' satisfaction, perceived appropriateness, and potential barriers to field implementation. Appropriateness to clinical situations (coverage of problems encountered and user intent to follow recommendations) was assessed through analyses of data collected by MSFeCARE. The impact on antibiotic prescription was assessed by comparing the 252 MSFeCARE consultations with 37 pre-MSFeCARE paper-based consultations.

Ethics
This innovation project involved human participants, and has had ethics oversight from the medical director or delegated representative according to the MSF Ethics Framework for Innovation.

Results
MSFeCARE was well accepted. It was perceived as a tool that: could help users be more systematic during clinical assessment and reduce antibiotic prescriptions; covered the majority of clinical situations encountered; and proposed treatments adapted to their local context. MSFeCARE addressed 95% (349) of the 367 symptoms reported in the 252 consultations and proposed a diagnosis and treatment in 93% (216) of 232 consultations with ≥1 symptom reported. The diagnosis and decision on antibiotic prescription was followed by the nurse in 84% (174/207) and 85% (213/252) of consultations, respectively. Prescription of antibiotics dropped from 46% (17/37) with the paper system to 25% (62) of 252 consultations using MSFeCARE (p=0.01). No technical problems were encountered, however, data transmission required the tablets being brought to an MSF office.

Conclusion
MSFeCARE shows strong potential in decreasing antibiotic prescriptions for acute childhood illnesses and was well accepted and able to be used by staff after minimal training. After this feasibility study, solutions for identified technical issues, such as data transmission, were developed. We plan to conduct a larger survey to assess the long term impact on health-worker performance and appropriateness of antibiotic prescriptions.

Conflicts of interest
None declared.

BIOGRAPHIES

SESSION 1

Velibanti Dlamini

Velibanti Dlamini joined MSF as a Qualitative Research assistant in March 2013. He has been involved in PMTCT B+, Viral Load, linkage to care and Early Access to ART for ALL (EAAA) studies being undertaken by MSF in the Shiselweni region south of Swaziland. Before joining MSF he worked for other NGO's providing HIV care and has extensive experience as a qualitative research assistant.

Viola Nunes

Viola Nunes has worked as the counsellor supervisor in MSF's project in Tete, Mozambique from 2009. He played a significant role in the formation and implementation of community ART groups (CAGs) in the Tete project and was part of the team that supported the national scale up of CAGs. He continues to adapt how CAGs support the delivery of HIV services across the cascade of care.

Dhodo Munyaradzi

Dhodo Munyaradzi holds a Bsc Honours Degree in Nursing Science with the University of Zimbabwe, and MSc Degree in Development Studies and is currently studying for a Masters in Health Informatics with the University of Sheffield. He has previously worked as a clinician with the Ministry of Health and Child Care Zimbabwe, and for the past ten years has worked with MSF as a clinical nurse, monitoring and evaluation supervisor and is currently deputy field coordinator in the MSF project in Manicaland focusing on HIV and non-communicable diseases.

Buci Beko

Buci Beko is a former patient, diagnosed with multi-drug resistant tuberculosis (MDR-TB) in Khayelitsha in 2005. During the course of treatment, her child was also diagnosed with MDR-TB at the age of 5 months. After two years of difficult treatment with limited counseling and psychosocial support, Buci and her daughter completed treatment and were cured of the disease in 2007. Since then she has been employed by MSF as a MDR-TB counselor to support other patients diagnosed with the disease within the decentralized DR-TB programme in Khayelitsha. In recent years her focus has been particularly on supporting patients diagnosed with extensive drug resistant TB (XDR-TB). She is currently pursuing her studies further in order to train as a social worker.

SESSION 2

Sarah Jane Steele

Sarah Jane Steele is currently the Mission Epidemiologist for MSF South Africa & Lesotho. She started this position in 2015 after completing a PhD in Epidemiology (Collaborative Doctoral Program in Global Health) at the University of Toronto, Canada. Her PhD work explored the relationships, attitudes, and sexual encounters of men who have sex with men in Shanghai, China using a web-administered sexual events diary. Sarah Jane has worked in academic and applied settings in Canada, The Gambia, Zambia, South Africa, Kenya and China primarily in the epidemiology of sexual behaviour and sexual health, and HIV and other sexually transmitted infections.

