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18th ICASA
INTERNATIONAL CONFERENCE
ON AIDS AND STIs IN AFRICA
ZIMBABWE - 2015
AIDS in Post 2015: Linking Leadership, Science & Human Rights

Abstract Book

Society for AIDS in Africa Permanent Secretariat, Ghana

18th ICASA
INTERNATIONAL CONFERENCE ON AIDS AND STIs IN AFRICA
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AIDS In Post 2015: Linking Leadership, Science & Human Rights

ICASA-2015 * 18th International Conference on AIDS and STI's in Africa

Abstract Book

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TABLE OF CONTENTS

OPENING CEREMONY SPEAKERS

OPENING CEREMONY SPEAKERS

Welcome Statement By Dr. Ihab Ahmed Abdelrahman

Dr. Ihab Ahmed Abdelrahman

"Fifteen years ago there was a conspiracy of silence. AIDS was a disease of the "others" and treatment was for the rich and not for the poor. We proved them wrong, and today we have 15 million people on treatment—15 million success stories." said Michel Sidibé, Executive Director of UNAIDS.

This statement resonates with me as it reflects the hard work and commitment of all stakeholders reaching this crucial point. Recent reports indicate that between 2000 and 2014, new HIV infections dropped from 3.1 million to 2 million, a reduction of 35%. As In 2014, 83 countries, which account for 83% of all people living with HIV, have halted or reversed their epidemics, including countries with major epidemics, such as India, Kenya, Mozambique, South Africa and Zimbabwe.

Can we celebrate this success? Yes we can, unless we increase investments in the AIDS response in order to pave the way for an AIDS free generation. ICASA as the platform creates the means by which we can achieve this goal.

The 18th ICASA in Zimbabwe will bring together professionals and activists from across the world and provide the opportunity to take stock of the gains made, showcase groundbreaking research, and develop strategies to achieving the targets set in the Sustainable Development Goals (SDGs).

Zimbabwe has gracefully accepted to host ICASA 2015 in the beautiful city of Harare from the 29th of November to the 4th of December 2015, under the theme: "AIDS in Post 2015: Linking Leadership, Science & Human Rights". This theme reflects the three basic components central to an efficient AIDS response in Africa and worldwide for the upcoming 15 years.

I wish to welcome all delegates to the 18th edition of ICASA, which will be organized by the Society for AIDS in Africa in partnership with the government of Zimbabwe through its Ministry of Health and Child care.

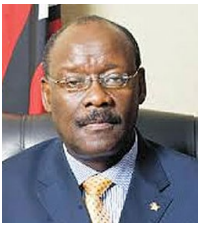
Dr Ihab Ahmed

ICASA 2015 President

SAA President

OPENING CEREMONY SPEAKERS

Welcome Statement By **Dr. Pagwesese David Parirenyatwa**



Dear ICASA Delegates,

My name is Dr. Pagwesese David Parirenyatwa, the Minister of Health and Child Care for Zimbabwe. Zimbabwe will this year host the 18th edition of the International Conference on AIDS and STI's in Africa at The Rainbow Towers Hotel and Harare International Conference Centre from 29 November to 04 December 2015.

I therefore would like to warmly invite you to this biennial International AIDS conference, which is a premier gathering for those working in the field of HIV, leaders, people living with HIV and others committed to ending the pandemic. ICASA is a tremendous platform for researchers from all around the globe to share latest scientific advances in the field, learn from others experiences and develop strategies for facets of a collective effort to prevent and treat HIV. ICASA 2015 is expected to convene 7000 delegates from nearly 150 countries including over 200 journalists.

Zimbabwe has a long history in the response to HIV and AIDS. As one of the countries severely affected by the pandemic, we have recorded some internationally acclaimed milestones particularly the reduction of both HIV incidence and prevalence and scaling up access to treatment under difficult conditions as well as our leadership role as a pathfinder in domestic financing for HIV through our AIDS levy, which has now been recorded and shared as an international best practice. We are confident that ICASA delegates will benefit from our efforts and challenges as well as those of the entire African region as we move towards ending AIDS by 2030. The response of HIV and AIDS has been closely linked with efforts to end co-morbidities such TB and cancer as well as other sexually transmitted infections which will be addressed at the upcoming ICASA.

In the meantime, we are seized with developing a top quality scientific programme that will include presentations from leading researchers, workshops, expert sessions and sharing of best practices. There will also be a global village for exhibitions and activism.

Zimbabwe is a peaceful and safe country with a diverse culture animated by its hospitable people and natural wonders. I therefore would like to also invite you to take time before or after ICASA to visit our magnificent tourist attractions such as the majestic Victoria Falls, the Great Zimbabwe Monuments, national parks with diverse flora and fauna as well as the Eastern Highlands.

Dr. Pagwesese David Parirenyatwa

Minister of Health and Child Care
Zimbabwe.

Welcome to ICASA 2015, welcome to Harare the sun shine city.

OPENING CEREMONY SPEAKERS

Welcome Statement By Michel Sidibé

Since his appointment as Executive Director of UNAIDS and Under-Secretary-General of the United Nations by Secretary-General Ban Ki-moon in 2009, Michel Sidibé's vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths has echoed around the world.

Under his leadership UNAIDS works to ensure that no one is left behind in the response to HIV and that everyone in need has access to life-saving HIV services. He initiated the global call to eliminate HIV infections among children and his global advocacy has firmly secured HIV at the top of political agendas. His idea of shared responsibility and global solidarity has been embraced by the international community and has encouraged increased ownership of their epidemics by countries most affected.

Mr Sidibé has spent more than 30 years in public service. His passion for advancing global health began in his native Mali, where he worked to improve the health and welfare of the nomadic Tuareg people. He later became Country Director for Terre des Hommes. In 1987, Mr Sidibé joined UNICEF in the Democratic Republic of the Congo and went on to serve with UNICEF for a further 14 years, overseeing programmes across 10 francophone African countries and serving as country representative in a number of countries.

Mr Sidibé has been awarded honorary doctorates from Tuskegee University, Clark University and the University of British Columbia, as well as an honorary professorship at Stellenbosch University. In 2012 he was named one of the 50 most influential Africans by the Africa Report and one of 50 personalities of the year by the French newspaper Le Monde in 2009. He received the Emerging Leader Award from the UN Foundation and the United Nations Association of the USA, is a Knight of the National Order of the Legion of Honour of France, an Officer of the National Order of Mali, an Officer of the National Order of Benin, a Chancellor of the National Order of Chad and was awarded an Order of Saint-Charles by Monaco. He also serves on the Global Board of Directors of Grassroot Soccer.

He holds two Post-Master's Diplomas-Social Planning and Demography-and Development and Political Economy-from the University of Blaise Pascal, Clermont-Ferrand, France. He also holds a Master's degree in economics.

Mr Sidibé is fluent in English and French and speaks several African languages. He is married and has four children.

OPENING CEREMONY SPEAKERS

Welcome Statement By Dr. Babatunde Osotimehin

United Nations Under Secretary General and Executive Director of United Nations Population Fund,UNFPA

Dr. Babatunde Osotimehin is a global leader of public health, women's empowerment and young people, particularly focused on promoting human rights, including sexual and reproductive health and rights, as well as population and development. Since his appointment as UNFPA Executive Director, effective 2011, he has spearheaded efforts by the international community to advance the milestone consensus of the International Conference on Population and Development, held in Cairo in 1994.

Already into his second term as Executive Director as of 2015, Dr. Osotimehin has introduced new reforms that have increased the effectiveness and efficiency of UNFPA and outlined a more robust vision for improving the lives of women, adolescents and youth around the world. His leadership and advocacy with governments and other key stakeholders will continue to focus on youth and voluntary family planning. He is also steering UNFPA's humanitarian action and efforts around eliminating gender-based violence and other harmful practices.

Dr. Osotimehin believes that humility is the key to engaging people and facilitating change. "Humility to engage with the other person of the other community in such a way that they know that you respect them," he says. Cultural sensitivity and understanding are vital.

Dr. Osotimehin's professional background is in health and medicine. He has extensive knowledge of the global and national frameworks and processes that are critical to UNFPA's work. He previously served as Nigeria's Minister of Health and as the Director-General of the National Agency for the Control of HIV and AIDS, which coordinates all HIV/AIDS work in Nigeria.

The UNFPA Executive Director serves in various advisory boards and councils. He chairs the World Economic Forum's Global Agenda Council on the Demographic Dividend and co-chairs the Family Planning 2020 Reference Group.

Dr. Osotimehin completed his medical studies at the University of Ibadan, Nigeria, in 1972 and received a doctorate in medicine from the University of Birmingham, United Kingdom, in 1979. He was named Professor at the University of Ibadan in 1980 and headed the Department of Clinical Pathology before being elected Provost of the College of Medicine in 1990. He has served as chair and member of several academic and health organizations, including as Chair of the National Action Committee on AIDS, between 2002 and 2007. Dr. Osotimehin received the Nigerian national honour of Officer of the Order of the Niger, in December 2005.

Dr. Osotimehin is married and has five children.

OPENING CEREMONY SPEAKERS

Welcome Statement By Ms. Leila Pakkala

Leila Pakkala is the UNICEF Regional Director for Eastern and Southern Africa, a position she has held since March last year. Based in Nairobi, she is responsible for leadership, oversight and guidance to 21 UNICEF country offices as well as the representation of the organization with governments, donors, the private sector and civil society in this region.

From 2010 to 2014, Ms. Pakkala was UNICEF's Director of Private Fundraising and Partnerships leading UNICEF's strategic relationship with 36 UNICEF National Committees and guiding UNICEF country offices in private sector fundraising and partnerships activities.

Ms. Pakkala brings more than 20 years of experience in development and humanitarian programming and management to this position, having previously worked for UNICEF in Switzerland (Geneva), Mozambique, Somalia, the United States of America (New York), FYR Macedonia and Uganda, and for the United Nations and the private sector in Ethiopia and Lesotho.

Ms. Pakkala is a national of Iran. She holds a Post Graduate License and a Master of Arts in Psychology and is a qualified counsellor in child development psychology.

Welcome Statement By Dr. Matshidiso Moeti

Dr Matshidiso Moeti, a public health veteran, is the first woman WHO Regional Director for Africa. She joined the WHO Regional Office for Africa in 1999 and has held several senior positions in the Organization.

At the height of the HIV/AIDS epidemic, Dr. Moeti led WHO's "3 by 5" Initiative in the African Region, an Initiative that helped establish systems for the provision of antiretroviral therapy in countries and resulted in a significant increase in the number of HIV-positive individuals accessing antiretroviral drugs.

Prior to joining WHO, Dr. Moeti worked with UNAIDS as the Team Leader of the Africa and Middle East Desk in Geneva, with UNICEF as a Regional Advisor, and with Botswana's Ministry of Health in various capacities.

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yoann madec

SCHOLARSHIP

Every two years scholarships and other types of financial support are awarded to a large number of individuals to enable them to attend, participate and present at the conference. This is crucial to ensure that a balance is maintained in relation to representation at the conference and its continued relevance as a global forum.

To enable us to do this we rely on financial support from a number of organizations. This year Scholarships for ICASA was funded by the PEPFAR.

Volunteers Supporters

18th ICASA is supported by excellent and dedicated team of volunteers.

Conference Organizers would like to especially thank all who supported volunteer's recruitment and management process.

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The ICASA Conference Rapporteurs was supported mainly by UNICEF and also UNFPA.

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The Rainbow Towers Hotel & Conference Centre

The 18th International Conference on AIDS and STIs in Africa is taking place in Harare, Zimbabwe at The Rainbow Towers Hotel & Conference Centre. The full address of the venue is:

The Rainbow Towers & Conference Centre
Belvedere South
Harare, Zimbabwe

Please refer to the venue floor plan in the conference book. We hope that this will assist you in navigating your way around the venue.

Should you have any problems, or require any additional information, please as one of the conference staff or volunteers, or visit our General Information Desk, which is located in the Registration Area on the ground floor.

Certificates of attendance

Certificates will be issued upon request at the Registration Desk, starting after 10:15 Thursday, 3 December.

Community Village

The Community Village is an integral and vibrant element of the ICASA programme. Located on the ground floor (see venue map) the Community Village is open to both registered conference participants and the general public.

The Village will host community talks, giving conference participants and the general public the opportunity to interact with leaders, NGOs and government activities throughout the conference on the Main Stage. Delegates and visitors are encouraged and invited to visit the Village exhibition areas and networking zones.

The Official Opening Ceremony of the Community Village will commence at 15:30 on Monday, 30 November on the Main Stage. Please see the Community Village programme in your conference bag for the full schedule of sessions, performances and activities.

Opening House:

Monday, 30 November:	10:45 AM - 18:00 PM
Tuesday, 1 December:	10:45 AM - 18:00 PM
Wednesday, 2 December:	10:45 AM - 18:00 PM
Thursday, 3 December:	10:45 AM - 18:00 PM
Friday, 4 December:	10:45 AM - 18:00 PM

Conference Registration

The Registration Area is located on the ground floor and is clearly marked on the venue floor plan.

Opening House:

Sunday, 29 November:	10:00 AM - 16:00 PM
Monday, 30 November:	8:00 AM - 16:00 PM
Tuesday, 1 December:	8:00 AM - 16:00 PM
Wednesday, 2 December:	8:00 AM - 16:00 PM
Thursday, 3 December:	8:00 AM - 12:00 PM
Friday, 4 December:	8:00 PM - 12:00 PM

Conference delegates must wear their badges at all times in order to gain access to the session rooms and exhibition area. Conference volunteers and the venue security will not allow anyone to enter the conference venue without a valid badge. If you have lost your badge, please contact the registration desk. Replacement badges will be issued at a cost of $60 each (including VAT).

Accompanying adult participants are permitted access to the opening and closing ceremonies. Only children (under 18) registered as a accompany person will be admitted to all conference sessions.

Poster Exhibition

The Exhibition booths are located in the Exhibition Hall on the ground level, offering delegates a chance for dynamic interaction with exhibitors. There are plenty of exciting exhibitors at ICASA and delegates are encouraged to visit all stands to discover the latest news from our supporting organizations. Some exhibitors will give demonstrations in the Exhibition Hall which promises to add an extra level of interest to conference participation. All the stands are marked on the dedicated Exhibition Map to make each booth easy to find.

Information Desks

A General information Desk is situated in the Registration Area. There are additional area-specific information counters in the Exhibition areas.

Volunteers will be stationed throughout the conference to assist participants with any queries.

Internet/WiFi

The Rainbow Towers Hotel & Conference Centre Wireless internet is available in all conference venues free of charge. If you need help to access the internet with your device, please visit the General Information Desk.

Interpretation (EN/FR)

The official languages of the conference are English and French. Simultaneous interpretation from English to French and from French to English will be provided in the following session rooms:

Plenary Hall (Note: French will be translated to English)

Committee Room 6

Committee Room 4

If you would like to use the simultaneous interpretation service, collect a headset before the session immediately outside the relevant session room. Delegates are required to deposit a valid passport or US$100/80 in cash when collecting a headset. This will be returned when the headset is returned. Delegates will be charged US$100 for lost, misplaced or damaged headsets.

To avoid a long wait, Please obtain headsets during the break before the session. Please return the headset equipment at the end of each day to ensure they can be recharged for use the following day.

Media Centre

Media registration must be carried out at the dedicated Media Registration Desk in the Registration Area on the ground floor. Accredited media will have full access to the Media Centre located on the ground floor

The Media Centre will be open daily from Monday, November 30 until Thursday, 3 December, from 07:00 AM to 19:00 PM.

The Media Centre will be equipped with computers and printers for use by accredited journalists. Information on press conference and briefings will be posted in Media Centre with updated dates and times.

Journalists wishing to secure interviews with conference speakers will be assisted in the Media Centre.

More information on the Media Centre and press conference facilities will be available in the Media Guide with will be issued to all journalists accredited for the conference.

Participation Guidelines/ Code of Conduct

The conference acknowledges the freedom of expression of speakers, participants and exhibitors. It does, however, subscribe to the widely-held principles associated with exercising such freedom of expression, i.e. that such expression may not lead to any harm or prejudice to any person or damages to any property. If anyone abuses these principles, Zimbabwean law applies.

Positive Lounge

The Positive Lounge is provided exclusively for people living with HIV as a place where they can rest, refresh themselves, network and take medications. The Positive Lounge is located at the Rainbow Towers Hotel & Conference Centre and it is open from Sunday, 29 November to Friday, 4th December, 08:00AM and 18:00PM.

Presenters, Speakers, Chairs and Facilitators

The Speakers' Room is located on the ground floor (please refer to the venue floor plan).

All speakers, chairpersons, moderators, facilitators and oral presenters are requested to report to the Faculty immediately after registration to sign consent forms, confirm their presentation date, time and venue and receive specific security information relevant to their session.

The Faculty is THE ONLY PLACE where slide presentations can be uploaded onto the system. All presenters are requested to do so at least six hours before their session. The organizers cannot guarantee projection in the session room if presenters upload their slides later.

Presenters will not be able to upload their presentation in the session's room.

Please note: Failure to report to the Faculty on time may result in the conference organizers appointing replacement.

Opening Hours:

Sunday, 29 November:	10:15 AM - 17:00 PM
Monday, 30 November:	7:00 AM - 17:00 PM
Tuesday, 1 December:	7:00 AM - 17:00 AM
Wednesday, 2 December:	7:00 AM - 17:00 AM
Thursday, 3 December:	7:00 AM - 17:00 AM

Friday, 4 December: 7:00 AM - 17:00 PM

Poster Exhibition

The Poster Exhibition is located on the ground floor in the main exhibition hall. Please refer to the poster exhibition map for an overview of the colour-coded Track Areas. All boards are sequentially numbered to help presenters and viewers find the poster they want. There are four poster sessions from Monday to Thursday:

Times:

10:15 AM –	10:45 AM
12:15 PM –	12:45 PM
14:15 PM –	14:45 PM
16:15 PM –	16:45 PM

INSTRUCTIONS FOR POSTER PRESENTERS:

The posters will be displayed for one day. During breaks the presenters are required to stand by their posters and answer questions and provide further information on their study results.

The Poster Exhibition will take place within the Exhibition Hall on Level 0. Your poster board will be marked with your new abstract number. All authors are responsible for mounting and removing their own posters.

Poster mounting and removal time

Your paper poster should be mounted and removed at the following times:

- Poster should be mounted 7:30 AM – 8:30 AM
- Poster must be removed 6:30 PM

When removing your poster, please make sure to also remove all poster-mounting material from the board. The Congress staff will remove all posters not taken down on time. The Congress organizers will not take any responsibility for posters or other material left in the Poster Exhibition area.

Presenting authors should stand by their poster during the following break times on one day only. Please see details below

Security

The Safety and Security Office is located on-site and can be contacted on our emergency lines: +263772522250 or +263718722250.

For security reasons, access to all the Congress venues will be controlled. Access to the session rooms and Exhibition Halls of The Rainbow Towers Hotel & Conference Centre will be accessible only to registered delegates displaying conference badges. In the interest of personal safety and security, delegates should only display their conference badges on the The Rainbow Towers Hotel & Conference Centre premises.

Neither the Conference Secretariat, nor any of their contracted service providers, will be responsible for the safety of any articles brought into the conference facilities by conference participants, whether registered or not, their agents, contractors, visitors and/ or any other person/s whatsoever. The conference participant shall indemnify and hold neither the organizers not associates and subcontractors liable in respect of all cost, claims, demands and expenses as a result of any damage, loss or injury to any person howsoever caused as a result of any act or default of the Conference Secretariat or a person representing the Conference Secretariat, Their contractors or guests. In addition, the conference participant shall take all necessary precautions to prevent any loss or damage to his/her property with special regard to mobile phones, carry/handbags and computing equipment.

Smoking Policy

Smoking is not permitted anywhere in the building. When smoking outside please show respect for the environment, fellow conference delegates and other venue guests by properly disposing of cigarette buds and other waste in the bins provided.

Social Media

Connect with ICASA through our social media platforms and stay abreast with happenings during the conference. Follow us on Twitter (@ICASA2015) and like our Facebook page (ICASA International Secretariat).

Young Investigator Awards

The ICASA young Investigator Award was established by Society for AIDS in Africa (SAA), the custodian of ICASA, to encourage young researchers and to recognize excellence.

An award will be given to the author of the highest scoring abstract for each of the conference tracks. The Prize will be given at Holiday Inn, on 1st December during the SAA Award reception.

BEST ABSTRACT AWARD RECIPIENTS ICASA 2015

TRACK A

Dr. Almoustapha I. MAIGA, is Director of Molecular and Epidemiology of HIV drug resistance laboratory at the University of Sciences Techniques and Technologies of Bamako and Director of Clinical laboratory in the University teaching Hospital of Gabriel Toure in Bamako. He is the Vice-President of National Scientific committee of HIV in Mali. He had an experience with the National AIDS Program in Mali, Solthis and Esther. He did his Pharmacy Doctorate in Mali, Two Masters degrees in Paris and a PhD degree at UMPC in Paris. He is a Researcher of the NIH/Fogarty Center AIDS International Training and Research Program (AITRP) based in Mali and Nigeria, and was trained in Northwestern University. He is member of many editorial boards of peer review journals, member of many international associations and organizations and member of the scientific committee of many national, regional and international conferences in HIV field. He authors and co-authors many peer review papers in international journals.

TRACK B

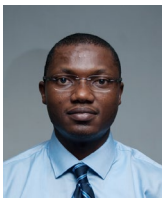
Dr. Tadesse T. Mekonen is a qualified doctor of medicine and public health specialist. He has worked as a lecturer to medical students, clinician, trainer, mentor and public health program leader in Ethiopia and Namibia. Currently, he's working as a Chief HIV Clinical Mentor for the National HIV and STI Control program at the Ministry of Health and Social Services of Namibia. He is responsible for training and mentoring of HIV clinical mentors and clinicians.

Dr. Mekonen graduated as a doctor of medicine from Addis Ababa University in 2005. He also obtained his Masters in Public Health from Walden University in the USA. He completed his master studies top in his class with very great distinction. He is a life time honorary member of the Golden Key International Honor Society for his academic achievements.

His areas of top research interest include persistent HIV remission and evolution of HIV resistance.

TRACK C

Dr. Tajudeen OYEWALE, MB;BS, MPH, PhD



Dr. Tajudeen Oyewale currently serves as Programme Specialist, HIV (Adolescents) at UNICEF New York as well as Executive Manager in the office of UNICEF Deputy Executive Director (Management). Dr Oyewale is a member of several global working groups on HIV/AIDS, and adolescent health. He served as Chief of the HIV/AIDS section and Acting Chief of Field Operations in UNICEF Bangladesh where he was central to developing one of the strongest cross-sectoral programmes on adolescents and HIV for UNICEF in South Asia. He also served as HIV/AIDS Specialist for UNICEF in Indonesia and Nigeria. A national of Nigeria, he trained as a physician at the University of Lagos, Nigeria, and holds a Masters of Public Health and Doctorate degree in Health Studies (Maternal Health) from the University of South Africa. Dr. Oyewale is married with children, enjoys golfing and reading, and has authored / contributed to several publications.

TRACK D

Mr. Yao Hyacinthe Koffi, 36, married with 2 children, was born in Yamoussoukro, Côte d'Ivoire. He is a social worker by training, specializing in psychosocial support for people and in particular children living with HIV. A certified "citizen journalist," he is also involved in instructional design and advocacy work. Mr. Koffi has worked in the fight against HIV/AIDS since 2008 and for the Centre Solidarité Action Social (CSAS) in Bouaké since 2012, currently managing the NGO's "Grandir" program (funded by Sidaction) as well as its communications and resource mobilization initiatives. He has attended several workshops organized by Solidarité Sida and the Platform ELSA in Burkina Faso and Togo, helping to develop knowledge capitalization and NGO empowerment techniques. In addition to his work with the CSAS, since 2013 Mr. Koffi has coordinated communications for 23 hospitals in Bouaké.

TRACK E

Dr. Tichaona Nyamundaya is an experienced public health professional, with over ten years of experience implementing HIV prevention, care and treatment projects and collaborating with varied stakeholders to develop national guidelines and tools for ART, MCH integration, and TB control. He has been responsible for ensuring that clinical mentorship is expanded to all provinces in Zimbabwe and scaling up pediatric HIV care and treatment. He has been instrumental in rapidly rolling out of WHO 2010 and WHO 2013 guidelines. He was also responsible for strengthening community linkages through the development and rollout of the tracking and tracing standard operating procedures to ensure retention in care and treatment. He received his Bachelor of Medicine and Surgery degree from the University of Zimbabwe, and has attended numerous trainings to build his competencies in HIV/AIDS commodities and clinical management, quality improvement, and operations research.

SESSION CODING FOR ICASA 2015 PROGRAMME

EXAMPLE 1: MOAA01 = MO (Weekday) - (Session type) AA - (Session order) 01

EXAMPLE 2: MOAAO105LB = MO (Weekday) - (Session type) AA - (Session order) 01 (Session order) 05 (abstract order)

EXAMPLE 3: MOPE001 = MO (poster presentation day) - PE (presentation type) - 001 (abstract order)

WEEKDAY

SU (Sunday)
MO (Monday)
TU (Tuesday)
WE (Wednesday)
TH (Thursday)
FR (Friday)

SESSION TYPE

NON-ABSTRACT-DRIVEN SESSIONS AND PROGRAMMES ACTIVITIES

CA (Cultural Activity)
CV (Community Village)
PL (Plenary Session)
SS (Special Session)
SY (Symposia Session)
WS (Workshop)

ABSTRACT-DRIVEN SESSIONS

ORAL ABSTRACT SESSION

AA (Track A)
AB (TRACK B)
AC (TRACK C)
AD (TRACK D)
AE (TRACK E)
PDC (TRACK C)
PDE (TRACK E)
PE00 PUB001

(Publication Only)

POSTER SESSION

PDA (TRACK A)
PDB (TRACK B)

SESSION ORDER

01, 02, 03, 04 etc

SATELLITE SESSIONS

SA (Satellite Session)
SU
MO
TU
WE
TH
FR

PROGRAMME OVERVIEW

Non-Abstract Driven Sessions

The non-abstract driven sessions address a variety of current viewpoints and issues. The format and focus of these sessions varies. Theses sessions are developed by the programme committees with stakeholder input ,

Session Types:

Plenary Sessions feature some of the world's most distinguished researchers, scientific leaders and clinical specialists. Plenary sessions bring all conference delegates together at the first session of every morning.

Special Sessions feature presentations by some of the world's key research leaders, high-level international AIDS Ambassadors and policy specialists. These 90-minutes session are highly engaging for all delegates.

Symposia session address critical issues that defy simple solutions. Focusing on a single, clearly defined topic or issue, speakers and delegates will share experiences, contribute relevant research findings and brainstorm ideas to identify possible ways forward.

ICASA 2015 features 46 high-quality, targeted professional development workshops that promote and enhance opportunities for knowledge transfer, skills development and collaborative learning. Twenty of the workshops are designed by the Conference Programme Committees, and the remaining workshop are selected from proposals submitted by the general public. Workshop can be 90 minutes in length and held in languages other than English.

A rapporteur summary session will be held immediately before the closing session on December 4th from 12:45 to 14:15. The summary session synthesizes presentations made during the week, focusing on critical issues addressed, important results presented and key recommendations put forward. The rapporteur teams will publish daily reports and session summaries on the conference website.

ABSTRACT-DRIVEN SESSIONS

The abstract driven component of the conference programme offers the highest calibre of state-of-the-art peer-reviewed research. Abstract driven sessions are either specific to one of the five tracks (A-E), or are composed of abstracts from different tracks that focus on one theme.

Over 1,545 abstract submissions went through a blind peer-review process, carried out by a panel of around 114 international reviewers. Around 1,206 abstracts were selected by members of the Scientific Programme Committee for inclusion in the conference programme. The highest-scoring accepted abstracts were selected for presentation in oral abstract sessions. The majority of the selected posters are displayed in the Poster Exhibitions.

Session Types:

Oral Abstract Sessions - These sessions are organized into themes which address new developments in each of the five scientific tracks, or focus on a topic which crosses various tracks. Oral abstract sessions are 90-minute sessions that consist of five oral presentations of ten mutinies followed by a five-minute question and answer session. An interactive moderated discussion, facilitated by the co-chairs, is held at the end of the session.

Poster Exhibition - Organized by track and covering a wide variety of topics, the Poster Exhibition includes approximately 945 posters. Each poster is displayed for one day and presenters will stand by their posters at scheduled times to answer questions and provide further information on their study results. The Poster Exhibition is open from Monday 30 - Thursday 03 December, and is located on the Ground Level. See the Poster Exhibition map.

PROGRAMME ACTIVITIES

Programme activities at ICASA 2015 are hosted by individuals, groups and organisations in the Global village area of the conference venue. Accessible to registered conference participants and free of charge to the general public, they offer a unique platform for diverse activities that bridge all areas of science, leadership and accountability and community.

COMMUNITY VILLAGE

The Community Village activities include: Panel discussions and debates on cutting-edge HIV issues; Film screenings; Art exhibits; Networking zones focusing on key populations and issues; NGO and marketplace booths showcasing the work and products and organizations working with-in the products of organizations working within the HIV field; and a range of live performance from local and international artists which will be held on the Main Stage. The Community Village area covers to 6,000 square metres and is located at the Rainbow Towers & Conference Centre .

Additional information about the Community Village and Youth Programme can be found on the conference website at: www.icasa2015zimbawe.org.

Stay up to date with everything happening in the Community Village by following @ ICASA2015.

SATELLITE SESSION

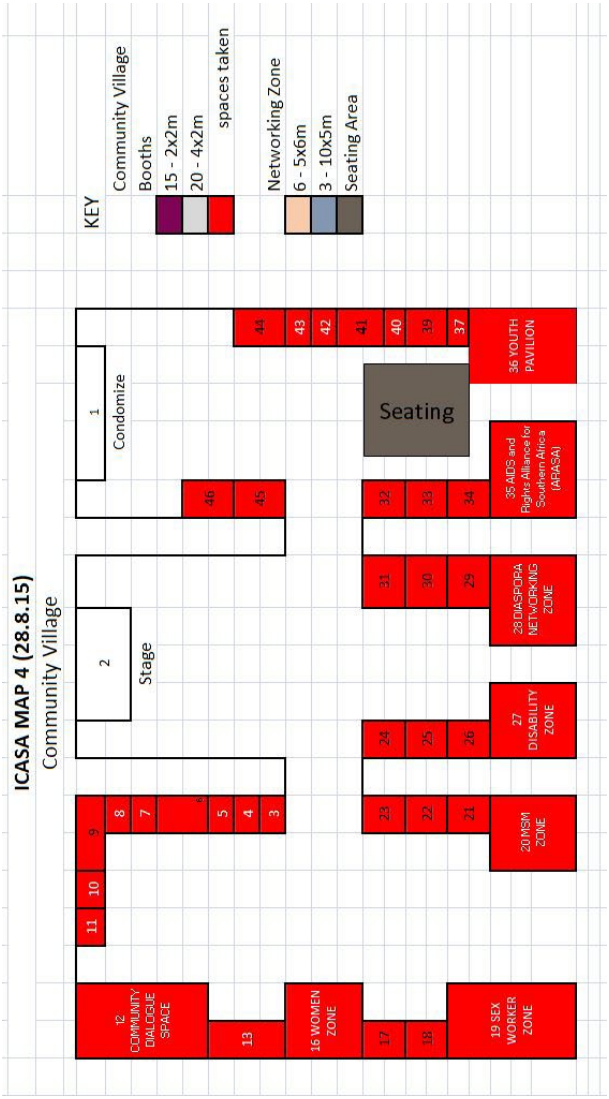
Satellite sessions will take place all day on Sunday 29 November only in the morning and from Monday, 30 November to Friday, 4 December. Satellite sessions take place in the conference centre, but are fully organized and coordinated by the organization hosting the satellite. The programme committee will review the contents and speakers of the satellite sessions to ensure that they meet the scientific and ethical principles of the conference.

ENGAGEMENT TOURS

Engagement tours provide delegates with unique learning experiences through interactive site visits to organizations that work on HIV and AIDS issues in Harare, Zimbabwe. The goal is to exchange knowledge, best practice, successes, challenges and innovative solutions through dialogue and hands-on activities.

To register visit the registration desk.

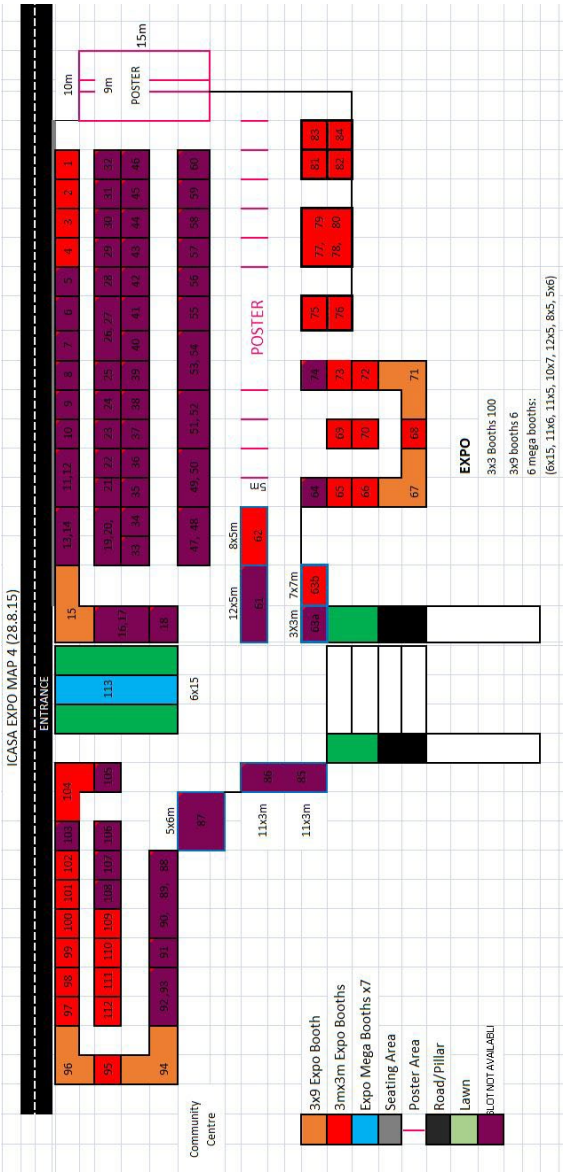
COMMUNITY VILLAGE BOOTHS



COMMUNITY VILLAGE BOOTHS

- Oxfam
- International Federation of Red cross
- International Community of Women Living with HIV
- Southern African AIDS Trust
- International Treatment Preparedness Coalition
- Aids Fonds
- HIV Vaccine Trials Network
- Global Interfaith Network
- ILO
- REPSSI
- World AIDS Campaign International (WACI)
- International HIV AIDS ALLIANCE
- SAfAIDS
- Champions for Life
- Jointed Hands Welfare Organisation
- Dance 4life
- Hivos
- Sonke Gender Justice
- ICP Compassionate Trust
- National AIDS Council, Zimbabwe
- AIDS and Rights Alliance for Southern Africa
- OPHID
- SRC
- PPSAC

EXHIBITION HALL



EXHIBITORS

» Abbott Laboratories	Stand 92, 93
» Africaid Zvandiri	Stand 34
» Alere International ltd	Stand 87
» American International Health Alliance	Stand 39
» BD Biosciences	Stand 53, 54
» Beckman Coulter	Stand 37
» bioMérieux	Stand 44
» Cepheid HBDC	Stand 35
» Circ MedTech	Stand 106
» Diagnostics for the Real World	Stand 19, 20
» Doctors without Borders	Stand 60
» EANNASO	Stand 109
» Expertise France	Stand 24
» Ghana AIDS Commission	Stand 22
» Gilead Science Inc.	Stand 51, 52
» HETERO LABS LTD	Stand 16, 17
» Hologic	Stand 88,89,90
» Hospice & Palliative Care Association of Zimbabwe	Stand 110
» HUMAN Gesellschaft für Biochemica und Diagnostica	Stand 18
» Humana People to People	Stand 41
» International AIDS Society (IAS)	Stand 21
» IPPFAR - Parenthood Federation Africa Region	Stand 91
» Malacas	Stand 103
» MEDIRITE DISTRIBUTION	Stand 112
» Merck	Stand 59
» MM African Technology (pvt) ltd	Stand 38
» Mylan	Stand 61
» National AIDS Control Council, Kenya	Stand 28
» National AIDS Council, Zimbabwe	Stand 32, 43
» New Avakash International	Stand 85, 86
» Omega Diagnostic	Stand 57
» OraSure Technologies Inc	Stand 58
» Oxfam	Stand 40
» PerkinElmer/Wallac Oy	Stand 30
» Population Services Zimbabwe	Stand 108
» Premier Medical Corp.Pvt Ltd	Stand 29
» Priontex	Stand 63 A
» Quidel Corporation	Stand 25
» RELIANCE	Stand 26, 27
» Réseau Accès aux Médicaments Essentiels	Stand 56
» RIATT-ESA	Stand 33
» SAfAIDS	Stand 55
» SAM Nutritional Products	Stand 31
» Save the Children	Stand 95
» SD Biosensor	Stand 105
» Sysmex South Africa	Stand 36
» Society For AIDS in Africa (SAA)	Stand 74
» The Girls legacy	Stand 111
» Trinity Biotech	Stand 49, 50
» U.S. Embassy Public Affairs Section	Stand 8
» UN Women	Stand 7
» UNAIDS Regional Support Team for Eastern and Southern Africa	Stand 10
» UNESCO	Stand 9
» UNFPA	Stand 13, 14, 46
» UNICEF	Stand 11, 12
» ViiV Healthcare	Stand 47, 48
» Virology Education	Stand 107
» WHO AFRO	Stand 5
» World Health Clinicians/BEAT AIDS Project Zimbabwe	Stand 42
» ZESA ENTERPRISES	Stand 83
» Zimbabwe National Family Planning Council	Stand 23
» ZIMNAT Life Assurance Company	Stand 102

COMMUNITY VILLAGE PROGRAM

MONDAY 30/11/2015

COMMUNITY DIALOGUE SPACE

TITLE:
COMMMUNITY PROGRAM OPENING - Minister of Health/ICASA President/ UNAIDS Executive Director/Community Activist/Young woman/Samuel Eto, UNFPA SYP music performance

TIME: 10:45 AM - 12:15 PM

TITLE:
Science and citizens: partners in the search for an HIV vaccine - HIV Vaccine Trials Network (HVTN)/University of Zimbabwe-University of California San Francisco Collaborative Research Programme (UZ- UCSF)

TIME: 14:45 PM - 16:15 PM

TITLE:
IAVI

TIME: 16:45 PM - 18:15 PM

COMMUNITY VILLAGE SQUARE

TITLE:
COMMMUNITY PROGRAM OPENING

TIME: 10:45 AM - 12:15 PM

TITLE:
Interactive Theatre on HIV and SRHR - SAT Johannesburg

TIME: 12:45 PM - 14:15 PM

TITLE:
Start Dancing Stop AIDS - Dance4Life

TIME: 16:45 PM - 18:15 PM

ART EXHIBITION

TITLE:
PHOTO EXHIBITIONS TO MEET KEY POPULATIONS by award winning photographer Chris de Bode - Aids Fonds Netherlands

TIME: 10:45 AM - 18:15 PM

TUESDAY 01/12/2015

COMMUNITY DIALOGUE SPACE

TITLE:
End child marriage: Case study of a girls Campaign - ROOTS Africa

TIME: 10:45 AM - 12:15 PM

TITLE:
Beyond 5 senses video screening - ICASA YouthFront

TIME: 14:45 PM - 16:15 PM

TITLE:
Film show - Aidsfonds

TIME: 16:45 PM - 18:15 PM

COMMUNITY VILLAGE SQUARE

TITLE:
Music against AIDS - SYP UNFPA

TIME: 10:45 AM - 12:15 PM

TITLE:
ART EXHIBITION BRIEFING - Aidsfonds

TIME: 12:45 PM - 14:15 PM

TITLE:
Start Dancing Stop AIDS - Dance4Life

TIME: 16:45 PM - 18:15 PM

ART EXHIBITION

TITLE:
PHOTO EXHIBITIONS TO MEET KEY POPULATIONS by award winning photographer Chris de Bode - Aids Fonds Netherlands

TIME: 10:45 AM - 18:15 PM

COMMUNITY VILLAGE PROGRAM

WEDNESDAY 02/12/2015

COMMUNITY DIALOGUE SPACE

TITLE:
Film show - Aidsfonds

TIME: 10:45 AM - 12:15 PM

TITLE:
Africa Civil society platform for health

TIME: 14:45 PM - 16:15 PM

TITLE:

TIME:

COMMUNITY VILLAGE SQUARE

TITLE:

TIME: 10:45 AM - 12:15 PM

TITLE:
Music against AIDS - SYP UNFPA

TIME: 12:45 PM - 14:15 PM

TITLE:
"Champions for Life Psycho-social Support & Leadership Development Program Exhibition"- Champions for Life

TIME: 16:45 PM - 18:15 PM

ART EXHIBITION

TITLE:

TIME: 10:45 AM - 18:15 PM

THURSDAY 03/12/2015

COMMUNITY DIALOGUE SPACE

TITLE:
Life changing fun and games - Bridges of Hope

TIME: 10:45 AM - 12:15 PM

TITLE:

TIME: 14:45 PM - 16:15 PM

TITLE:

TIME: 16:45 PM - 18:15 PM

COMMUNITY VILLAGE SQUARE

TITLE:

TIME: 10:45 AM - 12:15 PM

TITLE:
Disability Drama Group -

TIME: 12:45 PM - 14:15 PM

TITLE:

TIME: 16:45 PM - 18:15 PM

ART EXHIBITION

TITLE:

TIME: 10:45 AM - 18:15 PM

FRIDAY 02/12/2015

COMMUNITY DIALOGUE SPACE

TITLE:
Unique couples Experience sharing - FASO

TIME: 10:45 AM - 12:15 PM

TITLE:

TIME: 14:45 PM - 16:15 PM

TITLE:

TIME:

COMMUNITY VILLAGE SQUARE

TITLE:

TIME: 10:45 AM - 12:15 PM

TITLE:

TIME: 12:45 PM - 14:15 PM

TITLE:

TIME: 16:45 PM - 18:15 PM

ART EXHIBITION

TITLE:

TIME: 10:45 AM - 18:15 PM

PLENARY SESSION

MONDAY 30 NOVEMBER 2015

30.11.2015, 08:45 – 10:15 Main Auditorium

PLENARY: WORKING TOGETHER TO ACHIEVE SUSTAINABLE EPIDEMIC CONTROL.

Chair: Judge James Cameron
Speaker: Ambassador Birx

AMBASSADOR BIRX

Ambassador Birx has dedicated her life to changing the course of HIV/AIDS in the United States and throughout the world. She currently serves as Ambassador at Large and U.S. Global AIDS Coordinator, leading all U.S. Government international HIV/AIDS efforts. Ambassador Birx oversees implementation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the largest commitment by any nation to combat a single disease in history, as well as all U.S. Government engagement with the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Ambassador Birx is a renowned medical expert in the field of HIV/AIDS. For over three decades, her career has focused on HIV/AIDS immunology, vaccine research, and global health. Since 2005, she has served as Director of the Division of Global HIV/AIDS at the U.S. Centers for Disease Control and Prevention (CDC) leading PEPFAR implementation. Birx was awarded the first Lifetime Achievement Award from the African Society for Laboratory Medicine in 2011, in recognition of decades of impassioned support for development of sustainable country-led health systems.

Prior to her work with CDC, Ambassador Birx, a proud Army Veteran, having risen to the rank of Colonel in the US Army, served at the Department of Defense as Director of the U.S. Military HIV Research Program at the Walter Reed Army Institute of Research. In that role, she led development of the Thai vaccine trial which became the first clinical HIV/AIDS research study to show the potential that a vaccine could protect against HIV. She also served as an Assistant Chief of the Hospital Immunology Service at Walter Reed Army Medical Center.

PLENARY: BIOMEDICAL ADVANCES: IMPACT ON HIV EPIDEMIOLOGY

Speaker: Prof. Mike Chirenje, Zimbabwe

PROFESSOR ZVAVAHERA MIKE CHIRENJE

Zvavahera Mike Chirenje, MD, FRCOG, is a Professor in the Department of Obstetrics and Gynecology at the College of Health Sciences at the University of Zimbabwe. He is an attending Gynecological Oncologist at Parirenyatwa Hospital in Harare, Zimbabwe. He also conducts HIV prevention clinical trials in women with a particular emphasis on microbicide and Pre-Exposure Prophlyaxis (PrEP) development. He was one of the founding members of the University of Zimbabwe – University of California, San Francisco (UZ-UCSF) Collaborative Research Programme in Womens Health, and has served as the Executive Director since 2002. He provides fiscal, operational, and scientific oversight of a complex research unit that employs over 280 staff and research investigators. For the last 25 years, Dr. Chirenje has been Director for the UZ – UCSF Dysplasia Clinic at Spilhaus Clinical Research Site in Harare where he has introduced digital colposcopy, loop excision treatment and cyrotherapy training syllabus for VIA workshops. He is chair of the Mentored Research Scholarship Program at the University of Zimbabwe.

PLENARY: ENDING AIDS BY 2030: AN ACHIEVABLE GOAL

Speaker: Dr. Luiz Loures, Geneva, Switzerland

DR. LOUIZ LOUREZ

United Nations Programme on HIV/AIDS (UNAIDS) and Assistant Secretary-General of the United Nations

Dr Luiz Loures, Deputy Executive Director of Programme of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and Assistant Secretary-General of the United Nations

Dr Luiz Loures joined UNAIDS in 1996 and was appointed Deputy Executive Director of Programme and Assistant Secretary-General

of the United Nations in January 2013. He leads UNAIDS' efforts in leveraging critical support to countries to meet 2015 global AIDS targets and establish a sustainable response to AIDS. Dr Loures is a medical doctor with nearly 30 years of experience in the AIDS response. His engagement ranges from providing medical care to people living with HIV in the early days of the epidemic, to his dynamic involvement in global policy framework development.

Born, raised and educated in Brazil, Dr Loures completed his medical studies at the Federal University of Minas Gerais, specializing in critical care. He holds an MPH degree from the University of California at Berkeley.

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PLENARY: VALUING COMMUNITIES

Speaker: Mr. Innocent Liason, Senegal

MR. INNOCENT LIASON

Innocent Laison is the Executive Director of the African Council of AIDS Service Organizations (AfriCASO), one of the major regional networks of community organizations intervening in HIV and AIDS responses in Africa. Mr Laison is known as a community actor working, during more than a decade, for the improvement of the community involvement in the overall aspects of the HIV and AIDS responses at national, regional and global levels.

He has contributed to several manuals and guidelines related to this community involvement. He also represented civil society organization in key health and/or Human Rights-related committees (e.g. the International Advisory Group on Universal Access, the International Health Partnership CSO Forum, the Regional Advisory Group for Africa Dialogue for HIV and the Law). Mr Laison is a Sociologist with a double specialization in Urban Sociology and Sociology of Work and Organizations.

TUESDAY 01 DECEMBER 2015

01.12.2015, 08:45 – 10:15 Main Auditorium

PLENARY: ACHIEVING 90:90:90: A GLOBAL GAME CHANGER FOR PUBLIC HEALTH

PLENARY SESSION

Chairs: Dr. Badara Samb, South Africa
Speaker: Prof. Stefano Vella

PROF. STEFANO VELLA

Dr Vella served on the Technical Review Panel (TRP) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), where he acquired an extensive experience in the evaluation of country programs to fight poverty-related diseases. Dr Vella subsequently served as the Italian board member of the GFTAM (2006-2007), and is currently a member of the Italian Constituency.

- Dr Vella participated, since the beginning, to the building of the EDCTP. He is currently the Italian member of the General Assembly of EDCTP2 and vice-chair of the Board.

- As member of the Program Committee of the 7° Framework Research Program of the European Commission (DG – Research, Health) he acquired an extensive exerience on the functioning of European Commission Health Research System.

- Dr Vella is Vice President of the Scientific Council, ANRS (Agence Nationale de Recherche sur le Sida), Paris, France, and Vice-President of the Friends of Global Fund – Europe.

- Member of the UNAIDS Scientific and Technical Advisory Committee , of the Quality Hub Program of the Global Fund, Geneva.

- He chaired the Panel who developed the 2013 WHO Consolidated Guidelines on HIV Treatment and Care, and is currently a member of the Core Group developing the 2015 WHO Guidelines

PLENARY SESSION

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PLENARY: CLOSE THE LEADERSHIP GAP: EMPOWER AFRICAN WOMEN & GIRLS

Chairs: Hon. Andre Mama Fouda, Cameroon
Speaker: Dr. Phumzile Mlambo-Ngcuka, South Africa

DR. PHUMZILE MLAMBO – NGCUKA

Phumzile Mlambo-Ngcuka (PhD-education and technology) is United Nations Under-Secretary-General and Executive Director of UN Women. From 2005 to 2008, Ms. Mlambo-Ngcuka served as Deputy President of South Africa, overseeing programmes to combat poverty and bring the advantages of a growing economy to the poor, with a particular focus on women. She held ministerial and par-

liamentary positions in Minerals and Energy (1999 to 2005) Trade and Industry (1996 to 1999), Member of Parliament (1994 to 1996).

Ms. Mlambo-Ngcuka began her career as a teacher and gained international experience at the World YWCA in Geneva, where she established a global programme for young women. She is the founder of the Umlambo Foundation, which supports leadership and education. A long time champion of women's rights, she is affiliated with several organizations devoted to education, women's empowerment and gender equality and has devoted her career to issues of human rights, equality and social justice.

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PLENARY: MAKING SEX SAFER, MAKING SEX BETTER: INNOVATIVE
HIV PREVENTION BY & FOR YOUNG PEOPLE

Chairs: Ruvheneko Parirenyatwa, Zimbabwe
Speaker: Mrs. Bidia Deperthes, United States

BIDIA DEPERTHES

Bidia Deperthes is a Senior Technical Advisor at the United Nations Population Fund, where she leads the Comprehensive Condom Programming Framework and 10-Step Approach to increase access and use of male and female condoms. This approach is currently being implemented in 87 countries. She previously worked at the World Health Organization leading the global research agenda on condoms.

Ms. Deperthes is also the Team Leader of CONDOMIZE!, a campaign of UNFPA and The Condom project to prevent HIV. Ms. Deperthes is a co-author of several publications, public speaker, and has appeared widely in the media. Visit her at www.linkedin.com/pub/dir/Bidia/Deperthes

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WEDNESDAY 02 DECEMBER 2015

02.12.2015, 08:45 – 10:15 Main Auditorium

PLENARY: HAVE WE ELIMINATED MTCT?

Chairs: Dr. Leila Pakkala, Nairobi, Kenya
Speaker: Dr. Didier Ekouevi, Benin

DR. DIDIER KOUMAVI EKOUEVI

Dr Didier Koumavi Ekouevi is a medical epidemiologist working on HIV infection and its prevention in sub-Saharan Africa within the "HIV Africa" team of the INSERM U897 research center since 2001 at the University of Bordeaux. Since 2002, he is working at the PACCI/ANRS research site in Abidjan, Côte d'Ivoire. From 2000 to 2010, he was involved in several studies on PMTCT, including an assessment of the effectiveness of a short-course peripartum antiretroviral regimen for the prevention of mother-to-child transmission. He is also an Associate Professor in Epidemiology at the University of Lomé (Togo).

Dr. Ekouevi has 15 years of experience in research on HIV epidemiology and global health. His scientific interest is on the public health challenges of HIV prevention and care: PMTCT in Africa, prognosis of antiretroviral-treated adults and children in West Africa and more broadly on operational research on HIV programs in resource-limited settings. His scientific productivity can be described through more than 150 publications in peer-reviewed journals.

PLENARY: THE AFRICA WE WANT: YOUTH REFLECTING ON THE DEMOGRAPHIC DIVIDEND & THE AIDS RESPONSE

Chairs: Mme. Annah S. Sango, Harare, Zimbabwe
Speaker: Mr. Bob Munyati, Cape Town, South Africa

BOB MWIINGA MUNYATI

Bob is a Zambian and a Researcher at AIDS Accountability International (AAI) with an academic background in Demography and Public Health from the University of Zambia and University of Cape Town respectively. Bob currently manages the global and regional commitments section of AAI's work with particular focus on the Maputo Plan of Action, ICPD Beyond 2014 and Post 2015 development agenda. In addition, he currently is a board member of Southern African AIDS Trust. With almost 10 years of work experience, Bob has previously worked for Clinton Health Initiative Access, Population Services International, and Centres for Disease Control and Prevention and Family Health International in various portfolios in the area of sexual and reproductive health and rights. Bob also remains passionate about Afri-

can youth empowerment through health stemming from his early days of work as a youth leader at the University of Zambia. His work was then recognised with the first of its kind award for 'most outstanding student in the fight against HIV' presented by Zambia's first republican president, Dr. Kenneth Kaunda.

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PLENARY: HIV IN PRISONS & PLACES OF DETENTION: USING RIGHTS-BASED APPROACH

Chairs:	Dr. Evidence Gaka, Zimbabwe
Speaker:	Dr. Ehab Salah, Egypt

DR. EHAB SALAH

Dr. Ehab Salah, Prisons and HIV Advisor, HIV/AIDS Section, UNODC HQ in Vienna. A medical doctor with more than 20 years of hands on experience in communicable disease research, prevention and control. Prior to joining the HIV/AIDS Section in UNODC, Vienna, he was coordinating UNODC's HIV in Prisons Programme in Sub-Saharan Africa (2011 – 2014). Earlier, he was the HIV focal point in UNODC Regional Office for MENA region (2007-2011). Before joining UNODC in 2007, Ehab worked as a Senior Medical Epidemiologist at Ain Shams University, and also as the Manager of the Egyptian National AIDS Program.

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THURSDAY 03 DECEMBER 2015

03.12.2015, 08:45 – 10:15 Main Auditorium

PLENARY: SUSTAINABLE FUNDING: INNOVATIVE APPROACHES, NATIONAL & GLOBAL ACCOUNTABILTY

Chairs:	Minister of Health of Equatorial Guinea
Speaker:	Dr. Marijke Wijnroks, Geneva, Switzerland
Co-speaker:	Hon. Patrick Chinamasa, Minister of Finance Zimbabwe

DR MARIJKE WIJNROKS

Marijke Wijnroks joined the Global Fund to fight AIDS, Tuberculosis and Malaria as its Chief of Staff on 15 July 2013. In her position she has a broad responsibility and a particular focus on gender and human

rights and on engaging with all partners in the cause of global health.

Before joining the Global Fund Marijke Wijnroks was Ambassador for HIV/AIDS and Sexual and Reproductive Health and Rights, and also Deputy Director of the Social Development Department, in the Ministry of Foreign Affairs in the Netherlands. In that position she has overseen policy and strategy development in areas related to HIV and AIDS, sexual and reproductive health and rights, gender, education and civil society.

She earned a medical degree from Maastricht University in the Netherlands and a degree in tropical health and medicine from the Institute for Tropical Medicine in Antwerp, Belgium.

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PLENARY: SUCCEEDING WITH PROGRAMS FAILING WITH THE LAW?

Chairs: Mr. Wanjiku Kamau, Kenya
Speaker: Mrs. Michaela Clayton, Namibia

MICHAELA CLAYTON

Michaela Clayton is a human rights lawyer and Director of the AIDS and Rights Alliance for Southern Africa (ARASA), a regional partnership of over 80 civil society organisations working together to promote a human rights based response to HIV and TB in 18 countries in Southern and East Africa.

She serves as co-chair of the UNAIDS Reference Group on Human Rights and co-chair of the Global Fund Human Rights Reference Group. She was the recipient of the 2009 Human Rights Watch and Canadian AIDS Legal Network International Award for Action on HIV/AIDS and Human Rights.

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PLENARY: PUTTING THE RADAR ON HEPATITIS B & C IN AFRICA

Chairs: Dr. Gottfried Hirnschall, Switzerland
Speaker: Prof. Leslie Fumilayo, Nigeria

PROFESSOR OLUFUNMILAYO LESI

Olufunmilayo Lesi is an associate Professor of Medicine in the College of Medicine, University of Lagos, Nigeria. She is the Head of Gastroenterology and coordinates the liver disease clinic and patient care in viral hepatitis and HIV-hepatitis co-infection at the Lagos University Teaching Hospital. She is also involved in the HIV program pioneered by the US PEPFAR program, which provides HIV care to over 15,000 persons.

She is a member of the Technical Working group on Hepatitis control in Nigeria, is involved in WHO guidelines development for viral hepatitis in resource-limited settings and has many peer-reviewed publications in viral hepatitis and liver disease.

FRIDAY 04 DECEMBER 2015

04.12.2015, 08:45 – 10:15 Main Auditorium

PLENARY: STEPPING UP THE PACE ON REMOVAL OF PUNITIVE LAWS TO ADVANCE HUMAN RIGHTS & GENDER EQUALITY

Chairs: Dr. Meskerem Grunitzky Bekele, Togo
Speaker: Hon. Nana Oye Lithur, Accra, Ghana

HON. NANA OYE LITHUR

Hon. Nana Oye Lithur is the Honourable Cabinet Minister for Gender, Children and Social Protection of the Republic of Ghana. She is a lawyer by profession and holds a Bachelor of Laws (LLB) from the Faculty of Law, University of Ghana, and a Masters in Law, in Human Rights and Democratization in Africa (LLM) from the University of Pretoria, South Africa.

She was called to the Ghana Bar in October, 1992 and has 23 years of legal experience in human rights, court advocacy and solicitor's practice. She over the years specialized in human rights law, women's rights and sexual and reproductive rights.

Her significant achievements include being awarded the Vera Chirwa Award for Human Rights in Africa in 2007. She was appointed Champion Torchbearer for Women's Rights, one of the 100 selected globally by the Danish Government on 10th March, 2008. She was awarded the African Servant Leadership Award, legal service category, 2011. She was named the 4th most influential African woman achiever amongst

25 other African female presidents, politicians and Nobel Peace laureates by the United Kingdom Guardian Newspaper in March 2013.

Her field of expertise is legal advocacy for human rights legislative reform. For over a decade, she has led legal advocacy in Ghana to pass laws protecting human rights in Ghana including the Domestic Violence Act, the Persons with Disability Act, the Mental Health Act, the Property Rights of Spouses Bill, the Intestate Succession Law Bill, and the Right to Information Bill.

She has international, regional and national experience in protecting, promoting and fulfilling human rights and has been appointed on several advisory and steering committees of various international, regional, and national Commissions and Boards including the International Consortium on Medical Abortion, the African Consortium on Medical Abortion, the Global Consortium on Realizing Rights, International Advocates for Freedom of Information, the African Women Leaders Network to Promote Sexual Health and Rights.

In 2009, she was appointed by the President of Ghana as a Commissioner for the Ghana Aids Commission, Law Reform Commission, and the National Media Commission.

She has used her strong advocacy skills to conduct human rights monitoring and fact finding missions to investigate human rights violations including police brutalities, forced evictions, torture and extra judicial killing. These include the extra judicial killing of 44 Ghanaians in the Gambia, that led to the United Nations setting up a fact finding Committee to investigate the killing.

She instituted the first ever national human rights lectures in Ghana with the Commission on Human Rights and Ghana Bar Association. She also created a Human Rights Clinic. She set up the first ever Pro Bono Lawyers Network in Ghana made up of 219 lawyers throughout Ghana offering free legal services and representation to indigent persons.

Significant public interest law litigation cases she has argued in court on pro bono basis include an amicus curie in the Supreme Court case on the rights of LGBT persons, a declaration on the legal effect of expired remand warrants for remand prisoners, the detention of juveniles in adult prisons, protection of rights of an HIV positive woman etc.

In January, 2013, after winning the 2012 Ghana presidential elections, Honorable Nana Oye Lithur was appointed by His Excellency President John Dramani Mahama as a member of the Presidential Transition Team and made Chair of the Sub-Committee on Ex-Gratia awards for public office holders.

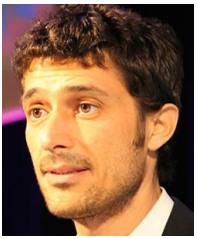
On 18th February, 2013, she was sworn in by the President as Cabinet Minister for Gender, Children and Social Protection.

PLENARY SESSION

PLENARY: EBOLA CRISIS IN AFRICA: PROGRESS, LESSONS LEARNT & IMPACT

Chairs: Prof. Mabingue Ngom, Senegal
Presentation: Dr. Gilles Van Cutsem, Belgium

DR. GILLES VAN CUTSEM



Gilles Van Cutsem is Medical Coordinator for Doctors Without Borders (MSF) in South Africa and Honorary Research Associate at the Centre for Infectious Disease Epidemiology and Research of the University of Cape Town. He was the Emergency Medical Coordinator for MSF's Ebola Response in Liberia in November and December 2014. He holds a Medical Doctor degree from the University of Louvain, a Diploma of Tropical Medicine from the Institute for Tropical Medicine in Antwerp and a Masters in Public Health and Epidemiology from the University of Cape Town. He's worked with MSF in Southern Sudan, Angola and Mozambique, South Africa, Lesotho and Liberia.

PLENARY: HIV RESPONSE IN CONSERVATIVE SETTINGS: STRIKING THE BALANCE

Chairs: Mrs. Lois Chingandu, Zimbabwe
Presentation: Rev. Phumzile Mazibela, South Africa

REV PHUMZILE MABIZELA

Rev. Phumzile Mabizela is the Executive Director of the International Network of Religious Leaders Living with or personally affected by HIV and AIDS (INERELA+) INERELA+ is an Interfaith Network that was formed in 2002, it exists to equip, empower and engage its members to live positively and openly as agents of hope and change in faith communities and countries.

Rev Mabizela is a member of the Circle of Concerned African Women Theologians. Before joining INERELA+ she was employed by Norwegian Church Aid as the Senior Policy Advisor on Gender Justice in Southern Africa and prior to that she was the Chief Executive Officer of the KwaZulu-Natal Christian Council, which is one of the Provincial Councils of Churches in South Africa. Rev Mabizela is a passionate Gender, HIV and AIDS activist.

NOTE

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Committee Room 6	30.11.2015
MOAB0101: Chairs:	Track B/1 - Putting children first: the right to ART Chewe Luo, Zambia, Alain Azondekon, Benin	

Impact of Implementing "Test and Treat" Policy on Paediatric ART Enrolments and Coverage in Uganda

10:45 – 11:00

Elyanu Peter James1,2, Namusoke-Magongo Eleanor1, Asire Barbara1, Bitimwine Harriet3, Katureebe Cordelia1, Achii Pamela1, Mulema Vivienne4, Dziuban Eric5, Sugandhi Nandita6, Musiime Victor7, Namuwenge Norah1, Musinguzi Joshua1

1Ministry of Health - Uganda, AIDS Control Program, Kampala, Uganda, 2University of Texas, School of Public Health, Houston, United States, 3Baylor College of Medicine Children's Foundation-Uganda, Kampala, Uganda, 4Clinton Health Access Initiative (CHAI), Kampala, Uganda, 5Center for Disease Control, Atlanta, United States, 6Clinton Health Access Initiative (CHAI), Boston, Uganda, 7Makerere University College of Health Sciences, Pediatrics and Child Health, Kampala, Uganda

BACKGROUND: In 2013, it was estimated that 193,500 of children under 15 years were living with HIV in Uganda and 83% would be eligible for treatment according to WHO guidelines; Recommending lifelong treatment for all children under 5 years and all older patient based on clinical or immunologic staging. However despite efforts to scale up pediatric treatment, coverage remained low at 22% in 2013. Programmatic barriers to ART initiation in children include the perception that pediatric ART is complicated, unavailability of CD4 testing and difficulty in accurate clinical staging. In September 2013, Uganda adopted a "test and treat" antiretroviral therapy (ART) policy for all HIV infected children under 15 years of age to simplify recommendations and remove programmatic barriers to ART initiation in children.

METHODS: The MOH launched and disseminated these guidelines to all stakeholders though 3 day health facility based trainings and mentoring during the period January to December 2014. To evaluate the impact of this new policy a comparison was made between the number of children initiated between June-December 2013 and those initiated between January-June 2014.

RESULTS: By December 2014, 1340 (84%) of 1600 ART providing health facilities and 17,238 health workers were trained on the new guidelines. There was 1.4 fold increase in the number of HIV infected children newly initiated on ART from 5540 in June-Dec. 2013 to 9145 in Jan-June 2014. The increase was greater among children aged 5-14 years and 2-4 years (2.4 and 1.4 fold respectively), however there was no change among the under 2 year olds(see figure 1). Pregnant adolescents constituted 2.5% (229/9145) of children less than 15 years of age enrolled on ART in Jan-June 2014. Paediatric ART coverage has increased from 22% (43,481/193,500) in December 2013 to 27% (51,305/193,500) in June 2014.

CONCLUSIONS AND RECOMMENDATIONS: Expanding eligibility criteria increases initiation of older children on ART but to enroll those who are at higher risk of disease progression/mortality, more work needs to be done to improve EID and early case detection.

11:00 – 11:15	Committee Room 6	30.11.2015
MOAB0102:	Track B/1	

12-month Response to Early LPV-based Antiretroviral Therapy in West-African Children

Dahourou Désiré Lucien1,2, Divine Avit3, Coulibaly Malick4, Amorissani-Folquet Madeleine3, Barry Mamadou5, Emieme Arlette6, Meda Nicolas7, Timité-Konan Marguerite8, Dattez Sophie9, Devaux Carole10, Leroy Valériane9, MONOD ANRS 12206 Study Group

1Bordeaux University, Bordeaux, France, 2Centre Muraz, Bobo-Dioulasso, Burkina Faso, 3PACCI Programme, Treichville Teaching Hospital, Abidjan, Cote D'Ivoire, 4Centre de Recherche International pour la Santé, Ouagadougou, Burkina Faso, 5Laboratoire du CHU Charles de Gaulle, Ouagadougou, Burkina Faso, 6Laboratoire du CeDReS, Abidjan, Cote D'Ivoire, 7Centre de Recherche Internationale pour la Santé, Ouagadougou, Burkina Faso, 8Service de Pédiatrie, Centre Hospitalier Universitaire (CHU) de Yopougon, Abidjan, Cote D'Ivoire, 9Inserm, Unité U 897, Université Bordeaux Segalen, Bordeaux, France, 10Laboratoire de Rétrovirologie, CRP-Santé, Luxembourg, Luxembourg

BACKGROUND: We described the 12/15-month virologic response to LPV/r based-ART in Burkina Faso (BF) and Côte d'Ivoire (CI).

METHODS: All HIV-infected children under 2 years of age diagnosed and confirmed by DNA-

PCR were enrolled in a 12/15-month therapeutic cohort based on LPV/r in Ouagadougou, BF, and Abidjan, CI. CD4 % and viral load (VL, Biocentric) were measured three-monthly. Virological success (VS) at 12/15 months (VL< 500 copies/ml) and correlates of VS using a logistic regression were assessed. HIV-1 genotyping was performed in children with VL>1000 copies/ml.

RESULTS: In the context of low early infant diagnosis coverage (16% in Abidjan; 29% in Ouagadougou), 226 HIV-infected children under 2 years of age were screened between 05/20011 and 01/2013. Among them, 162 (72%) children were included and initiated on EART. The median age at diagnosis and ART initiation were 8.6 months [IQR: 4.1 to 16.2] and 13.4 months [IQR: 8.3 to 18.6], respectively. 64% of infants were from Abidjan, 53% were girls, 48% were not exposed to a PMTCT-intervention. Mother was the main caregiver in 82% of cases, 68% had access to tap water at home. At inclusion, median CD4% was 19%, median VL was 6 log copies/ml and 56% of the children were classified 3-4 WHO-stage. At 12/15 months on ART, 13 infants have died (8%), 5 were lost-to-follow-up (3%), and 139 were followed (89%). VS was achieved in 73% of children enrolled and in 82% of children alive. When adjusting for country and sex, a 74% and 93% reduction of VS rate was respectively associated with a lack of access to tap water (aOR: 0.26 [0.10-0.73]) and with a father as the main child caregiver compared to mother (aOR: 0.07 [0.02-0.34]). An increase of CD4 greater than 10% between inclusion and M6 was associated with a higher rate of VS (aOR: 5.63 [1.89-16.75] at 12/15 months. At 12-months, 25 of the 28 eligible children had a genotype, 19 (76%) had ≥1 resistance (64% to 3TC; 28% to EFV, 4% to AZT and LPV/r).

CONCLUSION: In 2011-2013, challenges still remain for improving EART in HIV-infected children in West Africa. Nevertheless, rate of VS on LPV-based EART is high and comparable to those observed in Europe. Lack of tap water and father as the main child caregiver, correlates of lower VS, are probably markers of a poor adherence. These risk factors could be identified at ART initiation and adherence systematically reinforced.

KEYWORDS: HIV-infected infants early ART virological failure HIV drug resistance.

18:50 - 20:30	Committee Room 6	30.11.2015
MOAB0103:	Track B/3 -	

Complete Pro-viral HIV DNA PCR and Sero-reversions in Successfully Treated HIV-1 Infected Infants in Northern Namibia

Hamunime Ndapewa1, Nghiimbwasha Helvi2, Mpariwa S.3, Kamangu J.4, Mulang R.4, Nkongolo O.5, Hango Johannes5, Mekonen Tadesse1

1Ministry of Health and Social Services (MOHSS), Directorate of Special Programs, Windhoek, Namibia, 2Okongo Hospital, MOHSS, Okongo, Namibia, 3Eenhana Hospital, MOHSS, Eenhana, Namibia, 4Engela Hospital, MOHSS, Engela, Namibia, 5Ohangwena Regional Health Bureau, MOHSS, Ohangwena, Namibia

ISSUE: We present four cases of HIV-infected infants, who reverted from HIV DNA PCR positive state to DNA PCR and rapid HIV anti-body test negative status following fully suppressive anti-retroviral therapy (ART). These reversion phenomena can pose clinical dilemmas to health care workers and may lead to potential misclassification of HIV-infected children, as un-infected.

DESCRIPTION: In infants vertically infected with HIV, ART can achieve maximal suppression of viral replication. In some children, such durable suppressions may lead to reversions of HIV plasma pro-viral DNA PCR, and serum HIV antibodies to negative state. Children with such reversions could mistakenly be classified as HIV-uninfected. In Namibia, HIV-exposed infants are eligible for DNA PCR testing at six weeks of age.

DESCRIPTION: We followed four children who initially tested positive for HIV using DNA PCR in whom HIV antibody and/or DNA PCR tests reverted to negative after fully suppressive ART. Sustained undetectable viral loads (VLs) did prompt health care workers to repeat HIV diagnostic and screening tests. To establish whether these children were actually HIV-uninfected or had reversions, we retrospectively reviewed medical records and in 3 cases, implemented structured treatment interruptions followed by VL testing. Two of the children were females. All cases were tested positive for HIV DNA PCR within six months of age, and initiated ART before the age of 1 year. Three children had records of detectable VLs in the range of 83-218 RNA copies/ml after 6-14 months of ART. All VLs were undetectable by 21-35 months of treatment. After about 2 years of ART, HIV antibody and DNA PCR tests were negative for all cases. Following structured treatment interruption for a median duration of 6 weeks, we detected high level rebound viremias in all children in the range of 135,409 and 8,400,337 RNA copies/ml. Subsequently, all children were re-started and maintained on ART.

LESSONS LEARNT: pro-viral HIV DNA PCR and sero-reversions were identified in four Namibian children vertically infected with HIV-1 on ART. Reversions followed full and durable suppression of HIV-1 replication.

NEXT STEPS: Such cases may become more common with early initiation of combination ART in HIV-infected infants. Health care workers need to be aware of these phenomena. This can help avoid incorrect misclassification of such children as HIV-uninfected and prevents jeopardizing their HIV care.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Committee Room 6	30.11.2015

MOAB0104: Track B/1 -

Efavirenz-based Therapy Is Not a Public Health Strategy to Simplify a Successful LPV-based Therapy Initiated before the Age of 2 in HIV-infected Children in West-Africa? The MONOD ANRS 12206 trial

Amorissani-Folquet Madeleine1, Dahourou Désiré Lucien2,3, Malatesťe Karen4, Coulibaly Malick5, Avit Divine1, Seguin-Devaux Carole6, Barry Mamadou7, Yonaba Caroline8, Amani-Bosse Clarisse1, Van de Perre Phillipe9, Timité-Konan Margueritte10, Meda Nicolas11, Lepage Philippe12, Blanche Stephane13, Leroy Valériane14, MONOD ANRS 12206 Study Group

IPACCI Programme, Treichville Teaching Hospital, Abidjan, Cote D'Ivoire, 2Bordeaux University, Ouagadougou, Burkina Faso, 3Centre Muraz, Bobo-Dioulasso, Burkina Faso, 4Institut de Santé Publique, Epidémiologie et Développement (ISPED), Université Bordeaux, Bordeaux, France, 5Centre de Recherche Internationale pour la Santé, Ouagadougou, Burkina Faso, 6Luxembourg Institute of Health, Luxembourg, Luxembourg, 7Laboratoire du CHU Charles de Gaulle, Ouagadougou, Burkina Faso, 8Service de Pédiatrie, Centre Hospitalier Universitaire (CHU) de Yalgado Ouedraogo, Ouagadougou, Burkina Faso, 9Inserm U 1058, Université de Montpellier-1, Montpellier, France, 10Service de Pédiatrie, Centre Hospitalier Universitaire (CHU) de Yopougon, Abidjan, Cote D'Ivoire, 11Centre de Recherche International pour la Santé/Université de Ouadagougou, Ouagadougou, Burkina Faso, 12Service de Pédiatrie, Centre Hospitalier Universitaire (CHU) de la Reine Fabiola, Bruxelles, Belgium, 13EA 3620, Université Paris Descartes, Paris, France, 14Inserm, Unité U 897, Université Bordeaux Segalen, Bordeaux, France

BACKGROUND: An early antiretroviral therapy (EART)< 2 years of age in HIV-infected children virologically supressed after 12/15 months of a lopinavir (LPV)-based therapy could be simplified with an efavirenz-based therapy (EFV).

METHODS: The MONOD ANRS12026 study is an randomized, phase 2-3 non-inferiority trial conducted in Abidjan, and Ouagadougou (ClinicalTrial.gov registry number: NCT01127204). All HIV-1-infected children, tuberculosis-free, receiving < 2 years, a 12-15 month suppressive twice-daily LPV/r based-therapy (undetectable viral load [VL]< 500 copies/mL, confirmed) were randomised in two arms: once-daily ABC-3TC-EFV (EFV) therapy versus continuation of the twice-daily AZT or ABC-3TC-LPV/r (LPV). The primary endpoint was the difference in proportion of children virologically suppressed by 12-month post-randomisation, between arms (14% non-inferiority margin), Chi-square-test.

RESULTS: Between 05/2011 and 01/2013, 156 children were included at median ages at diagnosis and at ART initiation of 8.6 months and 13.7 months respectively. After 12/15 months on EART, 13 infants have died (8%), 2 were lost-to-follow-up (1%), 3 withdrew (2%), 32 virologically failed (21%) and 106 (68%) were randomized (54 LPV, 52 EFV). At 12-month post-randomization, 46 (85.2%) children from LPV vs. 43 (82.7%) EFV had VL< 500 copies/mL; difference: -2.5% (95%CI:-16.5;11.5); 47 (87.0%) from LPV vs 47 (86.5%) from EFV had VL< 1000 copies/mL; difference -0.5% (95%CI: -13.4;12.4). Adjusted baseline correlates of virological success (< 1000 copies/ml) were Abidjan site (aOR: 0.38; 95%CI: 0.09-1.59), NVP-single-dose exposure (aOR: 0.19; 95%CI: 0.02-1.52) and absence of malnutrition (aOR: 6.87; 95%CI: 1.34-35.11). No significant difference in Severe Adverse Events was observed: 3 (5.6%) in LPV vs 4 (7.7%) in EFV (p=0.71). 13/14 children with VL>1000 copies/ml had a genotype (6/7 EFV, 7/7 LPV): 9 (5 EFV of whom 3 were acquired, 4 LPV all transmitted) had at least one major NNRTI mutations at VL failure (K103N; Y181C; P225H) whereas none had LPV/r mutation.

CONCLUSIONS: Considering the 1000 copies/mL threshold, the non-inferiority of EFV compared to LPV on VL suppression was shown. Resistance analyses highlight the high frequency of transmitted NNRTI drug resistance mutation after PMTCT. Switch to EFV-based regimen could be a valuable individual strategy in virologically suppressed children with good clinical and adherence profiles, and not exposed to any PMTCT intervention.

and maintained on ART.

LESSONS LEARNT: pro-viral HIV DNA PCR and sero-reversions were identified in four Namibian children vertically infected with HIV-1 on ART. Reversions followed full and durable suppression of HIV-1 replication.

NEXT STEPS: Such cases may become more common with early initiation of combination ART in HIV-infected infants. Health care workers need to be aware of these phenomena. This can help avoid incorrect misclassification of such children as HIV-uninfected and prevents jeopardizing their HIV care.

ABSTRACT DRIVEN SESSION

11:45 – 12:00	Committee Room 6	30.11.2015

MOAB0105: Track B/1 -

The Worrying Face of the Paediatric HIV Epidemic in Togo

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BACKGROUND: In Togo, scale-up of antiretroviral therapy (ART) program is effective but virological monitoring is often lacking and the paediatric cohorts receiving ART still have not been virologically evaluated. We aimed to assess virological outcomes among HIV-1 infected children and adolescents receiving ART according to the national guidelines in Togo.

METHODS: HIV-1 infected patients aged 2 to 19 years on ART>12 months were consecutively enrolled. Viral load (VL) was carried out in plasma samples in Lomé (ABBOTT m2000rt). DBS samples of patients with VL>1000 copies/ml were analysed for genotypic drug resistance at UMI233-IRD, Montpellier, France.

RESULTS: From June to September 2014, 286 paediatrics patients including 116(40.6%) children (age< 9years) and 170(59.4%) adolescents (10 to 19 years) were enrolled. Among them,145(50.7%) were female.The median age was 10 years [IQR 8-13 years].The main ART combination was AZT+3TC+NVP/EFV (231/286, 80.8%). Only 28(9.8%) were receiving a PI-based regimen. The median duration of ART was 48 months (IQR 28-68 months). Detectable VL (VL>40 copies/ml) was found in 182(63.6%) with a median of 39810 copies/ml (IQR 3715-151356). Of them, 147(80.8%) had VL>1000 copies /ml.Virologic failure (VF) rate was 51.4%(147/286), CI95%(45.6-57.2%). According to the duration of ART, the VF rates ranged from 48.6% to 55.7%.

Genotypic resistance results were available for 126/147(85.7%) patients. The prevalence of drug resistant strains was 94.4%(119/126), CI 95%(90-98.4%). From them, 111/126(88.1%) were resistant to both NRTIs and NNRTIs, 1(0.8%) to NRTI only, 4(3.2%) to NNRTI only, and 3/111(2.7%) harboured viruses both resistant to reverse transcriptase and protease inhibitors. 7/126(5.6%) patients carried sensitive viruses.

Upon genotyping results, 56(44.4%) patients were resistant to two drugs of their treatment and 50(39.7%) to their whole regimen. The most prevalent NRTI mutations were M184V/I (91.7%) and T215Y/F (42.1%). The most prevalent NNRTI mutations were Y181C (40.5%) and K103N (38.9%). The prevalence of HIV-1 strains sensitive to Abacavir, Tenofovir and Didanosine was respectively 69.8%, 81.7% and 85.7%.

CONCLUSIONS AND RECOMMENDATIONS: Regardless of ART duration, half of this paediatric cohort was at VF due to high prevalence of NRTI and NNRTI resistance mutations.The study also showed the limitations to apply WHO guidelines with 2 NRTI for second line ART in children.

12:00 – 12:15	Committee Room 6	30.11.2015

MOAB0106: Track B/1 -

Second Line Antiretroviral Treatment Failure and Profile of Drug Resistance Mutations among HIV-1 Infected Children in Mali

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1CHU Gabriel Toure, Department of Pediatrics, Bamako, Mali, 2SEREFO - University of Sciences Techniques and Technologies of Bamako, Bamako, Mali, 3Pitie-Salepetriere, Department of Virology, Paris, France, 4CHU Gabriel Toure, Laboratoire, Bamako, Mali, 5Northwestern University, Department of Infectious Diseases, Bamako, Mali, 6Pitie-Salepetriere, Department of Infectious Diseases, Paris, France

BACKGROUND: Mali has initiated its program of access to antiretroviral called IMAARV in

2001. Around 31,726 patients were on treatment and only 2,372 are children. In Mali 529 children are on second line treatment in Mars 2015. The virological monitoring is very limited in this country. Some of the patients are being initiated on antiretroviral therapy (ART) in second line since long time without virological monitoring. In this study we wan to determine the profile of HIV infected children failing to antiretroviral therapy of second line in order to provide a better therapeutic option for the future.

METHODS: 24 plasma samples from HIV-1 infected infants in virologic failure to second line antiretroviral treatment (ART), from the department of Pediatric in Gabriel Toure Hospital in Bamako were collected. Genotypic resistance testing (GRT) was done with a ViroSeq;. The sequences were analyzed with the software ViroSeq and GRT were interpreted according to the list of ANRS 2014.

RESULTS: The median age was 12 years [5 - 18 years]. The mean plasma viral load was 111,358 copies/ml and mean of CD4 count was 256 cells/mm3. Most patients (56%) were treated with a combination for first line treatment by Triomune (d4T/3TC/NVP) and for second line by ABC + (DDI or 3TC) + LPV/r 20 (83,3%). The median duration of the treatment was 84 mont [36 - 144 months]. Of the 24 infants, 100% genotypes were successfully made. The predominant subtype was CRF02_AG 19 (79%), followed CRF06_cpx 5 (12%) and CRF19_cpx. The prevalence of resistance mutations by class of ARV drugs was as follows: - NRTIs: M184V/I (54%), 215Y/F (33,33%), 41L (29,17%), 67N (16,67%) and the others Q70R 219 (13%). - NNRTIs K103N (40%), Y181C/IV (28%). Among the patients 58,33% horbored at least one PI resistance mutation. The most PI resistance mutations were M36I/L/V in 69,57% cases, H69K/R/Q in 69,56% and L89M/V/I in 68,48% which are minors resistance mutations. 25% and 20.9% were resistant respectively to ETR and RPV. 87,5% were exposed to LPV/r but we detect only 12,5% of resistance to LPV/r.

Conclusion: The NRTI regimen is very limited in HIV-1 infected infants after second line failure. The LPV/r remain sensitive in 88.5% of infants. It is important now to have some new drug in HIV children treatment in resources limited setting.

10:45 – 12:15	Committee Room 4	30.11.2015
MOAC0101:	Track C/1 - Condoms - tried & tested	
Chairs:	Mrs. Bidia Deperthes, United States	

Knowledge, Access and Utilization of Female Condom among Women of Reproductive Age (WRA) in Communities in the Federal Capital Territory (FCT) of Nigeria

10:45 – 11:00

Saman Andrew Yusuf1, Bamidele Omolara1, Aizobu Dennis2, Ocholi John3

1Society for Family Health Nigeria, Operations, Abuja, Nigeria, 2Society for Family Health Nigeria, Abuja, Nigeria, 3Society for Family Health Nigeria, Global Fund Department, Abuja, Nigeria

ISSUES: There is the urgent need for additional effective dual protection prevention methods to protect women and couples from STIs, HIV and unintended pregnancy in Nigeria. National Demographic Health Survey (NDHS), 2013, reported that only 28.6% of women in Nigeria know about female condom while less than 0.5 % use female condoms, noting that, teenage pregnancy is high in Nigeria while 23% of young women from 15-19 years had started child-bearing. The need for Nigerian women to make a choice in terms of using the female condom for protection themselves against STIs cannot be over emphasized. This study was carried out to improve consumer knowledge and perception of female condoms among WRA in communities in FCT with the aim of increasing the demand and utilization of the FC.

DESCRIPTIONS: The Universal Access to the Female Condom Joint Programme (UAFC) aims to make female condoms widely available by supporting a range of activities including advocacy. The Society for family Health (SFH) carried out Community level intervention from May 2014 through December 2014. Community mobilization strategy was employed, 40 Interpersonal Communication (IPC) Conductors (21 males and 20 Females) were trained to convey information. Use of Promotional items were also used to enhance effectiveness of the message conveyed.

LESSONS LEARNT: Awareness of the FC is best promoted through integration, 42 Influencers were carried along during the period of the intervention, 2,918 Patent Proprietor Medicine Vendors (PPMVs) were sensitized. A total of 184,477 Persons were reached through IPC, 14,404 (7.8%) of the persons reached were in Tertiary Institutions. 87,564 FC were distributed in the communities. 9,687 repeated users were reported and Information gathered during IPC sessions revealed that preference for male condoms was given as reason for non use of the female condoms among men and women of reproductive age. Male involvement and support was also strengthened during community mobilization by the IPCs.

NEXT STEPS: FC should be offered as an additional choice rather than as replacements for male condoms and it should be ensured that target groups are properly sensitized on FC insertion and provide follow up as much as possible to encourage the woman to practice insertion of FC and get familiar with product before having sex. Further intervention is needed to assure access, availability, and comfort with female condoms and male participation in their use.

ABSTRACT DRIVEN SESSION

11:45 – 11:15	Committee Room 4	30.11.2015

MOAC0102: Track C/1 - Condoms - tried and tested

Condom Demonstration and Supply to Index Clients in HIV-sero Discordant Relationship a Key Component in Positive Health, Dignity and Prevention (PHDP) Compliance in Nairobi County, Kenya

Akolo Maureen1, Osano Justus2, Kimani Joshua3,4, Gelmon Larry3,4

1Kenya Aids Control Project, Nairobi, Kenya, 2Kenyatta University, Nairobi, Kenya, 3University of Nairobi, Nairobi, Kenya, 4University of Manitoba, Nairobi, Kenya

BACKGROUND: The undertaken study evaluated compliance to Positive Health, Dignity and Prevention (PHDP) practice among index partners in HIV sero-discordant relationship in Nairobi County, Kenya. PHDP involves a set of interventions that helps people living with HIV lead a complete and healthy life besides reducing the risk of transmission of the virus to others. These interventions were adopted in Kenya in 2013 by the National AIDS and STI Control Program (NASCOP) and the United States Government (USG) affiliates that support HIV prevention programming by the Ministry of Health (MOH). The evaluation focused on demographic factors, knowledge, perception and challenges encountered while adopting PHDP practices among index client.

METHODS: A cross sectional descriptive study that utilized both quantitative and qualitative designs was used. 370 index partners in sero discordant relationship were recruited from three clinics within Nairobi County. HIV infected clients in discordant relationships who were enrolled in the three clinics and had accessed services within the last 3 months were eligible for the study. The clinic's patient registry was used to contact sequentially those who meet the inclusion criteria. Standardized data collecting tools were administered. Data was cleaned and analyzed using SPSS VER 22.

RESULTS: Out of 370 respondents 73 (19.7%) were male. The mean age was 36.6 years and 151 (40.1%) had education level of primary school and below. The group exhibited high level of PHDP knowledge at 336 (90.8%) and above however, only 245 (66.2%) complied with PHDP practice. There was significant relationship between condom supply, condom demonstration and PHDP compliance at P values of 0.034 and 0.018 respectively. Odds ratio showed those index partners who had no challenge in accessing condom demonstration and supply complied more to PHDP practice. Consistence condom use was at 175 (53.4%), but only 9(5%) demonstrated correct condom use.104 (28.2%) had multiple sex partners of which 88(86.4%) did not know their casual sex partners HIV status. 100 (27.3%) consumed alcohol:18(4.9%) had sexually transmitted infections.

CONCLUSIONS AND RECOMMENDATIONS: PHDP compliance at 245(66.2%) is low hence, calls for its evaluation. Condom demonstration and supply are very important in helping index partners to comply with PHDP intervention therefore should be scaled up. Status disclosure is still a burden to many

11:15 – 11:30	Committee Room 4	30.11.2015

MOAC0103: Track C/1 -

Challenges of Condom Compatible Lubricants Usage amongst MSM Communities in South Africa, Botswana, Zimbabwe and Zambia: A Qualitative Study

Odumosu Olusegun1, Langen Bram2, Katumba Munya1, Ricardo Marie2

1COC, Pretoria, South Africa, 2COC, Amsterdam, Netherlands

BACKGROUND: Men who have sex with men have a heightened vulnerability to HIV infection. Condoms still remain the single most effective safer sex aid in prevention of HIV. However, without the accompaniment with personal water based lubricants, they may break off, slid off during anal intercourse increasing vulnerability to HIV. This study sought to explore challenges and experiences of condom compatible water based lubricants use amongst MSM.

METHODS: Two focus group discussions were conducted per city with men who have sex with men aged 18 years and above. Purposive sampling was used to recruit study participants through announcements at relevant meetings, safe spaces and peer networks in Bulawayo, Harare, Gaborone, Pretoria, East London and Lusaka. Focus group discussions were digitally recorded and transcribed verbatim. Using ATLAS.ti software, a set of a priori concept-driven codes were applied to the transcripts. The analysis concentrated on availability and accessibility of lubricants, sexual practices including lubricant use and HIV risk perception.

ABSTRACT DRIVEN SESSION

RESULTS: Majority reported easy access to lubricants by virtue of being in contact with their local LGBTI organisation and having peer networks close to LGBTI organisations. However, a few of the respondents sighted stigma associated with identifying with MSM and distance from the LGBTI organisation safe spaces, as a reason for poor accessibility. As it transpires, a significant majority of respondents revealed poor usage of water based lubricants despite accessibility. Some of these respondents alluded this to fear of losing a partner, water based lubricants drying fast, preference for oil based lubricants. HIV risk perception still remains low despite unprotected anal sex. Their narratives revealed that, majority use some form of lubrication with no condoms. A significant number highlighted stigma and discrimination and heteronormative assumptions amongst health care workers as a reason for not seeking HIV tests.

CONCLUSIONS: Southern African countries should be lobbied to include water based lubricants in their programme interventions for men who have sex with men. These interventions should be MSM targeted and promote and distribute condom compatible water based lubricants with condoms. Condom-compatible lubricant use, should be promoted among all MSM irrespective of sexual roles in anal sex, this will help increasing lubricant use and decreasing HIV transmission.

11:30 – 11:45	Committee Room 4	30.11.2015
MOAC0104:	Track C/1 -	

Condom Use for Prevention of HIV/AIDS and Ebola Virus Disease (EVD) Transmission in Liberia

Livingstone Maybe Garmai

United Nations Populations Fund (UNFPA), Monrovia, Liberia

ISSUES: Promotion of condom use in EVD context.

DESCRIPTIONS: Liberia has a history of relatively low condoms use (Contraceptive Prevalence Rate for modern methods at 19%) and high HIV prevalence in Most At Risk Populations (MARPs) with female sex workers and MSMs at 9.8% and 19.8% respectively despite general population being at 1.9%. The 2013 DHS revealed that only 3 out of 10 persons used condoms during their last sexual activity. Among women and men who reported having multiple sexual partners; only 19% of women and 23 % of men reported using condoms during their last sexual contact.

In addition, Liberia is one of the three West African Countries battling with the devastating Ebola Virus Disease (EVD) outbreak with cumulative 4,844 deaths out of 10,915 suspected, probable and confirmed cases as of 13th July 2015. The country was on its first countdown of zero EVD case towards a declaration of being Ebola free when on 8th March 2015 a new case was announced. Laboratory tests of semen belonging to a spouse of this case confirmed existence of Ebola virus beyond 90 days after being tested negative for the disease. Additionally, investigations in the resurgence of EVD in Liberia on 29th June 2015 after being declared Ebola free have failed to establish an Epi-link to cross boarder transmission from Guinea and Sierra Leone thereby leaving sexual transmission as the most likely cause of the EVD third wave in the country.

EVD outbreak critically weakened the fragile and underfunded health system through redirecting all resources from the steady HIV prevention programs thereby derailing national plans to strengthen prevention of HIV/AIDS and potentially exacerbating new HIV infections especially amongst MARPs.

LESSONS LEARNT: Community engagement and partnership can increase access to and promote condom utilization.

NEXT STEPS: In order to sustain HIV prevention amidst the EVD outbreak, UNFPA has led the promotion of condom use for HIV/AIDS prevention through integration in the national response to stop sexual transmission of EVD and a six months condom promotion campaign targeting all sexually active people with special emphasis on EVD survivors was launched on 4th June 2015 to; provide accurate information and awareness on condom use, improve condom negotiation skills between partners and ensure increased free access condoms to especially young people, most at risk populations and EVD survivors. A robust research is also needed on sexual transmission of EVD.

11:45 – 12:00	Committee Room 4	30.11.2015
MOAC0105:	Track C/5 - Condoms - tried & tested	

Acceptability Study for the Cupid Female Condom in Zimbabwe

ABSTRACT DRIVEN SESSION

Machiha Anna1, Mugurungi Owen1, Kureya Tendayi2, Kureya Cynthia2, Musemwa Lovemore2, Hanisch Dagmar3, Loning Loes3, Chidiya Samson3, Nyamukapa Daisy3

1Ministry of Health and Child Care, AIDS & TB, Harare, Zimbabwe, 2Development Data, Harare, Zimbabwe, 3UNFPA, Harare, Zimbabwe

BACKGROUND: Zimbabwe's adult HIV prevalence rate is 15% and more than 80% of new infections are through heterosexual transmission. Currently, Zimbabwe distributes the FC2 female condom, and seeks to widen the choice of condoms available to women. Therefore, a study to determine the acceptability of the Cupid Female Condom (CFC) was commissioned in 2014 by the Ministry of Health and Child Care and UNFPA. The objectives were to obtain insights into the acceptability of the CFC; learn about women's ability to negotiate for its use; and obtain recommendations for programme design if the CFC is an acceptable method of HIV prevention in Zimbabwe.

METHODS: Qualitative methods (focus group discussions (FGDs), key informant interviews (KIIs) and case studies) were used alongside quantitative data collected through enrolment forms, coital logs and evaluation tools. The purposive study sample included 325 sexually active participants from 5 districts in 5 provinces; 125 women, 75 men, 50 female sex workers, 50 youths, and 25 people living with HIV. Each participant was given up to 80 CFCs to use over a data collection period of 8 weeks. At each study site, four FGDs with study participants and 7 KIIs with key community and healthcare stakeholders were conducted. SPSS 22 and NVIVO 10 software were used for analysis of quantitative and qualitative data respectively.

RESULTS: The study tracked 318 participants successfully and these had a total of 15,579 sex acts using the CFC over 8 weeks. Acceptability was based on criteria that included appeal of design, sexual satisfaction, ease of use, partner negotiation and social acceptability. Quantitative results show that the CFC is easy to use (women reporting difficulties with inserting the condom was 3% at the start of the study and 1% at the end) and the design was enticing (more than 80% of users found the size and colour enticing). Qualitative data illustrated that the CFC allowed for great sexual satisfaction; women were able to successfully negotiate for its use; and distribution and marketing of the CFC should consider the specific needs and context of each target group.

CONCLUSIONS AND RECOMMENDATIONS: Results show that the CFC is acceptable in Zimbabwe. There is evidence that this is condom will be liked by all participants of this study; men, women, young people, sex workers and people living with HIV. Thus, the CFC provides an additional safer sex option and should be considered for introduction into Zimbabwe.

12:00 – 12:15	Committee Room 4	30.11.2015

MOAC0106: Track C/1 -

Evaluation of Community-based Intervention for HIV/STI Prevention: Application of PRECEDE-PROCEED Model

Saito Akiko1, Sunai Shutaro2, Tsuchida Wakako3, Fukushima Hiroyasu3, Fujishiro Tomoaki3, Izumi Mitsuru3, Yonemitsu Emi3, Fushimi Takayuki3

1Nagasaki University, Nagasaki, Japan, 2AIDS Orphan Support NGO PLAS, Tokyo, Japan, 3Japan Overseas Cooperation Volunteer, Tokyo, Japan

BACKGROUND: The Condom Program was designed to promote condom use and prevent Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infection (STI) transmission. It was developed within a framework of PRECEDE-PROCEED (Predisposing, Reinforcing, and Enabling Constructs in Educational/Environmental Diagnosis and Evaluation-Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development) Model and it consists of 5 topics; Perception towards HIV/STI, Knowledge of HIV/STI, Condom use skill, Negotiation and Access. It was rich in visual materials and participatory group works, and unique to involve local resources such as shops. Ten different groups of the male youths aged 18-35 in Rongo, Kenya, participated in the program during the period from May 13 to 17, 2014. Trained community health workers facilitated this 2-hour program in local language. This study aims to evaluate the efficacy of the program.

METHODS: e self-administered questionnaire was conducted at baseline and 3-month follow-up. Consistent condom use, attitude (Condom Use Self-Efficacy, Multidimensional Condom Attitude and Condom Barrier) and knowledge about HIV/STI and condoms were compared. Change in proportion of consistent condom use was examined by chi-square test. Wilcoxon signed-rank test was applied to analyze the statistically significant differences in attitude and knowledge.

RESULTS: Among 305 questionnaires answered, 299 were analyzed at a baseline, mean age of 25.23 years (SD=5.09), and 79.0% (243) of baseline were analyzed for 3-month follow-up. The participants retained in the study were more likely to have tested HIV (P< 0.05) and be circumcised (P< 0.01). The self-reported consistent condom use increased 43.0% to 64.9% (P< 0.001). Among

different partners, significant positive changes were observed with a wife (P< 0.001) and girlfriend/cohabiting (P< 0.001). However the changes were not significant with casual acquaintance, paying client and other although the positive changes were observed. There were also preferably significant changes in all attitude scales and knowledge.

CONCLUSIONS AND RECOMMENDATIONS: The evaluation analysis illustrated this type of theory-based program, is effective in promoting condom use as well as positive attitude towards condom use and knowledge of HIV/STI and condoms for the male youth. Much consideration of local context is also considered as an important contributor.

Condom Use Promotion, Evaluation, Male Youth, Kenya

10:45 - 12:15	Committee Room 5a & b	30.11.2015
MOAE0101:	Track E/1 - Reaching towards elimination of mother to child transmission	
Chairs:	Agnes Mahomva, Harare, Zimbabwe	

How Did we Miss them? High HIV Prevalence among Women Testing for the First Time in Labour and Delivery in Zimbabwe: 10:45 – 11:00

Agnes Mahomva, Harare, Zimbabwe

Page-Mtongwiza Sara1, Webb Karen1, Chigavure Trust1, Mukungunugwa Solomon2, Engelsmann Barbara1, Mbetu Patricia1

1Organisation for Public Health Interventions and Development Trust, Harare, Zimbabwe, 2Ministry of Health & Child Care, National PMTCT Program, Harare, Zimbabwe

ISSUES: Early ART initiation among HIV positive pregnant women increases health benefits to mothers and prevents vertical transmission in exposed infants. Recent evidence that Zimbabwe is approaching elimination of mother to child transmission (eMTCT) will require identification of key populations at greatest risk for MTCT for high yield interventions. Our objective was to analyze the HIV positivity rates among pregnant women in antenatal care (ANC) versus those presenting to labour and delivery (L&D) untested after 32 weeks gestation, and those retesting in L&D between January and June 2015.

DESCRIPTION: We utilised routinely collected data from a nationally representative database of 1, 494 health care facilities in Zimbabwe. We descriptively analysed program data from January to June 2015 to determine HIV prevalence rates among three groups: all women enrolled in ANC, women HIV tested for the first time in L&D, and those re-tested in L&D. Chi square tests were used to determine significance in proportion of women testing HIV positive in each care setting.

LESSONS LEARNT: Among 220,139 women booking for ANC from Jan-Jun 2015, 202,699 (92.1%) received an HIV test. HIV prevalence among all women in ANC (known and test positive) was 13.0% (n=28,584). Overall, more HIV positive women entered ANC with known HIV positive status (6.7%; n=14,661) vs. unknown status (6.3%; n=13,923). With an HIV positivity rate of 18% among women testing for the first time in labour and delivery, a significantly greater proportion of women tested HIV positive in L&D than in ANC (n=1,170) =1,203.66, p< 0.001. Among 15,982 women who re-tested in labour and delivery, 2.0% (n=314) tested HIV positive.

NEXT STEPS: We documented high HIV prevalence among a nationally representative sample of women testing for the first time in labour and delivery. Women presenting with unknown HIV status in L&D should be treated as a key at-risk population for vertical transmission. Future research should document characteristics of women testing HIV positive in L&D and seek to understand the reasons for failure to test for HIV in ANC and pregnancy intentions among this group of women. Targeted interventions to support all pregnant women to know their HIV status, and if positive, receive ART will be required to achieve Zimbabwe's goal to eliminate pediatric HIV.

11:00 – 11:15	Committee Room 5a & b	30.11.2015
MOAE0102:	Track E/1 -	

Accelerated Transition to Option B+ in a Rural Zimbabwean Province: Impact of a Decentralised Antiretroviral (ART) System

Nyagura Tendai Esnat1, Tshuma Cremance1, Mukungunugwa Solomon2, Nyamurera David 3

1Ministry of Health and Child Care, Bindura, Zimbabwe, 2Ministry of Health & Child Care, AIDS & TB Unit, Harare, Zimbabwe, 3 National AIDS Council, Bindura, Zimbabwe

BACKGROUND: Following Zimbabwe's adoption of Option B+ in February 2013, Mashonaland Central (MC) rural province was faced with the task of transitioning from Option A to Option B+

for PMTCT as stipulated in the national plan. Whilst the national target was for 500 facilities to transition to Option B+ by February 2014, 296 facilities had transitioned to Option B+ by March 2014 according to the Interim review of the Option B+ Implementation Plan in Zimbabwe with MC province contributing nearly half, 137 (46%) to this national achievement. This striking contribution led to the in-depth analysis of how MC province achieved such accelerated transition in a short time period.

METHODS: A retrospective review of Option B+ roll out in MC was conducted in the October 2014. Both quantitative and qualitative research methods were used.

RESULTS: As a strategy to increase access to ART, MC province started decentralisation of ART services to the lowest level health facilities in 2009. MC became the first province in Zimbabwe to achieve 100% ART decentralisation (including ART initiation) to all its health facilities. Preparations for transition to Option B+ began in September 2013 in MC as was across the country. By then however, MC had already decentralised ART initiation to 73% of its facilities which was far above the national average of 35%. Less resources and time were required for capacitating facilities. Health workers were already confident in ART initiation. The majority of health workers were already familiar with the national ARVs ordering system as well as the HIV health information system. Patient follow up mechanisms were mostly in place.

CONCLUSIONS AND RECOMMENDATIONS: Decentralisation of ART services had strengthened the health system in MC as demonstrated by the accelerated transition to Option B+. It is recommended that decentralisation of HIV services be prioritised and promoted as it has the potential to catapult the expansion of other prevention, care and treatment services even beyond HIV and AIDS.

11:15 – 11:30	Committee Room 5a & b	30.11.2015

MOAE0103: Track E/1 -

The Role Played by Community ART Support Agents (CASAs) in a Rural Health District Based PMTCT Program in Uganda

Mushabe Elizabeth1,2, Etukoit Benard Michael3, Wamasebu Gideon4

1Makerere University School of Public Health, Kampala, Uganda, 2UNWomen, Gender Equality Health and HIV/AIDS, Kampala, Uganda, 3The AIDS Support Organization, Kampala, Uganda, 4Manafwa District, Health Services, Manafwa, Uganda

ISSUES: In Uganda, provision of services to prevent mother-to-child-transmission (PMTCT) of HIV is sub-divided into different aspects of antiretroviral therapy (ART); Early infant Diagnosis; nutritional-assessment and counseling-support and pediatric HIV care. Sub-dividing poses un-anticipated challenges to the health system including loss-to-follow-up at every step of the care continuum. Early 2013, the Ministry of Health (MoH) in Uganda launched a nationwide campaign to scale-up PMTCT services without commensurate investments in the health service delivery system. A year later, the same MoH issued new HIV-treatment guidelines and directed all districts to ensure that all HIV+ pregnant women are started on ART irrespective of disease stage. Districts were not helped to support women cope with HIV-treatment which once started was for life. This study examines the role of CASAs a rural health district based PMTCT program in Uganda.

DESCRIPTIONS: The district health team (DHT) conducted a stakeholder analysis to understand potential roles to be played by health workers & CASAs. A problem-solution analysis was done using Bryan et al.2009 model. CASAs were identified, trained & mentored. Changes in utilization were assessed at 19-months post intervention i.e. Pre-Post evaluation design. Improvements in treatment support estimated against baseline-values.

LESSONS LEARNT: A total of 248 HIV+pregnant mothers were studied for 19-months. 1)Use of CASAs helped address stigma/myths associated with HIV- treatment&child-development. Improvements were seen - ART initiation [from 25.8% to 48.3%], partner-disclosure [from 18.8% to 47.1%] , CD4-testing, receipt and acceptance of results increased from19.7% to 67%. 2)Shifting of a few non-specialized tasks from professional health-workers to CASAs facilitated rapid scale-up of PMTCT services -utilization of PMTCT services postnatally improved -1stDNA-PCR testing from 34.4% to 94.2%; receipt and acceptance of results to 94%; all HIV-exposed babies testing HIV+ started ART and 30% of mothers testing HIV positive accepted to start HIV treatment. 3)CASAs are resourceful for treatment support i.e. home visiting - 42.3%; proportion of HIV+ mothers linked to peer support groups- 97.1%; households with backyard gardens-87.6%; HIV+mothers accepting family-planning-14.2%.

NEXT STEPS: MoH to provide guidance on working with non-professional cadres e.g CASAs in district based HIV treatment programs.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Committee Room 5a & b	30.11.2015

MOAE0104: Track E/1 -

Near Real Time Data Analysis by Frontline Health Workers for Improved Mother/Baby Pair PMTCT Outcomes

Sandfolo Stephano G1, Joaki Zuze2, Phoso Malocho2

1mothers2mothers South Africa, Programs & Technical Support, Cape Town, South Africa, 2mothers2mothers Malawi, Programs & Technical Support, Lilongwe, Malawi

ISSUES: Mothers2mothers (m2m) trains and employs mothers living with HIV from local communities as Mentor Mothers (MMs), to work alongside health workers. MMs educate, support and empower pregnant women and new mothers to take up PMTCT/RMNCH services and health behaviors. Paper-based M&E systems fall short in providing data on uptake of services, in real time to allow for timely program quality improvement interventions. m2m has introduced Client Appointment Dairy, a tool that allows tracking and reporting uptake of PMTCT priority events in near real time, thereby expediting identification and follow-up on clients missing appointments.

DESCRIPTIONS: MMs record clients' priority appointments in the diary, identify appointments due and appointments missed - all structured by date of appointment, as in a regular diary. Missed appointments are tracked and followed up through phone calls and home visits. Daily records are aggregated on Summary Sheets (daily & monthly) in the diary to show uptake of priority PMTCT services, missed appointments and clients followed-up. MMs generate simple graphs on key client outcomes to show site performance. Together with facility staff, MMs review monthly data to identify program achievements and challenges, discuss gaps in service delivery and data quality. They then develop and implement action to address challenges identified.

LESSONS LEARNT: The restructuring of the data along a standard diary format has improved effectiveness of service delivery because there is quick feedback on uptake of services. Client tracking using the diary is easier and more effective in supporting follow-up of clients who miss appointments. Frontline staff appreciates the diary as it quickly demonstrates daily, weekly and monthly site performance. The current ring-binder format allows flexibility in making changes against the background of ongoing program innovation. However as a ring-binder paper based system, it is bulky and cumbersome to use.

NEXT STEPS: The diary format transforms data into meaningful information in near real time at point of service delivery. It enables collection and analysis of data in useful format to frontline staff and managers in near real time, helping them improve client PMTCT outcomes. With the pilot in Malawi, the diary will be rolled out in all 6 m2m countries in the next 3-6 months. To further improve efficiency and effectiveness, m2m is currently developing Client Appointment Diary as an mHealth application.

11:45 – 12:00	Committee Room 5a & b	30.11.2015

MOAE0105: Track E/1 -

Strengthening the Processes for Effective Early Infant Diagnosis (SPEEiD): Lessons and Results from Peripheral HIV Clinics in Kwara State, North Central Nigeria

Ndulue Nwokedi Austin1, Etsetowaghan Andrew1, Gabriel Chima2, Ibrahim Jimoh3, Abdulraheem Abubakar4

1Management Sciences for Health (MSH), Clinical Unit, Abuja, Nigeria, 2Management Sciences for Health (MSH), Laboratory System Strengthening, Ilorin, Nigeria, 3Nigeria Postal Services, Expedited Mail Service, Ilorin, Nigeria, 4Management Sciences for Health (MSH), Clinical Unit, Ilorin, Nigeria

ISSUES: WHO recommends that all children exposed to HIV be tested within four to six weeks of birth to ensure that all infected infants are initiated on treatment early. One major challenge with EID of HIV in Nigeria remains the absence of standardized logistic sample transfer systems, resulting in long turnaround times between date of sample collection and date of return of result to the mother-baby pair.

DESCRIPTIONS: The USAID-funded ProACT project implemented by MSH pioneered a unique dried blood spot (DBS) transport model in Nigeria-Strengthening the Processes for Effective Early infant Diagnosis (SPEEiD) of HIV model, which involves the transportation of dried blood spot (DBS) samples to regional PCR labs in partnership with the Nigerian Postal Service (NIPOST) utilizing its courier Express Mail Service (EMS) platform. The NIPOST mail route has a network of over 900 post

offices and 3,000 postal agencies spread across the country, ensuring coverage of most localities where HIV services are delivered. The objective of this study was to review the effect of utilizing an innovative DBS transport model in improving DBS transportation.

LESSONS LEARNT: We carried out a retrospective analysis of logistic data from 177 samples transferred from 28 PMTCT sites using the SPEEiD model over a 12 month period from March 2013 to February 2014 in Kwara state, North Central Nigeria.A review of the data showed a reduction in Turnaround Time (TAT) for return of results from 3-6 months to 3-4 weeks utilizing the SPEEiD model. Results were received for 97% of samples (171/177) transported with this model, compared to 51% previously. The average cost of sample transfer was estimated at between$20-$40 per batch and remains comparatively less expensive to other models by at least 30%.

NEXT STEPS: The MSH SPEEiD model remains an indigenous, cost effective, sustainable, and time sensitive sample transfer model which ensures that exposed infants are able to receive their EID test results quickly.This approach may be easily replicated by other partners within Nigeria and other similar resource limited setting with existing mail infrastructures. This model thus helps to provide a practical solution to DBS sample transfer, which remains one of the major challenges affecting early infant diagnosis of HIV in Nigeria.

12:00 – 12:15	Committee Room 5a & b	30.11.2015
MOAE0106:	Track E/1 -	
Chair:	Victor Mwapasa, Blantyre, Malawi	

Acceptability and Challenges of Mother Infant Pair Clinics as a Model for Provision of Integrated HIV and Maternal, Neonatal and Child Health Care: Lessons Learnt from the INSPIRE-PRIME Study

Mwapasa Victor1, Nyambi Nurse2, Sadalaki John2, Mtaula John2, Jousset Aurelie2, Mvula Andrew2, Tchereni Timothy2, Gunda Andrews2

1College of Medicine, Blantyre, Malawi, 2Clinton Health Access Initiative, Lilongwe, Malawi

ISSUES: Successful implementation of elimination Mother-to-Child Transmission of HIV (eMTCT) programmes requires provision of integrated Maternal Neonatal and Child Health (MNCH) services. Yet, in most sub-Saharan African countries, components of MNCH services are provided at multiple services delivery points and at different times which compromises their access by HIV-infected mothers and HIV-exposed infants (HEIs). Mother-infant-Pair (MIP) clinics utilize a "one-stop shop" service delivery model to improve provision of integrated MNCH services. As part of cluster-randomized trial to assess the impact of MIP clinics on retention of HIV-infected mothers and HEIs in eMTCT programmes, we assessed factors associated with successful establishment of MIP clinics and their acceptability to mothers and health workers in 15 semi-urban and rural primary health facilities in Malawi.

DESCRIPTIONS: We conducted 20 in-depth interviews with health workers and 20 focus group discussions with pregnant and post-partum women.

LESSONS LEARNT: Regular on-the-job mentorship was more effective than centralized training in the establishment of MIP clinics while clinic space limitations and frequent staff turnover hindered clinic operations. Health workers reported improved team work following the introduction of MIP clinics but noted increased demand for these services and increased workload and expressed concern over the potential negative impact on the provision of non-HIV services at the facilities. Women frequently reported HIV-related stigma associated with MIP clinics. However, many preferred the clinics due to reduced frequency of health facility visits, comprehensiveness of services provided per visit, supportive interactions with fellow HIV-infected women and positive perception of the impact of the MIP clinics on their wellbeing.

NEXT STEPS: MIP clinics appear to increase demand for eMTCT services but may negatively affect provision on non-HIV services, especially in health facilities with severe health worker constraints. Stigma reduction programmes and regular health worker mentorship are crucial in the successful establishment and sustainability of MIP clinics.

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Jacaranda 3	30.11.2015
MOAD0101:	Track D/1 - Improving access to treatment and adherence	
Chairs:	Kwasi G. Okai, Accra, Ghana	

Improving Access to Treatment of PLHIV, the Role of the National Health Insurance

10:45 – 11:00

Okai Kwasi G1, Dery Samuel K2, Larbi Emmanuel1, El-Adas Angela3, Kwao Isaiah D1, Adjei Cosmos Ohene4

1Ghana AIDS Commission, Research Monitoring and Evaluation Division, Accra, Ghana, 2University of Ghana, School of Public Health, Department of Biostatistics, Accra, Ghana, 3Ghana AIDS Commission, Director General Secretariate, Accra, Ghana, 4Ghana AIDS Commision, Technical Service Division, Accra, Ghana

ISSUES: The provision and access to treatment and care services by Persons Living with HIV (PLHIV) is critical in the prevention of new infections as well as reducing AIDS related deaths. Evidence shows that, there is high defaulter rate among PLHIVs due to social and economic factors which are mainly household expenditure and stigma. In 2003, the National Health Insurance Scheme (NHIS) law was passed as a social protection strategy to make healthcare accessible and affordable to all Ghanaians. The Ghana AIDS Commission (GAC) as part of the National Strategic Plan (NSP 2011-2015) implementation strategy had sought to use the NHIS to support PLHIVs to access health care services.

DESCRIPTIONS: GAC with support from the Global Fund in October 2010, undertook an assessment of the health facilities that provide antiretroviral therapy (ART) services to facilitate the enrollment of PLHIVs onto the NHIS. Subsequently, GAC signed memorandum of understanding (MOU) with the facilities to enroll (registration of new people and renewal of persons already registered) PLHIVs and their dependents under 18 years across the country onto the scheme. Facilities were provided with logistical support to carry out weekly meetings for smooth implementation of the exercise. A quarterly monitoring and evaluation system was put in place that required quarterly reporting by facilities, on-site data verification and supportive supervision, annual technical and financial audit, and provision of feedback to facilities by GAC. A database system was also developed to track reporting by the health facilities.

LESSONS LEARNT: A total of 6,497 PLHIVs and their dependents were enrolled in 2010, the first year of intervention was 24,896 in 2011, 16,507 in 2012, 12,748 in 2013 and 15,367 in 2014. In addition, 3,294 clients were newly registered in 2010, 12,000 in 2011, 5,018 in 2012, 3,030 in 2013 and 3,474 in 2014. The M&E systems put in place facilitated the smooth implementation of the exercise. Cumulatively, a total of 26,816 people were newly registered with the scheme over the 5 year period. This has contributed to more PLHIVs and their dependents accessing treatment care and support services.

NEXT STEPS: GAC intends to extend the intervention to all facilities that provide ART services in Ghana. Quarterly supportive visits initiated will ensure facilities conform to implementation arrangements, reporting guidelines, quality data and timely submission of reports by health facilities.

11:00 – 11:15	Jacaranda 3	30.11.2015
MOAD0102:	Track D/1 -	

Implementing the HIV Treatment Cascade for Key Populations: A Result from Pilot Sites in Togo and Burkina Faso

Tchupo Jean-Paul1, Folly Akouete Aristide2, Konate Issouf3, Sodji Dometo4, Honu Marian1, Me-Tahi Hortense5, Traore Clotilde6, Ettiegne-Traore Virginie1, Kapesa Laurent1

1FHI 360, Accra, Ghana, 2Espoir Vie-Togo, Lome, Togo, 3Clinique Yerelon, Bobo-Dioulasso, Burkina Faso, 4FAMME, Lome, Togo, 5FHI 360, Lome, Togo, 6FHI 360, Ouagadougou, Burkina Faso

BACKGROUND: Over the decades, various innovations have been developed in the fight against HIV/AIDS that have considerably changed HIV programming. The treatment cascade is one of these which tracks different steps of HIV care that PLHIV go through from HIV diagnosis to viral suppression and the proportion of PLHIV who are engaged at each stage.

The PACTE-VIH project has adopted the cascade model in Togo and Burkina Faso since April 2014. The results have been used to reshape project activities and optimize beneficiaries' outcomes.

The objectives are to:

- Track KP diagnosed with HIV who are linked to care, retained in care, receive ART and achieve viral load suppression
- Determine the gaps in the treatment to viral load suppression progression
- Minimize losses and missed opportunities to engage and retain KP in care and implement appropriate interventions.

