20TH ICASA

INTERNATIONAL CONFERENCE ON AIDS AND STIs IN AFRICA

KIGALI 2019

PROGRAMME BOOK

LIVRE DU PROGRAMME

AIDS FREE AFRICA - Innovation, Community, and Political Leadership

AFRIQUE SANS SIDA - Innovation, communauté et leadership politique

2 - 7 DEC. 2019

KIGALI, RWANDA

Society for AIDS in Africa
Organizer of the International Conference
on AIDS and STIs in Arica

“Pour enrayer le VIH/SIDA, il faut un engagement politique et une attention soutenue dans la mise en place des institutions solides en santé publique afin de répondre aux besoins de nos populations en matière de santé et du développement.”

Son Excellence Paul Kagame
Président de la République du Rwanda

“Containing HIV/AIDS requires political commitment and sustained focus on building strong public health institutions, to address the health and development needs of our people."

His Excellency Paul Kagame
President of the Republic of Rwanda

Welcome address by ICASA President

The International Conference on AIDS and STIs in Africa is once again here with us. It comes at a critical juncture when we hardly have any time left to actualize the bold ambition of ending AIDS by 2030. It also comes a year before the review of UNAIDS global 90-90-90 targets in 2020.

True to its identity, the 2019 edition of the International Conference on AIDS and STIs in Africa promises to offer a strategic forum for Leaders, Activists, Scientists and the Community to engage and find solutions to our common health problems. The Conference will provide a platform to take stock of progress made towards achieving the 90-90-90 targets. It also offers us an opportunity to collectively reflect on Hepatitis, TB, Malaria, NCDs, emerging infections in Africa and the opportunities available for strengthening our health systems on the continent to tackle these diseases.

Visionary leadership and collaboration have been central to the achievements made in the response to HIV and AIDS thus far in Africa and globally. ICASA 2019 provides us with opportunities to re-invigorate our African commitments as well as global solutions that will allow us pave the way for new and efficient innovations towards a generation without AIDS in Africa. The intersection of cutting-edge science, innovations, effective community models, funding dynamics and policy that will be provided by the conference is expected to contribute greatly to achieving an AIDS free Africa.

As we share evidence and reflect on progress made, let us keep in mind that despite the availability of a widening array of effective HIV prevention tools and methods and massive scale-up of HIV treatment, domestic financing for the response remains sub-optimal. New infections remain unacceptably high especially among Adolescent Girls and Young Women as well as in Key Populations. Despite a growing strong political leadership, there are still legal and human rights barriers that threaten progress towards achieving the goal of ending AIDS in Africa by 2030.

For this 20th Edition of ICASA, the programme has been built around 200 sessions with 578 expected speakers. ICASA 2019 promises to be an exciting experience full of science and fun. I wish all delegates a safe trip and I thank and congratulate all our co-organisers, partners, all UN organizations and ICASA steering committee members. Finally, I wish especially to express our gratitude to the Head of State of the Republic of Rwanda, His Excellency President Paul Kagame for giving the conference maximum attention and support.

Welcome to ICASA 2019! Welcome to KIGALI!
Very best regards,

Prof. John Idoko,
ICASA 2019 President, Society for AIDS in Africa

Welcome Address / Allocution de Bienvenue

La Conférence Internationale sur le SIDA et les Infections Sexuellement Transmissibles en Afrique est une fois de plus avec nous. Elle se tient à un moment critique, où il nous reste peu de temps de réaliser les objectifs ambitieux de mettre fin à l'épidemie du VIH et SIDA d'ici 2030. La conférence ICASA qui se tient à Kigali du 2 au 7 Décembre 2019 se déroule également un an avant la revue des objectifs globaux 90-90-90 de l'ONUSIDA en 2020. Fidèle à son identité, l'édition 2019 de la Conférence Internationale sur le SIDA et les IST en Afrique promet offrir un forum stratégique aux Leaders, Activistes, Scientifiques et à la Communauté pour plus d'engagement à trouver des solutions à notre problème de santé commun. La Conférence d'offrira une plateforme pour faire le point des progrès réalisés en vue de l'atteinte des objectifs 90-90-90. Elle nous offre aussi une unique opportunité pour réfléchir de manière collective sur les infections aux 'hépatites virales, la tuberculose, le paludisme, les maladies non transmissibles, les infections émergentes en Afrique et les stratégies disponibles pour renforcer nos systèmes de santé sur le continent Africain afin de lutter contre ces maladies citées ci-haut.

L'engagement effectif du leadership et la collaboration ont été au cœur des résultats obtenus dans la réponse au VIH et SIDA à ce jour en Afrique et dans le monde. . La conference ICASA 2019 nous offre une plateforme pour revigorer nos engagements en tant que africains en tenant compte des solutions globales, qui nous permettront, d'ouvrir la voie à des innovations efficaces pour une génération sans SIDA. L'intersection entre la science de pointe, les innovations, les modèles communautaires efficaces, le dynamisme et les politiques de financement qui seront apportés lors de ladite conférence devraient contribuer grandement à l'atteinte d'une Afrique sans SIDA.

Tout en partageant les évidences les progrès réalisés et les outils disponibles en matière de prevention et de prise en charge du VIH et SIDA, les resources financières nationales allouées à la lutte contre le VIH et SIDA restent insuffisantes. Les nouvelles infections à VIH continuent d'être élevées en particulier chez les adolescentes et les jeunes femmes, ainsi que chez les populations clés. Malgré un leadership politique de plus en plus fort, il existe encore des barrières juridiques relatives aux droits humains qui menacent les progrès vers l'atteinte de l'objectif de mettre fin au SIDA en Afrique d'ici 2030. Pour la 20^{ere} édition de ICASA 2019, le programme est construit autour de 200 sessions avec 578 orateurs attendus. ICASA 2019 promet d'être une opportunité passionnante pleine de science et de joie de partager les expériences. Je souhaite un bon voyage à tous les délégués ; je remercie et félicite tous nos co-organisateurs, partenaires, toutes les organisations des Nations Unies et tous les membres du comité de pilotage. Finalement, je voudrais exprimer manière particulièrement notre profonde gratitude au Chef de l'Etat de la République du Rwandais, Son Excellence le président Paul Kagame pour avoir accordé une grande attention et soutient à l'organisation de la conference ICASA 2019.

Bienvenue à ICASA 2019! Bienvenue à KIGALI!Cordialement,
Prof. John Idoko, ICASA 2019 President, Société Africaine Anti-Sida

Welcome note by the Honourable Minister of Health, Rwanda

Distinguished Guests,
Ladies and Gentlemen,

I greet you and welcome to Rwanda,

The Government of Rwanda appreciates to have been chosen to host the 2019 ICASA.

We recognize challenges related to the HIV/AIDS epidemic and the risk associated to the increasing rate of sexually transmitted infections Sexually Transmitted Infections.

Rwanda, like many other African countries, has made tremendous progress to achieve HIV epidemic control, because of the strong and effective national response, championed by the highest leadership of the country. Over the last few years, the number of new HIV infections has dramatically decreased, and the HIV prevalence has stabilized at around 3%. Rwanda has also made huge gains towards reaching the UNAIDS 90-90-90 targets. Indeed, achieving zero new infections, zero AIDS related deaths and zero stigma is possible.

However, despite the achievements in the fight against HIV/AIDS, there are a number of vulnerable groups in which new HIV infections are unacceptably high, regardless of widespread availability of HIV/AIDS services and resources. In order to sustain gains made over the last few years, and to continue making improvements in a cost-effective manner, there is need to further focus our attention on the vulnerable groups to ensure that we fully achieve national and global targets.

I take this opportunity to call upon Governments, national and International Organizations, partners as well as members of the civil society, to join us in developing and implementing strategic and cost-effective interventions aimed at reducing HIV/AIDS associated morbidity and mortality.

I wish you a fruitful, productive and exciting conference.