Ali Ouattara

Ali Ouattara graduated from the medical school of the University Bouake (Ivory Coast) in 1992. He joined MSF in 2002 during the Ivory Coast civil war. He continued to work for MSF for 10 years in different sub-Saharan countries where he gained strong experience in HIV/TB (Kenya, Malawi), nutrition and emergency response. During this time he also completed a master's in Public Health in Antwerp in 2009. Since 2015 he is the deputy operational director of ALIMA. He supports strongly the role of operational research as a way of improving medical practice and health outcomes.

Sandra Sedlmaier-Ouattara

Sandra qualified as a midwife in Germany, 1988. She worked as a midwife in Germany, UK and New Zealand before going on her first mission with MSF in 2007 to a HIV/TB project in Kenya. She has worked with MSF for the past nine years in Malawi, Kenya, Mali and Lesotho. Sandra is working as the project medical referent in a Sexual Violence project in Rustenberg, South Africa. As a midwife she has a strong interest in maternal and neonatal health especially in prevention of mother to child transmission of HIV.

SESSION 3

Uadiale, Kennedy Ikehinde

Dr Uadiale Kennedy Ikehinde is the medical team leader of MSF's Emergency Response Unit in Nigeria. In 2013, he led a team that investigated an outbreak of meningitis in Northwest Nigeria which was caused by a new strain of Neisseria menengitis serogroup C (NmC). He has spoken in a number of national and international expert group meetings on NmC meningitis.

Helen Bygrave

Helen Bygrave (presenting on behalf of the Pakistan project) trained as a UK-based general practitioner. She has been working in MSF's HIV/TB programmes since 2005 and as an HIV/TB advisor for MSF's Southern Africa Medical Unit (SAMU) has supported programmes across Sub-saharan Africa. Her particular areas of interest have been supporting the scale up of HIV viral load monitoring. In 2015, Helen supported the implementation of screening and treatment for Hepatitis C in the MSF project in Kibera, Kenya.

Anna Righetti

Anna Righetti is a medical doctor, with a Master's degree in Health Economics Policy, Law, Global Health and Development from Rotterdam University, Netherlands. Her research projects have involved the analysis of mass drug administration for NTDs in Lower to Middle Income Country (LMIC), tools for data collection and e-records in primary health care facilities for Syrian refugees in Lebanon as well as mobile health tools in LMICs.

BIOGRAPHIES

MIGRANT PANEL

Emilie Venables, Qualitative Research Mobile Implementation Officer, MSF

Emilie Venables is an anthropologist currently working as a Qualitative Research Mobile Implementation Officer (MIO), based in South Africa. Her work involves conducting qualitative research studies and offering support to other researchers in sub-Saharan Africa and globally. She has worked with MSF since 2012, and her research interests include HIV/AIDS, sex-work and migration as well as the role of anthropology in humanitarian aid.

Emilie has conducted research in sub-Saharan Africa for over a decade, and has worked in countries including South Africa, Kenya, Liberia, Senegal, DRC, Mozambique, Cambodia and Côte d'Ivoire. Emilie's most recent work was in Italy, working with Eritrean refugees and migrants in transit centres in Rome, and focussed on the needs of people in transit in Europe and how to provide medical and psycho-social services to them. She has also worked on migrant access to health-care in sub-Saharan Africa.

Aurélie Ponthieu, Humanitarian Specialist on Displacement, Humanitarian Innovation Team (HIT), Analysis and Advocacy Unit, MSF Operational Centre of Brussels.

Aurélie Ponthieu has been working for MSF since 2006, and as a Humanitarian Specialist for MSF in Brussels since 2011. Her area of expertise includes forced migration and the humanitarian impact of asylum and migration policies. She provides support to MSF operations in terms of context analysis, positioning and advocacy strategies.