METHODS: A size estimation of KP living with HIV at each intervention site was conducted, based on reported prevalence. KP diagnosed with HIV were promptly linked to care, tested for ART eligibility and provided with pre-ART services. Those enrolled on ART were provided with CD4 monitoring at project sites and referred to government labs for viral load tests. SMS reminders were also sent to individual mobile phones daily as an alert system to take ARV.

RESULTS: Of the 1,680 Female Sex Workers (FSW) estimated in Bobo-Dioulasso, Burkina Faso, 42% have been tested by PACTE-VIH and 10% of that number diagnosed with HIV. 51% of the diagnosed were linked to care, of which 89% retained in care and out of which 42% are on ART.

In Togo, of the 10,030 KP estimated at the project sites, 63% have been tested and 6% of that number diagnosed with HIV. 61% of the diagnosed were linked to care of which 86% retained in care out of which 58% are on ART.

CONCLUSIONS AND RECOMMENDATIONS: The results show gaps between the estimated number of HIV-positive KPs and the number diagnosed with HIV by the project and between the number of KP diagnosed and those linked and retained in care in both countries. Therefore, PACTE-VIH project has modified its approach to achieve the greatest impact:

(1) testing a network-based approach to increase the HIV positive yield in project's sites;

(2) recruiting case managers to manage the navigation of KP HIV positive across the continuum.

Indeed, several studies have shown that among people with HIV, having a case manager is positively associated with having one's needs for support services met.

11:15 – 11:30	Jacaranda 3	30.11.2015

MOAD0103: Track D/1 -

Enhancing ARV Adherence for Gay Men, MSM and Transgender Individuals (GMT) and Male Sex Worker (MSW) In Kenya

Mathenge John1, Ndunda Erastus2, Gakii Gloria3, Klindera Kent4

1Health Options for Young Men on HIV/AIDS and STIS, Health, Nairobi, Kenya, 2Health Options for Young Men on HIV/AIDS and STIS, Nairobi, Kenya, 3Swop Clinics, Nairobi, Kenya, 4amfAR, Foundation for AIDS Research, New York, Kenya

ISSUES: The National AIDS Indicator Survey (2009) states that 15.2% of new HIV infections occur in MSM. A recent cohort conducted in partnership with HOYMAS—a CBO which serves the health needs of GMT/MSW—revealed an HIV sero-prevalence of 40%. Delivering health services to these populations poses a major challenge because of perceived and actual stigma. GMT/MSW living with HIV face multiple stigma.

DESCRIPTION: HOYMAS' intervention undertook the following activities:

1) Ten "Encounter Groups" of 10 members each (totaling 100) were formed. The membership consisted of GMT/MSW living with HIV and AIDS. Each group met twice per month (May- July 2014) and was facilitated by a counselor, nurse, nutrition expert, and substance abuse expert. The members were provided with referral information on non-discriminatory health services where they could get ARV treatment:

2) Twenty peer leaders were trained as trainers on nutrition, ARV adherence and counseling, in a 5-day intensive course. Currently, 250 members receive supplements, nutritional support and training from peer leaders around nutrition;

3) Three key social events were organized (including World AIDS Day and International Sex Workers Rights Day). During these events, messaging on ARV treatment and adherence and safer sex was delivered. Educational materials on HIV/STIs were also disseminated

LESSONS LEARNT: Project outcomes include;

1) 37 members who kept their ARVs in shelves at HOYMAS improved greatly in adherence;

2) 15 members with opportunistic infections were treated in GMT friendly healthcare centers; no opportunistic infection reported in three months;

ABSTRACT DRIVEN SESSION

3) HOYMAS partnered with public referral hospitals to increase health services access and utilization, including treatment of STIs such as anal warts;

4) 225 new members visited HOYMAS's safe space to learn more about health issues and access preventive tools like condoms and lubricants;

5) More than 600 GMT participated in HOYMAS' annual HIV Champions Outreach Event (July 2014);

6) More than 2,500 pamphlets were distributed.

NEXT STEPS: HOYMAS developed the following recommendations;

1) GMT and MSW need a one-stop shop where a range of services can be accessed to support adherence and nutritional health;

2) Further advocacy is needed with key stakeholders and other government agencies;) Public health facilities need to be further sensitized around the negative health effects of homophobia and HIV-phobia.

11:30 – 11:45	Jacaranda 3	30.11.2015
MOAD0104:	Track D/1 -	

Donner l'Espoir d'Une Vie en Couple aux PVVIH: Expérience de la Fondation Espoir de Guinée (FEG), Une Association de PVVIH au Centre de Traitement Ambulatoire de l'Hôpital National de Donka, en Guinée

Bah Aissatou1, Diallo Aïssatou1, Wakou Brigitte Singa1, Balath Joseph1, Néboua Désiré2, Cissé Mohamed3

1Fondation Espoir de Guinée, Conakry, Guinea, 2Solthis, Conakry, Guinea, 3CTA de Donka-Service de Dermatologie-MST, Hôpital National de Donka, Conakry, Guinea

ISSUES: La découverte de sa séropositivité au VIH est source de stigmatisation de la part de la communauté ce qui rend davantage difficile toute possibilité de d'engager dans une vie de couple. Pour répondre à un tel besoin, la Fondation Espoir de Guinée (FEG), présente au Centre de traitement ambulatoire de l'hôpital national de Donka, s'est engagée depuis 2012 dans l'accompagnement des PVVIH à la recherche d'un partenaire pour une vie en couple. Le présent travail vise à présenter l'expérience de la FEG, une association qui offre la possibilité d'une vie en couple.

DESCRIPTIONS: L'association vient en appui au CTA de Donka dans la prise en charge des PVVIH notamment sur les volets appui à l'observance, les visites à domicile, la recherche des perdus de vie et depuis 2012 à l'accompagnement pour une vie en couple au profit de tous les PVVIH de la Guinée. Les clients intéressés sont répertoriés dans un registre avec au besoin quelques caractéristiques du conjoint recherché. Très souvent, les photos de certains clients sont mises à contribution dans ce processus de recherche qui est fait gratuitement par l'association.

LESSONS LEARNT: De 2012 au 31 mai 2015, 82 PVVIH en provenance du CTA de Donka et d'autres sites de prise en charge se sont inscrits pour bénéficier d'un accompagnement dans la recherche d'un partenaire pour une vie en couple. 78,5% étaient de sexe féminin avec une moyenne d'âge de 33 ans [18-59]. Plus de la moitié (54,32%) est issue du secteur informel et 45,7% sont célibataires. Parmi les critères recherchés par les clients, on retrouvait le plus souvent « un conjoint responsable », des préférences ethniques ou religieuses.

L'accompagnement a permis à 30 inscrits de trouver un partenaire, 6 d'entre-eux avec un partenaire séronégatif. 19 couples ont pu se marier et 8 ont déjà eu un enfant. Neuf des couples ont été constitués à partir de clients qui étaient tous inscrits.

NEXT STEPS: Etre séropositif et trouver un conjoint du même statut sérologique n'est pas chose aisée encore moins un de statut discordant. La FEG a réussi à offrir une vie de famille à 30 PVVIH dont 6 couples séro-discordants, certains ayant eu la joie d'être parent. Cette expérience de la FEG, qui participe à améliorer la qualité de vie des PVVIH, se doit d'être renforcée et mieux structurée.

11:45 – 12:00	Jacaranda 3	30.11.2015
MOAD0105:	Track D/1 -	

Adherence to Highly Active Antiretroviral Therapy in Bunda District - Tanzania

Thomas Alex S1,2, Koya Christina J3, Masatu Dr.Emmanuel L4

1Bunda Women Living with HIV, Community Health, Bunda, Tanzania, United Republic of, 2BDHH, Health, Bunda, Tanzania, United Republic of, 3Bunda Women Living with HIV, PLHIV / Health, Bunda, Tanzania, United Republic of, 4District Hospital BDDH, Health, Bunda, Tanzania, United Republic of

BACKGROUND: Non adherence can be influenced by a number of factors including socio demographic and behavioural characteristics as well as provider related factors. This study aimed at determine the factors associated with non adherence to art as to provide an entry point to the interventions.

Method: Across-sectional study of attendees conducted with Buwoliha at Bunda District Hospital in collaboration with CTC clinics that patients were on ARV was carried from August to December 2014. A face -to - face interview using a semi structure standard questionnaire was used to obtain a necessary information. Socio demographic and other behavioral characteristics were treated as explanatory variables where as missing / not missing dose was treated as outcome variable during analysis. Bivariate analysis examined the association and strength of relationship between explanatory and outcome variables using the 95% CI around proportion.

RESULTS: One hundred and two patient were recruited into the study twenty six of them 18.2% reported to had missed dose(s) in the previous month. Not knowing the consequences of intermittent dosing was highly associate with ART non adherence (95%) CI 35-62.77 vs 8.6 -16.45 Taking alcohol and using alternative medicine were other factors strongly associated with non adherence 31.62-55.23 vs 7.20 -11.47 and 36.77 -55.05 vs 9.27-14.64 respectively. Socio demographic characteristics and sero status were not significantly associated with ART non adherence. The most frequent reasons for missing dose were delayed refill to poor logistics at clinics (59%) and economics constraints (27%).

Conclusion and Recommendations: Socio demographic characteristics and sero status disclosure are not predictive of ART Adherence. Alcohol intake and using alternative medicine contribute to non adherence. Service providers contribute significantly to ART non adherence by failing to adequate educate their clients on the effects of non adherence and by poor plans of ARV refill. Both patients and service providers should be targeted by interventions aimed at improving adherence to ART.

	Jacaranda 3	30.11.2015
MOAD0106:	Track D/1 -	

Developing Strategies to Scale up ARV Treatment and Associated Diseases among (OVCs) Orphans and Vulnerable Children

Mutiga Paul Moses Ndegwa

Ambassadors of Change, Policy, Nakuru, Kenya

ISSUES: Estimated over 72% of orphan children are taken care of by elderly relatives aged 55-80 years with little knowledge about HIV prevention, ARV treatment in rural and semi-urban areas as slum dwellers following the deaths of their relatives after succumbing to TB/HIV. Adherence to ARV medication among OVCs is a major problem due to high costs of transport, poverty and low literacy levels. Pediatric ARV treatment is a challenge with only 22% of HIV+ accessing treatment in Kenya. Childhood TB face immense challenges in diagnosis, treatment due to acute shortage and regular drug stock outs in public clinics.

DESCRIPTIONS: Study was carried out between May - Dec 2014 to identify key barriers to treatment access among orphans and vulnerable children in Nakuru county, Kenya. Structured -group discussions, interviews ,questionnaires were undertaken involving 5 pediatricians, 47 care providers at household levels, 149 community health workers, and 12 clinicians in 5 public health clinics. Literature review. Data analysis.

LESSONS LEARNT: Study noted delayed initiation to ARV among OVCs. Community health workers play a key role in monitoring and reporting cases of treatment defaulters among OVCs by visiting households regularly and linking those detected with health clinics.Nutrition contributes to non-adherence to medication. Public health clinics are not child-friendly (adults mixed with children). stigma is rife both in the community and among health providers on HIV and associated diseases compromising treatment access.

NEXT STEPS: Ensure all HIV infected children access early initiation to ARV treatment and avoid treatment disruptions. Improve TB diagnostics, treatment for children. Strengthen health systems both in urban and rural areas to enhance universal access. integrate nutrition into TB/HIV responses. Ensure CHWs are knowledgeable about ARV treatment. De -stigmatize HIV and associated diseases both at community and among public health providers. Impove drugs procurement procedures to avoid stock outs and shortages, Increase domestic financing for health to sustain HIV responses.

ABSTRACT DRIVEN SESSION

12:45 – 14:15	Jacaranda 3	30.11.2015

MOAC0201: Track C/2 - Making VMMC work
Chairs: Emmanuel Njeuhmeli, United States

Female Partner Involvement Positively Influence Men Decisions on Voluntary Medical Male Circumcision in Homabay County 12:45 – 13:00

Waga Charles Okumu

Nyanza Reproductive Health Society, Mobilization and Demand Creation, Kisumu, Kenya

BACKGROUND: Given evidence of a 60% reduction in HIV acquisition for circumcised men, we examined the role of women in clients' decision to seek services through the VMMC program implemented in the kasipul and kabondo sub-counties in Homabay County.

METHODS: A cross sectional study was conducted including in-depth interviews (IDIs) with VMMC clients (n=35; n=12 HIV-positive), IDIs with VMMC service providers and stakeholders (n=35), and surveys with VMMC clients (n=350). IDI transcripts were analyzed through coding and identification of key themes. Surveys were analyzed at the univariate and bivariate level, utilizing standardized sampling weights.

RESULTS: Women influenced men's decision making for VMMC in a variety of ways. Women interacted with the formal health care system more regularly and served as message bearers to male partners. Among VMMC clients, 18.1% reported discussing their VMMC decision making with a wife or sexual partner. New notions of sexual desirability were connected with male circumcision for disease risk reduction, aesthetic preferences, and sexual pleasure enhancement. A belief that circumcision is more desirable to women was reported by 31.7% of men as one reason they decided to circumcise. However, male clients expressed discomfort with female VMMC providers and interacting with women while seeking services. Embarrassment was a main obstacle in VMMC decision making for 12.8% of clients surveyed, 40.9% believed this is an obstacle for their uncircumcised counterparts.

CONCLUSIONS AND RECOMMENDATIONS: Considering these small but significant numbers, women's ability to both persuade and dissuade men to participate in VMMC services should be considered in VMMC demand creation interventions.

18:50 - 20:30	Jacaranda 3	30.11.2015

MOAC0202: Track C/2 -

There Is No Observed Sexual Behavioral Change among Men Following Safe Male Circumcision in Kampala

Sebuliba Kirirabwa Nicholas1, Sentumbwe Simon2, Nabukera Sarah3

1SIM'S Medical Centre, PPP HIV Reference Laboratory, Kampala, Uganda, 2SIM'S Medical Centre, Kampala, Uganda, 3Social & Science Systems Inc., Kampala, Uganda

BACKGROUND: Despite male circumcision being a proven biomedical HIV prevention intervention, little is known about the personal and contextual profiles after its roll-out in African communities with HIV pandemic. Few studies have examined the sexual behaviours of men following Safe Male Circumcision (SMC). Given that SMC is not 100% effective in reducing the risk to HIV infection, there has been debate that behavioral disinhibition among newly circumcised men could potentially mitigate some of the protective benefits SMC.The purpose of this research was to examine the sexual behaviour practices of men before and after SMC.

METHODS: A cross sectional survey was conducted among 300 recently circumcised males 15-49 years in Kampala district. A closed and open-ended semi-structured questionnaire was used to collect socio-demographic, sexual behavioural practice data. Data collected were analyzed using quantitative analysis methods - descriptive and inferential statistics analyses with chi square estimation. Exposure variable was SMC and the outcome variables were: condom use, number of sexual partners, and history of STI.

RESULTS: A total of 300 circumcised males in Kampala city participated in the study. Approximately 22.3% (67/300) were residents of Nakawa division, 22%(66/300) Kawempe, 20.7% (62/300) Central, 19%(57/300) Rubaga while 16% (48/300) were residents of Makindye division. Findings from the study indicated that males were engaged in risk sexual behaviours as evidence by the fact that over 20% (71/298) of males reported a history of sexually transmitted infections (STI) before SMC. Following SMC, reports of STI declined with only 12% (37/300) reporting STIs. Furthermore, findings suggested a slight decline in number of sexual partners following SMC with 9% (27/292) males reporting multiple sexual partners after SMC compared to 10% (30/296) before

SMC. However, there was no statistically significant change in condom use before and after SMC (73% Vs 73%; P-value=0.845).

CONCLUSIONS AND RECOMMENDATIONS: There were no observed changes in sexual behaviour practices among males after SMC. The observed reduction in STI occurrence may have been a result of a biological benefit of SMC other than behaviour change. We recommend that SMC service providers emphasize that SMC is not 100% protective against HIV and put more emphasis on consistent condom use and partner reduction during SMC counseling.

13:15 – 13:30	Jacaranda 3	30.11.2015

MOAC0203: Track C/2 -

Age and Regional Targeting Scenarios for Uganda's Safe Male Circumcision Program: A DMPPT 2.0 Model Application

Kripke Katharine1, Vazzano Andrea2, Kirungi William3, Musinguzi Joshua3, Ssempebwa Rhobbinah4, Kyobutungi Sheila4, Akao Juliet5, Magala Fred6, Castor Delivette7, Njeuhmeli Emmanuel8

1Health Policy Project, Avenir Health, Washington, United States, 2Health Policy Project, Futures Group, Washington, DC, United States, 3Ministry of Health - Uganda, Kampala, Uganda, 4U.S. Agency for International Development (USAID), Kampala, Uganda, 5U.S. Department of Defense, Kampala, Uganda, 6Makerere University Walter Reed Project, Kampala, Uganda, 7U.S. Office of the Global AIDS Coordinator, Washington, DC, United States, 8U.S. Agency for International Development (USAID), Washington, DC, United States

BACKGROUND: In 2010, Uganda set a target of providing safe male circumcision (SMC) to 80 percent of males ages 15-49 by 2016 as part of its efforts to curb the HIV epidemic. To date, only 2 million men of the 4.2 million men required have received SMC. Programmatic data show that service uptake varies by age, and surveys indicate geographic variability in male circumcision (MC) prevalence, which may impact SMC scale-up. This study used mathematical modeling to estimate cost and impact of scaling up SMC via different age-targeting strategies, and determine regional differences in cost-effectiveness and progress of scale-up. Results will help Uganda refine its targets based on region and age group.

METHODS: The study team used the Spectrum/AIDS Impact Module (AIM) to create regional and national HIV incidence projections based on surveillance data. The Decision-maker's Program Planning Tool, Version 2.0 (DMPPT 2.0), a compartmental model implemented in Microsoft Excel 2010, was then populated with data on population, births, deaths, HIV prevalence, and incidence projections from AIM. Baseline MC prevalence was derived from the 2011 AIDS Indicator Survey.

RESULTS: Uganda can achieve the most immediate impact on HIV incidence by circumcising males ages 20-34. This strategy will also require the fewest circumcisions per HIV infection averted over 15 years. The greatest impact over a 15-year period can be achieved by circumcising males ages 10-19, while the age range of the most cost-effective strategy (lowest cost per HIV infection averted) is 15-34 years. There is little variation in cost-effectiveness of scaling up SMC across Uganda's eight regions. Scale-up is projected to be cost-saving in all regions and nationally. SMC program progress is variable across regions, highlighting the need for accelerated progress in two regions with low baseline rates of MC: Mid Northern and North East.

CONCLUSIONS AND RECOMMENDATIONS: The DMPPT 2.0 exercise shows that focusing SMC efforts on specific age groups and/or regions, while still providing SMC to medically eligible males regardless of age, may help accelerate SMC program progress. Policymakers in Uganda have already used DMPPT 2.0 outputs in planning efforts, proposing males ages 10-34 as a priority group for the SMC program in their 2014 application to the Global Fund's new funding model. As scale-up continues, the country should also consider greater efforts to expand SMC in regions with low MC prevalence.

13:30 – 13:45	Jacaranda 3	30.11.2015

MOAC0204: Track C/2 -

Modeling the Impact and Cost of Age-targeting for Voluntary Medical Male Circumcision Scale-up in Swaziland

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ABSTRACT DRIVEN SESSION

BACKGROUND: Swaziland is one of 14 priority countries identified in the WHO/UNAIDS Joint Strategic Action Framework for rapid scale-up of Voluntary Medical Male Circumcision (VMMC) for HIV prevention. In 2011, it implemented the Accelerated Saturation Initiative, which focused circumcision efforts on males ages 15-49. Program data showed that demand for VMMC varied by age. Over 75 percent of VMMC clients were under age 25 (with a large proportion ages 10-14), while less than 10 percent were above age 35. These trends may indicate a need for a targeted VMMC strategy to maximize program impact and cost-effectiveness. The Decision Makers' Program Planning Tool, Version 2.0 (DMPPT 2.0) was applied in Swaziland to assess the impact and cost-effectiveness of age targeting. Results have informed the development of the country's Male Circumcision Strategic and Operational Plan for HIV Prevention, 2014-2018.

METHODS: DMPPT 2.0 is a simple compartmental model implemented in Microsoft Excel 2010. The model was populated with national estimates of population, mortality, and HIV prevalence and incidence. HIV incidence was derived from the Swaziland Incidence Measurement Survey and the Spectrum/Goals model, while the most recent Demographic and Health Survey provided baseline male circumcision prevalence by age. Age-targeting scenarios were analyzed within a fifteen-year timeframe—long enough for benefits to accumulate but short enough to be relevant to planning.

RESULTS: Circumcising males ages 20-29 provides the most immediate reduction in HIV incidence in Swaziland. Over fifteen years, circumcising males ages 15-29 results in the greatest reduction in HIV incidence. The lowest cost per HIV infection averted, over a 15-year timeframe with a 3 percent discount rate, is also achieved by circumcising clients ages 15-29.

CONCLUSIONS AND RECOMMENDATIONS: The potential impact and cost-effectiveness of VMMC scale-up in Swaziland varies by age-targeting strategy, with males below age 30 offering the greatest benefit. Based on DMPPT 2.0 modeling results, the Ministry of Health refined its 5-year age-specific targets for VMMC nationally and by inkhundla (sub-district). The Swaziland Male Circumcision Strategic and Operational Plan for HIV Prevention, 2014-2018 aims to scale up to 80 percent male circumcision prevalence among 10-29 year olds, and 55 percent prevalence among 30-34 year olds by 2018.

13:45 – 14:00	Jacaranda 3	30.11.2015
MOAC0205:	Track C/2 -	

Evaluating the Impact of the Voluntary Medical Male Circumcision Program in Kenya

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BACKGROUND: Voluntary medical male circumcision (VMMC) has been shown to significantly reduce the likelihood of male acquisition of HIV infection. Kenya launched the National Male Circumcision program in 2008 with a target of circumcising 860,000 men by 2013. The program reached 793,000 men through 2013. The purpose of this activity is to evaluate the cost and impact of the program in terms of HIV infections averted, the cost per infection averted, and the reduction in future treatment costs.

METHODS: We collected national statistics on the number of circumcisions performed and the prevalence of male circumcision and are visiting facilities and program offices in 10 counties to collect detailed data on the characteristics of clients and costs. Using these and other data we worked with three different modeling groups (Avenir Health, Imperial College London, Intellectual Ventures) to set up mathematical simulations models at the national and county levels. These models replicate historical trends in HIV infection from 2005 to 2014 given actual conditions including circumcision levels, behaviors and the coverage of ART. The models will be used to compare actual trends in new infections with those that would have occurred if the VMMC program had not existed. A modeling workshop, to be held in October 2015, will review and compare model results and reach a consensus on the most likely impact of the program.

RESULTS: Final results will become available in October after the conclusion of the modeling workshop and review by program officials. Preliminary results indicate that the immediate impact has resulted in almost 8,000 infections averted among young men in Nyanza province from 2008-2014. The longer term impact will be much greater as these men will be protected throughout their sexually active lives. Preliminary projections indicate that the number of infections averted due to circumcision already performed will climb to over 100,000 by 2050 or about 8 circumcision per infection averted at a cost of less than $500 per infection averted.

CONCLUSIONS AND RECOMMENDATIONS: The VMMC program in Kenya has been the most successful in the world in terms of meeting its target. This work shows that the program will have a substantial impact in the areas where it is active and that the cost per infection averted is low compared to the costs of treatment. These finding should encourage other countries to give high priority to VMMC in order to achieve comparable results.

ABSTRACT DRIVEN SESSION

14:00 – 14:15	Jacaranda 3	30.11.2015
MOAC0206:	Track C/2 -	

Assessment of Quality of Voluntary Medical Male Circumcision Data in Southern West Uganda: Baseline Findings (2014)

Mera Moses1, Natumanya Eliab Kajungu1, Nanteza Barbara Marjorie2, Juan Palacin Seclen3

1Elizabeth Glaser Pediatric AIDS Foundation, USAID STAR SW Project, Mbarara, Uganda, 2Ministry of Health- Uganda, Kampala, Uganda, 3Elizabeth Glaser Pediatric AIDS Foundation, Washington DC, United States

BACKGROUND: The importance of having complete,accurate and reliable data to inform policies, interventions,and strategies,has always been one of the main standards of the Strengthening TB and HIV/AIDS response Project in Uganda's Southwestern Region (STAR-SW). Accordingly,EGPAF conducted an audit (assessment) of quality of data generated from the voluntary medical male circumcision (VMMC) program, implemented since 2010 through the STAR-SW Project.

METHODS: From October to December 2014,STAR-SW conducted an audit of national VMMC reported data as compared to those data recorded in facility registers at VMMC sites for the period between October 2013 and September 2014.Through an Excel-based standardized tool, a total of 36 VMMC sites were audited jointly by trained STAR-SW and district health office staff. The indicator of interest was 'number of males circumcised by skilled staff'. Data sources were VMMC registers and monthly HMIS reports submitted to MOH.The quality of data was measured using the 'data quality deviation index' (DQ_DI), calculated as: (# circumcisions reported - # circumcisions counted during audit) / # of circumcisions reported to MOH. This index, expressed in percentage, was defined on a scale ranging from 'adequate' quality of data (means deviation of up to; 5%); 'acceptable' (5% - 10%); and 'inadequate' when deviation is ;>10%. 'Adequate' quality of data expresses reliable data with minor discrepancy. Conversely, 'inadequate' reflected significant data discrepancies with either over or under reporting of less than or greater than 10%.

RESULTS: A total of 36 sites were audited. The overall DQ_DI was 8% (97,091 circumcision surgeries reported versus 88,939 counted during the audit),indicated over-reporting at facility-level of 8,152 surgeries in the 12-month observation period. Only the 20 high-volume sites (accountable for 80% of surgeries performed), 10 (50% of) sites had 'adequate data deviation', and 8 sites showed 'inadequate data deviation'. Out of all 36 sites audited,18 (50%) had 'adequate data deviation',and 15 (42%) depicted 'inadequate data deviation'.

CONCLUSIONS: This data quality audit revealed that safe male circumcision (SMC) was over reported, which falls under the "acceptable" standards of variation. Only half of VMMC service providing sites reported data accurately. Those sites with deviation greater than ;10% were targeted to receive intensive support to improve reporting of valid and accurate data.

12:45 – 14:15	Jacaranda 1 & 2	30.11.2015
MOAE0201:	Track E/2 - Systems delivery - better information and point of care	
Chairs:	Dr. Chintu Namwinga	

Strengthening the National HIV Health Information System Using an Electronic Reporting System (ERS): Experience of Monitoring, Evaluation and Surveillance Interface (MESI) in DR Congo 12:45 – 13:00

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ISSUES: Most national HIV programs are confronted by a lack of available data for national reporting and decision making. For countries such as DR Congo, using an Electronic Reporting System (ERS) could partially solve the problem. Since October 2014, FHI 360/DR Congo, through funding by CDC/PEPFAR, has been providing technical assistance to the Programme National de Lutte contre le Sida (PNLS) to reinforce the national HIV health information system.

DESCRIPTION: In collaboration with the PNLS team, FHI360 has strengthened the national HIV health information system through:

i) revising and harmonizing indicators and national tools,

ii) progressive computerization of the HIV health information system (paper-based reporting system to ERS) at peripheral level (health zone) and central level (national HIV/AIDS program) using the web-based database MESI www.mesirdc.cd, starting in Kinshasa province

iii) capacity building for staff (training sessions and supervision) and

iv) motivational strategy of assignment of "data coach" grade for health zone data managers who improve their skills in HIV data management.

LESSONS LEARNT: As of May 2015 all 35 health zones in Kinshasa province used ERS to transfer monthly HIV programmatic data (counselling and testing, PMTCT, ART and community sensitization) to the central level. Data availability in the ERS was significantly improved as shown by the following results (of monthly paper-based reports registered in ERS):

i) 88% for period January-December 2014 with 51% of health zones having registered 90% of monthly reports and

ii) 92% for period January-March 2015 with 83% of health zones having registered 90% of monthly reports.

HIV data management skills were strengthened in all 35 health zones. As of June 2015, 17% of health zone data managers reached "data coach" grade. The supervision conducted in June 2015 for low-performing health zones enabled improvement of HIV data registration in ERS:

i) 83% for January-December 2014 period and

ii) 93% for January-March 2015 period.

NEXT STEPS: In collaboration with PNLS, FHI360 team will continue to strengthen and extend the ERS in two major provinces (Orientale and Katanga) and improve HIV data quality by reinforcing the national data quality improvement system. Organization of national strategic information technical working group meetings will enable the PNLS team and implementation partners to discuss HIV health information system issues and review the data analysis.

13:00 – 13:15	Jacaranda 1 & 2	30.11.2015

MOAE0202: Track E/2 -

Cost-outcome Study Using Electronic Health Records to Inform Investment for HIV Treatment Scale-up - The Case of Cote d'Ivoire's Adults, Children, and Pregnant Women

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BACKGROUND: In 2014, UNAIDS unveiled its 90-90-90 target; second of its three part goal is to get 90% of all people living with HIV who know their status on antiretroviral therapy (ART). To meet this aspirational goal, countries must understand the cost of scale-up and effectively mobilize resources for it. This study generated data for Cote d'Ivoire, applying a novel cost-outcome method using electronic health records (EHR).

Objectives: The study objectives were to: determine the unit cost of providing ART to adults, children, and pregnant women; assess cost differences based on patient characteristics and outcomes; and, project future cost and impact, such as lives saved.

METHODS: This study focused on 28 EHR capable sites in five high-burden health regions in Cote d'Ivoire. The subjects were patients who initiated treatment between October 2012 and September 2013. Facility service delivery and financial data were collected to generate service-specific unit costs. This data was combined with patient records data to calculate the patient-specific annual cost of treatment. The study used correlation analysis to assess cost differences by patient characteristics such as age, regimen, and clinical outcomes after one year of treatment. The epidemic was modeled with the AIDS Impact Model to estimate future cost and impact of access to treatment. The study had two scenarios:

(1) status quo - historical rate of treatment coverage growth; and

(2) 90% treatment coverage goal achieved by 2020.

RESULTS: 3,318 patients initiated treatment during the study period. Preliminary results show that average annual cost of treatment was US$247 for adults, US$323 for children, and US$209 for PMTCT. This scale up will cost approximately US$350 million in total over the five years and will save an estimated 24,580 lives, while reducing infections by almost 9,000.

Discussion and Recommendations: To reach 90% treatment coverage, significant additional domestic and donor funding will be required. This study results will allow the government of Cote d'Ivoire to more effectively coordinate and plan its and stakeholders' short and long term investments in HIV treatment. Through this effort, by 2020, the country will start to see a decline in HIV

infection and death, leading to healthier and more productive lives for the citizens of Cote d'Ivoire, and contributing to the global goal to end the AIDS epidemic by 2030.

13:15 – 13:30	Jacaranda 1 & 2	30.11.2015

MOAE0203: Track E/2 -

Challenges and Opportunities in Implementing Electronic Health Management Information System for Key Population; The Nigerian Clinic Perspective

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1Population Council, FCT, Nigeria, 2Enovizion Limited, Information Technology, FCT, Nigeria

ISSUES: In recent times, electronic health management information system (HMIS) is seen as an important tool for managing data and ensuring confidentiality of beneficiaries in a project. The objective of this paper is to identify challenges and opportunities encountered in developing and implementing an electronic HMIS for key population.

DESCRIPTIONS: The strategic approach was to capture data on HIV & STI prevention data with the generation of unique identifier as a means of making every client anonymous and limit stigma. Between the months of March to December 2014, in-depth interviews were conducted with 10 users of the HMIS on acceptability and user friendliness in two clinics in Kaduna and Lagos States of Nigeria.

LESSONS LEARNT: HMIS implementation has become a challenge for researchers and programmers because of the significant proportion of differing needs of programmers and researchers. Issues raised were mainly on proper documentation of primary source documents at every level. A major challenge was conversion of paper questionnaires to electronic forms and having to retain the similarity in the way they appear. Users of the HMIS attributed this implementation effort to the complexity of tools and satisfying multiple requests by users as the need arise. With the air of stigma and discrimination hovering around key population due to the anti-gay law passed, the unique identifier made it easier to keep the identities of beneficiaries as anonymous as possible. The steady progress made in information technology and its integration into the HMIS has provided speedy access to community-level data that may be updated frequently. In addition, stake holders get to see first-hand the value of investment with tangible trace of evidence that data are not just framed up by field officers.

NEXT STEPS: This study has revealed that developing and implementing the electronic HMIS opens a door to automating every process of data capture as it shows the possibility of eliminating paper work from field to data reporting. This also enhances data management by identifying beneficiaries with unique identifiers generated and not nominally.

13:30 – 13:45	Jacaranda 1 & 2	30.11.2015

MOAE0204: Track E/2 -

Effects of Strengthening District Health Systems on HIV Service Delivery Outcomes in Mozambique: Findings from the CHASS-SMT Project

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1Abt Associates, International Health, Bethesda, United States, 2CHASS SMT Project, Maputo, Mozambique

BACKGROUND: In 2014, the Clinical HIV & AIDS Services Strengthening Project in Sofala, Manica and Tete Provinces of Mozambique (CHASS-SMT) developed a comprehensive intervention to strengthen district health systems through the provision of health-facility technical assistance and support at the district level - the "Graduation Path". The hypothesis was that a stronger district health system would lead to improved quality of, and access to, clinical HIV services. Such intervention was provided only to 12 districts in those three provinces, also called "high-priority districts". The other 24 districts received a less intensive maintenance support package. The priority-district assignments were defined by the Mozambican Ministry of Health, and are followed by PEPFAR.

METHODS: With data collected monthly from more than 250 health facilities (HF) over a period of three years, we utilize difference-in-difference analyses to evaluate the impact of health system

strengthening interventions on improving clinical outcomes at HF level. This was possible since only the "high-priority" districts received the complete intervention at both HF and district levels. The key objective was to explore the impact of the intervention on HIV service delivery outcomes, and whether districts with stronger management capacities, as measured by a Graduation Paths score - GPS, measured by the project - also exhibited improved service delivery performance at the HF level. Our key outcomes are (i) number of new enrollees in ART and pre-ART, and (ii) percentage of HIV+ pregnant women in ANC that received ARVs for PMTCT. In addition, qualitative data are currently being collected to complement the quantitative results.

RESULTS: Preliminary results show that districts with higher GPS in the high-priority districts did improve their rates of new pre-ART enrollment and also increased their percentages of HIV+ pregnant women in ANC receiving ARVs for PMTCT, relative to districts with lower GPS and the non-priority districts.

CONCLUSIONS AND RECOMMENDATIONS: Our analysis shows promising though mixed results regarding the linkages between strengthened district health systems and improved service delivery outcomes. Our comprehensive set of qualitative and quantitative inputs help present a more complete picture of the complex set of health systems strengthening interventions that can influence service delivery performance at the district and facility levels.

13:45 – 14:00 | Jacaranda 1 & 2 | 30.11.2015

MOAE0205: Track E/2 -

Strengthening District Health Information Systems for Improved HIV Response in Primary Health Care Settings: A Root Cause Analysis of Challenges Faced in Nairobi County, Kenya

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BACKGROUND: Availability of timely, complete and accurate data is core to scaling up interventions for an effective and accountable response against HIV. The District Health Information System (DHIS-2) is a Monitoring and Evaluation framework that is used to collect, collate and analyze routine health information to inform programming at the health facility, district and national level .Specific to the HIV response, DHIS is useful to monitor ART service quality and coverage, and identify gaps. Significant progress has been made in ensuring data quality, however, challenges still exist in understanding and reporting on indicators. This report describes findings of a data verification exercise for PMTCT reporting in selected facilities in Nairobi, Kenya.

METHODS: We conducted a survey on the timeliness, completeness and accuracy of data reported on 3 key PMTCT indicators (Maternal HIV Positivity, Maternal Prophylaxis issued at first contact, infant prophylaxis issued at first contact) at 72 health facilities randomly selected from all the 9 sub-counties in Nairobi for the period July - Dec 2014. Data for the 3 indicators was reconstructed from the registers at the clinics, which was then compared with the data in the physical copy of the monthly summary report previously submitted by the facility and the data elements entered into DHIS.

Findings: For the entire county, 494 reports were available in DHIS(66% reporting rate), with 78% submitted on time. On the Maternal HIV Positivity indicator, the final verified figure was 2866, which was under-reported in the summary report and DHIS by 14% and 15% respectively. Final figure verified for infant prophylaxis was 1823, which was also under-reported in the summary report and DHIS by 24% and 28% respectively. On the other hand, maternal prophylaxis had a final verified figure of 1449, which was over-reported in the summary reported (18%), and DHIS (0.8%).

CONCLUSIONS AND RECOMMENDATIONS: The quality of data was affected by various factors including referral of clients to other service areas due to lack of integration of services, wrong use or failure to use updated versions of standardized registers and poor understanding of indicators by the health facility managers. A comprehensive strategy has been put in place to strengthen reporting by training on indicators, demand for quality data, regular data utilization meetings at all levels and routine comprehensive data verification exercises.

ABSTRACT DRIVEN SESSION

14:00 – 14:15	Jacaranda 1 & 2	30.11.2015

MOAE0206: Track E/2 -

Application of Geographic Information Systems for Monitoring HIV Commodity Stock Levels among Private-not-For Profit Health Facilities, Uganda

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ISSUES: Availability and use of health logistic information systems remains poor in several HIV commodity supply chains across Africa. Poor visualization of reported consumption data and stock-on-hand levels,limits information usage most supply systems including Uganda.

Currently, logistics information is being presented as tables, graphs and narratives, not explicitly representing geographical coverage. Geographic Information Systems (GIS) provide a portal for data visualization for decision making, however application towards logistics management remains underutilized in Uganda.

DESCRIPTIONS: In 2014, Medical Access Uganda Limited (MAUL) utilized a four-stage approach of linking Logistics Management Information Systems (LMIS) to GIS. Logistics staff were trained in GIS spatial and temporal analyses. GIS coordinates were then collected from 195 supported Private-Not-For-Profit health facilities in Uganda. Confirmation of coordinates was done using mobile-phone reconnaissance and merged into a central level LMIS database, to form cross-walk tables. Bi-monthly consumption for HIV indicator commodities and stock-on-hand data from January 2013 to December 2014, was then used to map and visually present stock-outs.

LESSONS LEARNT: GIS maps provided a simplified mechanism to visually present geographical coverage and LMIS-related data to relevant stakeholders. In addition, GIS maps representing consumption and stock-on-hand information, assisted to guide decision making thus averting stock-outs. Stock transfers based on Geo-proximity, availability or need of HIV commodity to or from the nearby health facilities to addressed stock imbalances. There was a decrease in the number of reported stock-outs from a monthly average of 8 health facilities in 2013 before intervention, to 3 health facilities in 2014.Application of GIS in logistics management is effective, inexpensive and requires minimal training investment.

NEXT STEPS: To improve visualization and reduce stock-outs at health facilities, visual representation of stock levels should be linked to enterprise resource planning tools to display real-time stock positions. Linking stock availability and epidemic data can also result into better epidemic control through informed decision making.

ABSTRACT DRIVEN SESSION

12:45 – 14:15	Prof Soudré Room	30.11.2015

MOAB0201: Track B/2 - Beyond HIV infection: co-morbidities
Chairs: Elly Katabira, Uganda

The Risk of Cervical Cancer in HIV-infected Women Receiving Antiretroviral Therapy Compared to HIV-negative Women in the General Population

12:45 – 13:00

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BACKGROUND: HIV-infected women receiving antiretroviral therapy have a lower risk of cancer relative to their ART-naïve counterparts. We sought to investigate whether the protective effect of HAART could further diminish the risk to the baseline level of uninfected women in the general population.

METHODS: A cross sectional survey of women aged 35 years and above, attending a voluntary screening campaign for cervical cancer at the Nkongsamba Regional Hospital in Cameroon between February and May 2014. Intake questionnaire obtained information on socio-demographics, HIV and HAART status, lifestyle, reproductive characteristics and family history of cancer. Cervical abnormalities were screened serially by visual inspection with acetic acid, visual inspection with Lugol's iodine and confirmed by Pap smear cytology. Multiple logistic regression was used to compare the odds of precancerous lesions and cancer in women on HAART to those in HIV-negative women.

RESULTS: Included were 277 women of whom 131(47%) were HIV-infected and receiving HAART on the site while 131(53%) were HIV-negative women from the community. Their mean age was 48.7;8.4 years though the HIV-negative group was on average older than the HAART-experienced group (50.1;8.3 versus 47.1;8.3 years respectively, p=0.003). The two groups also showed differences between them in their occupations, places of residence, marital status, levels of education and family history of cancer. The prevalence of precancerous and cancerous lesions in the HAART group was 15% while in the HIV-negative group it was 32% (p=0.02). After controlling for age and other covariates, women in the HAART group had a 66% reduction in the odds of cancer lesions compared with HIV-negative group [adjusted odd ratio (aOR) = 0.34, 95%CI: 0.15 - 0.76, p = 0.009). Every one year increase in age was associated with 1.05 times increase in the odds of a cancer lesion in both groups (aOR = 1.05, 95%CI: 1.00 - 1.11, p = 0.043).

CONCLUSIONS AND RECOMMENDATIONS: Women receiving HAART seemingly have a lower risk of cancer than HIV-negative women in the general population. This finding may not be attributed to HAART alone but to all the health benefits derived from a comprehensive HIV care.

13:00 – 13:15	Prof Soudré Room	30.11.2015

MOAB0202: Track B/2 -

Cervical Cancer: Experiences from a Cohort of HIV Infected Women in Harare, Zimbabwe

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BACKGROUND: Cervical carcinoma is preventable, but is the most common malignancy in Zimbabwean women. The most important primary prevention strategy is human papilloma virus (HPV) vaccination. Secondary prevention includes screening & treatment of pre-cancerous lesions. Women living with HIV (WLWHIV) have a higher prevalence of cervical HPV infection, & infection with multiple subtypes including oncogenic HPV. They are at increased risk of higher grade lesions, higher rates of recurrent & persistent cervical disease & invasive cervical cancer (ICC). This study was done in order to describe the prevalence of cervical disease & to provide evidence to support the need for cervical cancer screening for WLWHIV in Zimbabwe.

Newlands Clinic provides HIV care & treatment for 5500 patients, of whom 60% are female. Cervical cancer screening using the visual inspection with acetic acid (VIAC) methodology was introduced for sexually active females. VIAC is done & appropriate treatment with either cryotherapy, loop electrosurgical excision procedure (LEEP) or cervical biopsy is provided.

Objectives: The objectives of this study were to describe the prevalence of cervical disease in women attending cervical cancer screening, & to ascertain the histological diagnosis for cervical biopsy specimens.

METHODS: A record review of patients undergoing cervical screening from January 2011 to December 2014 was done. The percentage of women with VIAC positive lesions was assessed, & 326 histological specimens were analysed.

RESULTS: The percentage of women with VIAC positive lesions at initial cervical cancer screening in 2011, 2012, 2013 & 2014 was 34.9% (314/899), 32.4% (439/1357), 31.0% (126/406) & 33.0% (110/333) respectively. The mean for the 3 years was 32.8 %. Histological diagnosis confirmed CIN I, II & III in 15.7%, 30.0%, & 29.4% & ICC in 2%.

Conclusions & Recommendations: 1/3 of women attending initial cervical cancer screening had cervical disease as defined by the presence of a VIAC positive lesion. Histological diagnosis confirmed precancerous lesions with moderate to severe dysplasia in 59.4% & ICC in 2%.The data confirm the high prevalence of cervical disease in this cohort of WLWHIV & support the need for cervical cancer screening as a mandatory component of care for all WLWHIV. They also highlight the urgency for HPV vaccination as a primary prevention strategy.

13:15 – 13:30	Prof Soudré Room	30.11.2015
MOAB0203:	Track B/2 -	

Insulin Resistance in HIV Positive Individuals on Combination Antiretroviral Therapy in Chennai, South India

Jacob Saramma Mini, Anitha D, Mary Sushi K, Sivasangeetha K

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BACKGROUND: Insulin resistance (IR) is one of the long term complications of combination Antiretroviral Therapy (cART). Limited data is available from India on insulin resistance in HIV positive individuals. The objective of this study was to estimate the prevalence of insulin resistance among HIV infected individuals on cART in South India.

METHODS: A cross sectional study was conducted among consenting HIV infected men and women attending an ART clinic in Chennai, South India. Those who have completed one year or more on cART were enrolled into the study. Demographics collected included age, gender, ART regimen and duration of cART. Anthropometric measurements were taken and BMI was calculated. Fasting Insulin levels were tested using ELISA (Monobind Inc. USA). Fasting serum glucose and total cholesterol were measured by enzymatic-linked colorimetric methods. Insulin resistance was calculated applying the homeostasis model assessment (HOMA) formula.

RESULTS: From September 2013 to October 2014, 84 HIV positive patients were recruited into the study. Forty six (55%) were males and thirty eight (45%) were females. Their age ranged from 21-60 years with a mean age of 42; 8.1yrs. Duration of ART ranged from one year to eleven years. The recent mean CD4 counts were 575 ; 288 cells/;l and mean BMI was 21.7;3.62. Mean total cholesterol was 215 ; 41mg/dl and hypercholesterolemia was observed in 16 patients (9 males & 7 females).

The fasting blood sugar ranged from 65 to 236mg/dl with a mean value of 82 ;24.8mg/dl. The mean of fasting insulin was 21.73 ;IU/ml. Twenty six (31%) patients were diagnosed with IR by HOMA. IR prevalence was 58% in men and 42% in women. Of 26 patients with IR, 21 were on Zidovudine/Lamivudine/Nevirapine combination. There was positive correlation with CD4 and HOMA (r=0.09), and BMI and HOMA (r=0.19) and total Cholesterol and HOMA (r= 0.098).

CONCLUSIONS AND RECOMMENDATIONS: In this study, occurrence of insulin resistance was found to be high among the HIV positive individuals on ART. While cART decreases morbidity and mortality, risk to diabetes and cardiovascular events are high. Therefore these patients should be monitored for the development of artherosclerosis, hypertension and type II diabetes mellitus.

13:30 – 13:45	Prof Soudré Room	30.11.2015
MOAB0204:	Track B/2 -	

Occult Hepatitis B Infection (OBI) among HIV Infected Individuals in Nigeria

Oluremi Adeolu S

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ABSTRACT DRIVEN SESSION

BACKGROUND: HIV has been known to interfere with the natural history of hepatitis B virus (HBV) infection. In this study we investigate the prevalence of occult hepatitis B infection (OBI) among HIV infected individuals in Nigeria.

METHODS: Overall 1200 archived HIV positive samples were tested for HBsAg, Anti-HBc, anti HCV by ELISA. Polymerase Chain reaction was used for HBV DNA amplification and CD4 counts were analysed by cytometery.

Result: Nine hundred and eighty of the HIV samples were HBsAg negative. HBV DNA was detected in21/188(11.2%) of patients without detectable HBsAg CD4 count for the patients ranged from 2 to 2,140cell/L(mean=490cells/L of blood).HCV coinfection was detected only in 3/188(1.6%) of the HIV infected patients. Twenty-eight (29.2%) of the 96 HIV samples screened were positive for anti-HBc. Averagely, the HBV viral load was < 50copies/mL in the OBI sample examined quantitative PCR. The prevalence of OBI was significantly high among HIV- infected patients.

Conclusion and **RECOMMENDATION:** These finding highlight the significance of nucleic acid testing in HBV diagnosis in HIV patients.

13:45 – 14:00	Prof Soudré Room	30.11.2015

MOAB0205: Track B/2 -

Adverse Drug Reactions in HIV/AIDS Clinics in Western Kenya: A Review of Spontaneous Reports in Kenya AIDS Response Program between 2011 and 2014

Kuhora Kairang'a Samson1, Muga Oduor Samson1, Kabira Daniel2, Nyabiage Lennah3, Mutai Hellen3

1Kenya AIDS Response Program, Clinical, Nairobi, Kenya, 2Kenya AIDS Response Program, Management, Nairobi, Kenya, 3CDC Kenya, Kisumu, Kenya

BACKGROUND: Knowledge on drug safety in resource-limited settings is limited. This study was designed to evaluate spontaneous reports from HIV/AIDS clinics between November 2011 and October 2014.

METHODS: Crude Adverse Drug Reaction (ADR) reports in the national suspected ADRs (pv.1) format were submitted through the program for any cases identified in the HIV clinics. All individuals regardless of age and gender were included with the unit of analysis being a suspected ADR. Datasets from 1,967 reports were analyzed with respect to age, gender, reported ADR characteristics and outcomes using the EpiInfo, v7.1.1.14 software.

RESULTS: A significantly lower proportion of the cases, 3.8%, were reported in children (< 15 years) and 73.7% of the reported cases were in females; mean age at ADR presentation was 40.81 years. The most common cause of ADRs was Stavudine (d4T) at 64.1% with a median time-to-presentation (mTTP) of 1134 days (IQR 741 - 1641), the longest among the reported drugs. Other commonly reported causes are Zidovudine (AZT), 13.1%, mTTP 531 days (IQR 139-1172) and Efavirenz (EFV), 7.6% mTTP 193 days (IQR 16 - 738). The most common ADRs were lipodystrophies at 50.2% with 94.8% of these being attributed to d4T. 14.1% of the reactions were classified as severe with 0.3% of the cases resulting in a fatality. The severity of the reactions did not have a gender bias.

The most common intervention was a single drug regimen switch at 93.0%. Of the documented outcomes, most patients, 89.7% (810/903) either fully recovered or their status improved upon the intervention.

CONCLUSIONS AND RECOMMENDATIONS: In our review, ADRs in children were less likely to be reported or identified even after adjusting for d4T which was phased out among children. Historically, though taking longer to manifest, d4T has contributed to most of the reported ADRs. The proportion of TDF associated renal toxicities showed a gradual rise with increased TDF-based regimens uptake. We propose adoption of active pharmacovigilance especially among children and patients on TDF. Further characterization would be necessary to evaluate ARVs association with hypertension and diabetes in this patient population.

ABSTRACT DRIVEN SESSION

14:00 – 14:15	Prof Soudré Room	30.11.2015

MOAB0206: Track B/2 -

Severe Morbidity in HIV-infected Children before and after Initiating a Lopinavir-based Therapy before the Age of Two in West-Africa, 2011-2014

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BACKGROUND: To describe the incidence of severe morbidity before and after 12 months of early antiretroviral therapy (EART) initiation in West-African HIV-infected children treated before the age of two years.

METHODS: All HIV-1 infected children(confirmed by DNA PCR), < 2 years old, whose parents agreed toparticipate in the MONOD ANRS-12206 project in Abidjan (Côte d'Ivoire) and Ouagadougou (Burkina Faso), were included in an initial therapeutic cohort to receive an EART based on LPV/rtwice daily together with a cotrimoxazole prophylaxis and therapeutic education. We documented all severe morbid events (SME), leading to death or hospitalization, during the pre-inclusion period and within the first 12 months on EART. All SME were validated by a pediatric committee. Incidence rates (IR) of SME per 100 child-months (CM) of follow-up were computed with their 95% confidence intervals (CI); there were based on log-transformed IRs.

RESULTS: From August 2011 to February 2013, 177 HIV-infected children were pre-included (Abidjan: 110; Ouagadougou:67). Among these, 161 were initiated on EART (Abidjan:103; Ouagadougou:58). Before EART initiation, 47 SME occurred in 43 children, overall 9 (21%) died. The overall incidence of SME pre-ART was 35.33 per 100 CM (95%CI: 26.70-47.29). In Abidjan and Ouagadougou, this was respectively 21.37 (95%CI: 13.63-33.50) and 64.62 (95%CI: 44.62-93.59). Before EART, the main diagnoses (n=74) were gastroenteritis (24%), sepsis (16%), severe malnutrition (15%), respiratory infections (12%), anemia (9%), malaria (8%), tuberculosis (7%), others (9%). At EART initiation, median age was 13.5 months; 56% of the children reached WHO stage 3/4, median CD4% was 19% (IQR:13-26). During the first 12 months on EART, 71 SME occurred in 53 children; 14(8.6%) children died during the first 12 months of EART.The overall incidence of SME was 3.92 per 100 CM (95%CI:3.11-4.95); it was 2.71 (95%CI:1.91-3.83) and 6.22 (95%CI:4.54-8.51) in Abidjan and Ouagadougou, respectively. The main diagnoses (n=97) were gastroenteritis (27%), respiratory infections (24%), malaria (13%), anemia (10%), severe malnutrition (8%), sepsis (7%), others (11%). The median delay to SME after EART was 1.9 months (IQR: 0.7-6.9).

CONCLUSIONS: Despite a late access to EART, the incidence of SME was seven times lower after EART initiation compared to the pre-ART era, with a change in morbidity pattern. Earlier infant diagnosis is needed to initiate ART earlierin West-Africa.

NOTE

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Committee Room 6	30.11.2015
MOAE0301:	Track E/3 - Integration: orienting services across diverse needs	
Chairs:	Dr. Ihab Ahmed	

Integrating Health Prevention Information and Services for Employees in Private Sector Structures: Experiences and Lessons Learnt from Zimbabwe

16:45 – 17:00

Gatsi Theresa1, Chimbidzikai Tinashe1, Wong-Grünwald Ramona1, Kapamara Sympathy2

1GIZ, HIV Prevention Project, Harare, Zimbabwe, 2Family AIDS Caring Trust, Health and HIV Department, Mutare, Zimbabwe

ISSUES: The private sector plays an important role in the response to the disease burden of a country. However, the private sector often inadequately exposes employees to health prevention information and services. An example of successful cooperation between the private sector and an NGO in Zimbabwe demonstrates lessons learnt on how to reach employees effectively.

DESCRIPTION: Since 2011 and with support of GIZ the NGO Family AIDS Caring Trust (FACT) is implementing an Employee Wellbeing Programme (EWP) with private companies. The EWP approach includes information sessions led by peer educators on HIV, TB, malaria, cancer, hypertension and diabetes and linked to health services such as mobile HIV testing and counselling (HTC) and in-house clinical services including HTC, TB screening, ART initiation, care and treatment for PLWHA, PMTCT, family planning, condom distribution, ANC/deliveries, malaria treatment, STI screening and treatment among others. Company Safety, Health and Environmental Management (SHE) Officers were trained as EWP Focal Points to support peer educators, integrate clinic staff and to get buy-in from management. FACT provides continued technical backstopping including to management, arranges exchange visits among companies and trainings for peer educators, focal points and nurses.

LESSONS LEARNT: Annual person exposure rates for EWP information sessions increased by 86% from 10,660 in 2012 to 19,834 in 2014. HIV tests performed per year increased by 98% from 3,631 tests in 2012 to 7,217 in 2014. Since the start of the EWP some companies reported declining absenteeism especially for NCD, TB and malaria. One company decreased illness related absenteeism by 40% from 1008/year to 612/year after two years of implementing EWP. Accordingly, a 40% decrease has been seen in lost production due to absenteeism resulting in US$63,700 less average financial loss per year due to absenteeism.

NEXT STEPS: It is evident that EWP can effectively strengthen access to health information and services for employees in the private sector, if well integrated in given company structures, supported by medical staff and provision of clinical services on site. The success of these interventions is also dependent on management buy-in and partnership with other key service providers. Documentation of results and impact should be an integral part of results-based monitoring and continued advocacy for financial buy-in from companies needs to be achieved.

17:00 – 17:15	Committee Room 6	30.11.2015
MOAE0302:	Track E/3 -	

Integrating Social Protection and HIV Programs for Sustaining HIV Services for Informal Economy Workers

Muhika Damaris W1, Amakobe Hellen M2

1Central Organization of Trade Union in Kenya, Nairobi, Kenya, 2International Labour Organization, ILOAIDS, Nairobi, Kenya

ISSUES: Kenya has a HIV prevalence of 5.6% with the 15-49 year age group being most affected. The informal economy in Kenya accounts for 83% of the workforce (Economic Survey, 2014). Workers in the informal economy are hardly covered by social protection programmes. The National Social Security Fund (NSSF) covers about 1,175,300 workers, of whom 90% are from the formal sector. Similarly, the National Hospital Insurance Fund (NHIF) has a membership of 1,115,424 and 90% are from the formal sector.

DESCRIPTIONS: The Central Organization of Trade Unions in Kenya (COTU-K) has been working with informal sector associations to enhance coverage of informal economy workers to HIV and social protection initiatives. It has partnered with the International Labour Organization (ILO) through an OFID funded programme, to provide onsite HIV testing and counselling to informal economy workers at congregate worksites. This is coupled with sensitization on benefits of enrolling with social protection programmes and onsite registration with NHIF and NSSF. Advocacy

is done through involvement of informal business association leaders who lead by example. Social Protection and HIV sessions have been integrated in all training activities organized by COTU-K. As a result, 10,689 male and 8,101 female informal economy workers have been enrolled with NHIF and 6,124 male and 5,131 female informal workers with NSSF. NHIF offers comprehensive health care and maternity cover in public institutions for contributors and their dependants and in-patient services in private hospitals on a daily rebate basis. NSSF provides for future income security.

LESSONS LEARNT: Involvement of the informal economy leadership structures paved the way for enhancing access of HIV and social protection services to informal economy workers. Social Protection provides income security for PLHIV and informal economy workers and enables them to access HIV services.Trade unions have a significant role in reduction of HIV-related stigma and discrimination and enhancing the uptake of HIV testing, treatment and support not only in formal but also in informal workplaces. Onsite testing/enrolment of informal economy workers enhances the uptake and coverage of HIV services and social protection programmes.

NEXT STEPS: The programme is being up scaled with a view to enhance social protection coverage of informal economy workers as it is proving to be an essential element of sustaining HIV prevention, treatment and care.

17:15 – 17:30	Committee Room 6	30.11.2015

MOAE0303: Track E/3 -

HIV Sensitive Social Protection Programming Experience: A Critical Strategy to Address Impact of HIV and AIDS on Vulnerable Population

Munge Nelly W1,2

1HelpAge International EWCARDC, Nairobi, Kenya, 2AfricanPlatform for Social Protection, Nairobi, Kenya

ISSUE: Social protection is now recognized to involve Protection, Prevention, and Promotion. The socio economic ripple effects of HIV/AIDs pandemic shows the failure of economic growth. Social protection would seem like a prevailing instrument of choice for low income countries in combating poverty.

DESCRIPTION: The "Strengthening universal access to HIV/AIDS and Social Protection services to prevent and mitigate the impact of HIV and AIDS and poverty in sub-Saharan Africa" programme implemented in 5 countries is a HIV Sensitive Social Protection programme born from the tie that social protection can respond to wide ranges of different needs and vulnerabilities. The programme proves that despite the effects of HIV, Social protection is a key instrument assisting beneficiaries to survive, cope and alleviate the effects of shocks.

Social assistance: Like cash transfers, financial grants and livelihood programmes were transferred to older persons groups;

Social insurance: Such as Access to home-based care, HIV information and services and Advocacy for Policies, strategies and interventions to address the needs/rights of older carers such as accessing entitlements, identification papers and paralegal support to protect older persons from stigma and discrimination from other social protection schemes.

LESSONS LEARNT: Inclusion of older persons and their dependants in such a programmes requires consideration of several important factors;

a. Awareness of factors associated with aging that creates vulnerabilities for an older person and their dependants.

b. Low Literacy levels requires that the programmes to be simple, without complicated targeting and procedures and conditions.

c. Lack of awareness of HIV Transmission methods necessitates none identification of HIV affected families specifically but inclusion of all the most vulnerable in the communities while ensuring that there will be access to HIV Information.

NEXT STEPS: Advocacy and awareness creation to older people will be used to encourage to effective use existing structures to access both Social Protection and HIV Services.

The development and disseminations of Social Protection HIV behavioural communication messages is a key strategy which will encourage the beneficiaries to demand and for inclusion in necessary mechanisms.

Conclusion: HIV-sensitive social protection programmes can; Reduce vulnerability to HIV infection; Improve and support the lives of vulnerable people living with and affected with HIV.

ABSTRACT DRIVEN SESSION

17:30 – 17:45	Committee Room 6	30.11.2015

MOAE0304: Track E/3 -

Link-up Project Reaches Very Young Adolescents (Ages 10-14) with Quality, Appropriate and Integrated SRHR and HIV Services

Nakazzi Gracie1, Katooke Racheal2, Nassaka Jacqueline3, Musubika Winnie4, Caswell Geogina5, Elang Margret1, Tuhaise Mark6

1Community Health Alliance Uganda (CHAU), Kampala, Uganda, 2Family Life Educational Programme, Jinja, Uganda, 3Uganda Youth Development Link, Kampala, Uganda, 4Naguru Teenage Information and Health Centre, Kampala, Uganda, 5International HIV/AIDS Alliance, Cape Town, South Africa, 6Mildmay Uganda, Wakiso, Uganda

ISSUES: According to the AIDS Indicator Survey (AIS) 13% young women and 12% of young men aged 15-24 in Uganda reported that they had sex before the age of 15.10% of girls are married off before the age of 15, while boys have to support their families. 10-14 engage in sexual activities as a way to gain social acceptance. They lack adequate SRHR/HIV information.

It is a challenge to provide SRHR/HIV services/information to the 10-14 because they need consent from parents and caretakers. Yet most caretakers do not want them to access this information for fear of exposure to sexual and risky behaviors.

DESCRIPTIONS: Link Up is a three-year programme implemented with 10 national and 2 local organisations in 13 districts in Uganda. The programme seeks to increase access to SRHR and HIV information and services for young people most affected by HIV (10-24 years).

Link Up employs the following strategies to reach 10-14 years with SRHR/HIV information/ services:

- training 10-14 as peer educators to pass on information to their fellow peers;

- production of IEC materials focused body growth and development;

- Media engagements through teen radio talk shows

- use of edutainment and interactive learning activities like; MDD, sports and film shows;

- targeted outreach like; camps, teen and school outreaches;

- Community dialogues with parents and caretakers on SRHR/HIV and their roles.

Key **RESULTS:** Between October 2013 to March 2015, Link Up has achieved the following:

- 50 (10-14 old) people trained as peer educators on SRHR/HIV issues;

- 18,397 (10-14years) reached with integrated SRHR /HIV information and services;

- 30 community dialogue meetings conducted with parents and caretakers on SRHR/HIV.

LESSONS LEARNT:

- 10-14 interested in receiving SRHR and HIV information and services with influenced from parents.

- Community dialogues with parents and caretakers are important since they demystify misconceptions about promotion of sexual behavior among young people.

- SRHR/HIV information given to 10-14years should be basic, participatory and attractive.

- 10-14 can be reached through schools and through innovative community approaches.

NEXT STEPS: Continued investment in peer-led interventions as part of SRHR and HIV programming is critical, as is the involvement of parents, teachers and caretakers in community dialogues on SRHR and HIV since they are key influencers in decision-making for 10-14 year old.

ABSTRACT DRIVEN SESSION

17:45 – 18:00	Committee Room 6	30.11.2015

MOAE0305: Track E/3 -

Integration of HIV/AIDS and Cervical Cancer Programs for Improved Health Outcomes

Nyamupachitu Theresa

IMA World Health, Programs, Washington, United States

ISSUES: Tanzania faces a dual disease burden of HIV/AIDS and cervical cancer (CaCx). Women living with HIV have been found to be 8 times more likely to develop CaCx than women who were not HIV+. If detected early and the pre-cancerous lesions treated, CaCx is almost 100% preventable.

DESCRIPTION: IMA World Health (IMA) supports the Cervical Cancer Prevention and Control Program (CECAP), integrating CaCx interventions into existing HIV/AIDS services to leverage resources and create strong referrals between the two programs. The GOT has adopted Visual Inspection with Acetic Acid (VIA) and treatment of precancerous lesions with cryotherapy (cryo). At the facility level, screenings are conducted, and if diagnosed with pre-cancerous lesions, women are treated with cryo on the same day. Clients detected with large cervical lesions are referred for further management at other health facilities. Women are also screened for HIV and if found positive, are immediately linked to HIV care and treatment. At the community level, IMA works with health teams to conduct mass screenings of women in remote areas for CaCx and HIV.

LESSONS LEARNT:

• High demand for CaCx treatment services. On average 450 women per month screened; 23,530 women between 20-40 years of age, and all HIV positive women.

• The average VIA positivity rate among 23,530 women is around 6%.

• VIA and SVA are cost effective and efficient in low resource settings. Bottle of Acetic Acid costs $3.50 and can run 90 tests. Cryo machines cost $3000. 86% of VIA + women were treated same day;14% referred for further management.

• 6-day training course of over 100 health workers builds capacity in CaCx screening and treatment.

• Integrated CaCx/HIV programs are efficient and effective. Serves as an entry point to HIV testing and counseling and referral link to care and treatment. 36% of HIV+ women were linked to care and treatment.

NEXT STEPS:

• Continued integration of CaCx interventions into HIV/AIDS programs.

• Scale up of the HPV Vaccination program to provide the greatest protection against CaCx.

• Integration of CECAP into all health system components.

• Strengthen referral system for complicated cases through provision of LEEP machines and punch machines at all Regional Hospitals.

• Explore mechanisms for reducing/eliminating client user fees for advanced services.

• Advocacy to donors on the integration of CaCx programs into HIV care and treatment programs.

18:00 – 18:15	Committee Room 6	30.11.2015

MOAE0306: Track E/3 -

Improving Maternal, Neonatal and Child Health (MNCH) through the Results Based Financing Programme for Health in Zimbabwe

Seid Endris M, Rietsema Arjanne

Cordaid Zimbabwe, Health, Harare, Zimbabwe

ISSUES: Maternal Mortality Ratio (MMR) in Zimbabwe has increased from 570/100,000 live births in 1990 to 920/100,000 live births in 2010. The under 5 (< 5) mortality rate has also increased from 75 to 103/1000 live births from 1990 to 2010.

DESCRIPTIONS: In view of this, the World Bank between mid-2011 and 2015, awarded grants

to the Government of Zimbabwe, to pilot and roll out Results Based Financing for Health (RBF)-a strategy of financing health care delivery based on results (output, performance), which are measured through predefined indicators at 394 rural health centres and district hospitals in 18 rural districts.

The program is implemented by CORDAID, a Dutch based NGO and is meant to support the Ministry of Health and Child Care in its effort to increase the availability, accessibility and utilisation of quality health care to improve maternal and child health at primary and secondary health facility level by providing free MNCH services.

Inorder to assess the program, a pre-defined list of indicators including PMTCT with prices were developed to assess the quantitative aspect of service delivery. Likewise a comprehensive quality checklists including retention on care of pregnant women on ART, and client satisfaction survey tool were developed to assess the provider and perceived aspect of quality of care, respectively. The quantity indicators are assessed by CORDAID field health officers monthly while the quality checklists and client satisfaction survey tools are administered by District and Provincial Health Executives and Community Based Organizations, respectively.

LESSONS LEARNT: The number of children and women getting MNCH services including PMTCT services has shown an increased trend over time. The quality scores have also increased from 55% in 2012 to 80% in 1st quarter of 2015. As a country, MMR and < 5 Mortality has decreased to 470 and 89 in 2013, respectively and the program might have partly contributed to these achievements as it is MNCH focused and improves the referral linkage between primary and secondary level facilities.

The program has contributed to the health system strengthening by improving health information; availing medicines; creating a motivated health force through incentivizing performances; and autonomous leadership that can utilize the subsidies as per their priorities.

NEXT STEPS: Impact evaluation studies should be conducted inorder to evaluate the program and take measures accordingly.

16:45 – 18:15	Committee Room 4	30.11.2015

MOAD0201: Track D/2 - Improving access to integrated SRHR and HIV
Chairs: Rennius Mundigi

Differentials in Fertility Desires and Contraceptive Use among HIV Positive Women Receiving HIV Care Services in Kampala, Uganda 16:45 – 17:00

Gwokyalya Violet1, Matovu Joseph KB1,2, Wanyenze Rhoda K1,3

1Makerere University School of Public Health, MakSPH-CDC Fellowship Program, Kampala, Uganda, 2Makerere University School of Public Health, Department of Community Health and Behavioral Sciences, Kampala, Uganda, 3Makerere University School of Public Health, Department of Disease Control & Environmental Health, Kampala, Uganda

BACKGROUND: Fertility desires and contraception among HIV-positive women may differ by antiretroviral therapy (ART) enrollment status. We explored differentials in fertility desires and contraceptive use among HIV-infected women receiving HIV care services at two urban clinics in Kampala, Uganda to inform appropriate health services planning for this population.

METHODS: We analyzed cross sectional survey data of 512 HIV infected women aged 18-49, attending two urban HIV clinics in Kampala Uganda. Data were collected on socio-demographic and reproductive health characteristics (including past and current pregnancy), ART status, duration on ART, desire for future pregnancies and contraceptive use. Descriptive, bivariate and multivariable analyses were conducted to test for differences in fertility desires and contraception between those on ART and ART naïve women.

RESULTS: Majority of the women were young (62.9% aged 18-34); and had primary or no education (53.1%). Overall, 76.2 % of women were receiving ART and 45.6% of those on ART had taken it for at least 3 years. Overall, 43.7 % had ever been pregnant since HIV diagnosis while7.4% were currently pregnant. Of those who were not currently pregnant; (n=75, 15.8 % desired to have another child immediately; (n=181, 38.2 %) desired to have a child but later; while (n=218, 46 %) were not sure/did not want to have another child at all in future. There was no significant difference in future desire for another child among those who were on ART (n=198, 54.7%) compared to those who were not (n=58, 51.8%; P=0.59). A significantly higher proportion of women who were not sure/did not want another child (n=142, 65.1%) reported current use of effective modern FP methods than those who wanted another child in future (n=131, 51.2%; p-value=0.002). Use of effective modern contraception was higher in women who did not desire to have another child and were not on ART (n=39, 72.2 %) than those who did not desire to have another child and were on ART (n=103, 62.8 %), although this difference did not reach statistical significance (P=0.21).

CONCLUSIONS AND RECOMMENDATIONS: ART enrollment did not influence fertility desires and modern contraceptive use among HIV-infected women. However unmet need for contraception is still high (34.9%) among HIV infected women. These findings suggest a need for appropriate interventions aimed at reaching HIV-infected women irrespective of their ART status with reproductive health services.

ABSTRACT DRIVEN SESSION

17:00 – 17:15	Committee Room 4	30.11.2015
MOAD0202:	Track D/2 -	

How Effective Is Sexual and Reproductive Health Counselling in Reducing Unintended Pregnancies and STIs among HIV Positive Women in Kenya?

Kisaakye Victoria Kanobe1, Kombe Yeri2, Ngure Kenneth3

1UNESCO, Education, Johannesburg, South Africa, 2KEMRI/CPHR, Nairobi, Kenya, 3Jomo Kenyatta University of Agriculture and Technology (JKUAT), Nairobi, Kenya

BACKGROUND: For over eight years, Kenya has been trying out four models of Sexual and Reproductive Health (SRH)/HIV integration innovations i.e. through stand-alone family planning clinics and post antenatal clinics, through STI screening clinics, through HIV counselling and testing sites and through HIV care and treatment centres. There was however limited evidence in comprehending the extent to which health workers and counselors implementing SRH counseling services within the comprehensive care centres provide quality and effective services to HIV positive women help avoid unintended pregnancies and also reduce the risk for acquiring STIs and transmitting HIV to their unborn babies.

METHODS: A case control study was carried on 71 cases and 71 controls aged between 18 and 49 years was selected to establish the prevalence of STIs and unintended pregnancies in women living with HIV that have undergone SRH counseling at the CCCs and those that did not. Quantitative & qualitative methods of data collection and analysis using chi squares (at p=0.001 and 0.05) and odds ratios were utilized to analyze the relationships among variables. The study also explored factors that promote or hinder the utilization of SRH counseling information and services provided to women living with HIV at the CCCs in Langata constituency.

RESULTS: The findings show a close match for demographical data amongst the cases and controls in terms of the age, education level, period and frequency for accessing SRH service with HIV diagnosis with women aged 30-39 years seeking the SRH counselling services more among the cases and controls as compared to other age groups. Among the cases, all HIV positive women were equally and likely to get unintended pregnancies irrespective of whether they had received SRH counselling or not (odds ratios [OR]: 1.114; 95% confidence interval [CI]: 0.427-2.911). The study further reveals a statistically significant association between the prevalence of STIs amongst HIV positive women that have undergone SRH counselling and those that have not undergone counselling (X2 1= 0.049, p=0.825) at p< 0.05.

CONCLUSIONS AND RECOMMENDATIONS: Factors such as stigma and discrimination, lack of follow-up, financial and logistical to access the health facility, the long queues are impacting on the uptake of SRH counselling services. This calls for more training for SRH counsellors; more mentorship and constant support supervision to uphold their proficiency in SRH.

17:15 – 17:30	Committee Room 4	30.11.2015
MOAD0203:	Track D/2 -	

Violations of Sexual Reproductive Health and Rights of Women Living with HIV within Clinical Settings in Uganda: Cases of Forced and Coerced Sterilization

Mworeko Lillian Kyomuhangi1, Mworeko Lilian1, Azizuyo Brenda Facy2

1International Community of Women Living with HIV &AIDS Eastern Africa (ICWEA), Kampala, Uganda, 2International Community of Women Living with HIV & AIDS Eastern Africa (ICWEA), Arua, Uganda

BACKGROUND: Sexual reproductive health and rights (SRHR) violations among women living with HIV (WLHIV) are a concern, despite existing policy frameworks for human rights protection. The Uganda Stigma Index (2013) showed that 12% of female respondents had been coerced into sterilization by health care providers because of their HIV status.

Objectives: As part of the Link Up project, the International Community of Women Living with HIV Eastern Africa (ICWEA) conducted a study in 2014 to examine SRHR violations of WLHIV in the reproductive age within HIV and SRH clinical settings with a focus on forced and coerced sterilization.

Method: The research was conducted in 8 districts & included desk review, focus group discussions, in-depth interviews, case studies & a quantitative field survey.

ABSTRACT DRIVEN SESSION

Respondents included 700 WLHIV, service providers, district leaders, CSOs & men. 35 young WLHIV were trained as research assistants, which proved to be an empowering process in itself.

RESULTS: WLHIV experience SRHR violations in clinical settings, communities and at home, ranging from misinformation, mistreatment and abuse to forced or coerced tubal ligation.

24 Cases of coerced or forced sterilization between 1991-2014 were recorded. These mostly occurred during child birth and through misinformation, where women were made to believe sterilization was the best option given their HIV status & were also made to understand that it could be undone if they wanted to have children in future. Power dynamics between health workers and women, and childbirth through C-section, limited women's choices.

Forced & coerced sterilization impact women's lives, resulting in divorce, violence, psychosocial problems, being ashamed by the clan and loss of economic and social support. Even though most women knew they could seek legal redress, none had done so.

Conclusion: WLHIV who have undergone forced sterilization need: psycho social support to raise their self-esteem; legal aid; and financial support for infertility treatment.

Recommendations:

1) Build WLHIV's capacity & agency to resist violations and seek legal redress

2) Conduct massive sensitization campaigns on quality & non-discriminatory care, right information & rights-based service delivery;

3) Support and improve the performance of institutions to provide effective legal services for women;

4) Promote psycho social support through support groups.

Keywords: SRHR violations, Uganda, young women

17:45 – 18:00	Committee Room 4	30.11.2015

MOAD0204: Track D/2 -

A Male Friendly Approach to Prevention of Mother to Child Transmission of HIV: Men's Perspectives from Mashonaland East, Zimbabwe for Promoting Male Involvement for Optimal Health Outcomes

Chitiyo Vivian, Webb Karen M, Ndoro Theresa, Patel Diana, Mbetu Patricia, Page-Mtongwiza Sara, Engelsmann Barbara

Organisation for Public Health Intreventions and Development, Operations Research, Harare, Zimbabwe

BACKGROUND: Prevention of mother to child transmission of HIV (PMTCT) interventions have been integrated within the antenatal care (ANC) settings, which traditionally focused on women. Men's involvement in ANC services are critical for the utilisation of PMTCT interventions among pregnant and breastfeeding women. In 2013, a low proportion (17%) of the male partners of antenatal care attendees was tested for HIV in ANC settings in Zimbabwe. The objective of the study was to investigate men's perspectives of a "male friendly" ANC facility to actively engage men in PMTCT.

METHODS: From December 2013 to March 2014, 309 male partners of pregnant or lactating women who had received ANC/PMTCT services at twelve health facilities in Mashonaland East Province were randomly selected for participation in a study to assess male involvement in ANC/PMTCT. Data were collected using open ended pre-tested questionnaires. To provide depth to the questionnaire data, six focus group discussions were conducted at community level with 59 men purposively selected in the catchment areas of participating health facilities. The thematic approach was used to analyse the qualitative data.

RESULTS: The median age of participating men was 31 years and 67% resided in rural areas. Participants emphasised the need for intensive community and workplace awareness campaigns as the foundation to improve men's understanding of the PMTCT program to promote positive family health seeking behaviour. Availability of services during non-working hours including weekends was repeatedly reported as critical to men's involvement in PMTCT in the context of patriarchal societies where traditional norms point to men as bread winners. Trained, competent and welcoming health care workers that are able to serve couples in a timely private and confidential manner was an essential requirement for male friendly service provision. Participants highlighted that male friendly services should have more male service providers for engaging and offering psychosocial support.

CONCLUSIONS: Improving and strengthening male involvement in PMTCT services offered in ANC settings requires a "male friendly" approach. This qualitative study highlight the urgent need for targeted interventions going beyond structural components and addressing knowledge and awareness gap, processes, service availability and interpersonal relationships towards a "male-friendly" environment for increased involvement in the PMTCT program.

ABSTRACT DRIVEN SESSION

18:00 – 18:15	Committee Room 4	30.11.2015

MOAD0205: Track D/2 -

Difficulties in Accessing PMTCT Services in Post-conflict Zones of Bakassi in the South West Region of Cameroon

Lundi-Anne Omam Ngo Bibaa, Esther Omam Njomo, Hans Effesoa Mosenge

Reach Out Cameroon, Health Department, Buea, Cameroon

In Cameroon, with approximately 48,736 children living with HIV in 2010, only 36.5% of pregnant women were seen at first ANC. ARV coverage in HIV-positive pregnant women was 20.3% and 34.5% for their exposed babies. In rural areas only 46% of pregnant women who reach the health facility are attended to by skill personnel. In post-conflict zones such as Bakassi of the South West Region of Cameroon; difficult accessibility, bad roads, poor communication network, kidnapping and pirate attacks further compounds the low ANC attendance. This study sought to identify the difficulties faced by women in post-conflict areas in accessing PMTCT services.

LESSONS LEARNT: The constant threat of kidnapping or pirate attacks faced by women in these enclave communities contributed largely to the poor use of health facilities. The under-equipped nature of the health centers were also earmarked. Most participants acknowledged giving birth at home or in churches, since it was safer and health facilities were too far off. The poor state of the roads especially during the rainy seasons also accounted for most home deliveries. Lack of information, ignorance, cultural factors, and the non-willingness of male partners in attending clinics with women were highlighted. Stigma and discrimination is still very high in these communities. The myths of family planning prevents women from using these services.

NEXT STEPS: A re-enforced security system, improved communication network, good roads and adequately equipped health centers are required in these zones. Furthermore, resource centers that provide women and men with information and services to prevent MTCT, treat, care and support PLHIV are also required. A comprehensive community education component will contribute in boosting uptake of PMTCT services by women in post-conflict zones.

18:15 – 18:30	Committee Room 4	30.11.2015

MOAD0206: Track D/2 -

Provision of Comprehensive Sexuality Education and Youth Friendly Healthy Services: An Effective Strategy for HIV Prevention in Malawi

Njatiyamphongo Moffat

Education Expertise Development Foundation, Programmes, Blantyre, Malawi

ISSUES: Sexual and reproductive health and rights (SRHR) and HIV among adolescents (10-24) are major public health issues in Malawi. Adolescents represent more than 30 percent of Malawi's population. A recent national survey showed that sex debut in some children as early as at age 10. Low rates of contraceptives and safe sex practices at first sex were reported. Among 15-19 age group sex with multiple partners is reported common. Access to SRH services was reported as an unmet need. This results in high number of new HIV infections and STIs among adolescents. Adolescents account for half of all new HIV infections in Malawi.

Despite the Ministry of Health in Malawi invested heavily in the provision of SRHR services for adolescents, access, acceptability and uptake of the services among young people is still too low because the services are not youth friendly (YFHS).

DESCRIPTIONS: The education in Malawi provides an opportunity for effective HIV prevention. The school attendance rates show that 80% of young Malawians aged 6- 13, 60% of 14 - 17 and 40% of 18-20 are in school. Life skills Education is already taught in school but it does not empower adolescents with adequate knowledge and skills that can help them prevent HIV infection.

Our experience has shown that the most effective way [DH1] to fight HIV infection among young people is through provision of age-appropriate CSE within the school system with an element of linking schools to YFHS centres. We are implementing this strategy 26 primary schools and we are already seeing positive change. More young people have come to realize that they share amongst themselves myths and misconceptions that have made them vulnerable to HIV. Their attitudes, risk perception and knowledge of HIV related issues have changed positively.

The component of HIV testing would mean "more adolescents knowing their HIV-status", which is an entry point for HIV prevention, treatment, care and support.

LESSONS LEARNT: Providing CSE without youth friendly healthy service provision is not effective.

Parenting education is needed to build the capacity of parents for them to discuss sexuality issues with their children.

NEXT STEPS: Lobby government to introduce CSE within formal school curriculum is a sustainable way of reducing HIV infection.

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Jacaranda 3	30.11.2015

MOAE0401: Track E/4 - Quality improvement and surly challenge
Chairs: Prof Chewe Luo

Contribution of Primary Healthcare Centres to PMTCT Coverage in Nigeria

16:45 – 17:00

Olakunde Babayemi, Oladele Tolulope, Alau Kenneth, Alagi Matthias, Wakdok Sabastine, Mamadu Ibrahim

National Agency for the Control of AIDS (NACA), Abuja, Nigeria

BACKGROUND: Prevention of mother-to-child transmission of HIV (PMTCT) services has been decentralized to primary healthcare centres (PHCs) since 2010 as an implementation strategy to improve PMTCT coverage in Nigeria. More PHCs with antenatal care services have been activated to provide antiretroviral (ARV) prophylaxis to HIV pregnant women as well as early infant diagnosis services for HIV exposed infants (HEI). The PHCs are also involved in community outreaches to increase uptake of PMTCT. With the underutilization of primary healthcare services in Nigeria as a result of loss of public confidence, it has become imperative to review the performance of the PHCs in PMTCT service delivery.

METHODS: A retrospective review of service data (January-December 2014) from Global Fund (GF) supported public health facilities was conducted. Key indicators along the PMTCT cascade were assessed.

RESULTS: A total of 986 public health facilities provided PMTCT under the GF Project in Nigeria. PHCs accounted for 75% (744) of these facilities. The total number of pregnant women counselled, tested and received result were 1,233,149 in 2014 in GF sites. Of these, 658,160(53%) were seen in PHCs as opposed to 574,989 (47%) tested in the Secondary health facilities. Ten thousand and seventy women were found positive in all, 40% (4034) of these women were those tested in PHCs resulting in a positivity rate of 0.6% among women counselled and tested in PHCs. Ninety three percent (3,752) of those women found positive in PHCs received ARV prophylaxis, accounting for 36% of all positive women in GF public health sites who received ARV prophylaxis. Only 15% (568) of women who received ARV prophylaxis in PHCs delivered there and 91% of infants born to these women had a Polymerase Chain Reaction (PCR) test within 2 months of life. Number of infants who had a PCR test within 2 months in all GF sites were 2936, 18% of them were infants born in PHCs.

CONCLUSIONS AND RECOMMENDATIONS: The contribution of PHCs to PMTCT coverage in GF sites in Nigeria ranges from as low as 18% in the provision of EID services to as high as 53% of all women counselled, tested and received result. PHCs recorded minimal loss to follow up along the cascade except for number of women who delivered in the facilities. Efforts should be directed towards improving uptake of facility delivery and strengthening tracking/follow-up at the PHCs.

17:00 – 17:15	Jacaranda 3	30.11.2015

MOAE0402: Track E/4 -

Option B+ Implementation in Rural Zimbabwe Accelerates General ART Provision: The Lablite Experience

Muzambi Margaret1, Ford Deborah2, Nkhata Misheck J3, Abongomera George4, Joseph Sarah2, Mabugu Travor1, Ndlovu Makhosonke1, Reid Andrew C1, Cataldo Fabian3, Kityo Cissy4, Hakim James G1, Gibb Diana M2

1University of Zimbabwe, Clinical Research Centre, Harare, Zimbabwe, 2University College London, Medical Research Council Clinical Trials Unit, London, United Kingdom, 3Dignitas International, Lablite, Zomba, Malawi, 4Joint Clinical Research Centre, Lablite, Kampala, Uganda

BACKGROUND: Lablite is an implementation project working with the Zimbabwe Ministry of Health and Child Care to evaluate ART provision at a district hospital and 3 primary care facilities in Zvimba district. Option B+ (lifelong ART for pregnant/breastfeeding women) was rolled out from March 2014.

METHODS: Routine individual patient-level data were collected from ART registers, attendance registers and facility patient cards. Most recent visit or outcome was used to estimate retention in care and lost to follow-up was defined as not seen for 97 days (1 week leeway for late visits).

RESULTS: Across 4 facilities (including one where ART roll-out began with Option B+) there were 1682 ART initiations between 09/2013-02/2015, 1523(91%) in adults. In the 3 facilities with established ART provision, initiations rose from 300 during 6 months prior to Option B+ to 867 (2.9-fold) and 463 (1.5-fold) respectively 0-6 and 6-12 months post Option B+. Increased initiations were seen in all patient groups, largest among pregnant/breastfeeding women. Post Option B+, 59/440(13%) of pregnant/breastfeeding women had WHO stage 3/4 and 191/381(50%) with WHO stage 1/2 had a CD4 recorded (34%≤350, 58%≤500), implying 43% pregnant/breastfeeding women were eligible for treatment based on WHO stage 3/4 or CD4≤350 (63% for CD4≤500).

Estimated retention on ART at 6 months in 1,107 non-Option B+ patients starting ART for WHO

stage 3/4 or CD4< threshold was 87% (95%CI 85%-89%). Retention in 384 Option B+ women starting ART during pregnancy/breastfeeding with WHO stage 1/2 was 85% (95% CI 81%-88%) (difference, p=0.25). There were no losses to follow-up among 7 Option B+ women at the facility with new ART provision. In the other 3 facilities attrition of Option B+ women was higher in adolescents < 20 years at initiation (HR 2.35 [95%CI 1.18-4.65]; p=0.02) and higher in women who started ART during pregnancy vs. breastfeeding (HR 1.43 [0.82-2.51]; p=0.21).

CONCLUSIONS AND RECOMMENDATIONS: Rollout of Option B+ is accelerating general ART provision in decentralized health facilities in Zimbabwe. Staging and CD4 testing of pregnant/breastfeeding women identifies a substantial proportion eligible for treatment outside PMTCT; continuing to identify these women could ensure optimization of care and follow-up. At 6 months retention of Option B+ women was similar overall to retention of other ART patients; adolescents require special attention as they are more likely to disengage from care.

17:15 – 17:30	Jacaranda 3	30.11.2015

MOAE0403: Track E/4 -

ARV Pédiatriques Recommandés par l'OMS: Accès au Point de Dispensation. Evolution dans 24 Sites de Prise en Charge du VIH Pédiatrique en Afrique Entre 2011 et 2014

Zio Réjane1, Langlois Julie2, Masson David3, Lebost Céline4, Grandir Associations Partenaires3

1Sidaction, Paris, France, 2Hôpital Saint Antoine, Paris, France, 3Sidaction/Initiative Développement, Paris, France, 4Initiative Développement, Poitiers, France

BACKGROUND: *Lablite is an implementation project working with the Zimbabwe Ministry of Health and Child Care to evaluate ART provision at a district hospital and 3 primary care facilities in Zvimba district. Option B+ (lifelong ART for pregnant/breastfeeding women) was rolled out from March 2014.*

CONTEXTE: Grandir, programme de renforcement des capacités des acteurs de prévention et prise en charge du VIH pédiatrique en Afrique, exécuté par Sidaction et ID, a dressé avec les sites associatifs partenaires un panorama de l'accès aux ARV pédiatriques recommandés par l'OMS en 2013.

Méthodes: 24 sites dans 9 pays (Bénin, Burundi, Cameroun, Congo, Côte d'Ivoire, Mali, RDC, Tchad et Togo) suivant 5500 enfants infectés dont 3800 sous ARV, ont été interrogés en 2011-2012 et fin 2014. Un questionnaire sur la disponibilité des ARV à dosages pédiatriques (combinaisons à dose fixe CDF et formes séparées), de la PCR et du Plumpy Nut, a été rempli lors des missions ou par courriel. La disponibilité au niveau central a aussi été renseignée.

Résultats obtenus: En 2014: La combinaison de 1ère intention AZT60mg+3TC30mg+NVP50mg en CDF est disponible sur 67% des sites (33% avant 2013). AZT60mg+3TC30mg CDF sur 63% des sites (25% avant 2013). La combinaison ABC60mg +3TC30mg est disponible sur 58% des sites (aucun n'en disposait avant). Aucun site ne dispose d'ABC60mg+3TC30mg+NVP50mg en CDF. 2 sites n'ont accès à aucune CDF de 1ère ligne (7 sites étaient dans ce cas en 2011-2012).

La NVP10mg/ml est accessible sur 75% des sites (46% en 2013). Seuls 13% des sites ont accès à la NVPcp50mg (aucun avant).

L'AZT10mg/ml est accessible sur 54% des sites (50% avant 2013).

2 sites n'ont accès à aucune forme buvable utilisable à la naissance (1 seul dans ce cas en 2011-2012). L'EFV200mg, indiqué en 1ère intention à partir de 10kg, est disponible dans 58% des sites en 2014 (29% avant 2013).

Le LPV/r sirop et comprimé pédiatrique sont disponibles que pour 13% des sites (4% avant 2013). Le sirop seul est accessible sur 46% des sites (21% avant 2013). Pour les sites restants le LPV/r200+50mg pour adulte est prescrit à des enfants >15kg.

Conclusion: En 2 à 3 ans, les CDF, plus pratiques et appréciées des enfants, se sont répandues mais manquent encore dans plus d'un tiers des sites. Pour 1/4 des sites, les formes séparées ne sont pas disponibles, obligeant encore à 'bricoler' avec des dosages adultes. Le LPV/r pédiatrique, indiqué pour tout enfant pré exposé à la NVP, progresse lentement mais reste accessible dans moins d'un site sur 2. La situation au niveau central est meilleure que sur les sites dispensateurs. Ces données seront partagées avec les sites partenaires et les responsables nationaux. Le recueil des données se poursuivra en 2015 et 2016 et s'étendra à 3 nouveaux sites.

ABSTRACT DRIVEN SESSION

17:30 – 17:45	Jacaranda 3	30.11.2015

MOAE0404: Track E/4 -

Determinants of Forecast Accuracy for Paediatric Antiretroviral Drugs in Kenya

Njogo Susan Muthoni

National AIDS/STI Control Program, Commodity Management and Logistics, Nairobi, Kenya

BACKGROUND: To ensure uninterrupted supply for antiretroviral drugs, the Ministry of Health, Kenya conducts annual quantification. Monthly review of available stock at national store and quantities under procurement have revealed existing and/or potential overstocking and/or under stocking of various paediatric antiretroviral drugs. Dosing of antiretroviral drugs among children is weight dependent. Demand forecast for paediatric antiretroviral drugs has been challenging due to lack of data on proportion of children on various weight categories leading to assumptions that children below age of 15 years weigh < 25Kg and use paediatric formulations. This study aimed to establish forecast accuracy for paediatric antiretroviral drugs in Kenya and determine factors affecting forecast accuracy.

METHODS: Mean Absolute Percentage Error (MAPE) was calculated for seven paediatric antiretroviral drugs for periods 2010/11, 2011/12 and 2012/13. Randomness of forecast errors was tested using Augmented Dickey Fuller and Run tests. Retrospective longitudinal cohort design was used to determine effect of age and weight on antiretroviral formulations dispensed to children at a selected public health facility. Univariate, bivariate, within-subject effects and population-averaged logistic regression data analysis were done.

RESULTS: There were 311, 306 and 285 children studied for periods 2010/11, 2011/12 and 2012/13, respectively. Forecasts for six paediatric formulations namely abacavir/lamivudine-60/30mg; zidovudine/lamivudine-60/30mg; zidovudine/lamivudine/nevirapine-60/30/50mg; efavirenz-200mg; Lopinavir/ritonavir-80/20mg and zidovudine-10mg/ml were found to be inaccurate. Only nevirapine-10mg/ml recorded reasonable forecasts with MAPE< 50% for the three periods. Forecast errors were non-random for all products. More than 50% of children weighed≥25Kg for the three periods. Children were likely to turn 25Kg at age of 8 years as opposed to the assumed 15 years. Only 19.0%, 30.3% and 32.6% of children used paediatric formulations in 2010/11, 2011/12 and 2012/13 respectively.

CONCLUSIONS AND RECOMMENDATIONS: Considerable forecast inaccuracies were found for six products. Only nevirapine-10mg/ml had reasonably accurate forecasts. Forecast errors for all products exhibited non-randomness. Assumptions that children aged< 15 years weigh< 25Kg and use paediatric formulations were incorrect. Weight was found to be an important determinant of formulation selection.

17:45 – 18:00	Jacaranda 3	30.11.2015

MOAE0405: Track E/4 -

Strengthening HIV Responses through Private Sector Involvement in Supply Chain Management: Medical Access Experience in Uganda

Muyingo Sowedi1, Olweny James1, Seru Morries2, Kasujja Ashraf1, Basajasubi Lubega1, Dea Monica3, Jjemba Pito3, Wiersma Stephen3, Settaala Rashid1

1Medical Access Uganda Limited, Kampala, Uganda, 2Ministry of Health, Kampala, Uganda, 3US Centers for Disease Control and Prevention, Kampala, Uganda

ISSUES: In the past decade, multiple, parallel and uncoordinated supply chains to health facilities (HF) limited HIV commodity access in Uganda. No dichotomy between supply systems for private and public sectors resulted into variable pricing for same items, inconsistent supply and doubtful quality of commodities procured. International organizations have invested heavily in improving access to ARVs, however resource utilization is still sub-optimal. Access must be tied to functional supply chain management (SCM) systems, which enable efficient procurement, distribution and rational use of life-saving medicines.

DESCRIPTIONS: Three central warehouses were assigned to either provide SCM services to the public, private-for-profit or private-not-for-profit (PNFP) HF. The U.S Centers for disease control and prevention(CDC)consolidated all HIV commodity procurement and SCM into one cooperative agreement as one mechanism. As such, Medical Access Uganda Limited (MAUL)has ensured uninterrupted commodity supply to 198 PNFP HF.In addition strengthened institutional commodity management capacity through on-the-job training, mentorship, performance assessment and regular HF support visits. Developed, Streamlined and standardized tools and processes to manage HIV

ABSTRACT DRIVEN SESSION

commodities from manufacturers to service delivery points. Quality assurance mechanisms have ensured all commodities procured, warehoused and distributed meet global standards.

LESSONS LEARNT: Stock-outs decreased from 17% in September 2012 to 6% in September 2014. All facilities providing elimination of mother-to-child transmission services were sufficiently stocked by March 2015. All PNFPs place orders to MAUL on a bimonthly pull supply schedule. The PNFP sector is integrated within government health management information system aiding national planning. Over 231,000 patients have received treatment by April 2015. With the same budget 30,000 more patients have been reached. Lastly, central to consolidation was collaboration with MoH, stakeholders and development partners.Duplicate processes,commodity loss &wastage have been eliminated and funds better utilized.Country ownership efforts and sustained performance gains are not hindered by social or political barriers. The private sector has demonstrated capacity to improve access to medicines.

NEXT STEPS: MAUL's capacity building and technical assistance approach can improve commodity access for epidemic responses e.g Ebola and for non-communicable diseases.

18:00 – 18:15	Jacaranda 3	30.11.2015

MOAE0406: Track E/4 -

Evaluation of Comprehensive Condom Programming in Uganda: Challenges to Providing Condoms on 24-hour Basis

Muwonge Moses1, Bukenya Justine2, Kajura Richard2, Wanyenze Rhoda2, Kindyomunda Rosemary Mwesigwa3

1Samatha Medical Foundation, Kampala, Uganda, 2Makerere University College of Health Sciences, Kampala, Uganda, 3United Nations Population Fund (UNFPA), National Programme Officer (HIV/AIDS), Kampala, Uganda

BACKGROUND: Access to condoms by individuals is a critical element to condom usage. The demand for condoms often happens during the evening, night time and over the weekends mainly Friday and Saturday at social places. Thus ensuring that condoms are available all through these times is a critical factor to access, and can be achieved through self-dispensers or ensuring that outlets for condoms are open during these times. We conducted a study to evaluate availability and state of dispensers as well as hours of operation for condom outlets.

METHODS: This was a cross-sectional study conducted in 10 districts in Uganda in April 2015. We visited and assessed 594 condom outlets including 197 (33.2%) Hotel/Motel/Lodge/Club/Bar/Restaurant, 161 (27.1%) health facilities, 99 (16.7%) drug shops/clinics/pharmacies, 24 (4%) Work Place/Office/Tertiary institutions. Structured interviews with the persons in charge of the outlets and physical inspection of condom dispensers were conducted to assess the state of the dispensers and hours of services.

RESULTS: Overall, 77.1% (459) of the outlets were operational (active). Of the active outlets visited 14.2% (65) had condom dispensers and 17% (11) of the dispensers were improvised boxes and polythene bags. On the day of the visit 23.1% (15) of the condom dispensers had no stock. Close to half of the outlets 48.6%, (220) were open 24hrs on weekdays and 36.6% were open 24hrs on Saturday. Additionally, 75.6% (323) of the outlets did not have alternative condom outlets within 15 minutes' walk when the outlet is closed or stocked out.

CONCLUSIONS AND RECOMMENDATIONS: There major gaps is ensuring access to condoms during the peak hours for their demand. There is a need to scale up installation of condom dispensers and/or extend the hours of operation for condom outlets within social places for easy access to condoms.

Keywords: Condom access, condom dispensers, outlets, Uganda

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Jacaranda 1 & 2	30.11.2015
MOAD0301:	Track D/3 - Programming for access to justice and care	
Chairs:	Berry Nigobora, Senegal	

Integrated Legal Aid in HIV Programming in Prison Rehabilitation Services for Better Access and Quality HIV Care - Mityana Uganda Charity Experience

16:45 – 17:00

Geoffrey Kinaalwa1, Florence Nabukalu2

1Mityana Uganda Charity, Management, Kampala, Uganda, 2Mityana Uganda Charity, Projects Department, Kampala, Uganda

ISSUES: Despite various interventions by Uganda government to increases access to health care, HIV/AIDS is still a threat among prisoners. This paper reviews Mityana Charity outreach program of Legal Aid services implemented to promote access to better quality HIV services in Mityana & Mubende prisons.

DESCRIPTIONS: In 2012, Mityana Charity initiated an integrated outreach clinics to provide legal aid services for inmates in 8 prisons of Mityana and Mubende districts. Services offered include; health education, HIV/AIDS counselling and guidance, human rights sensitization campaigns, coordination and capacity building among key stakeholders. The services are delivered by trained and experienced staff including lawyers and counsellors. The program works closely with the judicially and prison staff to ensure that court and medical appointments are given on the same day. Prison wardens, security guards and peer educators were trained in TB and HIV/AIDS, stigma and discrimination, STI, nutrition, sanitation and referral processes. Inmate clinical records were reviewed to assess progress of the outreach program

LESSONS LEARNT:

- Since project initiation, 2110 inmates received Legal Aid services including their right to care.
- Strengthened coordination of HIV service providers increased access to health care in prisons. In 2014, 615 were screened for HIV, of which 67 tested positive and enrolled in HIV care, 33 of them were initiated on treatment.
- All the 67 newly enrolled inmates in HIV care were adhering well to their medical appointments, 90% accessed CD4 services.
- The intervention helped to link health facilities to their HIV+ patients in prisons who had gotten lost to follow-up.

NEXT STEPS: Integrated legal aid in HIV programming in prison rehabilitation services reduced stigma and discrimination and promoted better access to legal aid and HIV services. There is need for a strong referral system to ensure continuity of HIV care for inmates.

17:00 – 17:15	Jacaranda 1 & 2	30.11.2015
MOAD0302:	Track D/3 -	

Human Rights Violations against Sex Workers: A Review of a Paralegal Project Implemented by the Sexual Rights Centre, Bulawayo, Zimbabwe

Ndondo Humphrey Melusi, Matshazi Sharon, Nyathi Nqobani

Sexual Rights Centre, Bulawayo, Zimbabwe

ISSUES: Sex Workers (SWs) play a pivotal role in HIV prevention and treatment interventions. However SWs continue to face barriers in accessing prevention and treatment services in Zimbabwe. This increases their vulnerability to HIV infection. Human rights abuses and social injustices, including poor working conditions, violence, police harassment and discrimination constitute the commonest violations. Lack of legislative protection and the general impunity towards sex workers is a violation of rights.

DESCRIPTIONS: The Sexual Rights Centre (SRC) in Zimbabwe has been implementing a paralegal programme run for SWs by SWs workers. The programme emerged from the needs articulated by SWs for support in dealing with police abuse, harassment, illegal arrest and detention and corruption. In light of these emergent needs the objectives of the programme are;

- To strengthen the capacity and leadership of SWs workers in Zimbabwe.
- To provide access to legal services for SWs and document human rights violations

with a view to improving interventions, informing research initiatives and influencing policy decisions.

- To organize SWs for policy advocacy and give them an amplified voice for collective policy proposals.

LESSONS LEARNT: Many human rights abuses experienced by SWs go unreported largely due to the futility and fears of violence and incarceration. Violations of SWs can directly and indirectly compound their risks to HIV infection due to lack of recourse to the law. Proactive and rapid response mechanisms by paralegals and lawyers to legal distress calls by SWs is pivotal. Real or perceived status as a sex worker is often used to abrogate rights of women. Increasing rights literacy among SWs is central to mitigating violence. The impetus for projects to increase rights literacy among SWs, sensitization of state and non state actors on the needs of SWs and advocating for decriminalization of sex work is of paramount importance in curbing human rights violations against SWs.

NEXT STEPS: There is need to scale up human rights advocacy work targeted at SWs. There is also need to interrogate an African model of decriminalisation in the light of the prevalence of street based sex work and the Zimbabwean government's propensity to control citizens. The SRC will seek to strengthen and systematize in our operations, the leadership of sex workers to document, denounce and redress violations perpetrated against sex workers.

17:15 – 17:30	Jacaranda 1 & 2	30.11.2015

MOAD0303: Track D/3 -

Strategic Litigation to Uphold the Rights to Health of Foreign Inmates Living with HIV in Botswana

Motimedi Felistus Mpho1, Kelemi Cindy Bigamoyo2

1Botswana Network on Ethics, Law and HIV/AIDS (BONELA), Programmes, Gaborone, Botswana, 2Botswana Network on Ethics, Law and HIV/AIDS (BONELA), Gaborone, Botswana

ISSUES: Botswana became one of the first country to provide HIV treatment in the continent; however foreign inmates are not provided with Antiretroviral as the National AIDS Policy allows provision to citizens only citizens the Botswana Constitution does not embody the right to health neither does any local legislation provide for the right to access ARV by people living with HIV.

DESCRIPTION: BONELA used this to advocate for the provision of ARV's for foreign inmates after a plea from foreign inmates. BONELA negotiated with the Government of Botswana (GoB) to provide treatment as an HIV reduction strategy in Prisons and protect the right to life and dignity of PLWIHV. Two male foreign inmates (Zimbabwean) and BONELA brought an application to High Court seeking that they be provided with HAART, using the Constitutional provisions to seek those reliefs, amongst them, the right to life, non-discrimination and dignity. The High Court agreed with the foreign inmates and opined that the denial of HAART to foreign inmates was discriminatory and a deprivation of the right to life. The precedent has set the tone for the demand and recognition of human rights in our country.

LESSONS LEARNT: Strategic litigation can be used as a means to test laws and set jurisprudence and an advocacy strategy to yield results and create impact. The landmark case offered the most salient legal arguments to defend the right to HIV treatment for foreign inmates in order to protect their right to life.

NEXT STEPS: GoB was ordered to place foreign inmates on HAART who met the criteria. However, GoB has appealed and will be heard in July 2015 at Court of Appeal. BONELA will continue advocating for the protection of people's rights, particularly minority rights and challenge the landscape of the law in doing so.

17:30 – 17:45	Jacaranda 1 & 2	30.11.2015

MOAD0304: Track D/3 -

HIV/TB in Prisons: Promoting Prisoners´ Rights through the Courts

Amadhila Nelago

AIDS and Rights Alliance for Southern Africa, Windhoek, Namibia

ISSUES: HIV/TB in prisons pose a serious threat to public health, yet there has been slow progress to advance access to HIV and TB prevention and treatment for prisoners by governments. Evidence from various studies conducted by the World Health Organisation (WHO) and the United Nations Office on Drugs & Crime (UNODC) shows that the prevalence of HIV/TB is generally higher

inside prisons than among the general population. This is compounded by poor health services, nutrition and living conditions in prisons. Governments bear the responsibility to ensure prisoners receive proper healthcare and that prison conditions promote their well-being. Health policies in prisons need to be aligned with national health policy.

DESCRIPTIONS: The AIDS and Rights Alliance for Southern Africa (ARASA) convened a two-day regional dialogue on HIV, TB and Human rights in Prisons. The dialogue brought together a cross-section of stakeholders and highlighted the important role the judiciary can play in addressing key human rights violations in prisons. Recent court judgements have shown that when a prison regulation or practice violates fundamental constitutional rights, courts are willing to uphold their duty to protect these rights. Courts have the ability to protect and promote prisoners' rights and compel governments to improve prisons.

LESSONS LEARNT: The judiciary plays an important role in creating legally enabling environments that allow prisoners to access health care services. Courts are can serve as a forum where rights that are not politically popular at a national level can be enforced. In 2014, for example, Botswana Network on Ethics Law & HIV/AIDS (BONELA) won a landmark case against the Botswana government in which government was ordered to provide ARVs to foreign inmates on the basis that it violated their constitutional right to life, equality and non-discrimination. CSOs play an important role in influencing court decisions, firstly through the advocacy and also the depth of the evidence and research.

NEXT STEPS: ARASA aims to:

- Support strategic litigation that to align prison policies to public health acts.

- Documentation of human rights violations in prisons such as written affidavits, and extensive research is needed to inform court challenges.

- Further engage with the judiciary on their role in protecting prisoners' rights

- Educate prisoners to put them in a position to assert their rights and demand services that are due to them.

17:45 – 18:00	Jacaranda 1 & 2	30.11.2015

MOAD0305: Track D/3 -

The Role of the Medical Military Senior Command in Mobilization for HIV/AIDS Prevention Interventions. A Case for Uganda Peoples Defense Forces

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ISSUES: Uganda has population of 34 million with an HIV prevalence of 7.3 and the military consists of approximately 45,000 active duty members whose prevalence is not documented. However, information from periodic reports is used to guide implementation of HIV/AIDS interventions that are designed to reach out to the military, their families and surrounding communities. RTI-International with funding from U.S. Department of Defense supports implementation of HIV/AIDS care and treatment services at Uganda's military facilities through a collaborative approach with the Military Directorate of HIV/AIDS. This abstract aims to highlight the role of the medical military command in HIV/AIDS activity implementation within the military in Uganda.

DESCRIPTIONS: Key senior military officers from the military Directorate of HIV/AIDS took lead in mobilization of military populations to create demand for HIV/AIDS interventions such as VMMC, HCT, Sexual and behavioral change education in the military settings especially the low level army units such as brigades and battalions. The senior officers moved to the field as advance teams ahead of key activities and also periodically moved to lower level army units together with unit commanders to strengthen sexual and behavioral change sensitization of the military communities. Activity and facility specific reports have been reviewed to highlight the role of the senior officers.

LESSONS LEARNT: After five (5) years of implementation at 11 military facilities including the Mobile HCT unit, 171,258 individuals have been reached with HCT, 8,820 enrolled on ARVs, 30,236 men circumcised, 14,222 reached with PMTCT services and 66,242 individuals(38,450 Males & 27,792 female) reached with sexual and behavioral change messages that are delivered in small dialogue groups since November 2008. Lower unit commanders have been reached with HIV/AIDS sensitization by the senior officers as peers. The success has been majorly due to the fact that the military is most times command driven.

NEXT STEPS: Since coverage numbers across program areas have increased over the years, the military senior command has been very key in mobilization for access to HIV/AIDS services within military units.

ABSTRACT DRIVEN SESSION

18:00 – 18:15	Jacaranda 1 & 2	30.11.2015

MOAD0306: Track D/3 -

Going Beyond Criminalisation: Engaging the Key Affected Populations (KAP) in the Consultative Process of the Global Fund NFM in a Challenging Environment

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BACKGROUND: The Global Fund New funding model expected a meaningful engagement of key affected population (KAP) throughout the processes leading to the Concept Note (CN). UNAIDS Nigeria piloted a consultative process, alongside a less-friendly environment with the ''same sex marriage prohibition act (2013)'' prohibiting gay organisations and meetings, their sustenance and engagement. Tension was also discernible amongst FSW & PWID who suffered rights abuse and were marginalized. The KAPs had no prior involvement in any national consultation or planning.

Methodology: The consultative process targeted confidence building, alliance formation in KAP constituents and role clarification. The KAP established a committee with a secretariat to facilitate coordination and feedback. Focused KAP discussions started in selected states leading to national meetings. The final priorities were raised by KAP representatives at the National Consultation meeting and included in the CN as intervention priorities of the KAP.

RESULTS: An unprecedented participation of KAP groups in the CN development processes was achieved resulting in $15m allocated for MSM, FSW and PWID interventions. The National Association of Female Sex Workers formalized and a consultative structure for KAP engagement established. The mutual mistrust and apprehension between the KAP groups and National AIDS Control Agency was resolved - a focal point for KAP issues was created.

Conclusion: Within conservative environments, tactful approaches drawing on officials' professionalism can still generate inclusive and meaningful KAP participatory processes and build their confidence. This experience could contribute to warming up the situation and through bottom-up policy dialogue, to a more democratic environment.

16:45 – 18:15	Prof Soudré Room	30.11.2015

MOAB0301: Track B/3 - Enhancing comprehensive care and support for children and adolescents

Chairs: Dennis Tindyebura, Uganda

Assessing the Perspectives of Health Workers and HIV-infected Mothers on Different Infant Feeding Options in Ghana in the Era of Antiretroviral

16:45 – 17:00

Laar Alexander Suuk1, Dalinjong Philip Ayizem2

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BACKGROUND: In many contexts, exclusive breast-feeding (EBF) combined with antiretroviral treatment (ART) ensures the best chance of human immunodeficiency virus (HIV)-free survival of infants exposed to HIV. The new guidelines incorporate evidence that provision of ART to either mother or child can significantly reduce postnatal transmission of HIV through breastfeeding. In Ghana, EBF is widely accepted and advocated; however, health workers are now faced with advising women infected with HIV about the risks and benefits of antiretroviral and other infant feeding options.

Objective: This study assessed health workers and HIV-infected mothers' perspectives on the new guidelines on infant feeding options in Ghana.

METHODS: The study was carried out in two urban hospitals: Tema General Hospital and Ridge Regional hospital in the Greater Accra Region. The study employed a mixed-method design with quantitative and qualitative methodologies. A cross-sectional hospital-based survey with 50 HIV-infected mothers with infants aged between 0-12 months, 6 key informant interviews with health workers and 2 focus group discussions with HIV-infected mothers. Quantitative data was analyzed using Statistical Package for Social Sciences Program version 16.0 and the Nvivo software version 10.0 for the qualitative data.

ABSTRACT DRIVEN SESSION

RESULTS: All infants 60 (100%) born to 60 HIV-infected mothers had been breastfed. At the time of the study, for 45 infants aged under 6 months, 40 (89%) were EBF. The remaining 15 infants who were between the ages of 6-12 months, 10 (66.7%) were exclusive breastfed between a period of 0-6 months. For the remaining ten, 5(50%) were exclusive replacement feeding (ERF) and 5 (50%) had mixed fed their infants. Factors such as inadequate breast milk, cost of formula, traditions and formal employment were some of the reasons for mixed feeding. All HIV-infected mothers had some knowledge on the new infant feeding guideline. Both the health workers and the HIV-infected mothers mentioned erratic supply of antiretroviral drugs as a major problem.

CONCLUSIONS AND RECOMMENDATIONS: There were several challenges related to infant feeding among HIV-infected mothers. Program managers need to examine their own contexts for factors that may affect uptake and duration of EBF and ERF when designing intervention programs.

Keywords: HIV-infected mothers, HIV, infant feeding, ART, Ghana

17:00 – 17:15 | Prof Soudré Room | 30.11.2015

MOAB0302: Track B/3 -

Food Banking for Improved Nutrition of HIV-positive Children: Emerging Evidence from Quality Improvement Teams in Food Insecure Regions of Kiambu, Kenya

Akulima Muhamed Juma1, Ikamati Rudia Inombambu1, Muhula Samuel2, Ambalu Rachel1, Karanja Sarah3

1Amref Health Africa in Kenya, HIV/TB, Malaria, Nairobi, Kenya, 2Amref Health Africa in Kenya, M&E, Nairobi, Kenya, 3Amref Health Africa in Kenya, Research, Nairobi, Kenya

BACKGROUND: While there are estimated 137 million children aged under five years in sub-Saharan Africa, 12.3 million of these are wasted, stunted and an estimated 2.3 million children aged 0-14 have HIV. An estimated 500,000 orphans and vulnerable children live in Central and Eastern Kenya. Majority of them are orphaned due to HIV/AIDS. A total of 140,000 (28%) are currently supported by Amref Health Africa in Kenya with funding from USAID through APHIAplus KAMILI project. Amref Health Africa in Kenya, initiated two food banks through Community Quality Improvement Teams (CQITs) to address nutrition for HIV-positive children.The food banks applied the universal concept of safe keeping, loaning, depositing, withdrawal, interest and repayment but within food and nutrition mechanisms. A total of 103 HIV positive children and their households received services in safe storage of seeds, dry food harvests and vegetables, loaning of seeds, linkages for therapeutic nutrition, provision of subsidized staple foods and free provision of food rations. Two assessments were conducted one before and another after the food banking initiative and results compared to measure improvement and change. The study's main objective was to assess and demonstrate the roles of community food banking in improving the nutrition status HIV-positive children in food insecure regions.

METHODS: A pre and post-test design study lasting 12 months (Oct 2013 to September 2014) was conducted in Kiambu County, Kenya covering 103 HIV infected children. The Child Status Index (CSI) and the Middle Upper Arm Circumference (MUAC) tools were used in data collection at households. The paired T-test and Wilcoxon test were applied for analyzing MUAC and CSI scores respectively.

RESULTS: There was a significant improvement in the children's nutrition status from a rating of 'bad' in CSI Median (IQR) score 2(2-1) before food banking to a rating of 'fair' in CSI Median (IQR) score 3(4-3) after food banking intervention (p=< 0.001) while MUAC increased from Mean (SD) of 5.6(2.6) before intervention to 7.2(2.8) after food banking (p=< 0.001).

CONCLUSIONS AND RECOMMENDATIONS: Community food banking contributed to improved nutrition status of the HIV positive children. Additionally, community quality improvement teams are imperative mechanisms for sustainable food security and HIV care initiatives.

Keywords: Child Status Index, Middle Upper Arm Circumference, food banking, Community quality improvement Teams.

17:15 – 17:30 | Prof Soudré Room | 30.11.2015

MOAB0302: Track B/3 -

Improving Feeding Practices and Nutrition Status of HIV-positive Children in Tanga, Tanzania: The Roles of Health Workers' Nutrition Training

Sunguya Bruno F1, Urassa David P1, Mlunde Linda B2, Ubuguyu Omary S3, Poudel Krishna C4, Yasuoka Junko2, Jimba Masamine2

ABSTRACT DRIVEN SESSION

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BACKGROUND: Undernutrition among HIV-positive children is also associated with poor feeding practices (Sunguya 2011, 2012, 2014). The detrimental impacts of such shortcomings can be averted if trained health workers provide tailored nutrition counseling to caregivers in general population (Sunguya 2014). Evidence is lacking in the context of HIV-positive children and regions. This research examined efficacy of nutrition training intervention involving midlevel providers (MLPs) on feeding practices, anthropometry, and nutrition status of HIV-positive children in Tanga, Tanzania.

METHODS: The cluster RCT research protocol was designed based on the results of the formative research (Sunguya 2014). It was conducted in a total of 16 out of 32 CTCs in Tanga, Tanzania. A total of 8 CTCs were randomly assigned to the intervention group and the same number to a control arm by coin flipping. A total of 776 pairs of HIV-positive children and their caregivers were recruited, of whom 397 were in the intervention arm. The intervention of interest was the nutrition training of MLPs. This intervention used the standard World Health Organization (WHO) guideline on nutrition training of health workers for HIV-positive children aged 6 months to 14 years. Following the training, the MLPs provided tailor-made nutrition counseling to caregivers of CTCs of the intervention arm. Children were followed up for six months. Data were analyzed using instrumental variable random effects regression with panel data.