Hon. Dr. Diane GASHUMBA
Minister of Health, Republic of Rwanda

Welcome Address / Allocution de Bienvenue

Mot de bienvenue par l'Honorable Ministre de la Santé de la République du Rwanda

Distingués invités,
Mesdames et Messieurs, Soyez les bienvenus au Rwanda

Le gouvernement Rwandais exprime sa satisfaction d'avoir été choisi pour accueillir « ICASA 2019 ».
Nous reconnaissons les défis pausés par l'épidémie de VIH et SIDA, et les risques associés à l'augmentation des infections sexuellement transmissibles.

Le Rwanda, comme au tant d'autres pays africains a accompli des progrès considerable dans le contrôle de l'épidémie de VIH et SIDA à cause d'une réponse nationale efficace et d'une bonne gouvernance au sommet du pays. Dans les dernières années, le nombre de nouvelles infections à VIH a considérablement diminué, et la prévalence a été stabilisée autour de 3%. Le Rwanda a fait des acquis considérable dans la lutte contre le VIH et SIDA et est en voie d'atteindre les objectifs 90-90-90 fixés par l'ONUSIDA . De part notre experience, nous sommes confidant que les objectifs d'atteindre zero nouvelles infections, zero décès, zero stigmatisation sont réalisables.

Cependant, malgré les acquis réalisés dans la lutte contre le VIH et SIDA, nous avons identifié des groupes vulnerables chez lesquels les nouvelles infections sont inacceptablement élevées en dépit de la large disponibilité de services et de ressources alloués pour le VIH. Dans le but de garder les résultats obtenus dans les dernières années dans la lutte contre le VIH, et de continuer à améliorer les services VIH en gardant dans la perspective le coût-efficacité, nous devons concentrés nos efforts aux groupes vulnérables pour nous rassurer de l'atteinte des objectifs nationaux et globaux.

Je saisis cette opportunité de lancer un appel aux gouvernements respectifs, les organisations nationales et internationals, les partenaires aussi bien les membres de la société civile et le secteur privé, pour un effort collectif dans le developpement et la mise en oeuvres des strategies et interventions visant à reduire la morbidité et la mortalité liée au VIH et SIDA.

Nous vous remerçions d'avoir organisé cette conférence et nous vous souhaitons des moments agréables et des échanges fructueux.

Hon. Dr. Diane GASHUMBA
Minister of Health, Republic of Rwanda

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Opening Ceremony Speakers/ Orateurs de la cérémonie d'ouverture

Winnie Byanyima
UNAIDS Executive Director

AIDS is not over anywhere and the picture on the African continent and globally is mixed, as we have seen impressive advances in some countries and troubling failures in others.

We must close the massive gaps in access to HIV and health services. We need a step-change, to rapidly adopt targeted policies and scaled-up programmes grounded in human rights that empower communities, responding to how people live their lives in all their diverse lives. We must end stigma and discrimination and create enabling legal environments. We will not end this epidemic without ambition, innovation and investments to expand services, right injustices and to transform the determinants that result in vulnerable populations.

I look forward engaging with all participants of ICASA 2019 to learn, exchange and together make plans to address these vital issues.

Dr. Julitta Onabanjo
Regional Director for UNFPA East and Southern Africa.

In 2016, the international community committed to reduce new HIV infections by 75% by 2020. We now stand on the eve of 2020, and are unlikely to reach this target. Let us not despair, for we have laid a solid foundation to end AIDS by 2030. Today more people in Africa are accessing treatment, children orphaned by AIDS are declining, Aids-related deaths are declining, mother to child transmission is declining. But to end AIDS by 2030 requires us to turn off the tap of new infections. Let us start by committing to ensure that by 2030 every adolescent girl in Africa is empowered, not only to prevent HIV, but also unintended pregnancies and STIs. Let us confront the harmful social, cultural and gender norms and practices, including all forms of gender based violence, by committing to ensuring the dignity of every young person, man, and women in all their diversity. Let us ensure that every African child has access to and is able to complete their education, including receiving quality comprehensive sexuality education. Let us make condoms "sexy" for a new and younger generation, who desire loving and fulfilling relationships. Let us engage and involve all African men and boys as partners and individuals with their own sexual and reproductive health needs, rights and choices, including for medical male circumcision. In short, let us recommit to the vision of the International Conference on Population and Development and the Sustainable Development Goals by putting people and their rights at the centre of what we do.

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The ICASA 2019 Youth Programme Committee leading the planning of youth programme activities at the ICASA 2019 towards an AIDS FREE AFRICA.
Le Comité du programme des jeunes de ICASA 2019 dirigeant le planning des activités du programme des jeunes lors de ICASA 2019 pour une AFRIQUE SANS SIDA.

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The conference organizers would like to thank all Abstract Reviewers for their outstanding committment in reviewing 3,107 Abstracts.

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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 their research 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 and we use this medium to thank them for their support of delegates attendance. This years Scholarship for ICASA 2019 was funded by the ICASA Conference. In addition, the Government of Rwanda gave more than 300 scholarships to local delegates.

Allocated scholarships captured all 5 geographical regions of Africa. Scholarship were allocated to all oral and poster presenters that applied for scholarship.

General Delegates	**(Registration and DSA)**	4
General Delegates	**(Accommodation and Registration)**	1
General Delegates	**(Registration, Travel, Accommodation and DSA)**	5
Oral presenters	**(Travel, Accommodation & DSA)**	41
Poster exhibitors	**(DSA only)**	200
Poster exhibitors	**(Accommodation & DSA)**	100
HIV+ Delegates	**(Registration, Accommodation & DSA)**	57
Community village	**(Registration, Accommodation & DSA)**	29
Youth Scholarship	**(Registration, Accommodation and DSA)**	20
Attendance from Mexico (Scholarship) + 43 Oral posters	**Registration only**	54
Total scholarship Awardees		**511**

VOLUNTEERS

ICASA 2019 is supported by an excellent and dedicated team of 250 volunteers. The Conference Organizers would like to especially thank all who supported volunteers recruitment and management process.

RAPPORTEUR SUPPORT

ICASA Conference Rapporteurs were sponsored by the conference organizers and their T-shirts was supported by AVACARE HEALTH.

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BOURSES

Tous les deux ans, des bourses et autres types d'appui financier sont octroyés à un grand nombre de personnes pour leur permettre de participer et de présenter à la conférence. Ceci est crucial pour s'assurer que l'équilibre est maintenu en ce qui concerne la représentativité de tous en assurant la pertinence du continue en tant que forum International.

Pour nous permettre de réaliser cela, nous dépendons de l'appui financier de certaines organisations. Cette année, les bourses de participation à ICASA ont été financées par les organisateurs de la dite Conférence. En addition, le gouvernement du Rwanda à octroyé plus de 300 bourses au participants locaux.

Les bourses ont été octroyées dans les 5 régions géographiques de l'Afrique. Des

bourses ont été octroyées à tous les conférenciers et présentateurs d'affiches ayant soumis une demande de bourse

Délégués	**(Inscription et Perdiem)**	4
Délégués	**(Hébergement et Inscription)**	1
Délégués	**(Inscription, Transport et Hébergement)**	5
Présentateurs Oraux	**(Transport, Hébergement et Perdiem)**	41
Poster	**(Perdiem)**	200
Poster	**(Hébergement et Perdiem)**	100
Délégués VIH +	**(Inscription, Hébergement et Perdiem)**	57
Village Communautaire	**(Inscription, Hébergement et Perdiem)**	29
Bourse des Jeunes	**(Inscription, Hébergement et Perdiem)**	20
Participation du Mexique (Bourse) + Orale, Poster (43)	**(Inscription)**	54
Total des bourses		**511**

VOLONTAIRES

La 20eme édition de ICASA est soutenue par une équipe de 250 volontaires dévouées et complémentaires.

Les Organisateurs de la Conférence aimeraient remercier particulièrement tous les volontaires et tous ceux qui ont apporté un appui dans le processus de recrutement des volontaires.