Before working at the MSF Headquarters in Brussels, she worked in the field with MSF for 5 years in Niger (2006), Sudan (2007-2008), Chad (2008), Colombia (2009) and Haiti (2010). She also worked in Liberia during the Ebola outbreak in 2014. Prior to her work with MSF, she also volunteered for organisations in Honduras and Chile. Aurelie holds a Masters degree in Humanitarian Action/ International Field legal Assistance and an LLM in International and European Law.

INTRODUCTORY SPEAKER

Professor Martin Veller, Dean of the Faculty of Health Sciences, University of Witwatersrand

Professor Veller was appointed as Dean of the Faculty of Health Sciences at Wits University in July 2014. Prior to this, Professor Veller served as Head of the Department of Surgery in the School of Clinical Medicine at Wits (November 2001 – February 2013) and Head of the Vascular Surgery division, Johannesburg teaching hospitals (January 1993 – June 2014).

Professor Veller, a vascular surgeon, received his pre- and post-graduate training at Wits where he qualified in general surgery in 1987. Professor Veller was appointed ad hominem Professor in the Faculty of Health Sciences at Wits in April 2002, and currently serves as President of the College of Surgeons of the Colleges of Medicine of South Africa, as well as President of the World Federation of Vascular Societies, and Treasurer of the Vascular Society of Southern Africa. Professor Veller is also on the board of directors of Wits Donald Gordon Medical Centre and Nelson Mandela Children's Hospital Operational Company, and Chairman of the Board of Directors for the Wits Health Consortium.

PANEL CHAIRS

Professor Ashraf Coovadia, Head of Department, Dept of Paediatrics and Child Health, Rahima Moosa Mother and Child Hospital, University of the Witwatersrand

Professor Coovadia is the Head of Department of Paediatrics and Child Health at Rahima Moosa Mother and Child Hospital and University of The Witwatersrand. He is involved with provincial and national departments of health and since 1998 has championed the cause of Paediatric HIV/AIDS and Prevention of Mother to Child Transmission of HIV (PMTCT). He continues to serve as technical advisor on the Paediatric Antiretroviral expert panel that assists the National Department of Health with developing and implementing paediatric treatment guidelines, and remains actively involved with research projects involving women and children who are HIV-infected. He is also a member of several different councils, committees and societies at the forefront of driving changes and improvement on policies for all HIV infected women and children.

Samantha Khan-Gillmore, Programme Manager, Rural Health Advocacy Project (RHAP)

Samantha Khan-Gillmore is RHAP's Programme Manager for Human Resources for Rural Health, including The Voice Project, which is aimed at empowering health care workers to advocate for patient's rights and for a quality health care system. Before joining RHAP she managed education, workers' and human rights programmes for over a decade in South Africa and across the African continent. Samantha has previously worked for the Discipline of Occupational and Environmental Health (DOEH) at the University of KwaZulu-Natal (UKZN), Durban, as well for local and international labour movements. She holds a post-graduate (Honours) qualification in Politics and an undergraduate Law degree from the University of KwaZulu-Natal in Durban.

Jacob van Garderen, National Director of Lawyers for Human Rights [LHR], South Africa

LHR is a leading human rights organisation with almost forty years' experience in social justice activism and public interest litigation in South Africa. Operating from six law clinics across South Africa, LHR has specialist programmes on strategic litigation, refugee and migrants rights, land reform, farmworkers, housing gender and environmental rights. Jacob received a BCom and LLB degrees from the University of Pretoria and is a member of the Johannesburg Bar. He has written and lectured on refugee law and practice. He also serves on the boards and advisory committees of various NGOs and research institutions.

Professor Lucille Blumberg, Deputy-Director, National Institute for Communicable Diseases (NICD), National Health Laboratory Service (NHLS)

Professor Lucille Blumberg is a Deputy Director of the National Institute for Communicable Diseases, of the National Health Laboratory Service, and currently head of the Public Health Surveillance and Response Division. She is also medical consultant to the Emerging Pathogens Centre on rabies and viral haemorrhagic fevers. She has specialist qualifications in clinical microbiology, travel medicine, and infectious diseases. Her special interests are in tropical diseases, travel medicine, malaria, the viral haemorrhagic fevers, and rabies. She is a member of a number of South African expert groups on Ebola, rabies, malaria and serves on various WHO Advisory Groups.

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