RESULTS: Feeding practices of HIV-positive children improved in the intervention arm following nutrition training of MLPs who cared for them. For example, feeding frequency improved significantly in the intervention arm and at follow-up (;=1.17, p< 0.001). Meanwhile, an increase in feeding frequency was associated with increase in the child weight (p< 0.001), BMI (p< 0.001), but not height (p = 0.830). The intervention improved dietary diversity (;=1.12, p< 0.001). An increase in dietary diversity was associated with increase in the child weight (p< 0.001), BMI (p< 0.001), but not with height (p=0.984).

CONCLUSIONS AND RECOMMENDATIONS: Nutrition training improved caregivers' feeding practices. These positive changes led to a modest weight gain among HIV-positive children in the intervention group. Such intervention did not, however, bring about linear growth after 6 months of follow-up.

17:30 – 17:45 | Prof Soudré Room | 30.11.2015

MOAB0304: Track B/3 -

Needs and Challenges of Lay Community Health Workers in a HIV/AIDS Palliative Care Environment for Orphans and Vulnerable Children

Visagie Bonita Bernice

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ISSUES: The escalation of HIV/AIDS infections in the last decade has increased the need for palliative care community organisations to care for adults and orphans who are in dire need of support. These organisations depend on lay community health workers (LCHWs) to provide palliative care to those in need. Hence, the focus of this qualitative study was to explore the needs and challenges of LCHWs in their role as palliative carers in community organisations. This study was unique in its choice of community and adult education perspectives that were critically analyzed through a job-demands and job-resources theoretical framework. This research focused specifically on LCHWs from Bronkhorstspruit, working at a community organisation in Sizanani Village.

DESCRIPTION: Based on the findings, the aim was to provide a framework that could further enhance the work of LCHWs. A phenomenological case study design was used to collect data through twenty-five individual interviews, two separate focus groups, observations and document analysis. The participants consisted mainly of people with skill resourcing needs; in total there were 46 participants, 9 males and 37 females, between the ages of 12 and 64. Participants were identified by the organization. Data were processed through rigorous thematic analysis.

LESSONS LEARNT: The findings vividly point out specific knowledge and skills community health workers need to be both satisfied and successful in their administration of palliative care to orphans and adults infected with HIV/AIDS. Furthermore, several organisational challenges, were identified by the participants negatively impacting on their work. These challenges were a lack of career pathing, insufficient career guidance, and inadequate employment processes, such as staff retention, succession planning, and promotion.

NEXT STEPS: The original contributions of this study are visible in the application of a phenomenological case study design, the utilization of community and adult education perspectives

embedded in a job-demands and job-resources theoretical framework, and the development of a work resourcing model that could easily be adapted by the numerous palliative care organisations that utilize LCHWs. Research in this area could provide critical insights into sustainability of community health organizations; strengths, aspirations, expertise of LCHWs, and the future prospects of patients' and OVC lives which are often painfully affected by HIV/AIDS.

17:45 – 18:00 | Prof Soudré Room | 30.11.2015

MOAB0305: Track B/3 -

Community Based Organisation Provision for Children Affected by HIV Developmental Delay

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BACKGROUND: Child cognitive and mental health may be adversely affected by HIV. Community based organisations (CBO's)may be well placed to provide for such children.

METHODS: 11 funding organisations provided listings of all child CBO's in South Africa and Malawai(N=588) and a random sample of 28 was generated. Consecutive attending children (4-13yrs) with primary caregiver were included (n=979; 99.3% inclusion - 86% one year follow up). Ethical approval preceded data gathering on mental health (depression, trauma, self esteem), quality of life (QOL), cognitive development (parental report and child testing) educational risks and CBO provision.

RESULTS: 135 HIV+ve and 844 comparison children showed HIV+ve was associated with developmental delay (p< 0.0001) for motor milestones, hearing difficulties, speech problems, and mental difficulties. HIV status remained a predictor of delay after adjusting for demographics. At follow up HIV+ve children had multiple disabilities (3+) p< 0.0001. HIV was also associated with lower QOL (physical health p=0.003;mental health p=0.009), and lower educational score t=-3.01,p=0.003. HIV+ve children were more often in the incorrect class, slow learners, struggled at school, and attended less regularly. Digit span and draw-a-person test scores significantly lower(p< .0001). In regression, adjusted for demographic confounders, HIV status remained a significant predictor of poor performance (;=.084, p=.008). On the Strengths and Difficulties Questionnaire(S-DQ),HIV+ve children presented more problems(t(977)=2.17,p=0.03. When controlling for other factors, HIV status remained a significant predictor. At follow-up, there was a significant decrease of educational risks. HIV+ve children were enrolled in CBO programmes for longer p< .0001). Under half with disability attended a CBO with disability inclusion policies or rehabilitation services. HIV+ve children were significantly less likely to get assistance/grants, education services or material supplies. Yet they were significantly more likely to get referral, parenting interventions, medical and psychological services.

CONCLUSIONS AND RECOMMENDATIONS: Our data clearly presents solid evidence of special needs - well suited to CBO provision. CBO's present an opportunity for specialised localised services to children with cognitive or mental health challenges, but screening, targeting and inclusion may need to be developed.

18:00 – 18:15 | Prof Soudré Room | 30.11.2015

MOAB0306: Track B/3 -

Effectiveness of Comprehensive Clinical Care and Psychosocial Support on Adherence to Antiretroviral Therapy (ART), Retention in Care, and Mortality in Adolescents Living with HIV

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ISSUES: Adolescents living with HIV (ALHIV) have been shown to have worse adherence to antiretroviral therapy (ART), lower rates of viral load suppression, and lower retention in care than adults with HIV. Whilst global HIV-related deaths are decreasing, they are increasing in adolescents. Baylor College of Medicine-Children's Foundation Malawi (BCM-CFM) has implemented a program

ABSTRACT DRIVEN SESSION

for ALHIV providing clinical care and psychosocial support.

DESCRIPTIONS: Disclosed ALHIV aged 10-19 years are enrolled into Teen Club, which includes bimonthly clinic visits monitoring adherence to ART, clinical and nutritional status, and screening for psychosocial issues by a multi-disciplinary team. Teens receive mentorship from staff and peers and have access to a 24-hour toll-free hotline for ALHIV.

LESSONS LEARNT: Retrospective review of the electronic medical record compared data for all active patients and patients 10-19 years at BCM-CFM as of December 31, 2014. Adolescents numbered 1208 (38% of active clinic patients): 605/50% were males. 1134/94% of adolescents were on ART, for an average of 5.3 years. Average age of adolescents was 13.6 years for males/14.1 years for females on ART, and 12.5 years for males/12.6 years for females not yet on ART. Of adolescents on ART, 1065/94% were on a first line regimen and 69/6% were on a second line regimen. Good adherence (95-105% by pill count) was present in 919/81% of adolescents, comparable to the clinic average of 79%. In the preceding 24 months, 832/73% of adolescents on ART had a viral load checked; 641/77% were suppressed (< 400 copies/mL), the same suppression rate as the clinic. Loss to follow up (LTFU) in patients on ART (4 months after last appointment) was 6.9% in adolescents, lower than the clinic average of 8.5%. However, LTFU in adolescents not yet on ART (7 months after last appointment) was higher at 19.6%. Mortality in patients on ART was 1.7 deaths per 100 patient years in adolescents, lower than the clinic average of 2.8. Mortality in patients not yet on ART was 1.3 deaths per 100 patient years in adolescents, significantly lower than the clinic average of 5.7 ($p< 0.01$ using Pearson's Chi-squared test).

NEXT STEPS: Comprehensive clinical and psychosocial programming targeting ALHIV is effective in improving retention in care, adherence to ART, and reduction in mortality. Further analysis is needed to identify the most successful components to ensure inclusion in national programming.

HIV, adolescent, adherence

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Committee Room 4	01.12.2015
TUAC0301:	"Track C/3 - Innovative approaches towards reaching the first ""90"""	
Chairs:	Serge Paul Eholie, Cote D`Ivoire	

Human Immunodeficiency Virus (HIV) Testing and Counselling (HTC) Trends Analysis, Midlands Province, 2010 to 2014- A Descriptive Study

10:45 – 11:00

Makoni Annamercy, Gombe Notion Tafara, Chemhuru Milton, Mungati More, Bangure Donewell, Tshimanga Mufuta

University of Zimbabwe College of Health Sciences, Community Medicine, Harare, Zimbabwe

BACKGROUND: HIV testing and counselling (HTC) indicators are captured for programming purposes, decision making and program monitoring and evaluation. A preliminary review of Midlands province HTC data showed that a small proportion of men and children were being tested for HIV. HTC data for the period had never been analyzed. We analysed secondary data to determine HTC trends in Midlands Province.

METHODS: We carried out a descriptive study using secondary HTC data. All HTC records for Midlands Province from 2010 to 2014 were analyzed using Microsoft Excel. Chi Square for trend analysis was conducted using Epi infoTM. Proportions, means and frequencies were generated.

RESULTS: There were 623 174 clients in the HTC dataset from 2010 to 2014. Of these, 7% were tested as couples. Females constituted the highest proportion (62%) of clients who tested as individuals. A higher proportion (88%) of the clients was ≥15 years. There was a significant increase in clients who received HTC from 3% in 2010 to 21% in 2014. All districts recorded the highest HTC uptake in 2014, Mberengwa having the highest rate (22%) and Gokwe the lowest rate (14%). HTC positivity significantly declined from 29% in 2010 to 7% in 2014, X2= 32 551; p< 0.01. Average positivity rates were 16% for males and 14% for females.

CONCLUSIONS AND RECOMMENDATIONS: There was a significant increase in the number of clients tested for HIV across all age groups, sexes and districts. HIV positivity rates significantly declined across all age groups, sexes and districts. Positivity rates were higher among the 25 to 45 age group and among males.

11:00 – 11:15	Committee Room 4	01.12.2015
TUAC0302:	"Track C/3 - Innovative approaches towards reaching the first ""90"""	
Chair:		

l'Expérience du Centre de Conseil au Dépistage Volontaire de Prise en Charge des IST des Jeunes à Bangui le CISJEU

Ali Mouhamadou Sani

CISJEU (Centre d'Information d'Education et de Communication pour la Santé Sexuelle des Jeunes), Jeunesse, Bangui, Central African Republic

Indiquer le problème étudié, la question de recherche

La connaissance par les individus de leur statut sérologique est un élément important dans l'adoption de comportements préventifs du VIH. D'après l'enquête de la vulnérabilité des jeunes Centrafricain au VIH réalisé en 2010, 20% des filles et 10% des garçons seulement avaient effectué un test de dépistage du VIH avant le passage des enquêteurs. La faible prévalence du dépistage du VIH chez les jeunes s'expliquent entre autre par la peur du résultat et surtout la quasi-absence des servies conseil et dépistage adaptés aux jeunes.

Méthodes: L'approche consiste à intégrer le service dépistage conseil spécifique aux jeunes dans un centre des jeunes. Le CISJEU dispose d'une salle de projection de film éducatif et ordinaire, un hangar servant de l'IEC et un cybercafé ouvert à tout le public surtout les jeunes, un point de santé gratuit et des espaces aménagés pour la distraction des jeunes. Cette stratégie permet de rassurer les jeunes sur la confidentialité avec un personnel formé et qualifié pour l'accueil des clients et les épargnes de la stigmatisation /discrimination.

Résultats: Du 09 juin au 31 décembre 2009, 600 jeunes dépistés. En 2010, 2985 dépistés en 2011, 4495 dépistés en 2012 ,6049 dépistés en 2013, 7815 et en 2014, 3270 dépistés. Il a noté que tous les clients sont venus cherchés leurs résultats.

ABSTRACT DRIVEN SESSION

Conclusions et recommandations: Les résultats démontrent que les jeunes ont besoin d'un lieu convivial pour se faire dépister du VIH. L'expérience du CISJEU peut être adaptée et intégré dans des structures des jeu. Cependant l'approche connait encore des limites en termes d'orientation ou de prise en charge des jeunes séropositifs. Ainsi la prochaine étape consiste à mobiliser les ressources pour offrir la prise en charge médicale au niveau du centre.

11:15 – 11:30	Committee Room 4	01.12.2015

TUAC0303: "Track C/3 - Innovative approaches towards reaching the first ""90"""

Chair:

Expenditures and Effects of Couples' Voluntary HIV Counseling and Testing in Reducing Heterosexual Transmission of HIV-1

Vwalika Bellington1, Wall Kristin2, Inambao Mubiana3, Kilembe William1, Parker Rachel2, Sharkey Tyronza1, Sonti Divya2, Tichacek Amanda2, Hunter Eric4, Yohnka Robert2, Abdallah Joseph2, Thior Ibou5, Pulerwitz Julie5, Allen Susan2

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BACKGROUND: Despite WHO recommendations supporting couples' voluntary HIV counseling and testing (CVCT) for HIV prevention, only a small percentage of African adults has been tested with their partners.

METHODS: From 2010-2015, CVCT with follow-up was established in 73 Zambian government clinics. CVCT cost-per-HIV-infection averted (CHIA) was calculated using actual expenditures and observed HIV prevention impact. CHIA estimates for a hypothetical 5-year national expansion of CVCT, antiretroviral treatment-as-prevention (TasP) for discordant couples identified after CVCT, and blanket TasP for all HIV+ married or cohabiting adults are compared.

RESULTS: 172,981 couples were tested at $52/couple. Among discordant couples in which the HIV-positive partner self-reported ART use, HIV incidence was 9.6/100 person-years (PY) before CVCT, dropping to 1.6/100PY after CVCT (84% reduction). Corresponding reductions for non-ART using discordant and concordant negative couples were 78% and 63%, respectively. An estimated 71% of new infections were averted by CVCT at $440 CHIA. In a hypothetical 5-year national implementation, CVCT CHIA is $229-$330; for TasP in discordant couples following CVCT is $5,865-$23,698; and blanket TasP without CVCT is $11,193-$27,552. By year five, the maintenance cost of this hypothetical nationwide CVCT implementation drops to 2% of the annual PEPFAR budget to Zambia; the annual cost of TasP would stabilize at 19-35% of the budget while blanket TasP would stabilize at 49-91% of the budget.

CONCLUSIONS AND RECOMMENDATIONS: Our results show

1) the effectiveness of CVCT with the potential to prevent the majority of infections in discordant and concordant negative couples;

2) the affordability and sustainability of CVCT;

3) the added effectiveness of providing CVCT to therapeutic ART users, for whom ART use alone only partially mitigated transmission risk; and

4) that TasP programs, where affordable, should not be implemented without prior CVCT.

11:30 – 11:45	Committee Room 4	01.12.2015

TUAC0304: "Track C/3 - Innovative approaches towards reaching the first ""90"""

Chair:

Conseil Dépistage Volontaire Anonyme Nocturne en Milieu HSH du VIH et la Syphilis dans la Ville de Ouagadougou par l'Association African Solidarité (AAS) au Burkina Faso

ABSTRACT DRIVEN SESSION

Abdoulazziz Soundiata Traore1,2, Romain Ouedraogo1, Joseph Ouedraogo3, Issouf Nikiema1, Sayouba Kouama1, Ousseni Ilboudo1, Pascal Tiendrebeogo1, Filemon Ouedraogo1, Issoufou Tiendrebeogo1,4,5

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BACKGROUND: La section Hommes ayant des relations sexuelles avec d'autres hommes (HSH) de l'Association African Solidarité (AAS) mène des activités de dépistage volontaire du VIH et de la syphilis. Des pairs éducateurs (PE) distribuent des bons gratuits de dépistage et les HSH viennent faire leur test au sein de l'association. Nous avons organisé des campagnes nocturnes dans nos locaux, avec remise de résultats sur place, puis, pour toucher plus de personnes, des campagnes sur sites (maquis, bars, dancings et grins).L'objectif pour nous est de toucher plus HSH ,beaucoup veulent faire les tests mais n'accepte de se déplacer et partir vers eux est plus motivant

METHODS: Nous travaillons avec l'unité mobile de prévention et du dépistage du VIH de AAS. Les PE sélectionnent les sites les plus fréquentés par les HSH et aussi a la demande des HSH . L'équipe de la section Conseil dépistage de AAS a formé deux animateurs HSH qui administrent les questionnaires pré et post test. . Le dépistage est réalisé avec les tests Détermine VIH et Syphilis et SD Bio line, le test est ouvert à tout le monde, même sans bon, les PE distribuent les bons et collent des distinctifs discrets sur ceux-ci. Ces identificateurs permettent une bonne référence au moment du déroulement du test pour les HSH. Nous avions pu réaliser onze sorties en trois mois

RESULTS: Nous avons touché 613 HSH. Tous ont été dépistés et ont reçu leur résultat. Parmi ces tests, 08 étaient positifs au VIH et 02 à la Syphilis et sur place ils ont eu leur première dose de traitement syphilitique et un RDV est pris pour la deuxième et troisième dose. Les cas positifs au VIH sont dans la file active de l'association

CONCLUSIONS AND RECOMMENDATIONS: Cette méthode a eu un impact : Le nombre de HSH dépisté a considérablement augmenté car en six mois en stratégie fixe on a touché 187 HSH alors qu'avec cette méthode on a touché en trois mois 613, en plus d'autres réseau nous font appelle pour organiser des campagnes de dépistage dans leur site Les HSH ont sélectionné d'autres sites et nous demandent d'organiser des actions de dépistage dans ces derniers. Ceci étant une phase pilote, nous comptons organiser d'autres actions dans d'autres sites et, ensuite, organiser un atelier national des associations militant dans le domaine HSH pour partager notre expérience.

11:45 – 12:00	Committee Room 4	01.12.2015

TUAC0305: "Track C/3 - Innovative approaches towards reaching the first ""90"""

Chair:

Closing the HIV Testing Gap through Workplace Action

Licata Margherita, Zug-Castillo Brigitte, Afsar Syed Mohammad

International Labour Organization, Geneva, Switzerland

ISSUES: Africa accounts for 71% of the 35.3 million persons living with HIV world;wide. Three out of five persons living with HIV still lack access to treatment on the continent and more than half of all adults in Africa do not know their HIV status.

Workplaces bring a large number of people together and, therefore, have a huge potential to upscale voluntary, confidential counselling and testing (VCT) for HIV.

DESCRIPTIONS: A recent ILO Study on "Effective Responses to HIV and AIDS at Work: A multi-country study in Africa" showed that workplaces play a key role in promoting access to HIV testing and linking those who test positive with care, while safeguarding their right to non-discrimination.

Of the 66 workplaces studied in 10 African countries, 79% provided evidence that they had increased VCT uptake; and 81% used behaviour change approaches to increase awareness on the need for testing and create demand for testing.

LESSONS LEARNT:

- The peer educator approach, adapted to workplace settings, allowed reaching out to employees during work hours and leisure time. Trained peer educators played a key role in promoting VCT, helping workers move from knowledge to seeking HIV testing.
- The meaningful involvement of PLHIV in behaviour change programmes helped alleviate fears about HIV testing and improved acceptability of testing. For example, in a South African workplace, VCT uptake increased from 72% in 2009 to 82% in 2010 as a result of inviting PLHIV to provide testimonies and support.

ABSTRACT DRIVEN SESSION

- Targeted training for managers and workers also empowered employees about the importance of knowing their HIV status and contributed to behaviour change. This is the case of a Kenyan workplace, where the behaviour change sessions resulted in 120 people seeking VCT during a family day; and 275 seeking VCT during a VCT campaign.
- Management is a key driver to run and maintain a successful behaviour change programme to increase demand for testing.
- Behaviour change is usually more effective if role models are established within a workplace. There was a positive impact when business or union leaders publicly took the HIV test.
- Behaviour change for VCT uptake can only be sustained if linkages to health and support services are ensured in order to guarantee follow-up for HIV-positive workers and dependants.

NEXT STEPS: The ILO is incorporating all lessons in up-scaling the VCT@WORK initiative that aims at promoting voluntary confidential counseling and testing for workers.

12:00 – 12:15	Committee Room 4	01.12.2015

TUAC0306: "Track C/3 - Innovative approaches towards reaching the first ""90"""

Chair:

How Do we Reach the First 90 of 90-90-90? Analysis of Approaches to Scaling-up HIV Testing in Sub-Saharan Africa

Korenromp Eline1, Stover John2, Gobet Benjamin3, Fazito Erika3, Lara Joe4

1Avenir Health, Center for Modeling and Analysis, Geneva, Switzerland, 2Avenir Health, Center for Modeling and Analysis, Glastonbury, United States, 3UNAIDS, Maputo, Mozambique, 4Ministry of Health, Maputo, Mozambique

BACKGROUND: UNAIDS' 90-90-90 treatment targets call for 90% of all HIV-infected people to be diagnosed by 2020. We analyzed the contribution of different testing approaches and target populations to achieve this goal including discordant couples, STI patients, TB patients, key populations, pregnant women and various general population approaches such as door-to-door and self-testing.

METHODS: We developed a model to project the number of tests, the number of identified HIV-positives and the costs to deliver testing through existing and novel channels, over 2015-2023. Country quantifications were based on UNAIDS and WHO estimates and representative surveys, of sizes of key population groups and their HIV prevalence, prior testing and ART coverage. Unit costs and existing budgets were obtained from UNAIDS country offices. We assumed that all People-living-with-HIV (PLWH) newly identified are immediately put on ART and will not retest. In projections, testing uptake is independent from HIV sero-status for high-risk groups and provider-initiated testing, but higher in HIV-infected clients for general population, community and voluntary testing.

RESULTS: Scaling-up testing through existing channels to near-universal coverage could, within 5 years, increase ART coverage by two-fold in most countries. For 90% of PLWH to know their status, and 90% of those put on ART, additionally partner testing and community outreach are needed - in particular for men. Reaching 90% testing coverage by 2020 (the UNAIDS Fast Track target) requires annual testing of 18-20% of adult men and 42-47% of adult women. For cost-effective pathways, priority channels are partners of PLWH, patients with AIDS symptoms, STI patients, and in generalized epidemics (e.g. Mozambique) tuberculosis patients. Female sex workers are a key target group in both high- and low-level epidemics.

Scale-up of community testing in general, low-risk populations - if not targeted to higher-risk people or areas - requires budget increases over 2016-2020 of 35% in Mozambique (where testing coverage is already high), 207% in Senegal and 267% in Nigeria (currently at low coverage), from 2014-2015.

CONCLUSIONS AND RECOMMENDATIONS: To enable universal ART coverage, it is key to pilot, optimize and expand novel testing delivery channels, notably partner testing and targeted modes of community outreach (e.g. mobile, door-to-door, multi-disease campaigns, and self-testing).

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Jacaranda 3	01.12.2015

TUAE0501: Track E/5 - Partnerships and transformations: advancing key population access

Chairs: Steave Nemande, Dakar, Senegal

Monitoring and Tracking ART Adherence among MARPs Using the Community MARPs-Peer System

10:45 – 11:00

Katushabe Gorretti, Ayebare Simon, Katende Peter, Lule John R

Most at Risk Populations Initiative, Kampala, Uganda

ISSUES: Provision of HIV care to MARPs is challenging in access to HCT, linkage to care for the positive and retention. The test and treat for MARPs offers limited time for preparing for long-term ART, there are limited health units for MARPs thus giving options for consulting health workers. In addition majority of diagnosis is done at community level. Health workers have limited interaction and MARPs are referral of those who test positive for HIV to the facility to initiate ART.

Objectives: To determine the effectiveness of the linkage and tracking system of MARPs that fail to honor their appointments for ART.

Methodology: Once a MARP tests positive during community outreaches, a list is forwarded to the adherence clinic at MARPI by the lead of the community team using a community referral form. The adherence nurse contacts the client by calling them on the phone to determine whether the client wishes to receive ART from MARPI or from another centre and makes an appointment for the patient to come to the clinic. At the clinic, the clients HIV status is confirmed by doing a repeat HIV test and the client starts preparations for initiating ART until they are ready for ART. All appointments are monitored by the adherence nurse by reminding the client within two to three days of the appointment. For those that fail to come to the clinic within 7 days of the appointment, the adherence unit tries to contacts the client. Failure of getting the patient by telephone, the treatment supporter is contacted and when not available the counselor then contacts the peer to track the client.

RESULTS: At the beginning of April 2015 there were 140 MARPs that had not returned for ART beyond three months of their appointments. Using the peer tracking system we were able to trace 56% of MARPs on ART who had missed their appointments. Of these 40 (29%) were getting ART from another health unit, 29 (21%) returned to MARPI for ART, 5 (4%) promised to come back to the unit, and 4 (3%) were dead. The system is yet to trace 62 (44%) of the clients, of whom 13 (9%) have no contacts and the peers cannot trace them within the community.

Conclusion and Recommendations: The community peer tracking system for MARPs that fail to return for ART is effective in tracking 56% of MARPs on ART lost to follow-up. However, there is still lack of an effective Inter health unit tracking system to trace of MARPs who change treatment sites, to exclude them from those that have stopped ART.

11:00 – 11:15	Jacaranda 3	01.12.2015

TUAE0502: Track E/5 -

Le Coût Économique de l'Homophobie en Afrique

Lamontagne Erik1, D'Elbee Marc2

1ONUSIDA, Genève, Switzerland, 2Université Paris-Est Créteil Val de Marne, Paris, France

ISSUES: Malgré des progrès considérables, la riposte au sida se heurte à des barrières sociales et culturelles, en premier lieu desquelles se trouve la stigmatisation. Un contexte homophobe par exemple, est non seulement incompatible avec les nouvelles stratégies d'accroissement de la riposte au sida mais induit également un coût social et économique aux pays concernés.

DESCRIPTIONS: Pour répondre à cette question, nous avons construit un modèle pour estimer le coût économique de l'homophobie. Nous avons estimés ce manque à gagner en terme de productivité d'une part et en terme de santé d'autre part. De plus, un indice statistiquement robuste permettant de classifier les pays selon leur contexte législatif homophobe a été conçu et permet une analyse plus précise des coûts par pays et par région.

LESSONS LEARNT: Les premières estimations montrent que le coût économique de l'homophobie pourrait représenter annuellement 1,1 milliard de dollars en Afrique, soit 0.05% de la production du continent (GDP 2013 réel), réparti à 69% et 31% entre l'Afrique Sub-Saharienne et l'Afrique du Nord respectivement. Ces résultats sous-estiment probablement la réalité. Les préva-

lences d'homme déclarant avoir des relations sexuelles avec des hommes (HSH) étant nettement inférieure (0.3% de la population) en Afrique par rapport aux autres régions (1/% de la population). Par conséquent, nous avons effectué des études de sensibilité et il apparaît que pour une proportion de HSH entre 1% et 2 % de la population masculine africaine, le coût de l'homophobie représenterait annuellement de 3,6 à 7,2 milliard $ en Afrique.

NEXT STEPS: Au-delà du coût humain et social, un tel coût économique de l'homophobie souligne l'importance et la pertinence de lutter contre la stigmatisation et constitue un élément de plaidoyer important auprès des gouvernements et des parlementaires pour mettre fin à l'épidémie de sida. Ceci sera particulièrement pertinent dans les pays d'Afrique du Nord où le coût par personne est disproportionnellement élevé.

11:15 – 11:30	Jacaranda 3	01.12.2015

TUAE0503: Track E/5 -

Between Tensions and Opportunities: Strengthening Partnerships Among Civil Society and Sex Worker-led Organizations in Kenya and Ethiopia

van Stapele Naomi1, Tadele Getnet2, Nencel Lorraine3, Sabelis Ida3, Markos Bisrate3, Igonya Emmy3

1VU University Amsterdam, Sociology, Amsterdam, Netherlands, 2University of Addis Ababa, Addis Ababa, Ethiopia, 3VU University Amsterdam, Amsterdam, Netherlands

BACKGROUND: This paper presents a comparative analysis of two stakeholder mappings in Kenya and Ethiopia. These maps identify interactions between civil society (CSOs) and sex worker-led organizations as strategic actors in combating HIV/AIDS. Both groups consider more horizontal partnerships between them as a crucial step in achieving a more unified and effective response to HIV/AIDS. In practice, such partnerships have yet to become fully established. Where and why do gaps exist between policy visions and actual practices? What challenges do the different actors face in achieving this ambition? And, how do these challenges tie into different imaginings of what such partnerships entail? Accordingly, this study delineates which factors obstruct further collaboration and provides clear recommendations on how to overcome these.

METHODS: The analysis is based on data gathered with 30 CSOs and sex worker-led organizations in Kenya and Ethiopia in December 2014-February 2015. The sex worker-led organizations involved both female and (gay) male sex workers-led organizations. The CSOs also included government agencies that receive funds from donors, as these predominantly follow donor guidelines. The comparative analysis looks at possible tensions between different positions of sex work by CSOs and sex worker-led organizations and how these shape power relationships between them. It also brings out tensions that result from their differences in access to donor- and key population networks.

RESULTS: Sex work is illegal in both Kenya and Ethiopia, but is regulated in completely different ways. Hence, comparing both countries allows a better understanding of the way different governance regimes of sex work enable or obstruct potential partnerships. This knowledge helps in determining a more targeted agenda for (legal) advocacy in HIV prevention.

CONCLUSIONS AND RECOMMENDATIONS: Different notions of sex work have bearings on the way possible partnerships are imagined. Such insights help in tackling diverging views, and ensuing power differences, as these obstruct the establishment of more horizontal partnerships in HIV prevention. These obstacles are also tied to differences in access to networks and other resources. Hence, understanding how this all plays out between CSOs and sex worker-led organizations in said countries enables us to give clear recommendation on how to overcome such power differences and improve health services to sex workers worldwide.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Jacaranda 3	01.12.2015

TUAE0504: Track E/5 -

Facilitators and Barriers to Linkage and Retention in HIV Care among Female Sex Workers Receiving HIV Testing Services at a Community-based Organization in Peri-urban Uganda

Nakanwagi Sharon1,2, Talemwa Rose3, Matovu Joseph4, Kintu Betty Nsangi5, Kaharuza Frank4, Wanyenze Rhoda4

1Reach Out Mbuya HIV/AIDS Initiative, Research, Kampala, Uganda, 2Makerere University School of Public Health, Fellowship Program, Kampala, Uganda, 3Bioversity, Human Resource, Kampala, Uganda, 4Makerere University School of Public Health, College of Health Sciences, Kampala, Uganda, 5Reach Out Mbuya HIV/AIDS Initiative, Management, Kampala, Uganda

BACKGROUND: Although nearly 40% of female sex workers (FSWs) in sub Saharan Africa are HIV positive, less than half are enrolled in HIV care. We explored the facilitators and barriers to linkage and retention among FSWs receiving HIV testing services at a community based organization in Uganda.

METHODS: We conducted a mixed-methods cross-sectional study among 301 FSWs who tested HIV positive at Reach Out Mbuya from May 2012 to December 2013. Structured interviews with 144 HIV-positive FSWs, in-depth interviews with 29 FSW (15 in care and 14 not in care), and key informant interviews with five staff and eleven peer educators were conducted. Data were collected on time to register in care, age, marital status and facilitators and barriers to linkage and retention. Univariate and multivariable logistic regression analysis conducted to identify factors associated with linkage using STATA v.13 while qualitative data were analyzed manually.

RESULTS: Of the 301 tested HIV positive, 144 (48%) were reached and 125 (86.8%) of these were registered into HIV care, with 112 (78%) registering within one month of diagnosis. Older FSWs (>31 years) were 2.6 times more likely to register early than the younger (95% CI: 1.01-7.04). Unmarried FSW were less likely than married FSW to be registered within one month (Adj. OR =0.11, 95% CI: 0.01-0.96). Linkage and retention facilitators included caring health workers; follow up by peer educators, saving group membership and perceived health need. Barriers included stigma, fear and myths related to ART, lack of clinic time, unaware of treatment centre, drug side effects, alcohol and drugs.

CONCLUSIONS AND RECOMMENDATIONS: Friendly health care services and intensive follow up, including support from peers and counsellors may enhance timely linkage and retention in care for FSWs.

11:45 – 12:00	Jacaranda 3	01.12.2015

TUAE0505: Track E/5 -

Using ICT to Reach Men Having Sex with Men in the Middle East and North Africa Region

Couffignal Manuel

International AIDS Alliiance, Rabat, Morocco

BACKGROUND: Information & Communication Technologies in MENA are used by MSM to access information safely, socialize and meet sexual partners. The International HIV/AIDS Alliance and civil society organisations in Algeria, Morocco, Lebanon and Tunisia are piloting, in partnership with B-Change Technology and supported by the USAID-funded LMG Project, a web-based outreach intervention that expands prevention services for MSM. Such expansion is critical: many MSM in MENA are not reached by the programs targeting them.

Objectives: The objective is to meet the needs of MSM, using ICT. Data was required to improve the understanding of their online habits and behaviours. We conducted formative research to inform the design of a regional web-based outreach intervention to increase HIV testing and uptake of other services among MSM.

METHODS: Two anonymous web surveys were conducted (one month period each). Facebook and instant messaging channels were used to recruit 200 MSM participants. The 1st survey assessed technology use and included questions about mobile devices, instant messaging, and

tech-based sexual networking. The 2nd survey collected further data on social media behaviours with questions about social networks' use, interpersonal communications, and negative experiences online.

RESULTS: The highest response rates were from localities near CSOs working with MSM. The majority of respondents were under 30. Mainstream social networks, and global gay dating apps, are frequently used by MSM, especially in the evening. Smartphone instant messaging is the main communication method among friends, while telephone remains the main method with health providers. Online videos are the preferred form of educational content. The websites and apps accessed for sexual networking were recorded per country. Negative experiences related to breach of confidentiality online were reported.

CONCLUSIONS: These results informed the design of a regional online outreach intervention targeting young MSM, which is being piloted in settings where CSOs already offer a package of services for MSM. It is implemented by trained 'online MSM peer educators'. Educational content is disseminated through social media channels and apps. MSM are reached via chat rooms, websites, apps and instant messaging. If supported by robust communication strategies and backed with strong digital security measures, it could be rapidly scaled up to reach high numbers of MSM in the region.

12:00 – 12:15	Jacaranda 3	01.12.2015

TUAE0506: Track E/5 - Partnerships and transformations: advancing key population access

Chair:

Understanding Low Threshold HIV Testing for People who Inject Drugs in Kenya

Kalama Onesmus Mlewa

Kenya AIDS NGO's Consortium (KANCO), Research, Nairobi, Kenya

BACKGROUND: Despite comprising only 0.05% of the entire population, people who inject drugs contribute 3.8% of all new HIV infections in Kenya making this key population (KP) group the most vulnerable to HIV infection. Since 2012 KANCO implemented a three year harm reduction program reaching 6000 people who inject drugs (PWIDs) in five high drug burden areas in Kenya. Results of the three year study evaluation findings show that only 28.5% of people who inject drugs have correct knowledge of their HIV status having taken an HIV test three months after their last possible HIV exposure act. According to national statistics, the prevalence of HIV among people who inject drugs has increased six fold from 3% in 2000 to 18.1% in 2013 (Ministry of health; 2013).

METHODS: The study utilized a quasi-experimental study utilizing cross sectional survey study design before and after intervention without comparison. A sample size of 188 respondents was randomly drawn from a sampling frame of 6000 PWIDs across five project implementation sites in Kenya.

RESULTS: 98.2% of PWID's had ever received HIV testing after the intervention compared to 60% before the intervention. However the proportion of PWIDs who have taken an HIV test three months after being exposed to a risky sexual contact was only 58% after the intervention compared to less than 26.3%% before interventions. Knowledge on the importance of HIV testing among PWIDs is above 90% but this knowledge has not been translated into actual service seeking practice. 40% of PWIDs interviewed believe they know their HIV status based on a test result taken more than 12 months besides having unprotected sex after their earlier HIV test. 58% of the respondents tested at an earlier date say they do not need another test. 96% of PWID's prefer outreach based HIV testing services while more than 80% of the PWIDs acknowledged that they lack family support. 40% of the PWID's interviewed reported lack of HIV testing services at the needle and Syringe collection points and over 50% of the PWIDs interviewed said they are now using clean injecting equipment hence not at risk of getting HIV.

CONCLUSIONS AND RECOMMENDATIONS: There is need to improve on the low threshold HIV testing services for People who inject drugs to ensure completeness of harm reduction interventions. The recommendation is to promote the integration of harm reduction and treatment services and scale up outreach based HIV testing and counseling.

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Jacaranda 1 & 2	01.12.2015
TUAD0401:	Track D/4 - Stigma, discrimination and disclosure	
Chairs:	Suzette Moses-Burton	

Combatting Internalised HIV Stigma: Urgent Need for Research Evidence

10:45 – 11:00

Pantelic Marija1, Shenderovich Yulia1,2, Cluver Lucie1,3, Boyes Mark4

1University of Oxford, Department of Social Policy and Intervention, Oxford, United Kingdom, 2University of Cambridge, Department of Psychiatry, Cambridge, United Kingdom, 3University of Cape Town, Department of Psychiatry and Mental Health, Cape Town, South Africa, 4Curtin University, School of Psychology and Speech Pathology, Perth, Australia

BACKGROUND: Three decades into the fight against HIV, stigma remains a major 'roadblock' to HIV prevention and treatment. Despite UN commitments to eliminate HIV/AIDS-related stigma by 2015, no well-established programmes to reduce internalised HIV stigma exist. This systematic review aims to synthesize evidence on predictors of internalised HIV stigma amongst people living with HIV in Sub-Saharan Africa.

METHODS: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were used. Studies were identified through electronic databases, grey literature, reference harvesting and contacts with key researchers. Quality of findings was assessed through Cambridge Quality Checklists.

RESULTS: A total of 590 potentially relevant titles were identified. Seventeen peer-reviewed articles and one draft book chapter were included. These papers represented 13 unique samples and a total of 9,088 PLHIV across nine Sub-Saharan African countries. Studies investigated socio-demographic, HIV-related, intra- personal and inter-personal correlates of internalised stigma. Eleven articles used cross-sectional data, six articles used prospective cohort data and one used both prospective cohort and cross-sectional data to assess correlates of internalised stigma. Poor HIV-related health weakly predicted increases in internalized HIV stigma in three longitudinal studies. Lower depression scores and improvements in overall mental health predicted reductions in internalized HIV stigma in two longitudinal studies, with moderate and weak effects respectively. No other consistent predictors were found.

CONCLUSIONS AND RECOMMENDATIONS: This review generated a wide range of implications for research, with no firm implications for practice. The majority of included studies were cross-sectional, with two thirds of included studies scoring below 50% on the Cambridge Quality Checklists. Longitudinal evidence is urgently needed to establish causality. Future research is also needed to help resolve inconsistent directionality of findings. The present review highlights inconsistent findings on the relationship between internalised stigma and socio-demographic variables, as well as on how internalised stigma changes over time on ART. High-risk populations, other stigma markers that might layer upon internalised stigma, and structural drivers of internalised stigma need to be examined.

11:00 – 11:15	Jacaranda 1 & 2	01.12.2015
TUAD0402:	Track D/4 -	

Disclosure of Parental HIV to Adolescent Children

Kumalo-Sakutukwa Gertrude1, Lightfoot Marguerita1, Campbell Renisha1, Chingono Alfred2, Disclosure Study Group

1University of California San Francisco, Center for AIDS Prevention Studies, San Francisco, United States, 2University of Zimbabwe, College of Health Sciences, Psychiatry, Harare, Zimbabwe

BACKGROUND: Parents living with HIV are often encouraged to disclose their HIV status to their children. The WHO and most national pediatric HIV guidelines, including those in sub-Saharan Africa (South Africa, Uganda, Zimbabwe) recommend developmentally appropriate disclosure to children. However, parents are challenged to decide whether, how and when to disclose their HIV status to their children. Parents often avoid or delay disclosure of their status to children for a number of reasons, including not being sure of what to say, worry that their children will disclose their status to others, worry that their children will judge them harshly or fear of some other negative consequence. Studies in developing countries suggest the parental disclosure rate is below 45%.

METHODS: To understand decision-making about HIV disclosure to children and its impact on family, we conducted 3 focus group discussions (FGDs) with parents living with HIV who had disclosed and not disclosed their status to their adolescent child. Parents (17 mothers, 11 fathers) were recruited from four rural primary health care clinics that initiate ARV treatment in Mutoko,

Zimbabwe. We focused on families with adolescents (10 - 18 years) because literature from developing countries indicates parental preference to wait until a child has reached early adolescence. The FGDs were digitally recorded, transcribed, translated, coded and analyzed using Dedoose, a data analysis software for analyzing qualitative data.

RESULTS: There were 6 themes identified from the focus groups:

1) reasons for parental disclosure (i.e., helped explain medication parent was taking, wanted to get child tested for HIV),

2) expectations after parental disclosure (i.e., children will reduce their HIV risks, stronger parent-child relationship),

3) which child was disclosed to,

4) methods used to disclose HIV status (i.e., asked children for help with HIV medications, leaving medical card out for children to see),

5) reactions of children to disclosure (i.e., fear parent was going to die, accepted parents HIV status) and

6) experiences after parental HIV disclosure (received love and encouragement, child assisted with medications).

CONCLUSIONS AND RECOMMENDATIONS: These data support current initiatives to assist parents living with HIV to disclose their status to their children. Disclosure benefits and impact to both the parent and child. Interventions are needed that will assist parents to disclose their HIV status.

11:15 – 11:30	Jacaranda 1 & 2	01.12.2015

TUAD0403: Track D/4 -

Is Counselor Supported Disclosure the Way to Go? An Intervention to Enhance Uptake of Couple HIV Testing and Counseling

Kababu Margaret, Sakwa Eric, Karuga Robinson, Njeri Inviolata, Ikahu Annrita, Mukoma Wanjiru

LVCT Health, Nairobi, Kenya

BACKGROUND: Heterosexual couples contribute to 44% of new HIV infections in Kenya. Awareness of partner status is low (45% for women and 61% for men aged 25-64). There exist no standards to facilitate disclosure of HIV status or follow up strategies to establish the disclosure of test results among couples. LVCT Health developed a Counselor Supported Disclosure (CSD) model to enhance the uptake of Couple HIV Testing and Counselling (CHTC) and mutual disclosure. This study aimed to assess the acceptability and feasibility of introducing the CSD model and the requirements for its scale up in clinical and community settings in Kenya.

METHODS: A quasi-experimental design was used. Six HTC sites in four administrative Counties were purposively selected. A total of 276 participants (54% male, 46% female) were recruited; 149 in the comparison arm and 127 in the intervention arm. Standard HTC was offered in the comparison arm whereas the CSD model was administered in the intervention arm. The model empowered the index clients to invite their sexual partner for CHTC and mutual disclosure. Phone follow up at 6 weeks and subsequent Community Health Worker (CHW) follow-up for non-responders were embedded in the model. Semi-structured questionnaires were used to collect data from study participants at baseline and 3 months into the study. Fifteen in-depth interviews were conducted with participants in the intervention arm who took up CHTC, and 6 HTC providers who offered CSD. The quantitative data was analysed using SPSS 22 and the qualitative data analysed using NVIVO 10.

RESULTS: Uptake of CHTC (including mutual disclosure) in the intervention arm was 46% (42% female, 58% male) and 12% in the comparison arm, however the figures were too low for statistical comparison. Participants reported that the model emboldened them to invite their partners for CHTC. Phone follow-up was preferred over physical follow-up by a CHW due to concerns about potential breach of confidentiality by the CHWs which could result in stigma from their community. The HTC providers recommended:

a) provision of clear CSD guidelines

b) standardization of the process and

c) capacity building to improve CSD delivery.

Conclusion and **RECOMMENDATION:** The model has the potential to increase the uptake of CHTC and was easily implemented by the HTC counsellors. This model can be integrated into the existing HTC structures with minimal additional cost to enhance uptake of CHTC.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Jacaranda 1 & 2	01.12.2015

TUAD0404: Track D/4 -

Difficult Decisions: An Ethical Decision-making Tool, Tested in Africa, for Carers Working with HIV-affected Children and Families in Key Populations

Miller John L1, Iorpenda Kate2

1The Coalition for Children Affected by AIDS, Toronto, Canada, 2International AIDS Alliance, Brighton, United Kingdom

ISSUES: A global consultation in 8 regions with both carers and recipients of care showed that carers working with children and families in stigmatized groups such as people living with HIV, people who use drugs and sex workers face difficult decisions--at least weekly and often daily. In the absence of guidance, carers can make decisions that are unethical, and often based on bias or influenced by stigma about who has the ability or right to parent. No community based tools exist to support workers to make fairer decisions and protect themselves from burnout.

DESCRIPTIONS: This presentation will describe how an international working group developed a tool to help carers working in community-based organizations to make better, more ethical decisions when faced with competing choices or when the rights or interests of two people are in conflict. The tool is available in 4 languages at www.careworkerethics.org

Anchored by a code of ethical values and principles and using a simple 4-step tool, the tool guides care workers in understanding how ethical decision-making differs from following the law, organizational policy, religion, culture or societal norms. They then gather all facts, challenge stigma, identify ethical principles in conflict, make a decision, and document, debrief and self-evaluate.

The tool, tested in Malawi and now being evaluated in Kenya, was revised six times over four years based on feedback from the working group, a key informant group, and based in pilot testing in five regions and four languages.

LESSONS LEARNT: In the development of this tool, key population working group members stressed the importance of

a) highlighting ethical dilemmas in which stigma played a key role, and

b) designing the tool to help carers identify their own bias as part of ethical decision-making.

The pilot testing identified the need for clearer explanations of the basic definitions: regular dilemma, ethics, ethical dilemma—as well as the need for a pocket guide for quick decisions needed in the field.

NEXT STEPS: The independent evaluation of usefulness to care workers and impact on perception of fairness by client groups will be completed in January 2016. This evaluation is being conducted in Nairobi, Melbourne and Beirut. The report will be reviewed by the working group to identify if any changes or adaptations are needed.

11:45 – 12:00	Jacaranda 1 & 2	01.12.2015

TUAD0405: Track D/4 -

We Are the Change: Dealing with HIV Related Self-stigma in Zimbabwe

Chiroro Patrick1,2, Ferris France Nadine3, Mapanda Bekezela Amanda2, Ni Cheallaigh Deirdre4, Nyamucheta Masimba5, Vumbunu Slyvia5, Tugwete Nyasha5, Mudede Dennis6, Conroy R.7, Bryne E7, Macdonald S8

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ISSUES: Self-stigma is an important and neglected aspect of living with HIV. High levels of self-stigma have been reported in the People Living with HIV (PLHIV) Stigma Index. Self-stigma

negatively impacts a person's ability to live positively with HIV, limits self-agency, affects quality of life, adherence to treatment and access to health service. Yet few initiatives exist to tackle this issue, especially providing people with a skill set to address self stigma, for use in peer-support groups in a resource poor setting such as Zimbabwe.

DESCRIPTIONS: Trócaire and ZNNP+ designed, implemented and evaluated a 12-week pilot project using Inquiry Based Stress Reduction: The Work of Bryon Katie. Based on formative research, a curriculum was designed to support participants to work through self-stigmatising beliefs covering self-abasement, shame, guilt, disclosure, restricted agency, hopelessness, sexuality and death. Two ZNNP+ facilitators worked with international certified facilitators to deliver and adapt the programme with two groups of 11 participants drawn from ZNNP+ support groups. Designed as an operations research study with the support of the Royal College of Surgeons, Ireland (RCSI) and approved by the Medical Research Council Zimbabwe, qualitative and quantitative data was collected at baseline, immediately post-programme and at three months follow-up. The Internalised-AIDS Stigma and the Quality of Life scales measuring mood, perceived stress and quality of life were used. RCSI guided data analysis.

LESSONS LEARNT: Results at three month follow up show positive impacts. Qualitatively, participants report profound shifts in their lives around living positively with HIV, lessened fears about disclosure, not feeling limited by HIV and increased peacefulness. 'I used to feel that I was unequal to other people but now I feel that I am just as good as anyone else'. Quantitatively, project results show significant improvements among participants in a number of areas (% improved): self-stigma (61%), depression (78%), life satisfaction (52%), fears around disclosure (52%) and daily activity (70%).

NEXT STEPS: Based on these results, plans are underway to strengthen capacity, fully localise and roll out the project making it available to support groups across the country, complementing work on the Stigma Index. Internationally, this intervention is being shared as an example of a successful project and tool that can be used by PLHIV to deal with self-stigma.

12:00 – 12:15	Jacaranda 1 & 2	01.12.2015

TUAD0406: Track D/4 -

HIV Equal Zimbabwe (ZIM): Fighting HIV Stigma in ZIM Using a Novel Innovative Approach

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ISSUES: In ZIM, only 11.8% of men have been HIV tested due to stigma associated with HIV and getting tested. Knowing one's HIV status, and, if HIV-positive, immediately starting HIV "Treatment as Prevention (TasP)", is proven to reduce HIV transmission.

DESCRIPTIONS: World Health Clinicians, Inc. (WHC) is a U.S.-based non-profit humanitarian organization founded in 2010 to prevent the spread of HIV/AIDS and STIs in the developed and developing world. WHC founded HIV Equal (HIV=), with a mission to end HIV and HIV testing stigma by:

- Creating an international multimedia educational campaign,
- Promoting HIV testing through the creation of a social art movement using photographs that reignite the dialogue about HIV/AIDS,
- Linking newly diagnosed HIV-positive individuals to medical care and treatment, and
- Ultimately reducing HIV transmission and new HIV infection rates.

As part of the campaign, participants must get HIV tested before taking a photograph with an HIV= sticker strategically placed on their body. The sticker serves as a proud display of support to know one's HIV status. On the photograph, a unique STATUS word chosen by the participant is included. It exemplifies an aspect of who they are and reinforces the fact that who we are as people is much more important than an HIV status. All participants receive the professional HIV= photograph and an HIV= T-shirt for showing their support for fighting HIV stigma. If a participant tests HIV-positive, they immediately receive counseling, followed by a PIMA POC Rapid CD4 test and initiation of ARV

ABSTRACT DRIVEN SESSION

if CD4< 500.

In a pilot project, HIV=, through BEAT AIDS Project Zimbabwe (another WHC initiative) hosted 8 testing events (5 in rural villages, 3 in Victoria Falls municipality) from 2013 Dec - 2015Jan. 1262 people were tested, including 42% men, 6% children (ages 12 and under), and 21% adolescents (ages 13-18). 17.8% (n=225) newly tested HIV-positive, had their CD4 cell counts analyzed, and were linked to care.

LESSONS LEARNT: ZIM men, women, adolescents and children respond to fighting HIV stigma by getting HIV tested with the reward of receiving an HIV= photograph and clothing (an HIV= T-shirt), which, when worn around the community, serves to promote HIV testing, further reducing HIV stigma.

NEXT STEPS: BAPZ intends to launch HIV= across ZIM in partnership with MoHCC, ZNNP+, and CHAI.

As part of BAPZ Skills Development, photographers will be trained and employed to create HIV= photographs.

SPECIAL SESSION ON TRADITIONAL MEDECINE

Phytochemicals as Potential Inhibitors of Human Immunodeficiency Virus Type-1 Proliferation

Sharma Bechan

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BACKGROUND: The current antiHIV-1 RT drugs including nucleoside, nucleotide and non-nucleotide reverse transcriptase inhibitors, antiproteases, antiintegrases and anti RNase-H molecules have proved to cause significant reduction in the overall percentage of mortality of AIDS patients. The application of primarily the antiHIV-1 RTs and antiproteases have immensely contributed in increase in the number of CD4+ve lymphocytes into such individuals, thereby offering protection from other opportunistic infections. On the other side, these synthetic regimens have been found to induce oxidative stress and many other side effects including impairment in cognitive functions, metabolic disorders and neurotoxicity in users. In order to combat drug resistance and toxicity issues, the attempts are being made in our laboratory to screen and identify certain traditional Indian medicinal plants constituting ingredients with antiHIV-1 potential which are expected to be highly useful, cost effective, safe and efficient in order to arrest the HIV-1 proliferation.

METHODS: Some of these plants have been collected, identified and dried in shade and stored in powdered forms. Their extracts are being prepared in different solvents (in order of increasing polarity) and the preparations are being concentrated in dried or semisolid forms. These preparations are being screened against HIV-1 replication using viral enzymes (RT, protease and integrase) following the protocols provided by different manufactures of specific kits. These extracts would be resolved on TLC and the antiHIV-1 activity of each fraction would be further tested.

RESULTS: The results of our investigation indicate that these preparations have strong potential to inhibit viral enzymes and thus some of them may possibly be developed as viable antiHIV-1 chemotherapeutics in future.

CONCLUSIONS AND RECOMMENDATIONS: Plant based principles may be useful in arresting HIV-1 progression and hence may be exploited for development of effective antiHIV-1 agent.

Activities of Chemical Compounds Isolated from Indian Traditional Medicinal Plants to Arrest HIV-1 Progression

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BACKGROUND: In the current HIV-1 therapy, all HIV-1 RT inhibitors inhibit the activity of DNA polymerase, but not that of RNase H. The information available on basic biological processes in the HIV life-cycle suggest that it destroys a subpopulation of T-lymphocytes containing CD4 receptor and CXCR4 co- receptor on their surface. Since the complete HIV-1 life cycle stages (docking, internalization, un-coating, reverse transcription, synthesis of a proviral cDNA, integration of cDNA, replication, transcription, synthesis of a viral polyprotein chain, processing of this chain by viral protease, assembly of viral particles, release of viral particles and maturation) are now well established, it is possible to explore plant based principles targeting specific steps in the viral life-cycle.

ABSTRACT DRIVEN SESSION

METHODS: In this study, we screened 50 medicinal plants and prepare their extracts according to the polarity of the solvents and evaluation of their bioactivity and HIV-1 reverse transcriptase activity.

RESULTS: The exploration of plant based principles isolated from many Indian traditional medicinal plants/herbs with significantly high antiviral activity suffered intensively because of

(1) highly infectious nature of viruses and

(2) lack of suitable techniques for the separation, identification and characterization of antiviral chemical components present in extracts prepared in different solvents.

These days, the development of vector-based strategies, in which non-infectious molecular clone of a virus could be used for antiviral screening.

Conclusion: Since only fewer new natural products have been discovered with anti-HIV potential as compared to a vast number of previously known natural products exhibiting activity against HIV, a multiplex approach is required for exploring cost effective, safe and efficient plant based anti-HIV drugs acting in the nanomolar / picomolar range, we have attempted to evaluate anti-HIV-1 efficacy of extracts .These extracts have been resolved on TLC and the anti-HIV-1 potential of different fractions recovered in specific solvents is being tested using viral reverse transcriptase, protease and integrase enzymes as viable screens.

12:45 – 14:15	Committee Room 4	01.12.2015
TUAC0401:	Track C/4 - Key populations: integrated bio-behavioural surveillance - key to effective programming	
Chairs:	Daughtie Ogutu	

Differences in Demographic Profiles and Sexual Behaviors among FSW in Zambia´s Two Largest Cities 12:45 – 13:00

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BACKGROUND: Commercial sex work is often the only recourse that women may have to survive. Understanding the demographic profiles and sexual behaviors is necessary for development of HIV prevention materials.

METHODS: 1725 FSW from Lusaka (N=782) and Ndola (N=943) were tested and counseled for HIV. Demographic and sexual behavior profiles were collected. Unless specified, differences are significant.

RESULTS: In both cities, HIV+ women were an average 7 years older than HIV- (32 vs 25 years). HIV+ FSW in both cities were less likely to be single (56%) than HIV- FSW (69% in Lusaka and 79% in Ndola). Among HIV+, those in Lusaka were more likely to be divorced/separated (31% vs 20% in Ndola) and less likely to be widowed (10% vs 16% in Ndola). Literacy in the local language (Nyanja in Lusaka, Bemba in Ndola) differed by HIV status, with higher literacy among HIV- in Lusaka (28% able to read easily compared with 15% of HIV+) and lower literacy in Ndola (35% of HIV- and 44% of HIV+ able to read easily). Understanding and reading English was not common in Ndola (25-28% and 20% respectively) with no difference between HIV+ and HIV-. In contrast, among Lusaka dwellers HIV- women reported substantially higher levels of English comprehension (52% understand and 50% read easily) than HIV+ women (34% and 27%, respectively). All reported vaginal sex with clients, with few reporting oral (3%-9%) or anal (2%-12%) sex. In Ndola only 15% reported use of condoms all or most of the time with HIV+ reporting never using condoms slightly more often than HIV- (28% vs 22%). In contrast, HIV- Lusaka FSW were more likely to report using condoms all or most of the time (29%) compared with HIV+ (17%).

CONCLUSIONS AND RECOMMENDATIONS: HIV+ FSW were older and more likely to have lost a spouse to death or divorce than HIV- women in both cities. Condom use with clients is universally low. Ndola is linguistically homogeneous with higher levels of literacy in the local language than Lusaka, the centrally located capital home to migrants from all 5 major language groups. Overall, literacy was low which limits the usefulness of written educational and referral materials. English lessons and literacy training may be helpful both for HIV prevention and to increase opportunities for alternative income generation.

ABSTRACT DRIVEN SESSION

13:00 – 13:15	Committee Room 4	01.12.2015
TUAC0402:	Track C/4 -	

HIV Prevalence and Sexual Behavioral Roles among MSM in Nigeria

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BACKGROUND: In Nigeria, an increasing HIV prevalence among men who have sex with men (MSM) has been observed in the last two rounds of Integrated Biological and Behavioral Surveillance Survey (IBBSS) (13.5% in 2010 &17.2% in 2010). These surveys indicated that high-risk behaviors and HIV transmission continue to occur within this population. We examine correlates of HIV infection among MSM in six states in Nigeria.

METHODS: We analyzed data from the second round of IBBSS. Between April-May, 2010, 1545 MSM aged 15-49 years were recruited through the respondent driven sampling (RDS) technique. A structured questionnaire was administered through face-to face interviews, and a blood specimen collected and tested for HIV. Multivariable logistic regression was used to determine correlates of HIV infection.

RESULTS: Of 1545 MSM recruited, 51% were bisexual, 36% reported to have sold sex and 22% to have bought sex in the 6 months preceding the survey. Almost two-fifth (39%) reported only penetrative anal sex, 27% only receptive and 33% both penetrative and receptive anal sex. Of those who practiced receptive anal sex, 59% were below 25 years, 95% never married and 57% were non-paying partners. Inconsistent condom use varied with partner type (72.1%, 68.3% and 68.6% for paid, paying and non-paying partners respectively). Overall 17.2% tested HIV positive. Of these, 61% were aware of their HIV status prior to the survey. Factors associated with HIV infection were: older age [25-35: (AOR=1.56, 95% C.I (1.07 -2.28)], reporting receptive anal sex [AOR=2.15, 95% C.I (1.39-3.32)], having multiple male partners [AOR=1.78, 95% C.I (1.03-3.06)] and knowing an HIV infected person [AOR=1.56, 95% C.I (1.06-2.29)].

CONCLUSIONS AND RECOMMENDATIONS: This study showed a relatively high prevalence of HIV and sexual risk behavior among sampled MSM. Differences in HIV prevalence amongst MSM engaging in receptive and penetrative anal sex suggests that targeted behavioral and biomedical interventions tailored to the specific sexual roles are urgently needed. Inconsistent condom use reported by many in this group must be addressed.

Keywords: MSM, Anal sex, HIV prevalence

13:15 – 13:30	Committee Room 4	01.12.2015
TUAC0403:	Track C/4 -	

Profil Socio-professionnel et Estimation des Tailles des Professionnelles de Sexe (PS) et des Hommes Ayant des Rapports Sexuels avec d'Autres Hommes (HSH) au Togo

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Introduction: La prévalence de l'épidémie du VIH est de 2.5% au Togo. Derrière cette moyenne nationale, il y a des disparités régionales et surtout dans certaines populations clés. Ainsi la prévalence du VIH chez les professionnelles de sexe (PS) était de 13.1% et de 19.6% chez les hommes ayant des rapports avec d'autres hommes (HSH). L'objectif de cette étude était de déterminer le profil sociologique des PS et de HSH et d'estimer la taille de ces populations afin de mieux mener les interventions dans ce groupe.

Méthode: Il s'agissait d'une étude transversale menée durant trois mois entre octobre et décem-

bre 2014 dans les principales villes du pays. La méthode utilisée est de type boule de neige a permis de toucher et interviewer les PS et HSH.

Résultats: L'étude a permis de toucher 1473 professionnelles de sexe et 1230 HSH et ces échantillons touchés qui ont été interviewés pour définir le profil socio-professionnel ces deux populations.

Professionnelles de sexe (n= 1473).

Sur le plan socio-professionnel, l'âge moyenne des PS était de 28,7;5 ans ; 36,8% étaient adolescentes (10-19 ans).49% des PS étaient célibataires, 28% des veuves. Plus de 55% vivaient dans la capitale. Les PS affichées représenteraient 10,90 % de cet échantillon et les clandestines étaient de 87,10%..Les zones de concentrations sont les plus grandes villes et le long de grand axes routiers. La technique d'estimation de la taille a permis d'estimer à 6340 le nombre de PS.

Hommes ayant des rapports sexuels avec d'autres hommes (n=1230).

L'âge moyen des HSH était de 25,2;8 ans. Les HSH de moins de 25 ans représentaient 91%, les plus de 40 ans étaient minoritaires (01.3%). Sur les 1230 HSH, 43% étaient bisexuels, 7.8% vivaient en couple avec une femme.Plus de 60% étaient élèves et étudiants. Plus 80% vivaient dans les deux grandes villes du pays (Lomé et Kara). La taille estimée des HSH était de 7740.

Conclusion: La connaissance du profil de ces populations clés permet de mieux orienter l'élaboration de programme d'interventions pour plus d'efficacité dans la riposte contre le VIH au Togo. En effet l'investissement dans la prévention des populations constitue une intervention à haut impact.

Mots clés: Populations clés, cartographie, Togo

13:30 – 13:45	Committee Room 4	01.12.2015
TUAC0404:	Track C/4 -	

HIV and HBV Infection, Knowledge and Risk Behaviour in Ghanaian Prisons

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BACKGROUND: HIV and HBV infections are more common among prison inmates than the general population. Infections often occur before as well as in prison. This situation is often attributed to high-risk sexual behaviour, injecting drug use, tattooing and sharing of needles. The objectives of this study were to measure HIV and HBV prevalence among male and female prison inmates in Ghana, and to investigate knowledge, risk behaviour and attitude among inmates.

METHODS: A cross-sectional Integrated Bio-Behavioural Surveillance Survey was conducted among prison inmates from June to August 2012. A total of 2,443 prisoners were involved in the study comprising of 205 female and 2,238 male inmates. Stratified sampling technique was employed to select male inmates, while a census of all female prisoners was carried out. A standardised questionnaire was used to collect behavioural data, this was immediately followed by biological data collection through whole blood sample to determine the HIV and HBV status. Bi-variate and multiple logistic regression was also carried out to establish, which factors were significantly associated with inmates' HIV and HBV prevalence. Approval was obtained from Noguchi Institutional Review Board.

RESULTS: The overall prevalence of HIV was 2.3%, males 1.5 % and female 11.8. The overall prevalence of HBV was 12.8 percent, males 13.3 and females, 7.8 %. About 29% of males and 9% female inmates reported sharing razor blades in prison. Only 1.4% and 1.5% of male and female inmates respectively have ever tattooed within prison. Prior to incarceration, about 49% engaged in sex with more than one casual partner. 2.5% of female inmates engaged in commercial sex work. Injecting drug use was virtually absent in Ghanaian prisons.

CONCLUSIONS AND RECOMMENDATIONS: While HIV prevalence among males was low, that of females was several fold that of the general population, confirming the vulnerabilities of female prison inmates. HBV prevalence among both males and females was high. Risky behaviours (sexual/drug use/sharing implements) appear to be rare in Ghanaian prisons. There was no statistically significant relationship between these risky behaviour in prison and HIV and HBV positive status. Given that inmates in prison are less likely to get infected, new entrants should be offered voluntary counseling and testing before admission into the prisons.

ABSTRACT DRIVEN SESSION

13:45 – 14:00	Committee Room 4	01.12.2015
TUAC0405:	Track C/4 -	

High HIV, HBV and HCV Prevalence among People who Inject Drugs: Results from the First Integrated Bio-behavioral Survey of PWID in Mozambique

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BACKGROUND: While People who Inject Drugs (PWID) are globally recognized as a key population for HIV infection due to high transmission rates of needle and drug-equipment sharing, only a handful of sero-surveillance surveys exist among PWID in southern Africa. In 2014, we conducted the first Integrated Bio-Behavioral Surveillance Survey (IBBS) among PWID in Mozambique; a country where HIV prevalence among the general population is 11.5% with no national harm-reduction policy and few health and prevention services specific for PWID.

METHODS: Using Respondent-Driven Sampling (RDS), we recruited PWID, defined as adults 18 years and over who had ever injected drugs without a prescription. Participants completed a behavioral questionnaire, provided dried blood spots for central laboratory testing for HIV, HBV and HCV, and received results from voluntary on-site rapid tests. We used RDS Analysis Tool v.7.1 to produce population estimates and 95% confidence intervals.

RESULTS: We enrolled 353 participants in Maputo and 139 in Nampula/Nacala (94.1% and 97.1% males), of which drug injection in the past month was reported by 75.9% and 89.2% in Maputo and Nampula/Nacala, respectively. HIV prevalence was 50.3% (CI: 40.7-58.8%) and 36.8% (24.1-49.6%), while HCV prevalence was 32.1% (25.2-38.5%) and 36.4% (22.6-49.8%), and HBV prevalence was 44.6% (33.4-53.9%) and 7.0% (2.0-12.5%). Among HIV-positive PWID, 49.7% and 85.4% were unaware of their HIV status. Nearly half (50.3% and 42.4%) of PWID ever shared a needle, with one in four having done so in the past month. Heroine was the primary drug injected (82.2% and 73.0%) and 28.9% of PWID in Maputo and 25.2% in Nampula/Nacala used drugs for more than 10 years. HIV prevalence was higher among those who have been injecting drugs for more than 10 years and those who inject daily ($p< 0.01$).

CONCLUSIONS AND RECOMMENDATIONS: These results demonstrate that PWID in Mozambique are at high risk for acquiring and transmitting HIV, HBV and HCV because of unsafe and frequent injection practices. Harm reduction interventions, such as needle exchange programs, distribution of safe injection kits, addiction treatment services and PWID-specific peer education programming, are urgently needed to curb the transmission of these infectious chronic diseases among this population.

14:00 – 14:15	Committee Room 4	01.12.2015
TUAC0406:	Track C/4 -	

Female Injecting Drug Users in Egypt: A Hard to Reach Population

Tawakol Ghazel1, Abaza Oumnia1, Abdel Malak Maryham1, Khoury Carla1, Elkamhawi Sherif1, Elbeih Wessam2, Youssef Hala3, Elkott Nabil4, Sanan Nehad5, Elkharrat Ehab6, Ramy Hisham7, Soliman Cherif1

1FHI 360, Cairo, Egypt, 2Drosos Foundation, Cairo, Egypt, 3Ford Foundation, Cairo, Egypt, 4Hayat, Giza, Egypt, 5Befrienders, Giza, Egypt, 6Freedom, Cairo, Egypt, 7Ain Shams University, Cairo, Egypt

BACKGROUND: Female Injecting Drug Users (IDUs) have limited access to Harm Reduction services due to cultural constraints, weak network, low social status, and lack of motivation. Little information is known about them, which hinders designing proper interventions tailored to their needs.

METHODS: Between March 2013 and November 2014, The Network of Associations for Harm Reduction (NAHR) Comprehensive Care Centers (CCCs) provided services to Key Populations in-

cluding Female IDUs. Socio demographic, behavioral and biological data were collected and analyzed from four of the Network CCCs located in Greater Cairo.

RESULTS: Out of 237 females outreached in Greater Cairo, 112 were IDUs (47.3%). Of these 112 IDUs, a total of 78 female IDUs (69.6%) visited NAHR Centers. About 40% of them were between 16 and 24 years old and more than half were between 25 and 35 years old. Almost 25% reported being currently married, 65.4% attended university, and about 80% were unemployed. The age of first drug injection was between 16 and 24 years for more than 70% of female IDUs. In the past month Heroin was the most common drug used (52.6%). Sharing needles and syringes in the last month was reported by 71.8%, and about 10.0% reported sharing needles the last time they injected drugs. Alcohol consumption in the last month was reported by 15.4%. More than 96.0% ever had sex, only 5.3% used condoms with a non-steady partner during the last sex, and 40.0% were not willing to use condoms in the future. Almost half of females ever having sex reported exchanging sex for drugs, and more than one fifth were engaging in same sex relations. Ever being tested for HIV was reported by only 11.5%. HIV prevalence among female IDUs was 6.3%.

Conclusion and Recommendations: Gender sensitive Harm Reduction services that respond to the specific needs of female IDUs are required. A combined approach including safe sex and safe injection should be considered along with creating an enabling environment to persuade female participation in Harm Reduction projects.

12:45 – 14:15	Jacaranda 3	01.12.2015
TUAD0501:	Track D/5 - Sex workers, access to services and human rights	

Determinants of Family Planning Uptake among Female Sex Workers Enrolled in an HIV Incidence Study in Eldoret Kenya 12:45 – 13:00

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BACKGROUND: Female sex workers (FSWs) have limited access to reproductive health services due to marginalization and stigmatization. This limited access poses the risk of the risk of HIV acquisition and/or transmission, unintended pregnancies, and also the risk of vertical transmission thus described as an important HIV prevention priority population.

The efforts to mitigate the above risks are largely missing in many family planning settings. To guard FSWs against this; education on FP methods, its provision and safe sex practices should be emphasized at all levels of care provision. This study sought to find out the commonly used their uptake levels and the factors associated this uptake within this population.

METHODS: This was a crossectional study. FSW were screened between June 2012 and Dec 2013. Identification was through a peer recruitment strategy. At screening, data on the socio-demographic and FP planning methods was obtained. This data was presented for analysis. Descriptive statistics and measurement of association (odd ratio and confidence intervals) were performed.

RESULTS: We screened 734 FSWs; median age was 26 years, interquartile range 23-31. 23.6% were HIV infected and 64.2% reported alcohol intake. 3.7% of the FSWs were married and 64.6% had two or more children. 58.2 % had attained primary education, 20.5% secondary, 1.6% post secondary and 9.7% had no education. 39.1% of FSWs did not use any form of contraception. Injection was cormonest method used (35.8%) and intrauterine device the least (0.7%). Age above 30yrs was associated with low FP uptake p=0.001, OR=0.54; 95% CI: 0.37-0.77. Married FSWs were less likely to use FP p= 0.005, OR 0.30; 95% CI 0.13-0.69 while those with more than 2 children were more likely to use FP p= 0.002, OR 1.72; 95% CI 1.21-2.43.

CONCLUSIONS AND RECOMMENDATIONS: In order to scale up uptake of family planning among FSWs, focused counseling messages should be developed to target FSWs who are below 30yrs of age, married and those with less than 2 children. Effort should also be geared towards provision of long acting FP methods.

ABSTRACT DRIVEN SESSION

13:00 – 13:15	Jacaranda 3	01.12.2015

TUAD0502: Track D/5 -

An Exploration of the Health, Human Rights and Economic Needs of Male Sex Workers in Nairobi, Kenya

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BACKGROUND: The male sex worker (MSW) collective known as HOYMAS holds a membership of 1650 individuals. In collaboration with SOAIDS Nederland, HOYMAS undertook a qualitative study to understand four overlapping areas that programs were unable to address (due to lack of evidence in the literature and from existing HIV prevention programmes). Four program evidence gaps were explored: general health; working environment; alternative sources of employment and income generation, and psychosocial support.

METHODS: Between March and June 2013, the team conducted a participatory mapping to identify key hotspots in five separate counties (Mombasa, Nakuru, Kisumu, Thika, and Nairobi). The team interacted with approximately 100 community contacts who agreed to participate in 5 focus group discussions (FGDs). The team also conducted 20 in-depth qualitative interviews. Participants ranged from 18 to 40 years of age. Participant observation, note-taking and the documentation of life stories took place throughout the entire research process. Because of the traumatic memories that surfaced, a trained counsellor was on hand to help participants manage their emotions. Participants were chosen by community leaders and therefore highly experienced in working with MSWs and helping them with their health problems. The resulting interviews were transcribed and manually analyzed using conventional approaches to content analysis.

RESULTS: Major themes that emerged included:

1) intense stigma and discrimination from public health care providers, law enforcement, religious groups, family members, and the general population;

2) internalized stigma in the form of self-hatred, shame, and low self-esteem;

3) Physical, emotional, and sexual violence;

4) for many, they were uncomfortable being referred to public health facilities;

5) Hepatitis B was reported as a major problem among MSWs in each county.

6) Distance from health facilities was a major obstacle in adhering to HIV and TB treatment regimes.

7) Most were unable to earn a sufficient livelihood from sex.

CONCLUSIONS AND RECOMMENDATIONS:

1) Equip clinics with basic diagnostic equipment for anal warts; Hep B vaccines;

2) Peer-led community safety programs and crisis response teams are necessary to respond to and mitigate violence;

3) Ongoing advocacy to decriminalize sex work is essential for improving the health and well-being of sex workers;

4) Micro-financing and small business start-up loans should be made available to help supplement their income.

ABSTRACT DRIVEN SESSION

13:15 – 13:30	Jacaranda 3	01.12.2015
TUAD0503:	Track D/5 -	

Stepping Stones: Young People and Minors Selling Sex

Vidovic Biljana, Ridder-Wiskerke Marieke

Aids Fonds, Amsterdam, Netherlands

ISSUES: Young people who sell sex are neglected in fields of HIV and sex work, particularly minors. Human rights conventions consider under 18 year olds selling sex as sexually exploited. Reality seems to be more complex. Not only situations of sexual exploitation, but also livelihoods and labour needs via transactional sex are explanatory factors for young people to start selling sex. As most countries criminalize sex work, young people selling sex are even further disengaged from access to HIV and social services. This is explained by fear of legal repercussions and social exclusion.

DESCRIPTION: Stepping Stones is a project that aims to improve the security, dignity and livelihoods of young people selling sex or vulnerable for, affected by, sexual violence or exploitation. In six African countries, Aids Fonds collaborates with (N)GO's and sex worker led organisations to empower young people selling sex and to prevent and end sexual violence or exploitation. Stepping Stones is one of the frontrunners in programming on minors and young people selling sex from a holistic and human rights based approach. Moving away from traditional 'rescue' and rehabilitation perspectives, participation of young people selling sex, advocating for their needs and building youth-led networks is essential. Pioneers are local community based organizations eager to pave the way for a new movement, building organizational capacity and sustainability.

LESSONS LEARNT: Minors selling sex are excluded from HIV services by legal constraints or the attitudes of service providers towards them. Minors selling sex are often disengaged from adult caretakers while adult consent is often needed to participate in research. Young people selling sex would choose education above selling sex but feel responsible to care for their siblings or to provide for their own livelihood. Once engaged in transactional sex, they experience violence, abuse and health risks such and lack of assertively to negotiate condom use.

Recommendations: When adult consent is not possible, the focus of interventions should be on young people between ages 18-24 who have had experiences selling sex during adolescence. Engage local society and health providers, progressive police and media as channels to lobby and advocate for needs of young people and minors selling sex. Increasing young people's knowledge of and access to HIV services and sexual and reproductive health and rights are essential for effective programming.

13:30 – 13:45	Jacaranda 3	01.12.2015
TUAD0504:	Track D/5 -	

Prévention, Dépistage du VIH et l'Accès aux Soins chez les Travailleuses de Sexe: Cas de Kénédougou Solidarité

Nimaga Adboulaye Ablo

Asssociation, Sikasso, Mali

INDIQUER LE PROBLÈME ÉTUDIÉ, LA QUESTION DE RECHERCHE : La prévalence du VIH au Mali reste relativement faible 1,1% et atteint 24% chez les travailleuses de sexe. Sikasso de par sa position géographique fait frontière avec trois pays et constitue une forte migration et d'échanges commerciaux qui attirent les travailleuses de sexe. Par ailleurs la région dispose de plusieurs sites d'orpaillage et des usines d'égrenage du coton où travaillent les saisonniers venant d'horizons diverses. Pour réduire la transmission du VIH, il faut agir au niveau des populations qui constituent le moteur de sa propagation dont les travailleuses de sexe. C'est ainsi que Kénédougou Solidarité en partenariat avec Danayasso a obtenu un financement de Solidarité Sida en 2010 pour la réalisation des activités.

MÉTHODES: Pour la réalisation des activités, nous avons mis en place une équipe de cinq personnes dont un médecin soignant, un conseiller, un laborantin deux animatrices. La démarche utilisée est la suivante:

- Programmation du lieu et fixation des horaires d'activité avec les bénéficiaires;

- Animation avec les TS sur le VIH/SIDA et les IST par les animatrices avant l'arrivée de l'équipe de dépistage;

- Dépistage volontaire sur place;

- Référence des cas positifs pour la prise en charge;

- Traitement IST sur place ou référence au centre.

RÉSULTATS: De 2012 à décembre 2014, 586 séances d'animation ont été réalisées au profit de 2342 participantes, 438 personnes ont accepté le dépistage volontaire soit 19%,46 cas positifs soit 10,50%. En termes d'IST, 208 travailleuses de sexe ont bénéficié la consultation dont 133 cas pris en charge soit 64% et par rapport aux préservatifs 126160 unité ont été distribué. Chaque année, 10 leaders parmi les travailleuses de sexe ont bénéficié de formation.

Conclusions et Recommandations: La prévention et le dépistage en stratégie mobile est une approche qui marche au près des travailleuses de sexe. La prise en charge des personnes séropositives reste cependant confrontée à la mobilité des bénéficiaires qui change régulièrement de sites voir même de pays sans aviser l'équipe en charge de l'encadrement. Il faudrait trouver d'autre stratégie pour pouvoir maintenir le plus longtemps possible les travailleuses de sexe séropositives dans le circuit de la prise en charge.

13:45 – 14:00	Jacaranda 3	01.12.2015
TUAD0505:	Track D/5 -	

Challenging Abusive Laws through Legal Literacy Capacity Building of Female Sex Workers (FSW) to Enhance Universal Access to SRHR/HIV Services: The Case of Malawi

Shumba Humphreys T

UNFPA, Reproductive Health, Lilongwe, Malawi

ISSUES: On Wednesday 20th May, 2015 Malawi High Court in Blantyre ruled that mandatory testing of HIV by doctors and nurses at Mwanza District hospital in 2009 was a violation of human rights. On 10 March 2011, eleven women from Mwanza, Malawi, filed an application in the Blantyre High Court through judicial review challenging their subjection to mandatory HIV tests, the admission of the HIV test results as evidence in criminal cases against them, and the public disclosure of their HIV status in open court. The women argued that these actions by Mwanza Police, Mwanza District Hospital and Mwanza Magistrate Court violated their constitutional rights and negatively impacted on their ability to access services due to stigma and discrimination.

DESCRIPTIONS: The FSW were arbitrarily arrested in Mwanza in September and November 2009 by the police. Although the police arrested both men and women only the FSW detained. The FSW were then subjected to Mandatory HIV Testing blood tests without their informed consent. The medical officers noted the women's names and test results on pieces of paper and handed these over to the police. Thereafter, the women were taken to the Magistrate's Court where some were charged with spreading sexually transmitted infections in contravention of one of the sections (section192) of the Penal Code of the laws of Malawi. In the courtroom, the particulars of the offence were read out loud including the fact that the women were HIV positive.

Prior to this case UNFPA had been supporting one of its Implementing Partners to develop legal literacy capacity of the female sex workers. Through the Malawi national sex work alliance, the alliance leaders were oriented and sensitized on legal issues around sex work and sex workers rights. With support from a legal counsel with a strong human rights background the female sex workers were therefore able to successfully sue the government for gross violation of rights and wrongful arrests.

LESSONS LEARNT: Mandatory HIV tests was unreasonable, arbitrary and violated their constitutional rights.

; It is possible for sex workers to challenge the laws if they are empowered to claim their rights.

; Violation of human rights impede vulnerable groups from accessing SRHR/HIV services.

NEXT STEPS: The case will now inform the final deliberations of the proposed HIV and AIDS (Prevention and Management) Bill which also purports mandatory testing of sex workers.

ABSTRACT DRIVEN SESSION

14:00 – 14:15	Jacaranda 3	01.12.2015
TUAD0506:	Track D/5 -	

Economic Empowerment to Prevent HIV among Sex Workers. Lessons Learnt from Botswana, Egypt, Ethiopia, Kenya and Zimbabwe

Wijne Marie-Louise, Ridder-Wiskerke Marieke

Aids Fonds, Sex Work Projects, Amsterdam, Netherlands

ISSUES: Sex workers are disproportionately affected by exploitation, violence, and HIV. In the many African countries where sex work is illegal and morally condemned, HIV prevalence rises over 50% among sub-populations of sex workers. Sex workers are reluctant to seek health care or other forms of protection out of fear for prosecution. When in dire need for their own or their dependents' survival, sex workers have limited negotiation power with clients who are violent or demand unprotected sex.

Sex workers who are more empowered to access additional sources of income and to control their financial resources, are better able to negotiate safe sex, extricate themselves from violent relationships and access health and support services. Economic empowerment also improves sex workers' livelihood in times of illness, pregnancy, or low season.

DESCRIPTIONS: In 2013 and 2014, over 1.100 sex workers in Egypt, Ethiopia, Kenya, Zimbabwe and Botswana participated in economic empowerment activities as part of the SUSO project. This Aids Fonds project was implemented primarily by sex worker-led organisations. Sex workers participated in vocational training, saving groups and loans for the development of small businesses. Leadership training and training in transferable skills such as English proficiency and computer skills also proved effective to reduce sex workers' vulnerability to HIV and violence.

LESSONS LEARNT: Sex workers cooperated with the implementing organizations to define what economic empowerment for sex workers entails. The following aspects are considered essential:

- Economic empowerment is not necessarily a means to step out of the sex industry. Being able to earn more from sex work in better working conditions is also economic empowerment.
- Limited access to financial institutions is a crucial constraining factor for sex workers' economic empowerment.
- In sex work, the body is a form of capital, and health care is an investment in key resources.
- Economic empowerment increases self-esteem and reduces self-stigma.
- Basic financial skills are a precondition for the success of other economic empowerment interventions.

The findings are confirmed in the project's midterm evaluation by the Dutch Radboud University.

NEXT STEPS: Good practice examples are disseminated as hands-on advice to CBOs and NGOs to implement effective economic empowerment interventions.

Keywords: 'economic empowerment', 'HIV prevention', 'sex work'

ABSTRACT DRIVEN SESSION

14:45 – 16:15	Committee Room 4	01.12.2015
TUAC0501:	Track C/5 - HIV Testing beyond the health facility	
Chairs:	Henry Nagai, Ghana	

Measuring the Burden of Undiagnosed HIV Infection from a Population-based Survey in Bukoba, Tanzania: Merits of a Home-based Testing Approach 14:45 – 15:00

Maruyama Haruka1, Ernest Oscar1, Porter Sarah2, Mackellar Duncan2, Kikaro Samwel3, Weber Rachel4, Josiah Robert5, Mbilinyi Deo6, Justman Jessica7, Antelman Gretchen8

1ICAP at Columbia University, Dar es Salaam, Tanzania, United Republic of, 2Centers for Disease Control and Prevention, Atlanta, United States, 3Tanzania Health Promotion Support, Dar es Salaam, Tanzania, United Republic of, 4CTS Global, Inc., Assigned to Centers for Disease Control and Prevention, Dar es Salaam, Tanzania, United Republic of, 5National AIDS Control Program, Dar es Salaam, Tanzania, United Republic of, 6Centers for Disease Control and Prevention, Dar es Salaam, Tanzania, United Republic of, 7ICAP at Columbia University, New York, United States, 8Elizabeth Glaser Pediatric AIDS Foundation, Dar es Salaam, Tanzania, United Republic of

BACKGROUND: In Tanzania, HIV testing and counseling (HTC) is typically offered through voluntary or provider-initiated testing at health facilities, primarily benefiting people who seek health services. Few studies in Tanzania have evaluated the uptake and impact of home-based HTC (HBHTC) on identifying persons with undiagnosed HIV infection.

Objectives: This analysis investigates patterns of self-reported past HTC behavior, current HBHTC acceptance, and prevalence of undiagnosed HIV.

METHODS: A cross-sectional, population-based, household survey was conducted in Bukoba Municipality, Tanzania, between November 2013 and January 2014. A one-stage, cluster sampling design was used to select 53 census enumeration areas (EAs) in the municipality. All households within a selected EA were visited, and survey participation was offered to all adults aged 18-49 years. For consenting persons, computer-assisted personal interviews on HIV-related risk and prevention behaviors were conducted, followed by HTC using the national rapid test algorithm. Survey data were analyzed using SAS v9.3; reported frequencies are not weighted and do not account for the sampling design or potential demographic differences in participation rates.

RESULTS: A total of 5405 adults (39% men [M], 61% women [W]) from 3401 out of 3686 (92%) contacted households participated in the survey interview. Out of interviewed participants, 4805 (89%) accepted HTC (87% M, 90% W), of whom 9.1% (6.1% M, 10.9% W) tested HIV positive. While 62% of all participants (52% M, 68% W) reported HIV testing at least once within the past two years, only 38% of the 436 seropositive participants (31% M, 41% W) were aware of their HIV infection prior to this HBHTC survey. The prevalence of undiagnosed HIV among all participants was 5.6% (4.2% M, 6.4% W) and among this previously undiagnosed subgroup, 47% (26% M, 56% W) reported they had tested in the past two years.

CONCLUSIONS AND RECOMMENDATIONS: HBHTC acceptance rates in this survey were high among both men and women. Although nearly two-thirds of interviewed adults reported HIV testing in the prior two years, over half of seropositive adults had undiagnosed HIV. Our findings suggest that current HTC practices may not be reaching the right groups. HBHTC is a promising strategy in Bukoba and similar settings in Tanzania to increase HTC uptake among both men and women and identify those with undiagnosed HIV infection.

15:00 – 15:15	Committee Room 4	01.12.2015
TUAC0502:	Track C/5 -	

Home-based HIV Testing and Counselling as an Innovative Approach to Reaching First Time Testers in a Peri-urban Area

Abdalla Phelister Wamboi, Both Female and Male Sex Workers in Kenya

Kenya Sex Workers Alliance, National Coordinator, Nairobi, Kenya

ISSUES: Kenya continues to record about 166,000 new HIV infections annually. Prevention efforts have focused on providing HIV testing and counseling services to all. Despite intensified efforts to achieve universal access, there still remains a sizable population that has never been tested for HIV (58.2% men and 41.6% women).KESWA is implementing a Home-based Testing and

Counseling(HBTC) program with the aim of increasing HIV testing coverage , reaching couples, families and those who have never been tested, thus contributing to the goal of universal access.

DESCRIPTIONS: HBTC program offers HIV testing and counseling services at the household level. The services are initiated by the provider and offered to willing individuals, couples and families in the households.The program utilizes community health workers from the specific areas to create demand for the HBTC services and support referral and follow-up of HIV -infected and affected persons .Between May 2013 and November 2014 HBTC was implemented in the Peri-urban area of Kawangware, Nairobi.

LESSONS LEARNT: 28,890 households were visited out of which 14,868(51.5%) received HBTC services ,27,943 (57% female and 43% male) individuals received HTC , of whom 15676 (56.1%) were first timers , among them 5,324 children aged 2-14 years. The program recorded 56.1% first time testers with 3% HIV prevalence rate and 44% couple/family testing sessions. An overall prevalence rate of 3.7% and 1.8% was established for females and males respectively.64% Of those referred for care and treatment went to the referral point. This was made possible by utilization of CHWs living with HIV who escorted clients to the referral points and did a follow-up back to the households.

NEXT STEPS: The 56.1% of the first-time testers indicate that HBTC is an effective approach in reaching first-time testers and should be scaled up .Community strategy has an important role to play in ensuring that HBTC achieves these positives results. Utilization of CHWs is critical in ensuring enrollment and retention in care.

15:15 – 15:30	Committee Room 4	01.12.2015

TUAC0503: Track C/5 -

Experience Nationale de la Mise en Oeuvre du Conseil et Depistage a Domicile du VIH dans un Pays Francophone: Le Cas de La Côte D'Ivoire

Yapi Yepié Stephane Hervé Lin

Programme National de Lutte contre le Sida (PNLS), Abidjan, Cote D'Ivoire

Introduction: En Côte d'Ivoire, selon l'Enquête Démographique de Santé III, la prévalence du VIH est de 3,7% et seulement 12,6% d'adultes de 15 à 45 ans avaient bénéficié d'un dépistage au cours des 12 derniers mois. Pour accroitre la connaissance du statut sérologique dans la population et couvrir les besoins d'offre de traitement ARV, le Ministère de la Santé, à travers le Programme National de Prise en Médicale des PVVIH (PNPEC) a initié de nouvelles approches de dépistage dont le conseil et dépistage à domicile (CDD).

Objectif: Il s'agissait de démontrer la faisabilité du conseil et dépistage à domicile du VIH en Côte d'Ivoire.

Méthode: Cette expérience a été possible grâce à un partenariat avec une ONG Kenyane (Liverpool VCT), qui a renforcé les capacités des acteurs terrain et des chargés de programme du PNPEC. La conduite de ce projet a reposé sur un plan dont les éléments clé étaient le développement des outils de gestion, la formation des conseillers communautaires, enfin le coaching et la supervision de ces derniers. Ainsi, sous la coordination du PNPEC, ce projet pilote qui a impliqué trois partenaires techniques du PEPFAR a été conduit sur 6 mois (Octobre 2009 à Mars 2010) dans 6 districts sanitaires et a mis à contribution 25 conseillers communautaires.

Résultats: 1174 domiciles ont été visités et l'offre de service de CDD acceptée dans 1026 (87.4%), permettant ainsi de proposer le dépistage à 4785 personnes parmi lesquelles 4751 se sont soumises au test VIH. Le taux de refus de ce service était estimé à 12,6%. Dans les domiciles visités, le taux d'acceptation du dépistage était de 99.29%. 164 couples ont également été dépistés et représentaient 3,45 % des individus dépistés. Le taux de séropositivité au VIH dans la population visitée était de 3,97% soit 189 personnes dont 6 couples sero discordants et 4 cas séropositifs. Aucun incident majeur y compris des cas de violence n'a été rapporté.

Conclusion and Recommandation: Les résultats obtenus traduisent la possibilité de la conduite de cette approche de dépistage communautaire dans le pays. Le taux élevé d'acceptabilité du dépistage témoignent, du besoin pour ce service mais aussi de la nécessité de rapprocher l'offre des populations.

Une évaluation coût - efficacité du CDD s'avère nécessaire pour envisager cette approche comme opportunité pour accroitre la connaissance du statut sérologique au sein des populations particulièrement celles d'accès difficiles comme les populations clés.

ABSTRACT DRIVEN SESSION

15:30 – 15:45	Committee Room 4	01.12.2015
TUAC0504:	Track C/5 -	

Using Social Media to Target Hard-to-Reach Men who Have Sex with Men (MSM) with HIV Services in the West Africa Region

Honu Marian1, De Hardt-Kaffils Harvey1, Me-Tahi Hortense2, Yina Gwatiena2, Traore Clotilde3, Zoungrana Zakaria3, Tchupo Jean-Paul1, Ettiegne-Traore Virginie1, Kapesa Laurent4

IFHI 360, Accra, Ghana, 2FHI 360, Lome, Togo, 3FHI 360, Ouagadougou, Burkina Faso, 4USAID/WA, Accra, Ghana

BACKGROUND: Empirical evidence in West Africa, shows that hidden Key Populations (KPs) especially men who have sex with men (MSM) are difficult to reach through face-to-face HIV interventions but could be accessible through social media on which they are quite active. The results of a situational analysis conducted within the context of the PACTE-VIH project implemented by FHI360 revealed that social media is one of the preferred channels used by several MSM to receive HIV prevention messages. FHI360 has extensively used social media to reach KPs in various countries around the world. In the light of this, PACTE-VIH has piloted and tested the feasibility of using social media to reach MSM with HIV prevention messages in Burkina Faso and Togo.

Objectives:

1. To provide HIV-prevention messages to hard-to-reach MSM not reached through conventional outreach activities.

2. To promote the uptake of HIV counselling and testing and other prevention services for hidden MSM.

Methodology: In July 2014, three MSM knowledgeable in social media were recruited among peer educators to receive additional training in the following: use of social media for HIV prevention, HTC and STI testing, gender-based violence, stigma and discrimination messaging, and data collection and reporting. They each received data bundles for a internet connection on their phones and laptops to connect with MSM online. Websites they frequently visited were Gay Romeo, Facebook, Dragues.net, Whatsapp, Badoo, and Skype. These social media users were mentored and supervised by a community liaison officer.

RESULTS:

- At the end of March 2015, 725 NEW MSM contacts had been made via the internet.
- Majority of MSM contacted were reached through the following websites: Gay Romeo (50%), Facebook (31%), Dragues.net (9%), Whatsapp (7%), Badoo (2%) and Skype (1%).
- Of those referred to HIV prevention services, more than one quarter of MSM referred for HIV testing, self-reported to have accessed the service.
- Two out of ten MSM referred for STI screening also reported to have accessed the service.
- 85% self-reported to have accessed condoms and lubricants as a result of reference.

Conclusion & way forward: Social media may provide an important additional avenue to target hard-to-reach MSM in the West Africa region. However, linking such virtual contacts to service provision remains a challenge.

15:45 – 16:00	Committee Room 4	01.12.2015
TUAC0505:	Track C/5 -	

Developing Understandable, Culturally Sensitive Self-test Instructions: Insights from Cognitive Interviewing among Clients Testing at Two HIV Testing Sites in Zimbabwe

Ruhode Nancy1, Sibanda Euphemia1, Madanhire Claudius1, Hatzold Karin2, Cowan Frances1,3, Napierala Mavedzenge Sue4

ABSTRACT DRIVEN SESSION

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BACKGROUND: HIV self-testing (HIVST) has the potential to increase uptake of HIV testing. Success of self-testing largely depends on achieving accurate results through understandable test instructions. In order to support implementation of HIVST in Zimbabwe, we are developing culturally relevant HIVST instructions. Here we report on one component of this process.

Objectives: To use cognitive interviewing (CI) to develop written and pictorial materials for the promotion and support of HIVST and linkage to care in Zimbabwe.

METHODS: The study was conducted in an urban and rural HIV testing site between July 2014-January 2015. Individuals who had just tested HIV- negative were recruited using convenience sampling. We gave participants HIVST kits and HIVST instructions and asked them to go through the HIVST procedures. At each step we observed participants' actions, interviewed them on their thought process and understanding of instructions and asked for recommendations for improving instruction clarity. CIs were audio recorded, transcribed, translated, and analyzed thematically.

RESULTS: 8 and 6 participants were interviewed in urban and rural settings respectively. CI gave the following insights to instruction development:

1) providing spatial descriptions alone was inadequate, e.g. reference to "bottom pouch" and "top pouch" caused confusion as this depended on how the test packet was held;

2) Inadequate labelling, e.g. not showing where to tear when opening the HIVST package, can cause confusion;

3) failure to locate some test kit items, e.g. the stand for the developer solution;

4) Unclear translation causing difficulty in execution of instructions;

5) Results interpretation was difficult if pictures were not adjacent to text explanations;

6) Some symbols/pictures were interpreted differently, e.g. a 'no food' symbol was not always interpreted as intended;

7) Participants of lower literacy relied more on pictorial instructions.

As a result of these and other insights instructions were revised to improve clarity, make them more pictorial and less wordy.

CONCLUSIONS AND RECOMMENDATIONS: CI provided useful insight into user interpretation and understanding of HIVST instructions that resulted in evidence-based and contextually adapted instructions. Predominantly pictorial, concisely written instructions were found to be easier to understand.

16:00 – 16:15	Committee Room 4	01.12.2015
TUAC0506:	Track C/5 -	

Targeting Zero New HIV Infections: Determinants of HIV Seroconversion among Individual Receiving HIV Testing and Counseling (HTC) in Uganda: Retrospective, Cross-sectional Review of Routine HTC Data

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1The AIDS Support Organization (TASO), Programme Management, Kampala, Uganda, 2The AIDS Support Organization (TASO), Research, Kampala, Uganda

BACKGROUND: This paper examines the determinants of HIV seroconversion among patients receiving HIV testing and counseling at 11 TASO sites in Uganda. Findings will be used to come up with strategies, to enhance continuum of care among HIV negative individuals.

Methodology: Retrospective review of routine HTC patient dataset of individuals who were counselled and tested for HIV at 4 TASO service. .We reviewed data of Jan 2013 to December 2014. Four TASO centers-Gulu, Masindi, Mulago, and Tororo were purposefully selected from the four regions of Uganda, to represent 11 The AIDS Support Organisation(TASO) centers located countrywide. Individuals who had previously tested HIV negative at 3 months or 6months or 12months and had been re-tested at the time of analysis, were analyzed to establish their current HIV sero status. We used a logistic regression to identify factors associated to seroconversion. Probability values

(P-values) and Adjusted Odds ratios (AOR) were computed.

RESULTS: Males were 67873 (67%), Females 33,181(33%). Individuals from TASO Gulu were 11724, Masindi 36,424, Mulago 20861, and Tororo 32,045. Out of 101,054 individuals who received HIV testing and counseling services, 12,413(12%) who had previous tested HIV negative, had seroconverted, while 88,641(88%) were HIV negative. At multivariate analysis, HIV seroconversion was associated with male (p< 0.001, AOR 0.768, 95% CI 0.73-0.81), location of TASO site-TASO Masindi (p< 0.001, AOR 0.66, 95% CI 0.60- 0.71), TASO Mulago (p< 0.001, AOR 0.56, 95% CI 0.51- 0.62), and TASO Tororo (p< 0.001, AOR 0.60, 95% CI 0.55 0.66), religion-SDA(p< 0.006, AOR 1.759, 95% CI 1.175-2.633), marital status-Never Married (p< 0.001, AOR 0.77, 95% CI 0.72 to 0.82), Most at risk populations-Incarcerated(p=0.001), youth in school(p=0.002), youth out of school(p=0.008), MSM(p=0.003), Client of sex worker(p=0.001), plantation worker(p=0.039, orphanage(p< 0.001) and market vendor(p< 0.001), and couple results(p< 0.001, AOR 3.01, 95% CI 2.57 to 3.52).

Conclusion and **RECOMMENDATION:** Seroconversion was 12% among patients who accessed HIV testing and counseling. However, this was high among females and individuals from TASO Gulu. Sero conversion was also high among Incarcerated populations, youth in school, and youth out of school, MSM, Clients of sex workers, Orphanage, market vendors and couples. These suggest that additional measures could be implemented to enhance continuum of care among HIV negative individuals.

14:45 – 16:15	Jacaranda 3	01.12.2015

TUAB0401: Track B/4 - TB and HIV tango: are we winning the battle?

French Abstracts

Tolerability of Isoniazid Preventive Therapy in an HIV Infected Cohort

14:45 – 15:00

Mudzviti Tinashe1,2, Shamu Tinei2, Kunzekwenyika Cordelia2, Chimbetete Cleophas2, Bote Sandra2, Pascoe Margeret2

1University of Zimbabwe, School of Pharmacy, Harare, Zimbabwe, 2Newlands Clinic, Harare, Zimbabwe

BACKGROUND: Treating patients with latent tuberculosis infection in order to prevent the development of active disease is an essential strategy for eliminating tuberculosis (TB). However, there are concerns regarding the application of isoniazid (INH) due to the potential for hepatotoxicity, In 2010, Zimbabwe adopted Isoniazid Preventive Therapy (IPT) as policy for all HIV infected patients. The guidelines recommended that 10mg/kg of INH (with a maximum dose of 300mg once daily) be given to people living with HIV without TB disease for 6 to 9 months. This study was conducted to determine the incidence of adverse hepatic events after IPT commencement in a cohort of HIV infected patients. Adverse hepatic events were defined as elevations in liver enzymes which required IPT discontinuation.

METHODS: A retrospective records review was conducted using existing data captured during routine clinical visits at Newlands Clinic, Harare, Zimbabwe. All laboratory tests and investigations conducted are recorded in the database against the respective patient. Data collected was compiled in an excel spreadsheet for analysis. Patients who were included in the analysis were those who were commenced on IPT between January 2014 and June 2015 (inclusive).

RESULTS: Data from 549 patients commenced on IPT was analysed with 252 (45.9%) of them being female. The median age of the participants at the time IPT was started was 11 (range 1 - 73) years of age. The mean age of the patients was 17 (SD = 15) years. The mean duration of IPT use was 148 (SD = 43, range = 1 - 280) days. Forty-six patients (8.4%) developed adverse hepatic events which required discontinuation of IPT after a median duration of 84 (range 1 - 149) days. Incidence of adverse events while on IPT was 20.5 per 100 person-years (CI: 15.0-27.3). The median and mean age for patients who developed adverse hepatic events to IPT was 10 (range = 4 - 66) years and 14 (SD = 13) years of age respectively. Twenty-eight (61%) of the participants who had adverse hepatic events were female.

CONCLUSIONS AND RECOMMENDATIONS: Incidence of IPT related adverse hepatic events was high among younger patients. We recommend vigilant monitoring of liver enzymes for patients receiving IPT.

ABSTRACT DRIVEN SESSION

15:00 – 15:15	Jacaranda 3	01.12.2015

TUAB0402: Track B/4 -

Résistance aux Antituberculeux chez les Adultes VIH+ Suivis dans l'Essai Temprano Recevant ou Non une Prophylaxie par Isoniazide (ANRS 12136)

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CONTEXTE: La prophylaxie par isoniazide (NH) est recommandée par l'OMS chez toute personne infectée par le VIH (VIH+) n'ayant pas de tuberculose active. Elle n'est pas appliquée en Côte d'Ivoire en raison de craintes d'émergences de résistances.

Objectif: Décrire la fréquence et le profil des résistances aux antituberculeux chez les adultes VIH+ peu immunodéprimés recevant ou non une prophylaxie par INH dans le cadre de l'essai Temprano ANRS 12136 en Côte d'Ivoire.

Méthodes: L'essai randomisé Temprano, réalisé chez des adultes VIH+ ayant moins de 800 CD4/mm3, avec deux objectifs : (i) comparer l'efficacité d'un début traitement ARV immédiat à un début différé (ie : jusqu'à l'obtention des critères OMS de mise sous traitement); (ii) comparer l'efficacité d'une prophylaxie par 6 mois d'isoniazide au fait de ne pas prendre de prophylaxie. Après 30 mois de suivi, le critère de jugement principal était un critère combiné, incluant morbidité sévère (SIDA, maladies bactériennes invasives, cancers non SIDA) et toute cause de décès. L'essai a débuté en mars 2008 et s'est terminé en janvier 2015. En cas de survenue de tuberculose, une culture puis un antibiogramme étaient systématiquement réalisé.

Résultats: 2056 patients ont été suivis dans l'essai pendant 4755 patient-années. La médiane de CD4 à l'inclusion était de 465/mm3 (intervalle interquartile 369-573). 85 épisodes de tuberculose active sont survenus pendant le suivi (incidence globale 1,8/100 personne-années), dont 26 chez les personnes randomisées pour prendre l'isoniazide et 57 chez celles randomisées pour le pas prendre l'isoniazide (hazard ratio: 0.44, IC95% 0,28-0,66). La culture a été positive à M. tuberculosis dans 40 épisodes. Un antibiogramme a pu être réalisé dans 40 de ces 41 cas, montrant une souche multisensible dans 26 cas (65%), une monorésistance à l'INH dans 5 cas (12,5%), une multirésistance dans 4 cas (10%), et un autre profil de résistance dans 5 cas (12,5%). Parmi les 9 monorésistants ou multirésistants, seuls 2 avaient reçu de l'isoniazide et 7 n'en avaient pas reçu.

Conclusion: Dans cet essai, l'isonazide diminuait spectaculairement le risque de tuberculose active, sans augmenter le risque de résistance aux antituberculeux.

15:15 – 15:30	Jacaranda 3	01.12.2015

TUAB0403: Track B/4 -

Performance Monitoring of Tuberculosis Infection Control in Zimbabwe

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ISSUES: Zimbabwe currently ranks 17th among the world's 22 high-burden TB countries, and approximately 72% of all TB patients are co-infected with HIV. In this context, both patients and healthcare staff are at high risk of TB infection in health facilities lacking proper tuberculosis infection control (TBIC) measures. The PEPFAR-funded Zimbabwe Infection Prevention and Control Project (ZIPCOP) aims to improve TBIC in health facilities. One aim of the project was to assess the performance of these facilities against standardized TBIC metrics, to identify specific areas for improvement.

ABSTRACT DRIVEN SESSION

DESCRIPTIONS: From July 2014 through March 2015, 82 health facilities in Zimbabwe were assessed by ZIPCOP: of these, 22 were baseline assessments and 60 were follow-up visits following an intervention which included training in TBIC. Assessments were carried out using a color-coded scoring tool adapted from a U.S. Centers for Disease Control TBIC checklist. Facilities were scored on TBIC domains including: triage of TB suspects using a screening tool; timely isolation, diagnosis and treatment of patients with presumed or confirmed TB; presence of decongestion measures and adequate ventilation; availability of respirators and IEC materials; and routine TB screening for clinical staff.

LESSONS LEARNT: The assessment tool scored each domain as follows: 2=intervention available, 1=intervention in progress, and 0=intervention not available. Among baseline assessments, only 11 of 22 facilities scored above 50%. However, among follow-up assessments, 54 of 60 facilities scored above 50% overall. Facilities having received TBIC training showed improvements in domains including signage for doors and windows for TB isolation rooms; utilization of IEC materials; appropriate triage and isolation of patients; and availability of respirators. Conversely, TB screening for healthcare workers (HCWs) and airflow in clinical areas continued to be suboptimal at all facilities.

NEXT STEPS: Given the morbidity and mortality burden of the HIV and TB epidemics upon Zimbabwe, TBIC should be uniformly implemented in all healthcare facilities, with a multidisciplinary approach involving environmental health authorities to assist with ventilation and airflow challenges. Finally, the survival of the health system is contingent upon the health of its workforce. TB screening among HCWs is a critical gap, and must become a national priority given the elevated risk confronted by these front-line professionals.

15:30 – 15:45	Jacaranda 3	01.12.2015
TUAB0404:	Track B/4 -	

Facteurs Associés à la Co-infection Tuberculose Multi-résistante/ VIH au Togo

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Introduction: La tuberculose multi-résistante (TB-MDR) est un problème majeur de santé publique à cause de sa fréquence et des difficultés liées à son traitement. L'objectif de cette étude était de rapporter la fréquence de TB-MDR associée à l'infection au virus de l'immunodéficience acquise (VIH) et de rechercher les facteurs associés à cette co-infection

Méthodes: L'étude a été réalisée dans 2 populations : les patients tuberculeux en retraitement (rechute, échec ou reprise du traitement antituberculeux de première ligne) et les patients infectés par le VIH (PVVIH) et suspects de tuberculose pulmonaire nouveau-cas (PVVIH-TPNC). Les échantillons de crachats ont été traités par GenExpert pour le diagnostic de la tuberculose et la résistance à la rifampicine. En cas de résistance à la rifampicine, un antibiogramme sur milieu liquide (MGIT, BACTEC 960, Becton Dickinson), a été réalisé pour établir le profil de résistance aux antituberculeux de première ligne. Chez les patients en retraitement de la tuberculose, le dépistage du VIH a été effectué selon l'algorithme national en utilisant les tests rapides.

Résultats: Un total de 404 patients ont été inclus dans l'étude répartis en 268 cas de tuberculose en retraitement et 152 cas de (PVVIH) suspects de tuberculose pulmonaire nouveau cas (PVVIH-TPNC). La tuberculose a été dépistée chez 268 patients réparties en 216 patients en retraitement et 52 PVVIH-TPNC avec une fréquence respective de 85,7% (216/268) et 34,2% (52 /152). Parmi les 268 cas de tuberculose diagnostiquée, la résistance à la rifampicine (TB-MDR) a été observée dans 28 cas (6,9%) dont 26 cas chez les patients en retraitement (12,3%). Chez les 196 patients en retraitement chez qui la sérologie VIH a été réalisés, 40 ont été positifs (20,4%). En fonction de l'infection à VIH, la fréquence de la TB-MDR était de 25% chez les patients en retraitement (10/40) contre 1,3% chez les PVVIH-TPNC (2/152) avec une différence statistiquement significative. Dans le groupe des patients en retraitement, le risque de développer une TB-MDR est 4 fois plus élevé chez les patients en échec du traitement que dans les autres types de retraitement (rechute ou reprise de traitement). Comparée aux résultats de l'antibiogramme par la méthode de proportion, la résistance à la rifampicine par GenExpert a été confirmée à 100%.

CONCLUSIONS: L'échec du traitement antituberculeux de première ligne est un facteur majeur associé de la co-infection TB-MDR/VIH.

ABSTRACT DRIVEN SESSION

15:45 – 16:00	Jacaranda 3	01.12.2015

TUAB0405: Track B/4 -

Integration of TB and HIV Care across Two Time Periods in Three (Sub) Districts in South Africa

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BACKGROUND: South Africa has a dual HIV and TB epidemic, with two-thirds of new TB cases occurring among persons living with HIV. As a result, the 2012-2017 National Strategic Plan called for integration of HIV and TB treatment. Although they may be offered at the same location, often TB and HIV care remain disjointed. To evaluate a clinical TB and HIV training and mentoring program for nurses, two cross-sectional retrospective un-matched chart assessments were conducted in 2014 for patients initiating ART in 2011-12 (baseline) and 2013 (follow-up) to measure changes in clinical practice and outcomes in adult/adolescent care at 76 public health care facilities in three districts in South Africa. The assessments aimed to identify potential improvements in clinical care, and challenges requiring targeted intervention.

METHODS: Data were collected from 1,074 (baseline) and 1,048 (follow-up) HIV records and from 1,132 (baseline) and 1,098 (follow-up) TB records. The percentage of HIV patients with documentation of TB symptom screen, Izoniazid Prophylactic Therapy (IPT) screen, IPT initiation and TB treatment initiation were compared between time periods. Similarly, the percentage of TB patients with documentation of an HIV test, ART initiation, and CD4 test results were compared between time periods.

RESULTS: Among HIV charts, documentation of TB symptom screening was 71.8% at baseline and 81.3% at follow-up (p=< 0.001). No change was seen in documentation of TB treatment initiation in HIV charts, 13.9% compared to 13.6% at baseline and follow-up, respectively (p=0.828). Documentation of screening for IPT increased from 41.2% at baseline to 63.1% at follow-up (p=< 0.001). Documented IPT initiation increased from 32.8% at baseline to 41.0% at follow-up (p=< 0.001). Among TB charts, documentation of an HIV test among those not known to be HIV positive was 77.7% at baseline and 80.2% at follow-up (p=0.213). Documentation of ART start was 34.1% at baseline and 33.5% at follow-up (p=0.845). CD4 test documentation was 89.0% at baseline and 85.1% at follow-up (p=0.112).

CONCLUSIONS AND RECOMMENDATIONS: Significant differences were seen between the baseline and follow-up time periods for three of the variables measured in the HIV chart reviews. There were no changes in the TB chart review variables. Continued interventions toward integration, coordination, and alignment of TB and HIV care documentation and services are needed.

16:00 – 16:15	Jacaranda 3	01.12.2015

TUAB0406: Track B/4 -

Attrition between TB / HIV Testing and Linkage to Care in South Africa's Correctional Facilities

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BACKGROUND: The benefits of the intensified TB case finding programs that are being rolled out nationally in South Africa's correctional facilities can only be realized with the successful linkage to care of inmates who test positive. Here we describe attrition along the TB and HIV care cascade in South Africa's correctional facilities.

METHODS: We retrospectively analysed routine data from a TB active case finding program using point-of-care GeneXpert testing and providing HCT using point-of-care HIV tests and off-site laboratory CD4 testing. The program was implemented between January and December 2014 in five correctional centres across four provinces in South Africa. We augmented program data with individual level clinical data abstracted from patient files.

ABSTRACT DRIVEN SESSION

RESULTS: Of the 40869 inmates screened for TB; 95% (38710/40869) were male with a median age of 29 years [IQR: 25 - 35] and duration of detention of less than a year [IQR: 0 - 1 year]. 22% (9170/40869) had TB symptoms and 90% (8252/9170) were able to produce sputum for TB investigation on Xpert. 4% (330/8252) of the Xpert tests were unsuccessful with 2% (165/792) testing positive for TB. Of those testing positive 6% (10/165) had rifampicin resistance. The median time to Xpert result was same day as date of sputum production [IQR: 0 - 1 day]. 86% (142/165) of TB cases were initiated on treatment within 24 hours [IQR: 0 - 4 days]. Of the 14% (23/165) who were lost to follow up; 78% (18/23) were released directly following a court hearing and 22% (5/23) were transferred or released before treatment initiation. Of inmates screened for TB, 53% (21773/40869) accepted HIV testing; 14% (2945/21773) tested positive, with 12% (349/2945) of these being of known HIV positive status. 62% (1597/2596) of new HIV cases received a CD4 test and result. Amongst HIV cases who were not clinically staged; 47% (468/999) did not have blood drawn; 51% (504/999) were released prior to receiving CD4 result and results could not be tracked for 2% (21/999). The median time to CD4 result was 5 days [IQR: 2 - 8].

CONCLUSIONS: We observed marked success in rapid treatment initiation among most inmates diagnosed with TB (median time to treatment was < 24 hours). Loss from the TB care continuum was mostly due to release from the correctional facility shortly after testing and before the opportunity to start treatment. Greater attrition was observed with HIV care, possibly due to a longer turn-around time with off-site CD4 testing.

16:45 – 18:15	Committee Room 4	01.12.2015
TUAD0601:	Track D/6 - Community empowerment	
Chairs:	Jonathan Gunthrop, South Africa	

Exploring the Role of Socio-cultural and Political Construct in Influencing Behaviour Change in Zimbabwe - The Case of HIV and AIDS Affected Households in Makoni District

16:45 – 17:00

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1Family AIDS Caring Trust, Children Tariro, Mutare, Zimbabwe, 2Univerisity of South Africa, Johannesburg, South Africa, 3Family AIDS Caring Trust, Mutare, Zimbabwe

BACKGROUND: Over the years the fight against effects of HIV and AIDS has largely concentrated on the financial, human and physical capital with little attention being accorded for social, cultural and governance dimensions. The absence of a strong social network outside the common psycho-social support, arguably limits the capacity of HIV and AIDS affected households to fully recover from HIV and AIDS related shocks. Culture is recognised as an emerging determinant for HIV and AIDS reduction alongside local level governance. The paper stresses the value of social capital in the fight against HIV and AIDS while examining the net effects of culture and governance continuum in developing the social capital.

Objectives:

- Assessing the role of community safety nets on mitigating the effects of HIV and AIDS in rural settings•
- Determining the extent to which social capital is complemented by culture and governance•
- Establish key players in the social economy, their roles and frustrations

METHODS: Focus group discussions and semi - structured key informant interviews were used to generate scenarios. The research was based on perceptions of different community based structures (CBS) such as churches, village and chiefdom courts, and government. Data were analysed using social content analysis and guided by a social network framework.

RESULTS:

- Households living with limited social capital comparatively struggle more to recover from any form of shocks.•
- CBSs are an integral component for the provision of social capital. The effectiveness of these is however a function of political environment and culture•
- Churches are key in shaping morality and human behaviour in communities affected by HIV and AIDS but can also be disfranchised by a polarised political environment.

CONCLUSIONS AND RECOMMENDATIONS: Social capital presents as an emerging mech-

anism for shaping human behaviour in an environment affected by HIV and AIDS but its potential can be limited by poor governance. Bad governance weakens the social network and negatively affects HIV and AIDS adaptation mechanisms. The role of culture in shaping the social capital cannot be underestimated, therefore the need to design interventions within an existing cultural context.

Keywords: social capital, culture, governance and human behaviour

17:00 – 17:15	Committee Room 4	01.12.2015
TUAD0602:	Track D/6 -	

Un Processus Exemplaire de Mobilisation Communautaire: l'Exemple du Programme "Gundo-So"

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1Coalition PLUS, Pantin, France, 2ARCAD-SIDA, Bamako, Mali, 3SEREFO - University of Sciences Techniques and Technologies of Bamako, Bamako, Mali, 4Université du Québec à Montréal, Montréal, Canada, 5Université Lumière Lyon 2, Lyon, France

CONTEXTE: Le partage du statut sérologique est un enjeu majeur pour les femmes vivant avec le VIH (FVVIH), puisqu'il peut avoir des conséquences positives (soutien social et financier, dépistage du partenaire...) mais peut également engendrer des situations de discrimination et de rejet. Au Mali, c'est un enjeu d'autant plus fort que les FVVIH se trouvent souvent dans une situation de dépendance économique et de faible pouvoir de décision. Ainsi, un programme québécois d'accompagnement des FVVIH (Pouvoir Partager / Pouvoirs Partagés, ou PP/PP), a été adapté au Mali au sein d'ARCAD-SIDA, structure communautaire d'accompagnement et de prise en charge des PVVIH.