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Les Rapporteurs de la Conférence ICASA ont été soutenus par les organisateurs de la conférence et les T-Shirt par AVACARE HEALTH

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Semafara Sage	–	RRP+
Semakula Muhammed	–	Division VIH - Centre Biomédical du Rwanda
Tina Nyunga	–	Université du Rwanda-ONUSIDA
Umukunzi Martine	–	Fondation Imbuto
Uwineza Jacqueline	–	ONUSIDA
Uwitonze Jean Marie	–	Ministère de la Santé

KIGALI CONVENTION CENTRE, RWANDA

The 20th International Conference on AIDS and STIs in Africa is taking place in Kigali, Rwanda at Kigali Convention Centre. The full address of the venue is: Highway KN5, adjacent to the KG2 Roundabout, about 6 kilometers west of Kigali International Airport. Please refer to the venue floor plan in the conference pocket programme. 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 ask any of the conference staff or volunteers, or use ICASA2019 App or visit our General Information Desk, which is located in the Registration Area at the car park.

CERTIFICATES OF ATTENDANCE

Certificates will be issued upon request at the Registration Desk, starting at 10:15am, 5th, 6th and 7th December, 2019 in addition, certificates will be sent by email.

COMMUNITY VILLAGE

The Community Village is an integral and vibrant element of the ICASA programme. Located at the KCC Annex (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 officials throughout the conference on specific thematics. Delegates and visitors are encouraged and invited to visit the community village and networking zones.

The official opening ceremony of the Community Village will commence on Tuesday, 3rd December, 2019 at 10:45. Please see page 55 for the Community Village programme.

OPENING HOURS:

Tuesday, 3rd December:	10:45 – 19:15
Wednesday, 4th December:	10:45 – 19:15
Thursday, 5th December:	10:45 – 19:15
Friday, 6th December:	10:45 – 19:15
Saturday, 7th December:	10:45 – 19:15

CONFERENCE REGISTRATION

The conference registration area is located at the car park of the Kigali Convention Centre (Kindly view the conference map)

OPENING HOURS:

Sunday, 1st December:	12:00 – 16:00
Monday, 2nd December:	06:30 – 16:00
Tuesday, 3th December:	06:30 – 20:30
Wednesday, 4th December:	06:30 – 20:30
Thursday, 5thDecember:	06:30 – 20:30
Friday, 6th December:	06:30 – 20:30
Saturday, 7th December:	06:30 – 12:30

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 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 accompanying persons will be admitted to all conference sessions.

EXHIBITION

The Exhibition booths are located in the Exhibition Hall at the KCC Annex, offering delegates a chance for dynamic interaction with exhibitors. There are many 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 area 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 DESK

A General information desk is situated in the Registration Area. There are additional area-specific information counters in the Exhibition area.
Volunteers will be stationed throughout the conference to assist participants with any enquiries.

INTERNET/WIFI

The Kigali Conference Centre Wifi is available in the conference venue. The Government of Rwanda is graciously providing wireless internet services 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 all session rooms.

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 $100 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 devices at the end of each session to ensure that 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 at the car park. Accredited media will have full access to the Media Centre located at the Mezzanine room at the Kigali Convention Centre(KCC). The Media Centre will be open daily from Monday, December 2nd untill Saturday, 7th December, from 07:00 to 15:00.

The Media Centre will be equipped with computers and printers for use by accredited journalists. Information on press conferences and briefings will be posted in the 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 on the website: www.icasa2019rwanda.org.

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. such expression may not lead to any harm or prejudice to any person or damages to any property. If anyone abuses these principles, Rwanda law applies.

VVIP LOUNGE

The VVIP Lounge is provided exclusively for people living with HIV as a place where they can rest, refresh themselves and network.

The Positive Lounge is located on the Top Floor at the Kigali Convention Centre and it is open from Tuesday, 3rd December to Friday, 6th December, 10:15 and 18:00 pm(closing at 13:00 on Saturday).

PRESENTERS, SPEAKERS, CHAIRS AND FACILITATORS

The Faculty is located at AD5 in the Kigali Convention Centre (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 into the system. All presenters are requested to do so at least six hours before their session. The organisers cannot guarantee projection in the session room if presenters upload their slides later. Presenters will not be able to upload their presentation in the sessions room.

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

OPENING HOURS:

Monday, 2nd December:	10:00 – 17:00
Tuesday, 3rd December:	07:00 – 17:00
Wednesday, 4th December:	07:00 – 17:00
Thursday, 5th December:	07:00 – 17:00
Friday, 6th December:	07:00 – 17:00
Saturday, 7th December:	07:00 – 12:00

POSTER EXHIBITION

The Poster Exhibition area is located at the KCC Annex within the main exhibition area. (Please refer to the exhibition map). All boards are sequentially numbered to help presenters and viewers find the exact poster they need. There are four(4) poster sessions per day from Tuesday to Friday representing approximately 350 posters per day.

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 area at the KCC Annex. 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 between 07:30 – 08:30
- Poster must be removed by 18:30

When removing your poster, please make sure to also remove all poster-mounting material from the board. The Conference staff will remove all posters not taken down on time. The Conference organizers will not take any responsibility for posters or other materials left in the Poster Exhibition area. Presenting authors should stand by their poster during the following break times on one day only. Please see break time details below:

TIMES:

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

SECURITY

The Safety and Security Office is located on-site and can be contacted on our emergency lines: Rwanda National Police (RNP): +250788311533, Emergency number: SAMU: 912. KCC Security Manager: +250724000022

For security reasons, access to the conference venue will be controlled. Access to the session rooms and Exhibition area of Kigali Convention 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 Kigali Convention 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 nor associates and subcontractors liable. This is 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 smoking at the designated smoking areas as well as 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 (@ICASA2019Rwanda), like our Facebook page (ICASA2019Rwanda) and download the AttendeeHub App from Google PlayStore or AppStore and search for "ICASA2019" in Current & Upcoming events and download to your mobile device. Or via https://event.crowdcompass.com/icasa2019 to access the ICASA 2019 Conference Programme)

CENTRE DE CONVENTION DE KIGALI, RWANDA

La 20e Conférence Internationale sur le SIDA et les IST en Afrique se déroulera au Centre de Convention de Kigali, Rwanda. L'adresse complète du lieu est la suivante: Autoroute KN5, non loin du rond-point KG2, environ 6 kilomètres à l'Ouest de l'aéroport international de Kigali. Veuillez-vous référer au plan du site dans le programme de poche de la conférence. Nous espérons que cela facilitera vos déplacements sur les lieux.

Si vous rencontrez des difficultés ou si vous avez besoin d'informations complémentaires, veuillez-vous référer à un membre du personnel ou à un bénévole ou utilisez l'App ICASA2019 ou visitez notre Bureau d'Information Générale qui se trouve dans l'aire d'inscription sur le parking de l'esplanade.

CERTIFICAT DE PRÉSENCE

Les certificats seront émis, à la demande auprès du Bureau d'Inscription les 5, 6, 7 Décembre 2019 après 10:15 et seront également envoyés mail.

VILLAGE COMMUNAUTAIRE

Le Village Communautaire est un élément indissociable et dynamique du programme de ICASA.
Situé dans l'annexe du KCC (voir le plan du site), le Village Communautaire est ouvert aussi bien aux participants inscrits pour la conférence qu'au grand public.

Le Village abritera des discussions communautaires, offrant ainsi aux participants à la conférence et au public d'une manière générale la possibilité d'interagir avec les leaders, les ONG et les membres du gouvernement tout au long de la conférence sur des thématiques spécifiques. Les participants et les visiteurs sont encouragés à visiter le village communautaire et les zones de réseautage.

La cérémonie officielle d'ouverture du Village Communautaire débutera le mardi 03 décembre 2019 au village communautaire. Veuillez consulter le programme du village communautaire se trouvant dans le livre à la page 55 pour le programme complet des sessions, des performances et des activités.

HEURES D'OUVERTURE:

Mardi 3 Décembre:	10:45 – 19 :15
Mercredi 4 Décembre:	10:45– 19 :15
Jeudi 5 Décembre:	10:45– 19 :15
Vendredi 6 Décembre:	10:45– 19 :15
Samedi 7 Décembre:	10:45– 19 :15

INSCRIPTION A LA CONFERENCE

L'aire d'inscription pour la conférence dans l'annexe du Centre de Convention de Kigali(veuillez consulter le plan de la conférence).