DESCRIPTION: Le processus d'adaptation s'est inscrit dans une démarche communautaire, i.e. les FVVIH ont été impliquées à toutes les étapes du processus. Trois comités incluant des FVVIH ont été créés pour l'adaptation. De plus, une commission regroupant 4 FVVIH animatrices a été créée pour suivre le processus. L'adaptation s'est réalisée en deux étapes : phase test pour réaliser l'adaptation des outils et produire un guide d'animation intermédiaire, puis une phase pilote pour tester la nouvelle version et rétroalimenter à partir du vécu des FVVIH et des animatrices, afin de produire la version finale du guide d'animation. De nombreux temps d'échanges avec les différents partenaires, les comités et les animatrices ont été organisés.

Leçons apprises: La présence de FVVIH dans les différents comités et la commission de suivi ont permis une vraie appropriation des enjeux liés à l'adaptation et une vraie mobilisation communautaire sur ce projet, permettant l'adaptation des outils et la production d'un guide d'animation. Tout au long du processus, les FVVIH ont pu exprimer leurs interrogations, leurs suggestions et leurs craintes. De plus, le processus a permis le changement des pratiques des travailleurs sociaux sur la thématique du partage du statut. Enfin, il a permis un vrai renforcement de capacités de certaines FVVIH. Par exemple, certaines FVVIH ayant bénéficié du programme sont aujourd'hui devenue animatrices du programme.

Conclusion: La mobilisation communautaire encouragée par le mode d'organisation du processus d'adaptation de ce programme a permis la création d'un programme d'accompagnement des FVVIH sur la question du partage du statut sérologique adapté au contexte malien. Aujourd'hui, le programme a été développé dans plusieurs sites d'ARCAD-SIDA et est proposé à de nombreuses FVVIH.

17:15 – 17:30	Committee Room 4	01.12.2015
TUAD0603:	Track D/6 -	

Visions, Voices, and Priorities: Evidence and Rationale Directly from Young People Living with and Affected by HIV

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1Global Youth Coalition on HIV/AIDS (GYCA), Brooklyn, United States, 2ATHENA Network, London, United Kingdom, 3ICW-East Africa, Kampala, Uganda, 4Global Youth Coalition on HIV/AIDS (GYCA), Addis Ababa, Ethiopia

ISSUES: Young people aged 15-24 account for 40% of new HIV infections globally. Often young people are unable to access sexual and reproductive health and rights (SRHR) services including contraceptive methods, sexually transmitted infection screening, and comprehensive sexuality education. Young people living with HIV, young men who have sex with men, sex workers, LGBT people face particular stigma and discrimination.

Link Up, a three-year project aiming to improve the SRHR of young people most affected by HIV in five countries in Asia and Africa, seeks to address these issues.

DESCRIPTIONS: In order to inform policy and programming, Link Up partners Global Youth Coalition on HIV/AIDS (GYCA) and the ATHENA Network conducted a global youth consultation on HIV and SRHR, with a special focus on the experiences and needs of young people living with and affected by HIV. More than 1,250 people took part over a five month period. Nearly 800 people from every region responded to an online survey that collected data in 5 languages, and over 450 young people affected by HIV participated in a series of youth-led and designed community dialogues with partners in Ethiopia, Uganda, Burundi, Bangladesh, and Myanmar.

Results and **LESSONS LEARNT:**

Participants in the consultation identified 5 major priority areas for positive change:

1. Provide integrated HIV and SRHR services delivered by knowledgeable, ethical, and supportive health-care providers.

2. Ensure full access to age-appropriate comprehensive sexuality education, including information on HIV and SRHR.

3. Protect, respect, and promote young people's human rights, of which SRHR are an integral part.

4. Address gender-based violence, including sexual violence and violence on the basis of sexual orientation or gender identity.

5. Meaningfully and directly engage young people in decision-making on HIV, SRHR, and family planning.

NEXT STEPS: After the policy report outlining these needs was published, think tanks were held by and for young people in each country to inform advocacy strategy development, and youth-led implementation of advocacy strategies have begun in all 5 countries. After the conclusion of the project in 2016, partners will continue to prioritize meaningful youth engagement in their work. On a broader note, health providers, policymakers, and CSOs must continue to prioritize the complex needs of young people living with and affected by HIV.

17:30 – 17:45	Committee Room 4	01.12.2015
TUAD0604:	Track D/6 -	

You Can Talk about Abstinence, Faithfulness and Condoms, but the Strategies Are nothing without Empowering People to Embrace Safer Ways of Making the Money they Need

Ajakaye Joseph, Crossman Darryl

International Labour Organisation, Pretoria, South Africa

ISSUES: Poverty exacerbates HIV and AIDS vulnerability.

DESCRIPTION: The Corridor Economic Empowerment Project (CEEP) is a project implemented by the ILO with support from Sida. The aim is to reduce HIV vulnerability through economic empowerment. The project focusses on women and girls, and workers in the informal economy in six countries. This study explores the depth of the life changing results through a qualitative thematic analysis. Data collection occurred through individual interviews (n=30). The themes explored include:

a) New business strategies lead to improvements in profits: A beneficiary from Malawi says:"In my food project I have improved my promotion strategies…I have even put a poster to advertise my business and I improved the surroundings of my business premises…My clients have increased and my profits also has gone up"

b) Increased profits improve personal income and life-styles: Beneficiaries move out of dire poverty with an increase in profits. In a Zimbabwean beneficiary's words "[I] can afford to eat twice

a day with my three children. Previously, we had only one meal per day. I can pay house rent every month without problems"

c) Increased income reduces reliance on high risk and survivalist strategies: A former sex worker captures this:"Life as a sex worker is always risky. Every day you meet different clients and some offer attractive monies for unprotected sex, and because you have no choice and you want money to pay rent, rates and school fees, you just have to satisfy your client. But now I have a choice because I now have a stable source of income to sustain my life and family"

d) Increased income helps to mitigate the impact of AIDS: A Zimbabwean beneficiary says:"I am HIV-positive living positively. I am no longer a beggar and my dignity as a human being has been restored, and I am well equipped because of this CEEP programme"

e) Empowerment is the key: A Tanzanian beneficiary comments "I am living with HIV for a long time but this training helped me to be more positive about it. Previous trainings attempted to console and show sympathy. This made us feel different, like people to be pitied. But the CEEP project empowered us to take the lead to deal with our situation as active actors".

LESSONS LEARNT: Economic empowerment is a good complementary prevention approach that makes a real difference in the lives of people.

NEXT STEPS: The ILO intends to expand this model to other countries in support of the post-2015 development agenda.

17:45 – 18:00	Committee Room 4	01.12.2015

TUAD0605: Track D/6 -

Addressing Stigma through the Economic Empowerment of Women in the South West Region of Cameroon - The Case of Reach Out Cameroon

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1Reach Out Cameroon, Health Department, Buea, Cameroon, 2Reach Out Cameroon, Buea, Cameroon

ISSUES: The means to fight HIV/AIDS does not reflect any connection with other social parameters in the community and little is being done to link anti-HIV/AIDS campaigns to social stigmas, negative cultural tendencies, ignorance and poverty in general. As a response to the increasing social and economic consequence of the HIV pandemic, we sought to implement a pilot micro-project, and evaluate its impact on poverty and stigma experienced by People Living with HIV (PLHIV), mostly women in South West Region (SWR) of Cameroon.

DESCRIPTIONS: An integrated community approach to reducing HIV related stigma was used. Sixty women from 03 female headed support groups of women infected and affected by HIV were provided with seed capital ($140) to establish micro-projects. Beneficiaries were trained on book keeping and how to function well as a group (group dynamics). A survey was also carried out to examine how socioeconomic changes may affect the rate of stigmatization suffered by PLHIV. The project was carried out by Reach Out Cameroon (NGO) in the SWR of Cameroon. The project ran from November 2013 - August 2014.

LESSONS LEARNT:

Qualitative - Beneficiaries described how successful their businesses were after being trained on book keeping and on group dynamics. Businesses such as sales of kerosene, firewood, groundnuts, rice and communication credit were established. Micro- poultry and pig farms were also established. Participants acknowledged experiencing a reduction in stigma they experience daily.

Quantitative - Sixty micro-projects were established. All beneficiaries who had started a micro-project could save monthly with 48% of the women saving a minimum of $40 per month. 50% acknowledge that the grant helped in reducing stigma against them.

NEXT STEPS: The income status of women who are HIV infected within a mix group of both infected and affected was improved. Due to the economic empowerment of HIV positive women in this project, these women began experiencing a reduction in stigma they use to face in their communities. Thus we recommended that this project be scaled up in other rural communities targeting a larger number of infected women.

ABSTRACT DRIVEN SESSION

18:00 – 18:15	Committee Room 4	01.12.2015
TUAD0606:	Track D/6 -	

D 20: Assurer une Prise en Charge (PEC) Inclusive et Participative des OEV et de Leur Famille: La Stratégie de l'Approche Famille du Centre Solidarité Action Sociale de Bouaké

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Centre Solidarité Action Sociale de Bouaké, Bouaké, Cote D'Ivoire

Introduction: L'approche famille est un ensemble de stratégies permettant d'utiliser un sujet index comme point d'entrée dans la famille pour amener le conjoint (e) , les enfants et les autres membres de la famille à un conseil et dépistage du VIH pour une PEC globale de toute la famille. Quant on sait que le VIH/sida appauvrit les familles, dénoue les liens familiaux et accentue la Déscolarisation des enfants. Cette stratégie peut contribuer à restaurer la cohésion familiale autour du malade.

OBJECTIFS: Le centre SAS, crée depuis le 15 M 1995 cherche à répondre à ces 3 questions: Comment Maintenir les Orphelins dans leur famille? Comment Amener les familles à s'impliquer dans la PEC d'un des leurs et comment amener la PVVIH à partager son statut sérologique avec au moins un membre de sa famille ou son conjoint (e)?

MÉTHODOLOGIE: Le centre SAS met en ;uvre un projet dénommé ma famille financé depuis 3ans par Sidaction pour la décentralisation des soins. Ce projet consiste à mettre en ;uvre cette approche dans 3 régions de la cote d'ivoire par un soutien technique et financier à 6 associations communautaires. L'approche famille est une stratégie qui intègre des messages valorisants le rôle prépondérant de la famille dans les activités de sensibilisation, d'accueil et d'orientation, du conseil dépistage volontaire, de la prise en charge psychosociale et médicale.

Résultats: Le centre sas a aujourd'hui un taux de 80% de rétention dans les soins des PVVIH, 70% des couples séparés du fait du VIH se sont réconciliés, 100% des Orphelins et enfants vulnérables soit la totalité des 3000 enfants sont intégrés dans des familles. Le taux de respect des RDV qui était de 55% avant la mise en ;uvre de l'approche est passé à 90% enfin le nombre de décès a baissé de 70%.

Prochaines étapes: Après avoir conçu des fiches techniques et un module de formation, Un guide pratique sur la capitalisation de cette approche sera produit pour partager plus largement les réflexions et les outils créés.

16:45 – 18:15	Jacaranda 3	01.12.2015
TUAC0601:	Track C/6 - Key population: innovative implementationt	
Chairs:	Kene Esom, Nigeria	

Micro-planning: The Sex Workers Outreach Programme (SWOP) Experience Nairobi, Kenya 16:45 – 17:00

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BACKGROUND: SWOP was established in 2008 to provide HIV prevention and care services among Key populations in Nairobi. The outreach team utilizes a peer-led hotspot-based model where peer educators (PE) provide sex workers (SW) with a minimum package of outreach services. A one on one approach was used but had its shortcomings including inconsistency of data and double enrollment due to mobility of SWs. The PE: SWs ratio was also low, remuneration poor as it was based on enrollments and coverage remained a challenge. A strategy change was needed to scale up coverage and meaningfully involve the PEs & outreach workers (ORW) in the program. Micro-planning was therefore adopted from the Avahan India AIDS Initiative in 2013 to strengthen the outreach activities. Micro-planning tools include hotspot load map, hotspot analysis, contact listing, peer plan

and gap analysis. SWOP also adopted the Ministry of Health key population data capture tools.

METHODS: Retrospective comparative study whereby data before micro-planning (2011-2012) and after (2013-2014) was retrieved and analyzed. Key variables; number of SWs reached, numbers enrolled into the program, retention and commodity distribution.

RESULTS: Micro-planning helped in defining PE & ORW coverage areas, enhancing effectiveness and efficiency of outreach activities through their involvement in the planning, data collection and analysis. PEs also analyzed gaps in their sites and helped meet identified needs improving community ownership. Micro-planning is data-driven hence more consistent, accurate and less duplicated data from the field. There were improvements in, enrolments-30%, retention-from 57%-75% & condoms-1000000 pieces/quarter. More relevant indicators including number of individuals receiving commodities& tracking referrals emerged. Tracing lost clients had become easier irrespective of the hotspot typology. HIV incidence had reduced to 2.2% and 11.1% (95% CI) among female SWs and male SWs respectively. Challenges included illiteracy among PEs and additional paperwork. Hostility by managers in select hotspots makes distribution of condoms and other commodities according to individual needs challenging. Lastly, PEs turnover is challenging as new ones have to be trained every time they are recruited.

CONCLUSIONS AND RECOMMENDATIONS: Micro-planning is an effective outreach approach. However, implementation should be customized to be in line with local situations, typologies and legality of sex work.

17:00 – 17:15	Jacaranda 3	01.12.2015
TUAC0602:	Track C/6 -	

Scaling up Combination HIV/AIDS Prevention Services for Most at Risk Populations. Engaging Urban Leaders to Making it Happen in Kampala and Entebbe Councils

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ISSUES: Uganda is now in its third decade of HIV and AIDS response with significant achievements registered in the management and control of the epidemic, however Uganda continues to experience increasing new HIV infections. AIDS Indicator Survey 2011 shows HIV prevalence in urban areas in Uganda reduced from 10% in 2005 to 8.3% by 2011, this was still higher than the national average (7.3%) which is largely attributed to the fact that HIV prevalence is still very high among the Most At Risk Populations (MARPs) who are predominantly in the urban areas. However there are limited direct and friendly interventions targeting the key populations and also there is limited leadership engagement to support Interventions.

DESCRIPTIONS: Alliance of Mayors and Municipal leaders Initiative for Community Action on HIV/AIDS at Local Level (AMICAALL) Uganda Chapter with support from Danish Royal Embassy is implementing an 18 months project aimed at engaging urban leaders to scale up comprehensive HIV and AIDS services targeting MARPs and other high risk groups." The project targets MARPs (Female Sex Workers, Men who have sex with Men, Long Distance Truck Drivers, fisher folks, Uniformed service personnel) and other high risk groups (boda boda cyclists and Market vendors) in the five divisions of Kampala Capital City Authority and Entebbe urban authority. The project adopted innovative and MARPs friendly implementation strategies and approaches that included; Peer to peer education, Outreaches and Moonlight service in the MARPs hot spots, Test and Treat for MARPs, Use of Combination HIV prevention service delivery model, and Working through the local leadership structures to enhance service delivery.

LESSONS LEARNT: HIV prevention and behavior change messages through peer education, the project reached a total of 21,715 (46% F, 54% M) individuals among MARPs.

Test and Treat, a total of 19,987 (38% F, 62% M) counseled, tested and received HIV test results of which 515 (48% F, 52% M) tested HIV positive and were referred for care.

Family Planning and eMTCT services and information reached 1776 and 1694 people respectively.

A total of 1,292 men were circumcised and distributed 660,676 condoms (653,679 M, 6,997 F) in the implementing urban councils.

NEXT STEPS: Engaging urban leadership in scaling up service to MARPS is critical in ensuring community mobilization and sustained results of service delivery. This approach can be replicated to other city centers in the country.

ABSTRACT DRIVEN SESSION

17:15 – 17:30	Jacaranda 3	01.12.2015

TUAC0603: Track C/6 -

A programmatic Assessment of the Utilization of Sexual Reproductive Health (SRH) and HIV Services among Key Populations in Zanzibar

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ISSUES: Sexual Reproductive Health and HIV are problems of public health importance in Zanzibar, and undeniably, access to health services is crucial to the general and key populations. However, there is dearth of information on factors that affect utilisation of SRH and HIV services among Female Sex Workers (FSW), People living with HIV (PLHIV) and People who inject drugs (PWID) sub-populations.

DESCRIPTIONS: This is a descriptive type of assessment, and a purposive sampling of 378 respondents were engaged in, and among them 278 were key populations of whom, males accounted for 53.6% [n=149/278] and females with the mean age group of 33.9 years [SD ;9.3]. Key informant Interviews, observations, focus group discussions and in-depth interviews were deployed using structured tools. Data collectors were trained, and generated data were checked for completeness and posted using Microsoft excel software for cleaning and Epi-info version 7 software for analysis.

LESSONS LEARNT: About 95.24% (n = 20/21) of the respondents did vividly acknowledged that, there is a strong collaboration between SRH and HIV. Young people organizations were mostly engaged in SRH &HIV services including advocacy and health promotion [27.02%], condom programming [16.20%], training and capacity enhancement [18.90%], impact mitigation [8.10%] and planning [10.80%].The results also showed that, 88.9% of the KPs acknowledged to have at least visited the health facilities for services. Furthermore, PWID reported high facility visit compared to other remaining sub populations [PWID-33.3%, MSM-17.7%, SW-19.3%]. However, more female KPs [88.4%, n=114/129] than males [83.9%, n=125/149] reported to have used these facilities for HIV services. MSM were using these facilities less when compared to other sub-populations 16.7% [n=40/239].

NEXT STEPS: Key populations knowledge on HIV services delivery points and on the nature of HIV services delivered were remarkably higher compared to those which are SRH related. The policy and legal environment have somehow been affecting the utilization of services by these sub-populations, and a study to examine more on issues that should address the needs and mitigate service related biases to the KPs and PLHIV in Zanzibar is very much recommended.

Keywords: KPs, HIV, SRH, services, Zanzibar

17:30 – 17:45	Jacaranda 3	01.12.2015

TUAC0604: Track C/6 -

Assessing HTC and STI Consultation Service Delivery for Key Populations in Nigeria through a Mystery Client Survey

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BACKGROUND: Through the implementation of the Strengthening HIV prevention Services for Key Populations in Nigeria, a gap in the quality of sexual and reproductive health services received by key Populations in Nigeria has been noticed.

Method: Data for this study was collected using a mystery client technique. 314 members of the key populations were pre-recruited and trained for the study and their composition were 109 Female Sex Workers, 101 Persons Who Inject Drugs and 104 Men who have Sex with Men. They visited targeted health facilities where health care providers have been identified and trained to provide sexual and reproductive health services to Key populations. After receiving the service, they completed a standard checklist to document their experience with the health care providers.

ABSTRACT DRIVEN SESSION

RESULTS: About 85% of the respondents reported that the health facilities visited were easily accessible and found operations time from Mondays to Fridays convenient. Posters, pamphlets and other health communication materials were visible to about 50% of respondents but only about a third believed the materials addressed their needs and concerns indicating many of the facilities have communications targeted at the general population. Although a good majority (71%) reported that they were counselled in separate rooms, confidentiality of interactions could not be guaranteed or was compromised as 50% of the respondents believed that their conversation could be overheard by others around; a little over half were assured of confidentiality of the counselling session; and less than a fifth were asked to use a number, pseudonym or another name to ensure confidentiality. On STI consultation and treatment, about 50% adjudged the providers to be friendly, welcoming, and non-judgmental as they felt comfortable during the session.

Conclusion and **RECOMMENDATION:** A critical issue that emerged from this study is a situation of poor information exchange between providers and their clients. Providers did not firmly follow the National HTC and STI protocols for eliciting required information that should inform their interactions with clients, particularly on assuring and ensuring confidentiality. There is a need to provide communication materials that are key population specific at health facilities and also a need to strengthen health workers training to offer more satisfactory health services to members of the key populations in Nigeria.

17:45 – 18:00	Jacaranda 3	01.12.2015

TUAC0605: Track C/6 -

Enhancing HIV Prevention and Treatment by Increasing Literacy and Effective Linkage to HIV Services through Bulk SMS

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ISSUES: Almost one third of young people in Southern and Eastern Africa don't know where they can access HIV services. On the other hand, mobile telephony penetration in Kenya stands at 77.3% with 88% SMS popularity amongst adolescents and youth aged between 15 and 24 years. Furthermore, the proliferation of mobile telephony in both urban and rural areas ensures that there is basic access to the SMS platform on their phone. LVCT Health, a local NGO runs a bulk SMS platform to offer comprehensive HIV literacy and linkage to HIV services to young people.

DESCRIPTIONS: The Lvct Health's innovative one2one Integrated Digital Platform (OIDP) that has harnessed the growing utilization of digital technologies by young Kenyans adolescent and youths to provide services. One of the OIDP components, the one2one Bulk Short Messaging Service (SMS) runs toll free on the short code 1190. Accurate, credible yet relatable and appealing HIV and related messages are disseminated on a regular schedule via bulk SMS to over 3000 registered clients. Within 24 hours, the responses from the clients are addressed by an adolescent and youth friendly professional counsellors in form of direct replies, referral to a service delivery point and follow up for uptake of services. In some instances, the counselor requests for consent to call for further information and counselling with the client. Monthly SMS Data is collated, analyzed and used for research agenda, policy advocacy and programmatic decisions.

LESSONS LEARNT: The bulk SMS tool has improved HIV literacy, linkage to, and uptake of HIV services. During an assessment done in September 2014, it was noted that the utilization of Bulk SMS for HIV Patient reminders that has since been able to increase keeping of medical appointments from 72% to 83% among adolescents and youth. Issues arising from the texts received included HIV symptoms, HIV transmission, window period, adherence, nutrition, discordancy and follow up for supported disclosure. Males accounted for 56% while females accounted for 44%, most of whom are below the age of 24 (63%).

NEXT STEPS: As a free and widely accessible service, SMS has proved to be a suitable tool in increasing HIV literacy and linkage to service. This is because it promotes bilateral communication, and it is personalized to the client's need in a short period of time. The bulk SMS service should be adopted and scaled up to promote literacy and linkage to services in other key areas in Health.

ABSTRACT DRIVEN SESSION

18:00 – 18:15	Jacaranda 3	01.12.2015

TUAC0606: Track C/6 -

Plateforme SMS de Santé Sexuelle et de la Reproduction Bila7araje

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Association de Lutte contre le Sida, Casablanca, Morocco

Problématique: La prévention de la transmission des infections sexuellement transmises (IST), dont le VIH, chez les jeunes au Maroc a été renforcée, par l'ALCS, grâce à l'utilisation des nouvelles technologies de l'information et de la communication (NTIC) en approche de proximité. Les études montrent que la tranche d'âges 15-35 ans est celle le plus touchée par les IST et l'utilisation des NTIC est la plus appropriée pour cette tranche d'âges.

Description de l'intervention: "Bila7araje" (prononcer "bilaharaje", mot arabe pour "sans inconfort" est une plateforme destinée aux adolescent(e)s et aux jeunes. "Bila7araje" est un projet en partenariat avec One world UK et Butterfly Works et mis en ;uvre depuis 2011.

Elle vise la prévention de l'infection à VIH et l'accès aux informations liées à la santé de la reproduction en utilisant les supports numériques que sont l'internet, les téléphones portables pour rendre accessibles les informations liées à la santé de la reproduction.

Les internautes peuvent poster des questions via le site web de l'ALCS ou via l'envoi de SMS (coût d'un sms normal). 65 % des questions reçu via le net est d'une population jeune entre 15 et 28 ans

Durant la période juin 2011 à mai 2015 nous avons reçu 4594 sms et 5541questions via le net 45% des questions portent sur les orientations aux structures de santé dont 90% des CIDAG de l'ALCS, et nous avons conclus.

Leçons apprises: La mobilisation médiatique est importante pour le succès de la plateforme. Ainsi, et c'est visible lors des campagnes de dépistage, 40% des questions reçues concernent le dépistage.

Les jeunes préfèrent la voie du net 65% plus que les sms.

Prochaines étapes: Bila7araje reste l'unique service qui emploie les NTICs pour la promotion de la santé sexuelle et de la reproduction au Maroc chez les adolescents et les jeunes.

Bil7araje est une valeur ajoutée aux divers services de l'ALCS, permettant une orientation facile pour les bénéficiaires afin de profiter des services proposés.

L'ALCS va s'engager dans la conception d'une interface informatique pour une gestion simple des réponses reçues et qui peut générer des statistiques plus précises.

NOTE

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Committee Room 6	02.12.2015
WEAA0101:	Track A/1 - HIV drug resistance	

High Rates of Baseline NNRTI-resistance and Virologic Failure among ART Naïve HIV-1 Infected Children in Mali 10:45 – 11:00

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ISEREFO - University of Sciences Techniques and Technologies of Bamako, Bamako, Mali, 2CHU Gabriel Toure, Department of Pediatrics, Bamako, Mali, 3Pitie-Salepetriere, Department of Virology, Paris, France, 4Northwestern University, Department of Infectious Diseases, Chicago, United States, 5Children's Memorial Hospital, Chicago, United States

BACKGROUND: Limited data exist on drug resistance and antiretroviral treatment (ART) outcomes in HIV-1 infected children in West Africa. We determined the prevalence of baseline resistance, and correlates of virologic failure (VF) and on-treatment resistance in a cohort of HIV-1 infected children in Mali.

Methodology: Prospective observational study of HIV-1 infected children < 10 years initiating first-line ART in Bamako, Mali. Assessments occurred at baseline and after 6months of ART. Genotypic resistance testing on stored baseline and 6-month samples occurred at study end. Reverse transcriptase and protease genes were sequenced using in-house methods. Resistance was defined as intermediate or high-level according to the Stanford HIV Genotypic Resistance Algorithm v7.0. VF was defined as viral load (VL) ≥1000copies/mL. Clinical and immunological failure were based on WHO criteria. Logistic regression was used to evaluate factors associated with VF and resistance.

RESULTS: 150 children were enrolled; 60% male and mean age 3.4 years. 94% reported no PMTCT exposure. Median baseline CD4 count and VL were 633 cells/mm3 (IQR: 381-1039) and 675,651copies/mL (IQR: 40,000-1,583,200). Initial ART regimens were lopinavir/ritonavir-based (43%) or NNRTI (efavirenz or nevirapine)-based (57%). Of 141 children with amplifiable baseline samples, 28 (19.86%) had NNRTI resistance, only 2 of whom had PMTCT exposure, and none had PI resistance. Mean age of children with baseline NNRTI resistance was 2.3 years. By 6 months of ART, 11 died, 8 were lost to follow-up and 6 had missing VL data. Among 125 remaining children, 41 (33%) had VF, 24 of whom (58%) had drug resistance (23 with NNRTI and one with PI mutations). 93% of children with VF did not meet criteria for clinical or immunological failure. In multivariate analyses adjusting for age, gender, adherence, and ART regimen, baseline NNRTI resistance was strongly associated with VF and 6-month resistance (OR: 6.7, p=0.001; OR: 20, p< 0.001).

CONCLUSIONS: Baseline NNRTI resistance was common in Malian children without prior NNRTI exposure and was associated with VF and a high resistance rate during ART. Clinical and immunologic criteria rarely detected VF. Our findings support WHO recommendations of PI-based regimens in all children < 3 years, and virological monitoring.

11:00 – 11:15	Committee Room 6	02.12.2015
WEAA0102:	Track A/1 -	

Serologic Markers and Molecular Epidemiology of HBV in an HIV Infected Cohort from Cameroon

Magoro Tshifhiwa, Mavhandu Lufuno, Bessong Pascal

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BACKGROUND: Hepatitis B virus (HBV) and human immunodeficiency virus (HIV) are generally transmitted through similar routes; and are of global public health concern, particular in sub-Saharan Africa. It is important to regularly assess the prevalence of HBV in HIV infected patients to generate data relevant for the management of HIV/HBV infections. The objective of this study was to determine the prevalence of HBV serologic markers, mutations associated with resistance to Lamivudine, and HBV genotypes in HIV-infected individuals from Cameroon.

METHODS: Plasma from 455 HIV infected antiretroviral drug naïve patients from the Southwest and Littoral Regions of Cameroon were investigated for serologic markers of HBV infection.

ABSTRACT DRIVEN SESSION

HBV polymerase gene was amplified by nested polymerase chain reaction, directly sequenced, and analyzed for viral genotypes and mutations associated with resistance to Lamivudine.

RESULTS: The observed prevalences for serologic markers for HBV infection were as follows: HBsAg (25.5%), anti-HBsAg (13.3%), anti-HBc (36.3%), anti-HBs + anti-HBc (20.8%), HBsAg+HBeAg (15.2%). Occult HBV DNA was detected in 6% of the HBsAg negative patients. Out of 46 available HBV polymerase sequences 7 (15.2%) harboured one or more lamivudine associated resistance mutations. HBV genotypes noted were E (72%) and A (28%).

CONCLUSIONS AND RECOMMENDATIONS: The observations suggest that a relatively high proportion of the HIV infected study population are co-infected with HBV. The detection of HBV variants resistant to lamivudine in HIV infected drug naïve individuals may have implications for the clinical management of HIV/HBV infected patients.

11:15 – 11:30	Committee Room 6	02.12.2015
WEAA0103:	Track A/1 -	

Genetic and Phylogenetic Analysis of HIV-1 Subtypes and Drug Resistance Profiles in Tunisia between April 2014 and April 2015

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BACKGROUND: The HIV viruses are characterized by extensive genetic variability, which has challenged the development of HIV drugs and vaccines. Recombination is one of the major mechanisms underlying the generation of HIV-1 variability.

With the development of recombination detection techniques and accumulation of HIV-1 reference stains, the identification of accurate mosaic structures of circulating recombinant forms (CRFs) can be made. Currently 72 circulating recombinant forms of HIV-1 have been identified. Despite great advances in the treatment of HIV/AIDS, the rapid evolution of resistance against drugs contributes significantly to the persistence of highly active retroviral (ART) failure.

Objectives: We propose to do a genetic and phylogenetic study of HIV-1 strains circulating in Tunisia and identify virus resistance profiles in naïve and treated patients.

METHODS: To assess the prevalence of HIV-1 drug-resistance and subtypes in Tunisia, plasma samples from ART-failure and naive individuals were collected during this study (April 2014 to April 2015). Genotyping was conducted using protocols of "ANRS AC11 Resistance Study Group" and "Viral Pathogenesis Department, Instituto de Salud Carlos III, Madrid, Spain" on plasma samples. A total of 114 pol sequences were obtained.

RESULTS: The prevalence of drug resistance was 38.6% in ART-failure and naïve individuals. Major mutations to nucleoside reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors and protease inhibitors were detected in 34/114 (29.8%), 31/114 (27.2%) and 13/114 (11.4%) samples, respectively. Mutations such as M184V, L74V, L90M, K103N, Y181C, V82A and P225H were common among the ART-failure individuals.

The nucleic acid sequences were analyzed to determine the HIV-1 subtypes/recombinants. We found that the circulating recombinant forms were the most common HIV-1 subtype (60%) especially CRF02_AG, followed by subtype B (34%), subtype D (3.5%) subtype G (1.7%) and sub-subtype F2 (0.8%).

CONCLUSIONS AND RECOMMENDATIONS: This study showed that the high prevalence of HIV drug resistance observed among the ART-failure individuals should be of increasing concern in the whole country. Furthermore, understanding the distribution of HIV-1 subtypes/recombinants and how it changes across time among individuals is crucial to establish strategies for the prevention of HIV transmission.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Committee Room 6	02.12.2015

WEAA0104: Track A/1 -

Candida albicans Isolates from Yaoundé HIV Infected Patients Provide Genetic Diversity of the Hwp1 Gene and HIS3, EF3, CDC3 Microsatellites and Exert Various Antifungal Susceptibility Profiles

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BACKGROUND: Candida albicans is the major fungal agent involved in mucosal yeast infections among HIV infected patients. Information about the molecular epidemiology of the species as well as the antifungal susceptibility profiles is scarce in Cameroon. Authors studied the genetic diversity and the antifungal susceptibility of C. albicans isolates from Yaoundé HIV infected patients.

Material and **METHODS:** Clinical isolates were obtained by mycological diagnosis of oropharyngeal swabs, stools, urine and vaginal swabs from Yaoundé HIV infected patients. Isolates were identified by conventional phenotypic and biochemical protocols and confirmed by the Light cycler real time PCR. The ABC genotypes were identified. The Hwp1 gene amplification was carried out with specific primers. Microsatellite length polymorphism of HIS3, CDC3, and EF3 microsatellites was also analysed. The antifungal susceptibility testing was carried out by the Clinical and Laboratory Standards Institute (CLSI) M27-A3 protocol. The minimal inhibitory concentration (MIC) results were interpreted according to updated clinical breakpoints (CBPs) recommended by the CLSI or epidemiological cutoff values (ECVs).

RESULTS: One hundred and thirteen (113) isolates were obtained from the analysis of 1218 samples. The ABC genotyping showed 79 (69.91%) isolates being genotype A, 24 (21.23%) genotype B and 10 (8.84%) genotype C. The Hwp1 gene amplification provided a newly observed genetic polymorphism. We then named the genetic diversity H and described 5 genotypes: H1 (≈941pb), H2 (≈941 and ≈1080pb), H3 (≈941 and ≈850pb), H4 (≈941 and ≈1200pb) and H5 (≈850 and ≈1080pb). Their respective occurrences were H1-57.52%, H2-18.58%, H3-16.81%, H4-6.19% and H5-0.9%. The microsatellite analysis generated 65 molecular types from the tested isolates. All the isolates were susceptible to amphotericin B (MIC≤1;g/mL); 79.64% of isolates were wild type to itraconazole (MIC≤0.12;g/mL); and 86.72% of isolates were susceptible to fluconazole (MIC≤2;g/mL). There was no relationship between genotypes and the antifungal susceptibility of isolates (p-value > 0.05).

CONCLUSIONS: These results highlight the important genetic diversity of C. albicans isolates in Yaoundé HIV infected patients, and bring clues for the comprehension of the molecular epidemiology of the yeast in Cameroon.

11:45 – 12:00	Committee Room 6	02.12.2015

WEAA0105: Track A/1 -

Investigating the Fitness Benefit of the Reverse Transcriptase (RT) Mutation A62V when Co-occurring with M184V and K65R in HIV-1 Subtype C

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BACKGROUND: Tenofovir (TDF) and lamivudine (3TC) or emitricitabine (FTC) combined with efavirenz is the predominant first line antiretroviral regimen in the Southern African region. Resistance to TDF and 3TC/FTC is largely through the occurrence of the drug resistance mutations (DRMs) K65R and M184V, respectively. We previously observed a significant co-occurrence of A62V with M184V and K65R in HIV-1 subtype C patients from our antiretroviral treatment cohort. This suggests a previously undescribed functional interaction between these DRMs. As A62V is not classified as a primary drug resistance mutation we postulate it to have a fitness compensation role, as both M184V and K65R decrease viral fitness.

METHODS: Using infusion cloning and site-directed mutagenesis we have constructed 8 full

length HIV genome recombinant clones having all combinations of DRMs A62V, M184V and K65R, either being present or absent and the mutations in these constructs have been confirmed by sequencing. The constructs were transfected in 293T cells for virion production and the harvested virus was used to infect the TZM_bl cell line which was then subsequently assayed for viral growth kinetics using qPCR.

RESULTS: Optimization of the fitness assay using the wild type construct has resulted in optimal harvest points for infectious virion production and a systematic basis on which the 7 mutant constructs can be characterised for phenotypic drug resistance.

Significance and rationale: The robust and accurate methods used for the synthesis of these clones provide a system to characterize phenotypic resistance and provide the first information on fitness interactions of these DRMs in an HIV-1 subtype C burdened setting.

12:00 – 12:15	Committee Room 6	02.12.2015
WEAA0106:	Track A/1 -	

HIV Drug Resistance among Women Attending Antenatal Clinic in Ghana

Enyan Philip, Batch 6/D1 Emergency Medical Technical Students

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BACKGROUND: WHO HIV drug resistance (HIVDR) threshold survey suggests that transmission of drug resistance strains is likely to be limited. However, as access to ART is expanded, increased emergence of HIVDR is feared as a potential consequence. We have performed a surveillance survey of transmitted HIVDR among recently infected persons in the geographic setting of Accra, Ghana.

METHODS: As part of a cross-sectional survey, 2 large voluntary counseling and testing centers in Accra enrolled 50 newly HIV-diagnosed, antiretroviral drug-naïve adults aged 18 to 25 years. Virus from plasma samples with >1,000 HIV RNA copies/mL (Roche Amplicor v1.5) were sequenced in the pol gene. Transmitted drug resistance-associated mutations (TDRM) were identified according to the WHO 2009 Surveillance DRM list, using Stanford CPR tool (v 5.0 beta). Phylogenetic relationships of the newly characterized viruses were estimated by comparison with HIV-1

RESULTS: Subtypes were predominantly D (39/70, 55.7%), A (29/70, 41.4%), and C (2/70; 2, 9%). Seven nucleotide sequences harbored a major TDRM (3 NNRTI, 3 NRTI, and 1 PI- associated mutation); HIVDR point prevalence was 10.0% (95%CI 4.1% to 19.5%). The identified TDRM were D67G (1.3%), L210W (2.6%); G190A (1.3%); G190S (1.3%); K101E (1.3%), and N88D (1.3%) for PI.

CONCLUSIONS: In Accra the capital city of Ghana, we found a rate of transmitted HIVDR, which, according to the WHO threshold survey method, falls into the moderate (5 to 15%) category. This is a considerable increase compared to the rate of < 5% estimated in the 2006-7 survey among women attending an antenatal clinic in mamobi. As ART programs expand throughout Africa, incident infections should be monitored for the presence of transmitted drug resistance in order to guide ART policies.

10:45 – 12:15	Committee Room 4	02.12.2015
WEAC0701:	Track C/7 - Influencing targeted HIV preventions among vulnerable populations	
Chairs:	Edith Maziofa, Harare, Zimbabwe	

Risk Perception for HIV Infection Using National Representative, | Multi-stage Stratified Random Cross-sectional Survey, South Africa, 2012

10:45 – 11:00

Manjengwa-Hungwe Patience Gamuchirai1,2,3, Kuonza Lazarus3, Ratya Lusizo3,4

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ABSTRACT DRIVEN SESSION

BACKGROUND: South Africa (SA) has a high HIV prevalence. In 2012 the HIV prevalence in South Africa was 12.2%. Incidence of HIV among male and females aged 15-49 years has been decreasing: from 1.9% during 2005 - 2008 to 1.7% during 2008-2012. However, prevention efforts must focus on high risk groups and assess their risk perception. We describe identified factors associated with perceived risk of HIV infection in an SA population using a national representative survey.

METHODS: To assess factors associated with perceived risk of HIV infection we used data from a multi-stage stratified random cross-sectional survey conducted in 2012 with South Africans aged 16-55 years. Multivariable logistic regression was used to determine factors associated with perceived risk of HIV infection. Forward selection, variables with p-value < 0.05 and improved fit model were retained in the final model. Analyses were adjusted for clustering and done using STATA. Results were summarized using Adjusted Odds Ratios (AOR) with their corresponding 95% confidence intervals.

RESULTS: Of the 8,756 respondents 19.9% (1,743) perceived themselves to be at high risk of HIV infection. Female gender (AOR 1.76, 95% CI: 1.53-2.04), living in Mpumalanga compared to Western Cape Province (AOR 3.53, 95% CI: 2.33-5.36), low socio-economic status (SES) (AOR 1.28, 95%CI: 1.05-1.57), having multiple sexual partners (AOR 2.58, 95%CI: 2.11 - 3.13), and low self-esteem (AOR 1.67, 95% CI: 1.23-2.27) were significant predictors of high risk of HIV perception. Factors associated with low HIV risk perception were male gender (AOR 1.51, 95% CI: 1.34-1.78), living in Western Cape compared to Eastern Cape Province (AOR 2.18, 95% CI: 1.54-3.06), condom use at last sex (AOR 1.66, 95% CI: 1.44-1.91) and knowing status of partner (AOR 1.56, 95% CI: 1.35-1.81). 80% (7013) who had low HIV risk perception. 19% (146/620) of the people who had multiple sexual partnerships in the past 12 months but did not use condoms at last sex had also reported having a low HIV risk perception.

Conclusion & Recommendations: Heightened risk perception of HIV infection in SA is associated with specific gender, geographic, economic, behavioral and self-esteem factors. People with low HIV risk perception who engaged in risky sexual behaviors were significant. Therefore efforts on HIV prevention needs to be targeted towards the group with low HIV risk perception as heightened risk perception is the first step towards behavior change.

11:00 – 11:15	Committee Room 4	02.12.2015
WEAC0702:	Track C/7 -	

Factors Influencing Utilization of Provider Initiated HIV Counselling and Testing Services among Tuberculosis Patients; A Case of County Referral Hospital Kakamega, Kenya

Khasewa Joab1, Akinyi Sarah2, Kinuthia Peter3, TB Patients

1National AIDS Control Council, Monitoring and Evaluation, Nairobi, Kenya, 2Lumino Nursing and Maternity, Kakamega, Nursing, Kakamega, Kenya, 3National Aids Control Council, Strategy and Planning, Nairobi, Kenya

BACKGROUND: Tuberculosis (TB) continues to be one of the most important public health threats. Globally, 1.1 million of the 8.6 million people who developed TB in 2012 were HIV positive (WHO, 2011). Over 75 % of these cases were in the African region. In Kenya, over 44% of TB patients are HIV positive (MOH, 2011). Such strong associations plus the need to provide comprehensive care offer compelling reason for testing TB patients for HIV. In 2007,WHO recommended that countries with high co-infection rates develop TB and HIV collaborative activities, including Provider- initiated HIV testing and counseling(PITC) of TB patients . The objective of the study was to determine the factors influencing utilization of provider initiated HIV counseling and testing services among TB patients.

METHODS: A cross sectional survey of TB suspects visiting the chest clinic was conducted. Consenting patients who visited the clinic during July to December 2012 were the study subjects. Data was collected through structured interviews with TB patients visiting the facility using a standard questionnaire and direct observation. The quantitative data was analyzed using descriptive statistics. A chi square test was used to interpret results for each possible barrier in terms of utilized versus declined to utilize HIV counseling and testing services. The test was considered to be statistically significant if the P-value was < 0.05.

RESULTS: Eighty seven percent (89.2 %) of TB patients tested for HIV. The main reasons for not being tested were that they don't trust confidentiality (16.7%), fear of positive test results (12.5%), fear of discrimination (9.6%) and fear to cope with dual diagnosis (4.5%) (;2=29.473, 9 df, p=0.030). Factors that were significantly associated with utilization of PITC services were gender (;2=5.919,1df,p=0.015), level of education (;2=116.045,2df,p=0.0001), HIV stigma (;2=36.947,3df,p=0.0001), awareness of HIV-TB link (;2=22.767, delay in offering counseling services (;2=75.48,1df,p=0.0001) and discussion of HIV/ TB link by nurse (;2=59.232,2df,p=0.0001).

ABSTRACT DRIVEN SESSION

CONCLUSIONS AND RECOMMENDATIONS: Utilization of PITC services by TB patients was high. The National AIDS Control Council, National Tuberculosis Program and Partners should scale up community awareness about HIV-TB co infection and train all providers on collaborative HIV-TB services. The policy on confidentiality should be enforced and infrastructure improved to allow privacy.

11:15 – 11:30	Committee Room 4	02.12.2015
WEAC0703:	Track C/7 -	

High HIV Prevalence due to Sexual Transmission in Heroin and Cocaine/ Crack Users in Abidjan, Ivory Coast

Bouscaillou Julie1, Evanno Jérome2, Proute Myrtille1, Inwolé André3, Kabran Mathieu3, N'Guessan Thierry3, Djé Bi Samedi4, Sidibé Souleymane5, Thiam-Niangoin Marguerite6, Nguessan Badou Roger7, Blanchetière Pascale2, Luhmann Niklas1

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BACKGROUND: The results achieved in the global fight against HIV may be compromised if we do not address the epidemic in most at risk populations. The number of people who use drugs (PWUDs) has dramatically increased these last 15 years in Sub-Saharan Africa, but targeted interventions are falling behind, notably because of the lack of awareness of PWUDs health needs. We aimed to assess the prevalence and risk factors of HIV and other infections in PWUDs in Abidjan, Ivory Coast, the country the most affected by HIV in Western Africa.

METHODS: We used respondent-driven-sampling to obtain a representative sample of heroin or cocaine/crack users aged 18 or more. Socio-behavioral data were obtained by face-to-face questionnaire. Blood samples were collected and tested for HIV, HBV, HCV and syphilis. Two sputa were obtained in TB symptomatic participants for AFB smear testing. After a descriptive analysis, crude prevalence was calculated, then weighted to take account of the sampling method. Risk factors of infections were studied using adjusted log-binomial regression.

RESULTS: 450 PWUDs were recruited in May 2014. The mean age was 33.5; 10.9% were women. Smoking was the main mode of consumption, injecting drug use at least once was reported by 12.7% of the participants (3.6% in the past month). Sex work was declared by 15.8% of the PWUDs (13.7% of the men), and 10.2% of the men reported sexual relationships with other men (MSM). We found a weighted prevalence of 9.5% for HIV. Women were 3.4 times more infected than men, with a prevalence of 26.5%. Among men, being a sex worker (SW) (adjusted OR 2.9; 95CI 1.06-7.98) or MSM (adjusted OR 11.5; 95CI 4.22-31.42) were the main risk factors in adjusted analysis. Injection was not associated with HIV. TB weighted prevalence was 1.8%, associated with poor living arrangements. Weighted prevalence for HBV (HBs antigen), HCV (antibodies anti-HCV) and syphilis were respectively 11%, 2.4% and 1.1%, with no obvious risk factors.

Conclusion: PWUDs are at high risk of HIV, mainly due to sexual transmission. In addition to developing classical harm reduction services, HIV prevention and linkage to care for PWUDs should be adapted and target women, SW and MSM who use drugs. Social vulnerability and living conditions also appear to be a major cause of illness in PWUDs.

11:30 – 11:45	Committee Room 4	02.12.2015
WEAC0704:	Track C/7 -	

Increasing Access and Utilization of Tailored HIV and AIDS Services among Long Distance Truck Drivers (LDTDs) in Uganda

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vention, Kampala, Uganda, 2AMICAALL (Alliance of Mayors and Municipal Leaders on HIV and AIDS) in Uganda, Programmes, Kampala, Uganda

BACKGROUND: The Long Distance Truck Drivers (LDTDs) are categorized as one of the Most at Risk Populations (MARPs) contributing to the increase of new HIV infections as well as bridging the spread of the epidemic to general population in Uganda. The HIV prevalence among LDTDs in Uganda is between 25-32%. This is because they engage in casual sexual relations while in transit due to nature of their work hence increasing the risk of HIV infections.

Given that most of the truck hot spots are located in urban areas with relatively higher HIV prevalence, The Alliance of Mayors and Municipal Leaders' Initiative for Community Action on AIDS at the Local Level (AMICAALL) Uganda Programme has prioritized and designed tailored interventions for HIV prevention among the LDTDs.

Program **DESCRIPTION:** AMICAALL with support from DANIDA is currently implementing an HIV prevention project targeting MARPs in Kampala City and Entebbe Municipality. Through this project, AMICAALL established an HIV and AIDS service and information in Kampala- Nakawa for LDTDs.

The key interventions included: Mapping of the LDTDs hot spots, Establishment of the service and knowledge centers with recreational facilities, Orientation peer educators among the LDTDs to manage the center, Provision routine and outreach HIV services such as HCT, ART, STIs treatment, free condoms and HIV education to mention, Establishment of the referral system for the drivers to access other HIV services.

Experiences: The major achievements of the truckers include;

There was over 78% increase in the number of LDTDs using HIV and AIDS services from 5485 drivers reached in the year before the center was established; Through the center, other groups of MARPs especially the sex workers have been reached because of the linkages between them and truck drivers; The Center has source of information for not only HIV but also other health related and road safety to the drivers.

LESSONS LEARNT: We have learnt that to increase uptake of HIV services among MARPs, we need to use tailored approaches which are convenient and friendly.

RECOMMENDATION: Establishment of the truck center to provide friendly services has led to increase in the number of Long Distance Truck Drivers accessing and utilizing HIV and AIDS services hence should be replicated to other MARPs hot spots.

11:45 – 12:00	Committee Room 4	02.12.2015
WEAC0705:	Track C/7 -	

Les Formes de Stigmatisation/Discrimination Quotidienne des Personnes Vivant avec le VIH en Mauritanie

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1Centre Hosptialier Regional d'Aioun, Medecine Interne, Aioun, Mauritania, 2Centre Hospalier National de Nouakchott, Centre de Traitement Ambulatoire, Nouakchott, Mauritania, 3Institut National d'Hépato-Virologie de Nouakchott, Nouakchott, Mauritania

Indiquer le problème étudié, la question de recherche : La prevalence nationale du VIH est estimée à 0,4% et les PVVIH ont bien souvent une connotation négative de la pathologie dont ils souffrent.

Méthodes: Cette étude, de type transversal descriptif avait comme objectif de décrire le vécu des PVVIH reçues au CTA de Nouakchott afin de faire un état des lieux des formes de stigmatisation à partir du point de vue de ceux qui la subissent. Ont été incluses toute personne séropositive au VIH et au courant de son statut sérologique âgée d'au moins 18 ans et qui a donné son consentement pour participer à l'étude. La collecte des données a impliqué 4 médecins et a été réalisée à l'aide d'un questionnaire préalablement testé sur une période de 4 semaines (du 1er au 29 juin 2015). La saisie et l'analyse des données ont été effectuées à l'aide du logiciel EPI INFO version 6.4. Pour la comparaison des variables qualitatives le test du Chi carré a été utilisé. Une valeur de $p < 0,05$ a été retenue comme seuil de significativité.

Résultats: Au total 210 PVVIH ont été interviewés. Les hommes représentaient 54% de l'effectif avec sex-ratio de 1,2. La moitié (51%) des répondants étaient mariés et résidaient à Nouakchott (55%). Les sujets n'ayant jamais été scolarisés représentaient 42 % des cas. Parmi nos interviewés, 64% connaissaient leur statut sérologique VIH depuis plus d'un an. Soixante (75 %) des répon-

dants ont déclaré avoir refuser de partager leur résultat avec quelqu'un de leur entourage. La distribution des formes de stigmatisation vécues par les PVVIH par catégorie sociodémographique est présentée dans un ordre décroissant, il s'agit de la stigmatisation dans les relations interpersonnelles (78%), suivi de l'auto-stigmatisation (20%) et enfin la stigmatisation dans les services de santé (2%). Il y'avait un lien significatif entre la forme de stigmatisation, la situation matrimoniale (p=0,007) et la connaissance du statut VIH pour une période supérieure à un an (p=0,02).

Conclusions et recommandations: Les formes de stigmatisation peuvent engendrer la discrimination et constituent un obstacle majeur à la réinsertion sociale et à la prise en charge des PVVIH. Cette situation crée un cercle vicieux qui alimente la souffrance et l'isolement des PVVIH, sans parler des effets délétères sur leurs relations familiales et sociales, l'estime et la confiance en soi.

00:00 - 00:00	Committee Room 4	02.12.2015
WEAC0706:	Track C/7 -	

Enhancing Access to Equitable Health Care and Well-being Services: Addressing HIV Vulnerability among Migrants and Host Communities in Tunisia

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ISSUES: Migration is a social determinant of health across the mobility continuum be this - at places of origin, transit and travel, at destination and upon return home. In Tunisia, vulnerable and hard-to-reach populations including migrants and their surrounding host communities' health and social protection needs must be addressed within and outside the health sector.

DESCRIPTIONS:

1. Review of IOM direct assistance covered by the component of the regional project SATRT from 2013 to 2014: 55 migrant files have been studied and a descriptive statistical analysis has been done.

2. Multi-sectoral consultative information sharing among GOs, NGOs through a 'Round Table on Migration and HIV' in Tunisia was organized to discuss issues, collect the available data and share experiences on HIV vulnerabilities among migrants, groups and host communities.

LESSONS LEARNT:

1. 16.6% of migrants assisted for a medical condition mostly coming from sub-saharan Africa provided with basic health care services through the IOM START Program were PLWHAs. Moreover, 16.6% of pregnant migrant women assisted were also PLWHAs.

2.Access to Health care services was limited: 66.6% migrant/PLWHAs were treated and monitored in public health facilities in 2014. The migrant/PLWVAs accessing free ART in the public health facilities was 13.9%; other migrant/PLWHAs were assisted by national NGOs. 83.7% of migrant/PLWHAs sought health care through the private health sector.

3. Availability of health care services was random: (i) Migrant/PLWHAs sought health care assistance only at an advanced disease stage : 32.2%consulted in stage B and 49.4% consulted at the stage C. Only a minority of migrant/PLWHAs could access free ART at public health centers; those under the care of NGOs received ART from 'time to time'; those who chose to go to private pharmacies faced challenges in getting ARTs including those with more income.

4. Migrant/PLWHAs were unaware of HIV prevention, infection risks, ways to seek treatment, ways for early detection and existence of CCDAG that offers free and anonymous screening for HIV.

5. Stigma and fear of deportation were core factors that deterred migrants' access services related to HIV; most migrants were unaware of rights to access Tunisian health care services;

NEXT STEPS: Ensuring access to correct, culturally sensitive and language appropriate information, ART and continuity of care is critical for migrant/PLWHAs to combat HIV in Tunisia and elsewhere globall.

ABSTRACT DRIVEN SESSION

12:45 – 14:15	Committee Room 5a & b	02.12.2015
WEAB0501:	Track B/5 - Retaining patients in HIV treatment: what is new?	
Chairs:	Jean Nachenga, South Africa	

Sulfamethoxazole/Trimethoprim/Isoniazid/Pyridoxine Scored Tablets Are Bioequivalent to Individual Products and Are Acceptable to Patients with Advanced HIV Infection in the REALITY Trial 12:45 – 13:00

Bwakura-Dangarembizi Mutsa1, Gibb Diana2, Abhyankar D3, Agate Clara4, Legume A5, Abongomera G6, Kabahenda S7, Musiime Victor8, Mallewa J9, Siika A10, Baleeta K11, Mehta V3, Malhotra G3, Griffiths A2, Kityo C8, Maitland K4, Chidziva E12, Chepkorir P10, Szubert AJ2, Gogtay J3, Hakim J13, Kaunda S9

1University of Zimbabwe College of Health Sciences, Paediatrics and Child Health, Harare, Zimbabwe, 2MRC Clinical Trias Unit, London, United Kingdom, 3CIPLA Ltd, Mumbai, India, 4KEMRI Wellcome Trust Research Program, Kilifi, Kenya, 5Joint Clinical Research Centre, Mbarara, Uganda, 6Joint Clinical Research Centre, Gulu, Uganda, 7Joint Clinical Research Centre, Fort Portal, Uganda, 8Joint Clinical Research Centre, Kampala, Uganda, 9University of Malawi, Blantyre, Malawi, 10Moi University Clinical Research Centre, Eldoret, Kenya, 11Joint Clinical Research Centre, Mbale, Uganda, 12University of Zimbabwe Clinical Reseracth Centre, Harare, Zimbabwe, 13University of Zimababwe Clinical Research Centre, Harare, Zimbabwe

BACKGROUND: Patients initiating ART with low CD4 counts benefit from isoniazid and cotrimoxazole prophylaxis, but these increase pill burden; stockouts of single formulations are also common.

METHODS: Sulfamethoxazole/Trimethoprim/Isoniazid/Pyridoxine (800/160/300/25mg) fixed-dose-combination (FDC) scored tablets (Cipla , India) were compared with Septrin;Forte (sulfamethoxazole-800mg/trimethoprim-160mg (GlaxoWellcome)) and Isoniazid-300mg (Sandoz) separate tablets in 28 healthy volunteers (18male; 10female) in an open-label, randomized, single-dose, two-treatment, two-period, 26-sample crossover pharmacokinetic bioequivalent study. Acceptability and adherence questionnaire data were collected in the ongoing, 2x2x2 factorial, REALITY randomised trial evaluating enhanced OI prophylaxis, 4-drug ART and enhanced nutrition for 12 weeks after ART initiation, in 1805 African adults/children(≥5years) with CD4 < 100cells/mm3. Within-individual data on FDC

(weeks 12-24) vs cotrimoxazole alone (weeks 0-12) were compared in 319 patients; and in weeks 0-12 among those receiving FDC+fluconazole (for prophylaxis against cryptococcal disease) (n=543) vs cotrimoxazole (n=604).

RESULTS: Geometric mean test-to-reference ratios for sulfamethoxazole (AUC: 99.8% (90% CI 96.2%-103.5%) and Cmax: 103.2%(99.5%-107.0%)), trimethoprim (97.2%(93.7-100.9)%; 98.2%(93.4-103.3)%) and isoniazid 103.8%(99.5-108.3); 104.3%(95.1-114.4)) were well within required 80-125% range. In REALITY, acceptability was similar between FDC (12-24 weeks) and cotrimoxazole (0-12 weeks): 99.7% vs 99.4% reported none/not much daily-life interference; 95.6% vs 96.6% reported drugs were very easy/easy to take. Comparing groups (0-12 weeks) gave similar **RESULTS:** 500/543 (92.1%) vs 565/604(93.5%),(p=0.8) reported taking medication was very easy/easy; 4.0% vs 3.9% reported missing ≥1 dose.

CONCLUSIONS AND RECOMMENDATIONS: Sulfamethoxazole/Trimethoprim/Isoniazid/Pyridoxine FDC tablets are bioequivalent to individual drugs (data submitted for WHO prequalification). They are acceptable, reduce pill burden and could improve adherence, in addition to simplifying drug distribution for programmes.

13:00 – 13:15	Committee Room 5a & b	02.12.2015
WEAB0502:	Track B/5 -	

Factors Influencing Adherence to Antiretroviral Therapy by HIV Patients in an Urban and Rural Setting, Tanzania

Mosha Fausta S1, Muchunguzi Victor2, Risha Peter3, Sangeda Raphael3, Kaale Eliangiringa3

1MOH, Curative, Dar es Salaam, Tanzania, United Republic of, 2MOH, Dar es Salaam, Tanzania, United Republic of, 3Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania, United Republic of

ABSTRACT DRIVEN SESSION

BACKGROUND: HIV care and treatment centers (CTC) are being established to support HIV patients, enabling them to live a healthy life through health education and treatment. Because adherence is one of the most crucial determinants of treatment response, we investigated how adherence and associated variables differ in an urban versus a rural CTC.

METHODS: An analytical cross-sectional study was conducted in 24 CTCs in Dar es Salaam and Iringa regions, Tanzania. Data was collected using records review and adherence measurements were carried out by using Visual Analogue Scale (VAS), Adult AIDS Clinical Trials Group (AACTG) questionnaire and consistency in keeping appointments. Chi-squared test was used for comparison of proportions. Logistic regression and multivariate analysis were used to analyse the factors associated with adherence.

RESULTS: A total of 943 patients attending care and treatment sites in Dar es Salaam (415) and Iringa (528) were recruited. Adherence based on consistency of keeping appointments and on four days recall was significantly higher among Dar es Salaam patients (77% versus 55%; P< 0.01 and 87% versus 80%; P< 0.01 respectively) while adherence based on consistency of taking ARV more than 95% of the time in one month was significantly higher among Iringa patients (81% versus 56%; P< 0.01). However, there was no correlation between consistency of keeping appointments and taking ARV with the clinical and immunological response. Patients in Dar es Salaam were significantly less likely to; be married, have family support, receive pre-ARV counselling, experience side effects and be satisfied with the services at CTC compared to patients in Iringa. However, patients in Dar es Salaam were significantly more educated and paid less transport costs to the CTC. In multivariate analysis, the following variables were positively impacting adherence to ART: being on treatment for more than one year, early registration to CTC, having treatment support and pre-ART counseling; while developing side effects, taking traditional medicine and taking alcohol were negatively impacting adherence.

CONCLUSIONS AND RECOMMENDATIONS: We found that provision of adequate education on the importance of strict adherence to the prescribed doses of ARVs during regular attendance to CTCs is an important factor towards achieving good adherence to ART. Proximity of the CTC to the clients was also a factor as reflected by the amount paid for the fare.

13:15 – 13:30	Committee Room 5a & b	02.12.2015

WEAB0503: Track B/5 -

Community-based Care and Support Services Contribute to Treatment Adherence and Reduce HIV Risk Behavior

Ngunga Mathew1, Chapman Jenifer2, Chariyeva Zulfiya3, Kaira Wezi4

1GRM Futures Group, Lusaka, Zambia, 2GRM Futures Group, Maputo, Mozambique, 3GRM Futures Group, Chapel Hill, United States, 4World Vision, Lusaka, Zambia

BACKGROUND: The United States Agency of International Development awarded a high-value, 5-year agreement in Zambia to improve the wellbeing of people living with HIV/AIDS, called STEPS OVC. We conducted an outcome evaluation of STEPS OVC, and at endline (2014) aimed to assess the impact of the project's care and support interventions on HIV outcomes, such as treatment adherence, condom use and knowledge. Here we provide important evidence of the contribution of community-based care and support services to the realization of positive clinical and prevention outcomes among adults living with HIV and AIDS.

METHODS: Data for the presented analyses are from the STEPS OVC outcome evaluation, which consisted of a pre-test / post-test survey of a random sample of 383 adults living with HIV in a maximum variation sample of nine districts, in both 2011 and 2014. Participants were randomly sampled from project rosters. At endline we examined associations between reported receipt of project services and HIV care and prevention outcomes using a chi square test. Ethics approval was obtained from Health Media Labs, Inc. (U.S.) and the Zambian Biomedical Research Ethics Committee.

RESULTS: The response rate was 73% (N=280). Seventy-four percent of respondents were female; the mean age was 42.8 years (range: 18-88). Adherence to any HIV drug regimen was high with 73% of PLHIV reporting never missing a dose (N=227). PLHIV who report receiving adherence counseling from a community care worker in the last six months were more likely to report never missing at dose (76% vs. 60%, p< 0.05) or never missing medication for a whole day (82% vs. 67%, p< 0.05) than those that did not receive this counselling. Likewise, sexually active PLHIV who reported receiving condoms from a community caregiver in the last six months were more likely to report using a condom at last sex (84% vs. 45%, p< 0.0001) and to use condoms consistently (57% vs. 28%, p< 0.001). PLHIV who report receiving information on HIV prevention in the last six

months were more likely to know that HIV cannot be transmitted by mosquitos (78% vs. 61%, p< 0.01) or by sharing a meal with an HIV-infected person (96% vs. 89%, p< 0.05).

CONCLUSIONS: Findings demonstrate that community based support services can have meaningful impacts on HIV related care and prevention outcomes including ART adherence, and are a critical component of the strategy to reach the UNAIDS 90-90-90 target.

13:30 – 13:45	Committee Room 5a & b	02.12.2015
WEAB0504:	Track B/5 -	

Improving HIV Care and Support Service Performances in Côte d'Ivoire

Kouadio Marc N'goran1, Brou Charles Joseph Diby1, Patricia Fassinou2, N'guessan Jean Paul N'da1, Ramachandran Shobana3, Joseph Essombo2

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BACKGROUND: To ensure the health of HIV-positive clients, HIV programs should provide clear access to treatment (ART), nutritional support, Cotrimoxazole prophylaxis and quarterly screening for tuberculosis (TB). Since the beginning of project Djidja in October 2011, reports showed low performances of care and support indicators from October 2011 to September 2013. Thus, by September 2013, the percentage of HIV patients who were nutritionally assessed was, 46%, the % of HIV patients receiving cotrimoxazole prophylaxis was 37% and the percentage of HIV patients screened for TB was 50% within the entire project. To address this, EGPAF implemented a strategy called CAR (Observation, Action and Results) in January 2014 in all the 76 care and treatment sites supported by the project.

METHODS: The CAR strategy was implemented by EGPAF program officers at site level in collaboration with data managers, community counselors and health care providers. The strategy has three phases.

Constat: (Observation): Weekly Checking of all data collection tools to assess care services provided to HIV patients during their last visit and identify if the clients have missed any needed care and support services.

Action: Identifying reasons for missing services to patients, immediately take corrective measures. Key actions were:

Interview care providers to know why they did not provide the specific care, then respond to their need.

Make phone calls to patients to bring them back to clinics to receive needed care

Update databases with correct patient data based on new informations.

Strengthen the capacity of care providers on specific issues rised up from gaps observed

RESULTS: Weekly and monthly monitoring care and support indicators to measure the effects of corrective actions.

The percentage of HIV patients who were nutritionally assessed increased from 46% (7229/15862) by September 2013 to 86% (25814/29920) by March 2015. During the same period, the percentage of HIV patients receiving cotrimoxazole prophylaxis increased from 37% (5921/15862) to 66% (19787/29920) and the percentage of HIV patients screened for TB increased from 50% (7855/15862) to 90% (26829/29920).

CONCLUSIONS AND RECOMMENDATIONS: The implementation of the CAR strategy has enabled EGPAF to improve the quality of care provided to HIV patients. . However, more closely technical assistance towards care providers is needed to ensure ownership and sustainability of this strategy.

ABSTRACT DRIVEN SESSION

13:45 – 14:00	Committee Room 5a & b	02.12.2015
WEAB0505:	Track B/5 -	

Associations between Mental Health, HIV Infection and the ART Cascade in East Zimbabwe: Analysis of Self-reported Data Corroborated with Biomarker Data on Adherence

Tlhajoane Malebogo1, Gregson Simon1, Eaton Jeffrey W.1, Perebcom Monique1, Nyamukapa Constance2, Masimirembwa Collen3

1Imperial College, London, United Kingdom, 2Biomedical Research and Training Institute, Harare, Zimbabwe, 3African Institute of Biomedical Science and Technology, Harare, Zimbabwe

BACKGROUND: By 2030 depression is predicted to be the greatest contributor to the global burden of disease. Depressive and behavioural disorders are risk factors for HIV infection and poor adherence to antiretroviral therapy (ART) in high income settings but little is known about this relationship in developing countries. We assess the prevalence of psychological distress (PD) in the general population in a Sub-Saharan Africa setting, and investigate:

(1) risk factors for PD,

(2) the effect of PD on sexual risk behaviours, and

(3) the effect of PD on progression through the HIV care cascade.

METHODS: Data were analysed from a cross-sectional survey of 13219 adults (aged 15-54) conducted between January 2009 and August 2011 in Manicaland, Zimbabwe. Prevalence of PD was determined through the Shona Symptom Questionnaire (SSQ) and the WHO Self-reporting Questionnaire (SRQ). Ordered logistic regression and binary logistic regression were used to assess associations between PD and hypothesized risk factors including: HIV infection, sexual risk behaviours and adherence to ART. Nevirapine (NVP) concentrations in dried blood spot samples were quantified using liquid chromatography-mass spectrometry to assess sub-therapeutic drug levels and corroborate self-reported adherence data.

RESULTS: Prevalence of PD was 9.61% (SSQ) and 11.89% (SRQ). Greater PD was correlated with female gender, unemployment, low education, HIV and STI infection and not being in a long term committed relationship. Sexual risk factors associated with increasing severity of PD were transactional sex in men, and sex work, concurrent sexual relationships and intermittent condom use in women. Individuals[SG1] [MT2] with severe PD were more likely to have tested for HIV at least once in their lifetime (AOR=1.36 95%CI: 1.13-1.64) but were more likely to be non-adherent to ART (AOR=3.40 95%CI: 1.04-11.05). Agreement between self-reported adherence to ART and detected drug concentrations was high (63% of those who reported sometimes forgetting to take their medication, had sub-therapeutic NVP levels).

CONCLUSIONS AND RECOMMENDATIONS: Greater severity of PD amplifies certain sexual risk behaviours and is associated with non-adherence to ART in east Zimbabwe. Integrated services tackling mental health may be beneficial in this context, particularly among HIV-infected women, as well as vocational interventions to improve access to employment in light of the country's economic recovery.

ABSTRACT DRIVEN SESSION

14:00 – 14:15	Committee Room 5a & b	02.12.2015
WEAB0506:	Track B/5 -	

ARV Provision for Longer Periods in Guinea Improves Retention in Care, Including during the Ebola Crisis

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1Médecins Sans Frontières, Conakry, Guinea, 2Médecins Sans Frontières, Cape Town, South Africa, 3Medecins Sans Frontieres, Brussels, Belgium

BACKGROUND: The West-Africa epidemic of Ebola has a knock on effect on health services availability & use. Regional reports indicate patients facing difficulties to continue ARV treatment. While Guinean health facilities remained open, utilization rates reduced. Increased loss to follow up for HIV was reported in selected facilities of Guinea.

In 2014 MSF supported 7639 HIV patients in 6 health facilities in Conakry with 7474 on ARV. A pilot scheme provides ARV for 6 months period (R6M) to stable patients (VL< 1000 & WHO clinical stage 1 or 2) and continued during the Ebola outbreak. Patients visit health facilities once every 6 months for consult and VL checking, receiving ARV for 6 months, plus a small buffer quantity. Patients living in Conakry are on 3 months refill.

Methodology: Outcomes were systematically monitored since June 2014 while scheme in place since 2013 for patients outside of Conakry. Outcome is measured as late appointments (5 days after appointment date) and loss to follow up (3 months no show). For specific review during this outbreak, we analysed outcomes for patients on R6M ARV provision before and during outbreak and compared these to outcomes for patients fitting same eligibility criteria but not yet started on alternative refilling scheme.

RESULTS: Patient outcomes on alternative R6M scheme were encouraging. In 2013, 96.2% patients on R6M are still active by March 2015 compared to 75.4 % for those not on R6M. During 2014 Ebola outbreak, 97.1% of patients on R6M were on time for appointment after 6 months, compared to 90.2% for those not on R6M. During same period other actors reported 40% of late appointments. Further analysis includes: 1. outcomes compared with people on usual monthly ARV provision scheme; 2. review other health facilities with varying degree of service reduction by Ebola; 3. retention in care 12, 18, 24 months respectively. Preliminary results available by Oct for 12 months follow up on R6M. During crisis health authorities were supportive to apply alternative model and now discuss its possible expansion, trying to mitigate current problematic retention rates and reduce workload.

CONCLUSIONS AND RECOMMENDATIONS: An alternative model of 6 month ARV refill for stable patients gives promising retention in care, including during Ebola crisis when access to health facilities was reduced. This strategy can be useful to avoid treatment interruption in other crises with compromised access to health facilities.

12:45 – 14:15	Jacaranda 3	02.12.2015
WEAD0701:	Track D/7 - Reaching adolescents / young people with HIV messages	
Chairs:	Cedric Nininahazwe, Bujumbura, Burundi	

Availability and Utilization of Youth-friendly Services on HIV Testing and Counseling among Youth in Three Districts of Tanzania 12:45 – 13:00

Ngilangwa David P, Michael Emilian, Noronha Rita

Amref Health Africa, Dar es Salaam, Tanzania, United Republic of

BACKGROUND: Majority of sexually active youth are denied or decline to access sexual and reproductive health services including HIV counseling and testing due to stigma from community members and service providers. Thus, having Youth-Friendly Services (YFS) sites where youth can access services comfortably is critical in reducing HIV infections, unwanted pregnancies and sexual transmitted infections. We conducted this baseline survey to understand availability, awareness and utilization of YFS in three selected districts to inform Amref Health Africa prior implementation of the intervention targeting youth.

ABSTRACT DRIVEN SESSION

METHODS: This study was a quasi-experimental baseline assessment among youths aged 15-24 in three districts of Tanzania namely Makete, Namtumbo and Temeke in August 2013. A multistage sampling technique was used to enrol 346 participants. In this mixed methods study, a standardized questionnaire and interviews guides were used to solicit information from participants. Quantitative data analysis was done using SPSS 16 while qualitative data was analysed manually.

RESULTS: Overall, 346 young people, 171 (49.4%) from the intervention and 175 (50.6%) from the comparison sites were interviewed. Of them, more than half were female. Their mean age was 17. The majority reported to have had completed secondary school. About 70% of youth from both arms were unaware of the availability of YSF in their nearby health facility (HF). Thus, handful of respondents (36.8% in treatment and 29.1%) reported to get tested for HIV in YFS in one of the nearby HF. The most preferred place of testing were Voluntary Counseling and Testing (VCT) centre inside HF; and standalone VCT. Furthermore, 50(79.3) and 44 (86.2%) youth from treatment and comparison respectively received their results the same day. Of them, more than 80% from both arms shared their HIV results with their partners. HIV prevalence was recorded at 15.8% and 15.6% for treatment and control respectively young girls contributing to more than 80% for both arms. In addition, some areas were reported to have active YFS whereas others not due lack of funds to run such services.

CONCLUSIONS: Findings from our study suggest that availability and accessibility of YFS is relatively low despite of readiness of youth to utilize them. We therefore recommend the scale up and promotion of YFS programmes to reach many marginalized youths to prevent HIV infections.

12:45 – 14:15	Jacaranda 3	02.12.2015
WEAD0702:	Track D/7 -	

The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People in Tanzania 12:45 – 13:00

McCarthy Katharine1, Hallman Kelly1, Mulokozi Aroldia2, Kaganda Subilaga2, Mrisho Fatma2, Mbarouk Nuru3, Jenkins Alison Louisa4

1Population Council, New York, United States, 2Tanzania Commission for AIDS (TACAIDS), Dar es Salaam, Tanzania, United Republic of, 3Zanzibar AIDS Commission (ZAC), Zanzibar, Tanzania, United Republic of, 4UNICEF Tanzania, Dar es Salaam, Tanzania, United Republic of

ISSUES: TACAIDS and ZAC commissioned a secondary analysis of the Tanzania Demographic Health Survey (2010), Tanzania HIV and Malaria Indicator Survey (2011) and Violence Against Children Study (2009) to better understand the vulnerabilities of young people in Tanzania and guide the actions of policy makers and program implementers in HIV, health, nutrition, education, child protection and social protection.

DESCRIPTIONS: ~40 indicators were examined by sex, age (10-14, 15-19, 20-24 yrs), wealth quintile and geographic region. Results mapped

1) diversity of young people (parental co-residence, orphan status, current school attendance, in school at grade for age, literacy);

2) context of sexual activity (marital status, age at first marriage, age at first sex, pregnancy, sex partner age difference, gender norms around domestic violence);

3) exposure to violence (forced first sex, exposure to and perpetrators of physical/sexual violence, violence during pregnancy);

4) HIV/AIDS (knowledge, attitudes, HIV testing, prevalence);

5) sexual risk behaviors (multiple partners, transactional sex and condom use among males, attitudes towards negotiating condom use, condom use during premarital sex);

6) reproductive and maternal health (current contraceptive use by marital status, antenatal care at most recent pregnancy, delivery assistance by provider type); and

7) exposure to mass media. Conclusions are drawn based on general trends in the data across surveys, and "moderate" and "extreme" geographic hotspots of vulnerability (regions that have ≥2 or ≥3 outcomes that are very unfavorable compared to national means) are identified for young females and males.

ABSTRACT DRIVEN SESSION

LESSONS LEARNT: Large variations across regions for most indicators reinforces the importance of geographic contextualization in implementation of national strategies. Findings provide data to advocate for policy/guideline change around child marriage, school re-entry after dropout, and age of consent for HIV testing and counseling and call for improved coordination and dissemination of existing policies as well as stronger implementation of existing policies that protect the sexual reproductive health and rights of adolescents and youth.

NEXT STEPS: Policy briefs will be prepared for parliamentarians to provoke policy debate and change in accordance with the validated policy recommendations. In Zanzibar, results were shared with faith-based organizations and youth, and further youth consultations are planned.

13:15 – 13:30	Jacaranda 3	02.12.2015
WEAD0703:	Track B/5 -	

Engagement Fort de l'Atbef pour Une Jeunessesans VIH/SIDA et Epanouie: l'Education Sexuelle Complete (ESC) au Togo

Ouagbeni Koffi Sangbana

ATBEF, Programme Jeunes, Lomé, Togo

Questions: Quelles sont les stratégies de lutte contre le VIH/Sida chez les jeunes au Togo?

DESCRIPTION: La population togolaise compte 6191155 habitants (RGPH 2010), caractérisée par une prépondérance de moins de 25 ans (60 %) de la population, dont 18,6 % des jeunes de 15 à 24 ans. Dans ce groupe on note une précocité des rapports sexuels, 8,81 % dont 7,98 % chez les filles et 9,70 % chez les garçons ont leurs premiers rapports sexuels avant l'âge de 15 ans chez les jeunes ; dont 11,73 % ont de multiples partenaires.

Le Ministère de l'éducation a introduit depuis 1987 l'enseignement de l'Education en matière d'Environnement de Population et de Santé de la Reproduction pour le Développement Humain Durable (EPD/SR) dans le cycle secondaire et dès 2002 au cycle primaire. L'EPD/SR a initié la lutte contre les IST/VIH/SIDA à travers l'un de ses 05 volets, mais les changements de comportements attendus, tardent à s'opérer et de nouvelles stratégies sont recherchées pour optimiser les résultats escomptés;

C'est dans ce contexte que l'ATBEF exécute depuis 2008 son programme d'ESC sous l'égide du Ministère.

Les activités des deux premières phases étaient consacrées au plaidoyer afin d'assurer l'intégration et la mise en ;uvre de l'ESC, spécifique à chaque niveau d'enseignement.

L'évaluation de ces phases par le cabinet CEDES en 2013 a, au-delà des répercussions positives du projet, mise en évidence des insuffisances dans:

• La prise en compte insuffisante de l'accès aux services des jeunes

• L'implication plus consistante des Parents

D'où la phase 3 pour y remédier.

Leçons apprises:

• Les jeunes sont prêts à assurer un rôle d'avant garde dans la prise en charge de leurs problèmes et besoins en SSR ce qui explique la motivation et l'engagement des PE en ESC

• Les parents reconnaissent volontiers que leurs enfants ont de sérieux problèmes et besoins en SSR et qu'ils devraient mieux s'impliquer dans leur éducation sexuelle complète à travers les activités du projet d'ESC.

• Beaucoup de prestataires de services de santé formés reconnaissent volontiers de sérieuses défaillances dans leur prise en charge des adolescents et de jeunes.

• Le projet a contribué dans la lute contre les IST/VIH/Sida.

Prochaines étapes: Duplication du projet sur toute l'étendue du territoire

Intégration des curricula de l'éducation sexuelle dans les écoles de formation des enseignants.

ABSTRACT DRIVEN SESSION

13:30 – 13:45	Jacaranda 3	02.12.2015
WEAD0704:	Track B/5 -	

La Réponse de Kénédougou Solidarité Face a la Question de Sexualité des Ados

Abdoulaye Nimaga

Association Kénedougou Solidarité, Sikasso, Mali

Indiquer le problème étudié, la question de recherche : Kénédougou Solidarité est une association communautaire qui a une longue expérience dans la lutte contre le VIH et le SIDA. Elle dispose de la file active d'enfants la plus élevée de la région de Sikasso. Dans le cadre du programme GRADIR avec ou sans le VIH, elle a bénéficié de financement permettant de soutenir un programme d'accompagnement psychologique et social des enfants et adolescents infectés par le VIH. Au décours des activités, nous avons constaté des insuffisances dans notre approche car les enfants qui atteignaient l'âge de l'adolescence n'avait aucun soutien spécifique les permettant de mieux affronter leur future à savoir connaitre au mieux leur corps et être mieux outiller pour faire face aux question de sexualité et aussi contribuer à la réduction du risque de transmission du VIH et les grossesses précoces et non désirées.

Pour remédier à ces insuffisances, nous avons mis en place un programme pilote d'éducation des adolescents sur la santé sexuelle et reproductive.

Méthodes:

- Identification des adolescents,

- Entretien individuel avec les parents pour leur adhésion aux activités que nous menons au profit des enfants;

- Organisation de groupes de parole ados;

- Entretien individuel avec les ados;

- Intégration des filles dans des séances d'animation de planning familiale;

- Le contact avec le personnel;

- L' accompagnement dans leur désir futur;

- Soutien trimestriel du psychologue clinicien.

Résultats: De 2011à 2014, (60) adolescents sont suivis au centre, 37 filles soit 62% et 23 garçons soit 38% dont l'âge compris entre (13-19) ans. Ils connaissent tous leur statut sérologique. Ils ont également bénéficié des séances d'éducation et de prévention sur la sexualité. Parmi eux 35 sont toujours dans le circuit de l'accompagnement pour le service adulte soit 58% et 25 sont au service des adultes soit 42%, deux(2) filles ont été mariées à deux patients suivis au centre. Ces deux filles sont toutes mères pour avoir conçu. Cela dénote une fois de plus toute l'importance voir les bénéfices de l'accompagnement psychologique et social des ados au centre.

Conclusions et Recommandations: Les services et efforts consacrés aux ados ont permis de surmonter des difficultés de communication liées à leur sexualité d'avant. Les ados suivis communiquent actuellement mieux avec les conseillers sur la question et sont rassurés d'avoir une vie meilleure dans le futur.

13:45 – 14:00	Jacaranda 3	02.12.2015
WEAD0705:	Track B/5 -	

La Communication sur le SIDA en Tunisie: Messages et Images (1987-2010)

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1Institut de Presse et des Sciences de l'Information, Sciences de la Communication, La Manouba, Tunisia, 2Emirates College of Technology, Mass-Media et Relations Publiques, Abu Dhabi, United Arab Emirates

ABSTRACT DRIVEN SESSION

CONTEXTE: En 1987, la Tunisie a instauré un programme national de lutte contre le VIH SIDA (PNLS). Un des principaux axes de ce programme, est la promotion d'une culture de prévention à travers différents moyens de communication, dont la télévision. Le défis est grand car le contexte culturel et religieux tunisien ne s'apprête pas à parler librement de santé de la reproduction ni de sexualité et ce d'autant plus lorsque toute la famille est réunie autour de la télévision.

OBJECTIFS: Analyser les messages télévisés produits sur la prévention du VIH SIDA depuis l'instauration du PNLS jusqu'à 2010 et définir la spécificité de l'image, sa construction et ses différents dispositifs de communication.

Méthodes: 25 spots télévisés ont été analysés faisant intervenir une pluralité d'acteurs en matière de communication aux compétences variées. Parmi ces spots 17 ont été réellement diffusés aux chaînes de TV tunisiennes. Huit parmi ces productions ont été conçus et non diffusés.

Résultats: L'analyse de corpus a révélé que le discours préventif est peu construit sur le plan lexical. Ces messages sur le SIDA, reposent pour l'essentiel sur des logiques différenciées des acteurs autour du triptyque « abstinence - préservatif - fidélité », intégrant les mêmes schèmas de communication développés depuis une vingtaine d'années.

Le discours adressé aux jeunes en matière de VIH SIDA reste globalisant avec un faible ancrage dans le concret et peu impliquant individuellement. La formulation des messages préventifs réfèrent à un mode de pensée particulier. L'accent est mis sur la nécessité de « se protéger » et de « protéger l'autre », d'enrayer l'épidémie et d'adopter un comportement responsable.

Conclusion et Recommandations: La diffusion des informations sur le SIDA en Tunisie marque une volonté de tenir un discours d'ordre général. Les efforts des acteurs de la communication sur le Sida en Tunisie ont été centrés sur la transmission des connaissances. Le changement des attitudes et de comportements sexuels n'a pas été pris en considération. L'analyse des images a révélé que la problématique du SIDA n'existe pas isolément mais qu'elle s'intègre dans des problématiques liées au corps, à la sexualité et à la relation avec l'autre. Développer des messages strictement ciblés et organisés autour d'argumentaires faisant ressortir les bénéfices du changement de comportement est recommandée.

Mots clés: Messages. Discours. Acteurs. Pratiques. VIH Sida.

14:00 – 14:15	Jacaranda 3	02.12.2015
WEAD0706:	Track B/5 -	

An Assessment of the Impact of Community-level Facilitated Viewings of the Shuga Television Program in Kenya

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1Population Council, Washington, United States, 2Cardno Emerging Markets, Washington, United States, 3Population Council, Nairobi, Kenya, 4PATH, Nairobi, Kenya

BACKGROUND: Mitigating HIV incidence among Africa's young people is critical towards reducing the overall impact of HIV and AIDS. Shuga, an HIV prevention-focused television drama series targeting young people, aired in Kenya in 2009 and 2012. To enhance the impact of the Shuga program themes and messages on young people, screenings followed by facilitated discussion was implemented in two Kenyan locations, and the impact of this community-level intervention was assessed.

METHODS: In May and June 2013, a cohort of young people age 15 to 24 in Nairobi and Voi, Kenya, were recruited purposively from local communities, administered a baseline survey, and assigned to participate in either

(a) non-facilitated viewings of the Shuga program (comparison group) or

(b) facilitated viewings of Shuga (intervention group).

Study interventions and activities were implemented during June to July 2013 and from December 2013 to March 2014. A follow-up survey of the same participants was implemented in March to April 2014. The impact of the facilitated intervention on Shuga message retention, HIV-related knowledge and attitudes, HIV testing, and sexual behavior was assessed.

ABSTRACT DRIVEN SESSION

RESULTS: Young people who attended 5 or more facilitated sessions were significantly more likely than other study participants to report discussing key Shuga themes with other people in their lives. Recent HIV testing (< 5 months ago) was significantly associated with increased exposure to the Shuga television series in both the comparison (P=0.024) and intervention (P=0.010) groups at endline. Participants in the intervention group who attended 5 or more facilitated sessions, however, reported a substantial increase in recent HIV testing from baseline (48%) to endline (62%; P=0.016). This intervention subgroup also reported the most minimal increase in sexual experience from baseline (80%) to endline (81%, P=0.824) and the smallest increase in recent sexual activity (baseline 57% to 59%, P=1.000) compared to significant increases within other groups.

CONCLUSIONS AND RECOMMENDATIONS: Watching Shuga without community-level facilitation has some positive effects, particularly in regards to increasing HIV-related knowledge and testing. Facilitated viewings, however, were more effective in increasing HIV communication among young people and in delaying new sexual activity. Continued implementation of focused community-level facilitated viewing sessions for Shuga is recommended.

12:45 – 14:15	Jacaranda 1 & 2	02.12.2015
WEAE0601:	Track E/6 - Operationalising 90:90:90 from inputs to outcomes	
Chairs:	Kenly Sikwese, Zambia	

Operationalizing 90-90-90 through Bottom-up, Locally Driven Planning: The South African Experience

12:45 – 13:00

Muzah Batanayi Prinsloo1, Overmeyer Romy2, Ratshefola Andronica Ndudu3, Diseko Lillian3, Mogale Zandile3, Pinini Zukiswa3, Mametja Lerole David3, Barron Peter3, Pillay Yogan3, Kiwango Eve4, Sehgal Sarita4, Brokenshire-Scott Catherine5, Reid Alasdair4

1Right to Care, Johannesburg, South Africa, 2Foundation for Professional Development, Pretoria, South Africa, 3National Department of Health, Pretoria, South Africa, 4UNAIDS - Regional Support Team Eastern and Southern Africa, Pretoria, South Africa, 5USAID-South Africa, Pretoria, South Africa

South Africa (SA) was the first country to adopt UNAIDS' ambitious 90-90-90 targets for HIV and similarly a set of 90-90-90 targets for TB both for achievement by 2020. Using evidence from the national HIV/TB Investment Case, SA is implementing a novel bottom-up District Implementation Planning (DIP) process for HIV/TB and MCWH. Starting at facility level, the process analyses the root causes of poor performance against a core set of indicators using cascade analyses, indicator dashboards and a standardised bottleneck analysis tool. This process builds on the UNICEF/Department of Health (DOH) '3 feet' approach used to accelerate SA's achievement of the Global Plan targets for elimination of mother to child transmission. The DIP process projects targets up to 2020 and aims to ensure that the US$2 billion invested in HIV/TB in SA (domestic & donor) is allocated and utilised on the basis of greatest need and priority populations The DIP tools promote the analysis and use of data at all levels, facilitate development of concrete plans to address specific challenges, cost and budget these plans, closely monitor progress towards the 90 90 90 targets and promote accountability for completing plans and achieving targets.

The DIP process is aligned to the planning and budgeting cycles at all levels. In financial year 2015/16 DOH has focused on refining the tools and capacitating all levels of health to understand and run the process at facility level. All 52 districts have submitted remedial action plans for 3 priority indicators to accelerate towards 90-90-90. DOH is initiating the 2016/17 process for District Health Planning which will begin at facility level, be consolidated and costed at district level and lead to allocation of budget based expected impact. Progress against the action plans will be monitored monthly at facility and district levels and on a quarterly basis at provincial and national levels. Results of the 2015/16 remedial plans and priority actions for the 2016/17 District Health Plans will be presented with examples of how core indicator performance for HIV, TB, PMTCT and MNCWH has been improved through this approach.

The DIP process is revolutionizing planning, aligning the top down and bottom up approaches; promoting integration and health system strengthening rather than vertical single disease programmes; and driving efficient allocation of resources. Although in its infancy, DIP has shaped PEPFAR planning and resource allocation.

ABSTRACT DRIVEN SESSION

13:00 – 13:15	Jacaranda 1 & 2	02.12.2015
WEAE0602:	Track E/6 -	

A Collaborative Approach to Establish Predictors and True Defaulters and Return the Defaulters Back into Care at Ntchisi District Hospital, a Rural Hospital in Ntchitsi District in Malawi

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1Elizabeth Glaser Pediatric AIDS Foundation, Lilongwe, Malawi, 2Ntchisi District Hospital, Lilongwe, Malawi

ISSUE: Use of antiretroviral therapy (ART) has led to a huge decrease in morbidity and mortality among people living with HIV. Retention on ART is the essential component in increasing positive health outcomes of those on treatment. National scale-up of ART has been successful in Malawi, with more than 70% of patients in need being initiated on ART. Malawi ART National program shows defaulter rates remain high, on average ranging from 10% to 30%. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) worked with the Ntchisi District Hospital to analyze patient records to identify and track a group of recent defaulters so that we could restart them on treatment.

DESCRIPTION: This was a retrospective review of patient records at Ntchisi District Hospital to identify defaulters, bring them back into care and identify possible predictors of defaulting. In November 2014, an EGPAF Technical Officer with Ntchisi data clerk generated a list of 55 patients who defaulted treatment since January 2014. EGPAF supported three community health workers attached to the Hospital to trace these defaulters. Results were recorded and analyzed using Excel. Further analysis was done using Epinfo StatCalc.

LESSONS LEARNT: Out of 55 listed patients, 50(90%) were > 14 years of age; 60% were females, 42 (76%) were successfully traced. Females were 60% of the traced patients. Of the 42 traced individuals, 15 (36%) self-transferred to other centers and 6 (14%) had died. Of the remaining 21 (50%) traced who had been confirmed defaulters, 12 (57%) returned back, 11 (53%) had been on ART < 12 months when they defaulted with 6 (57%) of these having been on ART < 4 months. Overall, among confirmed and suspected defaulters 58 %(18/34) were women initiated on Option B+ and 11 (63%) of these had been on treatment for < 4 months. Predictors of defaulting were: Initiated due to universal eligibility (pregnancy and children < 5 years): OR=3.33(95CI 1.66-17.76). Women initiated on Option B+ were 9 times more likely to default within 4 months of initiation: OR=9 (95CI1.72-26.45) than other women in WHO stage 3 or 4.

Conclusions and **NEXT STEPS:** The collaborative approach involving front-line providers was shown to be an effective way to optimize resources for conducting defaulter tracing and bringing patients back in care. The approach provided insight of predictors of defaulting that will allow the team to address the complex challenges associated with retention of clients on ART.

13:15 – 13:30	Jacaranda 1 & 2	02.12.2015
WEAE0603:	Track E/6 -	

Effective Referral and Linkages Improves Enrollment to Care Among Key Population Living with HIV, TASO Uganda Experience

David Kagimu1, Lazarus Oucul1, Stephen Okoboi2, Teddy Chimulwa1

1The AIDS Support Organisation (TASO), Program Management, Kampala, Uganda, 2The AIDS Support Organisation (TASO), Research Department, Kampala, Uganda

ISSUE: Sex workers (SWs), and the LGBTI belong to a group of sexual minorities with special health needs and as such are disproportionately affected by the HIV epidemic globally. The major challenge in programming for key populations has been lack of feedback from client referral and incomplete continuum of response due to their high mobility and unconducive environment to receive services. TASO initiated an effective referral and linkages system that ensures that all HIV positive Key Populations (KPs) are enrolled into care.

DESCRIPTION: TASO designed a linkage facilitation model involving 2 peer linkage facilitators

at each health service point and in the community to aid the intra and inter facility linkages of KP. During day outreaches, KP peer leaders mobilize their peers for HIV testing. The HIV positive KPs that opt to get services from TASO are commenced on treatment using a test and treat approach when ready. Those that defer treatment are given appointments to the facility and follow ups made with phone calls and through the peer leaders when appointments are not honored in 2 days. KPs that opt to go to other facilities are referred using duplicate perforated forms to their facilities of choice. Two days after the expected date for reaching the referral facility, the linkage facilitators call the client and the contact person at the referral point to confirm if client reached.

Outcome: By the end of 2014, out of 397 SWs who tested HIV positive, 319(80.4%) were linked into care and started on ART. Among the MSM, out of 165 who were tested, 17 tested HIV positive and 16 were linked into care.

LESSONS LEARNT: Having contact persons for KPs at facilities mitigates phobias, assures safety and increases access to services by KPs in a respectful and trusting relationship. Most of the challenges in providing services to KPs revolve around high mobility, stigma and unfavorable environment which all affect their access to services.

NEXT STEPS: The peer -led model is a promising strategy of facilitating linkages especially among SWs and MSMs. Program interventions targeting KPs should adopt effective models like the peer-led model in supporting KPs meet their health needs.

14:00 – 14:15	Jacaranda 1 & 2	02.12.2015
WEAE0604:	Track E/6 -	

Sustainable HIV Treatment in Africa through Viral Load-informed Differentiated Care

Phillips Andrew1, Shroufi Amir2, Vojnov Lara3, Cohn Jennifer4, Roberts Teri4, Ellman Tom5, Bonner Kimberly4, Rousseau Christine6, Garnett Geoff6, Cambiano Valentina1, Nakagawa Fumiyo1, Ford Deborah1, Bansi-Matharu Loveleen1, Miners Alec7, Lundgren Jens8, Eaton Jeff9, Parkes-Rotanshi Rosalind10, Katz Zachary11, Marman David12, Ford Nathan13, Vitoria Marco13, Doherty Meg13, Dowdy David14, Nichols Brooke15, Murtagh Maureen16, Wareham Meghan17, Palamountain Kara18, Chiedza Musanhu Christine19, Stevens Wendy20, Katzenstein David21, Ciaranello Andrea22, Barnabas Ruanne23, Braithwaite Scott24, Bendavid Eran21, Nathoo Kusum25, van de Vijver David15, Wilson David26, Bershteyn Anna27, Holmes Charles28, Walker Simon29, Raizes Elliot30, Jani Ilesh31, Nelson Lisa32, Peeling Rosanna7, Terris-Prestholt Fern7, Murungu Joseph33, Mutasa-Apollo Tsitsi33, Hallett Tim9, Revill Paul29

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BACKGROUND: For sustainable ART programmes in sub-Saharan Africa, it is critical that approaches to monitoring people on ART optimize effectiveness and cost. Currently, in most countries patients are required to attend clinics every 1-3 months for clinical assessment and drug refills with the costs of such visits being comparable with costs of the antiretroviral drugs themselves. Further, patients are often monitored with CD4 count measurement every 6 months and with clinical observation at least every 3 months, but are rarely switched to second-line therapies.

Objectives: To assess the cost-effectiveness of viral-load informed differentiated care whereby those with viral load < 1000 cps/mL are seen for clinical visits 6 monthly or less and those with viral load > 1000 cps/mL have an adherence intervention and, if remaining above 1000 cps/mL are switched to a 2nd line regimen, in line with WHO recommendations.

METHODS: We used an individual level simulation model to evaluate the cost-effectiveness of viral load-informed differentiated care compared with alternative monitoring strategies, including CD4 count- and clinical (symptom)-based strategies. It was assumed that only if viral load is

measured < 1000 cps/mL can clinic visits be reduced in frequency from 4 to 2 /year (resulting in a cost saving per year of $40). Viral load was assumed to be measured using dried blood spots (DBS), taking account of the resulting measurement error. Costs of viral load tests were $22, CD4 count $10 and 2nd line regimens $288 per person per year. Outcomes were DALYs and costs over a 20 year time horizon.

RESULTS: Viral load informed-differentiated care was associated with a similar number of DALYs averted (compared with no monitoring and no switching) to a strategy of CD4 count measurement and switching when CD4 count is < 200 after 3 years on ART (or < 100 after 1 year on ART), but was more cost-effective due to the reduction in clinic visit costs in those with viral load < 1000 cps/mL (incremental cost effectiveness ratio = $326 per DALY averted).

CONCLUSIONS AND RECOMMENDATIONS: Viral load-informed differentiated care using DBS is expected to be both effective and cost-effective and the evidence is sufficient to recommend the strategy for patient monitoring. Added value may be higher if reduced patient costs associated with reduced clinic visits improve patient retention and outcomes. Further empirical evidence as the approach is rolled out would however be of value.

13:30 – 13:45	Jacaranda 1 & 2	02.12.2015
WEAE0605:	Track E/6 -	

Evaluation of SAMBA Viral Load Point-of-Care Test Operation by Trained Non-health Workers in rural Health Centers in Chiradzulu District, Malawi

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Background: Routine viral load (VL) monitoring is strongly recommended for HIV-patients receiving anti-retroviral treatment (ART). Scaling-up access to VL testing in decentralized settings remains challenging. A simplified VL point-of-care (POC) test SAMBA (Simple AMplification Based Assay) has recently been developed. It is an isothermal amplification system with visual semi-quantitative detection of amplified viral RNA below or above the cut-off of 1000 copies/mL blood. Médecins sans frontières (MSF) is rolling out SAMBA since July 2013 to rural health centers (HCs) in Chiradzulu District, Malawi. Shortage of health care staff is a major constraint in this setting. The objective of this study was to evaluate SAMBA POC VL test operation by trained non-health workers compared to laboratory technicians in peripheral HCs.

Methods: Four non-health workers received a 2-weeks structured training on SAMBA POC operation. In total, 250 venous blood samples of ART-patients attending programmatic VL-testing are included in 2 rural HCs, and each sample is tested with SAMBA by a laboratory technician (LT) and by a trained community worker (TCW), respectively. Inclusion is expected to be finalized in August 2015. The percent agreement and the inter-operator Kappa-coefficient for VL-classification below and above the cut-off of 1000 copies/mL (SAMBA-test negative or positive, respectively) are assessed. Acceptability of test operation by TCWs is assessed with questionnaires.

Results: By July 2015, 181 venous blood samples were included (72.4% of total samples size). Thirty-two of the included samples (17.7%) were classified as SAMBA-positive (≥1000 copies/ml) by LTs, and 30 (17.1%) by TCWs. Three samples had discordant results: 2 samples were rated negative by TCW and positive by LT, one sample was rated positive by TCW and negative by LT. Overall agreement between TCW and LT was 98.3% (CI 95%: 95.2-99.7), corresponding to a kappa value of 0.94 (CI 95%: 0.88 - 1.0). No invalid SAMBA results were obtained.

Conclusions and Recommendations: Adequately trained community workers delivered viral load results equivalent to lab technicians using the semi-quantitative SAMBA VL POC test in health center laboratories. Our findings indicate that task shifting of simplified VL POC-testing to trained non-health staff can be a key strategy to overcome health worker shortage and to ensure sustainable access to routine viral load monitoring in rural facilities.

ABSTRACT DRIVEN SESSION

13:45 – 14:00	Jacaranda 1 & 2	02.12.2015

WEAE0606: Track E/6 -

The Effects of Shifting Responsibility from Pharmacy to Non-pharmacy Personnel for Dispensing Antiretroviral Medications to Patients Infected with HIV: A Systematic Review and Meta-analysis

Wiysonge Charles Shey1,2, Mbeye Nyanyiwe1, Adetokunboh Olatunji1, Negussie Eyerusalem3, Kredo Tamara2

1Stellenbosch University, Centre for Evidence-Based Health Care, Cape Town, South Africa, 2South African Medical Research Council, Cochrane South Africa, Cape Town, South Africa, 3World Health Organization, Geneva, Switzerland

BACKGROUND: The specifics of task shifting for dispensing of antiretroviral drugs have not been addressed in a systematic review, yet this is a potential method for ensuring universal access to antiretroviral therapy in low and middle-income countries where qualified pharmacists are in short supply. We assessed the effects of task shifting models that use lay people in dispensing antiretroviral drugs in countries defined by the World Bank as low or middle-income.

METHODS: We searched PubMed, CENTRAL, EMBASE, WHO Global Health Library, and relevant grey literature databases for eligible controlled trials, interrupted-time-series, and controlled-before-and-after studies. Two authors screened the search output, selected eligible studies, assessed the risk of bias, and extracted data from included studies; resolving discrepancies by discussion and consensus. We performed meta-analysis using fixed effects model, investigated clinical and statistical heterogeneity, and assessed the certainty of the evidence using standard Cochrane methods. The review was registered with PROSPERO (registration number: CRD42015017034).

RESULTS: Two cluster-randomized trials with 1,661 HIV-infected individuals on ART met inclusion criteria. there was no evidence of differences between lay people and standard care on mortality (2 trials, 1,661 participants, RR 0.99, 95% CI 0.74 to 1.33; moderate certainty of evidence), virological failure (RR 0.93, 95% CI 0.72 to 1.21; moderate certainty of evidence), loss to follow-up (RR 1.03, 95% CI 0.57 to 1.85; moderate certainty of evidence), and retention in care (RR 1.03, 95% CI 0.98 to 1.09; moderate certainty of evidence). In addition, there was no evidence of a difference in self-reported adherence to therapy, which remained above 90% in both groups.

CONCLUSIONS AND RECOMMENDATIONS: The use of non-pharmacy personnel or lay people in the delivery of ART is a promising strategy for addressing health personnel shortages in resource limited settings. There is need for more primary studies to establish whether this intervention would be applicable to children and HIV infected pregnant women since this review was not able to identify studies involving these populations due to lack of evidence.

ABSTRACT DRIVEN SESSION

14:45 – 16:15	Committee Room 4	02.12.2015
WEAE0701:	Track E/7 - Stretching the dollar (French ABS)	
Chairs:	Michael Bartos, Zimbabwe	

Measuring the Benefit of Effective HIV/AIDS Programs in Sub-Saharan Africa: Healthy Life Gained or Death and Sickness Averted? 14:45 – 15:00

Bershteyn Anna1, Klein Daniel J.1, Meyer-Rath Gesine2, Eckhoff Philip A.1, Over Mead3

1Institute for Disease Modeling, Bellevue, United States, 2Boston University School of Public Health, Global Health, Johannesburg, South Africa, 3Center for Global Development, Washington, United States

BACKGROUND: An effective HIV program prolongs lives and prevents HIV infections. Over the long term, these two effects produce significant changes in the structure and rate of growth of the beneficiary population. Two commonly used approaches to calculating the health benefits of HIV/AIDS programs differ in their treatment of the longer term demographic effects. One approach values incremental healthy life-years (HLYs) gained by implementing a program, including those lived by people who would otherwise not have been born. The other approach values only the years of death and disability, or disability-adjusted life-years (DALYs), averted by the program. By embedding HIV/AIDS epidemiology and interventions within a demographic model, we calculated the size of the divergence between the two measures and suggest policy questions that each can address.

METHODS: The long-term burden of HIV/AIDS in South Africa was estimated under different health care expansion scenarios using EMOD-HIV, an epidemiological model that provides detailed age-stratified outputs including the HIV-free lifespan for all individuals. The full EMOD-HIV model is available online. For the same model runs, we compared the HLYs and DALYs associated with expanded HIV services.

RESULTS: The divergence between HLYs gained and DALYs averted manifests within one decade and widens over time when children are born in the intervention scenario who otherwise would not have been born. Applying an annual discount rate diminishes the cumulative difference between the two benefit measured. With a 3% annual discount rate, in the most optimistic intervention scenario (annual testing for 80% of the population with linkage to ART for all those testing positive, in addition to baseline antenatal, couples, and symptom-driven testing), both benefit measures improved, but the gap between them continued to grow until 2050, when it stabilized but never declined.

CONCLUSIONS AND RECOMMENDATIONS: Policy analysts interested in both the health and the demographic impact of HIV/AIDS programs may prefer to study healthy life-years gained rather than valuing averted death and disability in order to fully capture the program's impact on the entire population. However, since dynamic population models do not yet exist for many other health risks, analysts wishing to compare interventions across diseases will prefer the static approach which values an intervention by the death and disability it averts.

15:00 – 15:15	Committee Room 4	02.12.2015
WEAE0702:	Track E/7 -	

Where did the Money Go? Findings from the National AIDS Spending Assessment Report

Annang Dennis1, Asante Felix2, Yeboah Kenneth3, Epeh Daniel4, Atuahene Steven1, El-Adas Angela5

1Ghana AIDS Commission, Research Monitoring and Evaluation, Accra, Ghana, 2Institute of Statistical, Social and Economic Research, Accra, Ghana, 3Pricewaterhouse Coppers, Monitoring and Evaluation, Yaounde, Cameroon, 4Ghana AIDS Commission, Finance, Accra, Ghana, 5Ghana AIDS Commission, Accra, Ghana

BACKGROUND: The financial burden on domestic economies in sub-Saharan Africa to fight the AIDS epidemic is enormous and although domestic public expenditure from governments in low-income countries has significantly increased, most of them heavily rely on external sources of funding. Despite the global recession seen in recent years in developed countries who provide technical and financial support to Ghana, there is the need to effectively monitor resource flows

for HIV and AIDS and track its effective allocation. To achieve this, the National AIDS Spending Assessment was conducted in Ghana for 2012 and 2013.The aims of the study was to1.Analyze expenditure patterns of HIV related services from public and private sector organizations, including bi and multilateral organizations.2. Enter and validate financial data3.Document and share the NASA findings with stakeholders.

METHODS: The NASA allows for the systematic and exhaustive accounting of the level and flows of financing and expenditures. It captures all HIV and AIDS spending according to the categories in the national strategic plan 2011-2015. Most of the key sources of data were obtained from stakeholders involved in HIV and AIDS using a questionnaire developed by UNAIDS and the results obtained using the Resource Tracking Software developed by UNAIDS.

RESULTS: Total expenditure on HIV and AIDS activities in Ghana decreased from $109,674,155 in 2012 to $67,026,665 in 2013, (constituting a 39% decrease). Contributions from international organizations amounted respectively to 79.7% and 60.4% in 2012 and 2013, with public funds increasing from 4.1% in 2012 to 10.2% in 2013. Most funds accrued in 2012 were spent on Prevention (41.7%) Treatment, Care and Support (31%) and in 2013 on Treatment, Care and Support (44.8%) and Prevention (23.2%). Total expenditure on prevention programmes decreased from $45, 741,616 in 2012 to $15,609,666 in 2013 with significant decrease in expenditure in 2013 as compared to 2012 for high risk populations.

CONCLUSIONS AND RECOMMENDATIONS: Although the study excluded sexual reproductive health spending related to HIV, it gives an estimate of the functional flow of application and distribution of funds. As a result of the decrease in funds allocated to prevention, Ghana has submitted a proposal to the Global Fund to support prevention programs from 2015 to 2017. Finally there is a need to improve accuracy of financial data and reporting mechanism to conform to the 3 Ones Principle.

15:15 – 15:30	Committee Room 4	02.12.2015
WEAE0703:	Track E/7 -	

Cost-effectiveness of a Sport-based, Once-off Voluntary Medical Male Circumcision (VMMC) Intervention in Zimbabwe

DeCelles Jeff

Grassroot Soccer, Cape Town, South Africa

BACKGROUND: Three randomized controlled trials (RCTs) have shown voluntary medical male circumcision (VMMC) can reduce female-to-male transmission of HIV by 50-60%. A review conducted by experts suggests that male circumcision is cost-effective and cost saving in settings with high levels of HIV and low VMMC prevalence.

Grassroot Soccer, an international NGO, in partnership with the London School of Hygiene and Tropical Medicine conducted two RCTs in Bulawayo, Zimbabwe and found a 60-minute, soccer-based educational session can increase demand for VMMC among both adult men and adolescent boys. The first intervention, called "Make The Cut" (MTC) targeted men ages 18-30 from Bulawayo soccer teams and found weak statistical evidence of an effect of MTC on VMMC uptake among men with 4.8% uptake among uncircumcised intervention participants, compared to 0.5% among control participants (OR=9.81, 95%CI=0.93,103.2, p=0.06). The second intervention, called "Make the Cut+" (MTC+), targeted secondary school boys ages 14-19 in Bulawayo and found strong evidence of an effect on VMMC uptake among adolescents with 12.2% uptake among uncircumcised intervention participants, compared to 4.6% among control participants (OR=2.65, 95%CI=1.19,5.86, p=0.02).

Cost-effectiveness analysis was conducted to determine the cost per new VMMC client generated.

METHODS: VMMC uptake over four months was measured via probabilistic matching of participants in the trial database and the registers in Bulawayo's two free VMMC clinics, using eight identifying variables.

Initial cost-effectiveness was measured by calculating the total cost of the intervention (including 15% overhead). Taking into account the difference in VMMC uptake between control and intervention groups among participants who did not report being circumcised at baseline, we determine the cost new VMMC procedure generated for both men and adolescent boys.

RESULTS: The cost per new VMMC client generated was approximately $48.63 for adolescent males and $101.35 for adult males.

CONCLUSIONS AND RECOMMENDATIONS: The MTC+ intervention was an effective and

cost-effective strategy for increasing VMMC uptake among adolescent male students in Bulawayo, while VMMC uptake findings for men appear less conclusive and more expensive. Additional analysis is needed to determine the cost-effectiveness of MTC at scale and to calculate the approximate cost per HIV infection averted.

15:30 – 15:45	Committee Room 4	02.12.2015
WEAE0704:	Track E/7 -	

Retrospective Review to Determine Cost per Client Visit for Programs Supporting ART Treatment and Retention in Uganda

Karukoma Gordon, Ssali Livingstone, Okoboi Stephen

The AIDS Support Organization, Kampala, Uganda

BACKGROUND: TASO has Provided ART to more than 68,584 patients since 2003 across the 11 centers serving 55 districts in Uganda. TASO uses a hierarchical structure with one headquarter, four regional offices, and 11 service delivery centers all associated with community drug distribution points (CDDPs). We examined the cost data on per-patient ART costs to provide information to guide budgeting, planning, modeling cost and cost-effectiveness.

METHODS: We Retrospectively abstracted the cost data from both electronic and hard copies of the financial records for the period January to December 2012 among the 4 (four) of the 11 (eleven) TASO service centers selected randomly, we mostly collected data for costs that were directly incurred by the providers in 2012 reflecting both financial costs of services for ART treatment such as drug and personnel costs; and economic costs such as equipment, training, and construction.

RESULTS: The average estimated cost per client visit was $39, human resource(personnel) was $1372845.439 (31%), Drugs and laboratory supplies was $1625915 (37%), office and operational costs $ 1076076 (25%), and training $285772 (7%). We learnt that this figures comparable with other studies in Kenya: 224 USD per patient/year (~56 USD per visit; 2009 data; Zambia: 198 USD per patient/ year (49.5 USD per visit; 2011).

CONCLUSIONS AND RECOMMENDATIONS: Outreach or more task-shifted models cost less to service providers. The analysisalso revealed a reduction in annual ART cost compared to findings from previous studies in Uganda and similar contexts. This might be due to increases in number of clients, reductions in drug costs, and the fact that these three organizations are mature. In addition, these three task-shifting models did not compromise service quality (over 80% reported satisfied) and retention rate (over 80% at 18 months) based on our separate analysis. Further studies are needed to identify and understand the quality and effectiveness of each model, as well as the economic costs to the clients who receive their services.

15:45 – 16:00	Committee Room 4	02.12.2015
WEAE0705:	Track E/7 -	

Mettre fin à l'Épidémie de Sida en 2030 en Afrique: Un Investissement Très Rentable

Lamontagne Erik1, Over Mead2, McGreevey William3, Stover John4, Izazola José-Antonio1

1ONUSIDA, Genève, Switzerland, 2Center for Global Development, Washington, United States, 3Georgetown University, Washington, United States, 4Avenir Health, Glastonbury, United States

Objectif: Le continent africain a réalisé des progrès fantastiques en matière de riposte au VIH. L'épidémie recule et le nombre de décès et de nouvelles infections recule. Grace à ces progrès, il y a un consensus grandissant comme quoi il est possible de mettre fin à l'épidémie de sida comme menace de santé publique d'ici 2030.

Dans cet esprit, l'ONUSIDA a lancé la stratégie d'accélération de la riposte. Un tel scénario nécessite des investissements annuels importants, culminant à 30,5 milliards de dollars en 2020 dont plus de la moitié pour l'Afrique, incluant l'Afrique du Nord. Afin de déterminer la pertinence d'un tel investissement, nous avons examiné les retombées économiques qu'un tel scenario pourrait

générer rapport à un scénario de couverture constante.

DESCRIPTION: Nous avons développé trois approches économiques:

i) une analyse coût-efficacité,

ii) une approche basée sur le coût de la maladie, et

iii) une approche de 'plein revenu' (full income).

Pour chaque approche, les coûts et bénéfices marginaux ont été estimés jusqu'à 2050 à partir des projections de l'ONUSIDA pour chacun des deux scenarios.

Résultats / Leçon apprise: L'intensification de la riposte représente en Afrique un investissement additionnel de 3,4 milliards de dollars par an par rapport au scénario constant. Mettre fin à l'épidémie du sida représenterait un gain net de 161 millions de QALY, dont près de 75% en Afrique. Les bénéfices économiques nets additionnels d'un tel investissement représenteraient de 2,080 - 3,078 milliards USD, ce qui représente des retombées économiques nettes 11,6 $ à 17,2 $ pour chaque dollar investi. Les deux tiers (66,1%) de ces bénéfices seront générés sur le continent africain.

Discussion: La stratégie d'accélération de la riposte pour mettre fin à l'épidémie de sida d'ici à 2030 apparaît être un investissement très efficace tant sur le plan humain qu'économique. Particulièrement en Afrique où les économies liées aux infections évitées dépassent les coûts marginaux de l'accélération de la riposte.

16:00 – 16:15	Committee Room 4	02.12.2015
WEAE0706:	Track E/7 -	

Local Investments with Global Implications: The Contributions of African Countries who Host clinical Trials in HIV Prevention Research & Development

Donaldson Emily D1, Fisher Kevin1, Warren Mitchell1, Harmon Thomas2, Izazola-Licea Jose Antonio3

1AVAC: Global Advocacy for HIV Prevention, New York, United States, 2International AIDS Vaccine Initiative, New York, United States, 3UNAIDS, the Joint United Nations Programme on HIV/AIDS, Geneva, Switzerland

BACKGROUND: Since 2004, the HIV Vaccines and Microbicides Resource Tracking Working Group has employed a comprehensive methodology to track trends in research and development (R&D) investments and expenditures for biomedical HIV prevention options, including HIV vaccines, microbicides, PrEP, treatment as prevention and medical male circumcision. Beginning in 2013, the Working Group endeavored to collect data from countries in sub-Saharan Africa which undertake clinical trials and demonstration projects in HIV prevention R&D.

METHODS: R&D data were collected on annual disbursements by public, private and philanthropic funders based in sub-Saharan Africa for product development, clinical trials and trial preparation, community education and policy advocacy efforts in order to estimate annual investment in HIV prevention R&D. While the financial contributions of these countries are often challenging to calculate, the Working Group has collected information on investments—financial, in-kind and human—in order to report on the full amount of African funding towards HIV prevention R&D.

RESULTS: With numerous clinical trials and demonstration projects taking place in countries across sub-Saharan Africa, and nearly 70 percent of all trial participants located in these countries, the region has invested considerably in HIV prevention R&D. While the financial spend is small by comparison to that of traditional donor countries, there is a trend towards increased financial investment in HIV prevention R&D, particularly implementation science. Promising results in pre-exposure prophylaxis, treatment as prevention and adult male circumcision have pushed countries to invest in studies that will aid in the rollout and uptake of these new prevention modalities.

CONCLUSIONS AND RECOMMENDATIONS: HIV prevention R&D could not advance without the contributions of the countries in which trials take place, including financial, collaborative and especially, the commitment of trial participants and the communities where trials take place. As HIV prevention R&D moves forward, the engagement and investment of funders from the global South in the outcomes of R&D taking place in their countries is imperative to advance science. As the state of donor funding is uncertain, country ownership of the HIV response is imperative, and already underway—including ownership of the research needed to discover, develop and deliver new HIV prevention options in order to drive new infections to zero.

ABSTRACT DRIVEN SESSION

18:50 - 20:30	Committee Room 5a & b	02.12.2015
WEAC0801:	Track C/8 - 'All in': evidence and initial implementation for adolescents	
Chairs:	Sydney Hushie, Ghana	

HIV Prevalence Trends among Young Women and Men in Sub-Saharan Africa from 2000-2013 - Evidence to Inform Gender-specific HIV Targets and Indicators in Generalized HIV Epidemics 14:45 – 15:00

Sherwood Jennifer A.1, Cooper Bergen2, Honermann Brian1, Roose-Synder Beirne2, Blumenthal Susan1, MacAllister Jack1, Millett Greg1

1amfAR, Foundation for AIDS Research, Washington DC, United States, 2Center for Health and Gender Equity, Washington DC, United States

BACKGROUND: Young women are among the most vulnerable populations for HIV infection in Sub-Saharan Africa (SSA). However, gaps remain in the evidence-base for HIV prevention services for young women and available HIV data are not always disaggregated by sex and age, creating barriers for gender-targeted programming. We report and analyze changes in youth HIV prevalence trends across SSA by sex from 2000-2013, providing evidence for incorporating gender-responsive programming into national strategies and informing realistic sex-specific HIV targets in generalized epidemics.

METHODS: HIV prevalence data for 15-24 year olds, collected by UNAIDS (2000-2013), were downloaded via the World Bank online database for all countries in SSA. Countries were excluded from analysis if their total youth HIV prevalence was less than 1%. Linear regression models for both sexes and analysis of covariance (ANCOVA) between the HIV prevalence of young men and women were parameterized for each country and SSA overall.

RESULTS: Overall youth HIV prevalence declined from 2000-2013 across SSA; however average annual declines were not statistically significant for South Africa, Lesotho, Swaziland, Mozambique, Kenya, Guinea Bissau, or Rwanda. In Uganda, average HIV prevalence among young people increased annually [.13%, CI: .05% to .20% p< .01]. In most countries, HIV prevalence among young women declined faster than among young men, with the exception of Uganda where HIV prevalence of young women increased faster than for young men. In all studied countries HIV prevalence among young women was significantly higher than among young men. In 2013, the HIV prevalence ratio (PR) between young women and young men (W:M) ranged from 1.32 in Zambia to 4.75 in Gabon, averaging 2.03 across SSA. From 2000-2013 the HIV PR (W:M) increased in South Africa, Mozambique, Guinea Bissau and Lesotho.

CONCLUSIONS AND RECOMMENDATIONS: Despite promising trends of declining HIV prevalence in SSA among young women and men, for many countries these reductions were not statistically significant and young women continue to comprise the vast majority of youth living with HIV. Critical elements for the success of the HIV response in SSA are the collection of data by sex and age group as well as the provision of age- and gender-specific HIV programming. Moreover, age- and gender- specific HIV indicators and targets must be central to National Strategic Plans and supported by donor governments.

15:00 – 15:15	Committee Room 5a & b	02.12.2015
WEAC0802:	Track C/8 -	

Ending the AIDS Epidemic in Adolescents: Sharpening Programme Focus and Improving Efficiency of HIV Response for Adolescents Aged 10 - 19 years - Lessons from "ALL IN" Assessments in 5 Countries

Kasedde Susan M1, Idele Priscilla A1, Oyewale Tajudeen O1, Suzuki Chiho1, Luo Chewe1, Melles Mimi2, Porth Tyler A1, Yasrebi Najin1, Murphy Padraic1, Bains Anurita3, Pinto Renato3, Kamenga Claudes4, Bacha Abdelkader4, Bergua Jose5, Midy Ralph6, Mugabe Mbulawa2, Mahy Mary2, Padayachay Jude2, Somse Pierre7, Raja Jyothi7, Guwani James7, Baggaley Rachel8, Armstrong Alice8, Mbola-Mbassi Symplice9, Zhukov Ilya10, Fraser-Hurt Nicole11, Licata Margerita12, Iorpenda Kate13, Chandler Caitlin14, Todesco Marina15, Sharer Melissa16, Achebe Kechi17, Condell Novia18, Naluyinda-Kitabire Florence19, Radosavljevic Tanya19, Nduwimana Therese20, Mphaya Joyce21, Senzanje Beula21, Whoolery Scott22, Chuwa Vicky23, Macfarlane Denise24, Mabuza Khanya25, Tswetla Nametsego26, Dennis Futhie25, Muzila Grace26, Huruva Solomon27, Billong Serge C28, Maguranyanga Brian29, Mcclure Craig1

ABSTRACT DRIVEN SESSION

1UNICEF New York, New York, United States, 2UNAIDS Geneva, Geneva, Switzerland, 3UNICEF ESARO, Nairobi, Kenya, 4UNICEF WCARO, Dakar, Senegal, 5UNICEF LAC, Panama City, Panama, 6UNICEF LAC, Santo Domingo, Dominican Republic, 7UNAIDS - Regional Support Team Eastern and Southern Africa, Sunninghill, South Africa, 8WHO Geneva, Geneva, Switzerland, 9WHO AFRO, Brazzaville, Congo, 10UNFPA New York, New York, United States, 11World Bank, Washington, United States, 12ILO, Geneva, Switzerland, 13International AIDS Alliance, Brighton, United Kingdom, 14The Global Fund, Geneva, Switzerland, 15UNESCO, Paris, France, 16JSI, Washington, United States, 17Save the Children, Washington, United States, 18UNICEF Jamaica, Kingston, Jamaica, 19UNICEF Swaziland, Mbabane, Swaziland, 20UNICEF Cameroon, Yaounde, Cameroon, 21UNICEF Zimbabwe, Harare, Zimbabwe, 22UNICEF Botswana, Gaborone, Botswana, 23UNICEF Tanzania, Dar es Salaam, Tanzania, United Republic of, 24Planning Institute of Jamaica, Kingston, Jamaica, 25NERCHA, Mbabane, Swaziland, 26NACA, Gaborone, Botswana, 27Ministry of Health - Zimbabwe, Harare, Zimbabwe, 28CNLS/Cameroon, Yaounde, Cameroon, 29Independent Consultant, Harare, Zimbabwe

ISSUES: The global AIDS epidemic will not be ended without improved investment and quality of programmes for adolescents aged 10 - 19 years. National programmes need to address legal barriers to access to HIV testing and scale up innovative strategies for timely diagnosis and linkage to care, improved retention, transition and referral to prevention for HIV negative adolescents at high risk of infection. Limited engagement of adolescents, weak coordination between sectors, weak systems for referral and linkage, weak and insufficient disaggregation and use of data as well as discriminatory laws also continue to significantly hinder progress.

DESCRIPTION: To address this, a global agenda, ALL IN, was launched by UNICEF and UNAIDS with other partners and youth networks to engage leaders and foster collaboration across multiple sectors. This agenda aims to achieve 3 global targets for adolescents by 2020 aligning this population to the global Fast Track effort, thus enabling achievement of the overall goal of ending the AIDS epidemic by 2030.

Through data-driven planning (a 3-phase assessment) in 25 lead countries and elsewhere globally, countries are gathering and analyzing data on adolescents aged 10 - 19 across a range of indicators from multiple sectors, in order to build a better understanding of the health and well-being of adolescents.

As a result of this analysis, country teams are able to take decisions on what actions to prioritize to address bottlenecks in strategic interventions for priority adolescent populations.

LESSONS LEARNT: In 2015, 5 countries (Botswana, Cameroon, Jamaica, Swaziland, Zimbabwe) conducted cross-sectoral assessments. Regional training and in-country and virtual south-to-south learning are helping accelerate roll-out.

Early experience has highlighted 3 strategic gaps:

1. Gaps between current coverage and targets resulting from sub-optimal performance.

2. Gaps in data on adolescents resulting from practices in data disaggregation and reporting as well as inclusion of adolescents in surveys.

3. Gaps in programme effort resulting from inadequate use of available data to inform priority actions.

NEXT STEPS: By bringing national partners together to agree on strategic gaps and related priority actions, and by linking the process to national strategic planning efforts, the assessments are helping contribute to improved accountability, resource allocation, data and monitoring and results for adolescents.

15:15 – 15:30	Committee Room 5a & b	02.12.2015
WEAC0803:	Track C/8 -	

Use of Couples' Voluntary Counselling and Testing for HIV (CVCT) and Long Acting Reversible Contraception (LARC) Services by Adolescents in Urban Zambia

Lockard Ann M1, Hoagland Alexandra2, Malama Kalonde2, Kwesele Change2, Fox Katie1, Sharkey Tyronza1, Parker Rachel3, Tichacek Amanda3, Inambao Mubiana2, Kilembe William1, Allen Susan3

1Zambia Emory HIV Research Project, Lusaka, Zambia, 2Zambia Emory HIV Research Project, Ndola, Zambia, 3Rwanda Zambia HIV Research Project, Atlanta, United States

ISSUES: Integrated HIV prevention and family planning services are needed in Zambia, as the country has both a high HIV incidence rate and a high unmet need for family planning. Adolescents under 20 are particularly at risk for both HIV infection and unplanned pregnancy and could benefit from integrated sexual and reproductive health services. Couples Voluntary Counselling and Testing (CVCT) is an evidence-based HIV prevention strategy endorsed by the WHO that can also be used as an entry point to other health services. Since 49% of girls in Zambia are married by the age of 18, couples-based services are also appropriate for many adolescents.

DESCRIPTION: The Zambia Emory HIV Research Project (ZEHRP) has provided CVCT in Zambia for over 20 years. In March 2013, ZEHRP services were expanded to include Couples Family Planning Counselling (CFPC) and Long-Acting Reversible Contraception (LARC) integrated with CVCT in 53 Government of Republic of Zambia (GRZ) urban clinics in 6 cities. CVCT/CFPC services are open to all couples, including couples who are not yet cohabiting. LARC services are offered to couples and to individual women.

LESSONS LEARNT: Couple-based services are currently used by many adolescent couples in Zambia. Of 83,339 couples tested since March 2013, 13,525 (16.2%) had an adolescent woman under 20 and 1,836 (2.2%) had an adolescent man. In 30.5% of these couples, neither partner had tested before. Seroprevalence was 92.4% M-F-, 4.0% M+F+, 2.1% M-F+, and 1.5% M+F-; 97.3% were cohabiting and 31.3% were pregnant. In non-pregnant couples 30.4% were using a modern contraceptive method and 5.4% were using LARC. Of 30,113 LARC insertions provided for women, 2,979 (9.9%) were for adolescents and 40.3% of those reported having been tested previously with their partner.

NEXT STEPS: Couple-based services offer several benefits: the opportunity to disclose HIV statuses, formulate an HIV prevention plan together with knowledge of both serostatuses, and discuss and chose a family planning method together. The HIV prevention benefits of CVCT may be particularly beneficial to adolescent couples due to the relatively low prevalence of HIV in this group. LARC may also be especially beneficial to adolescent women wishing to delay the start of childbearing due to its effectiveness and reversibility. Promotional campaigns for CVCT and LARC targeted specifically to adolescents could increase the numbers of adolescents seeking these services.

15:30 – 15:45	Committee Room 5a & b	02.12.2015
WEAC0804:	Track C/8 -	

Clinical, Ethical and Operational Considerations for the Implementation of Oral Pre-exposure Prophylaxis (PrEP) in Sexually Active Older Adolescents (aged 15-19) at High Risk of HIV Infection

Oyewale Tajudeen O1, McClure Craig1, Luo Chewe1, Richey Catherine1, Godfrey-Faussett Peter2, Baggaley Rachel3, Warren Mitchell4, Bekker Linda-Gail5, Kasedde Susan1, Collins Chris2

1UNICEF New York, HIV Section, New York, United States, 2UNAIDS Geneva, Geneva, Switzerland, 3WHO Geneva, Geneva, Switzerland, 4AVAC, New York, United States, 5University of Cape Town, Cape Town, South Africa

ISSUE: The efficacy of Tenofovir containing antiretroviral (ARV) regimen as oral pre-exposure prophylaxis (PrEP) for HIV prevention in different population groups at risk of HIV infection if used correctly and consistently has been established. Applying this new bio-medical tool for HIV prevention in sexually active older adolescents at high risk of HIV infection will contribute to ending AIDS as a public health issue by 2030.

DESCRIPTION: A global consultation of 58 scientists, researchers, community and development partners, and youth advocates was convened by UNICEF to consider the clinical, ethical and operational issues required to implement oral PrEP among sexually active older adolescents aged 15-19 in populations at higher risk of infection.

LESSONS LEARNT: Prioritizing individuals who are at substantial risk of HIV infection e.g. incidence > 3 per 100 person years and willing to take PrEP will have substantial cost-benefit on national HIV response. The delivery of PrEP in a safe space for adolescents, as part of combination HIV prevention package will be key to success. Entry points such as sexual and reproductive health (SRH), post-exposure prophylaxis (PEP) and family planning services, and youth centres offer strategic sites to identify and initiate eligible adolescents on PrEP. Task shifting among healthcare providers along the continuum of HIV testing, PrEP (ARV) dispensing and follow up care will avoid additional burden on the health system. In building demand, programs should consider the diversity of adolescents eligible for PrEP. Participatory development of communication strategies that target

different groups and prioritize social marketing of PrEP as a positive health choice will be key. Multiple and innovative adherence support strategies will be important for better PrEP effectiveness. Legal, ethical and policy issues, such as age of consent to HIV and SRH services for adolescents less than 18 years remains a challenge in some countries. In addition, mechanisms to assure confidentiality and protect adolescents from disclosure obligations may be required for the success of PrEP among adolescents. According to youth advocate at the consultation, "PrEP provides an opportunity for empowering adolescents to take control of their sexual health".

NEXT STEPS: The development of PrEP implementation guidelines by the World Health Organization (WHO) should incorporate these considerations to enable PrEP implementation for eligible

15:45 – 16:00	Committee Room 5a & b	02.12.2015
WEAC0805:	Track C/8 -	

Provision of Sexual, Reproductive Health and Rights Information through Board Games as Media of HIV and AIDS Prevention Strategy in Kenya

Otieno Nixon O1, Obuyyi Albert2, Adolescence (10-19 Years)

1Centre for the Study of Adolescence, Adolescence Sexual Reproductive Health and Rights, Nairobi, Kenya, 2Centre for the Study of Adolescence, SRHR, Nairobi, Kenya

ISSUES: Globally, there are about 1.2 billion people between the ages of 10 and 19, making it the largest generation of youths ever (International Women's' Health Coalition, 2010). Sub-Saharan Africa is home to over 372 million youths accounting for slightly over 30% of the population (The World's Youth 2006 Data).In Kenya, according to the 2009 Kenya Demographic and Health Survey (KDHS), about 43% of the population is less than 25 years old. This population has limited access to Sexual and Reproductive Health (SRH) Information thus increased risk to contracting sexually transmitted infections, unwanted pregnancies and unsafe abortion through high risk sexual activities. The Centre for the Study of Adolescents (CSA) initiated a program to address adolescent and youth sexuality issues in two counties in Kenya focusing on enhancing uptake of SRH information and services by young people aged between 10-19 years.

DESCRIPTIONS: The program is being implemented in Kisii and Kisumu counties of kenya. Board game based on sexuality curricula was developed to provide information on Comprehensive Sexuality Education including HIV and AIDs in a simplified, attractive, interactive and interesting way for adolescents to understand.Board games preparation content took into account SRHR and HIV and AIDs issues of young people directed at younger learners in primary schools using simple crosswords, case stories, questions-answer guides and illustration for learners. Through this young people generate discussions based on sexual reproductive health and information thereby helping them tackle myths and misconceptions on SRHR through engaging in discussions. The board games have been distributed to 40 primary schools in the two counties as a pilot project

LESSONS LEARNT: Young people have increased their expression of SRHR issues through group discussion. We have observed increased openness and discussions about SRHR topics among participating youths. In addition through weekly discussion groups in schools, we have observed improved learners' participation in schooling activities, development of basic skills and creativity, better behavioral attitudes and attributes and stronger peer to peer support among learners.

NEXT STEPS: Results will be disseminated to stakeholders and policymakers on how board games can contribute to students' perceptions on SRHR/HIV education and improved their knowledge and skills levels. Results will also be published in peer reviewed journals.

16:00 – 16:15	Committee Room 5a & b	02.12.2015
WEAC0806:	Track C/8 -	

Do Cash Transfers Work for HIV Prevention?

Chipanta David1, Abdool Karim Quarraisha2, Pettifor Audrey3, Kahn Kathleen4, Handa Sudhan-

ABSTRACT DRIVEN SESSION

shu5, Dehne Karl6, Godfrey-Fausett Peter7

1Joint United Nations Program on AIDS (UNAIDS), RGPCM, Geneva, Switzerland, 2CAPRISA Clinical Trials Unit, Columbia University-Southern Africa AIDS Training Program, KwaZulu-Natal, South Africa, 3University of North Carolina, North Carolina, United States, 4Wits University, Witwatersrand, South Africa, 5UNICEF, Office of Research - Innocenti, Florence, Italy, 6UNAIDS, RGPCM, Geneva, Switzerland, 7UNAIDS, Science, Geneva, Switzerland

ISSUES: Randomized Control Trials (RCT)in Kenya, Malawi, Lesotho, South Africa and elsewhere show that cash transfers prevent HIV infections especially for young women. In the Zomba district of Malawi, cash transfers reduced HIV prevalence by 64% and HSV-2 prevalence by 76%. Similarly, in Kenya a national, unconditional cash transfers for Orphans and Vulnerable Children programme reduced by 31% the odds of sexual debut among 15-25 year olds with larger impact among females (42%) compared to males (26%). Cash incentives in Lesotho reduced HIV incidence by 25%. In South Africa, a public funded cash grant program reduced by 53% incidence of transactional sex and by 71% age-disparate sex. However, two most recent large RCTs in South Africa - CAPRISA 007 and HPTN 068 - presented at IAS 2015 in Vancouver - found no effects of cash transfers on HIV incidence questioning assertions that cash transfers work for HIV prevention.

DESCRIPTIONS: In the CAPRISA 007 study there were 42 new HIV infections among girls in the schools that received the cash transfer intervention versus 33 in the girls in the schools that did not receive the intervention. The overall incidence HIV infections was lower than expected - 1.5% in the control group and 1.8% in the intervention group. The difference in HIV incidence between the two arms of the trial was not statistically different. In the HPTN 068 there were 59 new HIV infections among girls that received the cash transfer intervention versus 49 new HIV infections in the control arm. The difference in HIV incidence between the two arms of the study was not statistically different.

LESSONS LEARNT: Although these studies showed no effect on HIV incidence, social protection programmes including cash transfers, are beneficial for many human development outcomes including reducing intimate partner violence, delaying coital debut and reducing teenage pregnancies.

School enrolment and attendance is protective to HIV infection among adolescent girls and young women.

These studies confirm that reported risk behaviors are not always consistent and do not always correspond with biological outcomes. The key is to tailor social protection interventions including cash transfers to the relevant local context and to assess their impact.

NEXT STEPS: Decide on what research is needed to determine, the context and conditions under which cash transfers reduce HIV incidence.

16:45 – 18:15	Committee Room 6	02.12.2015
WEAC0901:	Track C/9 - VMMC - beliefs, acceptability and care	
Chairs:	Buhle Ncube, Zimbabwe	

Understanding Community Needs When Providing Voluntary Medical Male Circumcision Services to Adolescents: A Case of a Communal Farming Area in Mberengwa District, Zimbabwe

16:45 – 17:00

Hove Joseph1, Tafuma T.A .2, Chiwome L.3, Chitimbire V.T.S.1, Nzou C.1, Saburi J.R.1, Makunike B.4, Herman-Roloff A.2, Kilmarx P.H.2

1Zimbabwe Association of Church Related Hospitals (ZACH), Harare, Zimbabwe, 2Centers for Disease Control and Prevention (CDC), Harare, Zimbabwe, 3Masase Mission Hospital, Harare, Zimbabwe, 4International Training and Education Center for Health (I-TECH), VMMC, Harare, Zimbabwe

BACKGROUND: Zimbabwe began implementing Voluntary Medical Male Circumcision (VMMC) in 2009 and is currently scaling-up to rural areas. Uptake has been mainly in adolescents, who anecdotally believed to be in need of parental/guardian assistance with wound care. In June 2014, the Masase District VMMC team conducted 363 circumcisions in one week, far higher than their typical weekly performance. They reported an overall adverse event (AE) rate of 4.9% (18/363), which was much higher than any other site with similar performance.

DESCRIPTION: Chobelele communal farming area in Mberengwa has the 'Varemba' traditionally circumcising tribe. This farming area is 20km from the nearest clinic; there are no proper roads. All AEs reported were among the 325 adolescents circumcised resulting in an AE rate of 5.5% (18/325) in this age group. A quality assessment visit was conducted by a ZAZIC/CDC quality control team to

understand the clinical operation of the facility, management of the cases, systems that contributed to the AE cluster, and follow-up community engagement regarding VMMC.

LESSONS LEARNT: VMMC commodities were in stock and procedures were reported completed according to national guidelines. However, day-seven patient review was done by a nurse not trained in the national program. Of the 18 clients referred to the hospital and admitted, 15 (83%) had moderate AEs and were admitted on social grounds (distance travelled and poor hygiene at home). All clients were given broad spectrum antibiotics. Traditional medicine was noticed on the wounds of some clients, although their parents denied this practice. Most clients had poor personal hygiene and no underwear. Knowledge of post-op wound care was lacking among the interviewed parents resulting in reported use of home-made hypertonic salt solution. Two more boys with AEs were identified during the review of circumcised boys in the community and a nearby school. They had severe AEs and were taken to the hospital and admitted. The overall AE rate among adolescents rose to 6.2% (20/325). All clients recovered without permanent sequelae.

Conclusion: Understanding community practices and needs before VMMC service provision will help to reduce AE rate. Specified community engagement before services are provided has been routinized in our VMMC campaigns. Commodities which promote hygiene are being dispensed at all VMMC sites. Community structures with focal persons (e.g. school teachers or Village Health Workers/Mobilisers) and sensitization of outreach health care workers on VMMC post-op wound care have been recommended. Camping equipment has been procured and will enable trained teams to perform community-based post-op reviews.

17:00 – 17:15	Committee Room 6	02.12.2015
WEAC0902:	Track C/9 -	

Beliefs about Male Circumcision among Men from a Traditionally Non-circumcising Community in Rural Western Kenya, 2012-2014

Adega Anne, Mutai Kennedy K, Owuor Karen V A, Odongo Fred S, Kwaro Daniel P O, Burmen Barbara

Kenya Medical Research Institute (KEMRI), HIV Implementation Science and Services (HISS), Kisumu, Kenya

BACKGROUND: Male circumcision (MC) has been shown to reduce risk of heterosexual HIV acquisition in men but still faces challenges in uptake among traditionally non-circumcising communities. We assessed beliefs of men from a traditionally non-circumcising community in rural western Kenya, exposed to a voluntary medical male circumcision (VMMC) program roll-out, in order to inform programs on expansion of VMMC services.

METHODS: A large cross-sectional survey covering sexual behavior, HIV testing, HIV risk, reproductive health, HIV health programs and parent-adolescent communication was conducted among men aged ≥13 years in Siaya County, western Kenya between November 2012 and February 2014. This analysis included men who answered questions on MC. Respondents were grouped as uncircumcised, recently circumcised (within 2 years of interview date) or previously circumcised (more than 2 years prior to interview date). Beliefs of recently circumcised men were compared to those of uncircumcised men using Chi-square statistics at a significance of $p< 0.05$.

RESULTS: Of 2,066 respondents interviewed, 698 (34%) were circumcised, of whom 266 (38%) were recently circumcised. Compared to uncircumcised men (n=1368), recently circumcised males were significantly more likely to be aged 15-24 years (71% vs. 29%), single (88% vs. 41%), dependent on family (38% vs. 18%), have post-primary level education (34% vs. 22%) have never had sex (55% vs. 25%). Motivational factors for MC cited by 247(93%) recently circumcised men were: reducing risk of HIV(59%) or STIs (32%), marriage preparation (7%) and medical reasons (2%).Hindering factors for MC cited by1154 (84%) uncircumcised men were: tradition (45%), pain (30%), costs of circumcision (16%), duration of indisposition (7%), and extremes of age (2%); men dissuaded by tradition were more likely to be aged ≥45 years (55% vs. 14%), married (70% vs. 37%), uneducated (8% vs. 2%), employed (63% vs. 51%) and sexually inactive (26% vs. 13%).

Despite a higher proportion of recently circumcised males perceiving themselves at lower risk of HIV (43% vs. 32%), similar proportions of recently circumcised and uncircumcised males knew that condom use (98% vs. 99%) and reducing number of sex partners (98% vs. 99%) was vital to HIV prevention.

CONCLUSIONS AND RECOMMENDATIONS: Tradition was cited as a barrier to VMMC by nearly half of uncircumcised men; a detailed understanding of cultural issues is needed to conceptualize and overcome these barriers.

ABSTRACT DRIVEN SESSION

17:15 – 17:30	Committee Room 6	02.12.2015

WEAC0903: Track C/9 -

Acceptability of Voluntary Medical Male Circumcision among M-F+ HIV Serodiscordant Couples

Kilembe William1, Parker Rachel2, Malama Kalonde3, Halumamba Hanzunga1, Sharkey Tyronza1, Kimaru Linda3, Tichacek Amanda2, Lockard Ann1, Inambao Mubiana3, Allen Susan2

1Zambia Emory HIV Research Project, Lusaka, Zambia, 2Rwanda Zambia HIV Research Group, Atlanta, United States, 3Zambia Emory HIV Research Project, Ndola, Zambia

BACKGROUND: Male Circumcision (MC) reduces HIV transmission by 60%. Efforts to scale up MC in high endemic areas in sub-Saharan Africa have been ongoing for the past five years. We conducted a survey to assess acceptability of MC among heterosexual serodiscordant couples where the male partner was HIV negative.

METHODS: Zambia Emory HIV Research Project supports scale up of couple HIV voluntary counseling (CVCT) in Government or Zambia (GRZ) clinics. Men who were HIV negative were educated on benefits of MC with their partners and referred to the service. Discordant couples were invited to return for follow up one month after the initial visit and then quarterly thereafter. At the first follow up visit, a survey to assess acceptability of MC was administered to the male and female partner (when available) and separately. Descriptive analysis were conducted.

RESULTS: Surveys conducted with 352 M-F+ couples one month after CVCT in Ndola and Lusaka GRZ clinics showed substantial differences between the cities. In Ndola, 30% of men reported that circumcision was common in their tribe; 41% were circumcised at the time of CVCT and 55% of the others had sought MC after the referral from CVCT or were planning to do so. In contrast, only 17% of Lusaka men reported that circumcision was common in their tribe, 28% were already circumcised at CVCT and only 21% had followed up on the MC referral or planned to do so. Motivation for MC included prevention of HIV/STI, improved hygiene, and cultural/religious reasons. Reasons for not seeking MC included not being able to take time off work, fear of pain, fear of surgical mishap, and long recovery period without sex. HIV+ wives in M-F+ couples were also knowledgeable about the benefits of MC for HIV/STI prevention and improved hygiene but unaware of good or bad impact of MC on sexual pleasure or desirability or condom use. Two-thirds of the wives of uncircumcised men either had or would encourage their partners to seek MC.

Conclusion and Recommendations: CVCT coupled with MC counseling may be a model to scale up MC uptake especially in men at an increased risk of HIV acquisition from their HIV+ partners. Although knowledge on benefits of circumcision in reduction in risk of HIV transmission and other benefits are high, there is still reluctance among some men to access MC. Promotion and counseling on VMMC should focus on perceived client's barriers to encourage more men to take up MC.

17:30 – 17:45	Committee Room 6	02.12.2015

WEAC0904: Track C/9 -

Nine Cases of Tetanus Identified through Voluntary Medical Male Circumcision Programs Uncover a Gender Disparity in Risk

Dalal Shona1, Samuelson Julia1, Reed Jason2, Yakubu Ahmadu3, Ncube Buhle4, Baggaley Rachel1

1World Health Organization, Department of HIV/AIDS, Geneva, Switzerland, 2Office of the U.S. Global AIDS Coordinator and Health Diplomacy, United States Department of State, Washington, DC, United States, 3World Health Organization, Department of Immunization, Vaccines and Biologicals, Geneva, Switzerland, 4World Health Organization, Intercountry Support Team for East and Southern Africa, Harare, Zimbabwe

BACKGROUND: Voluntary medical male circumcision (VMMC) is an effective intervention to reduce the risk of heterosexually acquired HIV among men. VMMC programs have scaled up exponentially reaching over 9 million men through 2014 in 14 priority countries in East and Southern Africa. In preparation for a review of male circumcision method safety, WHO requested adverse event data from VMMC programs in 2014. Nine cases of tetanus among VMMC clients were re-

ported from five countries.

METHODS: We reviewed summaries of each tetanus case reported to VMMC programmes and the WHO. We analysed official WHO/UNICEF databases for country-specific annual numbers of reported tetanus cases and country vaccination coverage of diphtheria, pertussis and tetanus (DPT) vaccine infant series completion. We also searched the PubMed online database for tetanus publications in the past 10 years among adults and adolescents; studies on neonatal tetanus and case reports were excluded.

RESULTS: Tetanus cases occurred following surgical circumcision (6 cases; 4 deaths) and circumcision by an elastic collar compression device (3 cases; 2 deaths). The period from VMMC procedure to symptom onset ranged from 5-12 days, with an average of 11.7 days to diagnosis, and 17 days to death. Six cases either had other wound sites with potential for infection or had applied a potentially C. tetani-containing substance to the VMMC wound. Eight cases had no tetanus vaccination history. The African region reported the highest number of non-neonatal tetanus cases per million population and low historic DTP3 coverage (5% in 1980 and 75% in 2013). DTP3 coverage in the 14 VMMC countries was 65-98% in 2013. African hospital-based studies of non-neonatal tetanus showed a median of 70.9% of inpatient tetanus cases were men, the median age was 32.9 years and tetanus cases comprised 0.25-6.5% of all hospital admissions. The median case fatality rate was 45% (range 0%-80%).

CONCLUSIONS AND RECOMMENDATIONS: The identification of tetanus cases following VMMC has highlighted the gender gap in tetanus morbidity disproportionately affecting men who are not targeted by vaccination programmes. Incorporating tetanus vaccination for boys and men into national programmes should be a priority to address this gap and to align with the goal of universal health coverage.

17:45 – 18:00	Committee Room 6	02.12.2015
WEAC0905:	Track C/9 -	

HIV Shedding on Wounds of HIV Male Circumcised Persons in Usenge Township Township, Kenya

Kiplagat Charles1,2

1Jaramogi Oginga Odinga Teaching and Refferal Hospital, Kisumu, Kenya, 2Moi Teaching and Refferal Hospital, Eldoret, Kenya

BACKGROUND: A randomized trial of voluntary medical male circumcision (MC) of HIV-infected men reported increased HIV transmission to female partners among men who resumed sexual intercourse prior to wound healing. We conducted a prospective observational study to assess penile HIV shedding after MC.

Methods and findings: HIV shedding was evaluated among 200 HIV-infected men (150 self-reported not receiving antiretroviral therapy [ART], 8 self-reported receiving ART and had a detectable plasma viral load [VL], and 42 self-reported receiving ART and had an undetectable plasma VL [< 400 copies/ml]) in Usenge Kenya, between Jan 2012 and Jan 2015. Preoperative and weekly penile lavages collected for 5 wk and then at 10 wk were tested for HIV shedding and VL using a real-time quantitative PCR assay. Detectable HIV shedding was less common in visits from men with healed MC wounds compared to visits from men without healed wounds (adjPRR = 0.12, 95% CI = 0.07-0.23, p < 0.001) and in visits from men on ART with undetectable plasma VL compared to men not on ART (PRR = 0.15, 95% CI = 0.05-0.43, p = 0.001). Among men with detectable penile HIV shedding, the median log10 HIV copies/milliliter of lavage fluid was significantly lower in men with ART-induced undetectable plasma VL (1.93, interquartile range [IQR] = 1.83-2.14) than in men not on ART (2.63, IQR = 2.28-3.22, p < 0.001). Limitations of this observational study include significant differences in baseline covariates, lack of confirmed receipt of ART for individuals who reported ART use, and lack of information on potential ART initiation during follow-up for those who were not on ART at enrollment.

Conclusion: Penile HIV shedding is significantly reduced after healing of MC wounds. Lower plasma VL is associated with decreased frequency and quantity of HIV shedding from MC wounds. Starting ART prior to MC should be considered to reduce male-to-female HIV transmission risk. Research is needed to assess the time on ART required to decrease shedding, and the acceptability and feasibility of initiating ART at the time of MC.

ABSTRACT DRIVEN SESSION

18:00 – 18:15	Committee Room 6	02.12.2015

WEAC0906: Track C/9 -

Treatment Eligibility among Men Testing HIV+ in Voluntary Medical Male Circumcision (VMMC) at Two Clinics In Lesotho

Kikaya Virgile

Jhpiego, Maseru, Lesotho

BACKGROUND: In Lesotho, (VMMC) services are offered as a package of services which includes HIV testing and linkages to care and treatment. With funding from PEPFAR/ USAID, Jhpiego supports the Lesotho MOH to scale up VMMC services nationwide. Between February 2012 and December 2014 more than 78,000 clients received HIV testing and VMMC at Jhpiego-supported sites. In 2014, Lesotho adopted the WHO guidelines recommending ART initiation at a CD4 count of 500 or less. This review assessed CD4 level of clients who are newly HIV diagnosed when seeking VMMC services at two Maseru clinics with CD4 point of care diagnostics.

METHODS: Program data were used to determine what percentage of clients newly diagnosed with HIV were treatment eligible. CD 4 count data was collected for clients seeking VMMC services between January and December 2014.Mean CD4 as well as proportions of treatment eligible clients as per the 500 cut-off were analyzed per age group.

RESULTS: A total of 5398 clients were tested for HIV and 276 (5.1%) VMMC clients were newly diagnosed with HIV. 133 clients had a documented CD4 count of which 107 (80.5%) were eligible for ART. This percentage varied among different age groups: 80% (n=10) of clients aged [10 - 19]; 69.5% (n=59) aged [20 - 29]; 90.6% (n=64) in the age group older than 30 were eligible for ART. The mean CD4 count for all clients was 359 [50; 900] (399 [50; 896] and 311 [64; 900] in the age groups 20 to 29 and above 30 respectively). About 20% of these clients had a CD4 count below 200.

Conclusion: CD4 count results collected among VMMC clients show that the majority of clients (80.5%) who tested positive were already eligible for ARV treatment at the time of diagnosis although they were unaware of their status. These high percentages were found across all age groups. More than half presented with a CD4 count below 350. Further analysis and statistical tests are warranted to confirm the trend and assess if a "test and treat" strategy would be more relevant at VMMC sites in the Lesotho context considering generally low treatment enrollment after HIV diagnosis.

16:45 – 17:00	Committee Room 4	02.12.2015

WEAD0801: Track D/8 - HIV and disability

Chairs: Jacqueline Makokha

Situation Analysis of HIV Prevention Intervention among Young Persons with Disabilities (PWD) in Ekiti State 17:00 – 17:15

Doherty Charles Olusegun1, Ajayi Remi Oluwabamigbe2, Ajumobi Yemi1, Osuolale Bolatito1, Adeola P O1, Edward A3

1Ekiti State AIDS Control Agency, Ado Ekiti, Nigeria, 2Ekiti State AIDS Control Agency, Community Mobilization, Ado Ekiti, Nigeria, 3Eyelosun Nigeria Limited, Ado Ekiti, Nigeria

BACKGROUND: The Project is premised on the fact that many programmes and activities on HIV and AIDS have never been taking into cognizance the inclusion of persons with Disabilities (PWD) in Ekiti State, Nigeria. Little is known about HIV and AIDS within disabled population, yet growing evidences showed that PWD are at equal or increased risk of exposure to all known risk factors.

The objective of the study was to examine the situation analysis of HIV/AIDS prevention interventions among PWD, ensuring that PWD are targeted for HIV prevention activities.

METHODS: The assessment was conducted in three PWDs institutions and their host com-

munities, supported by Ekiti State HIV Programme Development Project II. A simple random sample technique was used.

The assessment tools were:

(1) An Overview of the PWD assessment response and the consent note

(2) General information and their Health seeking behavior

(3) Perception and the knowledge about HIV

(4) Attitude and practice toward HIV prevention intervention.

Quantitative data were collected, collated and analyzed using the Statistical Package for Social Science (SPSS) version 20.0. The analysis was a simple descriptive statistics of the responses using a cross tabulation of the percentages and counts.

RESULTS: Out of the total143 participants (77 male, 76 female) with male to female ratio 1:1. Distribution of respondent by disability included visually impaired 16%, Hearing impaired 48%, intellectually impaired 6%, Mobility impaired 7%; those with more than one disability 23%; the findings showed that 75% of the respondent are sexually active while 22% were not, 78% of respondent claimed to have started engaging in sexual activities such as sexual intercourse, masturbation, oral sex, dating, phonograph and sex film.

HIV prevention activities among PWD indicates that only 2% have been reached with Peer Education, 32% with STI services, 35% with condom message, and 10% with HIV prevention activities. HCT uptake among PWD was 10% out of the number tested, 85% did not collect result. However, condom use by PWD care providers were 32% and condom accessibility among their care provider was 42%.

CONCLUSIONS AND RECOMMENDATIONS: Although PWD are sexually active with a reasonable number involved in high risky behaviour and yet HIV prevention activities and services remain abysmally low among them. There should be intervention targeting increasing knowledge among the PWDs.

17:00 – 17:15	Committee Room 4	02.12.2015
WEAD0802:	Track D/8 -	

VIH et Handicap en Zone Cemac: Leçons, Defis et Perspectives

Touko Adonis1, Mboua Pierre Célestin2,3, De Beaudrap Pierre4, Beninguisse Gervais5

1Cameroon Psychology Forum, Research, Yaoundé, Cameroon, 2Université de Dschang, Dschang, Cameroon, 3Forum Camerounais de Psychologie, Yaoundé, Cameroon, 4Institut de Recherche pour le Développement (IRD), Centre Population et Développement (UMR 196), Paris, France, 5Institut de Formation et de Recherche Démographiques (IFORD), Yaoundé, Cameroon

Problematique: Les pays africains membres de la Communauté Economique et Monétaire de l'Afrique Centrale (CEMAC) paient le plus lourd tribut du fardeau du VIH, appartenant à l'Afrique subsaharienne qui totalise à elle seule 70% des nouvelles infections VIH dans le monde; avec plus de 1,1 million de décès sur les 1,5 million enregistrés fin 2013 (UNAIDS, 2014). Il y a une dynamique intra-CEMAC de l'épidémie, reflétée dans les taux de prévalence voisins: 4,3% au Cameroun, 4,9% en Centrafrique, 3,2% au Congo, 4,1% au Gabon, 5% en Guinée Equatoriale et 3,4% au Tchad. Alors que cette dynamique Intra-CEMAC a entraîné une robuste réponse à travers le Projet Prévention VIH-SIDA en Afrique Centrale (PPSAC), on se rend compte qu'il n'existe pas de réponse coordonnée pour les personnes en situation de handicap (PSH). Au niveau national aussi, plusieurs indicateurs témoignent du peu d'intérêt pour cette population. D'où l'interrogation sur les raisons qui expliquent cette situation.

DESCRIPTION: Dans la dynamique de lutte contre le SIDA, la littérature scientifique décrit les PSH tantôt comme un «groupe négligé», un «groupe oublié» ou encore «doublement handicapé», victime d'une mise à l'écart, aussi bien de la part des décideurs que des acteurs de la mise en ;uvre. Une telle situation prend une ampleur considérable quand elle concerne des zones où l'épidémie reste des plus sévères. En effet, il n'existe pas à l'échelle de l'Afrique Centrale, de programme de lutte contre le VIH/SIDA touchant le groupe des PSH. D'un pays à l'autre, cette mise à l'écart s'observe tantôt au niveau stratégique, en termes de non inclusion des PSH dans les plans stratégiques de lutte contre le SIDA; soit au niveau opérationnel avec l'absence des programmes les concernant, ou encore à ces deux niveaux à la fois. Pour mieux comprendre cette situation, cet article décrypte d'un pays à l'autre, l'état des statistiques concernant cette cible, la situation de la recherche sur l'épidémiologie du VIH dans ce groupe, en plus d'autres raisons qui contribuent à expliquer l'ostracisme envers les PSH.

Lecons apprises: Il ne sera pas possible d'atteindre l'objectif affiché de «mettre fin à l'épidémie

de SIDA d'ici 2030» (ONUSIDA, 2015) si les PSH qui représentent près de 15% de la population des pays sont mis à l'écart.

Recommandations: L'avènement d'un programme commun de lutte contre le VIH à l'échelle de l'Afrique Centrale revêt à présent le caractère d'une urgence régionale de santé publique.

17:15 – 17:30	Committee Room 4	02.12.2015
WEAD0803:	Track D/8 -	

Violences Sexuelles, Handicap et Vulnérabilité au VIH dans la Région de Ziguinchor au Sénégal

Faye Tine Marie Françoise Viviane Coumba1, Mukangwije Pulchérie U2, Zerbo Aida3, Deparde Sabine3, Mac -Seing Muriel4

1HELITE, Dakar, Senegal, 2Handicap International, Toronto, Canada, 3Handicap International, Dakar, Senegal, 4Handicap International, Lyon, France

CONTEXTE: Le groupe des Personnes Handicapées (PH) au Sénégal est reconnu depuis 2011 comme un groupe vulnérable face au VIH/Sida (PSLS/CNLS/2011). L'étude bio-comportementale auprès des PH face au VIH financée par l'Initiative 5% et menée en 2014 dans la Région de Ziguinchor/Sénégal par Handicap International avait pour but de contribuer à une meilleure connaissance de ces facteurs et orienter les interventions inclusives.

Méthodes: Approche transversale quantitative (questionnaires) et qualitative (entretiens individuels semi-structurés/ focus Group) auprès de 804 PH (≤15 ans) de 5 districts sanitaires de la région de Ziguinchor et recrutées « en boule de neige », avec un dépistage du VIH chez 793 PH consentantes. Les données quantitatives furent analysées par SPSS et celles qualitatives avec ATLAS.TI.

Résultats: L'infection VIH est de 2,7% chez les PH. 57,5% des enquêtés ont rapporté avoir subi au moins une forme de violence, 70,3% d'hommes et 63,5% de femmes ont subi des violences verbales, 21,7% femmes et 20,1% des hommes ont subi des violences physiques. 5,4% des PH sont des survivantes de violences sexuelles: 10% sont des femmes contre 2,2% hommes. Les groupes les plus sujets aux agressions sexuelles sont PH avec déficiences: mentales 10.8%, de communication 9,5%, intellectuelles 8,9% et auditives 7,8%. Ici les violences sexuelles font surtout référence aux viols.

CONCLUSIONS: Les PH sont vulnérables aux violences surtout aux violences sexuelles. L'association handicap et infection au VIH accroit leur vulnérabilité.

Recommandations: Pour une prévention et prise en charge holistique des violences sexuelles chez les PH, au niveau psychologique, médical et juridique, il est primordial d'améliorer leurs aptitudes sur leurs droits aux services de santé sexuelle et reproductive; engager les familles des PH, le milieu d'éducation et les communautés; mobiliser des décideurs, leaders et acteurs pour une réponse multidimensionnelle coordonnée et inclusive en leur faveur.

17:30 – 17:45	Committee Room 4	02.12.2015
WEAD0804:	Track D/8 -	

Les Sourds: Une Population Particulièrement Vulnérable au VIH

Granier Anne-Lise1,2, Dagron Jean3, De Beaudrap Pierre2, Mac Seing Muriel4

1LISST, 31, Toulouse, France, 2CEPED, 75, Paris, France, 3Sources-ls, 13, Marseille, France, 4Handicap International, 69, Lyon, France

CONTEXTE: Les personnes sourdes, ignorées des programmes de lutte contre le sida, constituent une minorité importante fortement exposée aux pratiques sexuelles à risque. La méconnaissance de cette population et de leurs langues des signes en fait un groupe d'exclus parce que difficile à atteindre. Cette étude qualitative menée à Ouagadougou, Burkina Faso, par Handicap International et l'Institut de Recherche et de Développement, a pour objectif d'évaluer les connais-

sances et attitudes des sourds face au VIH, comprendre les déterminants et les freins de l'accès à la prévention et aux soins et d'identifier des interventions pour l'améliorer.

Méthodes: 98 entretiens semi directifs ont été menés auprès de sourds communiquant en langue des signes (concernés ou non par le VIH), membres de leurs familles, personnels soignants et associatifs. Le côté novateur de ce travail tient à la prise en compte des différents niveaux de langue des signes (hétérogènes selon le niveau de scolarisation et socialisation), à l'étroite collaboration entre chercheur et médiateur sourd et à l'utilisation de la caméra.

Les résultats mettent en avant:

• Un accès à l'information limité (pas de relais professionnel en langue des signes)

• Des modes de transmission du VIH mal connus (confusion entre symptôme et maladie) et de faibles moyens de protection

•La nécessité d'une utilisation professionnelle de la langue des signes : une incompréhension de l'information reçue peut entraîner confusion et/ou déformation d'information (« le soleil amène le Sida »)

• Une absence des sourds au sein des structures de suivi VIH et la remise en cause de la confidentialité des informations en présence d'un accompagnant entendant

•Une forte précarité et un sentiment d'exclusion social et familial : peu scolarisés, les sourds sont souvent rejetés des familles et contraints de se livrer à des activités génératrices de revenus pouvant les exposer à de très gros risques (réseaux de mendicité/prostitution)

•La fréquence de multipartenariat et de violences sexuelles.

Conclusions et Recommandations: Les sourds sont fortement exposés au risque d'infection par le VIH. Leur principale vulnérabilité est l'absence de prévention adaptée, en particulier par des professionnels sourds, et d'échanges avec les soignants. Il semble urgent de prendre en compte la langue des signes et de mettre en place une recherche action engagée au sein de structures de références.

Sourds, VIH, accès aux soins, Burkina Faso, handicap

17:45 – 18:00	Committee Room 4	02.12.2015
WEAD0805:	Track D/8 -	

Depressive Symptoms, Post Traumatic Stress Disorder and Suicidal thoughts among Men Living with HIV in Zimbabwe

Machisa Mercilene Tanyaradzwa1,2, Shamu Simukai1,2

1South African Medical Research Council, Gender and Health Research Unit, Pretoria, South Africa, 2University of Witwatersrand, School of Public Health, Johannesburg, South Africa

BACKGROUND: Poor mental health conditions including depression and suicidality are known risk factors morbidity and mortality among people living with HIV. The unmet need for mental health services among men living with HIV in Zimbabwe is even more worrying and yet little documented. This study investigates the relationship between HIV status and selected mental health conditions whilst adjusting for potential confounders.

METHODS: A nationwide cross-sectional household survey was conducted in 2012 with a sample of men aged 18 years and above. The survey used a two stage proportionate stratified design based on the 2012 Zimbabwe Population census sampling frame. Structured questionnaires were and self-administered using personal digital assistants. Men were asked questions on socio-demographics, child trauma, self-reported HIV testing and HIV status . Poor mental health was assessed using the Harvard Trauma questionnaire (alpha=0.97), the Center for Epidemiologic Studies Depression Scale (alpha=0.81) and an adaptation of the Alcohol Use Disorders Identification Test scale. For this secondary analysis we included 3018 men whose data on HIV testing and status were available. We conducted regression modelling to test the relationship between poor mental health and HIV status while adjusting for socio-demographic characteristics and child trauma.

RESULTS: Forty five percent of men had never tested for HIV and 5% reported an HIV positive status. One in five men binge drank, one tenth (11%) had symptoms of clinical depression, 6% had Post-traumatic stress disorder (PTSD) symptomatology, 4% had suicidal thoughts in the past four weeks and 5 % attempted suicide in their lifetime . HIV positive status was associated with symptoms of clinical depression (RR 2.2: 95%CI 1.1; 4.4), and suicidal thoughts in the past four weeks

(RR 2.4: 95% CI 1.2; 4.6). Clinical depression symptoms were associated with PTSD symptomatology (RR 3.7: 95%CI 2.2; 6.1) and a history of child sexual abuse (RR 1.7: 95%CI 1.2; 2.3) but was not associated with binge drinking (RR 1.1: 95%CI 0.5; 2.1).

Conclusion and Recommendations: This study showed that men living with HIV are at increased risk of suicidal thoughts and clinical depressive symptoms that are comorbid with PTSD symptoms. There is need for improving the quality of care for men living with HIV through improved psychosocial and mental health services.

18:00 – 18:15	Committee Room 4	02.12.2015
WEAD0806:	Track D/8 -	

HIV Prevention Services for Patients with Mental Disorders in Nigeria: A Situation Analysis from a Psychiatric Hospital

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1Neuropsychiatric Hospital, Aro, Clinical Services, Abeokuta, Nigeria, 2Neuropsychiatric Hospital, Clinical Services, Abeokuta, Nigeria

BACKGROUND: There are bidirectional relationships between HIV/ AIDS, and Mental, Neurological and Substance (MNS) abuse disorders. This has led to growing research in this area. However most of the studies focused on common mental disorders in people living with HIV with little or no attention giving to HIV among people with MNS disorders. In most parts of the world, HIV services are available in psychiatric hospitals, but in Nigeria this is generally not the case. The global efforts at scaling up early uptake of HIV treatment necessitate the need to assess the current situation at psychiatric hospitals especially those in Low and middle income settings.

The study aim to assess the level of awareness and readiness for HIV/AIDS prevention services in a mental health facility in Nigeria.

METHODS: Study was conducted at the Neuropsychiatric Hospital, Aro, Abeokuta, Ogun state, Nigeria. This study design is cross-sectional .Adult patients (188) with case note diagnosis of schizophrenia were recruited through the outpatient clinic of the hospital. The diagnosis was validated using the schizophrenia module of MINI plus. Questionnaire containing socio-demographic, HIV awareness, readiness for engagement with HIV prevention services was administered. Descriptive statistics was used in analysing the data.

RESULTS: Respondent rate was 92.5%. Majority of the respondent are females (52.9%) and had at least secondary school education (81.8%). Only about 5% was unaware of HIV/AIDS. The mass media was the commonest medium of awareness (94.8%). Though 93.1% had HIV awareness, only 21.8% have ever had contact with HIV prevention services. Sixty seven per cent has never being tested for HIV while majority (64.4%) were in support of the provision of HIV prevention services in mental health facilities. Seventy per cent of the participants were willing to be tested.

CONCLUSIONS: There is high level of HIV awareness among patients with mental disorders. However there is low level of uptake of HIV prevention service.

Recommendations: People with mental disorders represent a vulnerable group that should be targeted for HIV prevention services.

There is need for policy and strategy to achieve this.

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Jacaranda 3	02.12.2015
WEAD0901:	Track D/9 - Key population and access to services	
Chairs:	Jan Beagle, Switzerland	

Pratiques Sexuelles et Besoins en Santé Sexuelle et Reproductive des Lesbiennes, Bisexuelles, Queer et Femmes Ayant des Rapports Sexuels avec des Femmes (LBQFSF) en Afrique Francophone Sub-saharienne

16:45 – 17:00

Gmakagni N'dla Nataka, Credo A, Christelle K, Manga Anne Marie

Queer African Youth Network (QAYN), Ouagadougou, Burkina Faso

CONTEXTE: La santé sexuelle et reproductive regroupe les questions dont toute femme est amenée à confronter le long de sa vie, y compris l'éducation sexuelle, la sexualité, la planification familiale, la fécondité et la grossesse. Cependant, force est de constater que ces programmes tardent à aborder la santé sexuelle et reproductive dans toutes ses dimensions. Par conséquence, ces programmes restent indifférents à la spécificité de certains groupes vulnérables, tel que les LBQFSF. Ceci est d'autant plus renforcée en Afrique Francophone sub-saharienne où les textes criminalisent les personnes lesbiennes, gays, bisexuelles, transgenres et queers (LGBTQ). Il est donc noté une absence de données concernant les pratiques sexuelles des personnes LBQFSF et leurs besoins réels.

Méthodes: Dans le souci de mieux cerner les pratiques sexuelles des LBQFSF et leurs réels besoins en mtière de santé sexuelle et reproductive, le Réseau de jeunes LGBTQ d'Afrique (QAYN) a décidé de mener une enquête à base communautaire. Pour la réalisation de cette dernière, l'échantillonnage a été établi auprès de 250 LBQFSF du Bénin (Cotonou et Porto Novo), Burkina Faso (Ouagadougou), du Cameroun (Douala et Yaoundé) et du Togo (Lomé).

Résultats: Parmi les résultats du rapport final, il est ressorti que des 250 répondantes, 21,8% de lesbiennes et/ou bisexuelles ont été exposées à la syphilis, 14,1% au Chlamydia, 3,8% au VIH et 2,6% au Papillomavirus-condylomes. De plus, seules 12% des enquêtées ont parlé de leur orientation sexuelle et/ou identité de genre à un personnel de santé ; et parmi elles, 2,8% se sont vu refuser ou mal administrés les soins de santé pour cette raison. Ceci fait que 56% des répondantes du Benin, 42% au Cameroun et 40.8% au Togo choisissent la méthode de l'automédication pour soigner leurs douleurs ou démangeaisons vaginales.

Conclusions et recommandations: Cette première enquête relève la complexité qui entoure les pratiques sexuelles des femmes LBQFSF dans le contexte d'Afrique sub-saharienne. Il est important de réévaluer et/ou développer les programmes de santé sexuelle à l'endroit des LBQFSF. A ce titre, les associations LGBTQ, les associations de femmes, les ONG qui travaillent dans le domaine de la santé, les institutions étatiques, les partenaires au développement, les professionnels de santé doivent mener des discussions pour l'élaboration de politiques de prise en charge inclusive des besoins en santé sexuelle et reproductive des femmes LBQFSF.

17:00 – 17:15	Jacaranda 3	02.12.2015
WEAD0902:	Track D/9 -	

Etat d'Avancement du Projet Intitulé « Prévention VIH/SIDA et IST auprès des HSH et Orientation vers les Structures Agréées de Prise en Charge à Yaoundé sur la Période du 16 Janvier au 30 Juin 2014

Menoga Dominique Ii Savio Nanga

CAMFAIDS, Yaounde, Cameroon

CONTEXTE: Au Cameroun, la prévalence VIH/Sida est de 37,2% chez les HSH (IBBS, 2011). Les HSH vivent dans un contexte marqué par la stigmatisation, ce qui compromet leurs DSSR et les rend vulnérables au VIH, alors qu'ils sont reconnus comme groupe vulnérable au VIH par le PNLS 2011-2015.

Descriptif: Dans ce contexte, CAMFAIDS a conçu en partenariat avec ESTHER un projet d'un an financé à hauteur de 20 013€ afin de renforcer la prévention, le dépistage et la prise en charge médicale et psychosociale du VIH/Sida/IST pour 480 nouveaux HSH et 15 détenus HSH.

La première étape a consisté à recruter 12 bénévoles et 4 salariés, acquérir un centre d'écoute équipé en matériel et mobilier.

La seconde visait à former les bénévoles, salariés, acteurs associatifs, personnel médical et paramédical, personnel de l'administration pénitentiaire sur la relation d'aide, le VIH/Sida/IST et les DSSR.

Résultats: La formation a permis d'apporter à 20 personnes des acquis sur la relation d'aide, le VIH/Sida/IST et les DSSR. Nous avons pu sensibiliser 268 HSH soit 56% de l'objectif annuel. 1210 kits de prévention ont été distribués, soit 2,5 fois l'objectif prévu durant la période. Les CPS ont assisté à 30 causeries éducatives et pu apporter les réponses aux questions des HSH. 92 HSH ont assisté aux 28 séances de counseling tenues par 2 CPS au décours desquelles 37 HSH ont été orientés (5 dépistés). Un accompagnement médico-social a été apporté à 3 détenus LGBTI de la prison de NKONDENGUE.

Leçons apprises: Des difficultés de recrutement des HSH ont été rencontrées vu le contexte de stigmatisation et de tabous autour de l'homosexualité. Les pairs éducateurs ont craint d'être assimilés à des promoteurs de l'homosexualité. Le succès des kits de prévention montre la nécessité d'en fournir plus. On note aussi le découragement des bénéficiaires post-counseling, la perte de suivi des HSH orientés et le stress de l'attente du résultat. L'accès aux détenus a été rendue difficile par l'absence d'une autorisation officielle du Ministère de la Justice.

Perspectives: Il conviendrait de multiplier les occasions de mobilisation des HSH, non stigmatisantes et rassurantes (réseaux sociaux). Pour pallier au manque en kits de prévention, nous prospecterons d'autres partenaires. Les CPS insisteront sur l'importance d'être pris en charge pour que les HSH adhèrent au dépistage. Un Appui institutionnel du Ministère de la Justice (autorisation de visite) permettra une meilleure prévention en SSR des détenus.

17:15 – 17:30	Jacaranda 3	02.12.2015
WEAD0903:	Track D/9 -	

Mental Health: Effects on Sexual and Health Seeking Behaviors among Men Who Have Sex with Men (MSM) in Nairobi

Mukanya Collins, Sore Paul, Wanjiru Rhoda, Gakii Gloria, Kimani Joshua, Gelmon Larry

Sex Workers Outreach Program (SWOP-Kenya), Prevention, Nairobi, Kenya

BACKGROUND: Scanty information exists on mental health issues among MSM in Africa. This is attributable to stigma, lack of expertise among care providers and inadequate mental health services. Since 2009, the Sex Workers Outreach Program (SWOP) has been working with MSMs with a majority who sell sex (MSW) through peer educators, community champions and encounter group sessions (EGS). By March 2014, more than 950 MSM/MSW had been enrolled in SWOP. Despite efforts at HIV care and prevention, persistent high HIV prevalence, incidence, low levels of initiation and adherence to ART and care were noted. Cases of unprotected sex, STI (re)infection, over dependence on alcohol and drugs and intentional exposure were also noted. Through EGS, mental health issues have emerged as key challenges that could explain the persistent high incidence and risky sexual behaviors among MSM/MSW.

METHODS: From March 2014-March 2015, 30 MSM/MSW who had been utilizing SWOP services for more than one year were recruited into the study. Three trained researchers were then assigned 10 MSM/MSW each for observations using a standardized tool. The researchers then exchanged the groups after every 4 months to ensure all the MSM/MSW had been observed by a different researcher at the end of 12 months. 30 articles on MSM/MSW and mental health disorders were also reviewed to provide answers to the observed attributes.

RESULTS: Common mental disorders observed (N=30) were anti-social disorders (56%), personality disorders (53%), dependent disorders (46%), dissociative identity (44%), agoraphobia (43%), impulsivity (43%), post traumatic disorders (37%). Causative factors include growing up in a world orientated to heterosexual norms, sexual experiences in childhood, unfriendly legal, political and economic environments, and feelings of social rejection, exclusion and helplessness. Participants exhibited attributes such as feelings of being discriminated, low self esteem, emotional and social oversensitivity, hopelessness, alcohol and drug over-dependence, self harm, promiscuity and identity antisocial behaviors, poor interpersonal relationships, closeted lifestyles, irresponsibility and homelessness.

CONCLUSIONS AND RECOMMENDATIONS: In Kenya living openly or closeted as an MSM/MSW has pressure on an individual's mental health status and this has negative effects on both sexual and health seeking behaviors among MSM/MSW. Provision of mental health services in MSM/W health programs is critical.

ABSTRACT DRIVEN SESSION

17:30 – 17:45	Jacaranda 3	02.12.2015
WEAD0904:	Track D/9 -	

La Prise en Charge Psychologique des Hommes d'Ayant des Relations Sexuelles avec des Hommes (HSH) Infectés par le VIH / SIDA à l'Action contre le SIDA (ACS) - TOGO

Yehouenou Comlan

Action Contre le Sida (ACS), Service de Psychologie, Lomé, Togo

CONTEXTE: Au Togo, la prévalence du VIH/sida auprès des HSH est de 19.6% en 2011. Cette prévalence est plus élevée que celle de la population générale (2.5%). L'estimation de la taille des HSH au Togo est de 7351.

Malgré cette prévalence élevée, les HSH sont réticents aux soins par peur d'être discriminés. Très peu sont observants à leur traitement, ou ont accepté leur statut sérologique. Les HSH positifs au VIH ne partagent pas leur statut sérologique (parents et partenaire sexuel).

L'objectif de ce travail est de décrire les activités de prise en charge psychologique menées à l'endroit des HSH infectés et suivis à ACS-TOGO en vue de leur adhésion au traitement et de l'amélioration de leur observance thérapeutique.

MÉTHODOLOGIE: Il s'est agi d'une étude prospective menée sur 33 cas d'HSH reçus dans nos services de février 2014 à janvier 2015. Quatre psychologues formés ont mené les activités; les patients sont référés par le service médical, le service social et les médiateurs chargés de faire les visites à domicile.

En tout 33 patients HSH ont été reçus; l'âge moyen de ces patients était de 26,5 ans (22-31 ans); parmi eux, 12 étaient sous antirétroviral (ARV).

- Tous les 33 patients ont bénéficié d'un soutien psychologique individuel avec pour motifs: inacceptation du statut sérologique, aide à l'observance, angoisse et dépression relatives à la discrimination et à la stigmatisation
- Psychoéducation: deux séances ayant réuni 19 bénéficiaires HSH
- ETP collective: 10 séances à l'endroit de 33 bénéficiaires HSH ont été réalisées.
- Causeries de groupe mensuelles: 11 séances regroupant en moyenne 18 HSH.

Résultats:

• 144 cas dépistés en 2014 vs 57 en 2013.

— Augmentation du taux des CD4 chez les HSH, allant de 349 à 649 cellules/¡l ou de 169 à 485 cellules six mois après le début du traitement ARV.

— Acceptation de se mettre dans le continuum de soins avec dépistage des IST.

Conclusion et recommandations: La prise en charge des HSH doit s'accompagner des mesures favorisant l'adhésion de cette cible. C'est en cela l'importance de la prise en charge psychologique qui, néanmoins est méconnue de nos pratiques. Cela exige que des structures impliquées dans cette prise en charge soient soutenues surtout dans nos pays à ressources très limitées.

Mots clés: HSH, psychologique, acceptation, observance, VIH/Sida

17:45 – 18:00	Jacaranda 3	02.12.2015
WEAD0905:	Track D/9 -	

Réduction des Risques auprès des Usagers de Drogues Injectables: La Belle Réussite de Kénédougou Solidarité Sikasso Mali

Traoré Cheick Abou Laïco, Sidibé Younoussa, Traoré Oumar

Association Kénedougou Solidarité, Sikasso, Mali

CONTEXTE: Au déficit quasi général d'informations fiables sur les IST/VIH/SIDA chez les Us-

agers de drogues injectables que nous avons touché à travers nos actions au manque de moyens de prévention adéquats (préservatifs, lubrifiants et surtout kits de consommation de drogues injectables), à leur mauvaise utilisation (périodique, usage d'antenne de radio..) et au coût élevé pour s'en procurer régulièrement et en quantité suffisante; nous avons d'initier des actions sur Sikasso auprès de cette couche isolée jusqu'ici dans les programmes de lutte contre le SIDA de la région qui les rend encore beaucoup plus vulnérable face à l'épidémie.

OBJECTIFS: Notre objectif est de permettre, avec les bénéficiaires, d'élaborer des stratégies pour réduire les risques d'infection de VIH/SIDA et d'hépatites auprès des usagers de dogues injectables à Sikasso.

Méthodes: Pour la réalisation de nos activités nous avons recruté cinq pairs éducateurs anciens usagers de drogue avec qui nous menons des activités de sensibilisation et de dépistage du VIH/SIDA. Les activités se passent dans les fumoirs et autres lieux de rencontre des bénéficiaires.

Résultats: De janvier 2014 à fin avril 2015 , nous avons pu toucher 148 personnes usagères de drogues injectables dont 40 femmes toutes des travailleuses de sexe. Parmi les personnes touchées on a dépisté pour le VIH 52 bénéficiaires dont 4 cas positifs pris en charge dans notre centre.23 CAS d'IST diagnostiqués et traités. Nous avons distribué 1069 seringues,2047 alcools,1974 eaux distillées.

L'âge des bénéficiaires varie entre 18 et 48 ans.

Conclusion et Recommandations: Etant la première Association à intervenir auprès des usagers de drogues injectables au Mali, nous avons su convertir le rêve de nos bénéficiaires en réalité. Nos activités intéressent de plus en plus les bénéficiaires car nous constatons une grande affluence de leur part lors des activités sur le terrain et au niveau de notre centre.

Au Mali la consommation de drogue est réprimée, les petits consommateurs payent de lourds tributs; malgré tout nous seront toujours actifs sur le terrain et demandons aux autorités de notre pays que la législation sur les drogues soit revue afin de permettre une prise en charge adéquate des usagers de drogue qui sont souvent victimes du système.

17:45 – 18:15	Jacaranda 3	02.12.2015

WEAD0906: Track D/9 -

amfAR's GMT Initiative an Evaluation of a Small Grants Program for Gay Men, Other Men who Have Sex with Men, and Transgender Women

Clapham Benjamin F

amfAR, Foundation for AIDS Research, GMT INITIATIVE, New York, United States

ISSUES: The GMT Initiative, (gay men, other men who have sex with men and trans individuals, collectively referred to as GMT) has provided funding to organizations for seven years with the objective of reducing the impact of HIV/AIDS in communities across Latin America, the Caribbean, Africa, Asia Pacific and Eastern Europe and Central Asia. This paper presents the impact of funding on HIV prevention, care and treatment programs for GMT organizations.

DESCRIPTIONS: Mixed methods evaluation recruited organizations that received funding from the GMT Initiative from 2007-2014. In-depth interviews and quantitative surveys assessed HIV service delivery, policy, institutional capacity and financial information. Two organizations from each region were invited to participate in the in-depth interviews conducted via Skype, lasting 45-60 minutes. The quantitative survey was developed and administered through Google surveys to 150 organizations.

LESSONS LEARNT: Nine organizations completed the in-depth interviews. 18 organizations responded to the internet-based survey. The results show an increase in the quality and uptake of HIV services for GMT, resulting in increasing the number of people tested, and self-re-

ported adherence for GMT living with HIV. Many respondents mentioned the GMT Initiative's flexibility and creativity as being an important factor in their success. Grantees reported positive policy steps to criminalize stigma and reported that the capacity strengthening was a critical component of the program.

NEXT STEPS: Further implementation science research is needed to establish effective evidence-based models to curb HIV incidence among GMT communities while effectively engaging them in the HIV response.

NOTE

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Committee Room 6	03.12.2015

THUAA0201: Track A/2 - Drug resistance among HIV co-infected with STD

Chairs: Almoustapha Issiaka

HIV-1 Reverse Transcriptase E138A Mutation Prevalence Driven by Cytotoxic T Lymphocyte Escape in a Subtype C Infected Population: Implications for Rilpivirine-containing Antiretroviral Therapy 10:30 – 10:45

Gaseitsiwe Simani1,2, Stangl Christina1, Diphoko Thabo1, Maruapula Dorcas1, Mohammed Terence1, Moyo Sikhulile1, Musonda Rosemary1, Makhema Joseph1,2, Shapiro Roger1,2, Essex Max1,2

1Botswana Harvard AIDS Institute Partnership, Gaborone, Botswana, 2Harvard School of Public Health, Immunology and Infectious Diseases, Boston, United State

BACKGROUND: The HIV-1 reverse transcriptase E138A mutation is a major resistance mutation for rilpivirine. E138A also has been identified as a cytotoxic T lymphocyte (CTL) escape mutation targeted by HLA-B*18. If E138A is selected by HLA-B*18+ individuals, they may be more likely to fail rilpivirine-containing combination antiretroviral therapy (ART). We sought to investigate the frequency of the E138A mutation and its association with HLA-B*18 in treatment-naïve HIV-1 subtype C infected patients.

Materials and **METHODS:** High resolution HLA class I typing was performed on samples from a completed mother to child prevention trial conducted in Botswana as part of a larger study. Among those with HLA-B*18+, stored plasma was retrieved and RNA was extracted and a 335 amino acid portion of the first part of HIV-1 RT was amplified and sequenced. A separate cohort of 230 treatment naïve patients from Botswana was identified, and HIV-1 RT sequences covering the 138 position were retrieved. The RT sequences from both groups were analyzed for the E138A resistance mutation using the Stanford HIV drug resistance database.

RESULTS: Of 421 treatment-naïve HIV-1 positive patients who were HLA class I typed, 31(7.4%) were HLA-B*18+. Stored plasma could be retrieved and successfully genotyped for 24 of these. Amongst the 24, 4(16.7%) were found to harbor the E138A mutation. Of the 230 unique RT sequences from treatment naïve patients who were not HLA typed, 13(5.6%) had the E138A mutation. This represents a trend toward statistically significant difference in the frequency of the E138A between the two groups (P=0.06). Compared with the E138A frequency of 133/3320 (4.0%) amongst all the HIV-1 subtype C sequences submitted to the Stanford HIV database, the frequency of E138A was statistically higher in our HLA-B*18+ cohort (P=0.0018).

CONCLUSIONS AND RECOMMENDATIONS: Treatment-naïve HLA-B*18+ individuals had a higher prevalence of E138A compared with a comparator group of non-HLA typed treatment naïve patients in Botswana. In regions with high prevalence of HLA-B*18+, close monitoring for failure of rilpivirine-based ART may be warranted.

10:45 – 11:00	Committee Room 6	03.12.2015

THUAA0202: Track A/2 -

Optimization of the Oligonucleotide Ligation Assay for the Detection of Nevirapine Resistance Mutations in Zimbabwean Human Immunodeficiency Virus Type-1 Subtype C

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1Biomedical Research and Training Institute, Harare, Zimbabwe, 2University of Zimbabwe College of Health Sciences, Harare, Zimbabwe, 3Seattle Children's Research Institute, Seattle, United States

BACKGROUND: In Zimbabwe, NVP has been utilized widely as prophylaxis for prevention of mother-to-child-transmission of HIV (pMTCT) and/or as part of first-line antiretroviral regimens (ART) Despite numerous scientific reports of selection of nevirapine (NVP)-resistance mutations, data from Zimbabwean infants are sparse. These data are unavailable due primarily to the unaffordable cost of consensus sequencing, the sequencing method used most commonly to assess HIV drug resistance (HIV-DR).

ABSTRACT DRIVEN SESSION

An economical oligonucleotide ligation assay (OLA) was developed to detect mutations generally associated with HIV-DR to NVP (K103N, Y181C, V106M and G190A) and other antiretrovirals (ARVs). Ligation confers 100% specificity to the assay, but inter- and intra-subtype genetic polymorphisms with mismatches within two bases of the ligation site of the oligonucleotide probes result in indeterminate reactions Therefore, to detect regional HIV polymorphisms within new geographical locations, the oligonucleotide probes should be redesigned to accommodate HIV polymorphisms common in the target population.

Method: OLA was used to evaluate 200 archived dried blood spots (DBS) from infected infants participating in the Zimbabwean Early Infant Diagnosis (EID) Program. Consensus sequencing of specimens with indeterminate OLA results was performed to identify genetic sequence polymorphisms that appeared to compromise performance of the OLA. When consistent patterns of polymorphisms were observed the probes were redesigned, and DBS specimens with indeterminate OLA results were retested with the new Zimbabwe-specific (ZW) probes. OLA results obtained in Zimbabwe were compared to repeat testing in a US reference laboratory.

RESULTS: Out of the 200 DBSs, 188 (94%) DBS yielded PCR amplification of HIV pol. ZW probes reduced indeterminate OLA results from 5.2% to 2.8% of codons evaluated (p=0.02), with 98.2% concordance between results obtained in the Zimbabwean and US laboratories.

Conclusion: Optimization of OLA probes to accommodate polymorphisms in regional HIV variants improved OLA performance, and comparison to US results showed successful implementation of the OLA in Zimbabwe for detection of NVP resistance mutations in DBS specimens.

Keywords: HIV, HIV drug-resistance, oligonucleotide ligation assay, point mutation, genotyping, nevirapine

00:00 - 00:00	Committee Room 6	03.12.2015
THUAA0203:	Track A/2 -	

Multiple Genotypes of Hepatitis B Virus among Occult Hepatitis B Infected Individuals in Nigeria

Opaleye Oluyinka O

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BACKGROUND: Occult hepatitis B virus (HBV) infection (OBI) is characterized by the presence of HBV DNA without any detectable HBV surface antigen (HBsAg). In Nigeria, as with many African countries, Nucleic acid testing (NAT) is not yet a prerequisite in blood banking. In this study the prevalence and genotypes of HBV in individuals with OBI in Nigeria were investigated.

METHODS: Blood samples collected from donors from blood banks in the southwestern part of Nigeria were reaffirmed for their HBsAg seronegative status and their respective HBV DNA status was determine using a PCR based approach. Individuals negative for HBsAg but positive for HBV DNA were further investigated for their viral load using a real time quantitative polymerase chain reaction (RTQ-PCR). Additionally antibodies to the core and surface antigen (anti-HBc, anti-HBs) as well as the envelope antigen (HBeAg) were assayed to validate their HBV status. The HBV genotypes of HBV DNA positive samples were determined using multiplex PCR and partial DNA fragment sequencing of the S- region of the HBV genome. Samples with ambiguous result with the multiplex PCR were subjected to cloning and sequencing to ascertain that they are mixed genotype of HBV in the same sample.

RESULTS: Of the 429 samples screened by rapid test, all were reaffirmed HBsAg negative by enzyme linked immunosorbent assay (ELISA), 204 (47.6%) were positive for HBV DNA after a nested PCR. Serological tests shows that 139 (68.1%) were positive for anti-HBc and 74 (36.2%) for anti-HBs, while only 3 (1.5%) were positive for HBeAg. The average viral load was 13.3copies/ml in the 128 samples examined by RTQ-PCR. Using the multiplex PCR, genotype E was the most prevalent (79.7%), 24 (15.7%) were a mixture of other genotypes with genotype E while 6 (3.9%) samples were of A genotype and only one (0.7%) of the 153 examined by the multiplex PCR was of genotype D. The mixed genotypes was confirmed by cloning and phylogenetic analysis.

CONCLUSIONS AND RECOMMENDATIONS: This study revealed that OBI is quite frequent among blood donors in Nigeria. Also, order than genotype E, multiple genotypes exist in occult hepatitis B infection in Nigeria. The study concludes that blood donor samples should be tested for OBI status by NAT or at least anti-HBc screening prior to any transfusion to minimize the risk of HBV transmission.

ABSTRACT DRIVEN SESSION

11:15 – 11:30	Committee Room 6	03.12.2015
THUAA0204:	Track A/2 -	

Intra Individual Variations of the Genetic Diversity and the Antifungal Susceptibility of Cryptococcus neoformans Isolates from Yaoundé HIV Infected Patients

Ngouana Thierry Kammalac1,2,3, Drakulovski Pascal2, Krasteva Donika2, Kouanfack Charles3, Delaporte Eric2, Fekam Fabrice Boyom1, Bertout Sebastien2

1University of Yaounde 1, Yaoundé, Cameroon, 2Université Montpellier, Montpellier, France, 3Yaounde Central Hospital, Yaoundé, Cameroon

BACKGROUND: Cryptococcal meningitis is a dreadful opportunistic fungal infection among HIV infected patients. One drawback in the management of the disease is the possible infection of a patient by many different strains of Cryptococcus neoformans. Authors investigated the intra individual genetic diversity and the antifungal susceptibility of C. neoformans isolates from Yaoundé (Cameroon) HIV infected patients with cryptococcal meningitis.

METHODS: Twenty five clinical isolates were obtained in a prospective study. Five colonies were randomly collected from each initial sample. The 150 obtained isolates (125 colonies and 25 initial samples) were submitted to serotyping by multiplex PCR. Genotyping analyses were achieved by restriction fragment length polymorphism and microsatellite length polymorphism. The antifungal susceptibility testing was carried out using the Sensititre Yeast One kit. Seven antifungals were tested: itraconazole, fluconazole, amphotericin B, ketoconazole, flucytosine, posaconazole and voriconazole.

RESULTS: The 150 isolates were identified C. neoformans var grubii serotype A and genotype VNI. The microsatellites analysis provided 15 molecular types. Six out of 25 (24%) patients were found to be infected by 2 different genotypes. The antifungal susceptibility showed the following profiles: posaconazole (0.015-0.25;g/mL), amphotericin B (0.06-1;g/mL), fluconazole (0.5-16;g/mL), itraconazole (0.008-0.12;g/mL), ketoconazole (0.008-0.12;g/mL), 5-fluorocytosine (0.25-16;g/mL), voriconazole (0.008-0.12;g/mL). It was noticed that isolates from the same patient might present different susceptibility profiles to an antifungal drug with more than 4 dilutions differences.

CONCLUSIONS: The achieved results highlighted possible presence of isolates with different genotypes in a patient with different antifungal susceptibility profiles during a single episode of cryptococcal meningitis. This point should be taken in account for the improvement of the management of the disease.

11:30 – 11:45	Committee Room 6	03.12.2015
THUAA0205:	Track A/2 -	

Application of an HIV-1 Subtype C Pseudovirus Assay in Screening Natural Products for Anti-reverse Transcriptase Properties

Mavhandu Lufuno G1, Cheng Hua2, Bor Yeor-Cheng3, Tebit Denis M3, Rekosh David3, Hammarskjold Marie-Louise3, Bessong Pascal O4

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BACKGROUND: The use of medicinal plants has been of interest in the management of HIV/AIDS prior to and after the availability of antiretrovirals. Efforts to identify plant derived molecules, as leads of potential antiviral sources require a reproducible system for routine screening of selected plant compounds. This study evaluated the use of an HIV subtype C based pseudovirus system to screen plant compounds for potential anti-reverse transcriptase properties activity.

METHODS: Pseudoviruses were generated by transfection of human embryonic kidney cells (HEK 293T cells) and pseudovirions capable of transducing firefly luciferase were detected by p24 antigen measurement. This was followed by infection of CF2/CD4/CCR5 and CF2/CD4/CXCR4 cell

lines. Selected plant substances were introduced at the infection stage to determine potential anti reverse transcriptase properties. Pseudoviruses were also subjected to the inhibitory properties of known anti reverse transcriptase compounds namely Zidovudine (AZT) and Nevirapine (NVP).

RESULTS: AZT and NVP inhibited the pseudoviruses in a dose dependent manner. This demonstrated that the pseudoviruses were susceptible to antiviral compounds. On the other hand, only low levels of suppression were observed with AZT and NVP when resistant mutant strain of the pseudovirus 4073 was tested. Among the plant-derived compounds used Catechin, obtained from stem-bark of Peltophorum africanum inhibited the HIV-1 subtype C pseudovirus with an IC50 of 0.114 mg/ml. An IC50 of 14.0 mg/ml and 30.18 mg/ml were obtained for Catechin against the NRTI and NNRTI resistant mutants respectively. Cytotoxicity was not observed for Catechin in an MTT assay with the CF2 cell line. The pseudovirus assay developed based on HIV-1 subtype C, the most common variant worldwide, can be used to identify molecules with anti-HIV activity. The system is also suitable for resource limited laboratories without a P3-containment facility.

Conclusion and Recommendations: The narrow range in standard deviation of the IC50 values obtained across replicates strongly suggests that the assay is reproducible. The assay can be deployed in at least class II containment facility for the evaluation of lead substances potentially targeting the reverse transcription and maturation stages of HIV replication. However, there is a room on improving the system for high throughput processes.

11:45 – 12:00	Committee Room 6	03.12.2015
THUAA0206:	Track A/2 -	

Discovery of Diaryltriazines (DATAs) as Potent Anti-HIV Agent via Engaging Entrance Channel of HIV-1 Reverse Transcriptase

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BACKGROUND: The role of NNRTIs in first-line drug regimens for the treatment of HIV infection has been seriously compromised due to the rapid development of drug-resistant HIV-1 variants. Following to the discovery of DATAs as a class of novel, potent and selective compounds against HIV-1 RT, attention has been focused on the substitution at 1,3,5-triazine, leading to the development of novel analogues due to low aqueous solubility and lack of orientation of existing NNRTIs towards entrance channel for the NNRTI binding site. This study characterized the activity, cytotoxitiy and binding affinity of series of novel derivatives of DATA.

METHODS: Analogs were synthesized by clubbing of 1,3-thiazine and 1,3,5-triazine derivatives using SNAr reaction to generate series of higher DATAs, 8(a-f). Anti-HIV activity was evaluated using TZM-bl cell lines along with Luciferase expression profile of the TZM-bl cells after infecting with NL4.3 virus. MTT assay was used for cytotoxicity determination using TZM-bl cells. Molecular docking studies were performed to quantify the binding affinities at the non-nucleoside inhibitor binding pocket (NNIBP) of HIV-RT.

RESULTS: Compound 8a showed utmost 97 % inhibition with Ki = 916.52 nM against HIV-RT. Compound 8 (b-e) exhibited significant inhibitory activity ranging from 63-89% with Ki = 1.68 - 28.12 ;M except compound 8f which displayed least activity against HIV (56 % inhibition with Ki = 34.64 ;M). Entire set of compounds did not appreciably lower the percentage of cell viability in MTT assay, i.e. more than 87 % of cells are viable at the maximum dose of 25 ;g/mL. Docking studies suggest that these molecules were able to fit into the protein/solvent interface respectively close to Pro236/Val106/Leu234 and an open region in front of Lys101/Glu138/Val179 which is considered the entrance channel for NNRTIs in NNIBP. Our molecules were also energetically proficient enough to make stable receptor-ligand complex, as shown by free energy of binding ranging from -6.09 to -8.24 kcal/mol.

CONCLUSIONS AND RECOMMENDATIONS: As a concluding remark, we have developed novel DATA analogues with potent anti-HIV activity, while presenting no significant toxicity at the test dosages. It was confirmed that the designed molecules have the possibility of introducing chemical diversity around the core skeleton to generate new, potent molecules.

ABSTRACT DRIVEN SESSION

10:45 – 12:15	Committee Room 4	03.12.2015
THUAC1001:	Track C/10 - Modelling, trend analysis and evaluation	

Process Evaluation of Behavioural Change Communication Materials Developed and Utilized for HIV Prevention by Non-governmental Organizations in Oyo State, Nigeria. 10:45 – 11:00

Bolarinwa Kolawole K

Oyo State Agency for the Control of AIDS, HIV Programme Management, Ibadan, Nigeria

Public health education is a major strategy for controlling the spread of HIV. An important component of this strategy is the effective utilization of well-designed Behavioural Change Communication (BCC) materials. The Oyo State World Bank-assisted HIV and AIDS programme funded 40 Non-Governmental Organizations (NGOs) from 2006 to 2008, to produce BCC materials to reach target audiences. However, the process evaluation of the development of the materials in line with the WHO model has not been systematically conducted. This study was therefore designed to assess the level of adherence by these NGOs to basic standards in the process of development of the BCC materials.

METHODS: The study was a descriptive cross-sectional survey. Balloting was used to select 20 out of the 40 funded NGOs. The NGOs were categorized into five equal groups based on target audience that is; Female Sex Workers, Mission Birth Attendants, In-school Youth, Women and People Living with HIV. A checklist was used to assess compliance with each of the following seven stages of educational materials development in line with the WHO model: Needs Assessment (NA); message conceptualization; design; pre-testing; production procedure; implementation and outcome evaluation. In-depth Interviews (IDIs) were conducted for the twenty NGO project coordinators while one Focus Group Discussion (FGD) was conducted among each of the five target groups. Descriptive statistics was used to analyze quantitative data while the FGD and IDI data were transcribed and analyzed using thematic approach.

RESULTS: Only two out of twenty NGOs complied with all the seven stages of WHO model of BCC material development. 95.0% carried out implementation involving target audience and 85.0% conducted outcome evaluation of the materials. Eighty percent pre-tested materials, while 25.0% of the NGOs involved target audience in the production procedure. Some (40.0%) project coordinators had one form of training or the other on BCC material development while 60.0% had no training. Weak technical capacity in BCC material development was a major challenge.

CONCLUSIONS AND RECOMMENDATIONS: Adherence to basic standard process of developing Behaviour Change Communication material is low among the Non-Governmental Organizations assessed. An intervention comprising training and supportive supervision is needed to enhance the skills of project coordinators in the development of behavioural change communication materials.

ABSTRACT DRIVEN SESSION

11:00 – 11:15	Committee Room 4	03.12.2015
THUAC1002:	Track C/10 -	

Using Facility-level Data and Geospatial Analysis to Examine Local HIV Prevalence Trends

Wanyeki Ian1, Mitto Benard1, Nganga Lucy1, Datar Anita2, Vazzano Andrea2, do Nascimento Nena2, Brodsky Isabel2, Tanser Frank3

1Health Policy Project, Futures Group, Nairobi, Kenya, 2Health Policy Project, Futures Group, Washington, DC, United States, 3University of KwaZulu -Natal, Africa Centre for Health and Population Studies, Mtubatuba, South Africa

BACKGROUND: Donors and implementing partners increasingly recognize the heterogeneity of HIV epidemics. Identifying localized patterns of HIV prevalence allows for more strategic and effective program planning. However, it is difficult to obtain accurate estimates of HIV prevalence at local levels, as population-based surveys tend to provide estimates at higher levels of aggregation. Existing routinely collected data from health facilities may offer a cost-effective means of examining updated and more granular patterns of HIV burden. The study team used spatial analysis of routinely collected HIV testing data, from women attending health facilities that provide prevention of mother-to-child transmission (PMTCT) services, to estimate and describe geographic variations in adult HIV burden at sub-district levels.

METHODS: Routinely collected HIV testing data from geocoded PMTCT clinics was obtained from three countries (Kenya, Tanzania, and South Africa). Annual HIV positivity was calculated, and estimates of HIV prevalence among adults were generated through adjustment with the most recent population-based survey. The study team evaluated several interpolation methods, and selected the most appropriate to generate a smooth (pixelated) predicted surface of HIV prevalence. Multiplying this HIV prevalence surface by a population surface adjusted to the most recent census results provided the authors with a surface of people living with HIV (PLHIV) at a 1km2 resolution. Variations in HIV burden were then described at various boundary levels. Geospatial statistical analysis also allowed for an examination of HIV hot and cold spots.

RESULTS: In all three countries, the authors were able to obtain approximations of HIV prevalence and PLHIV at a 1km2 resolution. This information was then aggregated to various administrative boundaries (i.e., district and sub-district levels) to allow the authors to describe and map variations in HIV prevalence and PLHIV, and to identify HIV hot and cold spots.

CONCLUSIONS AND RECOMMENDATIONS: This approach represents a feasible method of examining variations in HIV burden. It performed better in rural areas where an assumption is made that PLHIV seek care in clinics relatively close to their homes; however, the approach may have limitations in urban areas. The authors recommend use of this method to inform prevention programming in rural areas.

ABSTRACT DRIVEN SESSION

11:15 – 11:30	Committee Room 4	03.12.2015
THUAC1003:	Track C/10 -	

Modeling HIV Transmission and Prevention in Côte d'Ivoire: Impacts of a National Accelerated Response Plan to Reach UNAIDS' 90-90-90 Target

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BACKGROUND: Côte d'Ivoire has the highest HIV prevalence in West Africa and this infection remains a major public health problem. Despite a long-standing commitment to curb transmission, the national response has yet to attain its policy objectives. This study aims to assess the population-level impact of reaching UNAIDS' 90-90-90 target by 2020.

METHODS: First, an exhaustive literature review was performed and interviews were conducted with government informants and stakeholders from at-risk populations to identify bottlenecks and determine scenarios to improve the national response. Second, a detailed age-structured mathematical model representing HIV transmission and the level of existing interventions was developed (e.g. testing, treatment, condoms, PMTCT, etc.). Nationally representative surveys from 1994, 1998-99, 2005, and 2011-12 were analyzed to parameterize the model - complemented with data from the literature for key populations, HIV natural history, and evolving levels of intervention. The model was initialized in 1989 and fitted to HIV prevalence data among men and women from the general population (2005 & 2012), female sex workers (FSW; 1992 to 2014), and men who have sex with men (MSM; 2011). The model was used to assess the impact of reaching the 90-90-90 UNAIDS' target (scenario 1), as well as combining it with a condom intervention for MSM and FSW (scenario 2).

RESULTS: Preliminary results suggest that a cumulative fraction of 18% of HIV cases (uncertainty interval [UI]: 14-29%) could be averted from 2015 to 2020 by reaching UNAIDS' 90-90-90 target by 2020 (scenario 1) as compared to maintaining the standard of care (counterfactual). This impact was most pronounced in clients of FSW, with 20% of cases averted over 5 years (UI: 15-32%). These impacts are, however, expected to increase over time if intervention coverage is sustained. Above reaching the UNAIDS' target, expanding condom usage in MSM and FSW had a small impact - averting a further 1.4% of infections in the general population over 5 years (scenario 2) as compared to the counterfactual.

CONCLUSIONS AND RECOMMENDATIONS: Several bottlenecks and opportunities for improving the national response were identified (testing, treatment, PMTCT, etc.). Addressing these and reaching the UNAIDS targets by 2020 could substantially reduce HIV transmission in Côte d'Ivoire in the short term.

11:30 – 11:45	Committee Room 4	03.12.2015
THUAC1004:	Track C/10 -	

Infection à VIH-2 ou VIH-1+2 en Guinée Forestière

Hebelamou Jean, Guilavogui Agathe, Leuenberger David

Mission Philafricaine, Centre Médical de Macenta, Conakry, Guinea

Indiquer le problème étudié, la question de recherche :

Le VIH-2 est prévalent dans certains pays d'Afrique de l'Ouest, notamment en Guinée-Bissau. Il existe peu de données publiées sur le VIH-2 dans la Guinée voisine. La prise en charge et le pronostic de l'infection à VIH-2 et VIH-1+2 diffèrent de celle du VIH-1. Le Centre Médical est le seul site de la préfecture de Macenta (Guinée Forestière, à environ 800 km de la capitale) qui offre le dépistage et la prise en charge du VIH.

Notre étude vise à

1) établir la prévalence du VIH-2 ou VIH-1+2 en Guinée Forestière, et

2) décrire le profil des patients infectés par le VIH-2 ou VIH-1+2 au Centre Médical de Macenta.

Méthodes: Il s'agit d'une étude de cohorte prospective. Ont été inclus 1) tous les patients ayant effectué un dépistage du VIH au Centre Médical de 2010 à 2014, et 2) tous les patients infectés par le VIH-2 ou VIH-1+2 et enregistrés pour le suivi au Centre Médical pendant la même période.

Résultats: Entre 2010 et 2014, 10'969 patients ont reçu un test VIH au Centre Médical, en général à l'initiative des soignants sur la base d'une suspicion clinique d'infection à VIH. 2700 patients (24.6%) ont été testés positifs, dont 2662 (98.6%) de type VIH-1, 15 (0.6%) de type VIH-2, 16 (0.6%) de type VIH-1+2, et 7 de typage indéterminé.

Dans la même période, 13 patients (VIH-2 : 7, VIH-1+2 : 6) ont été enregistrés pour la prise en charge au Centre Médical, dont 2 transferts entrants d'un autre site. Il s'agissait de 7 femmes, 5 hommes et un enfant de 14 ans. L'âge médian était de 37 ans (intervalle interquartil [IQR] 28-38 ans). 9 des patients ont bénéficié d'un CD4 initial (69% - CD4 indisponible sur le site jusqu'en 2012). Ils avaient un CD4 initial médian de 207 (IQR 62-868). Deux patients présentaient une co-infection TB/VIH à l'enregistrement. 12 patients (92%) ont reçu une chimioprophylaxie au cotrimoxazole, et 9 des patients ont démarré un traitement antirétroviral, en général sur la base d'un inhibiteur de protéase potentialisé.

Conclusions et Recommandations: En dépit de la proximité géographique de la Guinée forestière du principal foyer de l'infection à VIH-2 (Guinée-Bissau), cette infection est rare et ne constitue pas un problème de santé publique majeur en Guinée Forestière. Néanmoins, le typage systématique des patients séropositifs pour le VIH et des protocoles spéciaux pour les patients infectés au VIH-2 ou VIH-1+2 sont nécessaires dans cette région.

11:45 – 12:00	Committee Room 4	03.12.2015
THUAC1005:	Track C/10 -	

Analyzing Trends in Patient Age and Gender for CD4 Testing in South Africa between 2010 and 2014

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BACKGROUND: The National Health Laboratory Service (NHLS) performs 4 million CD4 tests annually through a network of 60 laboratories. CD4 data provides an assessment of patient's immunological status in HIV care. The 2012 National Antenatal Sentinel HIV Prevalence Survey (NASHPS) reported the highest HIV prevalence in the 30-34 age-group (40.2%). The aim of this study was to understand the immunological status of CD4 samples for patient's within these high-risk age groups. Laboratory data could be used to identify trends/changes in prevalence over time.

METHODS: CD4 data for the 2010 and 2014 calendar years (n=7.1m) was extracted from the Corporate Data Warehouse (CDW). Age and gender values were captured using the information provided on the request form. Patient ages were categorized based on the NASHPS report. The CD4 absolute count was also categorized. Data was analyzed using Stata. Data analysis included age range, CD4 test range, gender frequencies and median CD4.

RESULTS: 29% (n=933k) of samples analysed in 2010 were from males, increasing to 31% (n=1199k) by 2014. This represents a 2% increase for males over 4 years. The median CD4 in 2010 was 258 cells/ul for males, and 323 cells/ul for females. This increased to 336 cells/ul and 442 cells/ul by 2014 respectively. There was a significant increase in CD4 results >= 500 cells/ul for females, increasing from 24% (n=537k) in 2010 to 41% (n=1083k) by 2014. For males the increase was from 18% (n=166k) to 27% (322k) respectively. Age category frequencies revealed a significant uptake in testing for patients between 20 and 24 years (66k in 2010, increasing to 239k by 2014). The median CD4 for this age category increased from 382 to 446 cells/ul. Overall, patient's aged 15 to 29 years reported a twofold increase in testing volumes (from 376k in 2010 to 826k in 2014). For patients in the 30-34 age category, there was a 39% increase in testing (increasing from 48k to 674k respectively).

Conclusion: Overall, CD4 data demonstrated an increased uptake of testing for males and patients between 15 and 29 years. The median CD4 increased across all age groups (increased between 64 and 118 cells/ul), except for the 15-19 adolescent age group, where there was only an increase in CD4 tests performed. The increase in the median CD4 could indicate the effectiveness of ART or healthier patients presenting for voluntary counselling and testing.

ABSTRACT DRIVEN SESSION

12:00 – 12:15	Committee Room 4	03.12.2015
THUAC1006:	Track C/10 -	

Benue State HIV & AIDS, Sexual and Reproductive Health Survey - An Analysis of Behavioural and Socio-cultural Dynamics that Predisposes Citizens to HIV

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BACKGROUND: Benue State HIV prevalence rate has consistently remained above 5.0% in all the Antenatal Care (ANC) sero-prevalence surveys conducted from 1991 to 2010. Drivers of the HIV epidemic in Benue State are classically related to structural and social factors that increases people's vulnerability to HIV infection. Benue State HIV&AIDS Reproductive Health Survey (SHARHS) was conducted to obtain information on the situation of HIV&AIDS, in order evaluate the effectiveness of the various interventions carried out to improve the knowledge and behaviour of the adult population in Benue State.

METHODS: The Survey employed a quantitative method using interviewer administered questionnaire on systematically selected respondents. An individual questionnaire for each respondent was customized on the Personal Digital Device Assistance. This instrument was adapted from International standard questionnaires such as those used in the Demographic Health Survey (DHS) to fit the specific indicator needs of the survey. A total of eight hundred and seventy-six (435M,441F) participated in the study across various background characteristics include age, sex, location, level of education, religious affiliation, and marital status.

RESULTS: The study findings revealed that 15.8% (in urban) of the male respondents have sex in exchange for gifts/favour compared with 11.3% of female in the rural setting. Sex in exchange for gifts or favour occurred more among male respondents with secondary education and among female respondents with primary education. Multiple sexual partnering occurred more among the male respondents (44.7% in urban; 42% in rural). Male respondents (predominantly aged 30-39 and 50-64) with higher level education were more likely involved in multiple sexual partnering, slightly followed by those with secondary level education. The study also revealed that these male respondents involved in multiple sexual partnering are currently married. Findings affirms the Mode of Transmission Study (2010) that the new trend of HIV infection in Benue State will be from low risk relationship who are currently married.

CONCLUSIONS AND RECOMMENDATIONS: The study findings revealed that myths &misconception, low and no risk perceptions, transaction/trans-generation sex (sex in exchange for gift/favour) are common drivers of HIV epidemic in Benue State. Policy makers and planners should prioritize HIV prevention on addressing these drivers of the epidemic.

10:45 – 12:15	Committee Room 5a & b	03.12.2015
THUAD1001:	Track D/10 - Adolescents living with HIV	
Chairs:	Jacquelyne Alesi, Kampala, Uganda	

Emerging Challenges among Perinatally Infected Adolescents in Zambia: Poor Mental Health and Non-adherence to ART 10:45 – 11:00

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BACKGROUND: Expanded access to pediatric HIV care/treatment has improved survival of children perinatally infected with HIV, but they are facing new challenges in their daily lives with HIV. The study was conducted to assess major depressive episodes (MDE) and non-adherence to ART, and investigated the associated factors among perinatally HIV-infected adolescents.

ABSTRACT DRIVEN SESSION

METHODS: A cross sectional study was conducted in Zambia University Teaching Hospital from April to July 2014. We recruited 200 adolescents aged 15 to 19 years with known HIV status. Participants administered structured questionnaires about their background characteristics, MDE using the Center for Epidemiologic Studies Depression Scale (CES-D) with 10 items, and three-day adherence to ART. We performed multiple linear regression and multiple logistic regression analysis to identify factors associated with higher scores of MDE and non-adherence to ART, accordingly.

RESULTS: We included 190 adolescents in the analysis, 57.9% were girls, and 94.2% have been taking ART. About 25.3% showed suspected depression. Unsatisfied relationship with health workers (;=1.32, p=0.01) and experience of being stigmatized (;=2.87, p=0.01) were significantly associated with higher scores of MDE. Meanwhile, 27.9% were non-adherent to ART. Maternal orphans (adjusted OR [AOR] 3.08, 95%CI 1.07-8.86), and lack of HIV knowledge (AOR 3.10, 95%CI 1.36-7.07) were significantly associated with non-adherence to ART. Major challenges for keeping good adherence to ART were "keeping time", "keeping privacy for taking antiretroviral drugs (ARV)", "carrying ARVs out of home", and "iredness of lifelong medication".

CONCLUSIONS AND RECOMMENDATIONS: HIV-positive adolescents have crucial needs for quality care of mental health and adherence to ART.

11:00 – 11:15	Committee Room 5a & b	03.12.2015
THUAD1002:	Track D/10 -	

Using PHDP to Explore the Experiences of YPLHIV in Kenya and Uganda

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BACKGROUND: Positive Health, Dignity and Prevention (PHDP) is a policy framework that highlights the importance of placing the person living with HIV at the center of managing their health and wellbeing. Through the ASK (Access, Services and Knowledge) programme, YPLHIV, supported by STOP AIDS NOW!, Y+, Global Network of People living with HIV and Population Council, conducted a PHDP study in Uganda and Kenya to understand which PHDP principles were applied by programmers and taken up by young people living with HIV (YPLHIV). The study had two objectives: i) To assess the extent to which the PHDP approach is espoused among YPHLIV in selected counties, and (ii) To provide a baseline against which the effect of advocacy interventions to promote a PDHP approach will be measured.

METHODS: YPLHIV were selected using non-random purposive sampling techniques. In Uganda and Kenya 275 and 315 individuals respectively were interviewed using a structured questionnaire. Participants included YPLHIV aged 10-24; aware of their HIV sero-status; diagnosed at least 6 months prior. Data was collected using tablets and downloaded into ACCESS database. Analysis using STATA package entailed the generation of simple frequencies and percentages.

RESULTS: YPLHIV didn't know their CD4 count(Ken: 20%, Ug: 13%); didn't get pre- and post-HIV counseling at first test (Ken: 67%); 30% didn't have access to ART or lived 2-4 hours from a health center (Ug 44%); experienced violence (Ug 59%), and intimate partner (Ken 60%,). Challenges were: sharing of ARVs (8%), poor adherence, poor access to socio-economic support and nutrition, and a high unintended pregnancy rate, and drug use (Ken.19%), healthcare professionals told YPLHIV to deliver through a C-section (Ug 25%). In Uganda, only 10.5% knew of laws protecting them and 72% couldn't access free legal services. 54% didn't know of organizations providing support in their areas. Clear differences between countries: in Uganda 30% could not disclose their status for fear of being left by partners, and while 76% in Kenya believed they would get support. In Uganda, 46% viewed HIV prevention as a shared responsibility, while in Kenya there was a high sense of personal responsibility.

CONCLUSIONS: Promote meaningful engagement of YPLHIV in policy and program development for comprehensive HIV and SRH services. YPLHIV need to be empowered with knowledge on policies to demand protection, observance of their rights and access to legal services.

ABSTRACT DRIVEN SESSION

11:15 – 11:30	Committee Room 5a & b	03.12.2015

THUAD1003: Track D/10 -

Creating an Active Teen Club to Improve Antiretroviral Adherence and Build Teenagers' Capacity to Cope with HIV/AIDS and Other Challenges: Experience from Northern Rural Namibia

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ISSUES: For teens with HIV, improved adherence to antiretroviral therapy (ART) is crucial for long-term health. It is also vital to build teens' capacity to face stigma/discrimination, develop self-confidence and goals, foster reproductive health, and generate income. Counseling sessions at Namibia's Shanamtango HIV clinic indicated that many teens fail to adhere to first-line ARV regimens due to inadequate caretaker support, stigma/discrimination, lack of money for transport, poor nutrition, and lack of youth-friendly services. In 2012, staff started a teen club to address these issues.

DESCRIPTION: The clinic, started in 2005 in the rural north, is one of the three highest-volume HIV clinics, with 896 clients under age 18; most acquired HIV via mother-child transmission. Club members include clients aged 10-19 years who have gone through the disclosure process, know their HIV status, and have caretaker consent. The club has grown exponentially, recruiting 30 teenagers in 2012, 80 in 2013, 120 in 2014, and 130 by April 2015. Members—subdivided into four age groups—elect three leaders and meet monthly. There are also monthly caretaker meetings, bi-monthly meetings with club leaders, end-of-year leadership conferences and cultural performances, and a kitchen-corner project, in which the HIV clinic nurse shows caretakers how to use local foods to prepare nutritious diets. Income-generating projects involve out-of-school members (of whom 40% are orphans and 50% raised by single mothers) who make traditional jewelry and gowns for sale to supermarkets and hospital staff.

LESSONS LEARNT: The clinic examined adherence in 50 randomly selected teen club members. Twelve months after joining the club, 40% of members with prior virological failure (VL>1000 copies/ml) had attained satisfactory virological suppression (VL< 1000 copies/ml). Two teens achieved an undetectable viral load and are enrolled at the university to obtain nursing degrees, illustrating club support for life goal-setting. Members have also participated in advocacy activities, such as carrying ''Stop the Stigma'' banners in public marches (n=60) and giving motivational speeches on World AIDS Day (n=5).

NEXT STEPS: Complete full HIV disclosure and enroll more teens; increase number of teens with virological suppression; expand the club's income-generating component; launch a vegetable garden; and help other clinics regionally and nationally to start teen clubs.

Keywords: Teen services; ART; adherence

11:30 – 11:45	Committee Room 5a & b	03.12.2015

THUAD1004: Track D/10 -

A Brighter Future for Tanzanian Teens Living With HIV - A Situation Analysis of Adolescents Living with HIV and Available Services

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BACKGROUND: Adolescents comprise almost one quarter of Tanzania's population. Given that little is known about this important population, TACAIDS and UNICEF carried out an assessment of the situation of adolescents living with HIV (ALHIV) in Mainland Tanzania.

METHODS: Data were collected in 2013 through focus group discussions and in-depth inter-

views with 456 (251 F, 205 M) ALHIV 15-19 years, recruited with informed consent through health centres in 7 of 21 regions of Tanzania, selected purposely on HIV prevalence, zonal and urban/rural representation.

RESULTS: 40% of ALHIV were sexually active (44% F, 36% M), compared to 31% and 38% of same-aged unmarried females and males (THMIS 2011/12). Two-thirds reported that last sexual intercourse was with a boy/girlfriend and 14% with a spouse. Half (54% F, 51% M) of ALHIV used condoms at last sex, compared to 60% and 51% of same-aged females and males, respectively (THMIS 2011/12). Reasons for not using condoms were: long-standing partner; know each other's status; don't like condoms; and use other means of family planning. Similar to findings of the 2009 Tanzania Violence Against Children Study, 32% of ALHIV reported sexual violence, with perpetrators usually familiar to them, yet few discussed it with friends/relatives or reported it to authorities. Awareness of family planning and child protection services among ALHIV was low (37% and 35%, respectively).

CONCLUSIONS AND RECOMMENDATIONS: The National Policy Guidelines for Reproductive and Child Health Services (2003), which allows for family planning and other sexual reproductive health services for adolescents without parental or partner consent, needs to be more strongly disseminated. Pre- and in-service training for health workers, social welfare officers and teachers must ensure that their respective sectoral work is confidential, non-judgmental and meets the needs of adolescents including ALHIV, with teachers and health workers also trained on child protection and referrals to effectively respond to violence. Support to ALHIV should provide peer support, promote condom use, family planning, disclosure and treatment adherence. Given lack of data to estimate of HIV/SRH service coverage among adolescents to identify areas of potential geographic and programmatic focus, the All In! data-driven advocacy initiative should be implemented to highlight gaps and priority actions to reach adolescents through an effective and tailored national HIV response.

11:45 – 12:00	Committee Room 5a & b	03.12.2015
THUAD1005:	Track D/10 -	

Barriers and Facilitators to Improve HIV Care for Children in Rural Uganda: Lessons from Children, Communities and Health Workers in Five Ugandan Districts

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BACKGROUND: Despite remarkable progress made by Uganda in the fight against HIV, treatment and care services for HIV infected children in the county remain sub-optimal. While over 190,000 children (under 15 years) are estimated to be living with HIV only 25% are in care. We explored barriers and facilitators to access and retention of children in HIV care and generated lessons for strengthening the delivery of HIV care for children.

METHODS: Participatory operational research was conducted in Serere (Eastern), Moroto, Napak (Karamoja) Mubende and Mityana (Central) Districts. Data were collected in April and May 2015, through focus group discussions (4 with children living with HIV, 10 with village health teams, 5 with networks of people living with HIV, 9 with general mothers, 2 with fathers) and 20 key informant interviews with health workers and district leaders involved in the provision of HIV care. Content thematic approach was used for data analysis.

RESULTS: Children living with HIV are constrained by the widespread stigma at home, in schools and community perpetrated by peers and adults. Distant health facilities, delays at health facilities, lack of support groups for children, limited family support due to poverty especially in Karamoja region made access to treatment and adherence to HIV care difficult. The major facilitators for children's access and retention in HIV care are: follow-up and referral by volunteers particularly from networks of people living with HIV, good quality care at health facilities and support to meet food and education needs of children by some organizations.

CONCLUSIONS AND RECOMMENDATIONS: The voices of children, community members and health workers in this study depict the intersectionality of stigma, health facility challenges and vulnerabilities related to poverty as major barriers to children's access and retention into HIV care. It is important that global and national actors in paediatric HIV care address these priority

ABSTRACT DRIVEN SESSION

needs in policy planning and intervention. Increasing access to treatment for children living with HIV in Uganda requires more investment in strengthening the health system and the community response. Peer support groups for children living with HIV, home visits by expert clients, community mobilization to have children tested and supported to access and remain in care are critical. Such programmes should include livelihood support to families and caregivers of children living with HIV.

12:00 – 12:15	Committee Room 5a & b	03.12.2015

THUAD1006: Track D/10 -

Improving Adherence, Retention in Care and Psychosocial Well-being amongst Adolescents on ART in Rural Zimbabwe - A Community-Based, Peer-led Intervention

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BACKGROUND: AIDS-related deaths in adolescents continue to increase as a result of poor linkage and retention in care, sub-optimal adherence and a lack of prioritisation of adolescents in service delivery. Yet there is a critical gap in evidence-based interventions which improve both clinical and psychosocial outcomes for this age group. This study measured the effectiveness of a community-based, adolescent-led treatment support and psychosocial intervention in improving retention in care, adherence and psychosocial well-being among adolescents on ART in a rural district of Zimbabwe.

METHODS: Fifty 10-15 year olds on ART received a 12 month peer-led intervention involving weekly home visits by a trained, mentored Community Adolescent Treatment Supporter (CATS) and monthly support group, compared with 50, 10-15 year olds receiving standard of care at the clinic. Qualitative and quantitative data was collected monthly and 6 monthly in both arms to measure retention in care, self-reported adherence and psychosocial well-being.

RESULTS: Intervention participants report improved adherence (60% never missed taking medicines compared to 0% in the control group) and psychosocial well-being following engagement with a CATS (97.3% in intervention to 59.7% in control). Retention in a support group was 90% and health care workers report improved attendance at clinic visit compared with standard of care. Disclosure of HIV status to participants by caregivers was improved (100% of participants who were unaware of their status at the start of the study were disclosed to compared to 0% in the control group). Identification of participants in need of CD4 count, investigations for possible treatment failure and linkage to protection services was improved. CATS were valued by health care workers and caregivers as a critical component of participant's treatment, care and support.

CONCLUSIONS AND RECOMMENDATIONS: This adolescent led intervention is effective in improving self-reported adherence, psychosocial well-being and retention in rural district in Zimbabwe. Further research of effectiveness is now required with objective measures of viral load.

10:45 – 12:15	Jacaranda 3	03.12.2015

THUAE0801: Track E/8 - Innovation in service delivery

Chairs: Precious Lunga, Zimbabwe

The Road to National Adoption: A Mixed-methods Study of Grassroot Soccer's Sport For Life Partnership Programme in Ethiopia

Hershow Rebecca B1, Merrill Jamison2, Gannett Katie2, Tsegaye Elsabeth3, Friedrich Kirk1, DeCelles Jeff1

1Grassroot Soccer, Cape Town, South Africa, 2London School of Hygiene and Tropical Medicine, London, United Kingdom, 3Partners for Health, Addis Ababa, Ethiopia

ABSTRACT DRIVEN SESSION

BACKGROUND: Findings from the first national HIV report in Ethiopia showed that prevalence among the general population increased from 1.0% in 1989 to 5.2% in 1996, leading the country to focus HIV prevention efforts on the general population, especially youth. Under a USAID grant, Grassroot Soccer (GRS), an international NGO, was contracted to develop a curriculum and training model for a sport-based HIV prevention programme for youth: Sport For Life (SFL). Since its conception, SFL underwent a massive scale-up across Ethiopia, culminating in Ethiopian Ministry of Education's national adoption of SFL in 2008 for primary school curriculum and in 2014 for secondary school curriculum.

GRS, with Ethiopian partners, carried out a mixed-methods study to explore:

(1) the quality and reach of SFL programming among youth beneficiaries; and

(2) the causal pathway for scale-up and national adoption of SFL.

METHODS: Participant attendance data were collected from 2004-2014. A 17-item paper-based questionnaire was administered to 275 SFL participants (mean age, females=15.5 years; mean age, males=15.2 years) from peri-urban areas in Addis Ababa, immediately before and after the 4-month programme. Questionnaire data were analyzed by external consultants using the Chi Square Test on SPSS software. Focus group discussions (FGDs) were conducted with SFL trainers, SFL-trained teachers, and SFL students (n=3). Key-informant interviews were conducted with personnel at Ethiopia-based organizations involved in SFL (n=3). FGDs and interviews were recorded, translated, transcribed, and coded for analysis using NVivo10 software.

RESULTS: From 2004-2014, 701,705 Ethiopian students participated in SFL. Questionnaire data demonstrated strong evidence of an effect of SFL in improving HIV-related knowledge, attitudes, and communication ($p < 0.05$). FGD and interview data highlighted reasons for the SFL scale-up:

(1) high acceptability of the sport-based methodology;

(2) favorable political environment in Ethiopia;

(3) high-quality training and frequent monitoring conducted by grant staff and local governmental structures; and

(4) partnership-building with local NGOs by grant staff.

CONCLUSIONS AND RECOMMENDATIONS: Findings suggest GRS's partnership on SFL helped lead to a national scale-up and governmental adoption of SFL. The development and roll-out of SFL should be considered an effective and sustainable partnership model for behavior change programming for youth.

11:00 – 11:15	Jacaranda 3	03.12.2015
THUAE0802:	Track D/10 -	

Socioeconomic Benefits of ART Decentralization in Malawi: Lessons from the Lablite Project

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BACKGROUND: The Lablite project is implemented in rural Phalombe district, Malawi to evaluate ART provision at peripheral, lower level health centres ('spokes') around a larger health facility (a 'hub'). Here we describe the consequences for patients of rolling out ART to lower level health facilities.

METHODS: We interviewed ART patients who had been transferred to a spoke after ART initiation (Mpasa Health Centre, n=25; Sukasanje Health Centre, n=29), or who initiated ART at a spoke (n=26, n=24 respectively) within the last 12 months as well as patients currently receiving care at the hub (Holy Family Mission Hospital, n=44). Patients were asked about socioeconomic factors and their experiences in accessing ART. Based on obtained socioeconomic data we mapped patients to wealth quintiles from the national Demographic Health Survey. For 131 (89%) participants we were able to link interview data with clinical data in routine clinic registers.

RESULTS: Of 148 patients interviewed, 109 (74%) were female; median (IQR) age at interview was 36 (30-46) years. More patients at the spokes walked to access care than patients at the hub (74% vs. 48%; p=0.002); most of the remainder travelled by bike (25% vs. 41%). Of the 54 transferred patients, 62% requested the transfer while 38% were referred. Patients who trans-

ferred from spoke facilities experienced reductions of median travel time from 2.5 hours to 1 hour (p< 0.001), distance from 13km to 6km (p< 0.001), and food cost from MK100 to MK90 per visit (approx. US$0.23 to US$0.21; 2014 values; p=0.002). Overall, 46% of patients mapped to the 2 lowest wealth quintiles; patients at spokes were poorer than at the hub (57% vs. 23% in the lowest 2 quintiles; p< 0.001). At the spokes 35% patients had started ART due to pregnancy or breastfeeding compared with 14% at the hub; excluding these patients there was still an association between lower wealth and accessing care at spokes (p< 0.001).

CONCLUSIONS AND RECOMMENDATIONS: Most patients request receiving ART near their homes when it is made available in local primary care facilities. Bringing ART care closer to patients' homes improves ease of access through reductions in distance to the facility, travel time, and out of pocket expenses. Malawi's National ART programme is reaching all socioeconomic strata and ART decentralization is particularly benefiting the poor.

11:15 – 11:30	Jacaranda 3	03.12.2015
THUAE0803:	Track D/10 -	

Improving the Quality of Health Service Delivery through Hands-on, Work-based Training: Experiences from the District Capacity Building Program, Uganda

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ISSUES: In most low income countries, health system challenges including staff absenteeism, long waiting times, and ineffective follow-up systems continue to hamper effective delivery of quality health care at public health facilities. We developed a hands-on, modular and work-based training program aimed at equipping health workers with knowledge and skills to innovatively and proactively improve the quality of services at public health facilities.

DESCRIPTIONS: Between March and December 2014, we implemented an innovative 8-months training for 42 providers at 19 public health facilities in Uganda. The training equipped trainees with quality improvement (QI) and Monitoring & Evaluation skills through 3 inter-related face-to-face sessions. Between sessions, trainees returned to their work stations to identify gaps in service delivery and develop QI interventions. Trainees had up to 6 months for project implementation. Mentors visited each facility to guide implementation and institutionalization of initiatives. Trainees also received ongoing support through emails and phone calls.

Overall, 19 projects were implemented; improving linkage & retention of HIV clients in care (6), increasing access to health services (5), reducing client delays in receiving care (3), improving reporting & records management (3) and improving infection control practices (2). Within 6 months, client linkage to care increased from 35% to 100%, client loss to follow-up reduced from 51% to 15.7%, client waiting time reduced from 288min to 90min, access to services increased from 36.6% to 98%, and timely submission of reports improved from 24% to 94%. Adherence to infection control practices improved from 37.5% to 90%. Teams established data storage & retrieval processes and systems to support sustainability of projects.

LESSONS LEARNT: This training model allows continuity of work while providing real life learning experiences. It achieves quick impact with limited resources, and provides opportunity to scale up & institutionalize QI efforts. Mentorship is critical in transferring skills and addressing attitude challenges among health workers.

NEXT STEPS: We collaborated with district based Non Governmental Organizations who continue to support teams onsite to enable sustainability of initiatives and application of skills to other identified gaps. We are now equipping district managers with leadership & management and QI skills to provide adequate support to service providers.

ABSTRACT DRIVEN SESSION

11:30 – 11:45	Jacaranda 3	03.12.2015

THUAE0804: Track D/10 -

Effect of Frequency of Clinic Visits and Medication Pick-up Antiretroviral Therapy Outcomes: A Systematic Review and Meta-analysis

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BACKGROUND: Most of the estimated 15 million people living with HIV (PLHIV) receiving antiretroviral therapy (ART) have been on treatment for at least 3 years. Many ART programmes require PLHIV to visit clinics on a monthly basis for medical checks and to collect medication, with consequent burden to PLHIV and health services. Adapted models of service delivery are needed to manage the growing cohort of stable patients. This systematic review assessed the feasibility and impact of less frequent clinic visits and less frequent medication pick-up on patient and programme outcomes. The review was carried out to support the formulation of World Health Organization (WHO) global guidance on ART service delivery.

METHODS: Electronic databases and major conference abstracts were searched up to 01 April, 2015 for studies comparing outcomes of frequent and less frequent clinic visits and ART dispensing. Differences in mortality, morbidity, viral failure, treatment adherence, and retention in care were assessed using using random-effects meta-analysis.