HEURES D'OUVERTURE:

Dimanche 1er Décembre 2019	12:00 - 16 :00
Lundi 2 Décembre 2019	06 :30 - 16 :00
Mardi 3 Décembre 2019	06 :30 - 20 :30
Mercredi 4 Décembre 2019	06 :30 - 20 :30
Jeudi 5 Décembre 2019	06 :30 - 20 :30
Vendredi 6 Décembre 2019	06 :30 - 20 :30
Samedi 7 Décembre 2019	06 :30 - 12 :30

Les participants à la conférence doivent porter leur badge en permanence afin de pouvoir accéder aux salles de sessions et à l'aire d'exposition. Les bénévoles de la conférence et le service de sécurité du site ne permettront à personne l'accès au site de la conférence sans badge valide. Au cas où vous perdez votre badge, veuillez contacter le Bureau des Inscriptions.

En cas de perte, les badges vous seront délivrés au prix de 60$ par badge (TVA inclus).

Les accompagnateurs adultes sont autorisés à assister aux cérémonies d'ouverture et de clôture. Seuls les enfants (moins de 18 ans) inscrits comme accompagnateurs seront admis à toutes les sessions de la conférence.

EXPOSITION

Les stands d'exposition sont situés dans le Hall d'exposition dans l'annexe du KCC ils offrent aux participants une occasion d'interaction dynamique avec les exposants. Il y a beaucoup d'exposants à ICASA et les participants sont invités à visiter tous les stands pour découvrir les dernières informations sur les organisations qui nous appuient. Certains exposants feront des démonstrations dans l'aire d'exposition ; ce qui permettra d'ajouter un intérêt supplémentaire à la conférence. Tous les stands sont indiqués sur le plan d'exposition afin de rendre facile l'identification de chaque stand.

BUREAU D'INFORMATIONS

Un bureau d'informations générales se trouve dans l'aire d'inscription. Il y a des guichets pour les informations supplémentaires spécifiques dans l'aire d'exposition. Des bénévoles seront positionnés pendant toute la conférence pour aider les participants.

INTERNET/WIFI

Le Wifi du Centre de Convention de Kigali est disponible gratuitement sur tout le site de la conférence. Le gouvernement du Rwanda fourni gracieusement l'Internet wifi à la conférence. Pour accéder à l'Internet, veuillez consulter le Bureau d'Informations générales .

INTERPRÉTATION (AN/FR)

Les langues officielles de la conférence sont l'anglais et le français. La traduction simultanée de l'anglais vers le français et du français vers l'anglais sera assurée dans toutes les salles.

Si vous souhaitez utiliser le service d'interprétation simultanée, prenez un casque d'écoute avant la session immédiatement devant la salle de la session concernée. Les participants sont priés de déposer un passeport valide ou 100$US en espèces au moment de prendre le casque. Cette somme sera retournée lors de la remise du casque. Les participants seront facturés à 100 dollars pour les casques perdus, égarés ou endommagés.

Pour éviter une longue attente, vous pouvez vous procurer les casques d'écoute pendant la pause avant la session. Veuillez retourner l'équipement du casque à la fin de chaque session pour vous assurer qu'ils pourront être rechargés et utilisés le lendemain.

CENTRE DE PRESSE

L'Inscription des médias doit être effectuée au bureau d'inscription consacré aux médias dans l'aire d'inscription sur le parking de l'esplanade. Les médias accrédités auront un accès total au Centre de Presse situé à la salle Mezzanine au Centre de Convention de Kigali. Le Centre de Presse sera ouvert tous les jours à partir du lundi 2 Décembre 2019 jusqu'au samedi 7 Décembre 2019 de 07:00 à 15:00.

Le Centre de Presse sera équipé d'ordinateurs et d'imprimantes que les journalistes accrédités pourront utiliser. Les informations sur les conférences de presse et les briefings seront affichées dans le Centre de Presse avec des mises à jour sur les dates et les heures.

Les journalistes qui souhaitent obtenir des interviews avec les conférenciers bénéficieront d'une assistance au Centre de Presse.

Des informations supplémentaires sur le Centre de Presse et les lieux des conférences de presse seront disponibles sur le site web www.icasa2019rwanda.org

DIRECTIVES POUR LA PARTICIPATION/CODE DE CONDUITE

La conférence reconnait la liberté d'expression aux conférenciers, aux participants et aux exposants. Elle souscrit cependant aux principes largement répandus associés à l'exercice de cette liberté d'expression, c'est-à-dire que ce genre d'expression ne doit pas nuire ou porter préjudice à des personnes ou des dommages sur des biens. Si l'un de ces principes est violé, la loi rwandaise sera appliquée.

LE SALON VVIP

Le Salon VVIP est offert seulement aux personnes vivant avec le VIH comme un lieu de repos, de rafraichissement ou de réseautage. Le Salon VVIP est situé au dernier étage du Centre de Convention de Kigali et il est ouvert du Mardi 3 Décembre au samedi 7 décembre 2019 de 10:15 à 18:00 (NB : De 08 :00 à 13:00 le samedi).

PRESENTATEURS, CONFERENCIERS, PRESIDENTS ET FACILITATEURS

La Faculté est située dans la salle AD5 du centre de convention de Kigali (veuillez consulter le plan du lieu de la conférence).

Tous les conférenciers, présidents, modérateurs, facilitateurs et présentateurs sont priés de se rendre à la Faculté immédiatement après inscription pour signer les formulaires de consentement, confirmer la date, l'heure et le lieu de leur communication et recevoir des informations de sécurité spécifiques concernant leur session.

La Faculté est LE SEUL ENDROIT où des communications sur diapositives peuvent être téléchargées sur le système. Tous les communicateurs sont invités à le faire au moins six heures avant leur session. Les organisateurs ne peuvent pas garantir la projection dans la salle de session si le téléchargement du diapositive est en retard. Les communicateurs ne pourront pas télécharger leur communication en salle de session.

NB: Ne pas contacter à temps la Faculté peut pousser les organisateurs à considerer les remplaçants.

HEURES D'OUVERTURE:

Lundi 2 décembre 2019:	10:00 – 17:00
Mardi 3 décembre 2019:	7:00 – 17:00
Mercredi 4 décembre 2019:	7:00 – 17:00
Jeudi 5 décembre 2019:	7:00 – 17:00
Vendredi 6 décembre 2019:	7:00 – 17:00
Samedi 7 décembre 2019:	7:00 – 12:00

EXPOSITION D'AFFICHES

L'Exposition d'affiches est située sur le parking de l'esplanade dans le hall d'exposition principal. Veuillez-vous référer au plan d'exposition pour un aperçu des couleurs qui servent de code à l'identification des zones. Tous les panneaux d'affichage sont numérotés de façon séquentielle pour aider les présentateurs et les visiteurs à trouver l'affiche qu'ils veulent. Il y a quatre sessions d'affiches du lundi au vendredi présentant approximativement 350 posters par jour.

INSTRUCTIONS POUR LES PRESENTATEURS D'AFFICHES:

Les affiches seront présentées pendant une journée. Pendant les pauses, les présentateurs sont tenus de rester près de leurs affiches pour répondre aux questions et donner des informations supplémentaires sur les résultats de leurs études.

L'exposition des affiches aura lieu dans le Hall d'Exposition sur le parking de l'esplanade. Votre panneau d'affichage sera indiqué avec votre nouveau numéro d'abstract. Tous les auteurs sont responsables de la fixation et du retrait de leurs propres affiches.

TEMPS DE FIXATION ET DE RETRAIT DES AFFICHES

Votre affiche doit être fixée et retirée aux heures suivantes:

- L'affiche doit être fixée de 7:30 – 8:30
- L'affiche doit être retirée à 18:30

Lorsque vous retirez votre affiche, assurez-vous que vous retirez également tout le matériel de fixation du panneau d'affichage. Le personnel de la conférence retirera toutes les affiches qui ne seront pas retirées à temps. La responsabilité des organisateurs du congrès ne sera pas engagée concernant les affiches ou tout autre matériel laissé dans le hall d'exposition des affiches.