RESULTS: Of 5624 citations screened 19 studies were included in the final review. Eight studies informed the comparative analysis for frequency of clinic visits. Three were from Uganda, two from the United States, and one was from each of Malawi, South Africa, and Kenya. Standard of care ranged from one to three months, and the intervention frequency was six months. Most studies restricted the intervention to clinically stable patients (tolerant of medication, virally suppressed, etc.) Less frequent clinic visits was associated with a greater likelihood of being retained in care (OR: 1.90; 95% CI: 1.21 - 2.99) and trended towards improved adherence, with no difference in mortality 1.12 (95% CI: 0.60 - 2.10), or other adverse outcomes. There was also some evidence, from Malawi, of improved retention associated with less frequent drug refills.

CONCLUSIONS AND RECOMMENDATIONS: The findings of this review are consistent other findings from non-comparative studies that reduced care burden may lead to improved retention to HIV care without adversely affecting clinical outcomes. These findings support the WHO 2015 recommendation to reduce the frequency of clinic visits and drug dispensing among PLHIV who are stable on ART.

11:45 – 12:00	Jacaranda 3	03.12.2015

THUAE0805: Track D/10 -

Mécanisme de Suivi du Traitement en Afrique de l'Ouest

Bukiki Sylvère

ITPC West Africa, NGO, Abidjan, Cote D'Ivoire

ISSUES: La faible couverture de l'accès au traitement antiviral ainsi que les pénuries et perturbations appelés «ruptures de stock» survenant dans l'approvisionnement de médicaments antirétroviraux dans les centrales d'achat et autres points de livraison dans presque tous les pays de la région de l'Afrique de l'Ouest ont emmené l'Internationale Treatment Preparedness Coalition (ITPC) à mener le projet STOP en Gambie, Sierra-Léone et en Côte d'Ivoire.

DESCRIPTIONS: Ce projet a permis de créer deux observatoires communautaires du traitement en Gambie, Sierra Leone et de renforcer le système d'alerte de la Côte d'ivoire (SAR). Un observatoire communautaire du traitement est un mécanisme qui recueille systématiquement et analyse des données qualitatives et quantitatives à utiliser en vue d'une action ciblée.

ABSTRACT DRIVEN SESSION

LESSONS LEARNT: Trois analyses situationnelles ont été menées dans les trois pays cibles du projet pour recueillir les informations réelles sur les causes et les défis en matière de logistiques, de stockage, de consommation des services, d'approvisionnement, de redistribution des ARVs, des équipements de laboratoires et de diagnostic de base.

En Côte d'Ivoire, Gambie et Sierra-Léone, STOP a soutenu le Réseau Ivoirien des Personnes vivant avec le VIH (RIP+) pour mettre en place deux comités de surveillance des stocks ARV et l'état des équipements de laboratoires de chaque pays. Ces comités sont gérés par les Groupes de Consultations Communautaires (GCC) qui organisent des réunions trimestrielles d'assises communautaires. Les données collectées sur la chaine d'approvisionnement des médicaments et équipements de laboratoires sont analysées, discutées et des solutions trouvées.

Le SAR du RIP+ appuyé par le projet STOP a permis de réduire à 3 jours maximum les ruptures de médicaments qui survenaient plus de 14 jours aux niveaux périphériques sur l'ensemble des 20 régions sanitaires de la Côte d'Ivoire.

En Gambie Les ruptures de stocks sont rares et la méthode de couplage des CPEC pallie parfaitement aux problèmes de rupture et d'expiration des stocks.

STW (Sierra-Leone Supply Watch) a favorisé la mise en place et l'opérationnalisation d'un Comité national de gestion des ARV et d'équipements de diagnostics de base.

NEXT STEPS: Organiser une réunion de dialogue politique entre les communautés affectées et le CCM.

Formaliser un cadre consultatif entre les communautés affectées et les autres acteurs de la société civile.

12:00 – 12:15	Jacaranda 3	03.12.2015
THUAE0806:	Track D/10 -	

Improving Access and innovation through Voluntary Licensing: The Experience of the Medicines Patent Pool

Burrone Esteban

Medicines Patent Pool, Geneva, Switzerland

ISSUES: Access to new ARVs at affordable prices and the development of improved paediatric formulations needed to treat children in Africa has generally taken a long time. As a result, in adult treatment, a gap has developed between the medicines being used in the developed world and those being used in resource limited settings. In paediatric treatment, the gap has been between formulations needed to improve treatment outcomes and the formulations available today.

DESCRIPTIONS: The Medicines Patent Pool was established in 2010 to accelerate access to affordable and adapted HIV formulations for adults and children in the developing world through voluntary licensing. Five years later, the MPP has signed licences on 12 priority ARVs with 6 patent holders and 59 sub-licences with 14 generic manufacturers. Its licences are:

(i) enabling more countries access recommended ARVs at more affordable prices,

(ii) accelerating the development of quality assured generic versions of new ARVs for use in the developing countries most hit by the epidemic, and

(iii) facilitating the development of needed paediatric formulations for different age groups.

LESSONS LEARNT: The experience has shown that public health oriented voluntary licensing can play an important role in accelerating access. The final abstract will present the most recent data from the Medicines Patent Pool on savings achieved to date and new formulations under development (for adults and children).

NEXT STEPS: Given the success of the MPP in its first 5 years of experience, UNITAID has agreed to continue funding the MPP in order to continue to play a key role in accelerating access to new ARVs and facilitate the development of new formulations. Next steps will include managing the licences to ensure they deliver, that the new formulations become available as per expected timelines and that new ARVs, currently in the pipeline, or other key technologies for HIV treatment, are made available through MPP licences.

ABSTRACT DRIVEN SESSION

12:45 – 13:00	Jacaranda 3	03.12.2015
THUAC1101:	Track C/11 - Towards eliminating mother to child transmission of HIV	

L'infection par le VIH chez l'Enfant Tunisien: Caractéristiques Épidémio-cliniques

12:45 – 13:00

Zayet Souheil, Ammari L., Hannachi S., Othmani M., Berriche A, Harrabi H., Aissa S., Abdelmalek R., Kanoun F., Kilani B., Tiouiri Benaissa H.

CHU La Rabta University Manar, Tunis, Tunisia

BACKGROUND: En Tunisie là ou la prévalence de l'infection par le VIH est faible estimée à 1 cas/ 10000 habitants adultes, les enfants sont encore moins touchés par ce virus. Le but de notre travail est de décrire les caractéristiques épidémiologiques et cliniques de l'infection par le VIH chez l'enfant tunisien.

METHODS: Nous avons mené une étude rétrospective sur 15 ans (2000-2014) concernant des nouveaux nés, nourrissons et enfants infectées par le VIH hospitalisés ou consultants au service de Maladies infectieuses au CHU la Rabta de Tunis.

RESULTS: 20 enfants ont été colligés qui étaient tous tunisiens dont 65% étaient de sexe féminin. La transmission verticale a été évoquée chez tous les enfants. L'âge moyen de découverte de l'infection rétrovirale était 36 mois avec une tranche d'âge entre 17 mois et 16 ans. Les circonstances de découverte de l'infection chez l'enfant étaient 38,8% des cas à l'occasion d'un dépistage néonatal chez des nouveaux nés asymptomatiques dont leurs mères sont connues séropositifs. L'accouchement par césarienne a été indiqué dans 5 cas. La prophylaxie par zidovudine a été prescrite durant le travail. Dans les mois qui suivent l'accouchement, la moitié des nourrissons ont eu un allaitement maternel. Initialement, la charge virale était en moyenne de 1.490.104 copies par millilitre avec un compte de lymphocytes CD4 à 672,66 par mm3. Parmi les infections opportunistes, la candidose buccale et ;sophagienne était au premier rang dans 25% des cas. Le traitement antirétroviral a été instauré dans 100% des cas. L'association zidovudine, lamuvidine et lopinavir/ritonavir dans sa forme sirop a été prescrite dans la moitié des cas avec 75% d'enfants qui étaient en succès immuno-virologique du faite de la bonne observance. Une prophylaxie primaire par le cotrimoxazole a été prescrite dans 50% des cas. Nous avons déploré 4 décès (20%).

CONCLUSIONS AND RECOMMENDATIONS: La prévention de la transmission mère enfant nécessite une prise en charge multidisciplinaire par un suivi régulier d'une grossesse programmée mais aussi au moment du travail et en post-partum par l'interdiction de l'allaitement maternel. Un dépistage doit être fait devant toute symptomatologie chronique chez le jeune enfant.

Mots clés: Infection VIH, transmission verticale, enfant, traitement antirétroviral.

13:00 – 13:15	Jacaranda 3	03.12.2015
THUAC1102:	Track C/11 -	

Maternal Antiretroviral Therapy and Infant Outcomes throughout the First Year of Life: Results from the DREAM Study in Dschang, Cameroon

Doro Altan Anna Maria1, Taafo Francis2, Fopa Francois2, Buonomo Ersilia3, Marazzi Cristina4, Scarcella Paola3, Ciccacci Fausto1, Orlando Stefano1, Mancinelli Sandro3, Liotta Giuseppe3, Palombi Leonardo3

1Community of Sant'Egidio, DREAM Programme, Rome, Italy, 2DREAM Centre Dschang, Dschang, Cameroon, 3University of Tor Vergata, Rome, Italy, 4University LUMSA, Rome, Italy

BACKGROUND: Cameroon is one of the priority countries for the elimination of Mother-to-Child-Transmission (MTCT). There are few studies describing use of triple Antiretroviral Therapy (ART) for prevention of MTCT in Cameroon. DREAM is a program of care for people living with HIV managed by the Community of Sant'Egidio, which has been implementing prevention of MTCT with triple ART since 2004 in low resource settings, and is operating in Dschang, Cameroon, since 2008.

Objectives: To evaluate transmission rates, infant mortality, HIV free survival and infant growth in a cohort of children born to HIV+ women on ART.

ABSTRACT DRIVEN SESSION

METHODS: HIV-positive pregnant women attending DREAM Centre of Dschang from 2009 to 2011 were enrolled in a prospective cohort study, and received ART until the end of breastfeeding or indefinitely if their CD4 count was < 350mm3. Also pregnant women already established on ART were enrolled. Women were counselled to exclusively breastfeed and to stop breastfeeding at 6 months. Infants were evaluated for HIV infection at 1, 6 and 12 months of age.

RESULTS: A total of 298 women (152 being already on ART at enrolment) gave birth to 275 living infants. Eighty-nine percent of infants were exclusively breastfed. HIV transmission rate was 1,1% at 12 months. We observed 22 deaths in the first year of life, corresponding to an infant mortality of 80;. HIV free survival at 12 months was 91%, while 4% of infants were lost to follow up. Forty-five infants (17%) were born with a birth weight of less than 2,5 kg. Women in the lowest quartile of duration of ART before delivery gave birth to children with a birth weight slightly lower than women in the highest quartile of ART duration (2,8;0,56 kg against 3,0;0,55 kg p=0,023). At 12 months of age, 3,4% of infants were underweight. In the proportional Cox regression analysis, the following factors resulted positively associated with infant mortality: maternal CD4< 350 cells/mm3, infants never breastfed, weight-for-age z score < -2 at any time from birth to 12 months.

CONCLUSIONS AND RECOMMENDATIONS: The study confirms effectiveness of maternal ART during pregnancy and breastfeeding for prevention of MTCT. HIV transmission rates in this cohort were low, and infant survival is likely to improve with earlier initiation of ART in mothers. Breastfeeding confirms to be highly beneficial for growth and survival of HIV exposed children.

Keywords: mother-to-child transmission, breastfeeding, Cameroon, HIV-free survival

13:15 – 13:30	Jacaranda 3	03.12.2015
THUAC1103:	Track C/11 -	

Contribution of Counselling and Testing at the Peadiatric Provider Initiative (CTPPI) in Improving the Early Infant Diagnosis (EID) with HIV in Togo: Lessons Learnt and Challenges, 2012-2014

Ayitou Akayao1, Singo Assètina1, Tatagan-Agbi Komlan2, Abalo Komi3, Adam Zakilatou1, Nassam Arizika1

1Programme National de Lutte contre le Sida et les IST, Lomé, Togo, 2Chu Sylvanus Olympio, Lomé, Togo, 3UNICEF, Lomé, Togo

BACKGROUND: Despite the free ARVs since 2008, pediatric ART coverage is still low in Togo (14% of needs covered in 2011). The absence of systematic screening of children for entrance doors of the health system was identified as a major barrier. Thus, National AIDS and Sexually Transmitted Infections Control Program (PNLS/IST) initiated in 2012 with support from UNICEF, HIV testing among infants in pediatrics. After three years, we report lessons learnt and challenges in designing an approach to increase case-finding of HIV in pediatric care settings.

METHODS: HIV screening is offered for children from 0 to 14 years of unknown HIV status after a group and/or individual counseling of mothers in immunization, consultation, hospitalization, etc. After a feasibility study, the PNLS/IST identifies sites, sources its inputs screening, data collection tools, supports and organizes supervisions. To address the bottlenecks related to the execution time of the EID results, a partnership was established with the National Post Corporation to transport dried blood specimens and results. A referral system has been designed to ensure that HIV+ children received ARVs.

RESULTS: The implementation of the approach was first piloted between 2012 and 2014 in 20 health facilities with 73 providers trained against 18 in 2012. 100% of health facilities were monitored, 90% (18) were endowed with reagents. However, 35% (07) of the sites have had a test out of an average of 5 months. However, 34% (6,330) of children diagnosed from 2013 to 2014 in the country is from the CTPPI and pediatric ARV coverage increased by 18.15% (2,377) to 20.23% (2,861). The good collaboration between pediatric providers is selected as element of success.

CONCLUSIONS AND RECOMMENDATIONS: The CTPPI contributed significantly to reduce missed opportunities for HIV screening and improve pediatric ARV coverage. Despite input's failure, provider's adherence and free ARVs are successful factors of CTPPI's scaling. This will require ensure continuous availability of inputs, improve linkage between the HIV+ children and ART clinics and revise routine data collection tools to strengthen monitoring and evaluation.

ABSTRACT DRIVEN SESSION

13:30 – 13:45	Jacaranda 3	03.12.2015
THUAC1104:	Track C/11 -	

Do Mother Support Groups Increase Retention in PMTCT Programmes? Preliminary Results of an 'INSPIRE' Randomised Controlled Trial in Zimbabwe

Foster Geoff1,2, Kangwende Abigail3, Maphosa Talent1, Mushavi Angela4, Rusakaniko Simbarashe5, Sengai Tonderai2, Shumba Bridget2, Zambezi Pemberai2, Eliminating Paediatric AIDS in Zimbabwe (EPAZ) Project

1Ministry of Health and Child Care, Mutare, Zimbabwe, 2Family AIDS Caring Trust, Mutare, Zimbabwe, 3Africa University, Clinical Research Centre, Mutare, Zimbabwe, 4Ministry of Health and Child Care, Harare, Zimbabwe, 5University of Zimbabwe, Harare, Zimbabwe

BACKGROUND: The rapid implementation of option B+ since 2011 has underscored the importance of measuring impact on eliminating new HIV infections among children and keeping their mothers alive. Retention-in-care is an important indicator of program outcome that involves following cohorts of people living with HIV to determine true outcomes. Mother support groups (MSGs) may improve retention-in-care and adherence to treatment in PMTCT programs and promote other maternal and child health outcomes. No RCT has previously assessed the impact of MSGs on retention-in-care.

METHODS: The Eliminating Pediatric AIDS in Zimbabwe project in Manicaland, one of six implementation research studies supported by WHO under the INSPIRE project (J. AIDS 67: Suppl 2) will assess whether a strategy of establishing clinic-based MSGs results in increased retention rates of HIV-exposed infants and their HIV+ mothers in clinic-based PMTCT follow-up systems 12 months post-delivery compared to clinics that lack MSGs. MSGs led by unpaid expert mothers were established at 15 clinics in 2013. We report formative research on the acceptability and design of MSGs and a mid-project evaluation of MSG functioning through interviews and group discussions with mothers, health workers and community members.

RESULTS: By mid-2015, 355 HIV+ pregnant mothers were enrolled at 30 rural clinics in either the the control arm (standard of care) or intervention arm (established MSGs); 192 mothers were enrolled at clinics with MSGs; 92.2% of scheduled twice-per-month MSG meetings were held out of a possible 180 meetings; 43.2% of mothers attended each meeting on average; 70.7% attended an MSG in the preceding two months; 7.9% never attended an MSG. As well as updated figures on MSGs, we will present mid-project evaluation findings on MSG functioning (male participation, liaison with clinic staff and retention activities of MSGs and clinics).

CONCLUSIONS AND RECOMMENDATIONS: Retaining mothers in health care systems under Option B+ offers new opportunities and challenges. Attendance of mothers at facility-based MSGs was high suggesting their acceptability and possible efficacy in retaining mothers and infants in PMTCT follow-up. If at the conclusion of this study in late 2016, the establishment of MSGs at health facilities is shown to have demonstrably improved health outcomes, this may inform program managers on whether investment to establish MSGs throughout Zimbabwe's 1,600 health facilities is justified.

13:45 – 14:00	Jacaranda 3	03.12.2015
THUAC1105:	Track C/11 -	

HIV, HBV & HCV Prevalence in Pregnant Women Attending ANC Sentinel Surveillance Sites in Eritrea, 2014

Mesfin Araia Berhane1, Kibreab Fitsum1, Ahmed Hagos2, Asrat Medhane2

1Ministry of Health, Public Health, Asmara, Eritrea, 2National Statistics Office, Asmara, Eritrea

BACKGROUND: Most countries monitor their HIV epidemic using ANC sentinel surveillance sites. Though, HIV surveillance in pregnant women attending ANC is well advanced, surveillance on Hepatitis B and Hepatitis C is far behind. In order to understand the prevalence and distribution of these infections, HBsAg and HCV antibodies testing were included in the HIV surveillance.

METHODS: The study was a cross-sectional, anonymous and unlinked sentinel surveillance survey conducted in Nov 2013-Jan 2014. A total of 5,091 pregnant women, aged 15-49 years,

attending ANC for the first visit in the current pregnancy were recruited consecutively. Eligible pregnant women were interviewed using structured questionnaire followed by blood drawing . Blood was tested for HIV, HCV and HBV at the National Health Laboratory.

RESULTS: Median age of respondents was 25 years and majority (92%) were married. The overall prevalence of HIV, HBsAg was 0.85[C.I: 0.5-1.6] and 2.30% [CI: 2.0%-2.7%], respectively. HBV was more prevalent in Southern Red Sea (6.27%), Northern Red Sea (3.55%) and Gash-Barka (2.26%) regions. HIV prevalence was higher in Southern Red Sea (1.18%) followed by Central Region (1.12%). Unlike HIV, HBV was significantly higher among women in rural (2.87%) than urban (1.96%), in Muslims (2.93%) than Christians (1.81%), in illiterates (3.38%) than those with secondary education (1.65%). The likelihood of infection with Hepatitis B was tested to vary significantly by region, residence, religion and level of education. Anti-Hepatitis C was negative in all the pregnant women tested. Analysis for co-infection revealed that all of the respondents infected with HIV were free from Hepatitis B infections.

CONCLUSIONS AND RECOMMENDATIONS: The overall prevalence of HIV, HBV and HCV is low in Eritrea. However, both HIV and HBV are relatively higher in some regions and are not associated to each other. HIV is more prevalent in urban while HBV is more common in rural clusters. Relatively higher prevalence in some regions, religion groups may indicate that some factors and practices may expose these pregnant women to these infections. Therefore, in-depth exploratory researches are recommended to understand why certain sub-groups of the population are more vulnerable to these infections than others. Moreover, with some modifications, existing HIV sentinel surveillance can be used to monitor HBV and HCV infections so that appropriate prevention and control measures can be taken.

14:00 – 14:15	Jacaranda 3	03.12.2015
THUAC1105:	Track C/11 -	

Recalibrating the EID Cascade in Zimbabwe: True Outcomes among a Sample of HIV-exposed Infants with No Documented EID in Mashonaland East Province

Karen Webb1, Chitiyo Vivian1, Ndoro Theresa1, Nesara Paul1, Zizhou S2, Mahachi Nyika1, Engelsmann Barbara1, Geng Elvin3

1Organisation for Public Health Interventions and Development Trust, Harare, Zimbabwe, 2Ministry of Health and Child Care, Mashonaland East Province, Marondera, Zimbabwe, 3University of California San Francisco, San Francisco, United States

BACKGROUND: In Zimbabwe, information on health services received by HIV positive pregnant women and their exposed-infants is documented in multiple, paper-based registers at health sites. The proportion of mother-baby pairs who uptake timely EID is not routinely reported. We conducted a population based survey in which individual HIV infected mother-baby pairs were followed through registers identify and trace a sample of HIV positive women with no documented EID for their exposed infants to ascertain true outcomes.

METHODS: A modified probability proportional to size schema was used to select 45 of 193 health facilities in Mashonaland East Province. Outcomes of all HIV positive mothers enrolled in ANC from Apr-12 to May-13 were traced through facility registers to determine documented uptake of EID for their HIV-exposed infant within three months of birth. A sample of women with no documented uptake of EID was traced at household level to determine true outcomes using a structured, pre-tested questionnaire.

RESULTS: Among a population of 18 065 women attending ANC, 2646 were HIV positive (14.6%); 35.5% (n=939) had documented uptake of EID within three months (95%CI: 31.1%-39.9%). From Mar-May15, a sample of 258 among the 1 707 with no documented EID were traced at household level. 75% (n=194) of infants traced were reported to have had DNA PCR samples for EID. The majority, 66.5% (n=129), reported EID within 3 months of birth. The majority of those who accessed EID (66.7%; n=86) indicated EID services were accessed at the same facility as ANC services, and 29% transferred to another facility. One quarter of infants (n=66) had not received EID at any time (95%CI: 18.4%-28.8%). Infant mortality among those traced was 17.4% (n=45).

Conclusion: The proportion of HIV-exposed infants who access early infant diagnosis prior to three months of age is underestimated by facility-based aggregate data. Discrepancies between facility and patient-reported EID uptake indicate need to strengthen health information systems to enable accurate documentation of service uptake of mother-baby pairs along the PMTCT cascade. The drive to eMTCT in Zimbabwe will require effective health information systems to capture outcomes of mother-baby pairs and rapid translation of implementation research on interventions to increase uptake and retention of at risk HIV positive mothers and improving health and development outcomes of mother-baby pairs.

ABSTRACT DRIVEN SESSION

12:45 – 14:15	Prof Soudré Room	03.12.2015
THUAD1101:	Track D/11 - HIV and law	
Chair:	Kene Esom, Nigeria	

Punitive Law a Barrier to Achieving UNAIDS 90-90-90- Target on HIV/ AIDS and STIs Prevention in Nigeria

12:45 – 13:00

Ibe Benjamin

International Center for Advocacy on Right to Health, Human Right / Program, FCT, Nigeria

BACKGROUND: In January 2014, the president of Nigeria signed into law a legislative Act that seeks to formally criminalize same sex oriented citizens and other Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) persons living in Nigeria for their human person, their sexual orientation and gender identity.

HIV/AIDS epidemic is one of the most formidable challenges Nigeria is facing today. Over 3.4 million Nigeria live with HIV making Nigeria the country with the second largest population of people living with HIV in the world. MSM & Transgender people represent less than 4% of Nigerians but over 10% of new HIV infections occur among these populations. Providing targeted services to these populations is essential to end HIV/AIDS in Nigeria. This law makes it virtually impossible for members of this population living with or affected by HIV to freely seek essential Health services.

Methodology: In a current research been conducted in the only MSM specific clinic in Nigeria to determine the retention rate among MSM accessing services in a trusted clinic; one of the health benefit of research participants is the treatment of STIs and OIs,

Prior to the Same Sex Marriage Prohibition Act (SSMPA) the TRUST research had in participation of about 60% MSM in the research but declined to 20% when the law was passed criminalizing MSM in Nigeria.

The law has a damaging effect on Nigeria's efforts to prevent the spread of HIV/AIDS imperiling ability of healthcare practitioners to provide services to key affected population (KAP) including MSM and Transgender people.

Result: Studies have shown that people are much less likely to seek HIV services when they face discrimination, including abuse, imprisonment and/or prosecution. Gay men are up to 13 times more likely to become infected with HIV than the general population. Nigeria anti gay law fuels the stigma around HIV and will surely lead to drop in the number of those seeking needed prevention, care and treatment.

RECOMMENDATION: Commonwealth countries should repeal discriminatory punitive laws against LGBTI people, sex workers, and drug users. These laws undermine the fight against HIV; we need your help to make sure they agree to remove legal penalties that discourage many vulnerable and marginalized people from coming forward for HIV education, prevention, testing, treatment and support.

Keywords: MSM, HIV, LAWS.

13:00 – 13:15	Prof Soudré Room	03.12.2015
THUAD1102:	Track D/11 -	

Law Criminalizing HIV Transmission Declared Unconstitutional by Kenyan Courts

Nyachae Jacinta M

AIDS Law Project, Legal NGO, Nairobi, Kenya

ISSUE: The HIV and AIDS Prevention and Control Act in Kenya provides for measures to prevent, control and manage HIV and AIDS, promote public health and deliver appropriate care for PLWHIV. This law was a big step toward realizing human rights; however, section 24 criminalized the transmission of HIV. The section was challenged in court by a local NGO for being discriminatory, vague, overboard and lacking in legal certainty. The court declared the section unconstitutional bringing forth the significance of using strategic litigation to advance health rights.

ABSTRACT DRIVEN SESSION

DESCRIPTION: AIDS Law Project (ALP) is an organization which works to provide a supportive environment that enhances and upholds human rights to health and protection of PLWHIV. ALP uses strategic litigation as a tool to advance health rights. ALP filed the case and was supported by amicus curiae, which made submissions on the effects that the provision would have on women, exacerbating stigma and undermining public health interventions. ALP continued with advocacy throughout the hearing of the case. In March 2015, the court delivered a precedent setting judgment which declared section 24 of the HIV Act unconstitutional.

LESSONS LEARNT: The decision effectively settles the debate concerning the criminalization of the transmission of HIV finding against such reading and interpretation of the law especially when the prohibited conduct is uncertain and over broad. Also, it underscores the critical role governments must play to prevent the disease whilst also protecting the rights and freedoms of persons living with HIV and AIDS through effective policies and laws that eliminate stigma and discrimination and advance the rights of women and girls.

The Judgement means that Section 24 of the HIV Act has been declared unconstitutional and cannot therefore be enforced. The success of this case can also be attributed to ongoing efforts to sensitize the judiciary on matters relating to health and human rights.

NEXT STEPS: There is need continue working around policy reforms including engaging in amending the HIV Act ;reviewing other existing laws on criminalization of the transmission of HIV with a view to advocate for the decriminalization of the same and amendments to guarantee access to the highest attainable health care in line with the Constitution and engaging all levels of government to focus on strategies that insist on public health policies and laws that are founded in evidence.

13:15 – 13:30	Prof Soudré Room	03.12.2015
THUAD1103:	Track D/11 -	

Training to Judges and Legal Professional Enhances PLHIV's Access to Justice and Ensures the Protection of Fundamental Labour Rights by Labour Courts

Sipi-Johnson Ingrid, Torriente Anna

International Labour Organization, Geneva, Switzerland

ISSUES: It is not sufficient to provide for protective policies and laws to protect the fundamental rights of persons living with HIV and key vulnerable groups—we must provide for access to justice and effective enforcement of those protections to make a difference. Providing training on international law, including international labour standards, has a significant impact on the protection of rights.

DESCRIPTIONS: The HIV and AIDS Recommendation, 2010 (No. 200), adopted by the International Labour Organization, calls for national judicial authorities to be part of the national HIV response, and provides that training in this respect should be provided to them. To facilitate this, ILO has rolled out a reference and training of trainers' tool: HIV and AIDS and Labour Rights: A Handbook for Judges and Legal Professionals (2nd Edition, 2015).

The judicial training handbook, published in 2013 and updated in 2015, has been used in training more than 300 labour judges and legal professionals, including judges from Kenya, Rwanda, Tanzania and Uganda. To ensure sustainability, the training aims to enable judges to become trainers themselves and promote application of international law, including international labour standards, in handling cases of HIV-related employment discrimination.

LESSONS LEARNT: The training has resulted in at least ten regional and national court decisions, upholding the labour rights of workers living with HIV. One example is a 2013 Kenya industrial court decision issued by a judge following his participation in the training. The judge applied national law and international labour standards in finding that the complainant, a woman living with HIV, had been discriminated against and unfairly dismissed due to her sex, pregnancy and HIV status. Another participant in a separate training, a Brazilian judge, cited international labour standards, including ILO Recommendation No. 200 and the training handbook itself in upholding the labour rights of a worker living with HIV who had been unfairly dismissed from employment due to HIV status.

NEXT STEPS: ILO continues to support provision of training based on Handbook and encourage its replication and inclusion in national judicial curricula where appropriate to enhance judges' familiarity with key human rights instruments relevant to HIV and AIDS and how national courts can and have applied these. Trainings in 2015 will include labour judges from all Portuguese-speaking countries throughout Africa.

ABSTRACT DRIVEN SESSION

13:30 – 13:45	Prof Soudré Room	03.12.2015

THUAD1104: Track D/11 -

Legislators Develop a Model Law on Eradicating Child Marriages and Protecting Children Already in Marriages in Southern Africa

Jhala Eva, Sekgoma Boemo, Magadza Moses, Dookhony Loveena, Musonda Claire

SADC Parliamentary ForumParliamentary Forum, Human and Social Development and Special Programmes, Windhoek, Namibia

ISSUES: The eradication of child marriages is of absolute importance for the Southern Africa Development Parliamentary Forum, if the SADC Member States are to develop both socially and economically by using a human rights based approach in eradicating its practice.

It is a truism that the majority of Member States, certain civil society, have put in place positive interventions and measures under various policies, strategies and programmes to try to eradicate child marriages, but the desired and real impact is yet to be achieved. This is evident from the increase in grim statistics of education completion rates, especially for the girl child, gender disparities, parental neglect, high child mortality rates, and high incidences of HIV and AIDS among the adolescent youths.

DESCRIPTIONS: The Model legislation is to serve as guidance, a yardstick and as an advocacy tool for legislators in the region. It will also provide best practice language without loopholes which can be easily adopted/adapted by Member States. In particular policy makers and legislative drafters will use it to address all the relevant areas in need of legislative reform without usurping the authority of national legislatures.

LESSONS LEARNT: Despite the fact that the majority of SADC Member States do have legislation in one form or the other to prevent early child marriages, such as penalizing sex with minors, age of majority laws, rights of the child laws, anti - gender based violence laws, anti-trafficking laws and forbidding child marriages, Child marriages are still a daily occurrence. An adequate and well planned legal and institutional framework is important to forestall the adverse effects on the child.

NEXT STEPS: A mixed methodology approach will be adopted to collect, collate, segment and evaluate qualitative data from the various stakeholders, laws, policies, legal audits, regional and international conventions, comparative laws and other sources. This approach will be based on the concept of 'triangulation', which involves the determination and authentication of a given situation through several sources of information. The Model law on Eradicating Child Marriages, will serve legislators and traditional leadership in early rationalisation of the root issues which adversely affect the survival and development of the child who is subjected to early and child marriages to help flashed them out.

13:45 – 14:00	Prof Soudré Room	03.12.2015

THUAD1105: Track D/11 -

Engaging Parliamentarians to Support Children to Access Treatment for HIV

Igweta Rhoda1, Blagojevic Aleksandra2

1Elizabeth Glaser Pediatric AIDS Foundation, Public Policy and Advocacy, Nairobi, Kenya, 2Inter-Parliamentary Union, International Development, Geneva, Switzerland

ISSUES: Only a quarter of children living with HIV in need of treatment are currently accessing it. Research shows that national laws and health policies have major impact on population health outcomes because they provide guidance on availability and access to services. Political will is needed to facilitate the right legal and social environment to enable children and families to have HIV treatment access. Yet, countries with high HIV burden often don't have the socio-legal environment to support pediatric care and treatment access.

DESCRIPTIONS: To mobilize political will and create an enabling environment to support pediatric treatment access, EGPAF together with IPU in November 2013 developed a briefing paper to raise the profile among members of parliament on issues children face in HIV treatment access and what parliamentarians can do to help these children in their various jurisdictions. The issue brief

was launched at the 130th IPU Assembly and copies were shared with the 166 IPU Member Parliaments. It was presented at the 2015 East African Legislative Assembly committee meeting on the legal framework and implementation of policies on the rights of the child and in several countries. Parliamentarians discussed what was hampering children from accessing HIV treatment and what can be done to address some of these challenges.

LESSONS LEARNT: There was considerable lack of awareness among parliamentarians to address pediatric HIV, including how far children lagged behind adults in treatment access. Once greater awareness was gained, parliamentarians were open to proposals with regards to the legal environment, budgets and accountability of national institutions. Parliamentarians were eager to collaborate across party lines to champion the rights of children and take actions to support children. IPU and EGPAF found value in developing a global advocacy tool that articulates the issue and use it as a basis to dialogue and influence change.

NEXT STEPS: Awareness raising efforts should go beyond parliamentarians serving on health or HIV committees since changes in national laws and budgets require the majority support. The next phase will focus on collaborating with parliamentarians to share best practices including field visits and helping them take appropriate steps to enhance access to HIV treatment for children. Efforts will include documentation of these processes to enhance learning in various jurisdictions.

14:00 – 14:15	Prof Soudré Room	03.12.2015
THUAD1106:	Track D/11 -	

Whom Should We Concentrate on in Enforcing Laws on Public Morality? The Dilemma of the Ghana Police Service

Salifu Thomas Ndeogo, Blantari Jones, Awotwi Esi, Sefa-Boateng Stephana

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ISSUES: Ghana has recorded significant progress in the fight against HIV/AIDS over the last decade with current infection rates around the prevalence of 1.3% among the general population aged 15-49 years.However there exists significant challenges amongst Key Populations where prevalence is 10 times higher than the general population ;(11% for FSW and 17% for MSM). But it is impossible to dissociate key populations from the general population in terms of HIV spread and public health implications thereof in a social, political, religious and legal setting that inhibits access to prevention, treatment and care services to this sub population a situation that might compromise the gains already achieved.

DESCRIPTIONS: Ghana Police Service with support of the Country Office of PEPFAR designed and implemented a program in 5 Regions from September 2014 to March 2015 which targeted 611 police personnel on three levels; senior officers, Inspectorate and other ranks.Personnel were from CID, DOVVSU and patrol units and sought to do the following;Solicit information on how Police would identify a Key Population(KP)•Definition of the laws that classify Key Populations and what constitutes a sexual offence.Sessions focused on the epidemic of bad laws that criminalize populations and behaviors and stand in the way of progress in addressing HIV. Creation and application of the law is often based on prejudice, fear, myth and not science or evidence. Presentations showed different issues in form of focus group discussions, followed by sensitization programs to address issues that came from Discussions. Identifying a Key population was by the nature of her dress, exposed breasts, chains on her legs and fancy hair styles'. Understanding laws and interpreting them ranged for one being an SPO (77%) to working at DOVVSU (70%) to operational men (38%) respectively.How does the Criminal Offences Act describe the offences of Solicitation or unnatural carnal knowledge?In all instances, participants could not define or state the key ingredients of the law as stated in Criminal Offences Act. Response levels were SPO (62%) DOVVSU (70%) with Other Ranks being 59% respectively.

LESSONS LEARNT: At the end of sessions, participants agreed on the following; Professionalism in their dealings with every segment of society; decoupling morality from law enforcement.

NEXT STEPS: Acceptance is a major breakthrough to reform. The program is also being rolled out throughout the nation.

ABSTRACT DRIVEN SESSION

14:45 – 16:15	Committee Room 4	03.12.2015
THUAE0901:	Track E/9 - Matching settings to entry points for better services	
Chairs:	Tsitsi Apollo, Zimbabwe	

Achieving Value for Money: The Scale-Up of an Integrated Service Package for the Prevention of HIV and Unplanned Pregnancy in Zambia

14:45 – 15:00

Mazarire Christine1, Drakes Janeen2, Fox Katie1, Hoagland Alexandra3, Lockard Ann1, Kwesele Change3, Malama Kalonde3, Sharkey Tyronza1, Yohnka Robert2, Inambao Mubiana3, Kilembe William1, Allen Susan2

1Zambia Emory HIV Research Project, Lusaka, Zambia, 2Rwanda Zambia HIV Research Group, Atlanta, United States, 3Zambia Emory HIV Research Project, Ndola, Zambia

BACKGROUND: In February 2013, Zambia Emory HIV Research Project (ZEHRP) was awarded a £4.5 million grant by UK DFID to scale-up Couples Family Planning Counselling (CFPC) and Long-Acting Reversible Contraception (LARC) integrated with Couples Voluntary Counseling and Testing (CVCT) in Zambia and to train counselors and nurses. While there is agreement that such integrated HIV and reproductive health services are needed, there is limited information on their cost effectiveness.

METHODS: ZEHRP created a Value for Money (VfM) framework to evaluate its economy (cost and quality of inputs- staff and goods), efficiency (ability to transform inputs into outputs- number of couples receiving services and number of providers trained), and cost effectiveness (impact on reducing HIV and unwanted pregnancy). Financial and programmatic teams were tasked with addressing obstacles to achieving VfM.

RESULTS: In Year 1, the cost drivers were travel, trainings and provider and promotions payments. To proactively address increasing costs, we implemented a modal shift from cars to motorbikes, stream-lined trainings, subsequently reducing per diem and accommodation costs, improved the efficiency of scheduling providers by prioritizing high performers who could provide the full integrated package and implementing a ratio of 1 provider to 6 clients. We also shifted from external to clinic based promoters who increased demand for services and required less in travel subsidies.

From Year 1 to Year 2, there were reductions in efficiency indicators: unit costs of providing CVCT/CFPC (£8.50 to £6.70) and LARC (£23.03 to £6) and unit costs of training an urban CVCT provider (£153.29 to £98.82). The unit cost of averting HIV, a cost-effectiveness indicator also decreased from £344 to £56 in comparison to our proposal estimates. There was a rise in transport cost per month (£5,789.39 to £10,234.37) and unit cost to train a rural CVCT provider (£509.33 to £627.26) but these are largely attributed to bringing providers to our urban training sites from rural areas, which were located increasingly further away as we expanded, and the increase in fuel prices in Zambia.

CONCLUSIONS AND RECOMMENDATIONS: ZEHRP's ability to ensure VfM strengthens the case for integrating services; which improves multiple health outcomes at a comparatively low cost. Due to competing priorities and limited funds within health systems, integrated packages should be pursued.

15:00 – 15:15	Committee Room 4	03.12.2015
THUAE0902:	Track E/9 -	

Successful Integration of Provider Initiated HIV Counselling and Testing at Family Planning Clinics: Experience from Ghana

Kusi Joseph Frempong, Paramedic and Emergency Medical School

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BACKGROUND: Family planning (FP) clinics can be used as an entry point to PMTCT by providing HIV counseling and testing (HCT) services during routine encounters. During the early phases of PMTCT implementation and scale-up in Ghana, integration of PMTCT services in FP clinics was not done. In 2007, ICAP-Columbia University (ICAP-CU) supported the introduction of routine opt-out provider-initiated HIV counseling and testing (PICT) at the FP units in health facilities supported by ICAP in Ghana.

ABSTRACT DRIVEN SESSION

METHODS: In collaboration with Regional Health Bureaus (RHBs), health care workers (HCWs) at FP units were trained on PICT using the national training guidelines and materials. ICAP facilitated creation of space for confidential counseling within the FP clinics, assisted in developing and introducing appropriate forms and registers, and initiating point-of-service HIV testing with same-hour result. ICAP clinical advisers, in collaboration with regional staff, provided periodic supportive supervision to all facilities and on-site clinical mentorship to the HCWs. Women who tested positive were referred to the HIV Care/ and Treatment (ART) clinics. Prevention messages were reinforced for women who tested HIV negative.

RESULTS: From January 2007- March 2011, routine opt-out PITC was successfully implemented at the FP units 75 of 80 ICAP supported facilities. HIV testing was offered to 81,579 FP clients with unknown HIV status and 64,302 (81.6%) accepted testing, of whom 570 (1%) were HIV positive. Clients with a positive result were referred to the HIV Care and Treatment (ART) clinics and enrolled in care and treatment services. Women who tested negative were counseled on HIV prevention.

CONCLUSIONS AND RECOMMENDATIONS: Integrating PICT into FP clinics is feasible and offers sexually active women of reproductive age the opportunity for routine HIV testing. HIV positive women identified in FP clinics will be able to access care and treatment services early in the course of HIV infection.

15:15 – 15:30	Committee Room 4	03.12.2015
THUAE0903:	Track E/9 -	

Monitoring and Evaluating the Integration of Family Planning Services and Methods into Couples Voluntary HIV Counselling and Testing

Malama Kalonde1, Kwesele Change1, Hoagland Alexandra1, Lockard Annie2, Fox Katie2, Sharkey Tyronza2, Parker Rachel3, Tichacek Amanda3, Inambao Mubiana1, Kilembe William2, Allen Susan3

1. Rwanda Zambia HIV Research Group, Ndola, Zambia, 2. Rwanda Zambia HIV Research Group, Lusaka, Zambia, 3. Rwanda Zambia HIV Research Group, Atlanta, United States

BACKGROUND: For over 20 years the Zambia-Emory HIV Research Project (ZEHRP) has provided Couples Voluntary HIV Counselling and Testing (CVCT) as an HIV prevention strategy, endorsed by the WHO. In March 2013, ZEHRP partnered with the Department for International Development (DFID) to scale up CVCT in Government of the Republic of Zambia (GRZ) clinics and provide the additional components of Couples Family Planning Counselling (CFPC) and Long Acting Reversible Contraceptives (LARC i.e intrauterine device (IUD) and implant) for couples desiring to limit fertility.

METHODS: Mutual referral systems were established in family planning and HIV testing services in 53 GRZ clinics in the Copperbelt, Lusaka and Southern provinces of Zambia. The monitoring and evaluation (M&E) tools assign a unique ID to couples accessing CVCT/CFPC services (combined), and a separate ID to women that access LARC in family planning clinic. Integration of CVCT/CFPC/LARC is counted if a woman requesting LARC reports prior CVCT/CFPC with her partner; the couple request a LARC method on the day of CVCT/CFPC; or CVCT clients report current LARC use.

RESULTS: Since November 2014 12,554 women accessed LARC services. Of those 4,474 (36%) reported previous joint HIV testing and family planning counselling with LARC referral with their partner. Of those previously tested, 3,124 (70%) opted for the implant, 267 (6%) chose the IUD and the remaining clients had either an implant (22%) or IUD (2%) removed. Of the 13,314 couples attending CVCT/CFPC services, 1,315 (10%) either indicated that they were current LARC users (20%) or received a LARC method on the day of their CVCT/CFPC visit (80%). A further breakdown of the proportion of clients receiving the integrated package of services (CVCT/CFPC/LARC) on the same day revealed that 91% chose the implant, and 6% IUD, while removals of both the implant and IUD accounted for 3%.

CONCLUSIONS AND RECOMMENDATIONS: Integration of CVCT/CFPC/LARC is possible with mutual referral and promotion of CVCT/CFPC services in family planning clinics and inclusion of CFPC and LARC education during CVCT. An integrated model of sexual and reproductive health provides an opportunity to tackle HIV prevention, unplanned pregnancy and perinatal transmission of HIV. M&E enables tracking of client uptake of integrated services and could help obtain buy-in from GRZ in routinely providing CVCT/CFPC/LARC as a standard of care in all clinics.

Keywords: Integration, CVCT, CFPC, LARC

ABSTRACT DRIVEN SESSION

15:30 – 15:45	Committee Room 4	03.12.2015

THUAE0904: Track E/9 -

Engaging the Private Sector to Increase Access to Sexual Reproductive Health (SRH) Information and Services for Young People in Business Enterprises

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ISSUES: Young people in business lack time to seek reproductive health and rights information, services and supplies because they are young, busy working, and yet have the ability to procure risk using their income. The Sexual Reproductive Health (SRH) issues faced by the young people in business enterprises are aggravated by deeply rooted tabcos around sexuality education with almost no access to appropriate SRH information and services.

DESCRIPTION: The Youth Enterprise Model (YEM) Project implemented by Straight Talk Foundation (STF) in partnership with Reproductive Health Uganda with support from UNFPA was designed on the premise of SRH/family planning integration into policies and programmes for young people in enterprise setting.

The three year project (2012-2015) is implemented in two districts of Mubende and Kampala in Uganda using a 3-Point access model. The project covers 40 youth enterprises, 15 vocational training institutes, 3 financial institutions and five health facilities. Integration of SRH/FP is done through health service delivery that targets youth within their vocational training institutes, enterprise networks and community interaction with financial institutions for financial services. Young people in youth enterprises are also reached through regular SRH integrated service into financial literacy classes, dialogues, debates, radio talk shows, SMS platforms and social media.

Since October 2012, the project has reached at least 63,278 young people. The young people in business are increasingly utilizing all methods of contraception including injectables (2%), orals (2%) and implants (3%). Over 31,140 male condoms and 7447 female condoms have been distributed. A peer educators' network of 338 VTI and youth enterprise peers, 42 VTI instructors and 27 health care workers have been trained on SRH service packages and guidelines and are supported to provide SRH information and services to fellow peers.

LESSONS LEARNT: To effectively engage financial institutions in integration of SRH programs, there is need for constant engagement with leaders of the financial institutions and clear definition of the tangible benefits to the financial institutions and how this will be achieved through the proposed interventions.

NEXT STEPS: Advocacy for integration of SRH issues for young people in business enterprises in Adolescent Health guidelines and entrepreneurship initiatives to create a lasting impact for the youth of Uganda.

15:45 – 16:00	Committee Room 4	03.12.2015

THUAE0905: Track E/9 -

Do Adolescents Equally Utilize ANC and PMTCT Services as Adult Women? Data from Patient Tracking Database in Zimbabwe

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BACKGROUND: HIV has affected men and women disproportionately. Among women, adolescent girls have higher vulnerability. But little is known about comparative access and use of PMTCT services between adolescent and adult women in Zimbabwe. We analyzed longitudinal data to compare adolescent (13 to 19 years) and adult (above 19 years) women's use of ANC/PMTCT

services in Zimbabwe.

METHODS: Data for 5,002 adolescent and 17,238 adult women using ANC/PMTCT services in 2013, collected through a longitudinal electronic patient database implemented in 36 ANC/PMTCT clinics in Zimbabwe, were analysed using Stata. Gestational age at first ANC visit, number of ANC visits and knowledge of HIV status was compared for all the women. HIV positivity rate, CD4 count, WHO staging, uptake of ARVs and ART initiation was compared between HIV-positive adolescent and adult women. Non-research determination was received from the Medical Research Council of Zimbabwe to analyse the data.

RESULTS: Adolescents and adult women had mean age of 17.6 years and 27.3 years respectively. Adolescents were more likely to attend first ANC visit before 14 weeks gestational age (15.6% vs. 12.0%, p< 0.001) and to attend more than four ANC visits (38.8% vs. 36.6%, p=0.005). Adolescents were less likely to have known HIV status (3.0% vs. 11.9%, p< 0.001) at first ANC visit, but more likely to test for HIV compared to adults (90.7% vs. 83.5%, p< 0.001) and to test HIV positive than adults (90.7% vs. 83.5%, p< 0.001). HIV positive adolescents were less likely to book already on ART compared to adult women (44.4% vs. 68.8%, p< 0.001) but equally likely to have CD4 count < = 350 cells/mm3 as adult women (17.0% vs. 20.1%, p=0.153) and less likely to initiate ART than adult women (14.7% vs. 22.8%, p=0.005). All outcomes were independently associated with age-group except first ANC attendance before 14 weeks gestational age (OR=0.99, 95% CI: 0.9, 1.01) which was independently associated with parity.

CONCLUSIONS AND RECOMMENDATIONS: Adolescents have better uptake and retention in ANC than adult women. Adolescents are less likely to be tested for HIV before ANC booking but more likely to test positive and less likely to book already on ART or to be initiated in ANC. We recommend strengthening adolescents' access to sexual and reproductive health education, HIV testing and treatment before and during pregnancy. Further studies are needed to explore reasons for lower uptake of ART among HIV-positive adolescents.

16:00 – 16:15	Committee Room 4	03.12.2015
THUAE0906:	Track E/9 -	

Améliorer du Taux de Rétention des PVVIH sous ARV à 12 Mois dans Deux Régions Sanitaires de la Côte d'Ivoire Grâce à l'Approche LDP+ de Renforcement des Systèmes de Santé

Rose Nguessan

Management Sciences for Health (MSH), Abidjan, Cote D'Ivoire

ISSUES: La Côte d'Ivoire, est l'un des pays les plus touchés de la sous-région Ouest-Africaine avec une prévalence VIH/SIDA de 2.7 (source UNAIDS) chez les 15-49 ans, et le pourcentage d'adultes et d'enfants éligibles pour un traitement antirétroviral et qui y ont accès est de 50,6% (MSLS 2012). La rétention des patients dans le circuit de traitement constitue un défi pour le Ministère de la Santé et de la Lutte contre le Sida et les partenaires qui souhaitent augmenter le taux de rétention des PVVIH sous ARV à 12 mois de 62,4% (données PEPFAR 2013) à 80% d'ici 2015. Le faible taux de rétention est favorisé par des défaillances de leadership, de gestion et de gouvernance au niveau institutionnel empêchant une meilleure prise en charge médicale des plus vulnérables. En 2013, USAID/PEPFAR a financé le projet pilote de Leadership, Management and Gouvernance (LMG) pour appuyer la décentralisation utilisant le Programme de Développement de Leadership Plus (LDP+) pour aider à améliorer la qualité des prestations de services et les indicateurs de santé.

DESCRIPTIONS: Le programme LDP+ est un modèle itératif qui repose sur le travail d'équipe et permet d'atteindre les résultats et d'améliorer les prestations de service en matière de santé. Au total, 11 formateurs et 46 membres des Equipes Cadres de District et des Equipes Régionales de Santé ont participé au programme LDP+ mené par le projet LMG couvrant leadership, gestion et pratiques de bonne gouvernance. Après une année de mise en ;uvre, de bons résultats sont atteints: le taux de rétention des PVVIH sous ARV à 12 mois a augmenté de manière significative de 58% à 79% et de 59% à 81% dans les deux régions.

LESSONS LEARNT: Principaux enseignements: L'adoption de l'approche LDP+ a eu un impact significatif sur taux de rétention des PVVIH sous ARV à 12 mois; Plusieurs programmes nationaux de santé désirent utiliser le LDP+ pour améliorer leurs indicateurs clefs ; L'engouement que le LDP+ a suscité au niveau central est en train de favoriser son adoption par d'autres partenaires qui le disséminеront dans d'autres régions sanitaires.

NEXT STEPS: Poursuivre l'utilisation du modèle expérimental et l'extension du programme LDP+ dans les hôpitaux de références et les Etablissements Sanitaires de Premier Contact et étendre ce modèle sur l'ensemble du territoire avec les partenaires au développement comme le Fonds Mondial, l'USAID et la Banque Mondiale.

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Committee Room 6	03.12.2015

THUAC1201: Track C/12 - PM TCT: effectiveness, trends and retention

Chairs: Joyce Mphaya, Zimbabwe

Trends in HIV Prevalence among Pregnant Women in Zimbabwe, 2002-2012

16:45 – 17:00

Dzangare Janet1, Mhangara Mutsa1, Gonese Elizabeth2, Mungati More3, Nyakura Justice1, Mugurungi Owen1, Shambira Gerald4, Tshimanga Mufuta4

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BACKGROUND: HIV prevalence data from Antenatal Care Clinics (ANC) is frequently utilized to monitor the trend of an HIV epidemic among in pregnant women and as an input into HIV estimate calculation in a generalised epidemic. The objective was to determine the trend of HIV prevalence among pregnant women attending sentinel ANC sites in Zimbabwe from 2002 to 2012.

METHODS: Cross-sectional ANC surveillance studies conducted in 2002, 2004, 2006, 2009 and 2012 were analysed to determine the prevalence of HIV among pregnant women attending ANC. Trends in median HIV prevalence were estimated using a mixed effects logistic regression model, where random effects were specified on the intercept and slope to account for clustering among pregnant women in ANC.

RESULTS: The HIV prevalence among pregnant women aged 15-49 years significantly declined from 25.7% (95% C.I: 24.7 - 26.7) in 2002 to 15.9% (95%C.I: 15.0 - 16.9) in 2012. A similar trend was observed in the 15-24 age-group where HIV prevalence significantly declined from 20.8% (95%: C.I 19.8 - 21.8) in 2002 to 9.9 (95% C.I:8.02 - 12.0) in 2012.

CONCLUSIONS AND RECOMMENDATIONS: A significant decline in HIV prevalence among pregnant women was observed during this ten year period in Zimbabwe. The decline among women aged 15-24 years represents decline in the epidemic as this age group act as a proxy for incidence. There is need to continue strengthening the current preventive efforts to sustain the reduction in new HIV infections.

17:00 – 17:15	Committee Room 6	03.12.2015

THUAC1202: Track C/12 -

Measuring the Effectiveness of Selected PMTCT Interventions in Reducing New Paediatric HIV Infections in South Africa

Ganyaupfu Elvis Munyaradzi

John Snow, Incorporated, Data Quality, Pretoria, South Africa

BACKGROUND: Prevention of mother-to-child transmission (PMTCT) of HIV is an essential intervention to eliminate new HIV infections among children. Since transmission can occur during pre and post natal phases, PMTCT must begin during early pregnancy. Against this background, the objective of this study was to measure the effectiveness of PMTCT interventions in reducing new paediatric HIV infections in South Africa during the period 2010 to 2013.

METHODS: PMTCT programme district-level panel data from 52 districts in all the 9 provinces for the period 2010 to 2013 were extracted from the Health Systems Trust (HST) District Health Barometer (DHB, 2013/14) data file. The infant 1st polymerase chain reaction (PCR) test positive around 6 weeks rate was used as the outcome variable; while antenatal (ANC) 1st visit before 20 weeks rate, antenatal client initiated on antiretroviral therapy (ART) rate and couple year protection rate were used as covariates in the model. Based on the longitudinal linear model selection procedure, the Pooled Ordinary Least Squares (OLS) technique was applied to estimate the relative impacts of the distinct PMTCT interventions on infant 1st PCR test positivity around 6 weeks.

RESULTS: Based on the computed R-squared, approximately 4% reduction in infant 1st PCR test positivity around 6 weeks during the period 2010 to 2013 was overall accounted for by antenatal 1st visits before 20 weeks, antenatal client initiations on ART and couple year protection rates.

The F(3, 204) statistic (= 7.31; $p < 0.05$) confirms significance of the model. Empirical estimates provide evidence that improvements in the ANC 1st visit before 20 weeks rate had a statistically significant effect of reducing infant PCR positivity around 6 weeks by nearly 0.06 percentage points. Though antenatal client initiation on ART demonstrates evidence of reducing infant HIV infection around 6 weeks, its distinct effect was not statistically significant. From the reproductive health side, couple year protection also had a negative but statistically insignificant effect of reducing infant HIV infection at 5% level.

CONCLUSIONS AND RECOMMENDATIONS: PMTCT interventions indeed reduce transmission of HIV if consistently managed effectively. Nonetheless, the insignificant contribution made by antenatal client initiation on ART in reducing infant HIV infection around 6 weeks suggests the need for considerable improvement in initiation of antenatal clients eligible for ART.

17:15 – 17:30	Committee Room 6	03.12.2015
THUAC1203:	Track C/12 -	

Preliminary Outcomes of the PMTCT Option B+ Programme in Thyolo, Malawi

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BACKGROUND: In July 2011, the Malawi government adopted PMTCT Option B+ as national policy to prevent mother-to-child HIV transmission.

Objective: To determine preliminary outcomes of the PMTCT Option B+ programme in Thyolo District, Malawi.

METHODS: We carried-out a prospective cohort evaluation of women who enrolled in the programme at six health facilities between April 2012 and June 2014, and their infants. Clinical and laboratory records of mothers and their infants were entered into a linked database. The study will end in December 2015. We assessed preliminary outcomes to May 2015.

RESULTS: Of 1,858 women enrolled, 1,574 (84.7%) were pregnant at enrolment. 94.1% had ≥1 ART refill visit, and retention-in-care was 81.3% at 12 months. Of those pregnant at enrolment, 70.0% had a live birth, 0.4% had a miscarriage, 0.3% had a stillbirth, and 29.2% had an unknown pregnancy outcome. 1,128 infants were enrolled in the infant cohort. Of these infants, 15 (1.3%) became infected with HIV, and 104 (9.2%) were discharged uninfected at 24 months. The median time to the first PCR test was 7.6 weeks, and 69.7% of infants were tested by 13 weeks. Of 1,002 PCR tests performed before January 2015, 10.5% of results had not been reported by May 2015.

CONCLUSIONS AND RECOMMENDATIONS: In order to optimize the effectiveness of the PMTCT B+ programme, programmatic interventions are needed to improve retention-in-care among mothers; to improve compliance with the national policy of testing HIV-exposed infants at 6 weeks; and to improve integration of care for mothers and infants.

17:30 – 17:45	Committee Room 6	03.12.2015
THUAC1204:	Track C/12 -	

Cascade of Prevention of Mother-to-Child Transmission of HIV (PMTCT) for Option B+ Transition: Findings from a Cohort of a Nationally Representative Mother-infant Pairs, Zimbabwe, 2013-2014

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BACKGROUND: Zimbabwe was transitioning from PMTCT/Option A to Option B+. We reconstructed a PMTCT cascade from antenatal care (ANC) to 18 months post-delivery to identify bottleneck during the transition.

METHODS: Between February and August 2013, we recruited a nationally representative sample of infants aged 4-12 weeks and their caregivers attending 151 randomly selected immunization clinics using a stratified multi-stage sampling design. Data collection included caregiver interviews, medical-record reviews, and infant Dried-Blood-Spot (iDBS) collected for HIV testing. We defined an HIV-exposed infant (HEI) if the mother's HIV-positive status was documented on the child's health-card and reported being HIV-positive by the mother; or if the iDBS was reactive with an HIV-antibody test. HEI and mothers were evaluated prospectively at baseline, age six months, then every third month through age 18 months. We analyzed data collected from mother-infant pairs and adjusted estimates for the study design, and non-response.

RESULTS: Of 6051 caregiver-infant pairs, 99.7% mothers completed interviews, and 94.4% infants were tested for HIV at baseline. Of mothers, 94.4% (95% Confidence Interval (CI): 93.6-96.7) reported having zone ANC visit (median 3.6; range 1-20); 96.6% (95% CI: 96.1-97.1) reported being tested for HIV, excluding those who knew they were HIV-positive before pregnancy. An estimated 20.3% (95% CI: 19.3-21.3) of infants were HIV-exposed [8.3% (95% CI: 7.6-9.0) born to mothers with known HIV-positive status before pregnancy; 7.7% (95% CI: 7.0-8.3) self-reported being HIV-positive and 3.5% (95% CI: 3.0-4.0) seroconversion among self-reported being HIV-negative antenatally]. Of HEI, 49.6% (95% CI: 46.7-52.4) of the mothers received antiretroviral treatment (ART), 34.6% (95% CI: 31.8-37.3) of AZT, and 15.8% (95% CI: 13.8-18.0) received no antiretroviral drug (ARV) during pregnancy. During 18 months post-delivery, 24.1% (95% CI: 21.5-27.5) of mothers were newly initiated ART and 26.3% (95% CI: 23.8-28.8) was not on any ARV, 30.6% (95% CI: 25.2-36.7) of HEI was initiated Contrimoxazole by 6 weeks, and 16.3% (95% CI: 12.9-19.5) of HEI was not provide any Cotrimoxazole.

Conclusion: High risk of HIV seroconversion antenatally, and low coverage of ART at 18 months post-delivery, and six-weeks cotrimoxazole initiation were identified during the transition. Impact of these bottlenecks on MTCT rates should be further investigated.

17:45 – 18:00	Committee Room 6	03.12.2015

THUAC1205: Track C/12 -

Accelerating Pediatric HIV Case-finding in Routine Health Care Settings: Lessons Learnt and Challenges in Togo, 2012-2014

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ISSUES: Despite increasing access to ART in general population, pediatric ART coverage remains low in Togo. Only 14% of 12,373 children in need of ART were receiving it in 2011. Limited access to pediatric HIV testing was identified as a major barrier to uptake of pediatric HIV treatment.

DESCRIPTION: HIV case finding among children in Togo was primarily based on voluntary and diagnostic testing approach until end of 2009. Early infant diagnosis (EID) was introduced in PMTCT clinics in 2010. But given the low uptake of pediatric HIV treatment, the National AIDS programme with support from partners designed in 2011 a comprehensive approach to address the bottlenecks for pediatric HIV testing and linkages to treatment in Togo. The approach combines scaling up early infant diagnosis, integration of HIV testing in routine child health care, and promotion of a family-centered approach to HIV testing. Key interventions included: review of national guidelines on HIV testing; development of training materials, and capacity building for the health system. To address bottlenecks related to turnaround time of EID results, a partnership was established with the national postal services corporation for dried blood samples and EID results transport. A referral system was designed to facilitate linkages of cases of HIV+ children to ART clinics.

LESSONS LEARNT: The implementation of the approach was first piloted between 2012 and 2014 in 19 health facilities. Within three years, the number of children < 15 who received an HIV testing reached 22,656 (against 7,373 reported in 2012): 8,203 children were tested in MCH/PMTCT clinics; 14,432 in pediatric ward, and 21 in TB clinics. Regarding HIV+ cases identified, 577

(34%) were found in MCH/PMTCT clinics; 1099 (65%) in pediatric ward and 4 (0.2%) in TB clinics. The number of children in need receiving ART progressed from 2098 to 2861 between 2012 and 2014. The major challenge faced was staff adherence to the intervention, regarding concerns about over workload. We learnt that case-finding for HIV+ children can be very effective with good collaboration between child care provider and devolution of HIV testing to front line nurses and midwives.

NEXT STEPS: We plan to roll-out the intervention to cover all regional and district hospitals; improve linkages of pediatric ART with adult HIV programme; revise routine data collection tools to integrate HIV testing data; and strengthen coordination at operational level.

18:00 – 18:15	Committee Room 6	03.12.2015
THUAC1206:	Track C/12 -	

Retention and Virological Outcomes from a PMTCT Programme in Rural Zimbabwe 2013-2015

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BACKGROUND: The WHO 2013 consolidated ART guidelines recommend that all HIV-infected pregnant and breastfeeding women take ART to prevent mother-to-child transmission (PMTCT). This recommendation was implemented in Gutu province in Zimbabwe from July 2013. Previous reports from other resource poor settings have highlighted the challenge of retention and adherence for women in PMTCT programmes.

Objectives: This analysis aimed to determine the retention rates and virological outcomes of women enrolled in the PMTCT programme in Gutu district Zimbabwe and to identify potential risk factors for lost to follow up.

METHODS: Information was extracted from the electronic cohort data and viral load laboratory records of pregnant or breast feeding women newly enrolled in the PMTCT programme from August 2013 until July 2015. Data was analysed to determine retention rates and virological outcomes. Binary logistic regression was used to determine factors associated with lost to follow up.

RESULTS: 541 women were included in the analysis. Median age was 27 with the majority 398 (74%) enrolled whilst pregnant. 10.5% of women did not return after the day of initiation. Retention was 78.3%, 67.1% and 59.4% and 83.6%,79.1% and 71.2% at 3,6 and 12 months for those initiated whilst pregnant and breastfeeding respectively. Loss to follow up was significantly higher in women aged 15-24 (OR 2.5; 95% CI: 1.3-4.9; p =0.007) compared to those aged 35-45. Facilities with higher numbers of patients on ART had higher rates of loss to follow up, though this was not significant. 248 (60.6%) of active patients received a viral load at 3 months on ART according to the local protocol and 90.7% supressed to < 1000 copies/ml.

CONCLUSIONS AND RECOMMENDATIONS: High rates of loss to follow up in PMTCT programmes remain a significant problem. Adequate investment in counselling at ART initiation and at key transition points such as post-delivery and after the first negative HIV result of the infant must be strengthened particularly for adolescents and young adults. For those retained but who do not achieve virological suppression, strategies to ensure adequate protection of the infant should be considered. Future regimens including drugs such as dolutegravir that achieve virological suppression earlier should also be considered in PMTCT.

ABSTRACT DRIVEN SESSION

16:45 – 18:15	Committee Room 4	03.12.2015
THUAB0601:	Track B/6 - From first line to functional cure	

First Role out of Universal Access to Antiretroviral Therapy under Routine Program Conditions in Rural Swaziland 16:45 – 17:00

Kerschberger Bernhard1, Mazibuko Sikhathele2, Zabsonre Inoussa1, Win May Myat1, Teck Roger3,4, Kabore Serge1, Ndlangamandla Mpumelelo1, Etoori David1, Ciglenecki Iza3

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BACKGROUND: Universal access to antiretroviral therapy (ART) has a dual benefit: it reduces the risk of HIV transmission by lowering viral load (VL), and improves the individual's health as demonstrated in clinical trials. Access to ART is rapidly increasing in Sub-Saharan Africa. Currently applied criteria for ART initiation, however, are still based on a CD4 threshold of 350 or 500. Here we report on the first experience of roll-out of universal access to ART within the public health system in southern Swaziland.

METHODS: All health facilities (n=9) in the rural Nhlangano health zone (Swaziland) adapted the universal treatment approach in October 2014. Immediate ART initiation irrespective of immunological criteria (CD4 count level/WHO staging) was offered to all clients ≥16 years of age and newly enrolled into HIV care. We used Kaplan-Meier methods to describe the three month probability of ART initiation, and the Cox proportional hazard model to assess predictors of ART initiation. We also assessed the pre-treatment baseline VL.

RESULTS: A total of 630 HIV+ clients enrolled in HIV care between 20/10/2014 and 15/05/2015. The median age was 29.5 (IQR 24-36) years, 74% were females of which 35% (n=162) were pregnant. 57% had a CD4< 350, 19% a CD4 350-499, 19% a CD4≥500 and 4% missing baseline CD4. Overall, 52 patients in the CD4≥500 group had a pre-treatment VL done, of which 27% had a VL between 1,000-9,999 and 31% ≥10,000 copies/ml. In total, 534 clients initiated ART and median time to ART was 7 (IQR 0-11) days. The 3 month ART uptake was 86% (95%CI 83-89) and was similar across CD4 strata (CD4< 350: 89%, 95%CI 85-92; CD4 350-499: 92%, 95%CI 85-96; CD4≥500: 82%, 95%CI 73-88; p=0.28). It was highest among pregnant females (96%, 95%CI 92-98; p< 0.01), and similar between non-pregnant females (82%, 95%CI 77-87) and males (86%, 95%CI 79-91) (p=0.91). In multivariate analysis, only being pregnant was associated with increased probability of ART initiation (aHR 1.88, 95%CI 1.54-2.30; p< 0.01).

CONCLUSIONS AND RECOMMENDATIONS: Early outcomes of the universal access to ART pilot project in a government health setting show high ART initiation rates across all CD4 levels. It also shows the importance of early ART initiation for HIV transmission reduction in clients with high CD4 as they have high pre-treatment viral loads. These findings should inform the next WHO guidelines on feasibility of ART initiation at CD4≥500 in resource constrained settings.

17:00 – 17:15	Committee Room 4	03.12.2015
THUAB0602:	Track B/6 -	

Is AZT/3TC/NVP Still the Best Choice? Clinical Outcomes of Antiretroviral Therapy in Ugandan Client Cohort

Gonzalez Perez Juan, Buzaalirwa Lydia, Ssamula Kate, Ikapule Jonathan, Ssali John, Lubanga Augustine, Ssemakadde Matthew, Babakhani Arin, Iutung Amor Penninah

AIDS Healthcare Foundation, Kampala, Uganda

BACKGROUND: Several studies have found that Tenofovir-containing regimens (TDF-CR) are associated with less drug substitution and better tolerance when compared with Zidovudine (AZT)-containing regimens. However, results on mortality and retention are conflicting, with some observational studies suggesting that AZT+Lamivudine(3TC)+Nevirapine (NVP) could be associated with better outcomes.

METHODS: Mortality and retention in adult patients initiated on antiretroviral therapy (ART)

between February 2002 and May 2015 in five facilities in Uganda were compared. To perform a "predominant exposure" analysis, only patients on a single regimen for at least 75% of the clinical appointments during the first year on treatment were included. Risk of death and attrition for every ART regimen was estimated using Cox proportional-hazards model. All analyses were adjusted for CD4 count, WHO stage, weight, age, sex, year of ART initiation and health facility. To reduce confounding by indication, a secondary analysis excluded patients initiated on Tuberculosis (TB) treatment or with severe anemia during the first year on ART.

RESULTS: 13,868 patients were included in the study. 60% were women with a median age of 32 years and a median CD4 baseline of 257 cells. 48% of patients were started on TDF+3TC+EFV, 25% on AZT+3TC+NVP and 17% on TDF+3TC+NVP. During 25,271 person-years follow up, there were 387 deaths and 1,400 lost to follow up. When compared with AZT+3TC+NVP, TDF-CR were associated to higher mortality (aHR:1.86, 95% CI 1.34-2.58 for TDF+3TC+EFV and aHR:2.69 for TDF+3TC+NVP) and attrition (aHR:1.41 in both cases, 95% CI 1.23-1.62 for TDF+3TC+EFV) after one year on treatment ($p< 0.001$ in all cases). After excluding patients on TB treatment (n=870) or with severe anemia (n=234), association continued to be statistically significant.

CONCLUSIONS: A strong association was found between receiving AZT+3TC+NVP during the first year of ART and better survival and retention compared with TDF-CR. Inferiority of TDF+3TC+NVP has been suggested in comparative studies before. For TDF+3TC+EFV, we hypothesized that in contexts like the one in our study, with limited access to investigations and reduced capacity to rule out opportunistic infections (OI), the increased potency of TDF+3TC+EFV to suppress viral replication (and therefore to cause more severe immune-reconstitution inflammatory syndrome (IRIS) in those with undetected OIs) could be one factor to explain its negative performance.

17:15 – 17:30	Committee Room 4	03.12.2015
THUAB0603:	Track B/6 -	

Comparison of Three Second Line Antiretroviral Regimens in Sub-Saharan Africa: 24-month Results of the 2LADY Clinical Trial

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BACKGROUND: Protease Inhibitors (PI) based second line antiretroviral treatment (ART) after failure of Non-nucleoside retro transcriptase inhibitors (NNRTI) first line has been proven effective in three randomised clinical trials, confirming WHO choice. Data on long-term outcomes are scanty but important for the choice of the best regimen.

METHODS: A 48-week randomized, open label, non-inferiority trial was conducted in 3 African countrie (Cameroon-Burkina Faso-Senegal), comparing efficacy and safety of 3 second line regimens:

Reference arm: tenofovir (TDF)/emtricitabine (FTC) + lopinavir/ritonavir (LPV/r)

ABC/ddI arm: abacavir (ABC) + didanosine (ddI) + LPV/r,

DRV arm: TDF/FTC + darunavir/ritonavir (DRV/r).

Patients were eligible if above 18 years, failed a first line NNRTI based ART (confirmed HIV-1 RNA≥1 000 copies/mL), showed good adherence (≥80%) and signed informed consent. Patient follow up was continued after the principal endpoint up to 24 months (M24). We report the results at M24. Efficacy was analyzed in both modified intention-to-treat (mITT) and per protocol (PP) populations. Non-inferiority was defined with a margin of 15%.

RESULTS: 454 patients were randomised between 2010 and 2012. Participants were mainly women (72%), with median ART duration of 49 months (IQR 33- 69), had a median CD4 count of 183 cell/mm3 (IQR 87 - 290) and a median plasma HIV-1 RNA (VL) of 4.5 log10 (IQR 4 - 5.1). Resistances to 2 classes of ARV were present in 95% of participants .At M24, 426 were still on follow up and analysed (11 deaths, 14 lost to follow up and 3 excluded from analysis). In the mITT analysis, 275(61.0%), 346(76.7%) and 374(82.9%) participants had a VL below 50, 200 and 1,000 copies/mL respectively. The mITT analyses showed differences of 10.6% (IC95% -0.4; 21.7) and 2.1% (IC95% -8.6; 12.9) between the reference arm and the ABC/ddI arm and the reference and DRV arm

respectively. Non inferiority of DRV/r regimen was demonstrated in mITT and PP analysis, but not for the ABC/ddI plus LPV/r combination, showing a significantly higher number of interruptions. To note that of the 122 participants with VL≥ 100.000 copies/mL at baseline only 39.3% had a VL < 50 copies at M24; with the worst results in the DRV group

CONCLUSIONS: Second line ART as proposed by WHO remains effective at 24 months. The combination TDF/FTC(3TC) + LPV/r seems the best choice among the tested regimens considering toxicity and efficacy in patients with high VL at failure.

17:30 – 17:45	Committee Room 4	03.12.2015
THUAB0604:	Track B/6 -	

Better Retention Rates Observed in Patients on Boosted Lopinavir than Boosted Atazanavir in Uganda

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BACKGROUND: Long-term retention of patients on 2nd line therapy in Africa´s rapidly expanding ART programs is essential for their success but has received relatively little attention. Limited access to third line ART makes patients who fail 2nd line in our context to have limited options for salvage therapy or 3rd line ART. This multicenter study reviews long term survival and retention of patients on 2nd line ART in Uganda.

METHODS: The study included patients initiated on 2nd line regimen due to treatment failure between January 2004 and December 2013 in 10 clinics supported by AIDS Healthcare Foundation in Uganda. Data analysis was done in STATA SE 13.1. Survival analysis was done using Kaplan Meier curves. Predictors of retention on a second line regimen were identified using a Cox regression model.

RESULTS: 710 patients (54% female) on 2nd line ART were included in the study. 99 (15%) died and 34 (5%) were lost to follow up. 587 (84%) Patients were initiated on a boosted LPV/r based regimen and 114 (16%) on a boosted ATV/r based regimen. The probability of retention on LPV/r based regimen was 0.92 [95% CI: 0.89-0.94] and 0.91 [95% CI: 0.81-0.95] for ATV/r based regimen at 12 months and 0.72 [95% CI: 0.67- 0.77) for LPV/r based regimen and 0.60 [95% CI: 0.44-0.73] in ATV/r based regimen at 84 months. The probability of survival in patients >46 years was 0.23 [95% CI: 0.18-0.61,

P = < 0.001]. Patients with immunological failure as a reason for switching to 2nd line had a higher probability of attrition [RR, 9.23; 95% CI: 5.21-16.4, P=< 0.001]. The adjusted rate ratio of attrition for patients who initiated on ATV/r based regimen compared to those who were initiated on LPV/r based regimen was 3.39 [95% CI: 2.02-5.68; P = < 0.001].

Conclusion: Age 45 and above and use of LPV/r based regimen were found to be predictors of retention on 2nd line while immunological failure as a reason for switching to 2nd line was associated with higher attrition. In our study retention on antiretroviral treatment was significantly better in patients taking a LPV/r containing regimen compared with ATV/r, even though both Protease Inhibitors are currently recommended for second line treatment. Further studies are needed to confirm these findings.

17:45 – 18:00	Committee Room 4	03.12.2015
THUAB0605:	Track B/6 -	

Echec Virologique et Accumulation de Résistances chez des Patients sous Traitement Antirétroviral Depuis au Moins 4 Ans au Togo

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ABSTRACT DRIVEN SESSION

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CONTEXTE: En 2008, la gratuité des antirétroviraux (ARVs) au Togo a permis d'accroître le nombre de personnes vivant avec le VIH (PvVIH) mises sous traitement (TAR). En 2012, les tests de charge virale (CV) ont été disponibles dans le pays, et le programme national de lutte contre le SIDA a offert en priorité aux patients sous ARVs depuis au moins 48 mois un bilan de CV. Ce travail documente la résistance aux ARVs chez les PvVIH sous TAR depuis au moins 48 mois.

Méthodes: Cette étude transversale a été réalisée en 2012. La quantification de la CV (ABBOTT m2000) a été faite à Lomé. Les échantillons de plasma des patients en échec virologique (CV>1000 copies/ml) ont été génotypés selon le protocole de l'ANRS au laboratoire accrédité OMS de l'IRD à Montpellier (France).

Résultats: En 2012, 867 PvVIH ont été recrutées dans 5 régions sanitaires du Togo. La population d'étude comprenait 69,4%(602/867) de femmes. La durée médiane de traitement était de 6 ans (IQR 5-7). Parmi eux 767(88,5%) étaient en première ligne (2INTI+1INNTI) et 100(11.5%) sous un régime à base d'IP (2INTI+1IP) dont 11 en première intention et 89 en deuxième ligne. Le taux d'échec virologique global était de 39,6%(343/867), et de 42.2%(324/767) et 19%(19/100) respectivement chez les patients sous schéma classique et pour ceux sous IP. Parmi les échecs virologiques, 45,7% des patients sous première ligne ont une charge virale de 4log contre 21,1% de ceux sous IP. 173/343(50.4%) prélèvements ont été génotypés, dont 9(5,2%) de patients sous IP. 18,5%(161/867) des patients avaient une CV détectable< 1000 copies/ml.

Chez les patients sous IP 4/7 étaient porteurs de résistances. Chez les autres, 163/164 portaient au moins une mutation de résistance et 161/163(98,8%) étaient résistants aux 2 classes INTI/INNTI. De plus 71%(115/163) avaient au moins une Thymidin Analog Mutation (TAM). Les TAM s'accumulaient progressivement chez 66,2%, 88,7% et 100% des patients qui avaient respectivement 4, 5 et 6 log de CV. 93,9% et 98,2% étaient respectivement résistants à l'éfavirenz ou à la névirapine. Les principales mutations sont M184V (99,4%), Y181CY (37,4%) et K103N (34,4%). Le taux de résistance croisée était de 21,3% et 64% respectivement pour l'étravirine et la rilpivirine.

Conclusions et Recommendations: Cette étude démontre l'urgence d'une meilleure surveillance de l'efficacité du TAR au Togo, pour améliorer la prise en charge des patients et pour diminuer le risque de transmission.

18:00 – 18:15	Committee Room 4	03.12.2015
THUAB0606:	Track B/6 -	

A Dose Escalation Study of Cyclophosphamide (CTX) to Enhance SB-728-T Engraftment

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BACKGROUND: CCR5-modified autologous CD4 cells (SB-728-T) are safe and increase total CD4 counts. The cells traffic to lymphoid tissues and have a selective survival advantage during ART treatment interruption (TI). Additional studies in CCR5 ;32 heterozygote HIV subjects showed VL reductions during TI correlated with circulating bi-allelic CCR5-modified CD4 cells supporting the importance of maximizing engraftment. Low dose CTX has been successfully used to increase T cell engraftment. This study examines the effect of escalating doses of CTX on SB-728-T engraftment.

METHODS: A dose escalation study of IV CTX, with doses ranging from 100 mg/m2 to 2 g/m2 (n=3-6/cohort), administered 1-3 days prior to SB-728-T (>90% CD4, < 1% CD8) infusion was performed in 18 aviremic, ART treated HIV subjects with CD4 Tcells ≥500/uL.

RESULTS: CTX was well-tolerated with low grade GI side-effects, managed with anti-emetics at doses up to 1g/m2. Grade 3/4 neutropenia requiring G-CSF developed at 1.5 and 2.0g/m2 CTX. On Day 7, a dose-related increase in CD4 count and engraftment of bi-allelic CCR5-modified cells

was observed with CTX doses up to 1g/m2 but did not increase at 2.0 and 1.5g/m2. By comparison, there was a progressive decline in CD8 cells with CTX dose escalation. Data iwill be presented and is expressed as Mean;SE.

A VL reduction from peak to < 10,000 copies/mL was seen in 4/15 subject with one subject experiencing a VL nadir to < 1000 copies/mL. At the conclusion of the study, 3 additional subjects were conditioned with 1g/m2 of CTX and administered CCR5-modified T cells containing 46.9;6.4% CD8 cells. CD8 count increased by 2236;967/uL (range 1029-4150/uL) with only modest increases in CD4 counts (733;233/uL; range 297-1096/uL) at 7 days in the 3 subjects. Two of the three subjects have had decreases in VL nadir to date during TI (< 1000 copies/mL), suggesting an effect on viral control with the added CD8 T cells.

CONCLUSIONS AND RECOMMENDATIONS: CTX conditioning is generally well-tolerated and was associated with increased engraftment of CCR5-modified T cells at doses up to 1 g/m2 in HIV subjects. CTX conditioning may be a useful strategy to maximize the engraftment and anti-viral effects of SB-728-T. The effects of co-administering CD8 cells with SB-728-T on VL will be presented.

16:45 – 18:15	Prof Soudré Room	03.12.2015

THUAD1201: Track D/12 - Gender based violence and intimate partner violence

Chairs: Caroline Nyamayemombe, South Africa

Sexual and Gender Based Violence: Are Schools Safe Spaces in Southern Africa?

16:45 - 17:00

Kisaakye Victoria Kanobe1, Machawira Patricia1, Cornu Christophe2, Yong Feng Liu2

1UNESCO, Education, Johannesburg, South Africa, 2UNESCO, Paris, France

BACKGROUND: In Southern Africa many young people are exposed to violence in and around educational settings which undermines their right to quality education in a safe environment. This violence takes on many forms ranging from sexual harassment and gender based-violence; physical and psychological punishment and bullying. A recent study from Zambia reveals that 39% of school girls and 36% of school boys aged between 10 and 24 years report having been abused or harassed at school in the past year (UNESCO 2015). In Tanzania, 15.1% of young girls aged 13-24 years reported experiencing sexual violence at school while 23% reported experiencing sexual violence on the way to and from school. This violence takes place in spaces such as empty classrooms, school toilets where girls are harassed in the staff rooms, the fieldsand the gates of the schools. The consequences of SRGBV include health (e.g. acquiring STIs, HIV infection, and unintended pregnancy amongst others); psychological impacts and school dropouts among others.

METHODS: UNESCO commissioned a regional study in five countries in Southern Africa (Botswana, Lesotho, Namibia, South Africa and Swaziland) on Gender, Violence and Diversity in schools from June 2014 to July 2015. The study aimed at collecting data on the nature, extent and consequences of school related gender-based violence and the extent to which the education sector is addressing the problem. Quantitative and qualitative data collection methods targeting 2000 - grade 9 and 11 learners) in 50 schools, 900 teachers and 50 MOE officials. Other respondents included parents, victims of violence that had dropped out of school, government officials, social workers and NGOs.

RESULTS: The findings reveal that the prevalence of school related gender based violence is as high as 79% in some countries with older boys mainly as the perpetrators. The predominant types are physical and verbal violence (71%-85%). Sexual violence is reported at 25% in some countries. All study countries did not have specific school policies that address SRGBV and curricula are weak to address the issue. The existing national frameworks and support systems for victims are not fully utilised or reinforced due to stigma, fear and/ or lack of awareness.

CONCLUSIONS AND RECOMMENDATIONS: There is the need to develop education policies/ frameworks that are communicated and enforced to promote principles of peace, equality, tolerance and social cohesion.

ABSTRACT DRIVEN SESSION

17:00 - 17:15	Prof Soudré Room	03.12.2015
THUAD1202:	Track D/12 -	

Implementing Nigeria's Plan of Action on GBV & HIV/AIDS Intersection

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ISSUES: From the analysis of the prevalence trend from NARHS 2007 and 2012, the epidemic in Nigeria is feminized. The HIV prevalence for females in 2007 and 2012 was 4.0% and 3.5%, and a leveling of prevalence for men from 3.2% to 3.3%. The burden is higher for women than men across all age groups except 35-39 years and 40-44 years age groups in 2012. The intersection between HIV and gender-based violence (GBV) has been analyzed in different studies and GBV is identified as a key driver of HIV infection among women and girls. Men who have sex with men; transgender people; and men, women and transgender sex workers are at greater risk of GBV due to well pronounced stigma and discrimination, coupled with legislations that criminalize homosexuality and sex work (UNDP, 2013).

DESCRIPTIONS: The National HIV/AIDS and gender policy documents recognize the need to intervene in this critical area but no coherent strategy or plan existed to address gender-based violence and HIV/AIDS intersections. In 2014, the UNDP, UN Women and USG supported the Federal Ministry of Women Affairs and NACA to develop a National Plan of Action on GBV/HIV Intersections. The action plan is based on needs assessment from the national mapping exercise and experts' opinion derived from national technical and consensus meetings. The three year plan (2015-2017) addresses: enabling environment, community participation, partnership and collaboration, services, and human resources capacity development, monitoring, evaluation, and research.

LESSONS LEARNT: With the unsuccessful efforts of stakeholders in the struggle for more than a decade to push for the promulgation of Violence against Persons Prohibition law in Nigeria, developing a national plan for GBV/HIV was hitherto seen as not easily realizable. The lessons learnt from this intervention is that with persistence and sustained advocacy, national consensus is possible in addressing even the most sensitive national issue. It gives hope that someday, some of the punitive criminalizing legislations against most at risk populations will be reversed.

NEXT STEPS: It is hoped that the current efforts of the Federal Ministry of Women Affairs and NACA to support the states through advocacy, technical backstopping, training and Orientation of Desk Officers on the implementation of National Plan of Action will result in increased resource allocation and improved capacity for implementation across the 36 states.

17:15 - 17:30	Prof Soudré Room	03.12.2015
THUAD1203:	Track D/12 -	

Confronting Violence and Discrimination against Men who Have Sex with Men (MSM) and Female Sex Workers (FSW) in Mali

Sidibé Garangué1, Clinton Trout2

1Soutoura, Bamako, Mali, 2Boston University School of Public Health, Center for Global Health and Development, Chino, United States

ISSUES: While neither homosexuality nor sex work are illegal in Mali, MSM and FSW report widespread stigma, rejection, discrimination, violent attacks and the inability to access justice. However, Mali has adopted the UNAIDS objective of Zero Discrimination and the 2013-2017 National Strategic Plan against AIDS includes reduction of discrimination and violence against key populations as a goal.

DESCRIPTION: The non-governmental organization Soutoura piloted a program funded by USAID to document and respond to violence and discrimination against MSM and FSW. Staffs were trained to document cases using a form developed by the National Committee for HIV Prevention for Key Populations.

Forty-Seven (47) cases of violence and discrimination were documented in 2014 (39 against

MSM and 8 against FSW). Perpetrators included the general population, particularly groups of youth (26 cases), police (14 cases: 3 against FSW and 11 against MSM) and families (7 cases: 4 against FSW and 3 against MSM).

Cases of violence against MSM included verbal insults (17), battery (11), arbitrary arrests (7), attempts to sodomize the MSM with foreign objects (4), expulsion from family homes (3), loss of employment (3) and destruction of a business (1). Documented cases of violations against FSW included battery (3), gang rape (3), expulsion from the family (1) and destruction of possessions. MSM peer educators reported being insulted and attempts to seize their prevention materials.

In addition to medical and psychosocial support to victims, field staff (physicians and MSM/FSW peer educators) intervened successfully with perpetrators, including reintegrating the 3 MSM expelled from their homes, calming agitated groups of youth, and advocating with a religious leader and a radio personality who then stopped inciting violence.

LESSONS LEARNT: MSM and FSW in Mali are at high risk of physical and sexual violence and stigma and discrimination, which contributes to their extreme vulnerability. However, interventions by respected community members with perpetrators can be effective to deescalate these situations and promote tolerance.

NEXT STEPS: HIV prevention programs should include interventions to address key populations' structural/environmental vulnerability to HIV such as violence and discrimination.

Keywords: Mali, Female Sex Workers, Men who have Sex with Men, Human Rights

17:30 - 17:45	Prof Soudré Room	03.12.2015
THUAD1204:	Track D/12 -	

High Prevalence of Verbal, Physical and Sexual Abuses among Young People Living with HIV in Uganda: Implications for Policies and Programming

Vu Lung1, Caswell Georgina2, Banura Cecily3, Alesi Jacquelyne4, Zieman Brady1, Yam Eileen1

1Population Council, Washington, United States, 2International AIDS Alliance, Cape Town, South Africa, 3Makerere University College of Health Sciences, Kampala, Uganda, 4Uganda Network of Young People Living with HIV and AIDS, Kampala, Uganda

BACKGROUND: Data on gender-based violence (GBV) among young people living with HIV (YPLHIV) are limited. There is a need to quantify GBV and its correlates and effects on the sexual and reproductive health of PLHIV. This is particularly critical for YPLHIV because they face unique challenges in navigating a wide array of social, health, and developmental challenges as they transition to adulthood.

METHODS: As part of the Link Up project led by the International HIV/AIDS Alliance, 473 YPLHIV (age 15-24) were recruited through peer-support groups in Luweero and Nakasongola Districts in Uganda. Participants were asked if they had experienced verbal, physical and sexual violence (past 12 months). Two validated stigma scales were used as covariates: perceived internal stigma measured negative self-image (7 items; ;=0.83); external stigma measured concerns with public attitudes about PLHIV (7 items; ;=0.80). Descriptive and multiple logistic regression analyses were used to identify correlates of experiencing either sexual or physical violence.

RESULTS: Participant median age was 20, two-thirds were female, two-thirds were single, and participants had been diagnosed with HIV an average of 5 years. 30% acquired HIV perinatally, 68% were on ART, 43% used condom at last sex, and 31% disclosed their status to a sex partner at last sex. One-third reported feeling ashamed or guilty because of living with HIV, 78% felt rejected, and 66% felt treated unfairly. 33% of males and 35% of females reported verbal abuse; 5% of males and 9% of females reported sexual abuse; and 14% males and 17% of females reported physical abuse.

Verbal violence was significantly more common among YPLHIV with higher levels of internal stigma [Odds Ratio (OR)=2.2; 95%CI:1.5-3.3], and external stigma [OR=1.9;1.3-2.8]. Physical or sexual violence was significantly more common among YPLHIV who suffered higher levels of internal stigma (OR=2.2;1.4-3.4), and external stigma (OR=1.8;1.3-2.9). We did not find significant relationships between violence and key sociodemographic factors, HIV disclosure, condom use and ART uptake.

CONCLUSIONS AND RECOMMENDATIONS: YPLHIV are highly vulnerable to abuse, and those experiencing abuse are likely to suffer from greater internal and external stigma. The findings indicate the need for targeted risk reduction and psychological counseling programs for YPLHIV to address the overlap of stigma and violence and to reduce on-going HIV transmission risks.

ABSTRACT DRIVEN SESSION

17:45 -18:00	Prof Soudré Room	03.12.2015

THUAD1205: Track D/12 -

HIV Infection and Intimate Partner Violence among Togolese Women: Findings from the 2013-2014 Demographic and Health Surveys

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BACKGROUND: While significant progress has been made in the fight against HIV and AIDS, young girls and women continue to be at increased risk compared to their male counterparts. Intimate partner violence has been implicated to contribute to this unequal burden, largely with data from clinic-based samples. Results from studies using the general population, however, have been less consistent and very few have came out of West-Africa.

Objective: To evaluate the association between HIV infection and intimate partner violence in a population based sample of Togolese women.

METHODS: Data for this analysis came from the Togo 2013-2014 Demographic and Health Survey (DHS). Our analytic sample comprised of women who were currently married or living with a partner, aged 15-49 with valid HIV serostatus test results (n = 2386). Responses to 13 items from the DHS domestic violence module were used to classify a woman's experience of emotional, physical, or sexual abuse. Multivariate logistic regression models adjusting for demographic variables and HIV risk behaviors were used to estimate prevalence ratios.

RESULTS: HIV prevalence in this sample of women was 2.8%, compared to 3.1% for the entire DHS sample. Prevalence of any, emotional, physical, or sexual intimate partner violence among HIV positive women compared to negative women were 39% vs 38%, 36% vs 31%, 21% vs 22%, and 06% vs 08%, respectively. The corresponding prevalence ratio estimates, adjusted for demographic variables were 1.20 (p = 0.46), 1.55 (p = 0.10), 1.05 (p = 0.87), and 0.87 (p = 0.80). Models with additional adjustment for HIV risk behaviors revealed similar point estimates and non-significant p-values.

CONCLUSIONS AND RECOMMENDATIONS: Significant associations between intimate partner violence, regardless of type, and HIV infection was not detected in this population-based DHS sample. Where HIV prevalence is relatively low, like that of Togo, gender-focused HIV prevention programs may be more effective when implemented at the clinic-level than at the community-level. Nonetheless, the high rates of violence in this setting warrants community-based interventions that address abuse and gender inequity broadly.

ABSTRACT DRIVEN SESSION

18:00 - 18:15	Prof Soudré Room	03.12.2015
THUAD1206:	Track D/12 -	

Gender Based Violence, HIV and Schools

Tumusiime Marion Natukunda

AIDS Information Center, Advocacy, Kampala, Uganda

ISSUES: The safe school program started by AIDS Information Center - Uganda ,2 year African Development Bank funded pilot. Safe schools works in 71 schools so far targeting 10-14 year old students in primary and secondary school. The aim is to reduce school related gender based violence (SRGBV) and increase gender-equitable behaviors -key to HIV. Interventions include three training programs to enable teachers, students and community volunteer counselors to prevent gender violence and transform harmful gender norms that contribute to inequality; revising national teacher codes of conduct; and mobilizing local communities to address SRGBV. Challenges include resistance by some parents to change entrenched cultural practices such as child marriage. Individuals wanting to report cases of gender violence still face barriers such as fear of reprisal, stigma and not understanding reporting procedures.

DESCRIPTIONS: Quarterly project reviews and monthly monitoring meetings are held to handle problems and find solutions. Challenges have been addressed through: the innovative use of student - selected community members to serve as counselors, a platform to sensitize parents and community members about gender violence and the need to delay marriage and keep girls in school.

LESSONS LEARNT: The program uses a quasi - experimental design where pre and post- test comparisons between intervention schools and control schools are being conducted. Anecdotal evidence shows promising trends in intervention schools. Corporal punishment has been reduced and counselling services are being used by victims and perpetrators of gender violence. School officials have noted that absenteeism and drop outs have decreased. Sexual relations between teachers and students have been reduced or stopped altogether in most schools. Incidents of early marriages are resolved with the concerned parties. Results on the changes in students and teacher knowledge, attitudes and practice relating to SRGBV have been assessed.

NEXT STEPS: Safe Schools is designed to protect adolescents from gender violence and transform the gender norms that make them more at risk of HIV infection. Natural linkages for the safe schools approaches include school- based and informal HIV prevention programs for the general schools populations in addition to specific groups such as orphans and vulnerable children.

18:30 – 20:30	Committee Room 4	03.12.2015
THUAD1301:	Track D/13 - Information technology and communication (ICT)	

Toll Free Call Centres a Preferred Option for HIV/AIDS Information in Highly Stigmatised Somalia 18:30 – 18:45

Warsame Anwar A

SAHAN Network, HIVPrevention, Hargiesa, Somalia

ISSUES: HIV-related stigma still deters many Somalis from utilizing prevention services or from being tested for HIV, severely limiting the efficacy of current SBCC interventions.

The most at risk populations in Somaliland include youth, sex workers, cross boarder truck drivers and refugees from neighbouring Ethiopia and Eritrea. Bio-behavioural surveillance was undertaken among sex workers in Somaliland in 2008 and in early 2014 and findings indicate an HIV prevalence of 5 times that in the general population. Data from the 2014 round of the survey amongst sex workers in Somaliland found that lack of comprehensive knowledge amongst them to be very low, with only 11.1% of those surveyed able to correctly identify ways of preventing transmission and reject major misconceptions.

DESCRIPTION: Somaliland HIV/AIDS Network (SAHAN) developed and is implementing a

hotline call centre for HIV/AIDS information. This is a first such call centre in Somaliland and is an innovation which has been tested in other countries. The call centre since its inception in June 2014 has provided to about 8,500 anonymous callers comprehensive information on HIV/AIDS and other related social issues and linked the callers to services. The organisation trained 12 dedicated counsellors in comprehensive HIV/AIDS information. An efficient referral system to services which is hinged on strict adherence to confidentiality was established with health care service providers. ex workers in Somaliland in 2008 and in early 2014 and findings indicate an HIV prevalence of 5 times that in the general population. Data from the 2014 round of the survey amongst sex workers in Somaliland found that lack of comprehensive knowledge amongst them to be very low, with only 11.1% of those surveyed able to correctly identify ways of preventing transmission and reject major misconceptions.

LESSONS LEARNT: The project used a comprehensive consultative process before its establishment which enabled the buy in from stakeholders and community members. The project learnt that communities are willing to get information on HIV/AIDS if it is provided in a safe environment which is not stigmatising and confidential. To date 8,500 callers have accessed the call centre with an average of 32 callers per day this is encouraging in a society where HIV/AIDS and sexuality issues are a taboo

NEXT STEPS: Demand for information is overwhelming sometimes as the call centre is considered to be the safest source of information.

18:45 – 19:00	Committee Room 4	03.12.2015
THUAD1302:	Track D/12 -	

Off the Shelves and into Action: Lessons Learnt in Using Social Media to Bring WHO HIV Guidelines to People who Need them Most

Deivanayagam Thilagawathi A1,2, Weikum Damian2,3, Johnson Cheryl2, Figueroa Carmen2, Namjilsuren Oyuntungalag2, Hodges-Mameletzis Ioannis2, Baggaley Rachel2

1Newcastle University, Faculty of Medical Sciences, Newcastle-upon-Tyne, United Kingdom, 2World Health Organization (WHO), HIV, Geneva, Switzerland, 3Yale School of Public Health, Department of Epidemiology of Microbial Diseases, New Haven, United States

ISSUES: Normative guidelines published by World Health Organization (WHO) are often criticised for not reaching people whose lives depend upon them. Traditionally, WHO guidelines are developed as print publications on WHO websites and disseminated at select international events. Recent advances in digital media and communications have raised questions on the potential role of social media in disseminating guidelines to diverse stakeholders. For the official launch of the Consolidated Guidelines on HIV Testing Services, the WHO HIV department turned to global health experts and partner organizations to develop a social media strategy. The implications of this initiative are explored.

DESCRIPTION: WHO, with support from Foxtrot Research, developed an online survey in 3 languages to gauge receptivity to a social media campaign to disseminate these guidelines. A total of 300 individuals engaged in the global HIV response were contacted, in addition to respondent referrals and posts on social networks. Out of 230 respondents, 170 expressed interest in promoting the guidelines. Respondents provided suggestions on how to execute the campaign and voted for a hashtag; #Test4HIV was selected. Regular use of social media platforms was gauged from respondents; Facebook (74%), Twitter (37%), LinkedIn (32%) and Instagram (27%). Based on these results, WHO provided supporters a timeline of pre- and post-launch key messages and corresponding images tailored to each social media platform. A Thunderclap (http://thndr.it/1MVY-Sof) page was also created.

LESSONS LEARNT: WHO received a high level of enthusiasm on the #Test4HIV campaign from the global health community. Promotion began with a small number of followers then increased exponentially as more individuals joined the Thunderclap campaign and began to use #Test4HIV. As of July 14th, the following metrics were developed:

1. 261 Thunderclap supporters (target reached)

2. Twitter: 1,347 tweets (including retweets) with a potential reach of over 2.6 million people

3. Facebook: 71 posts, 622 likes
4. Instagram: 20 posts, 178 likes
5. LinkedIn: 4 posts, 604 views, 34 likes
6. 4 online publications and news stories

NEXT STEPS: The successful milestones and targets met have occurred in the pre-launch period. Further tracking, monitoring and evaluation during the post-launch period is planned and will generate key insights. These findings serve as empirical evidence for putting social media at the heart of global health communications.

Keywords: HIV, Social Media, World Health Organization

19:00 – 19:15	Committee Room 4	03.12.2015
THUAD1303:	Track D/12 -	

Future Beats - Tomorrow Matters, Today! How Campus and Community Radio Stations Can Become Agents of Social Change in an HIV Fatigue Student Environment

Behrendt Miriam1, Ahluwalia Ramneek2

1HEAIDS, Future Beats, Pretoria, South Africa, 2HEAIDS, Pretoria, South Africa

ISSUES: Students at universities and colleges in South Africa grew up with HIV Prevention messaging through billboards, TV daily soaps, radio shows and more. Yet the latest South African household survey finds that young South Africans believe that they are at low risk of acquiring HIV infection. The HEAIDS (Higher Education and Training HIV/AIDS Programme) 'Future Beats' Baseline study further showed a deliberate ignorance of HIV by the student community.

Have we used the wrong strategies to communicate with the South African youth?

DESCRIPTIONS: The HEAIDS 'Future Beats' Project is based on the theory that when it comes to communication "one size doesn't fit all". The latest HEAIDS prevalence study shows that 73% of South African university students listen to radio two days a week or more, but only 8% find that campus radio programmes have led them to take the issue more seriously. The project aims to change that.

Building on a cutting-edge project design, developed and implemented by HEAIDS and the German International Cooperation (GIZ), the project establishes unique radio and social media programmes at campus and youth radio stations in South Africa that create awareness concerning HIV and AIDS and related social drivers of the pandemic that vary at the different campuses. Radio station managers and student journalists undergo an extensive Capacity Building Programme as part of the project that sensitizes them to the importance of their role as agents of social change in addressing the HIV pandemic to their audiences.

Lessons learnt and **NEXT STEPS:** In the pilot project in 2014 HEAIDS has worked with 7 radio stations in 3 provinces in South Africa and is extending the project to 2 additional provinces in 2015. Results of the 'Future Beats' Pilot Project Research Report, submitted in May 2015, have shown a connection between radio station staff taking on the role as agents of social change and increased HIV testing and awareness on the side of the student radio listeners.

This presentation explores the question: How do you mobilise entertainment focused campus and community radio station staff to become agents of social change and inspire their listeners to take responsibility for their health?

Keywords: HIV Prevention, higher education, social media, radio, behaviour change

ABSTRACT DRIVEN SESSION

19:15 – 19:30	Committee Room 4	03.12.2015

THUAD1304: Track D/12 -

Is Zimbabwe Ready for mHealth? Opportunities and Challenges to Health Care Worker Cell Phone Use for Improving Communication Across the EID Results Chain in Rural Zimbabwe

Webb Karen, Chitiyo Vivian, Chiruka Sweden, Patel Diana, Engelsmann Barbara

Organisation for Public Health Interventions and Development Trust, Harare, Zimbabwe

BACKGROUND: Early infant diagnosis (EID) among HIV-exposed infants is essential for ensuring timely access to care and treatment. Challenges faced communicating EID results to rural health facilities has been noted to cause delays in turnaround time across the EID results chain. From 2011-2013, cell phones and $20USD in monthly airtime were provided to 27 rural health facilities in two districts of Mashonaland East Province with the objective of facilitating communication to improve EID result turnaround time.

METHODS: A descriptive process evaluation was undertaken from January to September 2013 to assess cell phone use by facility and village healthcare workers and document barriers and facilitators to improving communication along the EID results chain. Cell phone utilization at health sites was captured using standardized facility-based registers. To explore the role of mHealth at community level, 286 village health workers (VHWs) completed a pre-tested, structured questionnaire on mobile phone access and use. Focus group discussions were conducted to explore barriers and facilitators to use of cell phones for communicating across the EID results chain. Utilization and survey data were analyzed descriptively using STATAV13, and focus group discussion transcripts analyzed thematically.

RESULTS: Cell phones were cited as the only consistently functioning form of communication at 94% of health sites. No Standard Operating Procedures were in place to guide cell phone storage and use. From Jan-Sept 2013, 3,597 cell phone contacts were recorded at participating facilities, with the facility nurse being the caller 100% of the time and 98% being voice calls; 2% texts. Contacting the village level for follow up of missed appointments was the most frequently recorded reason for calls. The vast majority of VHWs (94%; n=269) reported access to cell phones and network in their communities.

Conclusion: Cell phones have become essential technology for communication at rural health facilities in Zimbabwe, critical for community-level follow up of defaulters and referring patients to higher levels for HIV diagnosis and care. Missed opportunities for optimizing the use of cell phones to improve communication along the EID result chain include expanded use of text notification and formal inclusion of patients and village health workers through standardized procedures.

ABSTRACT DRIVEN SESSION

19:30 – 19:45	Committee Room 4	03.12.2015

THUAD1305: Track D/12 -

Using Mobile Phones (mHealth Technology) to Improve Tracking and Tracing of HIV Care and Treatment Clients

Mavudze Jabulani, Chingandu Lois, Eghtessadi Rouzeh

SAfAIDS, Harare, Zimbabwe

ISSUE: SAfAIDS' has a community referral network which strengthens linkages between communities and services providers especially health facilities. This system promotes a bi-directional referral system that improves HIV services uptake, client retention and reduces loss to follow up. For more than 20 years, the referral system has been paper-based and it has proved to be less effective on tracing of HIV clients.

Interventions: With financial support from USAID through OPHID, SAfAIDS piloted the use of mHealth to further to improve linkages between health facilities and communities for improved enrolment and retention of HIV clients. The pilot initiative was implemented from September 2014 to March 2015 at four health facilities namely Ngundu, Takavarasha, Vuranda and Zivuku in Chivi district Zimbabwe. 36 village health workers (VHWs) and Community Referral Facilitators (CRF) who support the four clinics were equipped with skills on how to use phones to trace and track HIV treatment and care clients.

LESSONS LEARNT: mHealth significantly contributed to improved linkage between health facilities and communities. CRFs were able timely communicate with VHWs who in turned relayed information to clients with appointments or lost to follow up. Number of clients with appointments who were followed up per month increased by 400% between September 2014 and March 2015 while the number of defaulters followed-up declined by 55% during the same period. mHealth also contributed to increased proportion of clients with appointments who honored appointment dates. At Takavarasha the proportion increased from 68% at baseline to 81% at endline, Ngundu (69% to 81%), Zivuku (62% to 70%) and Vuranda (55% to 65%). Village health workers confirmed that the introduction of mHealth motivated them to do their routine home visits and follow ups on clients with appointments and lost in follow up. The percentage of VHWs who used mHealth who were active increased from 65% in August 2014 to 100% in March 2015. mHealth intervention also contributed towards generation of good quality data compared to paper-based system

Recommendations: mHealth initiative has the potential to significantly contribute towards addressing current challenges on enrolment, and retention of HIV clients. When scaling up the initiative, it is critical to ensure accurate and complete documentation of client information in clinic registers and consistent mentoring, supervision & motivation of VHWs and CRFs.

ABSTRACT DRIVEN SESSION

19:45 – 20:00	Committee Room 4	03.12.2015

THUAD1306: Track D/12 -

The Unique Identifier Code (UIC) as a System to Track Key Populations - The Experience of PACTE-VIH Project in Burkina Faso and Togo

Me-Tahi Hortense1, Tchupo Jean-Paul2, Traore Fatoumata2, Honu Marian2, Yina Gwatiena1, Traore Clotilde3, Zoungrana Zakaria3, Ettiegne-Traore Virginie2, Kapesa Laurent4

1FHI 360, Lome, Togo, 2FHI 360, Accra, Ghana, 3FHI 360, Ouagadougou, Burkina Faso, 4USAID/WA, Accra, Ghana

BACKGROUND: In providing HIV prevention and care services, the confidentiality of beneficiaries is key and anonymity is cherished. On the other hand, providing accurate data to program managers and reducing the use of proxy indicators are highly desirable. A client information tracking system is therefore required to meet the needs of both donors and beneficiaries. The Unique Identifier Code (UIC) allows for the monitoring of coverage of target key populations (KP) while maintaining the anonymity of individuals receiving HIV services and avoiding double counting.

The objectives are to:

- Anonymously track KP individual-level exposure to prevention, treatment and care services.
- Avoid duplication in counting KP who access services.
- Track navigation of KP between outreach services and health facilities.

METHODS: A coding system which was culturally acceptable but anonymous was identified. This code was required to be easy to replicate and provide the same result in each instance over time. It therefore had to remain constant over time and be easy to retain. The UIC comprises a seven digit alphanumeric combination as follows:

1. Gender: example M or F
2. Last 2 digits of the year of birth: example 78
3. 1st letter of the last name: example H
4. 1st letter of the first name: example M
5. 1st 2 letters of mother's first name: example JU

The coding system was then piloted at the project sites. Peer Educators, health workers and representatives of implementing partners were then trained on how and when to issue, read and interpret the UIC. A database was designed based on the UIC system to capture project data.

RESULTS:

- The UIC code allows the project to determine de-duplicated KP reached.
- It allows the project to monitor coverage of target KP.
- The UIC system is used in tracking KP navigation between outreach services and health facilities.

CONCLUSIONS AND RECOMMENDATIONS: A successful UIC system helps to produce accurate coverage data at the individual and population level while maintaining confidentiality. It can help track the movement of beneficiaries between outreach campaigns and health facilities. It has the potential to increase the engagement of KP in services because of assured anonymity.

Dissemination of this experience to the national coordinating bodies (NACP, NAC) and regional bodies (WAHO) may lead to the adoption of the UIC in the various countries in West Africa.

NOTE

POSTER SESSION I

MOPDA001

Genetic Susceptibility to HIV: A Nested Case-study of Some Seroconverter Cases within the Bamenda City Council Area

Jude Nsom Waindim, Dschang, Cameroon

MOPDB002

Molecular Characterization and Antibiotic Resistance Profiles of Bacterial Isolates Cultured from HIV Seropositive Patients

Folasade Muibat Adeyemi, Osogbo, Nigeria

MOPDA003

Potentials of Fasligands(CD95L) in Monitoring HIV-1 Disease Progression in Adults in Yaounde Cameroon

George Mondinde Ikomey, Yaounde, Cameroon

MOPDA004

Investigating the Genetic Diversity and the Virulent Circulating Strains of Human Immunodeficiency Virus and Hepatitis C Virus in Co-infected Patients in Cameroon

Marceline Djuidje Ngounoue, Yaoundé, Cameroon

MOPDB005

Population-based Surveillance of HIV-1 Drug Resistance Patterns in Cameroonian Adults Initiating ART According to Recently Updated WHO-guidelines

Joseph Fokam, Yaoundé, Cameroon

MOPDB007

Nutritional Status and its Effect on Treatment Outcome among Patients Taking Haart in Ethiopia: Cohort Study

Sadikalmahdi H. Abdella, Jimma, Ethiopia

MOPDB008

Routine CD4 Cell Count Monitoring in the Presence of Viral Load (VL)Testing in Resource Limited Settings: Is it Still Necessary? A Cohort Evaluation from an Urban Informal Settlement Bamenda, Cameroon

Rogan Taboko Nyenti, Bamenda, Cameroon

MOPDB009

Treatment Outcomes among TB/HIV Co-infected Cases Treated under Directly Observed Treatment Short Course in Western Ethiopia

Eyasu Ejeta Duken, Nekemte, Ethiopia

MOPDB010

Résistance aux Antituberculeux chez les Patients Atteints de Tuberculose Pulmonaire dans Sept Régions du Tchad

Ossoga Gédéon Walbang, Dakar, Senegal

MOPDB011

Using Regular File Reviews to Track Patients due for CD4 Monitoring amongst Highly Active Antiretroviral Therapy (HAART) Clients in the Community Drug Distribution Point TASO Mbarara Experience

Kato Suuna, Mbarara, Uganda

MOPDC012

Determinant Factors Associated with Occurrence of Tuberculosis among Adult People Living with HIV after ART Initiation in Addis Ababa, Ethiopia. A Case Control Study

Kelemu T. Kibret, Nekemte, Ethiopia

MOPDB013

Comparing Glucose Metabolism in HIV/AIDS Patients on Antiretroviral Treatment with Drug Naïve Patients at Lagos State University Teaching Hospital

Bonaventure Chinedu Basil, Ikeja, Nigeria

MOPDB014

Incidence of ART-related Nephrotoxicity among HIV Infected Patients with Low Body Mass Index in Brazzaville, Congo

Martin Herbas Ekat, Brazzaville, Congo

MOPDB015

Retention of HIV-positive Pregnant and Lactating Women Using ART in Kisii County, Kenya

Judy Omare, Kisii, Kenya

MOPDB016

Is Proteinase Inhibitor Based Antiretroviral Therapy during Pregnancy Associated with Increased Risk of Preterm Birth? Systemic Review and a Meta-analysis

Kelemu Tilahun, Nekemte, Ethiopia

MOPDB017

Un Continuum d'Actions Intégrées pour la Réalisation de l'Objectif Zéro Nouvelle Infection chez le Nourrisson Né de Mère Séropositive: Cas du Centre ADIS de Cotonou de l'ONG RACINES

Doris Eugénie Sèyivè Agboton, Cotonou, Benin

MOPDB018

Impacts sur leurs Taux de CD4, de la Connaissance par les Adolescents de leur Statut Sérologique: Cas des Adolescents de l'ONG RACINES de Cotonou

Hermann Adjde, Cotonou, Benin

MOPDB020

Assessment of Bottlenecks Affecting Early Infant Diagnosis of HIV through Dried Blood Spot Testing in Rural Health Facilities Supported by Churches Health Association of Zambia (CHAZ) in Zambia

Doreen Shempela Mainza, Lusaka, Zambia

MOPDB021

Intestinal Parasitosis in Relation to CD4+T Cells Levels and Anemia among HAART Initiated and HAART Naive Pediatric HIV Patients in a Model ART Center in Addis Ababa, Ethiopia

Hylemariam Mihiretie Mengist, Nekemte, Ethiopia

MOPDB022

Clients' and Providers' Satisfaction Survey on Integrated SRH/HIV Services in Swaziland's Centres of Excellence (COEs)

Bongani Robert Dlamini, Mbabane, Swaziland

MOPDB023

Care Seeking Behavior among HIV-infected Children, Western Kenya 2008-2011

Barbara Burmen, Kisumu, Kenya

MOPDB024

Evaluating and Prioritizing Barriers in Cryptococcal Meningitis Diagnosis and Treatment in Ethiopia HIV Program - A Survey from 20 HIV/ART High Volume Hospitals

Habtamu Seyoum Tolla, Addis Ababa, Ethiopia

MOPDB025

Renal Safety in Patients Receiving a Tenofovir-containing Regimen in Abidjan, Côte d'Ivoire

Ahuatchi P. Coffie, Abidjan, Cote D'Ivoire

MOPDB026

Mise en œvre d'un Plan d'Extension de l'Accès à la Charge Virale dans les Pays à Ressources Limitées: Cas du Projet OPPERA en Côte d'Ivoire

Hervé Menan, Abidjan, Cote D'Ivoire

MOPDB027

HIV and HEPATITIS Infections Pose a Threat to Blood Safety for Recipients of Transfusion in Africa

Taiwo Modupe Oyesile-Balogun, Lagos, Nigeria

MOPDB028

Contribution de l'Informatisation du Dossier Médical dans l'Amélioration du Suivi de la Qualité de la Prise en Charge des PvVIH au Cameroun

Lucienne Djomassi Dempouo, Yaoundé, Cameroon

MOPDB029

Renal Failure and Use of Highly Active Antiretroviral Therapy in HIV-infected Persons at Nkongsamba Regional Hospital - Cameroon

Ewane Leonard, Nkongsamba, Cameroon

MOPDB030

Prévalence des Coïnfections VIH-1 et Virus des Hépatite B ou C au CTA de Pointe Noire en République du Congo

Oswald Ulrich Ndala, Pointe-Noire, Congo

MOPDB031

L'Education Thérapeutique du Patient, un Moyen pour Palier aux Difficultés d'Observances des Personnes sous Traitement ARV au Centre OASIS de Association African Solidarité (AAS)

Marcelline Ouedraogo, Ouagadougou, Burkina Faso

MOPDB032

Use of Multiple Interventions to Reduce Patient Attrition: Acase Study of AIDS Healthcare Foundation Supported Sites in 7 Countries in Africa

Kate Ssamula, Kampala, Uganda

MOPDC033

Factors Influencing Consistent Condom Use among Out-of-School Youths in an Urban Town of Cameroon: An HIV/AIDS Perspective

Elvis E. Tarkang, Kumba, Cameroon

MOPDC034

Closing the Gaps: Steps towards Improving T.B Screening among Persons Living with HIV and AIDs: A Case Study of TASO Gulu

Shafik Malende, Kampala, Uganda

MOPDC035

Integrating on Spot STI Screening and Treatment among Key Populations Targeted for HIV Prevention, Care and Treatment in Post Conflict Area of Northern Uganda

Shafik Malende, Kampala, Uganda

MOPDC036

Is HIV/AIDS is risk factor for Multi-drug Resistance Tuberculosis? Systemic Review and Meta-analysis

Yonatan Moges Mesfin, Harar, Ethiopia

MOPDC037

Factors Influencing Prevalence of HIV/Aids among Men Who Have Sex with Men (MSM) Aged 18-24yrs in Mtwapa Town, Kilifi County, Kenya

Oscar Irungu, Mombasa, Kenya

MOPDC038

Le TIC Comme Moyen de Prévention en PTME en Milieu Rural au Togo Cas de l'Association 2AVIE

Kokouvi Semenou Agbelekpo, Kpémé, Togo

MOPDC039

Tuberculosis and the Risk of Opportunistic Infections in Patients Infected with HIV from ARV Burundi

Ficard Ndayimirije, Bujumbura, Burundi

MOPDC040

Prevalence and Associated Factors of Female Child Early Marriage Practice from 2009 - 2013 in Sinane District Northwest Ethiopia in 2014

Sileshi Workineh Mengestie, Bahir Dar, Ethiopia

MOPDC041

Baseline Assessment of the Implementation of Provider Initiated Testing and Counselling (PITC) in a Rural Tanzania in 2014; A Case Study of Singida Region

Olimpia Laswai, Dar Es Salaam, Tanzania, United Republic of

MOPDC042

Uptake of Option B+ PMTCT Interventions in a Rural Tanzania; Is it Satisfactory?