Les auteurs qui font une présentation doivent rester près de leur affiche pendant les temps de pause de la journée. Veuillez trouver les détails des heures de pause ci-dessous.

HEURES:

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

SÉCURITÉ

Le Bureau de la Sécurité se trouve sur place et peut être contacté sur les lignes d'urgence: Rwanda National Police (RNP): +250788311533, Numéro d'Urgence: SAMU: 912 KCC Responsable de la Sécurité: +250724000022

Pour des raisons de sécurité, l'accès à tous les sites de la conférence sera contrôlé.

L'accès aux salles de session et aux Halls d'Exposition du Centre de Convention de

Kigali seront accessible uniquement pour les participants inscrits portant des badges de conférence. Dans l'intérêt d'une sécurité personnelle, les participants doivent présenter leurs badges de conférence seulement dans les locaux du Centre de Convention de Kigali.

Ni le Secrétariat de la Conférence, ni aucun de leurs prestataires contractuels, ne sera responsable de la sécurité des articles introduits sur les lieux de la conférence par les participants à la conférence, qu'ils soient inscrits ou non, ni leurs agents, ni leurs contractants, ni leurs visiteurs et/ou toute (s) autre(s) personne (s) quel qu'elles soient.

Les participants à la conférence doivent indemniser et ne doivent tenir ni les organisateurs, ni les associés, ni les sous-traitants responsables en ce qui concerne tous les frais, les réclamations, les demandes et les dépenses suite à des dommages, à des pertes ou blessures causées à toute personne résultant d'un acte ou d'une défaillance du Secrétariat de la Conférence ou toute personne représentant le Secrétariat de la Conférence, leurs contractants ou invités. En outre, les participants à la conférence prendront toutes les précautions nécessaires pour éviter toute perte ou dommage sur leurs biens avec une attention particulière sur les téléphones portables, les sacs à main et les équipements informatiques.

POLITIQUE NON-FUMEUR

Il est interdit de fumer partout dans le bâtiment. Si vous fumez à l'extérieur, veuillez respecter l'environnement, les collègues participant à la conférence et d'autres invités sur le site en vous débarrassant correctement des mégots et de tout autre déchet dans les poubelles prévues.

MÉDIA SOCIAUX

Connectez-vous à ICASA via nos plateformes des médias sociaux et restez connectés aux événements lors de la conférence. Suivez-nous sur Twitter (@ICASA2019Rwanda) « likez » notre page Facebook (ICASA2019Rwanda), et téléchargez l'application AttendeeHub (disponible en version IOS pour les appareils Apple et Playstore pour les appareils Android ou via le lien suivant https://event.crowdcompass.com/icasa2019 pour accéder au programme de ICASA 2019)

WINNER OF **ICASA 2019** LOGO COMPETITION /
GAGNANT DE LA COMPETITION DE LOGO DE **ICASA 2019**
Apevinyekou Komlanvi, Togo

20TH ICASA
INTERNATIONAL CONFERENCE ON AIDS AND STIs IN AFRICA
KIGALI 2019

The International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) is a major international AIDS conference which takes place in Africa. It is a biennial conference which alternates between Anglophone and Francophone African countries. ICASA has been organized since 1990 to mitigate the impact of HIV/AIDS through an African continent free of HIV, Tuberculosis and Malaria and the debilitating effects which these diseases have on our communities, where there is no stigma and discrimination against PLHIV and their families, and where social justice and equity to accessing treatment prevails. So far ICASA has been hosted in (16) sixteen countries with more than 100,000 direct participants. The last ICASA was hosted in Abidjan, Côte d'Ivoire in 2017.

The ICASA organizers desirous to get an identity to brand the upcoming 20th ICASA which will be held in Kigali, Rwanda 2nd – 7th December, 2019, launched a contest for a creative logo for the conference. The ICASA organizers, offered $1000 for the best designer of the logo.

The contest was open to all Africa countries. However, artistes mainly PLHIV and key populations were the most encouraged to participate in this contest.

Out of 51 logo submissions, the SAA Permanent Secretariat/ICASA International Secretariat shortlisted the 10 best proposals of the ICASA logo and presented them at the ICASA 2019 1st International Steering Committee meeting held on 7th - 8th June, 2018 at the Serena Hotel, Kigali, Rwanda after which the final selection was made. The awardee will receive her prize at the 2nd International Steering Committee meeting.

WINNER OF **ICASA 2019** LOGO COMPETITION / GAGNANT DE LA COMPETITION DE LOGO DE **ICASA 2019**

Apevinyekou Komlanvi, Togo

20TH ICASA
INTERNATIONAL CONFERENCE ON AIDS AND STIs IN AFRICA
KIGALI 2019

La Conférence Internationale sur le Sida et les Infections Sexuellement Transmissibles en Afrique (ICASA) est une importante conférence internationale qui se déroule en Afrique. Sa tenue biennale est alternée entre les pays africains francophones et anglophones. ICASA est organisé depuis 1990 afin de réduire l'impact du VIH/SIDA sur le continent africain qui sera libéré du VIH, de la Tuberculose et du Paludisme, ainsi que des effets néfastes de ces maladies sur nos communautés, où il n'y aura ni stigmatisation, ni discrimination contre les PVVIH et leurs familles et où la justice sociale et l'équité dans l'accès aux traitements prévaudront. Jusqu'à présent, la conférence ICASA s'est tenue dans seize (16) pays avec plus de 100 000 participants directs. La dernière conférence ICASA s'est tenue à Abidjan, Côte-d'Ivoire en 2017.

Les organisateurs de ICASA, désireux de se faire une identité pour marquer la 20e édition de ICASA qui se tiendra à Kigali, auRwanda, du 2 au 7 Décembre 2019, ont lancé une compétition pour la conception d'un logo original. Les organisateurs offrent une récompense de 1000 USD pour le meilleur concepteur de logo.

La compétition fut ouverte à tous les pays africains. Toutefois, les artistes notamment les PVVIH et les populations clés ont été davantage encouragés à participer au concours.

51 soumissions de logo ont été reçues. Le Secrétariat permanent de la SAA/ Secrétariat International de ICASA a retenu les 10 meilleures propositions de logo de ICASA et les ont présentés lors de la 1ère réunion du Comité Directeur International de ICASA 2019 tenue du 7 au 8 juin 2018 au Serena Hôtel, à Kigali, Rwanda à l'issue de laquelle la sélection finale a été faite. Le gagnant recevra son prix lors de la 2nde réunion du Comité Directeur International.

TRACK B

Title of Abstract: Real Time Medication Monitoring improves virological outcome among People Living with HIV on Antiretroviral Treatment in Moshi, Tanzania

Kennedy Michael Ngowi

For the last four years, as the Kilimanjaro Christian Research Institute ICT specialist, I have worked on numerous projects which employ the ubiquitous use of mobile phones in Tanzania to improve patient treatment and wellness. To date, I have successfully managed two studies which used mhealth to provide education on Family planning and HIV/AIDS. As software developer, I develop the Mobile Health System needed at our health center settings to improve the use of aRT.

My successful management of these project led me to obtaining a doctoral Scholarship (PhD)to investigate the effect of short message service (SMS) and real time medication monitoring (RTMM) to improve adherence to antiretroviral treatment in the Kilimanjaro region. As coordinator, I oversee the process of recruitment, enrollment, data collection, and follow-up of the participants based on work plans.

To ensure rigor and reproducibility in our project I have incorporated extensive advance training including project management, Good Clinical Practice, Policy Briefing, Communicating science to specific target-audiences, Qualitative Data Management and Analysis with NVIvo (Concept & Approaches) and Development of Mobile Health.

TRACK C

Title of Abstract: A mixed-method study exploring the clinical and social status of young mothers living with HIV and their children in Zimbabwe

Zivai Mupambireyi

Zivai Mupambireyi is a Zimbabwean research fellow with research experience of over 16 years. She currently manages a group of studies looking at how young adolescents are managing growing up with HIV.