Olimpia Laswai, Dar Es Salaam, Tanzania, United Republic of

MOPDC043

Using Combination of Prevention Interventions to Reduce HIV/Aids Burden in Lagos State of Nigeria

Oluwarotimi Henry Adenigba, Ikorodu, Nigeria

MOPDC044

Needs (Sexual and Non Sexual) of Migrant Women Working in Garment Sector Is a Priority

Syam Gunturu, Bangalore, India

MOPDC045

Factors Associated with Prevalent and Incident Bacterial Vaginosis in a Cohort of Heterosexual Couples in Kisumu, Kenya

Fredrick Odhiambo Otieno, Kisumu, Kenya

MOPDC046

Epidemiology of HIV-infection in Pregnancy in an Era of Increased Access to Antiretroviral Therapy in Cameroon

George Mondinde Ikomey, Yaounde, Cameroon

MOPDC047

Token Legalization of Homosexuality without Tangible Changes in Oppressive Social Climate Continue to Promote High HIV Infection Rate among LGBT and International Migration among Homosexuals

Apeksha Dahal, Kathmandu, Nepal

MOPDC048

Effect of Education Attainment of Injecting Drug Users (IDUs) on their Attitude towards People Living with HIV/AIDS in 10 States in Nigeria

Chukwunonso Gerald Iheoma, Owerri, Nigeria

MOPDC049

Availability of Mobile HCT Services and Willingness for HIV Screening among MARPs in Two States in Nigeria

Chukwunonso Gerald Iheoma, Owerri, Nigeria

MOPDC050

Intégrer le Programme de Prévention de la Transmission du VIH de la Mère à l'Enfant dans les Structures de Consultations Prénatales et de Soins de Santé au TOGO

Hodor Koami, Lomé, Togo

MOPDC051

Sauver les Nouvelles Générations: Expérience Communautaire de Prévention du VIH/Sida auprès des Adolescents en Zone Rurale. Cas de la Maison des Enfants et des Jeunes de Bafou (MEJ) Ouest Cameroun

Berthe Florence Ymele Nouazi Yemefack, Dschang, Cameroon

MOPDC052

Prévalence du VIH en Milieu Carcéral: Cas de la Maison d'Arrêt et de Correction de Ouagadougou, Burkina Faso

Désiré Nanema, Ouagadougou, Burkina Faso

MOPDC053

Variabilité de la Réponse Post-vaccinale Pédiatrique contre le Virus de l'Hépatite B en Fonction de l'Exposition au VIH à Yaoundé, au Cameroun

Joseph Fokam, Yaoundé, Cameroon

MOPDC054

Evaluating the Effectiveness of HIV Prevention Services for In-school Youths in Abia State of Nigeria

Chukwunonso Gerald Iheoma, Owerri, Nigeria

MOPDC055

HIV Awareness through Music Dance and Drama in General Population, Stunning Results in East Africa Southwestern Uganda, TASO Mbarara Experience

Kato Suuna, Mbarara, Uganda

MOPDC056

Initiative de Facilitation de l'Accès aux Soins aux HSH Dépistés au Centre de l'Association CAMFAIDS en 2014 à Yaoundé - Cameroun

Ella Ella Joris Eitel, Yaoundé, Cameroon

MOPDC057

C29: Programme de Prévention des Populations Déplacées au Temps de Guerre en RCA

Dimanche Lucien, Bangui, Central African Republic

MOPDC058

Getting to Zero New HIV infections: Through Man to Man and Woman to Woman a United Nations (UN) Cares Malawi Initiative

Veronica Chikafa, Lilongwe, Malawi

MOPDC059

Approche Facilitant l'Adhésion des Femmes Enceintes au Dépistage et le Suivi de la Cascade de la PTME. Cas de l'Association 2AVIE: Un Centre de Santé Prénatale, un Conseiller Psycho VIH

Sewa Komi Agbelekpo, Lomé, Togo

MOPDC060

Implementation of Voluntary Medical Male Circumcision(VMMC) in a Traditionally Circumcising Community: The Case of Bukusu Community in Bungoma County, Western Kenya

Joab Khasewa, Nairobi, Kenya

MOPDC061

HIV Counseling and Testing (HCT) Uptake among Nigerian Adolescents Aged 10-19 over a Seven Years Period (2007-2013): Progress or Decline?

Ifeanyichukwu Okechcha Nte, Abakaliki, Nigeria

MOPDC062

"Understanding Changes in Sex Worker Client Network" - A Strategy in HIV Prevention Programs

Gunturu Syam Ratnakar, Bangalore, India

MOPDC063

Not Only Kuchu but We Are All the Most at Risk Populations, Distributing Lubricant in Tanzania Is Illegal!!

Michael Robert Mhando, Dar es Salaam, Tanzania, United Republic of

MOPDC065

Facteurs de Vulnérabilité et Prise en Charge Médico-sociale des PVVIH en Tunisie

Amira Yaakoubi, Tunis, Tunisia

MOPDC066

Syphilis and Human Immunodeficiency Virus Co-infection in Algeria: Preliminary Results of a Study Carried out between 2011 and 2014

Soumia Benmahfoud, Algiers, Algeria

MOPDC067

Predictors of Safer Sex Practices among Commercial Sex Workers in Two Cities in Southwest, Nigeria: Implication for Behavioural Change Communication Intervention

Iyanuoluwa A. Olugbenga-Bello, Ogbomoso, Nigeria

MOPDC068

Prevalence of HIV Among Clients Diagnosed during Community Outreaches in the Federal Capital Territory of Nigeria

Andrew Saman, Abuja, Nigeria

MOPDC069

Poor Feeding Practices among HIV-positive Children Living in Food Rich Region - A Call for Tailored Feeding Counseling

Bruno F. Sunguya, Dar es Salaam, Tanzania, United Republic of

MOPDC070

Sensitizing Teachers and Parents to Use Life Skills for HIV and STI Prevention among Adolescents

Emily Nyanzi Kabuye, Entebbe, Uganda

MOPDC071

An Assessment of Community Knowledge, Attitude and Practice on Tuberculosis Infection Control in Ilorin, Kwara State, Nigeria

John Oluwasegun Ibitoye, Lagos, Nigeria

MOPDC072

Prevalence and Predictors of Human Immunodeficiency Virus Co-infection with Tuberculosis in Ilorin, Kwara State, Nigeria

John Oluwasegun Ibitoye, Lagos, Nigeria

MOPDC073

Comprehensive Knowledge of HIV and its Significant Determinants among Young People Aged 15-24 in Nigeria over a Decade, 2003—2013

Ayodeji Oginni, Abuja, Nigeria

MOPDC074

Knowledge Gaps on Sexual HIV Transmission Prevention among People Living with HIV in Western Kenya

Emmanuel S. Wamalwa, Nairobi, Kenya

MOPDC075

Mitigating the Impact of HIV/AIDS among in and out of School Youth through Peer Education Using Family Life HIV Education in Federal Capital Territory Abuja Nigeria

Falilu Opeyemi Agbaje, Lagos, Nigeria

MOPDC076

Increasing HIV Counseling and Testing Services Uptake among Young People Aged 15- 24 Years, a Pilot Intervention of Soccer Activities in AMAC Local Government Area FCT Abuja Nigeria

Falilu Opeyemi Agbaje, Lagos, Nigeria

MOPDC077

Sexual Partners and Risk Behaviors among People Living with HIV (PLHIV) in Kisii County, Western Kenya

Emmanuel S. Wamalwa, Nairobi, Kenya

MOPDC078

Infections Genitales chez les Professionnelles du Sexe: Prevalence et Facteurs Associes

Rahmatoulahi Ndiaye, Dakar, Senegal

MOPDC079

Using Mother-infant Pair Stickers to Improve Testing of HIV Exposed Infants at Age Two Months at Rumphi District Hospital (RDH) in Malawi

Meria Million, Lilongwe, Malawi

MOPDC080

Managing the Challenges and Threats to Programme Implementation with and for Sex Workers in Nigeria: Any Hopes in the Midst of Antagonistic Laws and Policies?

Ifeanyi Okekearu, Abuja, Nigeria

MOPDC081

Knowledge versus Attitude: A Comparative Study of 2 HIV Qualitative and Quantitative Studies on Knowledge, Attitude and Behaviour along Major Nigeria Transport Corridors

Ifeanyi Okekearu, Abuja, Nigeria

MOPDC082

Connaissances et Attitudes Pratiques (CAP) des PVVIH Suivis a Mopti Face au Risque de Transmission de l'Hepatite Virale B (HBV)

Daouda Traore, Mopti, Mali

MOPDC083

Factors which Effect the Uptake of HIV Testing and Counselling Services among Healthcare Workers in Sub-Saharan Africa: A Systematic Review

Allan Orago, Nairobi, Kenya

POSTER SESSION I

MOPDD084

HIV Risk Perception, Sexual Behavior and HIV Prevalence among Residents of a Rural Community in Western Kenya, 2012-2014

Barbara Burmen, Kisumu, Kenya

MOPDC085

Knowledge and Attitude to Female Condom Use among Heterosexual Men Receiving ART in Secondary Setting, Western Nigeria

Foluwaso Busayo Olaoluwa-Moronkeji, Ijebu Ode, Nigeria

MOPDC086

Predictors of Condom Use among Sexually Active Young Women - National HIV Communication Survey, South Africa, 2012

Thobani Ntshiqa, Sandringham, South Africa

MOPDC088

An Analysis of Post Exposure Prophylaxis as a Biomedical Strategy for HIV Prevention in Post Conflict Area: A Case Study of TASO Gulu

Ronald Opito, Kampala, Uganda

MOPDC089

Expanding Community - Based HIV Counseling and Testing Using Outreache Services during Public Events and Festivals: The Case of Community Mobilization in Ekiti State, Nigeria

Remi Oluwabamigbe Ajayi, Ado - Ekiti, Nigeria

MOPDC090

Predictors of Condom Failure among Brothel-based Female Sex Workers in Nigeria

Abiodun Olusegun Hassan, Abuja, Nigeria

MOPDC091

The Perceptions of HIV Counselling and Testing (HCT) Staff at the University of Johannesburg, South Africa, towards Students with Disabilities and HIV risk

Puseletso Maile, Johannesburg, South Africa

MOPDC092

Un Modèle d'Intégration de la Prévention des Hommes Ayant des Relations Sexuelles avec d'Autres Hommes (HSH) à la Prise en Charge des Personnes Vivant avec le VIH « Petit Village »

Traore Abdoulazziz Soundiata, Ouagadougou, Burkina Faso

MOPDC093

Prévention par les Nouvelles Technologie de l'Information et de la Communication (NTIC) au Sein des Hommes Ayant des Relations Sexuelles avec d'Autres Hommes (HSH) du Centre Oasis au Burkina Faso

Traore Abdoulazziz Soundiata, Ouagadougou, Burkina Faso

MOPDC094

Prévention du Virus de l'Ebola dans le Centre Communautaire Oasis de l'Association African Solidarité (AAS) à Ouagadougou au Burkina Faso

Traore Abdoulazziz Soundiata, Ouagadougou, Burkina Faso

MOPDC095

Partner HIV Serostatus Disclosure and Determinants of Serodiscordance among PMTCT Clients in Nigeria

Amobi A. Onovo, Abuja, Nigeria

MOPDC096

Reducing HIV Prevalence through Promoting and Sustaining Behaviour Change among Inject Drug Users (IDUS) in Nigeria

Boniface Oguche, Abuja, Nigeria

MOPDC097

HIV, Hepatitis, Tuberculosis, and Sexually Transmitted Infections Testing among People who Inject Drugs in Dar es Salaam, Tanzania: A Need to Increase Service Coverage

Linda Beatrice Mlunde, Tokyo, Japan

MOPDC098

'Breaking the Barriers': Exploring Innovative Approaches to Access to HIV Care Services for MSM at TASO Uganda

Collins Agaba, Kampala, Uganda

MOPDC099

Does the Knowledge, Attitudes and Practices of Young People and Community Stakeholders Influence the Uptake of Sexual and Reproductive Health and Rights Services by Young People

Linda P. Kamlomo, Lilongwe, Malawi

MOPDD100

Tackling HIV in Kenya: Would Traditionally Circumcising Communities Benefit from the MMC Rollout?

Margaret Kabare, Perth, Australia

MOPDC101

Combination of HIV Prevention, Care, Wellness and Reproductive Health Rights among PLHIV and Key Populations: A Case of Sex Workers and Cross Border Mobile Populations at Malaba Hot-spots, Kenya

Napoleon N. Nyongesa, Amagoro, Kenya

MOPDC102

Enhancing Intra-facility Linkages for HIV Exposed Infants and their Mothers through Linkage Facilitators

Jennifer Francesca Acio, Mbale, Uganda

MOPDC103

Characteristics of Newly HIV-infected Patients Diagnosed after 50 Years Old in Burkina Faso

Yempabou Sagna, Ouagadougou, Burkina Faso

MOPDC104

Could Cameroon Reach WHO "Virtual Elimination" of New Paediatric HIV Infection

by the End of 2015? A Computer Simulation-based Assessment

Hermine Lore Nguena Nguefack, Yaounde, Cameroon

MOPDC105

Safer Sexual Practices and Subsequent Prevention of New HIV Infections Would be Enhanced by Effective Encouragement of Knowledge and Disclosure of Serostatus between Sexual Partners

Taiwo Modupe Oyesile-Balogun, Lagos, Nigeria

MOPDC106

Alcohol Use Is Common and a Potentially Modifiable HIV Risk Factor in Sub-Saharan Africa

Taiwo Modupe Oyesile-Balogun, Lagos, Nigeria

MOPDC107

A Global Analysis of the Quality f HIV Diagnostic Testing Strategies

David Flynn, Gold Coast, Australia

MOPDC108

Identifying and Exploring Barriers and Facilitators to Introducing Early Infant Male Circumcision Among Key Stakeholders in HomaBay County, Western Kenya

Okeyo Timothy Adipo, Kisumu, Kenya

MOPDC109

Profiling Atherogenic Risk among HIV-infected Adults in a Rural Ugandan Community

Clara Wekesa, Kampala, Uganda

MOPDC110

HIV-related Characteristics, Attitudes and Behaviors of Older People in Botswana

Kabo Matlho, Sydney, Australia

MOPDD112

Making Treatment as Prevention a Reality for People Living with HIV in South Africa

Ntombesizwe Nombasa N. Gxuluwe, Tableview, South Africa

MOPDD113

HIV/AIDS within Malawi's Fish Value Chain - An Analysis of Factors, Implications and Interventions "Andrew Saukani, ExtensionSpecialist P/ Bag 7, Mangochi - Malawi

Andrew Saukani Banda, Lilongwe, Malawi

MOPDD114

"Life on my Own Terms" - Condom and Lubricant Brand Perceptions and Sexual Practices and Consumer Segments among Men Who Have Sex with Men (MSM) in South Africa, 2013

Ghairunisa Galeta, Johannesburg, South Africa

MOPDD115

"When People See Me Smiling, it's a Fake Smile. I'm Hiding All the Pain I Feel Inside". An Exploratory, Expressive Arts Study of the Experiences of HIV Positive Adolescents with Depression

Nicola Willis, Harare, Zimbabwe

MOPDD116

Knowledge of Sexually Transmitted Infections (STIs) among the Senior Students at a Secondary School in South West,Nigeria

Yetunde Oluwatosin Ajiwoluwa, Lagos State, Nigeria

MOPDD117

An Adolescent Clinic: Aiding Children Transition into Adult Hood. A Case Study of TASO Gulu

Shafik Malende, Kampala, Uganda

MOPDD118

Forced Sex among Young People in Slums, Malawi: Lessons from Material Deprivation Effects and Implications for Interventions Aimed at Reducing Sexual and Reproductive Health Risks in Poor Urban Areas

Mphatso Kamndaya, Johannesburg, South Africa

MOPDD119

Susciter la Création de Groupes Identitaires chez les HSH et les Travailleuses de Sexe (TS)

Jean Marie Tapsoba, Ouagadougou, Burkina Faso

MOPDD121

Results of People Living with HIV (PLHIV) Led Advocacy and Communication to Promote Prevention with Positives

Salum Kibet Mustafa, Eldoret, Kenya

MOPDD122

Coping Strategies of Children after Learning their HIV Positive Sero Status: A Case Study of Nsambya Hospital AIDS Programme

Sharifah Nalugo, Kampala, Uganda

MOPDD123

Family Therapy Promotes Positive Living among Adolescents Living with HIV/AIDS

Talal Hassan Galdgoan, Khartoum, Sudan

MOPDD124

Les Facteurs Favorisants la Prostitution chez les Travailleuse du Sexe (TS) à la Province de Mèknès-Maroc

Najib Dahbi, Meknès, Morocco

MOPDD125

Financial Stability, Treatment Literacy and Disclosure for Prevention among Women Living with HIV in Wakiso District-Uganda

Proscovia Namakula, Kampala, Uganda

MOPDD126

D30. La Stigmatisation et la Discrimination et Accès à la Justice Groupe dans les Réponses Nationales au Sida

Dieudonne Allogo Eyi, Libreville, Gabon

MOPDD127

Lutte contre le VIH/SIDA en Afrique:

Vers l'Education des Populations à une Participation Effective à l'Accès aux Soins

Paul Ndzie Messi, Yaoundé, Cameroon

MOPDC128

Depression in People Living with HIV/AIDS in Fitche Hospital, Central Ethiopia: A Cross-sectional Study

Tebikew Yeneabat, Debre Markos, Ethiopia

MOPDD129

Lutte contre la Stigmatisation et la Discrimination des Patients Séropositifs au Cameroun: Expérience de l'Association 3sh à la Conception d'une Grille d'Autoévaluation des Pratiques

Marius Tchassep, Douala, Cameroon

MOPDD130

D28: Rendre la Loi Fonctionnelle pour une Protection de la Réponse au VIH/SIDA

Dimanche Lucien, Bangui, Central African Republic

MOPDD131

D1: Les Dangers Liés au VIH/SIDA en Milieu des Filles Libres en RCA

Dimanche Lucien, Bangui, Central African Republic

MOPDD132

D2: La Consommation de Drogue, le VIH/SIDA des Enfants de la Rue en RCA

Dimanche Lucien, Bangui, Central African Republic

MOPDD133

Effective Community Participation in Stigma Reduction: A Strategy for Bridging the Gap of HIV Related Stigma Intervention in Communities

James Success Esther, Karu, Nigeria

MOPDD134

Increasing HIV Care Uptake by Men who Have Sex with Men in Kenya. Lessons from Ishtar-MSM Wellness Center

Macland Njagi Nyaga, Nairobi, Kenya

MOPDD135

Factors Influencing Uptake of Contraceptive Services among HIV Positive Clients. A Survey of Sexually Active Clients in TASO Masaka

Ivan Magala, Kampala, Uganda

MOPDD136

Strategies for Scaling up HIV Prevention among Adolescents: The TASO Masaka Safe Male Circumcision Experience

Ivan Magala, Kampala, Uganda

MOPDD137

Leveraging Collective Bargaining Agreements for Sustained and Effective HIV & AIDS Workplace Responses in Uganda

David Muddu Mawejje, Kampala, Uganda

MOPDD138

HIV/AIDS, Hepatitis and Sexually Transmitted Infections Prevention among Egyptian Substance Users

Atef Bakhoum, Cairo, Egypt

MOPDD139

Assessment of Knowledge, Attitude, and Practice of Risky Sexual Behaviour Leading to HIV and Sexually Transmitted Infections among Egyptian Substance Users: A Cross-sectional Study

Atef Bakhoum, Cairo, Egypt

MOPDD140

Assessment of Knowledge, Attitude, and Practice of Intravenous Drug Use Leading to HIV and Sexually Transmitted Infections among Egyptian Substance Users: A Cross-sectional Study

Atef Bakhoum, Cairo, Egypt

MOPDD141

WONETHA Programme Performance Evaluation 2014 - Annual Evaluation to Assess the Performance of the WONETHA Programme, to Guide Decision Making for Subsequent Programme Delivery

Flavia Kyomukama, Kampala, Uganda

MOPDD142

The Second Nigeria Stigma Index: Measuring the Level of HIV Related Stigma and Discrimination among PLHIV in Nigeria

Peter Nweke, Asokoro, Nigeria

MOPDD143

Acceptability of HIV Counseling and Testing among Vulnerable and Marginalized Group (VMG); A Case of Ogiek Community in Mt Elgon, Kenya

Joab Khasewa, Nairobi, Kenya

MOPDD144

Innovative Strategies to Ensure Integration of Sexual Minorities in Public Facilities in Burundi [u1]

Thierry Nahimana, Bujumbura, Burundi

MOPDD145

'We Need More Men to Come Forward' an Exploration of the Role of Male Community Care Workers in Supporting HIV Positive Male Clients

Lesley Gittings, Cape Town, South Africa

MOPDD146

Experiences of Disability-related Stigma and Discrimination among Persons with Disabilities Living with HIV in Lusaka, Zambia

Philimon Simwaba, Lusaka, Zambia

MOPDD147

IDUs Are at Risk of Spreading HIV Virus among Peers in Quetta, Pakistan

Hameed Ul Mehdi, Quetta, Pakistan

MOPDD148

Understandings of Sexual Faithfulness and Relationship Satisfaction among Men and Women in Peri-urban Uganda

Allison Ruark, Washington, United States

MOPDD149

Universal Access to HIV Prevention, Treatment, Care and Support as Intervention Strategy for HIV/AIDS and Co-infections

Paul Moses Ndegwa Mutiga, Nakuru, Kenya

MOPDD150

Water, Sanitation and Hygiene (WASH) in Community Based Care: Implications for Well-being for People Living with HIV/AIDS/TB in Durban, South Africa

Chanelle Mulopo, Durban, South Africa

MOPDD151

A Global Snapshot of Sexual Health Education: Insights from International Students at a Midwestern American University

Kristen E. Bunner, Bowling Green, United States

MOPDD152

Strategic Interventions to Reduce HIV Prevalence among Muslim Women and Girls in Nakuru County, Kenya

Halima Mohamed Ore, Nakuru, Kenya

MOPDD153

HIV Prevention Program in Education Sector in Rural Communities, where Psychosocial Behaviors Are Identified among Young People that Are Vulnerable to HIV and Other Related Diseases

Ejimole Fidelia Onwuekwe, Umuna, Nigeria

MOPDD154

Perspectives on Informed Consent: A Discussion of the LM Judgment on the Coercive Sterilisation of HIV-positive Women

Annabel Raw, Johannesburg, South Africa

MOPDD155

A Five Minute 24 Hour Tranquility Condom Distribution Model a Master Key to Stopping HIV Infection among the Most at Risk Populations (MARPS)

Gilbert Obore, Soroti, Uganda

MOPDD156

Use of Fictitious Identities by Patients on Antiretroviral Therapy: A Case of Mangochi District, Malawi

Kenneth Phiri, Zomba, Malawi

MOPDD157

ISP Sexual Reproductive Health Knowing Series through "LINK UP PROJECT"

Nalwanga Resty, Kampala, Uganda

MOPDD158

Use of Peer Educators in Enhancing Linkage of HIV Positive Men Having Sex with Men (MSM) into Care; Taso Mulago Experience

Agnes Tusiime Kateeba, Kampala, Uganda

MOPDD159

Making the Global Fund Money Work for Young People: A Case Study the Participation of Young People Living with and Affected by HIV in Uganda

Jacquelyne Alesi, Kampala, Uganda

MOPDD160

Challenges and Barriers in Working with Adolescent Transition and the Impact of Psychological Care among HIV Positive Children Followed by the Ambulatory Treatment Center of Brazzaville

Martin Herbas Ekat, Brazzaville, Congo

MOPDD161

Who Do You Tell? Patterns of Disclosure among People Living with HIV in Bukoba, Tanzania

Rachel A. Weber, Dar es Salaam, Tanzania, United Republic of

MOPDD162

Involving Young People Strengthens the Fight against HIV/AIDS

Mark W. Gachagua, Nairobi, Kenya

MOPDD163

Deep Sense of Meaning and Satisfaction of Female Sex Worker Peer Educators Working in HIV Prevention in Mali

Trout Clinton, Chino, United States

MOPDD164

Evolving Social Science Research on HIV/AIDS in Sub-Saharan Africa

Getnet Tadele, Addis Ababa, Ethiopia

MOPDD165

Despair and Optimism: Researching and Publishing Sexuality in Ethiopia

Getnet Tadele, Addis Ababa, Ethiopia

MOPDD166

Male Involvement in Women Reproductive Health in Nigeria

Abati Samuel, Lagos, Nigeria

MOPDC167

C29: Intervention Relative au VIH dans les Situations de Crise en RCA

Jean Vincent Mbenda, Bangui, Central African Republic

MOPDD168

Are Clinical Trials the Best Way to Access the Latest HIV Treatment and Care in Developing Countries?

Rosemary Musesengwa, Harare, Zimbabwe

MOPDD169

Community Linkages that Work: Strengthening the Continuum of Care for HIV Infected and Affected Children through Linkage Facilitators

Jennifer Francesca Acio, Mbale, Uganda

MOPDD170

Allègement du Circuit du Patient et Schéma Itinéraire Comme Instrument de

Réduction du Nombre de Perdus de Vue au Centre de Traitement Agrée (CTA) de Bafoussam

Jean Jules Kamgue Kopguep, Bafoussam, Camercon

MOPDD171

An Exploration of the Community Health Worker's Experiences in Implementing HIV Prevention at Community Level. Results from a Rural District in Uganda

Erick Ssegujja, Kampala, Uganda

MOPDD172

Sexualité Précoce chez les Adolescents en Milieu Scolaire Urbain au Burkina Faso: Frèquence, Facteurs Associés et Connaissance sur les MST

Adjima Sagna, Koudougou, Burkina Faso

MOPDD173

Violence against Women and Girls (VAWG) and HIV & AIDS Intersection Programme in Nigeria

Yinka Falola-Anoemuah, Abuja, Nigeria

MOPDD174

Disponibilité des Époux au Partage de Résultat de Leurs Femmes et à Être Testées pour l'Infection à VIH/Sida à Boulmiougou au Burkina Faso

Ouadéba Roger, Ouagadougou, Burkina Faso

MOPDD175

Coping with the Challenges of HIV/AIDS in Rural Areas of Uganda: A Case Study of HIV/AIDS Female Clients at Kasana Health Centre, Luwero District

Stanley Nsubuga, Kampala, Uganda

MOPDD176

Scaling up Adolescent Access to Quality Information and Utilization on HIV Prevention, Treatment and Support in Rural Areas of Uganda

Stanley Nsubuga, Kampala, Uganda

MOPDD177

Strategies and Options for HIV Prevention in an African University: The Copperbelt University Model in Zambia

Nawa Sanjobo, Kitwe, Zambia

MOPDD178

Increased Alcohol and Substance Abuse among Men who Have Sex with Men (MSM) in Keny: Increased HIV Rates and HIV Related Deaths due to Improper Health Service Provision

Macland Njagi Nyaga, Nairobi, Kenya

MOPDD179

Testing the Relevance of the Health Belief Model in Predicting Health Seeking Behaviour among Sex Workers

Humphreys T. Shumba, Lilongwe, Malawi

MOPDD180

Abstinance VS Condomisation: Peer Educators Perceptions towards the Female Condom

Prudence T. Mdletshe, Durban, South Africa

MOPDD181

Don't Ask, Don't Get: The State of Routine Viral Load Testing Across Africa Community Monitoring and Advocacy for Access to Routine Viral Load Testing in 12 Countries

Solange Baptiste, New York, United States

MOPDD182

VIH/Sida et Droits Humains au Togo: Activités de l'Observatoire Nationale sur la Stigmatisation et la Discrimination des Personnes Vivant avec le VIH au Togo

Essinam K. Hilaire Kpedzroku, Atakpamé, Togo

MOPDD183

Let's Talk about Sex: Families Matter! Program Participants Discuss HIV with their Preadolescent Children for the First Time in Tanzania

Kathryn Rosecrans, Dar es Salaam, Tanzania, United Republic of

MOPDD185

Discrimination against Transgender People in Health Care in Lebanon

Rabih Maher, Damour, Lebanon

MOPDD186

Accelerating HIV Prevention, Care and Treatment: A Comprehensive Approach Including Adolescent Programming

Macland Njagi Nyaga, Nairobi, Kenya

MOPDD187

Realization of Telefilm for Behavior Change on HIV ¨Course pour la Vie¨ Based on the Evidences of the Behavioral Study on Truckers and Staff of Hotels and Buildings Company in Benin, 2015

Ayédélé Amour Balogoun, Cotonou, Benin

MOPDE188

The Powerful Dynamics of ART Services Delivery in Limited Resourced Setting: A Ghanaian Experience

Josephine Naa Deisa Sasraku, Accra, Ghana

MOPDE189

Increased State Funding: A Vital Prerequisite for Improved HIV Care

Richard Serunkuuma, Kampala, Uganda

MOPDE190

Young People's Involvement in Reproductive Health and HIV/AIDS Activities in Nyambi and Chikwewo Areas in Machinga

Jali Sann, Lilongwe, Malawi

MOPDA191

Quality of Family Planning Services and Integration in the Prevention of Vertical Transmission Context. Perspectives and Experiences of Women Living with HIV and

Service Providers in Three Countries

Nganhale Francine, Yaoundé, Cameroon

MOPDB192

Policy and Practice of Health Care Waste Management in Community-based Care for People Living with HIV/AIDS/TB in Sub-Saharan Africa

Lydia L. Hangulu, Durban, South Africa

MOPDE193

Diagnostic Précoce du VIH, ARV Pédiatriques et Plumpy Nut: Accès au Point de Dispensation. Etat des Lieux dans 24 Sites de Prise en Charge du VIH Pédiatrique en Afrique en 2014

Réjane Zio, Paris, France

MOPDE194

Strengthening Governance for Effective Multi-sectoral HIV&AIDS Response: A Case Study of the Enhancing Nigeria's Response (ENR) to HIV&AIDS Programme in Cross River State, Nigeria

Mary Godwin Mbukpa, Calabar, Nigeria

MOPDE195

E25: Trafic Humain, Violence Sexuelle et VIH dans le Conflit en Republique Centrafricaine

Mounga-Ouatene Sosipater, Bangui, Central African Republic

MOPDE196

E26: Intérêt de Scolarisation et Réinsertion des Orphelins et Autres Enfants Rendus Vulnérables (OEV) dans la Vie Active

Dimanche Lucien, Bangui, Central African Republic

MOPDE197

Correlates of the Sustainability of ART Interventions in a National Sample of Health Facilities in Uganda

Henry Zakumumpa, Kampala, Uganda

MOPDE198

Local Capacity Initiatives: Plaidoyer Pilote pour une Meilleure Appropriation de la Lutte contre le SIDA et un Meilleur Soutien à la PTME par 10 Communes au Cameroun

Eugène-Lebrun Foyeth-Kamdem, Bamenda Nkwen, Cameroon

MOPDE199

Strategic Planning, Development and Implementation Process for HIV Response in a Devolved System of Governance in Kenya; Lessons Learned

Bryan Okiya, Nairobi, Kenya

MOPDE200

Potential Contributors to the Low Performance of Prevention of Mother-to-Child Transmission (PMTCT) of HIV Programs in Rural Ethiopia: Health Systems Perspective

Anteneh Asefa, Hawassa, Ethiopia

MOPDE201

Linking Key Populations into HIV Care by Use of "a Mobile Phone" in Rural Uganda: The AIDS Support Organization (TASO): Mbarara Experience

Ziporah Kyogabirwe, Mbarara, Uganda

MOPDE202

Infiltration of the MSM and Transgenger HIV Community: A Case Study of TASO Gulu-Uganda

Shafik Malende, Kampala, Uganda

MOPDE203

Condom Use among Men who Have Sex with Men (MSM) and Female Sex Workers (FSW) who Present with Sexually Transmitted Infections (STI) at a Community Health Centre (CHC) in Kaduna, North West, Nigeria

Akintunde Abimbola, Kaduna, Nigeria

MOPDE204

Nutrition Training Based on New Guidelines for Management of HIV-positive Children Improves Competence of Mid Level Providers Caring for HIV-positive Children in Tanga, Tanzania

Bruno F. Sunguya, Dar es Salaam, Tanzania, United Republic of

MOPDE205

Adolescents Count Today: Improving the Quality of Life of Adolescents Living with and Affected by HIV in Kenya

Ochieng Gordon, Nairobi, Kenya

MOPDE206

Data-Focused Management: Influencing Lasting Change in Prevention of Mother-to-Child Transmission (PMTCT) Programming

Regina Mankhamba, Lilongwe, Malawi

MOPDE207

Meaningful Youth Engagement: Linking Community- and Facility-based Sexual and Reproductive Health Services for Young People Living with and Affected by HIV

Cedric Nininahazwe, Bujumbura, Burundi

MOPDE208

Effectiveness of Community Based Information System to Monitor Program Progress for Service Delivery to OVC in Tanzania: Case of Africare Pamoja Tuwalee

Conjesta Shao, Dar es Salaam, Tanzania, United Republic of

MOPDE209

Access to Treatment and Care of MSM Infected in Nepal

Bishwaraj Adhikari, Kathmandu, Nepal

MOPDE210

Effectiveness of Supportive Supervision in Building CBO M&E Capacity for Better Data Quality

Conjesta Shao, Dar es Salaam, Tanzania, United Republic of

MOPDE211

Work as Consortium or Fail? The Realities of Working as Consortium for Effective HIV Programme Implementation

Ifeanyi Okekearu, Abuja, Nigeria

POSTER SESSION I

MOPDE212

Use of Social Media as an HIV/SRH Sensitization Tool among Adolescents: A Case Study of TASO Gulu-Uganda

Shafik Malende, Kampala, Uganda

MOPDD213

Approche Innovante de Structuration du Plaidoyer dans 4 Pays d'Afrique Francophone: L'Exemple du Projet « Plaidoyer Décentralisé »

Alexandra Phaëton, Pantin, France

MOPDE214

Promoting Community Based Support for Orphan and Vulnerable Children in Ekiti State, Nigeria

Yemi Ajumobi, Ado - Ekiti, Nigeria

MOPDE215

La Prise en Charge des Populations-clé, Expérience d'Espoir Vie - Togo par Léonie AMOUZOU, Ex-Présidente d'EVT

Amouzou Sidemeho Ameyo Blewussi, Lomé, Togo

MOPDE216

Kenya's Lower Middle Income Country (LMIC) Transition and the Need to Protect Investments in HIV and AIDS: Towards Greater Country Ownership

Peter Mwangi, Nairobi, Kenya

MOPDE217

Estimation des Coûts Unitaires des Activités à Base Communautaire de Lutte contre le VIH/Sida un Outil de Mobilisation de Ressources pour la Mise en œvre de l'Initiative 90-90-90 de ONUSIDA

Sosthene Dougrou, Geneva, Switzerland

MOPDE218

Antiretroviral Supply Chain Rationalization in Uganda: Eliminating Parallel Supply Systems

Barbara M. Namirembe, Kampala, Uganda

MOPDE219

A Field-based Stock-monitoring Tool Used to Improve HIV Commodity Availability among Private-not-For-profit Health Facilities in Uganda

Rashid Settaala, Kampala, Uganda

MOPDE220

Experiences of Reducing Health Facility Out-of-Schedule Ordering in an Integrated Antiretroviral and Laboratory Commodity Pull Supply System, Uganda

Sharifah Mwajabu, Kampala, Uganda

MOPDE221

A Model Support Supervision and Mentoring Strategy to Improve HIV Commodities Management among Private-not-For-profit Health Facilities in Uganda

Sheba Nakimera, Kampala, Uganda

MOPDE222

Leveraging Mobile Phone Instant Messaging to Improve Ordering and Reporting for HIV Commodities in a Resource Limited Setting, Uganda

Ronald Luyera, Kampala, Uganda

MOPDE223

Donor Coordination in Nigeria Using the Donor Consultative Forum

Opeola O. Abegunde, Abuja, Nigeria

MOPDE224

Capacity and Constituency Building for People Who Inject Drugs (PWID) in Nigeria

Gunasekaran Rengaswamy, Abuja, Nigeria

MOPDE225

Reduction of Vulnerability to HIV and AIDS among Young Persons with Disabilities in Ekiti State

Charles Olusegun Doherty, Ado Ekiti, Nigeria

MOPDE226

Situation Analysis on Orphans and Vulnerable Children (OVC) Access to HIV Testing in Southwest Nigeria: Achieving Health Nigeria Initiative (AHNi) Experience

Olukunle Daramola, Abuja, Nigeria

MOPDE227

Consequence of Community Engagement in HIV/AIDS Programming: Igbeti General Hospital Example

Olukunle Daramola, Abuja, Nigeria

MOPDE228

Scaling up Cervical Cancer Screening through Corporate Social Responsibility

Jennifer Francesca Acio, Mbale, Uganda

MOPDE229

Improved Leadership and Governance Capacity Enhances HIV/AIDS Diagnostic Services in Ethiopia

Jemal Mohammed Ali, Addis Ababa, Ethiopia

MOPDE230

Public-private Partnerships at Best: A Holistic Approach to Prevention and Economic Empowerment

Isaac Kiema Muema, Nairobi, Kenya

MOPDE231

Community Empowerment Greatly Impacts on the Functionality of Health Systems, Experience of Bufumbo Health Centre IV Mbale District Uganda

Sylvia Kabenge Nakasi, Kampala, Uganda

MOPDE232

Inadequate Governance and Accountability Mechanisms in HIV and AIDS Programs in Uganda-UNASO Experience

Namirimu Esther, Kampala, Uganda

MOPDE233

Caring for Care Givers: Enhancing

Health Workers' Occupational Safety and Health Relating to HIV and TB

Musa Nyandusi, Nairobi, Kenya

MOPDE234

Reaching Vulnerable Workers with HIV Programmes through Public-private Partnerships in Ethiopia

Margherita Licata, Geneva, Switzerland

MOPDE235

The Attitude of Botswana Health Policy-makers and Service Providers toward a Population aging with HIV

Kabo Matlho, Sydney, Australia

MOPDE236

A Tool for Cost and Time Effective Strategic Planning for HIV/AIDS Interventions at the Provincial Level

Martin I. Mc Intyre, Medford, United States

MOPDE237

HIV/AIDS Program Investment in Health System Strengthening Improves Access to Health Services: A Case Study of Primary Health Care Approach in Nigeria

Idoteyin Oton Ezirim, Abuja, Nigeria

MOPDE238

Maximizing Human and Financial Resources for Health Systems Strengthening: The Community-based PMTCT Project and Utilization of Comprehensive Maternal, Neonatal and Child Health Services

Misrak Makonnen, Addis Ababa, Ethiopia

MOPDE239

Assessing a Comprehensive Package for Building Health Workforce Education in Nigeria

Heather Ross, Washington, United States

MOPDE240

An Innovative Approach to Increasing Knowledge, Skills and Services Uptake: Sex Worker Peer Education and Outreach

Daniel Gudeta, Addis Ababa, Ethiopia

MOPDE241

SRHR - HIV linkages motion study - The Game Changer that Accelerated Leadership on the Ground

Asa Andersson, Johannesburg, South Africa

MOPDE242

Monitoring and Evaluation Priority Interventions: An Assessment of M&E Interventions that Promote Data Quality in HIV Care and Treatment Setting

David Damba, Kampala, Uganda

MOPDE243

Listening to Experts: Results from Key Informant Interviews and Evidence Review of Sexual Reproductive Health (SRH) and HIV Linkages in East and Southern Africa

Asa Andersson, Johannesburg, South Africa

POSTER SESSION II

TUPDB001

Validation of a Single-plateform Assay to Determine the Absolute and Percentages of CD4 T-cells Using Cameroonian Patients' Samples

Francois-Xavier Mbopi-Keou, Yaounde, Cameroon

TUPDA002

Chlamydia and Gonorrhoea: The Two Hardly Diagnosed STDs Predisposing Nigerian Youth to HIV Infection

Okikiola Morenike Olajide, Ilorin, Nigeria

TUPDA003

Co-infections of HIV: Synergies on Viral and Bacterial Prevalence Mapping for Better Patients' Management in Kenya

Joseph Mwangi, Nairobi, Kenya

TUPDA004

Antiretroviral Therapy Restores Age-dependent Loss of Resting Memory B Cells in Young HIV-infected Zambian Children

Hope C. Nkamba, Lusaka, Zambia

TUPDA005

Evaluation du Diagnostic Précoce par la PCR-ADN dans les Centres de Santé de Référence du District de Bamako

Niaboula Koné, Bamako, Mali

TUPDB006

Evaluating Quality of Care for PLHIVs on Second Line Therapy in a Tertiary Level Care Hospital through Clinical Data Audits: Results from Sokoto, North Western Nigeria

Nwokedi Austin Ndulue, Abuja, Nigeria

TUPDB007

Dose Reduction and the Duration of Efavirenz Associated Neuropsychiatric Impairment

Kuteesa R. Bisaso, Kampala, Uganda

TUPDB008

Morbidité et Mortalité Liées au VIH dans le Service des Maladies Infectieuses de l'Hôpital Général Adolphe SICE de Pointe-Noire (Congo)

Michel Mankou Mankou, Pointe-Noire, Congo

TUPDB009

Antiretroviral Therapy (ART) Rollout to Rural Healthcentres in Malawi, Uganda and Zimbabwe: What about the Children?

George Abongomera, Kampala, Uganda

TUPDB010

Outcome of Interventions to Reduce Loss to Care amongst HIV Positive Women Ineligible for Treatment

Chioma O. Nwuba, Enugu, Nigeria

TUPDB011

HIV-1 Subtype C Co-receptor Usage in Patients Failing Combination Antiretroviral Treatment in Botswana

Kenanao P. Kotokwe, Gaborone, Botswana

TUPDB012

High Rates of Drug Resistance among Newly Diagnosed HIV-infected Newborns: The Challenge of PMTCT in Real-life Conditions in Togo

Mounerou Salou, Lomé, Togo

TUPDB014

12 Ans de Prise en Charge des PvVIH au Cameroun: Evolution des Indicateurs Clés du Programme

Bouba Bassirou, Yaoundé, Cameroon

TUPDB015

Dépistage Systématique du VIH pour les Enfants Souffrant de Malnutrition Sévère et Aiguë

Boureima Zida, Ndjamena, Chad

TUPDC016

Facteurs de Risque de Retard de Croissance chez les Enfants Infectés par le VIH et Sous Traitement Antirétroviral au Sénégal: La Cohorte Pédiatrique MAGGSEN ANRS12279

Cecile Cames, Montpellier, France

TUPDB017

Monitoring ART Treatment: Viral Load and Creatinine Clearance Documentation and Results Across Two Time Periods in Three Districts of South Africa

Jeri Sumitani, Pretoria, South Africa

TUPDB018

La Planification Décentralisée au Niveau des Districts Sanitaires Comme Levier d'Accélération vers l'éTME au Tchad

Boureima Zida, Ndjamena, Chad

TUPDB019

Adult Mortality before and after Introduction of Antiretroviral Treatment in Rakai, SW Uganda

Dorean Nabukalu, Kampala, Uganda

TUPDB020

Early Initiation of ART in Patients with High CD4 Reduces their Chance of Developing Tuberculosis

Maureen Akolo, Nairobi, Kenya

TUPDC021

HIV, HAART and Metabolic Syndrome in HIV Infected Cameroonians' a Matter of Concern!

Henriette Therese Dimodi, Yaounde, Cameroon

TUPDB022

Échec Virologique des Traitements ARV dans une Cohorte de PVVIH en Mauritanie

Kelly Mamadou, Nouakchott, Mauritania

TUPDB023

Reasons for Missing Clinic Appointment

among HIV/TB Patients in Uganda Military Health Facilities

Abdulwahab Sessolo, Kampala, Uganda

TUPDB024

Facteurs Psychologiques Associés aux Conduites Sexuelles à Risque de l'Adolescent Séropositif Ayant l'Annonce: Cas de l'ONG "Espoir Vie-Togo" avec le Soutien du Programme Grandir de Sidaction

Yatimpou Tchedre, Lomé, Togo

TUPDB025

Evaluation de l' État d'Avancement de la Maladie Hépatique des Patients Infectés par le Virus de l'Hépatite B au Moment du Dépistage à Nouakchott (Mauritanie)

Kelly Mamadou, Nouakchott, Mauritania

TUPDB026

Analyse Immunoclinique du Traitement de Deuxieme Ligne dans Cinq Sites de Prise en Charge à Lomé

Patassi Akessiwe Akouda, Lomé, Togo

TUPDB027

Predictors of Incomplete Adherence and Immuno-virologic Failure among HIV-infected Adults on Antiretroviral Therapy in Southwestern Nigeria

Bashirat Tolulope Shittu, Osogbo, Nigeria

TUPDB028

Manifestations Oculaires chez l'Enfant au Cours du VIH à Ouagadougou

Caroline Nyangi Yonaba Okengo, Ouagadougou, Burkina Faso

TUPDB029

Devenir des Patients Traités par Antirétroviraux et Facteurs Associés à la Mortalité à l'Hôpital Universitaire de Cotonou, Bénin

D. Marcel Zannou, Cotonou, Benin

TUPDB030

Comparison of Biocentric and Abbott RealTime Assays in Plasma HIV-1 RNA Quantitation in Mali and Burkina-Faso, West Africa

Dramane Kania, Bobo-Dioulasso, Burkina Faso

TUPDB031

AIDS and Non-AIDS Infectious Morbidity after Second Line Antiretroviral Therapy Initiation in HIV-1 Infected Adults in Cameroon

Adrien Galy, Montpellier, France

TUPDB032

Faisabilité du Frottis Cervico-utérin chez les Femmes Séropositives Vivant au Tchad

M Kémian, Moundou, Chad

TUPDB033

Impact de la Mise en œvre de la Prise en Charge Intégrée des Maladies dans le Contexte du VIH/Sida dans le District Sanitaire de Pô, Burkina-Faso

Ouedraogo Pascal Honoré, Pô, Burkina Faso

TUPDB034

Focus Group Discussion (FGD) Helps in Improving ART Adherence amongst Adolescents

Grace W. Gakunju, Nairobi, Kenya

TUPDC035

Comportement des Personnes Ayant Pris un Risque d'Exposition au VIH et Qui Ont Consulté à l'Hôpital de Jour du Centre Hospitalier Universitaire Yalgado Ouédraogo de Ouagadougou au Burkina Faso

Martin Bazongo, Ouagadougou, Burkina Faso

TUPDC036

The Prevalence of HIV/AIDSs in Patients Suspecting of Having Ebola Viral Diseases in the Ministry of Defense Ebola Treatment Unit, Liberia (MOD-LIBERIA)

Jean Claude Nshimiyimana, Monrovia, Liberia

TUPDC037

Evaluation of Activities for the Promotion of Condom Use, Targeted Truckers and the Staff of Hotel and Bulding Compagny in Benin (2012-2015)

Balogoun Ayédélé Amour, Cotonou, Benin

TUPDC038

VIH et la Violence Domestique au Togo: Les Résultats de l'Enquêtes Démographiques et de Santé 2013-2014

Anthony Nguyen, Lomé, Togo

TUPDC039

A Study among Female Sex Workers in Kampala, Uganda to Identify Factors Associated with Lack of Uptake of HIV Counseling and Testing Services

Yunia Mayanja, Entebbe, Uganda

TUPDC040

Comparison of the HIV Surveillance Results among Female Sex Workers in Hargeisa, Somaliland between 2008 and 2014

Chiaki Ito, Nairobi, Kenya

TUPDC041

Harnessing Community Resources for HIV Prevention by Community Health Workers. Experiences from a Rural District in Uganda

Erick Ssegujja, Kampala, Uganda

TUPDC042

Assessing HIV and STI Prevention Strategies in Rural Area: Knowledge and Sexual Behaviours among Secondary School Girls in Côte d'Ivoire

Boris Kévin Tchounga, Abidjan, Cote D'Ivoire

TUPDC043

Treatment Outcomes among HIV Associated Tuberculosis Patients in Sindh, Pakistan: A Nested Case-control Study

Jamshed Hasnain, Karachi, Pakistan

TUPDC044

Monitoring and Evaluation: Using Low Cost Mobile Phone Technologies to Improve PMTCT Program Monitoring in Resource Limited Settings

David Damba, Kampala, Uganda

TUPDC045

Effectiveness of Focus Group Discussion as an Entry Strategy for HIV Intervention among People Who Inject Drugs (PWID). The SHiPS for MARPS Project Approach

Sylvia Ugonna Okeh, Abuja, Nigeria

TUPDC046

Frequency and Factors Associated with Late HIV Diagnosis in Burkina Faso

David Eric Ouedraogo, Ouagadougou, Burkina Faso

TUPDC047

Universal Access to Female Condom (UAFC) - The Intervention of Dual Protection Method from Unintended Pregnancies and STIs Including HIV/AIDS that Empowers the Women without Side Effects

Oluwarotimi Henry Adenigba, Ikorodu, Nigeria

TUPDC048

Outcomes of the Mobile Outreach Models for Improving Access to HIV Counseling and Testing among Female Sex Workers in a Community Based HIV Care Organization in Uganda

Sharon Nakanwagi, Kampala, Uganda

TUPDC049

100% Retention of HIV Positive Women Enrolled in PMTCT Option B+ Program at the AIDS Support Organization (TASO) Tororo: Sharing Best Practices and Understanding Outcomes

Lynette Opendi, Tororo, Uganda

TUPDC050

Combined Approaches for Improving Male Involvement in the PMTCT Program among the Urban Poor in the Slum Areas of Kampala-Uganda

Sharon Nakanwagi, Kampala, Uganda

TUPDC051

Achieving Zero Mother to Child Transmission of HIV through Using Mother to Mother Supporters: Experience of a Community Based Organization in Peri-Urban Uganda

Sharon Nakanwagi, Kampala, Uganda

TUPDC052

Joining Efforts for a More Inclusive and Sustained HIV Testing at Country Level: The Case of Nigeria

Oruno Onosode, Abuja, Nigeria

TUPDC053

Client-provider Interactions and Voluntary HIV Counseling and Testing Services in Uganda

Resty Nansubuga, Kampala, Uganda

TUPDC054

The Impact of HIV/AIDS Stigma on HIV Counseling and Testing in a High HIV Prevalence Population in Uganda

Dorothy Mubuuke, Kampala, Uganda

TUPDC055

Characteristics of People Living with HIV/AIDS (PLHA) in Egypt

Maryham Abdel Malak, Cairo, Egypt

TUPDC056

Identifying Interventions to Increase the Uptake of Male Circumcision in Southern and Eastern Africa: Evidence from Seven Impact Evaluation Studies

Eric Djimeu Wouabe, Washington, United States

TUPDC057

Sexual and Reproductive Health Vulnerabilities of People with Disabilities Begging in the Street: An Exploratory Study in Yaoundé, Cameroon (ANRS 12302)

Pierre De Beaudrap, Pars, France

TUPDC058

Couple Counseling Experiences in Fishing Communities along Lake Victoria, Uganda

Monica Ntende Balyeku, Kampala, Uganda

TUPDC059

Increasing uptake of Voluntary Medical Male Circumcision (VMMC) among Men Aged 20-34 Years in Njombe & Tabora Regions, Tanzania: A Cluster Randomised Controlled Trial

Mwita Wambura, Mwanza, Tanzania, United Republic of

TUPDC060

Les Consommateurs de Drogues Injectables Pairs Éducateurs pour Prévenir les IST/VIH/Sida dans la Région de Sikasso (Mali)

Mamadou Tiéman Doumbia, Bamako, Mali

TUPDC061

Determinants of Transactional Sex Using a Representative Survey in South Africa, 2012

Patience Gamuchirai Manjengwa-Hungwe, Pretoria, South Africa

TUPDC062

HIV, Gender and Mobility: Findings from a Knowledge, Attitudes and Practices Study of Fisherfolk in Six Districts in Uganda

Sunday Smith, Nairobi, Kenya

TUPDC063

Improving Tuberculosis Screening and Diagnosisiln People with HIV: Updates from the Intensified Case Finding Study in Kisumu County, Kenya

Patience A. Oduor, Kisumu, Kenya

TUPDC064

Community Mobilization: A Wake up Call for PMTCT Services in Gweru Urban District, Zimbabwe

Shelton Maguri, Harare, Zimbabwe

TUPDC065

Community Sensitization and Demand Creation on Cervical Cancer Screening/ Treatment in Tanzania: Experience from Facility and Community Based Screening Services in Iringa

Kamala Anathory Kamala, Dar es Salaam, Tanzania, United Republic of

TUPDC066

We Are Married; I Do Not Know his HIV Status and whether He Has Ever Tested for HIV. A Study Unfolds this at TASO Mbarara, South Western Uganda

Amelia Naturinda, Mbarara, Uganda

TUPDC067

Assessing HIV Prevalence and Vulnerability Factors among People with Disabilities (PwD) in Cameroon: Overcoming Methodological Issues. (HandiVIH Study - ANRS 12302 - NCT02192658)

Estelle Pasquier, Paris, France

TUPDC068

Campagne de Mobilisation sur la Prévention des IST et du VIH et des Grossesses Non-désirées auprès des Jeunes Déplacés du Site des DPI de l'Aéroport Bangui M'poko en Centrafrique

Suzanne Sobela née Danko, Bangui, Central African Republic

TUPDD069

Health Vulnerabilities Study of Mixed Migration Flows from the East and Horn of Africa and Great Lakes Regions to Southern Africa

Nkechi Obisie-Nmehielle, Pretoria, South Africa

TUPDC070

Sexual Behavioural Practices and HIV Risk Perceptions among Traditionally and Medically Circumcised Men in South Africa

Thobani Ntshiqa, Sandringham, South Africa

TUPDC071

Situation Analysis of HIV and Related Vulnerabilities of Young Workers Aged 16-24 in the Informal Economy in Greater Accra, Ghana

Margherita Licata, Geneva, Switzerland

TUPDC072

Des Zones de Concentration de l'Épidémie du VIH dans le Monde du Travail au Cameroun

Joseph Kemmegne, Yaounde, Cameroon

TUPDC073

Profil Épidémiologique du VIH au Togo en 2014. Résultats de la Troisième Enquête Démographique et Santé (EDS III)

Palokinam Pitché, Lomé, Togo

TUPDC074

Campagne Condomize au Togo en 2014: Une Innovation en Matière de Communication pour la Promotion de l'Utilisation des Préservatifs chez les Jeunes

Palokinam Pitché, Lomé, Togo

TUPDC075

Defeating Language Barrier and Confidentiality Challenges among Hausa-speaking Men who Have Sex with Men Living with HIV in Abuja, Nigeria

Uchenna Clifford Ononaku, Abuja, Nigeria

TUPDC076

HIV Prevalence and Risk Behaviors of Men who Have Sex with Men in Bamako, Mali 2014-2015

Nouhoum Telly, Bamako, Mali

TUPDC077

Assessment of Programmatic Challenges to Sexual & Reproductive Health and HIV Services Integration in Luapula, North Western and Western Provinces in Zambia

Vincent O. Okullo, Lusaka, Zambia

TUPDC078

Bottom up Approach to Design National Surveillance System: An Ethiopian Experience

Alankar Malviya, Addis Ababa, Ethiopia

TUPDC079

'If You Go and Get those Drugs Don't Come Back' - Masculinity as a Barrier to Women's Use of Elimination of Mother to Child Transmission of HIV Services in Five Ugandan Districts

Joseph Rujumba, Kampala, Uganda

TUPDC080

Contribution à la PTME dans les Centres de Santé Communautaire: Expérience de Kénédougou Solidarité

Mariam Koné, sikasso, Mali

TUPDC081

La PTME de Rattrapage dans les Maternités des Hôpitaux Nationaux de Donka et Ignace Deen en Guinée: Résultat d'un Partenariat Entre Solthis et le PNPCSP

Désiré Néboua, Conakry, Guinea

TUPDC082

HIV Counseling and Testing in Shopping Malls to Reach out to Young Workers in South Africa

Simphiwe Mabhele, Pretoria, South Africa

TUPDC083

HIV Vulnerability among Migrants and Local Community Members in the Mining and Extractive Industry in Uganda

Michela Martini, Nairobi, Kenya

TUPDC084

Mobility and HIV Risk in Fishing Communities in Uganda

Ismael Ddumba-Nyanzi, Kampala, Uganda

TUPDC085

Mobile Services Increase Access and Uptake in a Mobile Population: The Uganda Peoples Defense Forces (UPDF) Voluntary Medical Male Circumcision (VMMC) Rollout Experience

Alphonsus Kityo, Kampala, Uganda

TUPDB086

Mise en Place d'Un Programme de Prise en Charge des Couples à Action Contre le Sida (ACS)-TOGO

Degbe Dzodjina, Lomé, Togo

TUPDC087

Émergence du Leadership Parmi les Travailleuses/eurs du Sexe pour la Prévention de la Transmission Sexuelle du VIH/Sida: Enjeux pour la Protection de la Santé Publique en RDC

Alphonse Mihigo Ombeni, Bukavu, Congo, the Democratic Republic of the

TUPDC088

Is the eMTCT Programme in Calabar South LGA, Cross River State Yielding Results? Changes in ANC/PMTCT Service Uptake among Pregnant Women 15-49 Years over a Three-year Period: The DO Experience

Ukemeobong A. Ekong, Calabar, Nigeria

TUPDC089

Analysis of Changes in Treatment Outcomes of the Epworth HIV Cohort over Time and in Different Treatment Groups from 2006 to 2014

Rutendo Birri, Johannesburg, South Africa

TUPDC090

Increasing Visibility, Positive Change, Risk and Vulnerability among Gay/MSM in Kenya

Evans O. Odhiambo Opany, Nairobi, Kenya

TUPDC091

Connaissances des Personnes Handicapées sur le VIH/SIDA, Ziguinchor/Senegal

Aïda Zerbo, Ziguinchor, Senegal

TUPDC092

Evaluation of AIDS Impact Mitigation Project Targeting Pre-school OVC & their Caregivers in Nigeria

Muyiwa Oladosun, Canaan Land, Nigeria

TUPDC093

Why Pregnant Women Do Not Attend Antenatal Clinic (ANC) Services in Cameroon: Assessing Barriers to Uptake and Retention

Emmanuel Chia Kiawi, Yaounde, Cameroon

TUPDC094

Caractéristiques Socio-économiques et Obstétricales des Patientes Suivies dans un Projet d'Allaitement Protégé au Togo

Elom Takassi, Lomé, Togo

TUPDC095

Improving Uptake of Services along the Early Infant Diagnostic Cascade through Participatory Quality Improvement Approaches among mothers2mothers Supported Health Facilities in East Central Uganda

Sarah Auma, Jinja, Uganda

TUPDC096

Prevalence and Molecular Characterization of Hepatitis B Virus in Blood Donors in Botswana

Wonderful T. Choga, Bulawayo, Zimbabwe

TUPDC097

Etude de Base pour l'Intensification de la Lutte contre les IST/VIH/SIDA sur les Axes Routiers du Togo

Abra Afeli, Lomé, Togo

TUPDC098

HIV Prevalence among Pregnant Women Attending Antenatal Care (ANC) In Southwest Nigeria: Achieving Health Nigeria Initiative (AHNi) Experience

Itua J. Obaitua, Abuja , Nigeria

TUPDC099

Association between Motherhood and Sexual Behaviour in Zambian Female Sex Workers

Yuna T. Hammond, Lusaka, Zambia

TUPDC100

Programmes de Réduction de la transmission du VIH-1 de la Mère à l'Enfant au Togo: Importance des Groupes de Parole Mis en Place à Lomé, Atakpamé et Kara

Patassi Akessiwe Akouda, Lomé, Togo

TUPDC101

Determinants of Sexual Behaviour and Knowledge of Prevention of Sexually Transmitted Infections among Secondary School Students in Ibadan, Nigeria

Adebola A. Adejimi, Osogbo, Nigeria

TUPDC102

Modeling the Cost and Impact of the Voluntary Medical Male Circumcision Program in South Africa: Implications for Age and Regional Targeting

Katharine Kripke, Washington, United States

TUPDC103

Re-energizing HIV Prevention Response: Experiences of an HIV Prevention Campaign in Uganda

Asia Mbajja Namusoke, Kampala, Uganda

TUPDC104

A Comparison of Demographics and Risk Factors among Zambian Single Mothers and Female Sex Workers

Linda J. Kimaru, Ndola, Zambia

TUPDC105

Peer- led Intervention for the Use of Sexual Reproductive Health Services among HIV+ Youths Aged 15-24-years in Uganda

Asia Namusoke Mbajja, Kampala, Uganda

TUPDC106

Creating Awareness about HIV Prevention and Treatment Services in Uganda: The Power of Songs and Videos

Nantumbwe Shadidah, Kampala, Uganda

TUPDC107

Happy Clients: A Model for Promoting Long Acting Reversible Contraceptives and Couples' Voluntary Counseling and Testing

Alexandra B. Hoagland, Ndola, Zambia

TUPDC108

Building on the Mentor Mother Model to Improve the Sexual Reproductive Health and Rights of Adolescent Girls and Young Women

Anne Schley, Cape Town, South Africa

TUPDC109

Trend Analysis of HIV/TB Integrated Services Utilization and Coverage in Uganda South West Region (STAR-SW Project: 2011-2014)

Juan Seclen-Palacin, Washington, United States

TUPDC110

HIV and AIDS In Places of Detention in Nigeria: The South-west Experience

John Chukwudi Bako, Port Harcourt, Nigeria

TUPDC111

Standardizing Strategic Information and Evaluation (SI&E) Approaches, Procedures, and Practices: An EGPAF-Mozambique Experience (EGPAF, 2011-2015)

Etelvina Mbalane, Maputo, Mozambique

TUPDD112

Getting to Zero Stigma and Discrimination against Children Living with HIV (CLHIV) - The Experience of ZAPHA+, Zanzibar - Tanzania

Seif J. Abdulla, Zanzibar, Tanzania, United Republic of

TUPDD113

Improving and Increasing Access to Sexual Reproductive Health Rights and Elimination of Mother to Child Transmission Services for Women and Girls Living with HIV through Gender Transformative Approach

Hajjarah Nagadya, Kampala, Uganda

TUPDD114

Communicating to Enhance Acceptability and Utilisation of SRH Services

Isaac Kato, Kampala, Uganda

TUPDD115

Sustaining HIV Prevention Strategies. Straight Talk Foundations Seniors' Model

Isaac Kato, Kampala, Uganda

TUPDD116

Scaling up Testing among Informal Workers through Community Mobilization in Zimbabwe

Margherita Licata, Geneva, Switzerland

TUPDD117

Using mHealth as an Innovative Approach to HIV Prevention for Key Populations in West African Region (mHealth4KPs)

Harvey Kosigah de Hardt-Kaffils, Accra, Ghana

TUPDD118

The Impact of Anti-homosexuality Legislation on the Effectiveness of the HIV Response in Uganda

Richard Smith Lusimbo, Kampala, Uganda

TUPDD119

The Importance of Community Leaders (CLs) in Acceptance of New HIV Interventions - Key Strategy for Early Access to ART for All

Margaret Zanele Thwala-Tembe, Manzini, Swaziland

TUPDD120

Dire le VIH en Langue des Signes avec et pour Tous les Sourds

Jean Dagron, Marseille, France

TUPDD121

Community mobilisation for HIV Prevention, Treatment, Care and Support - The Case of Medhin HIV Positive Older People Association - Ethiopia, Hawassa Town

Sofia Mohamed Imam, Addis Ababa, Ethiopia

TUPDD124

Burundi: Peer Education and Outreach with Young MSM in a Restrictive Environment

Jeanne D'arc Kabanga, Bujumbura, Burundi

TUPDD125

Patterns and Determinants of Migrants' Health and Associated Vulnerabilities in Urban Settings of East and Southern Africa

Erick Ventura, Pretoria, South Africa

TUPDD126

HIV and TB Legal Clinic Aims to Reduce Stigma and Discrimination in the World of Work

Simphiwe Mabhele, Pretoria, South Africa

POSTER SESSION II

TUPDD127

What Is this Animal Called the Global Fund? Gender, Rights and Diversity: Making the Global Fund Work for Women

Luisa Orza, London, United Kingdom

TUPDD128

Enhancing Positive, Health, Dignity and Prevention in Gay Men, Other Men who Have Sex with Men (MSM) and Transgender Individuals (GMT) Living with HIV through Index Client Strategy

Kennedy O. Olango, Kisumu, Kenya

TUPDD129

Communicate "Benefits of Testing" and "Hook" the Communication on Zero Discrimination. It WORKS

Syed Mohammad Afsar, Geneva, Switzerland

TUPDD130

Lessons Learned of Setting up a Community-based HIV-related Human Rights Monitoring and Response System in Uganda.

Richard Smith Lusimbo, Kampala, Uganda

TUPDD131

Respecting Human Rights in VCT@WORK

Julian Hows, Amsterdam, Netherlands

TUPDD132

Prévention du VIH/SIDA en Milieu Communautaire: 5 Années d'Expérience de l'Approche Participative du Centre Intégré de Recherches Biocliniques d'Abidjan en Côte d'Ivoire

Dasse Claude Desire, Abidjan, Cote D'Ivoire

TUPDD133

Reaching out to the Informal Economy Workforce in Ghana

Margherita Licata, Geneva, Switzerland

TUPDD134

Leaving No One behind - Achieving Greater Successes through Integration and Joint Programming of Youth Activities

Elorm K. Adawudu, Accra, Ghana

TUPDD135

Enquête Connaissances, Attitudes et Pratiques en Matière de la Santé de Reproduction et du VIH/SIDA chez les Adolescents de 10 à 24 Ans au Togo

Palokinam Pitché, Lomé, Togo

TUPDD136

Les Pesanteurs Socio Culturelles Liées à Question de la Problèmatique de la Sexualité chez les Adolescents Infectés au VIH au Bénin

Henri Judicaël Kanhonou, Cotonou, Benin

TUPDD137

Profil Socio-professionnel et Comportemental des Usagers de Drogues par Injections Intraveineuse (UDI) en Matière de VIH et Santé de la Reproduction au Togo

Palokinam Pitché, Lomé, Togo

TUPDD138

Sexual Gender Based Violence and Child Marriage

Grace Njuki, Nairobi, Kenya

TUPDD139

Understanding and Addressing HIV and AIDS with Young Asylum Seekers from Key Populations in the MENA Region

Nadia Badran, Beirut, Lebanon

TUPDD140

The Dilemma of young FSWs in Ghana: Raising Challenging Issues for Policy Makers, Planners, Programme Managers and Health Professionals

Vivian Fanny Sarpomaa Fiscian, Accra, Ghana

TUPDD141

Sustaining Innovative Community-based Service Delivery to Optimize High Interventions for Key Populations in Ghana

Cynthia A. Asante, Accra, Ghana

TUPDD142

Addressing Mental Health Disorders and HIV Vulnerability of Marginalized Adolescents in Addis Ababa, Ethiopia

Nrupa Jani, Washington, United States

TUPDD143

Male Having Sex with Male and Transgender People Have Been Faced Much Stigma and Discrimination in Nepal of their Gender Identity, Gender Expression Because Social and Cultural

Koshit Kumar Rajdhami, Rajbiraj, Nepal

TUPDD144

Protecting Rights of Key Populations through Strategic Litigation a Stepping-stone for post 2015 HIV and AIDS Response a Zimbabwean Case Study

Jacob Ntsholeng Segale, Roodepoort, South Africa

TUPDD145

Using Conversations to Break down Misconceptions about HIV among Young People in Uganda - Straight Talk Approach to Sex Education

Godfrey Walakira, Kampala, Uganda

TUPDD146

Best Practices Model for Human Rights Based Response to HIV and AIDS Post 2015 a SADC Case Study

Jacob Ntsholeng Segale, Roodepoort, South Africa

TUPDD147

Financial Skills Training for Sex Workers. HIV Prevention through Economic Empowerment

Marie-Louise Wijne, Amsterdam, Netherlands

TUPDD148

Young People Living with HIV Leading Change: Advocacy for Better Services and Support in Zimbabwe

Kelvin K. Makura, Harare, Zimbabwe

TUPDD149

Religious Leaders and HIV in the MENA Region

Rita Wahab, Beirut, Lebanon

TUPDD150

Everyone Knows how to Protect Themselves. Everyone Is Demanding to Put an End to Stigma. Everyone Is Confirming our Rights. What Is the Role of Religious Agents in Reducing Stigma & Discrimination?

Rita Wahab, Beirut, Lebanon

TUPDD151

Stratégie de Lutte contre les IST/VIH et les Grossesses en Milieu Scolaire

Yao Konan Jules, Abidjan, Cote D'Ivoire

TUPDD152

Le Sport et la Culture pour la Prévention des IST/VIH/Sida Sous la Forme de « Caravane Jeunesse Saine, Protège-toi »

Yao Konan Jules, Abidjan, Cote D'Ivoire

TUPDC153

Ex-post Evidence of Improved Scholastic Ability among Targeted OVC in an AIDS Impact Mitigation Project in Nigeria

Muyiwa Oladosun, Canaan Land, Nigeria

TUPDD154

Carte Score sur la Santé des Hommes Ayant des Rapports Sexuels avec des Hommes (HSH) en Côte d'Ivoire

Kouadio Franck-Arnaud Amani, Abidjan, Cote D'Ivoire

TUPDD155

Mobilising, Supporting Traditional and Religious Leaders to Campaign and Motivate Communities to Access Integrated HIV and RMNHCH Services

Maria Chiwera, Harare, Zimbabwe

TUPDD156

Amour et Sexualité chez les Adolescents Séropositifs Suivis au CTA CNHU de Cotonou: Vécu et Perspectives

Souliatou Abiola, Cotonou, Benin

TUPDD157

Adolescents in Crisis: Unmet Reproductive Health Needs of IDPs

Obi Onyeigwe Peter, Abuja, Nigeria

TUPDD158

Understanding Self-appraisal of Risk to HIV Infection and Desire for HIV Test among Sexually Active Persons in Ogun State, South West Nigeria

Olufunke Adewoyin, Abeokuta, Nigeria

TUPDD159

Communicating Treatment as Prevention in the Context of Providing Antiretroviral Treatment for All: Material Development and Assessment

Emma Mafara, Mbabane, Swaziland

TUPDD160

Identifying, Addressing and Preventing Sexual and Reproductive Health Rights Violations in Kenya and Uganda: Practices and Approaches of WOFAK and Mama's Club

William Ssempebwa, Kampala, Uganda

TUPDD161

Involvement of Communities in the Implementation of Early Access to ART for All in Swaziland: A Coordinated Approach

Nonhlanhla Dlamini, Mbabane, Swaziland

TUPDD162

Young Voices for Access to Health

Gracias N.A. Atwiine, Kampala, Uganda

TUPDD163

Innovations and Best Practices: Impact of South-to-South Technical Assistance from Rwanda & Zambia in Couples Voluntary HIV Counseling and Testing (CVCT) Achievements 21 Countries

Nurilign Ahmed, Kigali, Rwanda

TUPDD164

Family-focused Community Model to Increase Male Involvement in RMNCH and PMTCT Services

Anne Schley, Cape Town, South Africa

TUPDD165

Legal Aid as a Tool to Promote Economic and Social Rights for People Living with HIV/AIDS - Egypt

Abd El Razek Abu El Ela, Cairo, Egypt

TUPDD166

Taking Care of our Own: Dealing with MSW/MSM Human Rights Violations in Nairobi

Pascal M. Irungu, Nairobi, Kenya

TUPDD167

Analysis of the Efforts towards the Twin Epidemics of Gender Based Violence and HIV in Nigeria

Mercy Egemba, Abuja, Nigeria

TUPDD168

HIV and TB in Prisons: Advocating for Re-integration Policies to Ease Recidivism and Curb HIV/TB Infections in the Community

Nelago Amadhila, Windhoek, Namibia

TUPDD169

Measuring Relationship Satisfaction among Men and Women in Peri-urban Uganda

Allison Ruark, Washington, United States

TUPDD170

Human Rights, HIV Related Stigma and Discrimination among LGBTI in Botswana

Anna Mmolai-Chalmers, Gaborone, Botswana

TUPDC171

Monitoring and Evaluation of a Capacity Building Programme for (Women) Parliamentarians to Improve Advocacy and Governance

Loveena Dookhony, Windhoek, Namibia

TUPDD172

Soccer-based Intervention to Reduce Drug Use and Address Perceptions of Gender and Sexuality among Adolescent Males in Alexandra, South Africa

Andrew Durkin, Cape Town, South Africa

TUPDD173

Post Exposure Prophylaxis: Unmet Need for Survivors of Sexual Violence in Ghana

Martin Jones Blantari, Accra, Ghana

TUPDD174

Que Cache le Décès d'Enfants Infectés au VIH? Au Cœur des Révélations de l'Entourage des Enfants Décédés

Tanguy Bognon, Cotonou, Benin

TUPDD175

"Why Do You Get Pregnant when You Know You Are Positive Living and Young?" Setting an Advocacy Agenda for Young Women's Access to Integrated Sexual and Reproductive Health / HIV Services

Tinos Kedebe, Addis Ababa, Ethiopia

TUPDD176

An Exploratory Survey of Lived Experiences of Young Persons in Sex Work, Bulawayo, Zimbabwe, 2015

Nombulelo Madonko, Bulawayo, Zimbabwe

TUPDD177

Documenting Human Rights Violations against Sex Workers and Lesbian, Gay, Bisexual and Transgender Persons in Zimbabwe

Humphrey Ndondo, Bulawayo, Zimbabwe

TUPDD178

Reaching Key Populations and Cross Border Communities in Southern Africa through Multi-media Communication Materials on HIV Prevention and SRHR Awareness

Bongiwe Ndondo, Johannesburg, South Africa

TUPDD179

Problématique de la Confidentialité et du Secret Professionnel Liés à l'Infection à VIH dans Une Unité Pédiatrique de Prise en Charge

Tanguy Bognon, Cotonou, Benin

TUPDD180

Responding to the Psychosocial Needs of Adolescents Living with HIV within their Health Facilities and Communities

Trevor Chirimambowa, Bulawayo, Zimbabwe

TUPDD181

Hope or Hype: A Case of Age Appropriate Comprehensive Sexuality Education in Kenya

Jane Kamau, Nairobi, Kenya

TUPDD182

Framing LGBTI Persons in Order to 'Hang' Them: A Critical Analysis of the Representation of LGBTI Persons in Selected National Print Media Publications of Southern Africa

Moses Eustace Danai Magadza, Windhoek, Namibia

TUPDD183

Taking into Account Adolescent Voices for HIV Prevention in Nakuru Kenya - The I Choose, My Life Experience

Catherine Wanjiru Nyambura, nakuru, Kenya

TUPDD184

Assessment of Adolescent and Youth HIV and AIDS Programming Though Digital Technology, Service Provision and Policy Advocacy in Kenya

Chelimo Keter, Nairobi, Kenya

TUPDD185

Can Litigation Tip the Scales on the HIV vs Humans Bout?

Caine J.K. Youngman, Gaborone, Botswana

TUPDD186

Increasing HCT Uptake among through Integrated Youth Friendly ASRH Services; Lessons from Naguru Teenage Information and Health Centre

Sebs Kadokech, Kampala, Uganda

TUPDD187

Academic Success and Hearing Loss, a Conundrum Associated with School Aged Children with HIV/AIDS in KwaZulu-Natal South Africa

Zandile V. Peter, Durban, South Africa

TUPDD188

Reaching Most Vulnerable People for Long Acting and Reversible Contraceptive (LARC) in Madagascar (Antananarivo)

Jeannette Danho, Antananarivo, Madagascar

TUPDE189

Securing Resources and Capacity for Effective Partnership of HIV Programs in Enugu State, Nigeria

Josephine Aniagolu, Enugu, Nigeria

TUPDA190

Standardized Site Monitoring as a Strategy for Quality Assurance for Public Health Facilities in Cameroon

Leonard Colince Keleko, Yaounde, Cameroon

TUPDE191

La Mobilisation des Ressources par la Réduction des Coûts: L'Expérience de l'ONG Togolaise Espoir Vie-Togo (EVT) de la Négociation de Remises et de Prestations Gratuites sur le Plan Local

Kpantchala Alégah, Lomé, Togo

TUPDE192

Including Disability in HIV Policy and Programming: Good Practices Drawn from Country-based Evidence

Pulchérie U. Mukangwije, Montreal, Canada

TUPDE193

Partenariat Public-privé pour une Prise en Charge Globale et Confidentielle des Travailleurs Infectés par le VIH/Sida au Burkina Faso

David Guiré, Ouagadougou, Burkina Faso

TUPDE194

Committed Managers Contribute to the Effectiveness of HIV and AIDS Workplace Programmes

Margherita Licata, Geneva, Switzerland

TUPDE195

HIV Programming for All: Leveraging the French Technical Assistance Program's "5% Initiative" to Include Persons with Disabilities. Project Experience in Senegal

Aïda Zerbo, Ziguinchor, Senegal

TUPDE196

Public-private Partnerships to Scale-up HIV Testing and Counseling amongst Workers in Zimbabwe

Margherita Licata, Geneva, Switzerland

TUPDE197

Mentoring for Performance Excellence (MPE): The Tanzania Experience

Chrispen Dandavare, Bethesda, United States

TUPDE198

Interventions to Increase Retention of Mother-baby Pairs in PMTCT Programs: A Case Study from Protecting Families against HIV (PREFA)

Ritah Nakigudde Waddimba, Kampala, Uganda

TUPDE199

Specifically: E7 Effective National Leadership - Indicators and Benchmarks to Measure Progress to Greater Country Ownership

Monica Davidson, Brighton, United Kingdom

TUPDE200

Tackling Inequalities & HIV Vulnerabilities through Economic Empowerment

Joseph Ajakaye, Pretoria, South Africa

TUPDE201

Going beyond the Funder/Recipient Partnership Paradigm to Support NGO Development and Strengthen the Fight against AIDS in Africa: Solidarité Sida's "Autonomisation" Program

Matthew Kalamar, Paris, France

TUPDE202

Mapping of HIV/AIDS and Related Services along Major Transport Corridors in the East African Community (EAC)

Michael J. Katende, Arusha, Tanzania, United Republic of

TUPDE203

Strengthening Social Protection to Mitigate Impacts of HIV and AIDS among Older People in sub-Saharan Africa

Martin Oyosa Mubisi, Nairobi, Kenya

TUPDE204

Access to Health Services for People Living with HIV under the National Health Insurance Scheme in Ghana: What Are the Views and Perspectives of Health Providers and Insurance Managers?

Philip Ayizem Dalinjong, Navrongo, Ghana

TUPDC205

Reducing HIV Vulnerabilities through Economic Empowerment in Tanzania

Getrude Zacharia Sima, Dar es Salaam, Tanzania, United Republic of

TUPDE206

Saving Lives through Routine Cervical Cancer Screening of HIV Positive Women in Reproductive Age Accessing Services at TASO Mbarara, South Western Uganda

Amelia Naturinda, Mbarara, Uganda

TUPDE207

Human Resources Strategies for the Long-term Sustainment of ART Interventions: Evidence from a National Survey of Health Facilities in Uganda

Henry Zakumumpa, Kampala, Uganda

TUPDE208

Government Supports Improved Access to Health Care for Sex Workers in Kenya Lessons Learned from Bridging the Gaps Programme in Kenya

Marieke Ridder, Amsterdam, Netherlands

TUPDE209

A Twinning Partnership between Debre Birhan and Elmhurst Hospitals: A Model for Sustainable Health System and Human Resource Capacity Building

Neil Landreville, Elmhurst, United States

TUPDE210

Active Post-surgical Follow up Significantly Reduces Moderate and Severe Adverse Events among Safe Male Circumcision (SMC) Volunteers in Resource Limited Settings in Tororo Uganda

Emmanuel Ocamare, Kampala, Uganda

TUPDE211

Condomize! Zambia Campaign: Expanding Access to Condoms and SRH Information among People Living with Visual Impairment and Other Disabilities

Vincent O. Okullo, Lusaka, Zambia

TUPDE212

Foundations of Laboratory Leadership and Management (FLLM) Strengthen Managers at the National Health Laboratory Services (NHLS) in South Africa

Kaiser Shen, Silver Spring, United States

TUPDE213

Feasibility of Using Cloud-based GIS and Data Collection Tools to Develop an Online Resource Map Linking Medical and Social Care for PLWHA in Eastern Congo

Givano Kashemwa, Bukavu, Congo, the Democratic Republic of the

TUPDE214

The Use of Patient Monitoring Registry to Evaluate Number of Active Patients on Art

Eric Abala, Nairobi, Kenya

TUPDE215

Strategies for Linking Young People Living with HIV with SR HR/HIV Services in Uganda

Gracie Nakazzi, Kampala, Uganda

TUPDE216

Catalyzing Improved Coordination of State Level HIV and AIDS Response in Nigeria

Aneotah Egbe, Abuja, Nigeria

TUPDE217

Strengthening Organizational Based Monitoring and Evaluation Techniques and Systems Can Enhance Quality Results and Impact in a Post 2015 Programmes

Jacob Ntsholeng Segale, Rooedpoort, South Africa

TUPDE218

How the ICASA2013 Scholarship Programme Contributed to Health Systems Strenghtening

Alet Bosman, Pretoria, South Africa

TUPDE219

Reaching the Hidden and Mobile Key Populations within the Community: The MARPI Model

John R. Lule, Kampala, Uganda

TUPDE220

Determining Whether Learnerships Supported Task Shifting in Public Sector Pharmacies in South Africa

Alet Bosman, Pretoria, South Africa

TUPDE221

Ensuring Effectively Managed Primary Health Care Facilities in South Africa through Training on a Toolkit

Alet Bosman, Pretoria, South Africa

TUPDE222

Improving Access and Acceptance of HIV Counseling and Testing for Key Populations Using the MARPI Model of Care

Majorie Nakimuli, Kampala, Uganda

TUPDE223

Community Client Lead ART Delivery Model

Ali Kasibula, Kampala, Uganda

TUPDE224

Prévention Combinée des IST et du VIH et des Grossesses non Désirées en Faveur des Professionnelles du Sexe en Centrafrique

Suzanne Danko Sobela, Bangui, Central African Republic

TUPDE225

Are Women Organisations Accessing Funding for HIV? A Rapid Situation Analysis of Access to Funding by Organisations of Women Living with HIV, Gender and Women Human Rights Organisations in Uganda

Bernard Gift Maridadi K, Kampala, Uganda

TUPDE226

VIH et Personnes Handicapées à Ziguinchor/Sénégal: Infection, Connaissances, Attitudes et Pratiques

Aïda Zerbo, Ziguinchor, Senegal

TUPDE227

Fragile Health System Coordination for Effective HIV Response - South Sudan Experience

Ayat Jervase, Juba

TUPDE228

How to Reach Key Populations with HIV Services in Kenya: Lessons from Operations Research within Bridging the Gaps Programme

Elizabeth Echoka, Nairobi, Kenya

TUPDE229

Strengthening the Capacity of CSOs Involved in HIV-AIDS Prevention and Support Services Projects in Nigeria

Muyiwa Oladosun, Canaan Land, Nigeria

TUPDE230

Decentralization for Effective HIV Response in Ghana - The Technical Support Units Concept

Welbeck Amoani Twum, Accra, Ghana

TUPDE231

Assessment of Household Economic Strengthening as a Sustainability Model in Care and Support for Orphans and Vulnerable Children in Kitui County, Kenya

Rachel Ambalu Ambalu, Nairobi, Kenya

TUPDE232

Réduire la Vulnérabilité des Professionneles de Sexe et Leurs Clients aux IST/VIH au Togo

Dometo Sodji, Lomé, Togo

TUPDE233

'Ya pas Drap': Un Projet de Réduction des Risques (RdR) Auprès des Usagers de Drogues (UD) à Abidjan, Côte d'Ivoire (RCI), pour un Meilleur Accès aux Soins et un Système de Santé Plus Adapté

Jérôme Evanno, Abidjan, Cote D'Ivoire

TUPDA234

New and Improved Evidence SRHR Programme for Young People in Nigeria

Daniel Onyeigwe Obi Peter, Abuja, Nigeria

TUPDE235

The Impact of Clinical Associates on the Provision of Voluntary Medical Male Circumcision (VMMC) in Rural South Africa

John B. Capati, Pretoria, South Africa

TUPDE236

Financial and Epidemiological Impact of Focusing Voluntary Medical Male Circumcision Efforts on Specific Age Groups and Regions in Tanzania

Katharine Kripke, Washington, United States

TUPDE237

Mobilizing Domestic Financial Resources for HIV/AIDS - State Level Experience from Nigeria

Olalekan Obademi, Abuja, Nigeria

TUPDE238

Role of Household Economic Empowerment Initiatives in Improving Essential Services for Orphans and Vulnerable Children: Aphia Plus Kamili Project, Tharaka Nithi County - Kenya

Charles N. Njuguna, Nairobi, Kenya

TUPDE239

Re-thinking Human Resource for Health and the Need for Integration of Unskilled Birth Attendants for Increased PMTCT Uptake: Preliminary Evidence from Nigeria

Iboro E. Nelson, Uyo, Nigeria

TUPDE240

Co-location as a Program Strategy to Build Nigeria' Government Capacity to Own and Sustain Comprehensive HIV/AIDS Services: Lessons from FHI 360 Experience in Nigeria

Samsu Gombwer, Abuja, Nigeria

TUPDE241

Empowering Male Sex Workers in Kenya to Reduce Vulnerability to HIV

John Mathenge, Nairobi, Kenya

TUPDE242

Prioritizing HIV Investment: Experiences of Improving Allocative Efficiency in HIV Programmes Using Mathematical Modeling

Emiko Masaki, Washington, United States

TUPDE243

Practical Data: How a Participatory M&E System Resulted in Evidenced-based Decisions for an HIV-prevention Program in Bulawayo, Zimbabwe

Katherine Morton, Cape Town, South Africa

TUPDE244

Impact of District HIV Consortiums' Networks-Mbale Experience

Muzaki Margaret, Kampala, Uganda

POSTER SESSION III

WEPDA001

APOBEC3G Variants and Protection against HIV-1 Infection in Burkina Faso

Tegwinde Rebeca Compaore, Ouagadougou, Burkina Faso

WEPDA002

Anti-retroviral Drug Resistance Mutations and Signature Marker Analysis in HIV Variants from Plasma and Peripheral Blood Mononuclear Cells Sample Pairs

Mayibongwe Mzingwane, Bulawayo, Zimbabwe

WEPDA003

Defining the Interactions between HIV-1 and the Cervical Mucins

Baxolele Mhlekude, Cape Town, South Africa

WEPDA004

Progress of the Prevention of Mother-to-Child Transmission of HIV-1 through Early Infant Diagnosis Program Performance in Cameroon

Celine N. Nkenfou, Yaounde, Cameroon

WEPDB005

Role of Treg and Th17 Cells during Infection by HIV-1

Mbadé Ngom, Dakar, Senegal

WEPDB006

The Impact of Early Telephone Call Follow up on Return to Care and the Associated Factors among HIV Positive Patients Attending Uganda Peoples Defense Forces (UPDF) ART Clinics

Abdulwahab Sessolo, Kampala, Uganda

WEPDB007

Risk Factor for LTFU in a Sample of HAART Established Patients

Leonardo Palombi, Rome, Italy

WEPDB008

The Frequency of N348I Mutation in Patient Failing Combination Antiretroviral Treatment in Botswana

Boitumelo Seraise, Gaborone, Botswana

WEPDB009

Impact of PIT Program on HIV Testing at Virunga Hospital in Goma/D. R. Congo

Mateus K. Sahani, Goma, Congo, the Democratic Republic of the

WEPDB010

Faisabilité de la Prise en Charge Nutritionnelle Ambulatoire des Grands Enfants et Adolescents Vivants avec le VIH à Dakar: Une Etude Pilote de la Cohorte Maggsen ANRS12279

Marie Varloteaux, Dakar, Senegal

WEPDB011

Coping Strategies of Children after Learning they Are HIV Positive: A Case Study at Nsambya Hospital - HIV and AIDS Programme Uganda Network of Young People Living with HIV and AIDS

Bwire Moses, Kampala, Uganda

WEPDB012

Infection by HSV-2 (Herpes simplex Virus Type 2) Acts as a Major Independent Cofactor of HIV Worsening, Virological Failure and Antiretroviral Drug Resistance Mutations Selection in Central Africa

Laurent Bélec, Paris, France

WEPDB013

Validation au Gabon d'Algorithmes pour le Sérodiagnostic de l'Infection à VIH Basés sur l'Utilisation Séquentielle de 3 Tests Rapides selon les Nouvelles Recommandations de l'OMS Révisées en 2012

Laurent Bélec, Paris, France

WEPDB014

Rate and Determinants of Immune Restoration among HIV-infected Adults on Combination Anti-retroviral Therapy in Northern Namibia: A Retrospective Comparative Observational Study of Patients on TDF/3TC/NVP vs AZT/3TC/NVP

Tadesse Mekonen, Windhoek, Namibia

WEPDB015

Clinical Profile and Predictors of Mortality in Hospitalised Patients with HIV/AIDS: A Retrospective Analysis from Tripoli Medical Centre, Tripoli, Libya, 2013

Nader Shalaka, Tripoli, Libyan Arab Jamahiriya

WEPDB016

Evaluation of Liver Diseases in HIV-infected Patients Admitted with HIV-related Complications

Nagat Bousifi, Tripoli, Libyan Arab Jamahiriya

WEPDB018

Follow-up of HIV Trans-border Patients: The Case of Save the Children in South Sudan

Emmanuel Males, London, United Kingdom

WEPDB019

Evaluation des Desirs et Intentions de Procreation chez les Femmes Vivants avec le VIH a la Veille du Passage a L'Option B+ de la PTME en Cote D'Ivoire

Apollianire G. Horo, Abidjan, Cote D'Ivoire

WEPDB020

Coinfection with Herpes Simplex V HIV Prevalence Trends among Young Women and Men in Sub-Saharan Africa from 2000-2013 - Evidence to Inform Gender-specific HIV Targets and Indicators in Generalized HIV Epidemics Virus Type 2 Is Associated with Reduced HIV-specific T-cell Responses and Systemic Immune Activation

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDB021

The Prevalence of Stunting Is High in

HIV-1-exposed Uninfected Infants in Kenya

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDB022

High Prevalence of Tuberculosis Infection in HIV-1 Exposed Kenyan Infants

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDB023

Nutritional Supplementation among Malnourished HIV-infected Children in Bamako, Mali

Julie Jesson, Bordeaux, France

WEPDB024

Challenges for Paediatric HIV Care and Treatment in Guinea-Bissau: Findings from a National Situation Analysis, 2014

Faustino G. Correia, Bissau, Guinea-Bissau

WEPDB025

Modèlisation de la Relation Entre le Déficit Immunitaire à l'Initiation du Traitement ARV et le Délai de Restauration Immunitaire des PvVIH: Cas des Patients de l'Hôpital Régional de Garoua (CTA-HRG)

Pascal Roland Enok Bonong, Montréal, Canada

WEPDB026

Trends in CD4 Count and Viral Load at Presentation for HIV Treatment in Swaziland

Sikhathele Mazibuko, Mbabane, Swaziland

WEPDB027

Country-level Perspectives on Implementation of Pediatric HIV Treatment Guidelines

Shaffiq M. Essajee, Geneva, Switzerland

WEPDB028

Outcomes of TB/HIV Co Infected Patients Enrolled for Care and Treatment at 27 Health Facilities in Western Kenya

Samson O. Muga, Nairobi, Kenya

WEPDB029

Improving One Year Survival Rate for Patients on ART in Southern Senegal

Isseu Diop Toure, Dakar, Senegal

WEPDB030

Barriers to Timely ART Initiation among HIV Infected Children Attending TASO Clinics AT Tororo, Mulago and Jinja

Kagimu David, Kampala, Uganda

WEPDB031

Predictors of Clinical Failure among Adults on First Line ART in a Community Based Intervention in TASO Uganda

Kagimu David, Kampala, Uganda

WEPDB032

An Evaluation of False Positive HIV Results due to Testing Errors

Tatenda Maparo, Harare, Zimbabwe

WEPDC033

HIV/AIDS Epidemic Appraisal among the Most-at-Risk Populations (MARPs) in Semi-urban and Rural Communities of North Central Zone of Nigeria

Amase Nyamngee, Ilorin, Nigeria

WEPDC034

The Role of Social Support Interventions in Pediatric HIV Care: The Mildmay Uganda Experience

Alice Businge, Kampala, Uganda

WEPDC035

Analyse de la Faisabilité de l'Introduction de la Cascade VIH dans le Suivi de la Performance des Programmes VIH en Guinée

Désiré Néboua, Conakry, Guinea

WEPDC036

Comparison between the First and the Second Rounds of the Biological Behavioral Surveillance Survey among Men who Have Sex with Men in Alexandria

Sherif Elkamhawi, Cairo, Egypt

WEPDC037

Incentivizing Safe Sex among Female Sex-workers in Dar-es-Salaam, Tanzania. Results from a Pilot Study

Damien de Walque, Washington, United States

WEPDC038

Role of Research Ethics Committees in Ensuring Adherence to National Research Ethics and Good Clinical Practice Guidelines in Uganda: Mildmay Uganda Research Ethics Committee's Experience

Eve Namitala, Kampala, Uganda

WEPDC039

Estimating HIV Incidence among Female Sex Workers in Tanzania Using Self-reported HIV Status in Bio-behavioral Surveys: Implications for Future HIV and STI Surveillance

Lung Vu, Washington, United States

WEPDC040

Using Facility-level Data and Geospatial Analysis to Visualize Local HIV Prevalence Trends

Ian Wanyeki, Washington, United States

WEPDC041

Role of Income Generation Activity (IGA) Support in Improving the Livelihood of Patients with Life-limiting Illnesses and their Families: Mildmay Uganda's Experience

Alice Businge, Kampala, Uganda

WEPDC042

An Analysis of the Progress towards Achieving Dual Elimination of Mother to Child Transmission of HIV and Congenital Syphilis during Immediate Post 2015 Era in Nigeria

Taiwo Oyelade, Abuja, Nigeria

WEPDC043

Developing Community-led Education

about Human Papillomavirus Vaccination as a Model for Future HIV Vaccination Campaigns

Karamoko Tounkara, Bamako, Mali

WEPDC044

Does the Cost of Testing for Syphilis in ANC Clinics in Nigeria Impact on Ability of Health Facilities to Provide Syphilis Screening and Treatment in ANC in Nigeria?

Taiwo Oyelade, Abuja, Nigeria

WEPDC045

Effects of a Systematically Developed Photo-novella on VMMC Communication and Uptake in Kisumu County, Kenya

Simon Odiwuor Ondiek, Kisumu, Kenya

WEPDC046

Pattern of Care of Sexually Transmitted Infections(STIs) at Different Level of Health Care in Nigeria

Olugbenga Ijaodola, Abuja, Nigeria

WEPDA047

Riposte VIH dans le Contexte de l'Épidémie de Maladie à Virus Ebola (MVE) en Guinée: ''Résultats CDV et TARV de PVVIH Districts Touchés par MVE et Non Touchés par MVE: 2013 et 2014 (Pendant MVE)''

Abdoulaye Kaba, Conakry, Guinea

WEPDC048

Parental Relationships as a Protective Factor against Risky Sexual Behaviours among in-school Adolescents in Ibadan, Nigeria

Emmanuel Segun Adebayo, Ibadan, Nigeria

WEPDC049

A Description of Hearing Loss in Children With HIV/AIDS at an Antiretroviral Clinic in KwaZulu-Natal South Africa

Zandile V. Peter, Durban, South Africa

WEPDC050

Evaluation of 10 Years of Mother to Child Transmission Prevention in a Community Health Center in Bamako, Mali

Karamoko Tounkara, Bamako, Mali

WEPDC051

Men who Have Sex with Men (MSM) Injecting Drugs in Greater Cairo

Oumnia Ibrahim Abaza, Cairo, Egypt

WEPDC052

A Systematic Review of Missed Opportunities for Improving Tuberculosis and HIV/AIDS Control in Sub-Saharan Africa: What Is Still Missed by Health Experts?

Florent Ymele Fouelifack, Yaounde, Cameroon

WEPDC053

Routine Syphilis Screening in Unbooked Patients during Labour and Delivery in Health Facilities in Nigeria

Olugbenga Ijaodola, Abuja, Nigeria

WEPDC054

Integrating SRH Services for Young People: Study of the Confidence and Young People's Centre in Uyo, Akwa Ibom State, Nigeria

Zubaida Abubakar, Abuja, Nigeria

WEPDC055

Zip up Plus: Building Capacity of Young People to Reduce STI and Teenage Pregnancy in Rural and Hard to Reach Communities in South South Nigeria

John Chukwudi Bako, Port Harcourt, Nigeria

WEPDC056

Barriers to Condom use and Opportunities for Targeting Condom Promotion among Persons at High Risk of HIV Infection in Ghana

Edward Adiibokah, Accra, Ghana

WEPDC057

Un Mécanisme de Suivi-évaluation Inclusif aux Personnes Handicapées dans la Réponse au VIH: Cas du Projet ACCESS, Ziguinchor / Sénégal

Ousmane Dieng, Ziguinchor, Senegal

WEPDC058

Adherence to National Guidelines in Prevention of Mother to Child Transmission of HIV

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC059

Trends in HIV-1 Incidence in a Cohort of Prostitutes in Kenya Implications for HIV-1 Vaccine Efficacy Trials

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC060

Increasing Access to Voluntary Medical Male Circumcision (VMMC) Services by Using Health Centers in Lesotho during High Demand Campaign Season

Litsoanelo Motsohae, Maseru, Lesotho

WEPDC061

Chronic Diarrhoea among HIV-infected Adult Patients in Nairobi, Kenya

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDB062

Children who Acquire HIV Infection Perinatally Are at Higher Risk of Early Death than Those Acquiring Infection through Breastmilk: A Meta-analysis

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC063

Connaissances, Attitudes et Pratiques des Étudiants de l'Université Gamal Abdel Nasser de Conakry Face aux IST/VIH/SIDA

Mohamed Macirè Soumah, Conakry, Guinea

WEPDC064

Les Circonstances de Découverte de la Séropositivité VIH des Patients Suivis au CTA

de l'Hôpital National Donka

Mohamed Maciré Soumah, Conakry, Guinea

WEPDC065

Hormonal Contraception and HIV Relationship: The Role of Advocates Amidst the Uncertainty Regarding the Data

Robinah Nakabugo, Kampala, Uganda

WEPDC067

Surveillance Sentinelle du VIH et de la Syphilis chez les Femmes Enceintes Frequentant les Services de Consultation Prenatale au Mali en 2012

Tako Ballo, Bamako, Mali

WEPDB068

Expérience de L'Intégration du VIH a la SSR / PF a L'Association Togolaise pour le Bien Etre Familiale: Cas de la Clinique Principale de Lome

Solange Séname Toussa-Ahossu, Lomé, Togo

WEPDC069

Integrating HIV Prevention into Reproductive Health, Care, Support and Treatment Programmes

Bridget Phiri, Lusaka, Zambia

WEPDC070

Prevalence, Perceptions and Correlates of Pediatric HIV Disclosure in an HIV Treatment Program in Kenya

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC071

Herpes Simplex Virus Type 2 and Risk of Intrapartum Human Immunodeficiency Virus Transmission

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC072

Risk Factors for Neonatal Conjunctivitis in Babies of HIV-1 Infected Mothers

Rahab Njeri Mbugua, Nairobi, Kenya

WEPDC073

Lessons Learned during theImplementation of Task Shifting for Scaling-up Option B+ in Senegal

Ndeye Fatou Ngom, Medina, Senegal

WEPDC074

Abstinence Sexuelle Comme Gage de Prévention de Nouvelles Infections à VIH chez les Jeunes: Cas des Trophées Vierges au Togo

Essi Christine K. Kotor, Lomé, Togo

WEPDC075

Analyse de la Vulnérabilité des Adolescents et des Jeunes au Sida en Côte d'Ivoire

Kouamé Jean Konan, Abidjan, Cote D'Ivoire

WEPDC076

Sante des Adolescents en Côte d'Ivoire: Des Grossesses en Milieu Scolaire vers une Stratégie Nationale Multisectorielle

Kouamé Jean Konan, Abidjan, Cote D'Ivoire

WEPDB077

Significant Declines in Severe Immunosuppression Observed over a Decade in a South African Paediatric Cohort

Hugh Adler, Dublin, Ireland

WEPDC078

Do National HIV Sero-prevalence Sentinel Studies among ANC Attendees Reflect the True HIV Prevalence in the Community?

Emmanuel A. Agogo, Abuja, Nigeria

WEPDC079

La Prévention des Hommes Ayant des Rapports Sexuels avec d'Autres Hommes sur les Sites de Rencontres: Un Outil Innovant de Relation d'Aide à Distance pour l'Accès à l'Information VIH/SIDA et aux IST

Mohcin Harri, Marrakesh, Morocco

WEPDC080

Factors Associated with ART Initiation among Eligible HIV-positive Pregnant Women in Swaziland

Caspian Chouraya, Mbabane, Swaziland

WEPDC081

Exploring the Existance of Laws and Policies that Restrict Key Populations from Accessing and Utilizing SRH, STI and HIV Services in Zanzibar

Kimwaga Muhiddin Ali, Zanzibar, Tanzania, United Republic of

WEPDC082

Factors Influencing the Uptake of Community Based HIV Counselling and Testing (HCT) Service in Vulnerable Households of Lagos State

Asaolu Olugbenga, Ibadan, Nigeria

WEPDC083

Increasing Condom Use among Female Sex Workers in Two States of Nigeria through Active Involvement of "Boyfriends"

Abimbola Titi Oladejo, Abuja, Nigeria

WEPDC084

Safety, Feasibility and Acceptability of the AccuCirc Device for Early Infant Male Circumcision in Zimbabwe

Webster Mavhu, Harare, Zimbabwe

WEPDC085

Scaling-up WHO-recommended PMTCT Services Using a Health Systems Strengthening Approach in a Resource-limited Setting: An Elizabeth Glaser Pediatric AIDS Foundation Experience in Zimbabwe

Agnes Mahomva, Harare, Zimbabwe

WEPDC086

Condom-use Perception by Old Peoples: A Big Challenge in Mitigation of HIV/AIDS in African Urban Slums

Rose Opara, Sydney, Australia

POSTER SESSION III

WEPDC087

Community Response to Prevent New HIV Infection in Four Communities in Enugu State Nigeria

Miriam Chinwe Menkiti, Enugu, Nigeria

WEPDC088

Sexual Behaviors and Prevalence of Consistent Condom Use among Adults Residing along Tunduru-Mangaka-Mtambaswala Road in Southern Tanzania

Waida Ramadhani, Dar es Salaam, Tanzania, United Republic of

WEPDC089

Are we 'All In' for PMTCT? Service Uptake among HIV Positive Pregnant Teens along the PMTCT Cascade in Zimbabwe

Theresa Ndoro, Harare, Zimbabwe

WEPDC090

Self-report of Sexually Transmitted Infections among Adults Residing along Tunduru-Mangaka-Mtambaswala Road in Southern Tanzania

Anatory Didi, Dar es Salaam, Tanzania, United Republic of

WEPDC091

Final Mother-to-Child HIV Transmission (MTCT) Rate among Breast-feeding Women: Findings from a Population-based Prospective Cohort from 4-12 Weeks to 18 Months Post-delivery in Zimbabwe, 2013-2014

Thu-Ha Dinh, Atlanta, United States

WEPDC092

Closing HIV Taps for Mobile Populations in Southern Zimbabwe

Darlington Changara, Zvishavane, Zimbabwe

WEPDC093

Defining a Catchment Area for Voluntary Medical Male Circumcision Clinical and Follow-up Services in Nyanza Province, Kenya

Amy Herman-Roloff, Chicago, United States

WEPDC094

Enhancing Uptake of Hepatitis B Prevention Services among Female Sex Workers' in Abuja, Nigeria

Dennis Aizobu, Abuja, Nigeria

WEPDC095

Results from Implementing Updated 2012 World Health Organization Guidance on Early-warning Indicators of HIV Drug Resistance in Zimbabwe

Janet Dzangare, Harare, Zimbabwe

WEPDC096

Understanding the Early Infant Diagnosis Value Stream for Improved Service Delivery

Lilian Anomnachi-David, Abuja, Nigeria

WEPDC097

Le VIH en Milieu Carcéral en Mauritanie

Zahra Fall Malick, Nouakchott, Mauritania

WEPDC098

Panel Discussion: Women´s Voices: Perceptions, Values and Preferences of Women Living with HIV Regarding Early Infant Diagnosis

Patricia Ukoli, Abuja, Nigeria

WEPDC099

Prevalence of Transfusion Transmissible Infections (TTI) in Rivers State: A 6 Month Study

Lekan S. Ajijola, Port Harcourt, Nigeria

WEPDC100

Trends in HIV Prevalence: Biennial Sentinel Serosurveillance or Prevention of Mother to Child Transmission Programme Data? Experience from a PMTCT Programme in Gombe State, Nigeria 2004 -2014

Elon Warnow Isaac, Gombe, Nigeria

WEPDC101

Failure to Return for Posttest Counseling and HIV Test Results at the Prevention and Voluntary Testing Centers of the Littoral Region, Cameroon: An Evaluation of 5 Years of Routine Program

Ngangue Patrice, Québec, Canada

WEPDC102

Antenatal HIV, Maternal and Child Health Outcomes in Low Income Urban Harare, Zimbabwe

Simukai Shamu, Pretoria, South Africa

WEPDC103

Nurse Midwife versus Doctor-performed Early Infant Male Circumcision in Zimbabwe: A Comparative Cost Analysis

Collin Mangenah, Harare, Zimbabwe

WEPDC104

Attaining a Generation Free of HIV through PMTCT, a TASO Rukungiri Experience for Period 2008 - 2014

Bennet Joseph Kizito, Kampala, Uganda

WEPDC105

Knowledge and Awareness of Prevention of Mother to Child Transmission of HIV among Male Partners of Pregnant and Breastfeeding Women in Mashonaland East, Zimbabwe

Vivian Chitiyo, Harare, Zimbabwe

WEPDC106

Ethno Medicinal Plants Used for HIV Infections in Africa

Celia Moffat Joel Matyanga, Harare, Zimbabwe

WEPDC107

Predictors of Uptake of and Retention on Lifelong Antiretroviral Therapy among Pregnant Women Newly Diagnosed with HIV in Jinja District-Uganda

Elizabeth Margret Asiimwe, Kampala, Uganda

WEPDC108

Long Turnaround Times for DNA PCR Results for EID: Impact of EID Decentralization to the Mutare Laboratory to Patient Management - Manicaland Province 2014

Charles Uzande, Mutare, Zimbabwe

WEPDC109

Club of Mutual Pleasure of Sex Workers as an Alternative to Fight against Violence towards Sex Workers and Transgender in Army Conflict Context for Promoting Sexual Health

Mambo Amisi Modeste, Bukavu, Congo, the Democratic Republic of the

WEPDC110

STI-pathogens as Predisposing Factors for Acquisition and Transmission of HIV in Infected and Non-infected Women in Rural Nigeria

Isaac Olayinka Oyewole, Ikeja, Nigeria

WEPDC111

PMTCT Cluster Reviews: Experiences from Mutare District-Manicaland Province Zimbabwe 2015

Charles Uzande, Mutare, Zimbabwe

WEPDC112

Do HIV Prevalence Trends in ANC Surveillance Represent Trends in the General Population in the ART Era? The Case of Manicaland, East Zimbabwe

Simon Gregson, Harare, Zimbabwe

WEPDD113

HIV and Aging in East and Southern Africa: Building Evidence for informed Policy and Programmes

Richmond Tiemoko, Johannesburg, South Africa

WEPDD114

Enquête sur la Discrimination et la Stigmatisation des PVVIH à Goma et Réponse de l'UCOP+ avec l'Appui de Save the Children

Whisky Kalume Safari, Goma, Congo, the Democratic Republic of the

WEPDD115

Fighting the Wrath of Isolation

Botho Maruatona, Gaborone, Botswana

WEPDD116

Empowering People who Inject Drugs to become Advocates of Drug Use Programs: The Experience of Centre for the Right to Health

Udeme Peter-Ijeh, Abuja , Nigeria

WEPDD117

Media Training to Change the Landscape of HIV Reportage for an Improved National Response

Margaret Akosua Yamoah, Accra, Ghana

WEPDD118

Addressing Human Rights of Key Populations and Persons Living with HIV in Ghana - Minimising the Human Factor

Fred Nana Poku, Accra, Ghana

WEPDD119

Quality of Life of ART Patients in Botswana

Nnamdi Obioma Ndubuka, Prince Albert, Canada

WEPDD120

Promotion of HIV Prevention, Treatment, Care and Support for Adolescents through Community Involvement

Dennis Tarimo, Dar es Salaam, Tanzania, United Republic of

WEPDD121

A Regional Approach to Making Wide Scale HIV Self-testing (HIVST) a Reality in Southern Africa: Multi-country HIV Self Testing Legal Review

Margaret Zulu, Johannesburg, South Africa

WEPDD122

Empowering Vulnerable Groups in Order to Mitigate of the Impact HIV and AIDS

Paulo Carlos Romao, Maputo, Mozambique

WEPDD123

Use of Community Level Evidence Informed Behavioral Interventions (EBIS) as a Strategy for HIV Risk-reduction in Young People: Results from 11 Counties in Kenya between October 2014 and March 2015

Jane Kanini Mutegi, Nairobi, Kenya

WEPDD124

'When you Visit a Man you Should Prepare Yourself' - Community Care Worker Approaches to Working with Male Client

Lesley Gittings, Cape Town, South Africa

WEPDD125

Youth and Adolescents' AIDS Response through Theatre and Sport: The Case of Mtendere Community "Bauze" Youth Centre - Zambia

Boyd Nyirenda, Lusaka, Zambia

WEPDD126

The Nigerian MSM Health Scorecard: A Tool for Assessing and Monitoring the Accountability of Stakeholders in Advancing the Health of Men who Have Sex with Men (MSM) in Nigeria

Michael Olasunkanmi Akanji, Lagos, Nigeria

WEPDD127

Narratives of Blame': HIV and Sexual Cultural Practices in Malawi. Implications for Policies and Programmes

Samantha Page, Liverpool, United Kingdom

WEPDD128

Integration of HIV Prevention Services into Socio-cultural and Religious Festivities: Lessons Learnt from Kwahu Easter Paragliding Festivals in the Eastern Region of Ghana

Golda Grace Asante, Accra, Ghana

WEPDD129

Strengthening Effective Collaboration and Partnership among Stakeholders on Early Referral of Persons Living with HIV for Services - Experience from Eastern Region of Ghana

Golda Grace Asante, Accra, Ghana

WEPDD130

Socio-cultural Determinants of Exclusive Breastfeeding: Lessons Learnt from Experiences of HIV-positive Mothers in Lusaka, Zambia

Alice N. Hazemba, Lusaka, Zambia

WEPDD131

Importing Heterosexual Male Privilege, Femininities and Masculinities in Gay Sexual Relations: Implications on HIV Transmission, Prevention and Access to Other SRHR Services among African Young Gays

Lucmore Jalisi, Monrovia, Liberia

WEPDD132

Challenges of Female IDUs in Accessing Drug Detoxification and Rehabilitation Services in Lagos State, Nigeria

Chinedu Onyekatu, Lagos, Nigeria

WEPDD133

Promoting Optimal Uptake of Antenatal Care (ANC) Services among Women of Childbearing-age: Findings of a Literature Review Conducted in Zimbabwe

Caroline Madiro-Zinyemba, Harare, Zimbabwe

WEPDD134

Womens Networking Zone: Amplifying the Regional Voices of Women and Girls Living with HIV

Florence Anam, Nairobi, Kenya

WEPDD135

Who Helps Women Uptake Services along the PMTCT Cascade? The Role of Social Network Engagement for Overcoming Barriers to Service Uptake in Rushinga District, Zimbabwe

Karen Webb, Harare, Zimbabwe

WEPDD136

Is Demand Generation or Quality Services the Chicken or the Egg? Ethics and Experience of Increasing Demand for Facility Births for PMTCT in One Remote Rural District of Zimbabwe

Karen Webb, Harare, Zimbabwe

WEPDD137

Human Rights Impact Assessment to Evaluate HIV/AIDS Policy in Mauritius

Sattiavattee Hurry, Le Reduit, Mauritius

WEPDD138

PMTCT and Patient's Rights in Zimbabwe - A Journey towards Equitable and Optimal Standard of Care for Informed Patients

Priscilla Matyanga, Harare, Zimbabwe

WEPDD139

Engaging Hidden Providers of Care for PMTCT- The Case of Apostolic Traditional Birth Attendants (AtBAs) in Zimbabwe

Andrew McLellan, Harare, Zimbabwe

WEPDD140

Apostolic Traditional Birth Attendant Management of Perinatal Complications - An Exploratory Qualitative Study in Mashonaland Central, Zimbabwe

Andrew McLellan, Harare, Zimbabwe

WEPDD141

Engaging Hidden Providers of Maternal Health Care for PMTCT - The Case of Apostolic Traditional Birth Attendants (AtBAs) in Zimbabwe

Andrew McLellan, Harare, Zimbabwe

WEPDD142

Engaging Media in HIV Vaccine Research and Development in Kenya: Untapped Potential?

Lillian Naigaga Mutengu, Nairobi, Kenya

WEPDD143

Enhancing the Capacity of WLHIV in Family Planning Access and Choice

Florence Anam, Nairobi, Kenya

WEPDD144

Analytics in a Flash: A Novel Approach to Interrogating Unstructured and Semi-structured Social Science Transcript Data

Michael D'Eredita, Syracuse, United States

WEPDD146

Sexual and Reproductive Health and Rights: The Experiences of Networks of Women Living with HIV in Addressing Rights Violations Across the Region

Rebecca Matheson, Nairobi, Kenya

WEPDD147

Innovative Strategies to Accelerate HIV Prevention Services in the Eastern Region of Ghana

Golda Grace Asante, Accra, Ghana

WEPDD148

Desir de Procreation chez les Femmes HIV+ A Cotonou, Benin

Fidelia Sessou, Cotonou, Benin

WEPDD149

Opportunities, Barriers and Prospects for HIV-sensitive Social Protection: Findings of a Qualitative Study of Cash Transfer Programs in Kenya

Justus B. Aungo, Mombasa, Kenya

WEPDD150

Antenatal HIV Testing and Disclosure: Unpacking the Risk for Intimate Partner Violence in Zimbabwe

Shamu Simukai, Pretoria, South Africa

WEPDD151

The Influence of HIV And AIDS Information Awareness, Access and Use on Sexual Risk Behaviours of Commercial Sex Workers in Lagos State, Nigeria

Helen O.J. Akinade, Ilisan-Remo, Nigeria

WEPDD152

HIV/AIDS Prevention Knowledge and Sexual Behaviour of Male Apprentices in Automobile Repair Workshops in Ogun State, Nigeria

Olayimika K. Adebola, Ilisan-Remo, Nigeria

WEPDD153

Intentions and Perceptions of PLHIV Framing in Two Songs: Implications for HIV Communication

Silinganiso Chatikobo, Johannesburg, South Africa

WEPDD154

Impact of Stigma and Discrimination on Sexual Wellbeing of LGBTI Students in a South African Rural University

Azwihangwisi Helen Mavhandu-Mudzusi, Pretoria, South Africa

WEPDD155

Factors Associated with Condom Use: A Comparative Study on Condom Use and Non-condom Use Male Youth in Kenya

Akiko Saito, Nagasaki, Japan

WEPDD156

Engaging Members of the Apostolic Faith: The Achievement of the Mbereko Project in Mashonaland Central

Priscilla Matyanga, Harare, Zimbabwe

WEPDD157

High Level Dialogue: How Can Young People Play a Role in Ensuring the SDG Targets on Ending AIDS and Universal Access to Sexual and Reproductive Health Services Will Be Met?

Meheret Melles, Geneva, Switzerland

WEPDD158

Strengthening the Capability of Teachers to Support Pregnant Adolescent Learners: The Role of Psychosocial Support in Preventing Marriage among School Going Adolescent Females

Sibongani Kayola, Lusaka, Zambia

WEPDD159

Engaging Men in Strengthening the Implementation of GBV Laws as an HIV Prevention Strategy in Kenya, Rwanda and Sierra Leone

Mabel Sengendo Nabaggala, Braamfontein, South Africa

WEPDD160

Successful HIV Combination Prevention Approach for Youth in Zimbabwe

Vaida Kontrimaite, Mutare, Zimbabwe

WEPDB161

The Influence of Socio-cultural Factors on HIV Prevention Strategies among HIV Sero-discordant Couples: A Qualitative Assessment in Harare-Zimbabwe

Elizabeth Shamabadza Magada, Harare, Zimbabwe

WEPDD162

Social Media and ICTs Integration in Addressing Sexual and Reproductive Health Challenges of Young People in Tertiary Institutions and Rural Communities

Jephiter Tsamwi, Harare, Zimbabwe

WEPDD163

African MSM Health Scorecards: Establishing a Baseline for Improvements in Programmes and Health Outcomes of MSM in Africa. The Cases of Cote D'Ivoire, Kenya and Nigeria

Steave Nemande, Dakar, Senegal

WEPDD164

The African HIV Epidemic, Human Rights and the Law: An Analysis of Views on the Right to Confidentiality of Selected South African AIDS Activists Involved in the HIV Response

Musara Lubombo, Marlborough, Zimbabwe

WEPDD165

The Attitudes, Perceptions and Experiences of Being LGBTI within a South African University

Putuke Kekana, Johannesburg, South Africa

WEPDD166

Placing Young People at the Forefront of their HIV & SRH Integrated Agenda: African Successes Driven by Young African Ambassadors

Rouzeh Eghtessadi, Pretoria, South Africa

WEPDD167

Farm Workers, HIV and the Struggle for Health after Land Reform in Zimbabwe: The Case of One Community-based Response

Maxwell Kapachawo, Chitungwiza, Zimbabwe

WEPDD168

No Condoms in Schools - Are we Not Reversing the Gains?