Zivai has acted as principal and co-investigator and have worked at senior level for internationally based organisations in various programmes, planning and implementation of projects within the HIV/AIDS sector. Zivai has gained significant exposure in designing and conducting qualitative research and randomized control trials on adolescents and children infected and affected by HIV.

Zivai is interested in child and adolescent health with the specific aim of improving mental, physical, social health and well-being of young people through excellent and interdisciplinary research focused on broader social and economic living conditions.

TRACK D

Title of Abstract: Violence victimization and viral load failure among HIV-positive adolescents and young adults in Ndola, Zambia: A mixed methods study.

Katherine Merrill

Katherine Merrill's research centers on the intersection between violence and HIV among young people in sub-Saharan Africa. She is currently completing her PhD in International Health at the Johns Hopkins Bloomberg School of Public Health and has a masters degree in Epidemiology from the London School of Hygiene and Tropical Medicine.

TRACK E

Title of Abstract: : Is it OK to not be OK in HIV Care? Mental Health Resources and Screening in HIV Care Environments in 24 Districts of Zimbabwe.

Karen Webb

Karen is the Knowledge Management and Impact Analysis (KMIA) Director for the Organization for Public Health Interventions and Development (OPHID). OPHID is a local organization supporting the Ministry of Health and Child Care (MOHCC) to implement the National HIV Care and Treatment Program in over 700 health facilities across Zimbabwe through support from PEPFAR through USAID.

She has over 17 years experience in HIV program design and evaluation in sub Saharan Africa. Holding an MSc in Public Health from London School of Hygiene and Tropical Medicine (LSHTM), Karen is currently in the final stages of her PhD in Infectious Disease Epidemiology at LSHTM.

A passionate advocate of implementation science, Karen's role at OPHID involves leading targeted health systems evaluation and facilitating collaboration between MOHCC, programmers, and researchers to pursue implementation of evidence-based interventions to optimize HIV prevention, care and treatment services in public health settings.

Notes

Session Coding/Codages des Sessions

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	SESSION TYPE	SESSION ORDER	SPEAKER ORDER
MO (MONDAY) TU (TUESDAY) WE (WEDNESDAY) TH (THURSDAY) FR (FRIDAY) SA (SATURDAY	PL, SS, SY	01, 02, 03, 04 ETC.	01,02,03,04

PROGRAMME SESSIONS	ABSTRACT-DRIVEN SESSIONS	OTHER SESSIONS
PROGRAMME SESSIONS AND PROGRAMMES ACTIVITIES	MO TU WE TH FR SA	

Special Session
Satellite Symposia
Non Abstract Driven Session
Workshop

CV (Community Village)
PL (Plenary Session)
SS (Special Session)
SY (Symposia Session)
WS (Workshop)
NAD (Non Abstract Driven Session)
e.g. SAPL0101, WEPL0306

Session Coding/Codages des Sessions

ORAL ABSTRACT SESSION	POSTER DISCUSSION OR POSTER EXHIBITION
SA = Weekday	SA = Weekday
A= Abstract	P = Poster
A-E = Track (see below)	D = Discussion / E = Exhibition
	A-E = Track (See below)
AA (TRACK A)	PDA (TRACK A)
AB (TRACK B)	PDB (TRACK B)
AC (TRACK C)	PDC (TRACK C)
AD (TRACK D)	PDD (TRACK D)
AE (TRACK E)	PDE (TRACK E)
01, 02, … = Session order 01, 02, 03… = Speaker order e.g., SAAA0101, MOAD0205	01, 02, … = Session order 01, 02, 03… = Speaker order e.g. TUPDA0101, WEPDD0205 *e.g. TUPE0905, SAPE0108*

EXEMPLE 1: MOAA01 = MO (JOUR DE LA SEMAINE) - (TYPE DE SESSION) AA - (NUMERO DE LA SESSION) 01

EXEMPLE 2: MOAAO105LB = MO (JOUR DE LA SEMAINE) -(TYPE DE SESSION) AA - (NUMERO DE LA SESSION) 01 (NUMERO DE LA SESSION) 05 (NUMERO DE L'ABSTRACT)

EXEMPLE 3: MOPE001 = MO (JOUR DE PRESENTATION DE L'AFFICHE) - PE (TYPE DE PRESENTATION) - 001 (NUMERO DE L'ABSTRACT

JOUR DE LA SEMAINE	TYPE DE SESSION	ORDRE DE SESSION	ORDRE DES ORATEURS
MO (LUNDI) TU (MARDI) WE (MERCREDI) TH (JEUDI) FR (VENDREDI) SA (SAMEDI)	PL, SS, SY	01, 02, 03, 04 ETC.	01,02,03,04

SESSIONS DU PROGRAMME	SESSIONS DIRIGEES	AUTRES SESSIONS
SESSIONS DU PROGRAMME ET ACTIVITES DU PROGRAMME	MO TU WE TH FR SA	

Session spéciale
Session Satellite
Session Non dirigée
Session
Atelier

CV (Village Communautaire)
PL (Session Plénière)
SS (Session Spéciale)
SY (Session Symposia)
WS (Atelier)
NAD (Session Non dirigée)
ex: SAPL0101, WEPL0306

Session Coding/Codages des Sessions

SESSIONS ORALES DIRIGEES	DISCUSSION AUTOUR DES AFFICHES OU EXPOSITION D'AFFICHE
SA = Jour de la semaine	SA = Jour de la semaine
A= Abstract	P = Affiches
A-E = Track (voir ci-dessous)	D = Discussion / E = Exposition
	A-E = Track (Voir ci-dessous)
AA (TRACK A)	PDA (TRACK A)
AB (TRACK B)	PDB (TRACK B)
AC (TRACK C)	PDC (TRACK C)
AD (TRACK D)	PDD (TRACK D)
AE (TRACK E)	PDE (TRACK E)
01, 02, … = Ordre de session 01, 02, 03… = Ordre des Orateurs *ex:* SAAA0101, MOAD0205	01, 02, … = Ordre de la session 01, 02, 03… = Ordre des orateurs Ex : TUPDA0101, WEPDD0205 *ex: TUPE0905, SAPE0108*

NON-ABSTRACT DRIVEN SESSIONS

The non-abstract driven sessions address a variety of current viewpoints and issues. The format and focus of these sessions vary.
These 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 2019 features 17 high-quality, targeted professional development workshops that promote and enhance opportunities for knowledge transfer, skills development and collaborative learning. 5 of the workshops are designed by the Conference Programme Committees, and the remaining 12 workshops were selected from proposals submitted by the general public. Workshops can be 90 minutes in length and held in French and English.

A rapporteur summary session will be held immediately before the closing session on December 7th from 10:45 to 12:15. The summary session synthesizes presentations made during the week, focusing on critical issue 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 (AE), or are composed of abstracts from different tracks that focus on one theme.

Over 3107 abstract submissions went through a blind peer-review process, carried out by a panel of around 330 international reviewers. 1570 abstracts were selected by members of the Scientific Programme Committee for inclusion in the conference programme, 120 oral abstract presentations and 1450 poster exhibitions.

The highest-scoring accepted abstracts were selected for presentation in oral abstract sessions. The majority of the selected posters are displayed in the Exhibition area.

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. ICASA 2019 features 120 oral abstract presentations. Oral abstract sessions are 90-minute sessions that consist of five oral presentations of 15 minutes followed by a five-minute question and answer session. An interactive moderated discussion, facilitated by the chair, 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 1,450 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 Tuesday 3rd December – Friday, 6th December, and is located at the car park. See the Exhibition floor plan.

PROGRAMME ACTIVITIES

Programme activities at ICASA 2019 are hosted by individuals, groups and organizations in the community 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 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 2500 m^2 and is located at the parking area of the Kigali Conference Centre.

Additional information about the Community Village and Youth Programme can be found on the conference website at: www.icasa2019rwanda.org.

Stay up to date with everything happening in the Community Village by following @ ICASA2019Rwanda on Twitter.