Chamunogwa Nyoni, Bindura, Zimbabwe

WEPDD169

Social and Community Protection for Orphans and Vulnerable Children

Akudo Nwogu, Ibesikpo, Nigeria

WEPDD170

POSTER SESSION III

An Exploration of the Structural Barriers to Support Group Attendance among HIV Infected Young Children Participating in the ARROW Clinical Trial

Zivai Nenguke, Harare, Zimbabwe

WEPDD171

Cluster Review Meetings - A Low Cost Initiative to Improve HIV Care and Treatment

Sabina Tinarwo, Harare, Zimbabwe

WEPDD172

Rethinking the Human Rights Response to HIV and TB in Zimbabwe: Challenges and Opportunities in the Post-2015 Era

Adolf Mavheneke, Harare, Zimbabwe

WEPDD173

Nurturing Young African Women as Leaders and Champions of their Own Sexual Reproductive Health Agenda

Juliet Mkaronda, Harare, Zimbabwe

WEPDD174

Sexual Behavior and Practices among Young People Aged 10 - 24 Years in Farming, Mining and Apostolic Sect Communities in Zimbabwe

Jabulani Mavudze, Harare, Zimbabwe

WEPDD175

Harnessing the Capacity of Young People (10-24 Years) in Promoting their Access to Sexual and Reproductive Health and Rights in Zimbabwe: Key Lessons and Successes of the SAfAIDS YPISA Model

Renias Mundingi, Harare, Zimbabwe

WEPDD176

Study on the Unmet Sexual and Reproductive Health Needs of Students Living with HIV in Zimbabwe's Tertiary Institutions

Jimmy Wilford, Harare, Zimbabwe

WEPDD177

Knowledge, Attitudes and Practices of Students towards their SRHR at Bulawayo Polytechnic

Chiedza Masanganise, Bulawayo, Zimbabwe

WEPDD178

Knowledge and Beliefs about Cervical Cancer among Men and Women at Bulawayo Polytechnic

Tafadzwa Tavagadza, Bulawayo, Zimbabwe

WEPDD179

Engaging Criminalized Communities in Research: Respect, Protect, Fulfill Updated Best Practice Guidance for MSM/HIV Related Research in Rights Constrained Settings in Africa

George V. Owino, Nairobi, Kenya

WEPDD180

Where Are the Men? Policy and Community Efforts to Address Men's Underrepresentation in the HIV Response

Remmy M. Shawa, Cape Town, South Africa

WEPDD181

The Role of Religion in Socialising Youth and their Sexuality

Mphokuhle Millie Mabhena, Johannesburg, South Africa

WEPDD182

Key Affected Populations in the HIV Response, Inclusion or Exclusion?

Lucinda van den Heever, Cape Town, South Africa

WEPDD183

Ben 10 and HIV Vulnerability: A Focus on Young Men's Relationships with Older Women in South Africa

Esmeralda Vilancuols, Johannesburg, South Africa

WEPDD184

Sexual and Gender Base Violence, HIV And STIs in Conflict Settings

Boki Evelyn Letio Unzi, Juba

WEPDE185

Leveraging Routinely Collected Data from National HIS Systems to Describe Geographic Variations in HIV Burden

Ian Wanyeki, Washington, United States

WEPDE186

Best Practices, Community Perspectives and Engagements in Policy, Research and Ending HIV among MSM in Kenya

Jeffrey Walimbwa, Nairobi, Kenya

WEPDE187

Addressing a Policy Gap: Community Advocacy for the Implementation of Distribution of Condom Compatible Lubricants in Kenya

Jonah M. Chinga, Nairobi, Kenya

WEPDE188

The Kenyan MSM Health Scorecard: A Tool for Evaluating and Monitoring the Accountability of Stakeholders in the Health of Men who Have Sex with Men (MSM) in Kenya

Jeffrey Walimbwa, Nairobi, Kenya

WEPDE189

Implementing an Integrated Approach to Facility Based Promotions of Couple's Voluntary Counselling and Testing and Long Acting Reversible Contraceptives in the Copperbelt Province of Zambia

Change Kwesele, Ndola, Zambia

WEPDE190

Nipping ARV Stock-out in the Bud through the HIV and AIDS Commodity Management Tool (OSPSIDA)

Jean Bedel Evi, Accra, Ghana

WEPDC191

Prioritised HIV Resource Allocations in

a World Pursuing Sustainable Development Goals: The Case of Niger

Nicole Fraser, Washington, United States

WEPDE192

Utilisation des Réseaux Sociaux pour Faire la Promotion des Services de Santé Sexuelle pour les HSH du Burundi

Fikirini Alain Maurice, Bujumbura, Burundi

WEPDE193

Managing Program Transitions of PEPFAR Supported HIV Treatment Services in Nigeria

Samsu Gombwer, Abuja, Nigeria

WEPDE194

Providing Stakeholders Monitoring Access to HIV and AIDS Commodities through the HIV and AIDS Commodities Management Tool in West and Central Africa (OSPSIDA)

Jean Bedel Evi, Accra, Ghana

WEPDE195

Accelerating Uptake of HIV Care and Treatment in Cote d'Ivoire: a Pre-service Training Approach

Allet Assi, Abidjan, Cote D'Ivoire

WEPDE196

Ownership of Quality HIV/AIDS Prevention Care and Treatment Services by Faith Based Organizations in Akwa Ibom State of Nigeria

Yemisi Ogundare, Akwa Ibom State, Nigeria

WEPDE197

Value for Money in Sudan's HIV Response: How Allocative Efficiency Analysis Contributed to Change in Use of HIV Resources

Clemens Benedikt, Washington, United States

WEPDE198

Older People's Access to Anti-retroviral Therapy (ART) in Africa

Wamuyu Manyara, Nairobi, Kenya

WEPDE199

Preserving the Future by Mitigating the Impact of HIV/AIDS on Orphans and Vulnerable Children in Nigeria: A Project Based Baseline Research Findings

Olugbenga S. Asaolu, Ibadan, Nigeria

WEPDB200

Increased Uptake of Family Planning Services through Integration of Reproductive Health and HIV/AIDS Services

Yemisi Ogundare, Akwa Ibom State, Nigeria

WEPDE201

Performance Based Financing Performing Wonders in Reducing HIV Stigma and Discrimation and AIDS Related Deaths 2011-2013 - A Success Story from Chikwawa Diocese Malawi

Emily Chibweya Kayimba, Blantyre, Malawi

WEPDE202

Income Generating Activities - Improving Livelihood of Vulnerable Households in Akwa Ibom State, Nigeria

Yemisi Ogundare, Akwa Ibom State, Nigeria

WEPDE203

Transfert de Compétences et Décentralisation des Soins de Réadaptation Fonctionnelle chez les Personnes Vivant avec le VIH/Sida - Cas du Projet ACCESS, Ziguinchor, Sénégal

Hugues Mathias Ondione, Ziguinchor, Senegal

WEPDE204

Inclusion du Handicap dans la Réponse VIH par l'Accessibilité: Un Instrument de Plaidoyer et de Renforcement du Système de Santé; Région Médicale de Ziguinchor, Sénégal

Aïda Zerbo, Ziguinchor, Senegal

WEPDE205

Combining Implementation Science and Impact Evaluation: Both Can Benefit

Anna Heard, Washington, United States

WEPDE206

Strengthening Laboratory Managers in Lesotho through Implementation of an Emerging Leadership Program

Sherrie Staley, Silver Spring, United States

WEPDE207

Assesing the Evidence for the Integration of HIV Services with Other Health Services to Address Linkage to Care, Retention and Adherence

Annette N. Brown, Washington, United States

WEPDE208

Taking the Fight of HIV/AIDS to the Unions in Kenya

Evans Wamiri, Mombasa, Kenya

WEPDE209

Leveraging the AIDS Response to Strengthen Medical Education and Health Systems and Improve Other Health Outcomes

Stephen Olus Okeyo, Nairobi, Kenya

WEPDE210

Quality Check at the Submission Desk as a Strategy to Improve Data Quality in Kenya Health Information System (KHIS) in Central Region, Kenya

Duncan Okubasu, Nyeri, Kenya

WEPDE211

Community Driven Re-usable Sanitary

POSTER SESSION III

Ware Production Empowers Women and Girls in Ward 12 of Mutasa District, Manicaland, Zimbabwe

Gladys Mukaratirwa, Manicaland, Zimbabwe

WEPDE212

Community Integration of TB Interventions into HIV and AIDS Programing: Chiwamba Health Centre Catchment Area, Malawi

Nephitale Chizongo, Blantyre, Malawi

WEPDA213

Expérience Pilote sur le Suivi des Femmes Enceintes et les Enfants Nés des Mères Séro Positives au VIH au Niveau Communautaire dans la Région de Maradi au Niger

Soumana Ali Soumana, Maradi, Niger

WEPDE214

Perceptions Affect Clients´ Access to HIV Care

Bereket Yakob, Durban, South Africa

WEPDE215

Délais d'Acheminement des Papiers Buvards et de Restitution des Résultats dans le Cadre de la Décentralisation de l'Accès au Diagnostic Précoce des Enfants Exposés au VIH au Mali

Yaya Cisse, Bamako, Mali

WEPDE216

Evaluation of the First Two Years of Transition of the PEPFAR Track 1.0 ART Program in Cote d'Ivoire

Delphine Achi-Kouassi, Abidjan, Cote D'Ivoire

WEPDE217

Engaging the Private Sector in Accelerating Progress toward eMTCT and in Implementation of New World Health Organization (WHO) 2013 HIV Guidelines in Zimbabwe

Esther Angeina Joyce Tumbare, Harare, Zimbabwe

WEPDE218

Review of a Model for Scaling up HIV Counselling and Testing (HCT) through Integrated Community Multi-disease Prevention Campaigns (ICMPC)

Emmanuel A. Agogo, Abuja, Nigeria

WEPDE219

Supporting an Integrated Specimen Transportation System to Scale up Early Infant Diagnosis (EID): Sharing Experience from Zimbabwe

Tichaona Nyamundaya, Harare, Zimbabwe

WEPDE220

Stepping up Pediatric HIV Case Identification: Using FedEx to Transport Early Infant Diagnostic Samples from Remote Areas in Zimbabwe

Esther Angeina Joyce Tumbare, Harare, Zimbabwe

WEPDE221

Barriers to PMTCT Service Uptake and Retention within Care and Treatment in Hurungwe

Addmore Chadambuka, Harare, Zimbabwe

WEPDE222

Using Lessons Learnt from Procurement of POC CD4 Devices to Inform New Procurement and Supply Management of Devices for Public Health Delivery System: An EGPAF Zimbabwe Experience

Faith Mbengo, Harare, Zimbabwe

WEPDE223

Strengthened Partnerships for Improved Scale-up of PMTCT Services

Uduak Bassey-Duke, Abuja, Nigeria

WEPDE224

Using Point-of-Care Technology to Enhance Clinical Quality and Patient Outcomes in Resource-poor Paediatric ARV Settings: Introducing the EMBRACE Cohorts

Craig Raymond Carty, Johannesburg, South Africa

WEPDD225

"You Just Have to Do what they Expect you to Do": Donor Programs, Community Priorities and the Democracy of International HIV/AIDS Funding

Gemma Oberth, Cape Town, South Africa

WEPDE226

Assessment of ARV Dosing after Introduction of an Update Paediatric ARV Dosing Chart

Gerishom Gimayo, Nairobi, Kenya

WEPDE227

Local Solutions for Sustainable Financing of HIV Treatment

Isseu Diop Toure, Dakar, Senegal

WEPDE228

A Local Level Response to HIV: Exploring the Implementation of the National Strategic Plan (2012 - 2016) in Six Local Municipalities in South Africa

Pinky Mahlangu, Johannesburg, South Africa

WEPDE229

A Successful Method for Strengthening HIV Prevention Services among Female Sex Workers: Ekiti State AIDS Control Agency Experience

Charles Olusegun Doherty, Ado Ekiti, Nigeria

WEPDE230

The Anal Sexual Relations in Jails: Convenient and Reasons

Ayité Sitou J.P. Amavi, Lomé, Togo

WEPDE231

Accelerating Mozambique´s HIV Re-

sponse in Districts and Municipalities

Karolina Luczak Santana, Maputo, Mozambique

WEPDE232

Growing Old in Zimbabwe: The Impact of HIV on Older Women and the Societies they Live in

Nesta Hatendi, Harare, Zimbabwe

WEPDE233

Increasing Access to Adolescents' Comprehensive Health Services through School Health Initiatives: Experiences from the South Africa Integrated School Health Programme

Nonhlanhla R. Dlamini, Pretoria, South Africa

WEPDE234

Making a Sound Business-case for Investing in Employee Wellbeing Programmes: Using A Cost-benefit Projection Tool in the Private Sector

Tinashe Chimbidzikai, Harare, Zimbabwe

WEPDE235

Interventions for Financing Resource-constrained Health Systems

Charles Shey Wiysonge, Cape Town, South Africa

WEPDE236

Engaging Communities in Identifying Gaps, Determining Priorities and Establishing Project Baseline Using a Participatory Approach: Report of a Study in Akamkpa - Nigeria

David Akpan, Abuja, Nigeria

WEPDE237

Evaluation of the TB Programme Focusing on TB/HIV Collaborative Activities in Gutu and Zaka Districts, Masvingo Province, 2014

Justice Mudavanhu, Harare, Zimbabwe

WEPDE238

Which Interventions Improve Postpartum Retention of Women in PMTCT and ART Care: A Systematic Review

Shaffiq M. Essajee, Geneva, Switzerland

WEPDB239

Mother and Early Infant Outcomes of a PMTCT B+ Implementation Study in Southern Swaziland

David Etoori, Mbabane, Swaziland

WEPDE240

Early Implementation of the New Horizons Initiative for Advancing Paediatric HIV Care: Applying WHO Guidelines for Medicines Donations in Practice

Carol Ruffell, Johannesburg, South Africa

WEPDE241

Outreach for Early Infant Diagnosis: Building on Existing Routine Services to Expand Entry Points for Early Infant Diagnosis in Mazowe District, Zimbabwe

Grapper Mujaranji, Harare, Zimbabwe

POSTER SESSION IV

THUPDA001

Genetic Diversity and Transmitted Drug Resistance of HIV-1 Subtypes in Northern Mozambique

Adolfo Vubil, Maputo, Mozambique

THUPDA002

Design and Discovery of Potent Hybrid 1,3,5-Triazine-1,3-thiazine Analogs as Novel Lead for Next Generation NNRTI

Hans Raj Bhat, Allahabad, India

THUPDC003

High Proportion of Treatment Failure among Hospitalized Patients Ten Years after ART Introduction in Rural Kenya

Aline Aurore Niyibizi, Cape Town, South Africa

THUPDA004

Optimization of a Cost-effective Viral RNA PCR Assay to Screen for Acute HIV-1 Infections in Resource Limited Settings

Ngao Sichalwe, Ndola, Zambia

THUPDA005

Validation and Implementation of a Novel, Cost-effective Viral RNA PCR Assay to Detect Early Subtype C HIV-1 Infections in Zambia

Towela Mfune, Lusaka, Zambia

THUPDB006

Linkage to Care and Outcomes in Patients Not Meeting Clinical Trial Eligibility Criteria

Wadzanai P. Samaneka, Harare, Zimbabwe

THUPDB007

Integrated TB HIV Care, Feasibility for Scale up in a Resource Limited Setting

Ronald Ncube, Harare, Zimbabwe

THUPDB008

Determining the HIV Status and Health Seeking Behaviors of Caregivers of Children Enrolled in the ARROW Study in Harare, Zimbabwe

Shepherd Mudzingwa, Harare, Zimbabwe

THUPDB009

Client Satisfaction with HIV Care and Treatment Services in Western Kenya

Emmanuel S. Wamalwa, Nairobi, Kenya

THUPDB010

Informing the Acceleration of Adolescent and Pediatric Care & Treatment Initiative (ACT) Using a Demonstration Pilot, Zimbabwe, 2015: Results of a Baseline Assessment in Hurungwe District

Auxilia Muchedzi, Harare, Zimbabwe

THUPDB011

Prevalence and Correlates of Depressive Disorders among People Living with HIV/AIDS, in North Central Nigeria

Shittu O. Rasaq, Ilorin, Nigeria

THUPDB012

Correlates and Consequences of Internalized Stigma of Mental Illness among People Living with HIV/AIDS in Nigeria, West Africa

Rasaq Olatunji Shittu, Ilorin, Nigeria

THUPDB013

HIV Policy Implementation in Two Health and Demographic Surveillance Sites in Uganda: Findings from a National Policy Review, Health Facility Surveys and Key Informant Interviews

Ellen McRobie, London, United Kingdom

THUPDB014

'Taking them Forever and Taking them on Time': The Treatment and Care Needs of Adolescents Living with HIV

Cedric Nininahazwe, Bujumbura, Burundi

THUPDB015

The Rise of Drug-resistant Tuberculosis in Southern Africa: Are we Learning from History or Repeating It?

Beauty N. Muringani, Bulawayo, Zimbabwe

THUPDB016

TB/HIV co-infection in Adults and Children from Gombe, North East Nigeria: 2000 - 2012

Elon Warnow Isaac, Gombe, Nigeria

THUPDB017

Adherence to Antiretroviral Therapy in Young Children in Resource-limited Setting? How Could it Be Evaluated in a Context of Therapeutic Education?

Parsifal Logbo, Porto-Novo, Benin

THUPDB018

Impacts Cliniques, Immunologiques et Thérapeutiques du Programme d'Appui Nutritionnel aux Personnes Vivant avec le VIH (PVVIH) à l'Hôpital du Jour au Burkina Faso

Yameogo Sibiri, Ouagadougou, Burkina Faso

THUPDB019

Une Alternative à l'Intégration des Services pour Prévenir la Transmission Mère-enfant du VIH dans les Centres de Santé Intégrés

Merlin Diafouka, Brazzaville, Congo

THUPDB020

Facteurs Limitant l'Observance au Traitement Antirétroviral chez les Adolescents de 10 à 19 Ans Suivis au Centre Médical avec Antenne Chirurgicale (CMA) de Pissy, Ouagadougou, Burkina Faso

Bintou Sawadogo, Ouagadougou, Burkina Faso

THUPDB021

Evaluation of a New Rapid Fourth Generation Point of Care Test Device for the Early Diagnosis of HIV Infection

Yuko Tamanoue, Matsudo, Japan

THUPDB022

Improving Access to Quality Health Care for LGBT People

Naa Ashiley Vanderpuye, Accra, Ghana

THUPDB023

Prévention des Perdus de Vue par Appel Téléphonique au Centre de Traitement Ambulatoire de Brazzaville

Anne-Marie Ibondo, Brazzaville, Congo

THUPDB024

Factors Associated with ARV Drug Adherence in Zvishavane and Shurugwi Districts, Midlands Province, Zimbabwe

Margaret Z. Mika, Gweru, Zimbabwe

THUPDB025

Reaching the 90-90-90 Treatment Targets: Implications for Kenya Treatment Program

Irene Mukui, Nairobi, Kenya

THUPDB026

Using Mobile Messaging to Improve the Quality of Nurse-led Anti-retroviral Therapy (ART) Management at 36 Mission Hospitals in Zimbabwe

Chidzewere Nzou, Harare, Zimbabwe

THUPDB027

Sero-prevalence and Correlates of Hepatitis B Co-infection among HIV Positive Patients on ART in North Central Nigeria

Joseph E. Enegela, Abuja, Nigeria

THUPDB028

Report of Five Years Early Infant Diagnosis (2009 - 2013) in Infants and Children Born to HIV Positive Mothers in Mali

Alou Sanogo, Bamako, Mali

THUPDB029

Nevirapine (NVP) Resistance Mutations among Infants Exposed to Single Dose NVP (sdNVP) in Zimbabwe: Detection and Characterization Using Oligonucleotide Ligation Assay (OLA)

Junior Mutsvangwa, Harare, Zimbabwe

THUPDB030

Mise en Place d'une Collaboration Entre un Centre de Prise en Charge du VIH Pédiatrique et un Centre de Traitement Anti-tuberculeux

Tanguy Bognon, Cotonou, Benin

THUPDB031

Prevalence of Malnutrition in HIV Infected Children in Douala Laquintinie Hospital Cameroon

Calixte Ida Penda, Douala, Cameroon

THUPDB032

Prévalence des Anomalies Cardio-vasculaires chez les Patients Sous Traitement Antirétroviral au Service des Maladies Infectieuses et Tropicales (SMIT) à Abidjan

Nogbou Frédéric Alexandre Ello, Abidjan, Cote D'Ivoire

THUPDB033

Causes de Décès chez les Adultes VIH+ Peu Immunodéprimés Suivis Dans l'Essai Temprano (ANRS 12136)

Raoul Moh, Abidjan, Cote D'Ivoire

THUPDB034

Group Therapy as One of the Strategies to Improve Adherence that Leads to HIV Prevention: TASO Rukungiri Experience

Justus Tumusiime, Kampala, Uganda

THUPDC035

Prevalence of Bisexual MSM Accessing HIV Counselling and Testing (HCT) Services at a Community Health Centre (CHC), in Kaduna, North West, Nigeria

Emmanuel Ogudoro, Abuja, Nigeria

THUPDC036

Prevalence of Renal Impairment among ART Naïve Patients Presenting at an Urban Clinic in Harare

Tinei Shamu, Harare, Zimbabwe

THUPDC037

HIV and Adolescents: Keep Calm and Take Care of them! The Friendly Health Services for Young and Adolescents (SAAJs) Experience

Damiano Pizzol, Beira, Mozambique

THUPDC038

Province- and District-level Estimates of HIV Incidence among Young Women in sub-Saharan Africa

Mary Mahy, Geneva, Switzerland

THUPDC039

Knowledge on Preventing Mother to Child Transmission: Determinants and Drivers among People Living with HIV in Western Kenya

Emmanuel S. Wamalwa, Nairobi, Kenya

THUPDC040

Averting the New Trend and Next Generation of HIV Infections Caused by Poor Biomedical Waste Management Practices in Nigeria

David Akpan, Abuja, Nigeria

THUPDC041

Utilisation of Option B+ for Prevention of Mother to Child Transmission of HIV in HIV Positive Pregnant and Breastfeeding Women in Harare, Zimbabwe

Yeukai Musodza, Harare, Zimbabwe

THUPDC042

Evaluation of a Clinic Based Behavioural Intervention to Empower HIV-infected Preg-

nant Women to choose Long Acting Reversible Contraceptives (LARC) upon Delivery

Precious Moyo, Harare, Zimbabwe

THUPDC043

HIV Prevention among Youth Aged 15-24 at the Military Camp in Kinshasa, DR Congo

Onema Tshonda Willy, Kinshasa, Congo, the Democratic Republic of the

THUPDC044

Advocating for Speedy Roll out of Pre Exposure Prophylaxis (PrEP) among Key Population Both Male and Female Sex Workers in Kenya

Carolyne W. Njoroge, Nairobi, Kenya

THUPDC045

Reaching Young People with Mobile Technology for Sexual and Reproductive Health Interventions: Experiences from the Voices and Choices Youth Project in Manicaland Province, Zimbabwe

Delia Chimedza, Harare, Zimbabwe

THUPDC046

Evolution des Determinants de l'Utilisation Systematique du Condom par les Travailleurs des Secteurs Hotels-batiments Travaux Publics (BTP)-routiers au Benin de 2012 a 2015

Ayédélé Amour Balogoun, Cotonou, Benin

THUPDC047

Public Sector Condom Acceptability among Youth in Zimbabwe

Anna Machiha, Harare, Zimbabwe

THUPDC048

Situation of HIV/AIDS among the Main Transport Corridors of Ethiopia, Djibouti & Sudan

Afework Kassa, Kampala, Uganda

THUPDC049

Baseline Hotspot Behavioral Surveillance Survey in Hot Spots of Ethiopia

Afework Kassa, Kampala, Uganda

THUPDC050

Enhancing the Rate of HIV Testing through Mobile HCT in Non-formal Sectors in Abuja, Nigeria

Moses Okpara, Abuja, Nigeria

THUPDC051

The Effect of Health Education on the Knowledge and Prevention of Sexually Transmitted Infections among Senior School Adolescents in South-Western, Nigeria

Kemisola B. Ajide, Ibadan, Nigeria

THUPDC053

Resultats des Campagnes de Communications pour un Changement de Comportements (CCC) sur les IST/VIH au Benin de 2012 a 2014 Aupres des Travailleurs des BTP, Hotels et Routiers

Wenceslas Mocktard Affagnon, Cotonou, Benin

THUPDC054

Le Co-investissement des Entreprises Privee dans la Lutte Contre Le VHI/SIDA: Experience du Benin de 2013 a 2014

Bertin Somavo Affédjou, Cotonou, Benin

THUPDC055

"Courses pour la Vie", un Téléfilm Réalisé en 2014 pour la Communication pour un Changement de Comportement (CCC) en Milieu de Travail au Bénin

Afissou Yéssoufou, Cotonou, Benin

THUPDC056

Considerations on the Accuracy and Reliability of HIV Self-testing: A Literature Review

Carmen Figueroa, Geneva, Switzerland

THUPDC057

Evidence of High Mortality among HIV-exposed Infants Born to Population-based Sample of Women Attending ANC in Mashonaland East Province, Zimbabwe

Karen Webb, Harare, Zimbabwe

THUPDC058

Branding Public Sector Condoms to Increase Access and Utilisation for Young People in Five East and Southern African Countries

Kanyanta Sunkutu, Johannesburg, South Africa

THUPDC059

Use of Media and Peer Education Model to Enhance Behavior Change, Voluntary Counseling and Testing among Young People in 5 Pilot States in Nigeria

Moses Okpara, Abuja, Nigeria

THUPDC060

Sexual Behaviour and Determinants of VCT Patronage among Youth in Urban Slum: A Case of Isale-Eko in Lagos, Nigeria

Peter O. Adeyeye, Lagos, Nigeria

THUPDC061

Community Mobilisation a Critical Attribute for Ex-miners and their Families to Access TB Care Services

Margaret Zanele Thwala-Tembe, Manzini, Swaziland

THUPDC062

Raising Knowledge to Youth towards Lowering HIV/AIDS Transmission and Other Related Sexually Transmitted Infection

Isdor Auka, Nairobi, Kenya

THUPDC063

Opportunities for Scale up of PMTCT Access through Integration with MNCH: A Case Study of Government Funded MNCH and GHI (PEPFAR & GF) Supported PMTCT Programmes in Nigeria

Chidozie Ezechukwu, Abuja, Nigeria

THUPDC064

Analysis of Vulnerability to HIV Infection among LDLD and Allied Transport Workers along the Nigeria North-South Transport Corridors

Chidozie Ezechukwu, Abuja, Nigeria

THUPDC065

Role of Family Planning in Prevention of Mother to Child Transmission (PMTCT): Addressing the Unmet FP needs of HIV Positive Women in Matabeleland South and Mashonaland Central Provinces, Zimbabwe

Munyaradzi Murwira, Harare, Zimbabwe

THUPDC066

Etude Épidemiologique d'un Groupe Spécifique (Homosexuels) à Ouagadougou au Burkina Faso: 21 Couples Colligés

Yameogo Sibiri, Ouagadougou, Burkina Faso

THUPDC067

Prevalence and Determinants of Cell-free and Cell-associated HIV-1 Shedding in Late Breast Milk of Mothers Not on Anti-retroviral Therapy (ART) Postpartum

Gatsinzi David Rutagwera, Lusaka, Zambia

THUPDC068

Improving Quality of Key-affected Population (KAP) Intervention Using Evidence: A Case Study of the EKPIN Project in Nigeria

David Akpan, Abuja, Nigeria

THUPDC069

HIV Prevention among Most-at-Risk Populations in Sagamu, Southwestern Nigeria - A Community-based Initiative

Oluwafolahan O. Sholeye, Sagamu, Nigeria

THUPDC070

Equity in Use of ART among Adults in South Africa

Sizulu Moyo, Cape Town, South Africa

THUPDC071

Knowledge and Awareness of HIV/AIDS and HIV Status among Pregnant Women Attending Antenatal Care in Ghana

Yohei Maruyama, Accra, Ghana

THUPDC072

Scaling up Voluntary Medical Male Circumcision in Zambian Prisons - The Mansa Central Prison Experience

Morrison Zulu, Lusaka, Zambia

THUPDC073

Towards Zero New HIV Infection: A Study of the Sexual Behavior of Young Persons in Sagamu, Nigeria

Oluwafolajimi O. Senjobi, Sagamu, Nigeria

THUPDC074

Modeling HIV Care from the Patient Perspective: Integrating HIV Epidemiology with a Health Care Design and Visualization Tool

Daniel J. Klein, Bellevue, United States

THUPDC075

Do Under-reported Age Gaps Matter? A Network-based HIV Modeling Study

Daniel J. Klein, Bellevue, United States

THUPDC076

Mapping HIV Epidemic Clustering for Decision Making in Zimbabwe

Oscar Tapera, Harare, Zimbabwe

THUPDC077

Provision of Integrated Sexual and Reproductive Health Services to Female Sex Workers in Kilifi County - Coast Region

Kingola Nzioki, Mombasa, Kenya

THUPDC078

ART Medicines Pick-up, Bindura, Zimbabwe

Isaac Taramusi, Harare, Zimbabwe

THUPDC079

Use of Innovative High Impact Strategies to Increase Access and Uptake of SRH Services by Female Sex Workers in Kilifi County

Dan Okoro, Nairobi, Kenya

THUPDC080

Spatial Patterns of Need, Availability and Uptake of HIV Services in East Zimbabwe

Robin Maximilian Schaefer, London, United Kingdom

THUPDC081

Evaluating the Effectiveness of HIV Counseling and Testing as an Interventional Tool for Behavioral Change among People Who Inject Drugs at a Community Health Centre in Kaduna North West, Nigeria

Akintunde Abimbola, Kaduna, Nigeria

THUPDC082

Developing a Culturally Relevant Set of HIV Self-testing Instructions in Zimbabwe: Insight from Video Recordings

Yvonne Mavengere, Harare, Zimbabwe

THUPDC083

How to Achieve the Recent UNAIDS and WHO Targets Regarding HIV Testing? Lessons from the MATCH Study in Burkina Faso

Odette Ky-Zerbo, Ouagadougou, Burkina Faso

THUPDC084

Why Repeat an HIV Test? An Analysis of Users' Motivations to Test for HIV in Burkina Faso

Odette Ky-Zerbo, Ouagadougou, Burkina Faso

POSTER SESSION IV

THUPDC085

Using the Community Score Card Approach to Assess the Quality of HIV & AIDS Service Delivery in Public Health Facilities in Uganda

Stella Kentusi, Kampala, Uganda

THUPDC086

Projet ESTHER-ACONDA: Bilan de 30 Mois de Soutien à la Transfusion Sanguine au Centre de Prise en Charge de Recherche et de Formation (CePReF), Abidjan Côte d'Ivoire

E Messou, Abidjan, Cote D'Ivoire

THUPDC087

Multi-sectoral HIV Programming for MARPS in Uganda: Review of Profiles, Sizes and Programme Coverage

Peter Mudiope, Kampala, Uganda

THUPDC088

The Join-In Circuit: An Innovative and Participatory Approach to Boosting HIV and AIDS Prevention within Zambian Young Adults

Mubita Simonda, Lusaka, Zambia

THUPDC089

Home Visit Approach (HVA) as a Tool for Demand Creation for Sexual Reproductive Health (SRH) Services and HIV Prevention in Manicaland Province of Zimbabwe

Patricia U. Ndebele, Mutare, Zimbabwe

THUPDC090

Modeling Cost-per-HIV Infection Averted by Couples' Voluntary HIV Counseling and Testing in Six African Countries

Chileshe Kambikambi, Ndola, Zambia

THUPDC091

Factors Associated with Increase in STI Cases in Harare Province

Adonija Muzondiona, Harare, Zimbabwe

THUPDC092

A Comparison of Female Sex Workers (FSW) in Lusaka and Ndola, Zambia

Lucy Banda, Lusaka, Zambia

THUPDC093

Evolution des Rôles et Responsabilités Autour de l'Option B+ au Sénégal et au Burkina Faso: des Professionnels Soulagés et des Médiatrices Surchargées

Khoudia Sow, Dakar, Senegal

THUPDC094

Empowering Young Positives for Youth Intervention Increase Uptake of HIV and Sexual Reproductive Health Services in Arua

Lulu Henry Leku, Kampala, Uganda

THUPDC095

Evaluation du Risque de Contamination de la Tuberculose chez le Personnel des Centres des Services de PEC des Personnes Infectées par le VIH: Cas du CePReF Yopougon-Attié, Côte d'Ivoire

E Messou, Abidjan, Cote D'Ivoire

THUPDC096

Prevention of HIV and Unplanned Pregnancies through Integrated Couples Voluntary HIV Counselling and Testing and Couples Family Planning Counselling in Zambia

Elias Gudo, Lusaka, Zambia

THUPDC097

Teenagers: The next Frontier for HIV Prevention Interventions in Nigeria

Emmanuel A. Agogo, Abuja, Nigeria

THUPDC098

Factors Associated with Late Presentation for HIV/AIDS Care in Harare City, Zimbabwe 2015

Howard Nyika, Harare, Zimbabwe

THUPDC099

Risk Perceptions and Sexual Behaviors Related to HIV Infection among Men Following Safe Male Circumcision in Kampala District

Nicholas Sebuliba Kirirabwa, Kampala, Uganda

THUPDC100

Integrating Family Planning and ART Care into MCH Service for HIV Positive Pregnant and Breastfeeding Women

Ausenda Maria Domingos, Maputo, Mozambique

THUPDC101

Evaluation of Voluntary Medical Male Circumcision Programme (VMMC) in Gwanda and Beitbridge Districts, Zimbabwe 2013-2014

Tsitsi Patience Juru, Harare, Zimbabwe

THUPDC102

CONDOMIZE! Malawi 2014

Milika Mdala, Lilongwe, Malawi

THUPDC103

Trends in Cervical Cancer Screening Using Visual Inspection with Acetic Acid and Cervicography at Gwanda Provincial Hospital, Zimbabwe 2013-2014

Tsitsi Patience Juru, Harare, Zimbabwe

THUPDC104

Profil Épidémiologique d'une cohorte de Patients Diagnostiqués Séropositifs pour le VIH Entre 2013 et 2014 en Mauritanie

Kelly Mamadou, Nouakchott, Mauritania

THUPDC105

Predictors of Dual Contraception among HIV Discordant Relationships in Zambia

Mubiana Inambao, Ndola, Zambia

THUPDC106

Determinants of HIV Testing among Transport & Allied Workers in Nigerian Junction Town

Emmanuel A. Agogo, Abuja, Nigeria

THUPDC107

L'Intégration des Services de Prévention SSR/VIH pour un Meilleur Impact de la lutte contre le VIH Auprès des Populations Clés: Projet Fonds Mondial, Série 10 VIH par l'ONG CAMNAFAW au CAMEROUN

Arouna Tena Ngounga, Yaounde, Cameroon

THUPDC108

Residual High Risk Behaviours Among Young Part-time Female Sex Workers during Implementation of a HIV Prevention Intervention in Burkina Faso

Isidore Tiandiogo Traore, Bobo-Dioulasso, Burkina Faso

THUPDC109

Cluster-randomized Controlled Study of SMS Text Messages for Prevention of Mother-to-child Transmission of HIV

Seble G. Kassaye, Washington DC, United States

THUPDC110

Transactional Sex in Rural Communities in South Africa

Mzikazi Nduna, Braamfontein, South Africa

THUPDC111

Exploring Perceptions of Mobility and Migration in HIV Risk in the Rural Eastern Cape and Mpumalanga

Mzikazi Nduna, Braamfontein, South Africa

THUPDB112

Embracing Safe Medical Male Circumcision among Traditionally Circumcising Communities, a Case of Bagisu in Bududa District Uganda

Ronald Tumusiime Ndoleriire, Kampala, Uganda

THUPDD113

Enhancing Antiretroviral Treatment Outcomes in Young People from a Mental Health Approach

Bahati Kasimonje, Harare, Zimbabwe

THUPDD114

Condomize! at the Centre of Community Mobilization

Kefilwe Koogotsitse, Gaborone, Botswana

THUPDD115

Focusing on Key Populations: SAfAIDS Sexual and Reproductive Health and Accountability in Prisons in Southern Africa

Katrina Wallace-Karenga, Harare, Zimbabwe

THUPDD116

Factors behind Sexual Risk Taking among Students in Tertiary Institutions: Case Study of the University of Zimbabwe's School of Social Work

Jacqueline Mpotsa, Harare, Zimbabwe

THUPDD117

Cascading the Process Oriented Approach (POA) on Comprehensive Sexuality Education through Partner Organizations in Order to Reach More Children and Young People in Africa

Tafadzwa Thelma Madondo, Hatfield, South Africa

THUPDD118

ZNNP+ Innovation to Enhance Communication for Youth living with HIV through Social Media

Edmore Mutimodyo, Harare, Zimbabwe

THUPDD119

Zero Tolerance to Child Sexual Abuse

Clive Zephaniah Simango, Bulawayo, Zimbabwe

THUPDD120

Economic Empowerment for Women Living with HIV/AIDS a Means to Reduction in Stigma and Discrimination

Doris Ngozi Brendan, Ibesikpo, Nigeria

THUPDD121

Barriers to the Implementation of the Accelerated Children's HIV/AIDS Treatment (ACT) Initiative in Hurungwe District, in Zimbabwe: Findings from a Qualitative Survey

Auxilia Muchedzi, Harare, Zimbabwe

THUPDD122

Between Policy and Practice in HIV and AIDS Education at Secondary School Level in Zimbabwe

Sipikelelo Mugari, Masvingo, Zimbabwe

THUPDD123

Making Comprehensive HIV Prevention and Sexual and Reproductive Health (SRH) Information and Services Accessible to Adolescents and Youth in Higher Learning Institutions

Meron Negussie, Addis Ababa, Ethiopia

THUPDD124

Engaging a Rural Community for PMTCT through Dialogue: Experiences from a Rural District in Zimbabwe

Norman Dzirambi, Harare, Zimbabwe

THUPDD125

Sexual Permissiveness and Reckless Sexual Behaviour among Parents in Rural South Africa

Esmeralda Vilanculos, Johannesburg, South Africa

THUPDD126

Integration of HIV Care Services into Human Rights-promotion Campaigns in Prisons - Mityana Uganda Charity Experience

Kinaalwa Ssemakula Geoffrey, Kampala, Uganda

THUPDD127

Catch Them Young - Life Skills Building for, Boys, Girls and Youth in Sexual Repro-

ductive Health, Rights and HIV/AIDS

Lennon Chinowaita, Harare, Zimbabwe

THUPDD128

Participatory Action Research (PAR) in Institutions of Higher Learning Facilitated by Student Researchers

Andile Joyce Mthombeni, Johannesburg, South Africa

THUPDD129

Assessing the Efficacy of Restless Development's Livelihoods Interventions for People Living with HIV and Opharns and Vulnerable Children from Rural and Urban Ghettos in Zimbabwe

Primrose Nanchani Manyalo, Harare, Zimbabwe

THUPDD130

Developing the HIV Literacy of Future African Leaders through the Curriculum in Higher Education

Managa Pillay, Pretoria, South Africa

THUPDD131

Factors Associated with HIV Positivity among Women Tested for HIV for the Tirst Time in Labour and Delivery

Paul Nesara, Harare, Zimbabwe

THUPDD132

ACT!2015: Youth-led Accountability for the Implementation of the SDGs

Meheret Melles, Geneva, Switzerland

THUPDD133

Evidence from Cameroon on Youth-oriented Service Delivery & Contraceptive Use

Gabriel Tchokomakwa, Yaoundé, Cameroon

THUPDD134

The Body Talks: Interrogating Stigma and Discrimination through Applied Drama

Silinganiso Chatikobo, Johannesburg, South Africa

THUPDD135

Knowledge, Perceptions and Attitudes of Students towards Female Condoms. A Case Study of Bulawayo Polytechnic

Faith Kurete, Bulawayo, Zimbabwe

THUPDD136

Implementation of Sexual Reproductive Human Rights (SRHR) by Female Students in Universities in Zimbabwe

Jephias Matunhu, Gweru, Zimbabwe

THUPDD137

Professional Family Therapy/Counselling is the Best Therapy. It Is Not a Secret that Reproductive Age Suffers Psychological Trauma, Stigma, Exploitation, Sexual Abuse, which Creates Cycles of Poverty

Linos Muvhu, Harare, Zimbabwe

THUPDD138

Annonce du Statut VIH aux Adolescents Infectes par le VIH Suivis au Centre Mere et Enfant de la Fondation Chantal Biya, Yaounde, Cameroun: Processus de Mise en Place et Evaluation

Juste Felix honore Bossolo, Yaounde, Cameroon

THUPDD139

Promote the Development and Scale up of Evidence-based Interventions for HIV and AIDS for Young in People in Tanzania: The Case Study of Lindi Region

Charles P. Kamugisha, Dar es Salaam, Tanzania, United Republic of

THUPDD140

Community Dialogues - A Tool for HIV Prevention in East and Southern Africa?

Obrian F. Nyamucherera, Harare, Zimbabwe

THUPDD141

The Role of Today's Teacher in the Prevention of Cross Generational HIV Infections and New HIV Infections amongst Themselves with a Main Focus on the HIV Positive Teenager

Doreen Margaret Diana Ndlovu, Bulawayo, Zimbabwe

THUPDD142

Engagement of the Faith Sector within Sub Saharan Countries for an Accelerated Country-specific Response to HIV

Eunice A.E. Odongi, Nairobi, Kenya

THUPDD143

Conducting an HIV Sensitive Social Protection Assessment

David Chipanta, Geneve, Switzerland

THUPDD144

Are Zimbabwe's Social Protection Mechanisms Adequately Addressing the Challenges of Orphans Living in Child-headed Households?

Emma Kudzai Chademana Munodawafa, Cape Town, South Africa

THUPDD145

Resilience of Orphans Living in Child-headed Households in Zimbabwe

Emma Kudzai Chademana Munodawafa, Cape Town, South Africa

THUPDD146

Quality of Life of Orphans Living in Child-headed Households in Zimbabwe

Emma Kudzai Chademana Munodawafa, Cape Town, South Africa

THUPDD147

Impact de la Perception du VIH / SIDA par les Personnes Vivant avec le VIH (PVVIH) sur Leur Qualité de Vie: 236 PVVIH Enquêtées au CHUYO

Yameogo Sibiri, Ouagadougou, Burkina Faso

THUPDD148

Mother to Daughter Sexuality Communication: Implication for Attaining Zero New HIV Infections in Sagamu, Nigeria

Oluwadamilola Opawale, Ogun State, Nigeria

THUPDD151

Understanding Barriers to Utilization of Maternal and Childhood Services through Community Dialogue in the Context of Results Based Financing

Priscilla Kusena nee Madzinga, Harare, Zimbabwe

THUPDD152

Narratives of Agency and Exclusion among Cisgender Male and Transgender Female Sex Workers in Cape Town, South Africa: Dominant Gender Constructs and their Implications for the HIV Epidemic

Zoe Samudzi, London, United Kingdom

THUPDD153

Supporting Citizen Engagement for Improved Health and HIV Policy and Financing in Kenya

Jennifer Stephens, Washington, United States

THUPDD154

"You Cannot Eat Rights": Views by Zambian HIV-vulnerable Women, Youth and MSM on Human Rights as Public Health Tools

Chcolwe Muzyamba, Maastricht, Netherlands

THUPDD155

Improved Psychosocial Well-being: Evidence for the REPSSI Teachers' Diploma in Psychosocial Care, Support and Protection from Teachers and Students in Zambia

Lisa Langhaug, Harare, Zimbabwe

THUPDD156

Low HIV Testing and Contraception Uptake in a Youth Friendly Centre in Mutwapa, Kilifi County

Peter Gichangi, Nairobi, Kenya

THUPDD157

An Assessment of the Community and Home Based Care Programme in the Era of Antiretroviral Therapy: The Case of Mashonaland East Province, Zimbabwe

Edgar Muzulu, Marondera, Zimbabwe

THUPDD158

To Be or Not to Be: Perceived Barriers and Facilitators to the Uptake of Voluntary Medical Male Circumcision among Married Couples in the Midlands Province, Zimbabwe

Mpikelelo M. Maseko, Gweru, Zimbabwe

THUPDD159

Impact de "l'approche pair" Dans la Divulgation du Statut VIH aux Adolescents Infectés par le VIH Suivis l'Hôpital Pédiatrique de Kalembelembe

Miriam Amida Titina, Kinshasa, Congo, the Democratic Republic of the

THUPDD160

Unrecognised Burden of Suicidal Ideation and Attempt among Persons Living with HIV and AIDS in Semi-Urban Uganda

Godfrey Zari Rukundo, Kampala, Uganda

THUPDD161

Factors Associated with HIV Transmission to Infants among Women on PMTCT Program in Mashonaland East Province

Edgar Muzulu, Marondera, Zimbabwe

THUPDD162

Harmful Cultural and Religious Practices: A Deterrent to 100% PMTCT uptake - A Case for Gweru District

Chipo Chimunhu, Gweru, Zimbabwe

THUPDD163

Review of Health Policies for HIV-NCD Comorbid Programming in 8 Sub-Saharan Nations

Jason Sreedhar, Washington, United States

THUPDD164

GALZ HIV and AIDS Programme

Sylvester Munyaradzi Nyamatendedza, Harare, Zimbabwe

THUPDD165

Evolution of South Africa's Response to AIDS: Lessons, Challenges and Opportunities

Nono Simelela, Pretoria, South Africa

THUPDD166

Out-of-School Girl Leaders Speak up about Access to Services, Safety, and Livelihoods in Tanzania

Alison Louisa Jenkins, Dar es Salaam, Tanzania, United Republic of

THUPDD167

Economic Strengthening (ES) at the Interface of Poverty, Resilience Building and Behaviour Change - The Case of HIV and AIDS Affected Families in Nyanga District

Diego Matsvange, Mutare, Zimbabwe

THUPDD168

Innovation in Litigation to Protect Sex Workers Rights: Litigating for Sex Workers Rights through Challenging Arbitrary Police Action

Tinashe Mundawarara, Harare, Zimbabwe

THUPDD169

Empowering Vulnerable Adolescent Girls Through Mentorship Clubs (Sista2Sista Clubs) in Zimbabwe

Walter Chikanya, Harare, Zimbabwe

THUPDD170

Experiences in Advocacy Litigation on Criminalisation of HIV in Zimbabwe: Pitty

Mpofu v the State; Samukelisiwe Milo v the State and Malandu Ncube vs State

Tinashe Mundawarara, Harare, Zimbabwe

THUPDD171

Just a Snip? Lemba Cultural Circumcisers' Perspectives on Medical Male Circumcision for HIV Prevention in Mberengwa District of Rural Zimbabwe

Kemist Shumba, Durban, South Africa

THUPDD172

Integrating Sexual and Reproductive (SRH), Maternal and Child Health (MCH) and HIV for Adolescents and Young People through Promotion of Comprehensive Sexuality Education (CSE) in Zambia

Namuchana Mushabati, Lusaka, Zambia

THUPDD173

WHO Policy Brief on Transgender People and HIV

Annette Digna Verster, Geneva, Switzerland

THUPDD174

Psychological Violence among Undergraduate Medical and Allied Health Students in Sagamu, Nigeria: Implications for HIV Control

Moyosore A. Buari, Sagamu, Nigeria

THUPDD175

Reducing Youth Vulnerability to HIV Infection in Sagamu, Southwest Nigeria: A Community-based Program

Abiodun A. Obafemi, Sagamu, Nigeria

THUPDD176

"I Didn't Know I Should Bring my Child" - Reasons for Failure to uptake EID among a Population-based Sample of HIV Positive Women in Mashonaland East Province, Zimbabwe

Webb Karen, Harare, Zimbabwe

THUPDD177

Children: The Missed Target in the Scaling-up of HIV Treatment in North Africa

Mohamed Msefer, Marrakech, Morocco

THUPDD178

Leadership Engagement Breaks Structural Barriers and Promotes Access to and Utilization of HIV/SRH and Socio-economic Services by Sex Workers: An Experience of AIDS Information Arua, Uganda

Raymond Byaruhanga, Kampala, Uganda

THUPDD179

Reducing Condom Stock Outs among High Risk Populations Using e-condom Distribution System in Kampala City

Raymond Byaruhanga, Kampala, Uganda

THUPDD180

Piloting an Economic Strengthening Program for Female Sex Workers in Abidjan, Côte d'Ivoire: Lessons Learned for Integrating Economic Strengthening into HIV Prevention

Emily Namey, Durham, United States

THUPDD181

When Laws Create Barriers to Care: Innovations and Solutions to Address Age of Consent as Barrier to HIV Testing and Counselling (HTC) and Care in Adolescents

Najin Yasrebi, New York, United States

THUPDD182

Increasing Accessibility to Health Services for Key Populations through Capacity Building of Health Workers and Empowering the Key Populations

Raymond Byaruhanga, Kampala, Uganda

THUPDD183

The Politics of Women's Empowerment in HIV/AIDS Prevention Programmes: A Comparative Qualitative Analysis of Five Women's Associations in Nigeria

Chinwe U. Madubuike, Abuja, Nigeria

THUPDD184

Traditional and Cultural Leaders Hold a Special Key to Unlocking Socio-cultural Drivers of HIV Infection and Sexual Reproductive Ill-health Especially among Girls and Women: Experiences from Uganda

Raymond Byaruhanga, Kampala, Uganda

THUPDD185

Addressing HIV and AIDS in the Small and Medium Enterprises and the Informal Sector

Fortunate Munhuweyi, Avondale, Zimbabwe

THUPDD186

Implementing a Programme for Young Women who Sell Sex in Zimbabwe: Experiences and Lessons Learnt

Sibongile Mtetwa, Harare, Zimbabwe

THUPDD187

The Calculus of Disclosure of Serostatus: Experiences of Pregnant Women at Bonda Mission Hospital, Manicaland, Zimbabwe

Sibangilizwe Maphosa, Gweru, Zimbabwe

THUPDD188

Community Systems Strengthening and the HIV/AIDS Response in Zimbabwe

Muchanyara C. Mukamuri, Harare, Zimbabwe

THUPDE189

Quality of SRH Services, Policies and Programs Including How they Target Marginalized Groups within Institutions of Higher Learning in Zimbabwe

Vimbai Yvonne Mlambo, Harare, Zimbabwe

THUPDE190

Sustainable Workplace HIV/AIDS Programmes: Seed Fund as a Catalyst for Return on Investments in HIV/AIDS Workplace Programmes through Public-private Partnership

Daniel Muigai Mwaura, Nairobi, Kenya

THUPDE191

Sexual and Reproductive Health and Rights (SRHR) & HIV Integration

Yumna Hattas, Cape Town, South Africa

THUPDE192

Development and Roll-out of SRH and HIV Integration Service Guidelines - A Participatory Approach in Zimbabwe

Fatima Mhuriro, Harare, Zimbabwe

THUPDE193

Enhancing Partnerships for Social Health Protection: The SADC Minimum Package of Services for Orphans and Other Vulnerable Children and Youth

Manasa Dzirikure, Gaborone, Botswana

THUPDE194

Use of Telemedicine Technologies and Systems to Increase Equity of Access to HIV/AIDS Specialist Clinical Care and Treatment: A Systematic Review of the Model Telehealth Programme in Zambia

Saviour Chishimba, Lusaka, Zambia

THUPDE195

Implementing a SMS Technology to Improve Retention of PMTCT Mothers in Malawi: Challenges and Lessons Learnt from the INSPIRE-PRIME Study

Andrews Gunda, Lilongwe, Malawi

THUPDE196

HIV Vulnerability amongst Young Women with Absent Fathers in Mpumalanga, South Africa

Oncemore Mbeve, Johannesburg, South Africa

THUPDA197

Mother to Child HIV Transmission and HIV Status Disclosure

Esmeralda Vilanculos, Johannesburg, South Africa

THUPDE198

The Challenges of Conducting Implementation Research in a Highly Unstable Environment: Experiences from the INSPIRE Nigeria PMTCT Studies

Nadia Sam-Agudu, Abuja, Nigeria

THUPDE199

African Youth, SRHR and HIV in the Post 2015 Era

Mr. Bob Munyati, Cape Town, South Africa

THUPDE200

Enhancing Nursing Education in Tanzania through Tablet Technology

Ndementria Vermand, Dar es Salaam, Tanzania, United Republic of

THUPDE201

An Integrated Approach to WASH and HIV in Southern Africa

Percy Ngwerume, Harare, Zimbabwe

THUPDE202

Fighting HIV/AIDS among Men Having Sex with Men (MSM)

Telesphore Nambajimana, Kigali, Rwanda

THUPDE203

Exploring the Feasibility of Collecting AIDS Levy from the Informal Sector in Zimbabwe

Victoria James, Harare, Zimbabwe

THUPDE204

Community-led Consultation to Inform the WHO 2015 Consolidated Treatment Guidelines Update: The Acceptability of Early Initiation of Antiretroviral Therapy (ART) and Viral Load Monitoring

Megan Dunbar, Harare, Zimbabwe

THUPDE205

Integrating Sexual and Reproductive Health and HIV Services for Marginalised Populations: The Case of Otse Village

Judith Shongwe, Gaborone, Botswana

THUPDE206

Harmonising and Standardising Condom Quality Assurance in East and Southern Africa through Regional Economic Communities (REC)

Kanyanta Sunkutu, Johannesburg, South Africa

THUPDE207

Standardizing Social Work Education to Strengthen Tanzania's Psychosocial Response to HIV/AIDS

Asiya Mwanzi, Dar es Salaam, Tanzania, United Republic of

THUPDE208

HIV/AIDS Information and Knowledge Management Priorities for Post 2015 Uganda - A Case for the National Aids Documentation and Information Centre (NADIC)

Nelson Musoba, Kampala, Uganda

THUPDE209

Global Fund New Funding Model: Lessons from Nigeria on Gains, Shortcomings and Recommendations for Refining the Process for Greater Impact

Chidi Victor Nweneka, Abuja, Nigeria

THUPDE210

Geo-mapping of Hotspots in Junction Towns along the North South Transport Corridor of Nigeria for Improved Access to HIV/SRH Services for Vulnerable Populations

Chidozie Ezechukwu, Abuja, Nigeria

POSTER SESSION IV

THUPDB211

EDCTP as a Model for Europe-Africa Partnership on HIV/AIDS Research - Achievements and Future Directions

Perry Mohammed, The Hague, Netherlands

THUPDE212

Evaluating Lifting Barriers to Universal Access Project: A Step by Step Transformative Process for Increased Access to HIV Services for Sexual Minorities in 2 Communities in Zimbabwe

Ngoni Chibukire, Harare, Zimbabwe

THUPDE213

Sexual Orientation and its Implications for HIV Control in Sagamu, Nigeria: A Gender Based Analysis of Medical Students' Views

Victor Jide Animasahun, Sagamu, Nigeria

THUPDE214

Effective and Sustainable HIV and AIDS Epidemic Impact Mitigation in Zimbabwe

Talent Murwendo, Masvingo, Zimbabwe

THUPDE215

Collaborative Civil Society Partnerships for Sustainable HIV Responses in a Funding-constrained Environment: The Blood: Water Model

Nadia Kist, Nairobi, Kenya

THUPDE216

The Use of Telecommunication Networks to Remotely Monitor Quality of POC CD4 Testing amongst HIV Infected Clients in Cameroon

Maria Rosezoil Rioja, Yaounde, Cameroon

THUPDE217

Eradicating Violence and Promotion of Sexual Health among Lesbians and Women who Have Sex with Women (WSW) through Building Healthy Relationship - Heartland Alliance Nigeria Innovative Grant Project

David Akpan, Abuja, Nigeria

THUPDE218

Programming for Evidence (P4E): An Evaluation of Innovative Program Conducted among Women who Have Sex with Women (WSW), Lesbian and Transgender in Nigeria

David Akpan, Abuja, Nigeria

THUPDE219

3 Feet Approaching: Using HIV as an Entry Point for Improved Outcomes along the Continuum of Care

Latasha Treger, Pretoria, South Africa

THUPDE220

Capacity Building of Local Organisations to Respond to the Needs of Key Populations through Development Worker Placement: A Case of Progressio Zimbabwe

Patisiwe Zaba, Harare, Zimbabwe

THUPDE221

Including HIV Testing into an Existing Red Cross Community TB Programme - Challenges and Lessons Learnt

Ruth Mufalali-van Rooyen, Port Elizabeth, South Africa

THUPDE222

Engaging PEPFAR - A Game Changing Partnership

Chamunorwa Mashoko, Harare, Zimbabwe

THUPDE223

Implication des Conjoints Dans les Activités PTME: Exemple du Projet de Prévention de la Transmission Parent-enfant (PTPE) d'Alliance Côte d'Ivoire

Lou Tana P. Irie Yapi, Abidjan, Cote D'Ivoire

THUPDE224

HIV Policy Implementation in South Africa: Evidence from a National Policy Review and Health Facility Surveys in Two Rural Demographic Surveillance Sites

Janet Michel, Durban, South Africa

THUPDB225

Implementing a National Quality Improvement (QI) Program for HIV Services in Zimbabwe

Bekezela B. Khabo, Harare, Zimbabwe

THUPDE226

Unique Service Delivery to Sex Workers, an Experience of AIDS Information Centre Arua

Henry Leku Lulu, Kampala, Uganda

THUPDE227

The Extent of Effectiveness of Wellness Centre in the Fight against HIV/AIDS Epidemic among the Cross Mobile Boarder Population: A Case Study of Oraba Wellness Center, Koboko District-Uganda

Halid Metaloro, Kampala, Uganda

THUPDE228

The 3-feet Model as an Approach to Fast Track Progress towards the 90-90-90 Targets in the Nelson Mandela Bay Health District (NMBHD) in South Africa

Jeannette Wessels, Pretoria, South Africa

THUPDE229

Préparation pour la Continuité des Programmes Communautaires de lutte Contre le VIH/Sida en Situation Humanitaire: Cas de Alliance Côte d'Ivoire

Ives Roland Koussan, Abidjan, Cote D'Ivoire

THUPDE230

Youth Patch: Involving Youths in Making Informed Choices

Mugenyi Paddy, Kampala, Uganda

THUPDE231

A Review of Community-facility Linkages to Support Lifelong Treatment for Pregnant and Breastfeeding Women Living with HIV: Promising Practices and Key Operational Considerations for Scale up

Laurie A. Gulaid, Dar es Salaam, Tanzania, United Republic of

THUPDE232

Impact of Facility-level Quality Improvement Activities on Unnecessary Patient Visits in Lusaka, Zambia

Elizabeth McCarthy, Lusaka, Zambia

THUPDE233

Availability and Distribution of Human Resource for HIV Service Delivery in Kenya

Maureen Kimani, Nairobi, Kenya

THUPDE234

Strengthening Access to HIV and AIDS Information and Knowledge for Informed Decisions: Experiences from Uganda AIDS Commission

Tumusiime Jennifer, Kampala, Uganda

THUPDE235

How to Translate High Level Political Targets into Programmatic Planning for Key Populations at Country Level?

Annette Digna Verster, Geneva, Switzerland

THUPDE236

Delivering HIV Services during an Emergency Response in Malawi

Judith Sherman, Lilongwe, Malawi

THUPDE237

Prévention du VIH et Prise en Charge Médicale des HSH et des PS en Lien avec les Structures de Santé Publiques en Côte d'Ivoire

Lucile Konan, Abidjan, Cote D`Ivoire

THUPDE238

From "Transactional" to "Transformational" Technical Assistance for Maternal and Child Health in South Africa

Ignatius Odongo, Pretoria, South Africa

THUPDE239

Community Led HIV/AIDS Initiatives in Kanungu District Southwestern Uganda

Steven Sebudde, Kampala, Uganda

THUPDE240

Community Monitoring of OL/ART Services by PLHIV in Zimbabwe - An Antidote for Meaningful Involvement and Ownership of Programmes in the National Response

Silibele Mpofu, Harare, Zimbabwe

THUPDE241

Adaptation and Implementation of the 2013 WHO Consolidated HIV Guidelines in Resource Constrained Settings: Country Experiences and Lessons Learnt in Zimbabwe

Joseph Murungu, Harare, Zimbabwe

THUPDE242

Passed by by the AIDS Revolution: Human and Medical Consequences of Low ARV Coverage in West and Central Africa

Mit Philips, Brussels, Belgium

THUPDE243

Using Counseling and HIV Testing for Early Diagnosis of Tuberculosis: Experience of Burkina Faso

Coulibaly FM Gisèle, Ouagadougou, Burkina Faso

THUPDE244

Etat des Lieux de la Prise en Charge du VIH Pédiatrique au Cameroun: Accès et Rétention dans le Circuit des Soins

Calixte Ida Penda, Douala, Cameroon

THUPDE245

The Effects of Economic Empowerment on HIV / AIDS Vulnerable Populations along the Transport Corridors in Zimbabwe: Eliam Mahohoma: Joseph Ajakaye-Corridor Economic Empowerment Project ILO, Harare

Eliam Mahohoma, Harare, Zimbabwe

NOTE

SPECIAL SESSION

MONDAY 30 NOVEMBER 2015

30.11.2015, 10:45 – 12:15 Jacaranda 1 & 2

Using TRIPS and other regional instruments for greater access to HIV medicines and commodities

Chairs: Christine Stegling, Botswana
Speakers: Othmana Mallouk, Egypt
Daniel Molekele, South Africa
Tapiwanashe Kujinga, Zimbabwe

30.11.2015, 10:45 – 12:15 Prof Soudré Room

Fast-track to ending AIDS by 2030

Chairs: David Parirenyatwa, Zimbabwe
Speakers: Michel Sidibe, Switzerland
Debby Birx, United States
Mark Dybul, United States
Sibongile Ndela-Simelane, Swaziland
Aaron Motsoaledi, South Africa
Félix Kabange Numbi Mukwampa, Congo, the Democratic Republic of the
Philippe Meunier, France

30.11.2015, 14:45 – 16:15 Jacaranda 1 & 2

Re thinking African community networks

Chairs: Ruvhereko Parirenyatwa, Zimbabwe
Speakers: Duncan Moeketse, South Africa
Olive Mumba, Tanzania, United Republic of
Shaun Mellors, South Africa

SPECIAL SESSION

30.11.2015, 14:45 – 16:15 Prof Soudré Room

African Union common position for the post 2015 agenda

Chairs: Jan Beagle, Switzerland
Speakers: Mustapha Sidiki Kaloko
Jullita Onabanjo, South Africa
Hazna Barkat Daoud, Djibouti
John Idoko, Nigeria
Aaron Motsoaledi, South Africa
Emmanuel Ntim, Ethiopia

TUESDAY 03 DECEMBER 2015

01.12.2015, 10:45 – 12:15 Prof Soudré Room

Traditional Medicine

Chairs: C. Maponga, Zimbabwe

Phytochemicals as Potential Inhibitors of Human Immunodeficiency Virus Type-1 Proliferation
Time: 10:45 – 11:00

Activities of Chemical Compounds Isolated from Indian Traditional Medicinal Plants to Arrest HIV-1 Progression
Time: 11:00 – 11:15

Implementation of the Regional Traditional Medicine Strategy
Time: 11:15 – 11:30
Charles Wambebe, Nigeria

Role of Traditional Health Practitioners in management of HIV and STIs
Time: 11:30 – 11:45
Sekuru Friday Chisanyu, Nigeria

The Philosophical underpinnings/basis of African Traditional Medicine
Time: 11:45 – 12:00
M. Gundidza

Incidence of Concomitant Use of Complementary Medicines among HIV patients
Time: 12:00 – 12:15
Tsitsi Grace Monera-Penduka

SPECIAL SESSION

01.12.2015, 12:45 – 14:15 Jacaranda 1 & 2

Interventions to improve adherence to medication

Chairs: Aka Kakou, Cote D`Ivoire

Combination interventions
Time: 12:45 – 13:30
Khoudia Sow, Dakar, Senegal

New electronic devices e.g. Sms
Time: 13:30 – 14:15
Jean Nachega, South Africa

01.12.2015, 14:45 – 16:15 Committee Room 5a & b

Gender-based violence

Chairs: Itumeleng Komanyane, South Africa

Speakers: Bafana Khumalo, South Africa
Diene Keita, Congo
Nkandu Luo, Zambia

01.12.2015, 14:45 – 16:15 Committee Room 5a & b

Gender-based violence

Chairs: Itumeleng Komanyane, South Africa
Speakers: Bafana Khumalo, South Africa
Diene Keita, Congo
Nkandu Luo, Zambia

01.12.2015, 14:45 – 16:15 Jacaranda 1 & 2

LPC - Special Session 6, Role of the First Ladies in embracing and sustaining change in the HIV response

Chairs: Sheila Tlou, South Africa
Speakers: Grace Mugabe, Zimbabwe
Lordina Mahama, Ghana
Margaret Kenyatta, Kenya
Gertrude Maseko, Malawi

SPECIAL SESSION

01.12.2015, 14:45 – 16:15 Prof Soudré Room

SPC - Special Session 5, HIV and TB

Chairs: Andrew Kambugu, Uganda

HIV and TB in special settings
TIME: 14:45 – 15:30
Panganai Dhliwayo

HIV and TB in children
TIME: 15:30 – 16:15
Diane Capo Chichi Achaoue, Benin

WEDNESDAY 02 DECEMBER 2015

02.12.2015, 10:45 – 12:15 Jacaranda 1 & 2

Recent advances in HIV vaccine research, including Vaccine therapy

Chairs: William Ampofo, Ghana
Speakers: Winson Tang, United States
Lynda Stranix, South Africa
Pontiano Kaleebu, Uganda

02.12.2015, 10:45 – 12:15 Prof Soudré Room

Optimizing prevention of mother-to-child transmission of HIV through community engagement and mobilization

Chairs: Deborah Von Zinkernagel, Switzerland
Speakers: Angela Mushavi, Harare, Zimbabwe
John Okoye, Nigeria
Florence Anam, Nairobi, Kenya
Sylvère Bukiki, Abidjan, Cote D`Ivoirea

02.12.2015, 14:45 – 16:15 Jacaranda 1 & 2

Early diagnosis, care, treatment and support of paediatric HIV infection

Chairs: Jane Muiza, Zimbabwe
Speakers: Michael Eliya, Malawi
Shaffiq M. Essajee, Geneva, Switzerland
Mariam Sylla, Mali
Pontiano Kaleebu, Uganda

SPECIAL SESSION

THURSDAY		03 DECEMBER 2015
03.12.2015,	10:45 – 12:15	Prof Soudré Room

HIV and NCDs
Chairs: James Hakim, Zimbabwe

HIV & Renal Risk
TIME: 10:45 – 11:07
Serge Paul Eholie, Cote D'Ivoire

HIV & Cervical Cancer
TIME: 11:07 – 11:29
Aristophane Tanon, Mali

HIV and cardiovascular risk
TIME: 11:29 – 11:52
Johnson Kumwenda, Malawi

Neuropsychological disorders
TIME: 11:52 – 12:15
Andrew Kambugu, Uganda

03.12.2015, 12:45 – 14:15 Jacaranda 1 & 2

Global Fund New Funding Model: Evaluating Community Participation in the Country Dialogue

Chairs: Linda Mafu, Switzerland
Speakers: Kunyima Banda, Zambia
Ifeanyi Kelly Orazulike, Nigeria
James Kamau, Kenya

03.12.2015, 14:45 – 16:15 Jacaranda 1 & 2

LPC - Special Session 3, Shaping the next five years: Africa's demands and commitments for the High Level Meeting on AIDS 2016

Chairs: Jan Beagle, Switzerland
Speakers: Alpha Oumar Konare, Mali
Steven Sianga
Mustapha Sidiki Kaloko
Félix Kabange Numbi Mukwampa, Congo,- the Democratic Republic of the
Loyce Maturu, Zimbabwe
Hakima Himmich, Casablanca, Morocco

SPECIAL SESSION

FRIDAY	04 DECEMBER 2015	
04.12.2015,	10:45 – 12:15	Committee Room 6

Linkages between HIV and Family Planning

Chairs: Justin Koffi, Togo
Speakers: John Idoko, Nigeria
Catherine Wanjiru Nyambura, nakuru, Kenya
Benjamin Buyemere, Congo

04.12.2015, 10:45 – 12:15 Jacaranda 1 & 2

Positioning HIV and AIDS in the Sustainable Development Goals

Chairs: Baba Goumbala, Senegal
Speakers: Olawale Maiyegun, Ethiopia
Samuel Kwesi Kissi, Ghana
Chris Collins, Switzerland

04.12.2015, 10:45 – 12:15 Prof Soudré Room

AIDS in Emergency, Conflict and Humanitarian contexts

Chairs: Dr. Luiz Loures, Geneva, Switzerland
Speakers: Marguerite Samba Maliavo,
Central African Republic
Zainab Hawa Bangura
Elhadj As Sy, Switzerland
Mashaer Aldawalab, Sudan

NOTE

MONDAY 30 NOVEMBER 2015

30.11.2015, 07:00 – 08:30 Prof Soudré Room

How to write a grant proposal

Chairs: Prof. Peter Mason, Zimbabwe

30.11.2015, 12:45 – 14:15 Committee Room 5a & b

The first 90: running a national HIV testing Campaign

30.11.2015, 14:45 – 16:15 Committee Room 6

Closing the evidence gaps: the role of KP leadership in research and data generation

Chairs: Hon. Marguerite Samba Maliavo, Central African Republic

TUESDAY 01 DECEMBER 2015

01.12.2015, 07:00 – 08:30 Prof Soudré Room

Health research ethics: Protecting our participants and community

Chairs: Dr. Paul Ndebele, Zimbabwe

01.12.2015, 10:45 – 12:15 Committee Room 5a & b

Leaving no one behind: Making the HIV response work for persons with disabilities

Chairs: Mad. Farai Mukuta, Zimbabwe

01.12.2015, 12:45 – 14:15 Committee Room 5a & b

Conducting an HIV sensitive Social Protection Assessment

Chairs: Mr. David Chipanta, Geneve, Switzerland

01.12.2015, 14:45 – 16:15 Committee Room 6

Mainstreaming Gender in the National AIDS Responses

Chairs: Mad. Caroline Nyamayemombe, South Africa

01.12.2015, 16:45 – 18:15 Committee Room 6

Leadership for Global solidarity and shared responsibility in closing the resource gap

Chairs: Prof. Mabingue Ngom, Senegal

01.12.2015, 16:45 – 18:15 Committee Room 5a & b

HIV, the law and human rights in Africa: key challenges and way forward

Chairs: Mr. Patrick Eba

WEDNESDAY 02 DECEMBER 2015

02.12.2015, 07:00 – 08:30 Prof Soudré Room

Publish or Perish

Chairs: Prof. Takafira Mduludza, Zimbabwe

02.12.2015, 10:45 – 12:15 Committee Room 5a & b

Managing adolescents and young people with HIV: Challenges and Solutions

Chairs: Dr. Tajudeen O. Oyewale, New York, United States

02.12.2015, 10:45 – 12:15 Jacaranda 3

Mental Health

Chairs: Dr. Dixon Chibanda, Zimbabwe

WORKSHOP

02.12.2015, 12:45 – 14:15 Committee Room 4

Reclaiming autonomy: African sex workers organizing to end HIV

Chairs: Miss. Georgina Caswell, South Africa

02.12.2015, 14:45 – 16:15 Committee Room 6

Empowering Adolescents and young people in enhancing their role in sustainable development

Chairs: Paska Kinuthia

02.12.2015, 16:45 – 18:15 Committee Room 5a & b

Integration of HIV and reproductive health: Expanding access to services

Chairs: Miss. Asa Andersson, Johannesburg, South Africa

THURSDAY 03 DECEMBER 2015

03.12.2015, 12:45 – 14:15 Committee Room 5a & b

Livelihoods

Chairs: Mad. Julian Hows, Amsterdam, Netherlands

03.12.2015, 14:45 – 16:15 Committee Room 6

Harm reduction programmes in Africa

Chairs: Miss. Georgina Caswell, South Africa

03.12.2015, 16:45 – 18:15 Committee Room 5a & b

Leveraging the existing and potential funding mechanisms to sustain the response

Chairs: Mad. Linda Mafu, Switzerland

03.12.2015, 16:45 – 18:15 Jacaranda 3

STIs in Key Populations in 2015

Chairs: Miss. Dagmar Hanisch, Switzerland

FRIDAY 04 DECEMBER 2015

03.12.2015, 16:45 – 18:15 Committee Room 5a & b

Leveraging the existing and potential funding mechanisms to sustain the response

Chairs: Mad. Linda Mafu, Switzerland

04.12.2015, 10:45 – 12:15 Committee Room 5a & b

HIV in crisis situation: the needs of migrants and displaced persons

Chairs: Mr. Niyi Ojuolape, United States

NOTE

NON ABSTRACT DRIVEN SESSION

MONDAY	30 NOVEMBER 2015	
30.11.2015,	12:45 – 14:15	Committee Room 6

TREATMENT OF HIV: What is new in the pipeline
Speaker: Craig McClure

30.11.2015, 14:45 – 16:15 Committee Room 4

"Transformative Leadership: The roles of African Women in sustaining the AIDS respone in the post 2015 era."

30.11.2015, 14:45 – 16:15 Committee Room 5a & b

STI's and HIV: Synergistic Epidemics with Implications for Control and Prevention

Chairs: Evaristo Marowa, Kees Rietmeijer
Speakers: More Mungati, Jeff Klausner, Kees Rietmeijer, Francis Ndowa, Sara Lowe, Frances Cowan

30.11.2015, 14:45 – 16:15 Jacaranda 3

Roles of fast track cities in achieving (90:90:90) by 2020

Chairs: Mbulawa Mugabe
Speakers: Carol Ngunu, Kenya, Prosper Chonzi, Zimbabwe
Nomakhosi Gxagxisa, South Africa
Célestin Dje Yao, Cote D`Ivoire
Smail Mesbah, Algeria
Mesfin Getahun

30.11.2015, 16:45 – 18:15 Main Auditorium

Reinvigorating HIV prevention in the context of fast track

Chairs: David Parirenyatwa, Zimbabwe
Speakers: James Macharia, Kenya
Sibongiseni Dhlomo, South Africa
Casper Erichsen, Namibia
Linden Morrison, Switzerland
Loyce Maturu, Zimbabwe

NON ABSTRACT DRIVEN SESSION

TUESDAY	01 DECEMBER 2015

01.12.2015, 12:45 – 14:15 Prof Soudré Room

Models to improve the first 90 target access to HIV testing

Speaker: Rachel Baggaley

01.12.2015, 16:45 – 18:15 Prof Soudré Room

LEADERSHIP: Lessons learnt and perspectives

Speaker: Father Bob, Switzerland

WEDNESDAY	02 DECEMBER 2015

02.12.2015, 12:45 – 14:15 Committee Room 6

LINKING LABS & PROGRAMS: Spearheading Change in diagnostics to achieve 90-90-90

02.12.2015, 16:45 – 18:15 Jacaranda 1 & 2

Molecular technologies including EID and viral load testing services for HIV in Africa

Speaker: John Nkengason, United States

THURSDAY	03 DECEMBER 2015

03.12.2015, 12:45 – 14:15 Committee Room 6

LEADERSHIP FOR RESULTS: public health & human right for social development and equity

03.12.2015, 14:45 – 16:15 Committee Room 5a & b

Public, Private Partnership for Innovation and achievement of fast track targets (90:90:90) by 2020 (LPC)

Chairs: Sheila Tlou, South Africa
Speakers: Bryan Brink, South Africa
Nyasha Masuka
Jürgen Baumhoff, Switzerland

NON ABSTRACT DRIVEN SESSION

FRIDAY	04 DECEMBER 2015

04.12.2015, 10:45 – 12:15 Committee Room 4

SCALING HIV/STI PROGRAMMING WITH SEX WORKERS: Roll out of normative guidance

Speaker: Dagmar Hanisch, Zimbabwe

04.12.2015, 10:45 – 12:15 Jacaranda 3

Fast-tracking HIV responses with sex workers in the Africa region

Chairs: Karl Dehne
Speakers: Babathile *, Zimbabwe
Fareed Abdullah, South Africa
Nduku Kilonzo, Kenya
Jean Bosco Elat Nfetam, Cameroon
Angela El Adas, Ghanae

SATELLITE SYMPOSIA

WHO AFRO

TITLE: Launch of the Global HIV Report

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: MAIN AUDITORIUM 2500 CAPACITY

SIS-INTERNATIONAL

TITLE: Online and Phone Support: Technology in the service of health

TIME: 10:45 AM - 12:45 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

UNFPA

TITLE: Scaling up HIV/STI program ming with sex workers: Roll-out of implementation guidance

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

UNAIDS/INERELA+/WCC

TITLE: Faith based leadership: Lessons learnt and perspectives

TIME: 10:45 AM - 12:45 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

GIZ ESA

TITLE: From a demand perspective-facilitating young people's access to sexual and repro ductive health services - what needs to be done?

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

BIOMEIDICAL RESEARCH AND TRAINING INSTITUTE

TITLE: Molecular Diagnostics for HIV and TB

TIME: 8:30 AM - 10:30 AM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 5a & b 200 CAP.

BIOMEDICAL RESEARCH AND TRAINING INSTITUTE

TITLE: Molecular Diagnostics for HIV and TB

TIME: 10:45 AM - 12:45 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 5a & b 200 CAP.

UNICEF

TITLE: Lessons learned from Option B+ operationalization and focal issues for improving effectiveness to reach elimination of mother-to-child transmission of HIV: A conversation with Option B+ early adopters

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: COMMITTEE ROOM 4 150 CAP.

UNAIDS

TITLE: 90-90-90 Pre-conference satellite workshop

TIME: 10:45 AM - 12:45 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: JACARANDA 3 250 CAP.

SCOPE, UNIVERSITY OF WASHINGTON

TITLE: Faith, Medicine, and Health: An Integrated Approach

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: JACARANDA 3 250 CAP.

NEW HIV VACCINE AND MICROBICIDE ADVOCACY SOCIETY

TITLE: 2015 Biomedical HIV Prevention Forum

TIME: 8:30 AM - 10:30 AM

DAY: SUNDAY, 29 NOVEMBER

ROOM: JACARANDA 1 & 2 CAP 600

NEW HIV VACCINE AND MICROBICIDE

TITLE: Biomedical HIV Prevention Forum

TIME: 10:45 AM - 12:45 PM

DAY: SUNDAY, 29 NOVEMBER

SATELLITE SYMPOSIA

NEW HIV VACCINE AND MICROBICIDE

TITLE: Biomedical HIV Prevention Forum

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: JACARANDA 1 &2 CAP 600

NAC ZIMBABWE AND CIPLA LTD.

TITLE: On the occasion of world AIDS day would like to show a documentary on the untold story of HIV/AIDS in Africa and the rest of the world

TIME: 1:00 PM - 3:00 PM

DAY: SUNDAY, 29 NOVEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

WHO AFRO

TITLE: What is new in the 2015 consolidated ARV guidelines?

TIME: 12:45 PM - 14:15 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: MAIN AUDITORIUM 2500 CAPACITY

UNFPA

TITLE: Leadership Session

TIME: 14:45 PM - 16:15 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: MAIN AUDITORIUM 2500 CAPACITY

UNFPA

TITLE: Revitalising/reinvigorating HIV combination prevention in Eastern and Southern Africa

TIME: 16:45 PM - 18:15 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: MAIN AUDITORIUM 2500 CAPACITY

UNAIDS RST ESA

TITLE: VMMC at Fast Track: WHO and UNAIDS Draft Action Framework for Discussion

TIME: 7:00 AM - 8:30 AM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

WHO PMTCT

TITLE: Early Findings and Lessons from PMTCT implementation research - The INSPIRE (INtegrating and Scaling up Pmtct through Implementation Research)

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

UNAIDS

TITLE: Integrating in and investing community-bsaed service delivery in national plans-the shift from health systems to systems for health.

TIME: 12:45 PM - 14:15 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

HIV MODELLING CONSORTIUM JOINT SATELLITE SESSION WITH SAA

TITLE: A Dialogue Between Program Planners and Model Makers

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

HOLOGIC

TITLE: HIV-1 viral load performance from the field

TIME: 7:00 AM - 8:30 AM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

SATELLITE SYMPOSIA

RIATT-ESA

TITLE: A sustainable HIV response leaves no child or youth behind!

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

LUKE INTERNATIONAL

TITLE: Linking Leadership and Technology for Equitable Access to Health Care among Migrants in the Southern Africa Region

TIME: 7:00 AM - 8:30 AM

DAY: MONDAY, 30 NOVEMBER

ROOM: JACARANDA 3 250 CAP.

MEDICAL ACCESS UGANDA

TITLE: Supply and Demand of HIV related Commodities: Can the Global market and national supply chain support the continued scale up of HIV / AIDS treatment and monitoring under the 90 x 90 x 90 Goal?

AIDS

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: JACARANDA 3 250 CAP.

PSI with WHO HIV

TITLE: PSI with WHO HIV Self-Testing and launch of the UNITAID/WHO/PSI HIV Self-Testing Project, the STAR Project AIDS

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: JACARANDA 1 &2 CAP 600

MEPI

TITLE: How to write a grant proposal

TIME: 7:00 AM - 8:30 AM

DAY: MONDAY, 30 NOVEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

NATIONAL AIDS COUNCIL (ZIMBABWE)

TITLE: Zimbabwe's national response to HIV and AIDS: key achievements, challenges and lessons

TIME: 18:30 PM - 20-30 PM

DAY: MONDAY, 30 NOVEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

AFRICA UNION

TITLE: Sustaining visionary leadership towards ending AIDS in Africa by 2030

TIME: 10:45 AM - 12:15 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: MAIN AUDITORIUM 2500 CAPACITY

SOUTH AFRICAN NATIONAL AIDS COUNCIL TRUST

TITLE: Key Populations

TIME: 7:00 AM - 8:30 AM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

INTERNATIONAL HIV/AIDS ALLIANCE

TITLE: Strategies for MSM program ming in highly restrictive and hostile environments.

TIME: 10:45 AM - 12:15 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

FORD FOUNDATION

TITLE: Sexuality and HIV in China

TIME: 12:45 PM - 14:15 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

SATELLITE SYMPOSIA

INTERNATIONAL TREATMENT PREPAREDNESS COALITIO

TITLE: Routine for You, But Not for Me

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

PANGAEA GLOBAL AIDS

TITLE: Evidence to Policy and Practice

TIME: 7:00 AM - 8:30 AM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

GIZ

TITLE: ICASA Satellite Session on Health Systems Strengthening and GFATM: Resilient and sustainable health systems – the fundament to combat diseases. Which role plays the Global Fund in supporting countries to build them?

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 4a 150 CAP.

UNAIDS

TITLE: Community-based service delivery

TIME: 7:00 AM - 8:30 AM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

AIDS FONDS

TITLE: How to end the AIDS epidemic by 2030? Key populations are paving the way.

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

UNAIDS/WEST AFRICAN HEALTH ORGANISATION

TITLE: Security of ARVs and essential medicines in Africa - the role of the Regional Economic Communities and ECOWAS Regional Pharmaceutical Plan

TIME: 7:00 AM - 8-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: JACARANDA 3 250 CAP.

GILEAD SCIENCES

TITLE: We can do it!! New thinking on prevention treatment and success

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: JACARANDA 3 250 CAP.

MYLAN

TITLE: Achieving More with Less: The Potential of Dose Optimization in ART Scale Up.

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: JACARANDA 1 &2 CAP 600

MEDICAL RESEARCH COUNCIL OF ZIMBABWE

TITLE: Health research ethics: Protecting our participants and community

TIME: 7:00 AM - 8:30 AM

DAY: TUESDAY, 1 DECEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

UNITAID/ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION/ CLINTON HEALTH ACCESS INITIATIVE/UNICEF

TITLE: Optimizing Testing and Treatment of HIV-Exposed Infants: Creating Sustainable Markets for Point-of-Care Technologies within National Diagnostic Networks.

TIME: 18:30 PM - 20-30 PM

DAY: TUESDAY, 1 DECEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

SATELLITE SYMPOSIA

UNAIDS/UNESCO

TITLE: Progress of implementation of the ESA Commitment: Effective engagement of civil society organizations and communities

TIME: 7:00 PM - 8-30 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

SYSMEX SOUTH AFRICA

TITLE: Funding HIV Management– should our focus be on the patient or the programme?

TIME: 18:30 PM - 20-30 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: COMMITTEE ROOM 6 150 CAP.

IPPFAR

TITLE: SRH & HIV Linkages in humanitarian settings

TIME: 7:00 AM - 8:30 AM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: COMMITTEE ROOM 4 150 CAP.

WHO AFRO

TITLE: Spotlight on dual elimination - concurrent elimination of congenital syphilis and mother to child transmission of HIV in the African Region

TIME: 7:00 AM - 8:30 AM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

CDC

TITLE: Interventions for Advanced HIV and Optimizing Viral Load Monitoring

TIME: 18:30 PM - 20-30 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: COMMITTEE ROOM 5a &b 200 CAP.

GNP+

TITLE: Stigma and discrimination; using to PLHIV Stigma Index - an interactive session

TIME: 7:00 AM - 8:30 AM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: JACARANDA 3 250 CAP.

WHO AFRO

TITLE: Ebola Session

TIME: 14:45 PM - 16:15 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: JACARANDA 3 250 CAP.

WHO/UNICFF IATT

TITLE: New Perspectives in the prevention, treatment and care of HIV in children and adoles cents – where do we go from here?

TIME: 18:30 PM - 20-30 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: JACARANDA 3 250 CAP.

CHAMPIONS FOR LIFE

TITLE: The key role of faith-based organizations inproviding psy chosocial-spiritual support & empowerment to adolescents and youth living with HIV

TIME: 18:30 PM - 20-30 PM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: JACARANDA 1 & 2 600 CAP.

UNIVERSITY OF ZIMBABWE

TITLE: Publish or Perish

TIME: 7:00 AM - 8:30 AM

DAY: WEDNESDAY, 2 DECEMBER

ROOM: PROF. SOUDRE CAP 550

SATELLITE SYMPOSIA

HEAIDS

TITLE: HEAIDS Best Practice Model
TIME: 12:45 PM - 14:15 PM
DAY: WEDNESDAY, 2 DECEMBER
ROOM: PROF. SOUDRE CAP 550

CAMBRIDGE UNIVERSITY

TITLE: Implementing POC HIV Viral Load and EID: Considerations and Challenges for Africa
TIME: 14:45 PM - 16:15 PM
DAY: WEDNESDAY, 2 DECEMBER
ROOM: PROF. SOUDRE CAP 550

AFRICAID ZVANDIRI

TITLE: Engaging Adolescents in HIV Treatment and Care: Approaches for Improved Service Delivery
TIME: 16:45 PM - 18:15 PM
DAY: WEDNESDAY, 2 DECEMBER
ROOM: PROF. SOUDRE CAP 550

NATIONAL AIDS COUNCIL (ZIMBABWE)

TITLE: Innovative Domestic Financing Mechanisms for HIV and AIDS
TIME: 18:30 PM - 20:30 PM
DAY: WEDNESDAY, 2 DECEMBER
ROOM: PROF. SOUDRE CAP 550

PANGAEA GLOBAL AIDS/PANGAEA ZIMBABWE AIDS TRUST, ON BEHALF OF THE OPTIONS CONSORTIUM

TITLE: Nationalizing the WHO guide lines on oral PrEP: What will it take?
TIME: 7:00 AM - 8-30 AM
DAY: THURSDAY, 3 DECEMBER
ROOM: COMMITTEE ROOM 6 150 CAP.

INTERNATIONAL TREATMENT PREPAREDNESS COALITION

TITLE: Why Viral Load Matters: In creasing viral load awareness in Sub-Saharan Africa
TIME: 18:30 PM - 20-30 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: COMMITTEE ROOM 6 150 CAP.

INSTITUTE FOR DISEASE MODELING

TITLE: The EMOD-HIV model of HIV/AIDS: Introduction and hands-on demo
TIME: 7:00 AM - 8:30 AM
DAY: THURSDAY, 3 DECEMBER
ROOM: COMMITTEE ROOM 5a &b 200 CAP.

GHANA AIDS COMMISSION

TITLE: "People Living With HIV Stigma Index Study in Ghana"
TIME: 18:30 PM - 20-30 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: COMMITTEE ROOM 5a &b 200 CAP.

WHO

TITLE: UNAIDS and WHO Celebrating Prevention: Medical Male Circumcision at 10 million
TIME: 14:45 PM - 16:15 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: JACARANDA 3 250 CAP.

GILEAD SCIENCES

TITLE: Management of Hepatitis B and C on different continents
TIME: 18:30 PM - 20-30 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: JACARANDA 3 250 CAP.

HEAIDS

TITLE: HEAIDS Model - Implementing a Best Practice Model amongst youth
TIME: 10:45 AM - 12:15 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: JACARANDA 1 &2 CAP 600

WHO

TITLE: HIV co-infections including Viral Hepatitis
TIME: 16:45 PM - 18:15 PM
DAY: THURSDAY, 3 DECEMBER
ROOM: JACARANDA 1 &2 CAP 600

SATELLITE SYMPOSIA

UNAIDS

TITLE: Male Engagement in the AIDS Response-a game changer

TIME: 18:30 PM - 20-30 PM

DAY: THURSDAY, 3 DECEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

VIIV HEALTHCARE

TITLE: TIVICAY (DOLUTEGRAVIR) IN CONTEXT – REAL LIFE, REAL PATIENTS

TIME: 18:30 PM - 20-30 PM

DAY: THURSDAY, 3 DECEMBER

ROOM: PROF. SOUDRE ROOM CAP 550

UNAIDS

TITLE: Fast-tracking HIV responses with sex workers in the Africa region

TIME: 10:45 AM - 12:15 PM

DAY: FRIDAY, 4 DECEMBER

ROOM: JACARANDA 3 250 CAP.

NOTE

SPONSORS & EXHIBITORS

SAfAIDS – Stand 55

Knowledge for action: The power to make a difference!

Mission

To be a centre of excellence that promotes effective and ethical development responses to Sexual Reproductive Health and Rights, HIV (including PMTCT) and TB through advocacy, communication and social mobilisation.

Vision

Ensure that all people in Africa realize their sexual and reproductive health and rights (SRHR) and are free from the burden of HIV, TB and related developmental health issues.

Our priority areas are HIV and TB prevention, care and treatment; sexual and reproductive health services; links between HIV, culture and GBV and rights of marginalised communities (LGBTI and (PLHIV) and sex workers to access health services.

Trinity Biotech – Stand 49 & 50

Trinity Biotech develops, manufactures and markets medical diagnostics for the Clinical Laboratory and Point of Care segments of the diagnostic market. These products are used to detect infectious and sexually transmitted diseases, autoimmune diseases, diabetes and disorders of the liver an intestine.

Trinity Biotech makes a very significant contribution to the global effort to meet the challenge of HIV. Our principal product is Uni-Gold™HIV, this has been used for several years in the sub-Saharan region of Africa. It provides a cornerstone for early detection and treatment intervention. Uni-Gold™HIV is recognised for its quality and reliability.

Hologic – Stand 88 (89 & 90)

More than healthcare. Hologic humancare.

We understand the real world challenges faced by our partners in resource-limited settings. And we are committed to delivering real solutions that help providers improve patient care across the globe. Our powerful diagnostic solutions maximize limited resources, adapting to meet the needs of settings both big and small. Harnessing big-lab, high-throughput technology within a small footprint, we provide real solutions for scale up of viral load monitoring. It's the right balance of performance, adaptability and efficiency to help you reach the 90/90/90 goals.

Hologic humancare - providing global health solutions for the way we live.

HUMAN Gesellschaft für Biochemica und Diagnostica mbH - Stand 18

Diagnostics Worldwide

Discover HUMAN! It is today one of the few global players in the in vitro diagnostics industry, maintaining what is perhaps the broadest distribution and service & support network in the world. Discover HUMAN! With its variety of products and services from Clinical Chemistry to Molecular Diagnostics and from manual Instruments to Fully Automated Analyzers. Discover HUMAN! With its quality of Made in Germany and CE IVD standards. Come and Discover your opportunities with HUMAN!

To Discover HUMAN online, please visit: www.human.de

Contact details:

HUMAN Gesellschaft für Biochemica und Diagnostica mbH

Tel.: 0049 6122 9988 0
Email: human@human.de

Gilead Science Inc. – Stand 51&52

For more than 25 years, Gilead has worked to develop medicines that address areas of unmet medical need for people around the world.

Our portfolio of medicines and pipeline of investigational drugs include treatments for HIV/AIDS, liver diseases, hematology and oncology, inflammatory and respiratory diseases and cardiovascular conditions.

Every day we strive to transform and simplify care for people with life-threatening illnesses.

Omega Diagnostic - Stand 57

Omega Diagnostics manufactures high quality IVD products for use in clinical diagnosis and has 25 years' experience in exporting to over 100 countries worldwide, many of them resource-poor. Product offerings cover Infectious Disease including a wide range of Syphilis tests, and we will be showcasing the latest Visitect CD4 Point-of-Care test at the congress including a new development in mHealth, a Smartphone App that can be used in the field to record and directly transmit test results to a host database.

OraSure Technologies Inc - Stand 58

OraSure Technologies manufactures oral fluid devices and other technologies designed to detect or diagnose critical medical conditions. Its innovative products include rapid tests for HIV and HCV antibodies (Including the OraQuick HIV Self-Test) , testing solutions for detecting drugs of abuse, and oral fluid sample collection, stabilization and preparation products for molecular diagnostic applications.

Merck – Stand 59

Internationally, Merck has positioned itself as the market leader in providing products that conform to the highest quality standards and innovative packaging solutions at all times, ensuring that safety for the user and protection of the environment is maintained.

Merck's global acquisition of Millipore in 2010 and local integration in 2012 has been a huge success. Merck is able to offer a wide range of over 60,000 products to our customers.

United, we have become a world-class Life Science partner offering a broader range of performance products, services, expertise and business relationships to support your success in analysis, research, development and in production in the health, pharmaceutical, biopharmaceutical and other related industries.

The new Merck is 10,000 employees and 64 countries strong. This larger size and scale provides immediate and long-term benefits for you as we bring together our research and development capabilities.

RIATT-ESA – Stand 33

The Regional Inter-agency Task Team on Children and AIDS in Eastern and Southern Africa (RIATT-ESA) is a network of civil society organisations, academia, regional economic bodies, donors and UN agencies working together to influence global, regional and national policy formulation and implementation for children and their families. RIATT-ESA supports a joint, scaled-up and sustainable drive towards universal access to prevention, treatment, care and support for children affected by HIV and AIDS.

Africaid Zvandiri – Stand 34

Theme: Closing the Gap for Children and Adolescents with HIV

Zvandiri adolescents and young people will share their own innovations and strategies which they have developed and implemented across Zimbabwe in their efforts to close the gap for children and adolescents with HIV. The Zvandiri team of young people will provide information and lessons learned from a range of community and facility based interventions which they have been scaling up with the Government of Zimbabwe. They will also demonstrate their own mixed media and IEC materials for HIV testing and counselling, treatment literacy, psychosocial support and community based activities to support children and adolescents through the HIV care cascade.

Cepheid HBDC – Stand 35

Cepheid is a leading molecular diagnostics company that is dedicated to improving healthcare by developing, manufacturing, and marketing accurate yet easy-to-use molecular systems and tests. By automating highly complex and time-consuming manual procedures, the company's solutions deliver a better way for institutions of any size to perform sophisticated genetic testing for organisms and genetic-based diseases. Through its strong molecular biology capabilities, the company is focusing on those applications where accurate, rapid, and actionable test results are needed most, in fields such as

critical and healthcare-associated infections, virology, sexual health, genetic diseases and cancer.

Beckman Coulter - Stand 37

Beckman Coulter develops, manufactures and markets products that simplify, automate and innovate complex biomedical testing. More than 275,000 Beckman Coulter systems operate in both Diagnostics and Life Sciences laboratories on seven continents. For more than 75 years, our products have been making a difference in peoples' lives by improving the productivity of medical professionals and scientists, supplying critical information for improving patient health and delivering trusted solutions for research and discovery.

Beckman Coulter serves customers in two segments: Diagnostics and Life Sciences.

Our diagnostics customers include hospitals and laboratories around the world and produce information used by physicians to diagnose disease, make treatment decisions and monitor patients.

Scientists use our life science research instruments to study complex biological problems including causes of disease and potential new therapies or drugs.

Alere International ltd - Stand 87

Alere believes that when diagnosing and monitoring health conditions, Knowing now matters™. Alere delivers on this vision by providing reliable and actionable information through rapid diagnostic tests, enhancing clinical and economic health outcomes globally. Headquartered in Waltham, Mass., Alere focuses on rapid diagnostics for infectious disease, cardiometabolic disease and toxicology. For more information on Alere, please visit www.alere.com.

MM African Technology (pvt) ltd - Stand 38

MM African Technology (PTY) Ltd was founded in 1999 and has permanent offices in nine African Countries.

The company's head office is situated in Johannesburg, South Africa.

The main activities of the company are to supply and service laboratory equipment and consumables to various countries within Africa.

Our customer basis ranges from NGOs such as USAID, Clinton Foundation, and Partners in Health, UNICF, WHO to government and parastatal intuitions as well as the private sector.

The future for the company is to expand into more countries so that more people are able to benefit from the advantages afforded by the company.

American International Health Alliance – Stand 39

The American International Health Alliance (AIHA) is an international nonprofit dedicated to providing technical assistance through comprehensive, integrated, and volunteer-driven partnerships and initiatives that help low- and middle-income countries build institutional and human resource capacity to create a strong foundation for delivering high-quality, inclusive health services. AIHA's partnership model recognizes that host communities must develop a strong sense of ownership to achieve successful, sustainable outcomes. To facilitate this, we seek out active investment and participation from the overseas partners, their respective governments, and a wide range of local stakeholders to assure programs meet the unique needs of each community.

SPONSORS & EXHIBITORS

Oxfam - Stand 40

Oxfam in Zimbabwe will be exhibiting at the ICASA 2015.Oxfam in partnership with 10 local civil society organisations will exhibit on the work that is being done under the Oxfam Securing Rights in the Context of HIV/AIDS Programme (SRP). Oxfam and partners will exhibit various materials at the conference that include poster abstracts, banners, pamphlets, booklets, stickers and flyers. The exhibition will profile the diverse models and innovative approaches under the SRP.The exhibition will be used for information exchange and dissemination with participants who will get a chance to visit and interact at the Oxfam stand.

Humana People to People – Stand 41

DAPP Zimbabwe Co-founder and member of the International Humana People to People Movement; will jointly exhibit at the 18th ICASA Conference 2015.

In response to the HIV Epidemic we present our experiences in Africa and beyond using Humana People to People's Total Control of the Epidemic Program. We have with TCE supported millions of people with community mobilisation, door to door HTC and linking HIV positive and people suspected of having TB, to the health facilities for treatment.

TCE is built on the idea that "Only the People can liberate themselves from AIDS – the Epidemic."

It is a collective affair for all mankind to end HIV/TB.

New Avakash International – Stand 85 & 86

Avacare Health is a multinational medico-marketing company with a focus on the supply of pharmaceuticals, medical disposables and devices across Africa. Our strategy has been to adopt a clinician's approach to healthcare with cognizance of the overall disease burden within the African continent. We place a special emphasis on continuous medical education of healthcare providers and are strongly committed to improving the standard of healthcare in Africa. Avacare Health provides a full suite of high quality, cost-effective medical products. We are geared and ready for the challenge ahead and are fully committed to the cause of ending the AIDS epidemic.

BD Biosciences – Stand 53 & 54

BD Biosciences, a segment of Becton, Dickinson and Company, is one of the world's leading businesses focused on bringing innovative tools to life science researchers and clinicians. Its product lines include: flow cytometers, cell imaging systems, monoclonal antibodies, research reagents, diagnostic assays, and tools to help grow tissue and cells.

Circ MedTech – Stand 106

Circ MedTech Ltd. is a social enterprise, offering innovative, affordable and scalable public healthcare solutions. Our mission is to contribute to the global fight against HIV/AIDS by providing PrePex- the only non-surgical device for male circumcision available in the marketplace. PrePex is the first device to be prequalified by the WHO, it is FDA cleared and CE marked. Currently available for adults and adolescents, new PrePex devices for children and infants, based on the existing technology have been successfully piloted. Zimbabwe, Rwanda, Uganda, South Africa, Kenya, Botswana, Tanzania, Zambia, Malawi, Mozambique, Lesotho & Indonesia are in scale-up or pilot stages of the PrePex device.

SPONSORS & EXHIBITORS

Mylan – Stand 61

Mylan is one of the world's leading global pharmaceutical companies. Our medicines include generic and brand name products in a variety of dosage forms, such as difficult-to-manufacture injectables, transdermal patches and HIV/AIDS antiretroviral (ARV) therapies. The company has innovative research and development capabilities and is one of the world's largest active pharmaceutical ingredient (API) manufacturers. Every one of our medications meets our one global quality standard regardless of where it is produced. Creating better health for a better world. That's what inspires Mylan in our mission to provide quality healthcare to the world's 7 billion people, one person at time.

Diagnostics for the Real World – Stand 19 & 20

Diagnostics for the Real World Ltd (DRW), develops and produces innovative in-vitro diagnostic medical devices specifically for point-of-care and resource-limited settings. DRW is ISO 13485 certified and was established in 2002 to support scale-up, validation and manufacturing for tests based on technology developed at the University of Cambridge, Diagnostics Development Unit. The team has developed two technology platforms: SAMBA (Simple AMplification Based Assay) for nucleic acids AND SAS (signal Amplified System) for protein targets.

National AIDS Council Zimbabwe – Stand 43

Do you want to know how much money is raised every year through the AIDS Levy and what it is spent on? Visit the National AIDS Council exhibition booth at the International Conference on AIDS and STIs in Africa (ICASA) at the Harare International Conference Centre (HICC). We have up to date data and information on HIV prevention, treatment and care, response management and coordination as well as partnerships and funding. Come and hear more about what we are doing to end AIDS by 2030!

SD Biosensor – Stand 105

SD Biosensor has quickly risen as one of the world's leading POCT diagnostic company specializing in chronic diseases management since its establishment in 2010. The company is currently developing blood glucose, cholesterol and HbA1c POC systems which are being exported to more than 100 countries around the globe. We have decided to expand our scope of business into the RDT markets. SD Biosensor is a company that has strategically separated from SD, a renowned maker of world's best RDT products. Starting with rapidly countering the threats of Ebola(Zaire), MERS(Middle East Respiratory Syndrom) with Q-Line.

Malacas – Stand 103

Malacas is the union of African tradition, beauty and creativity. It's the true essence of elegance. Primarily, there is inner beauty and self-appreciation and if one loves and appreciates themselves, the rest comes naturally. Malacas Made In Africa helps you showcase the true you.

Every bead that goes into Malacas products is intricately handwoven in Zimbabwe to give that irresistable elegance at every moment.

"Success is liking yourself, liking what you do and liking how you do it" (Maya Angelou). We at Malacas like what we do and how we do it!

Malacas Made In Africa, Malacas is you

National AIDS Council Zimbabwe - Stand 32

Do you want to know how much money is raised every year through the AIDS Levy and what it is spent on? Visit the National AIDS Council exhibition booth at the International Conference on AIDS and STIs in Africa (ICASA) at the Harare International Conference Centre (HICC). We have up to date data and information on HIV prevention, treatment and care, response management and coordination as well as partnerships and funding. Come and hear more about what we are doing to end AIDS by 2030!

SPONSORS & EXHIBITORS

World Health Clinicians/ BEAT AIDS Project Zimbabwe – Stand 45

BEAT AIDS Project Zimbabwe (www.whcbapz.org)

To prevent mother-to-child transmission (PMTCT) of HIV/AIDS to protect unborn Zimbabwean children from acquiring HIV/AIDS and improve the morbidity and mortality and future of Zimbabwean children with HIV/AIDS.

HIV Equal (www.whcbapz.org)

HIV Equal is an international social media campaign and online magazine that promotes HIV testing and aims to end the stigma associated with the virus. The campaign reopens the public dialogue about HIV and works to change the way people think about testing, stigma and prevention. The concept of HIV Equal was founded by World Health Clinicians and co-created by HIV/AIDS specialist Dr. Gary Blick and celebrity photographer Thomas Evans. The campaign photos include people from all walks of life who support the concept that regardless of their HIV status we are all equally valuable.

UNICEF – Stand 11 & 12

UNICEF promotes the rights and wellbeing of every child, in everything we do. Together with our partners, we work in 190 countries and territories to translate that commitment into practical action, focusing special effort on reaching the most vulnerable and excluded children, to the benefit of all children, everywhere. For more information about

UNICEF and its work visit www.unicef.org.

Ghana AIDS Commission – Stand 22

Stigma and discrimination among People Living with HIV (PLHIV) remain pervasive in Ghana and undermines efforts towards attaining national and international targets. ''The Ghana PLHIV Stigma Index Study'' was conducted in 2013, in accordance with the principles of Greater Involvement of People Living with HIV (GIPA).

The proposed session will highlight the key findings of the study and showcase innovative ways in which PLHIV were meaningfully involved.

Expertise France – Stand 24

Expertise France is the French international technical expertise agency. The aim of the agency is to increase the mobilization capacities of the various areas of public technical expertise in the international arena, in order to better respond to the growing needs of developing or emergent countries in terms of assistance to public policies. Under the joint tutelage of the Ministries of Foreign Affairs and Economy, the new agency fully bases its action within the framework of French foreign policy in the areas of development, solidarity, and influence. The 5% Initiative is a project implemented by

Expertise France.

Doctors Without Borders. (MSF) - Stand 60

Doctors Without Borders (MSF) is an international, independent, medical humanitarian organisation committed to two objectives: providing medical assistance to people affected by armed conflict, epidemics, healthcare exclusion, natural and man-made disasters; and speaking out about the plight of the populations assisted. MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation.

SAM Nutritional Products – Stand 31

SAM Nutritional Products supplies selenium supplements to governments, NGOs, wholesalers and retailers across Africa at highly competitive prices. We are the selenium experts. As the key element for immune function and adjunct therapy to ARVs, selenium supplements significantly increase CD4 count (Toronto Aids Conference 2006). Given prior to ARVs, selenium slows HIV progression by 50%. (Aids 2005). Selenium supplements have proved to help against most HIV opportunistic infections including TB, KS, candidiasis, hepatitis and cancer. Selenium increases appetite and energy, reduces stress and depression, and helps against inflammatory conditions and cardiovascular disease (Lancet, 2000). We train health professionals in selenium applications.

SPONSORS & EXHIBITORS

Parenthood Federation Africa Region- Stand 91

The International Planned Parenthood Federation Africa Region (IPPFAR) is the leading non-government sexual and reproductive health and rights (SRHR) service delivery organization in Africa and the leading SRHR advocacy voice in the region. Our overarching goal is to increase access to SRHR services and support for sub-Saharan's Africa most vulnerable youth, men and women.

Supported by thousands of volunteers, IPPFAR tackle's the continent's growing sexual and reproductive health challenges through a network of Member Associations (MAs) in 42 countries. We does this by developing our MAs into efficient entities with the capacity to deliver and sustain high quality, youth focused and gender sensitive, services.

Our work on SRH & HIV linkages and integration is underpinned by the rights based approach to service delivery. We work with organisations and networks of people left behind at national, regional and global levels to ensure everyone especially the marginalized exercise their rights while those that require services receive quality integrated SRH & HIV services through our expansive network of locally owned Member Association.

IPPFAR works with the African Union, regional economic commissions and the Pan-African Parliament as well as global UN bodies, to expand political and financial commitments to sexual and reproductive health and rights in Africa.

ViiV Healthcare – Stand 47 & 48

At ViiV Healthcare, we are all connected to HIV. Through our broad portfolio 100% focussed on HIV, we are committed to addressing the significant gaps and unmet needs of the 35 million people living with HIV. We are dedicated to delivering patient-centred innovation through focused clinical research and development programmes. We believe in constantly building and expanding meaningful partnerships to improve treatment, access and care. We also listen to and engage with people living with HIV, their healthcare providers and their families, to understand their concerns and challenges, and to respond to their rapidly changing healthcare and social needs.

Cavidi

HIV Viral Load

Cavidi is an HIV viral load specialist. Cavidi is focused on providing HIV viral load for small labs across the world. We want to make it possible for small labs to run viral load - even those labs with limited resources. We can help you provide more testing for less cost and less effort.

Contact Cavidi at www.cavidi.com to learn more about how you can get effective viral load testing today.

Save the Children - Stand 95

Save the Children is a preeminent provider of development and humanitarian assistance around the world, serving more than 48 million children and 35 million parents, community members, local organizations and government agencies. Save the Children provides management and technical expertise in health, HIV and AIDS, nutrition and child protection programs, as part of its global mission to create lasting, positive change in the lives of children in need. It is active in more than 50 countries and internationally recognized for its capacity to mobilize and strengthen communities, reach disadvantaged populations and facilitate lasting partnerships among communities, local organizations and government.

Quidel Corporation – Stand 25

Quidel® Corporation is committed to enhancing health and well-being through innovative diagnostic solutions. Quidel assays use lateral-flow, direct fluorescent antibody, molecular and other technologies to improve patient outcomes and give economic benefits to healthcare providers. With leading brands - QuickVue®, AmpliVue®, Lyra™, MicroVue™, D3 Direct Detection™, Thyretain®, Sofia®, and Solana™, Quidel aids in the detection and diagnosis of critical diseases and conditions. www.quidel.com

SPONSORS & EXHIBITORS

Premier Medical Corp.Pvt Ltd – Stand 29

Premier Medical Corporation Ltd is a major manufacturer of First Response brand rapid tests for detection of HIV, malaria, Hepatitis, Syphilis, Chagas and Dengue. First Response HIV 1-2-0 test is whole blood./serum/ plasma test and can differentiate between HIV 1 and 2 in under 15 minutes. The test is approved by WHO and USAID. It is a major screening test in many African countries.

PerkinElmer/Wallac - Oy Stand 30

PerkinElmer is a global leader in the health and safety of people and environment. The company serves newborn screening customers in 100+ countries all over the world. It has been estimated that since 1986 nearly 500 million babies have been screened using PerkinElmer products. The company supplies a complete range of high quality products for use at all stages of the newborn screening process, starting from dry blood spot (DBS) sample collection cards.

PerkinElmer's chemagen Technology offers automation for the isolation of viral DNA/RNA and bacterial DNA. The innovative solutions are based on the patented technology utilising magnetic beads separation.

UNESCO - Stand 9

The United Nations Educational, Scientific and Cultural Organization (UNESCO) is a specialized agency of the United Nations. Its purpose is to contribute to peace and security by promoting international collaboration through education, science, and culture to further universal respect for justice, the rule of law and human rights along with fundamental freedom proclaimed in the United Nations Charter. UNESCO pursues its objectives through five major programs: education, natural sciences, social/ human sciences, culture and communication/ information.

UNESCO's work on HIV and AIDS focuses on three key priorities:

- Building country capacity for effective and sustainable education responses to HIV;
- Strengthening comprehensive HIV and sexuality education; and
- Advancing gender equality and protecting human rights.

UNESCO is a UNAIDS cosponsor and supports countries' responses to HIV with advocacy, policy and programmatic guidance, and technical and strategic support, convening and coordination. UNESCO also supports responses that are gender and age responsive, culturally appropriate, evidence-informed, grounded in human rights, and involve people living with HIV and vulnerable populations at all stages.

Priontex - Stand 63A

PrionTex (Pty) Ltd is a leading South African specialist medical textile company supplying over 100 hospitals with high quality drapes, gowns and procedure kits.

Our surgical gowns and patient drapes are made from technical textiles that compare with the best in the world and are certified according to the highest international standards

Since 2008 Priontex has been a global leader in the manufacturer and supply of fully disposable male circumcision packs in the greater sub Saharan region. We manufacture a wide range of procedure specific sterile surgical kits that contain the components required for procedures such as C-Sections, birthing, examinations, IUD insertion/ removal, etc.

HETERO LABS LTD – Stand 16 & 17

- Hetero, a research driven global generic pharmaceutical player having presence in more than 120+ countries with more than 20 years of pharmaceutical expertise
- Largest global producer of ARVs with over 30 ARV products approved by global regulatory authorities
- With 25+ manufacturing facilities across Asia, US & Africa, Hetero delivers world class quality products to patients all over the globe
- Over a decade of ARV presence in Africa, more than 3 Mn HIV/AIDS patients are presently on Hetero's ARV medicines
- Foraying into biosimilars and comorbid HIV related conditions like hepatitis and TB

SPONSORS & EXHIBITORS

bioMérieux – Stand 44

Pioneering Diagnostics

A world leader in the field of in vitro diagnostics for 50 years, bioMérieux is present in more than 150 countries through 42 subsidiaries and a large network of distributors. In 2014, revenues reached €1.698 billion with 88% of sales outside of France.

bioMérieux provides diagnostic solutions (reagents, instruments, software) which determine the source of disease.

bioMerieux is committed to serve public health worldwide especially in the fight against infectious diseases. The Company has developped a wide range of solutions for the diagnosis and management of HIV and Hepatitis A, B and C infections that are easily accessible to laboratories and adapted to different healthcare se

About Abbott Molecular - Stand 92 & 93

Abbott Molecular is a leader in molecular diagnostics – the analysis of DNA and RNA at the molecular level. Abbott Molecular's tests can also detect subtle but key changes in patients' genes and chromosomes and have the potential to aid with early detection or diagnosis, can influence the selection of appropriate therapies, and may assist with monitoring of disease progression.

About Abbott

Abbott is a global healthcare company devoted to improving life through the development of products and technologies that span the breadth of healthcare. With a portfolio of leading, science-based offerings in diagnostics, medical devices, nutritionals and branded generic pharmaceuticals, Abbott serves people in more than 150 countries and employs approximately 69,000.

Sysmex South Africa - Stand 36

Sysmex is a global leader in diagnostic testing, we provide laboratories in the healthcare market with the tools, service and support they need to meet the challenges of increasing demands. We are committed to using our creativity, experience and scientific knowledge to shape the future of the laboratory.

Sysmex South Africa Ltd is the distributors and support network for automated hematology and coagulation analysers, for laboratories and healthcare facilities within Southern Africa and Africa. We have grown to become leaders in the provision of Hematology and Haemostasis diagnostics with a reputation for high quality products, service and reliability. We have a well-equipped Training Centre in Johannesburg for comprehensive training but can also provide on-site training to accommodate our customers if needed.

As a customer-centric company, we place great emphasis on the quality of our advice and service and have a dedicated team to help with Technical and Application questions via phone support.

These are just some of our passions, for more information and to meet the Sysmex Team please come and visit us on stand no. 36 at ICASA or log on to our website at www.sysmex.co.za

U.S. Embassy Public Affairs Section (PEPFAR) - Stand 8

UNFPA - Stand 13 & 14

UNAIDS Regional Support Team for Eastern and Southern Africa - Stand 10

UN Women - Stand 7

SPONSORS & EXHIBITORS

International AIDS Society (IAS) Stand 21

Medirite Distribution - Stand 112

National AIDS Control Council, Kenya - Stand 28

Zimbabwe National Family Planning Council - Stand 23

Population Services Zimbabwe- Stand 108

ZESA Enterprises - Stand 83

Virology Education - Stand 107

EANNASO -Anglophone Africa Comuincation and Coordination Platform - Stand 109

RELIANCE - Stand 26 & 27

The Girls legacy- Stand 111

Réseau Accès aux Médicaments Essentiels - Stand 56

ZIMNAT Life Assurance Company - Stand 102

NOTE

Advancing Therapeutics, Improving Lives.

For more than 25 years, Gilead has worked to develop medicines that address areas of unmet medical need for people around the world.

Our portfolio of medicines and pipeline of investigational drugs include treatments for HIV/AIDS, liver diseases, cancer, inammatory, and respiratory diseases and cardiovascular conditions.

Every day we strive to transform and simplify care for people with life-threatening illnesses.

GILEAD IS A PROUD SUPPORTER OF
THE 18TH INTERNATIONAL CONFERENCE ON
HIV/AIDS AND STIs IN AFRICA (ICASA 2015)

GILEAD

For more information, please visit www.gilead.com.

ICASA 2017:

Call for BID

Deadline: **26th of February 2016**

Kindly follow this link to access **ICASA 2017 Bid Document:** ***www.saafrica.org***

Address
SAA/ICASA Secretariat
Society for AIDS in Africa (SAA) Secretariat
P.O Box AF2072
Accra, Ghana

NOTE

AUTHOR INDEX

AUTHOR INDEX

B

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

F

G

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

L

M

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

AUTHOR INDEX

O

AUTHOR INDEX

P

AUTHOR INDEX

Q

R

S

AUTHOR INDEX

AUTHOR INDEX

T

AUTHOR INDEX

AUTHOR INDEX