SATELLITE SESSIONS

Satellite sessions will take place all day on 2nd December, 2019 untill 14:45 and only in the mornings and evenings from Tuesday, 3rd December 2019 to Saturday, 7th December 2019. 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 Kigali, Rwanda. The goal is to exchange knowledge, best practices, successes, challenges and innovative solutions through dialogue and hands-on activities. To register visit the Exhibition area (Booth no. 61).

SESSIONS NON DIRIGEES

Les sessions sans résumé traitent d'une variété de points de vue et de questions actuelles. Le format et le centre d'intérêt de ces sessions varient. Ces sessions sont développées par les comités des programmes avec les contributions des acteurs.

TYPES DE SESSIONS:

Les sessions plénières rassemblent les chercheurs, les leaders scientifiques et les spécialistes cliniciens les plus distingués du monde. Les sessions plénières rassemblent tous les participants à la conférence à la première session de chaque matin.

Les sessions spéciales présentent les exposés des principaux leaders mondiaux de la recherche, des ambassadeurs internationaux de haut niveau de lutte contre le SIDA et des spécialistes en politique. Ces sessions de 90 minutes engagent grandement tous les participants.

ICASA 2019 présente 17 ateliers de perfectionnement professionnel de haute qualité et ciblés qui favorisent et améliorent les opportunités de transfert de connaissances, de développement des compétences et d'apprentissage de collaboration. 5 des ateliers sont proposés par les comités de programme de la Conférence et les 12 restants des ateliers ont été choisis parmi des propositions faites par le grand public. Les ateliers peuvent durer 90 minutes en Français ou Anglais.

Une Session de résumé des rapporteurs aura lieu immédiatement avant la session de clôture le 7 Décembre de 10:45 à 12:15. La session de résumé fait la synthèse des présentations faites pendant la semaine en mettant l'accent sur les questions importantes traitées, les importants résultats présentés et les recommandations clés présentées. Les équipes de rapporteurs publieront les rapports quotidiens et les résumés des sessions sur le site web de la conférence.

SESSIONS DIRIGEES

La composante axée sur les résumés du programme de la conférence propose des recherches de pointe évaluées par les pairs.

Les sessions résumé sont soit spécifiques à l'un des cinq tracks (A-E), soit composés de résumé de différents tracks centrés sur un seul thème.

Plus de 3107 soumissions de résumés sont passés par un processus de revue par les pairs conduit par un panel d'environ 330 Lecteurs internationaux. Environ 1 570 résumés ont été sélectionnés par les membres du Comité de Programme Scientifique pour le programme de la conférence. ICASA 2019 propose 120 présentations orales et 1450 posters.

Les résumés ayant obtenu les notes les plus élevées ont été choisis pour être présentés aux sessions orales. La plupart des affiches sélectionnées sont présentées dans l'espace d'exposition des affiches.

TYPES DE SESSIONS

Sessions orales résumé – Ces sessions sont organisées en thèmes qui traitent des nouveaux développements dans chacun des cinq tracks scientifiques ou mettent l'accent sur un thème couvrant plusieurs tracks. ICASA 2019 propose 120 présentations orales. Les sessions orales résumées sont des sessions de 90 minutes qui consistent en cinq présentations orales de quinze minutes suivies de questions-réponses de cinq minutes. Une discussion interactive modérée, facilitée par les présidents à la fin

de chaque session.

Exposition des affiches – Organisées par track et couvrant une grande variété de thèmes, l'exposition des affiches comprend environ 1 450 affiches. Chaque affiche est présentée pendant un jour et les présentateurs se tiendront à côté de leurs affiches à un moment déterminé pour répondre aux questions et fournir davantage d'informations sur les résultats de leurs études. L'exposition des affiches est ouverte du mardi 03 au vendredi 07 Décembre 2019 et est située sur le parking de l'esplanade. Consulter la carte d'exposition des affiches.

ACTIVITES DU PROGRAMME

Les activités du programme de ICASA 2019 sont organisées par des individus, des groupes et des organisations au village communautaire du lieu de la conférence. Accessible aux participants inscrits à la conférence et gratuit pour le grand public, ils offrent une plate-forme unique pour diverses activités reliant tous les domaines de la science, du leadership, de la responsabilité et de la communauté.

VILLAGE COMMUNAUTAIRE

Les activités du village communautaire comprennent : des discussions et des débats sur des questions pointues en matières de lutte contre le VIH ; la projection de films, des expositions d'art, des zones de réseautage axées sur les populations clés et leurs challenges ; les ONG et les exposants présentant les activités et produits des organisations travaillant dans le domaine de la lutte contre le VIH et une série de performances en live d'artistes locaux et internationaux qui se tiendra sur la scène principale. Le village communautaire couvre près de 2500 m^2 et est localise au Centre de Convention de Kigali.

Des informations complémentaires sur le village communautaire et le programme des jeunes peuvent être trouvées sur le site web de la conférence: www.icasa2019rwanda.org et dans le programme de poche du village communautaire.

Restez informés sur tout ce qui se passe dans le village communautaire sur Twitter @ ICASA2019Rwanda.

SESSIONS SATELLITE

Les sessions satellites auront lieu toute la journée du 2 Décembre 2019 jusqu'à 14h45 et uniquement le matin et le soir, du mardi 03 Décembre 2019 au samedi 07 Décembre 2019. Les sessions satellites ont lieu sur le site de la conférence, mais sont entièrement organisées et coordonnées par l'organisation abritant la session satellite. Le comité de programme révisera les contenus et les orateurs des sessions satellites pour s'assurer qu'ils sont conformes aux principes scientifiques et éthiques de la conférence.

TOURS D'ENGAGEMENT

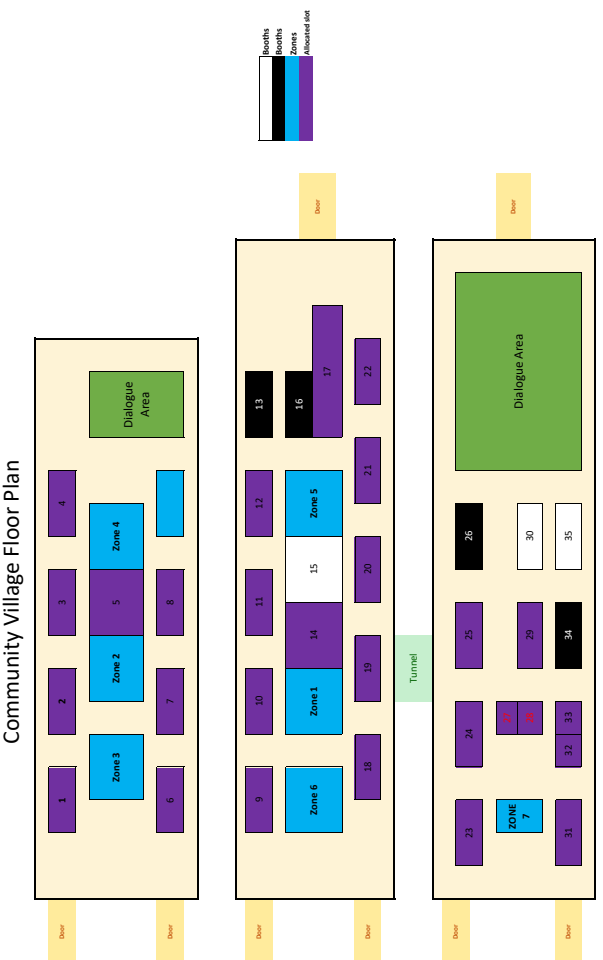
Les tours d'engagement offrent aux participants des expériences d'apprentissage unique par des visites interactives de sites à des organisations travaillant sur les questions liées au VIH et au SIDA à Kigali, Rwanda. L'objectif est d'échanger sur les connaissances, les meilleures pratiques, les succès, les défis et les solutions innovantes à travers le dialogue et les activités pratiques. Veuillez-vous inscrire au niveau du hall d'exposition (stand no. 61).

COMMUNITY VILLAGE BOOTH/STANDS AU VILLAGE COMMUNAUTAIRE

ORGANIZATION/ ORGANISATION	BOOTH NO./ STAND NO.
Affirmative Action	27
African Sex Workers Alliance (ASWA)	25
African Youth and Adolescents Network (AfriYAN)	20
Aidsfonds	17
Association IKAMBERE	33
Bong County Health System	32
Caritas Internationalis	1
Coalition Internationale Sida	5
Cordaid	4
Drugs for Neglected Diseases initiative	31
EANNASO	6
Frontline AIDS	23
Health Development Initiative	21
Humanity & Inclusion	24
John Snow, Inc	12
MAYAKI FASHION HOUSE	22
Medecins du Monde	7
Pact	8
Pan African Positive Women Coalition	11
PATA	3
Population Services International	9
Prevention Access Organisation	10
Rwanda Network of People Living with HIV-AIDS	18
Rwanda Network of People Living with HIV-AIDS	19
Transgender Coalition of Zimbabwe	28
WCC - Ecumenical Advocacy Alliance	2
Youth Against AIDS	14
World Health Organization	29

NAME OF ZONE / NOM DE LA ZONE	ZONE ALLOCATION /ALLOCATION DE LA ZONE
Disability Zone / Zone des personnes vivant avec un handicap	Zone 1
Women's Networking Zone / Zone de ré-seautage des femmes	Zone 2
PLHWA Zone / Zone des PVVIH	Zone 3
Youth Zone / Zone des jeunes	Zone 4
Diaspora Zone / Zone de la diaspora	Zone 5
Key Population Zone / Zone des Populations clés	Zone 6
Faith Based Zone / Zone des Organisations confessionnelles	Zone 7

COMMUNITY VILLAGE MAP/ PLAN DU VILLAGE COMMUNAUTAIRE



COMMUNITY VILLAGE PROGRAMME / PROGRAMME DU VILLAGE COMMUNAUTAIRE

DAY	Tuesday	03 December 2019
	Time/ heure:	10:45-12:15 hrs
	Programme:	Building capacity of Sex Workers for a meaningful participation in HIV related decision-making processes (ASWA)
	Networking Zone/ Zone de réseautage:	KEY POP Zone / Zone des Populations clés
	Time/ heure:	12:15-14:45 hrs
	Programme:	Un Institut de la Société Civile pour la Santé: services et valeur ajoutée **Moderator/ Modérateur:** • Pasteur Gaspard Obiang **Intervenants:** • Daouda Diouf (Enda Santé) • Hélène Badini (ONUSIDA) • Représentant OMS • Représentant Ambassade Luxembourg
	Time/ heure:	14:15-16:15 hrs
	Programme:	Integrating TB and HIV screening in the Community: Lessons learned from Ghana (Ghana National TB Voice Network)
	Networking Zone/ Zone de réseautage:	PLHWA Zone
	Time/ heure:	16:45-18:15 hrs
	Programme:	Nothing about US without US (Visual Echoes for Human Rights - Uganda)
	Networking Zone/ Zone de réseautage:	Women Networking Zone / Zone de réseautage des femmes
	Time/ heure:	18:45-19:15 hrs
	Programme:	From the dark to the light (Pina Uganda) Whose Choice (Peer to Peer Uganda) Africa Unite (Namugongo Uganda)
	Networking Zone/ Zone de réseautage:	Youth Zone / Zone des jeunes

DAY	Wednesday	04 December 2019
	Time/ heure:	10:15-12:45 hrs
	Programme:	HIV and Disability (Humanity & Inclusion)
	Networking Zone/ Zone de réseautage:	Disability Zone/ Zone des personnes vivant avec un handicap
	Time/ heure:	12:45-14:15 hrs
	Programme:	Community-based Monitoring: learning from key experiences **Moderator/ Modérateur:** • Tita Isaacs Discussants • Alain Manouan (ITPC-WA) • Simon Kaboré (RAME) • Fogué Foguito (Positive Generation)
	Time/ heure:	14:45-16:15 hrs
	Programme:	Breaking Barriers (Hope for Future Generations - Ghana)
	Networking Zone/ Zone de réseautage:	Women Networking Zone / Zone de réseautage des femmes
	Time/ heure:	16:45-18:15 hrs
	Programme:	The Condom Bash (Reproductive Health Uganda)
	Networking Zone/ Zone de réseautage:	Youth Zone / Zone des jeunes
	Time/ heure:	18:45-19:15 hrs
	Programme:	IKAMBERE LA MAISON QUI RELEVE LES FEMMES Musical Performance from Uganda “Mujebale” (Pina Uganda)
	Networking Zone/ Zone de réseautage:	Youth Zone / Zone des jeunes

DAY	Thursday	05 December 2019
	Time/ heure:	10:15-12:45 hrs
	Programme:	Advancing Human rights for Key populations
	Networking Zone/ Zone de réseautage:	KEY POP Zone / Zone des Populations clés

Time/ heure:	12:45-14:15 hrs
Programme:	• Increasing domestic funding for HIV and Health in Africa: Challenges and Opportunities **Moderator/ Modérateur:** • Dr Cheick Tidiane Tall **Discussants / Discutants:** • Rosemary Mburu (WACI Health) • Dr Safietou Thiam (CNLS Senegal) • MoH Rwanda • Global Fund Representative

Time/ heure:	14:45-16:15 hrs
Programme:	Young single mothers on the fore front in eradicating new HIV/AIDS infections (Rwanda Village Community)
Networking Zone/ Zone de réseautage:	Women Networking zone / Zone de réseautage des femmes

Time/ heure:	16:45-18:15 hrs
Programme:	Greater involvement of young positive mothers in cubing down new infections among infants (Live Alive Network - Uganda)
Networking Zone/ Zone de réseautage:	Women Networking zone / Zone de réseautage des femmes

Time/ heure:	18:45-19:15 hrs
Programme:	Zero Risk = Zero Excuses U=U (Love to Love - Uganda)
Networking Zone/ Zone de réseautage:	KEY POP Zone/ Zone des Popula-tions clés

DAY	Friday	06 December 2019
Time/ heure:	10:45-12:15 hrs	
Programme:	Les défis dans la prévention du Sida et des IST (APDS/ONGD - RDC)	
Networking Zone/ Zone de réseautage:	PLHWA Zone/ Zone des PVVIH	

Time/ heure:	12:15-14:15 hrs
Programme:	Universal Health Coverage: what does it mean for Africa? **Moderator/ Modérateur:** • Olive Mumba **Discussants / Discutants** • James Kamau (Kenya) • MoH Rwanda Representative • OMS Afro Representative

Time/ heure:	14:45-16:15 hrs
Programme:	Key Populations Organizing in Africa; community resilience and Leadership transition for a sustainable HIV Response
Networking Zone/ Zone de réseautage:	KEY POP Zone/ Zone des Popula-tions clés

Time/ heure:	16:45-18:15 hrs
Programme:	Making National Commitments Work: Advocacy for Change

Time/ heure:	18:45-19:15 hrs
Programme:	Engendering action for effective engagement of communities in UHC

Youth Pre-Conference/ Pré-Conférence des Jeunes

DAY Monday 01 December 2019

Time: 14:00 -18:00 hrs **Venue:** Kigali Room (Main Auditorum)

Moderators:
Dr. Cherise Umutoni Gahizi, Medical doctor, King Faisal Hospital
Nii Adjetey Ashiboe-Mensah, ICASA 2019 Youth Committee
Gloria Nawanyaga, Opening Plenary Moderator

TIME	ACTIVITY	PERSONS RESPONSIBLE
13:00 -14:00	Registration	Volunteers
14:00 - 14:30	Welcome Address	**Speakers** • Representative from ICASA 2019 Youth Programme Committee - Amanda Rurangwa • SAA President - Prof. John Idoko • Minister of Youth, Rwanda - Hon. Rosemary Mbabazi
14:30 - 16:00	Opening Plenary	• Minister of Health Rwanda - Hon. Dr. Diane Gashumba • Representative from ICASA 2019 Youth Programme Committee - Spiwe Dongo • Youth Friendly Spaces in Africa—Rihab Blidi • Raising the next generation to address the HIV Response through Mentorship—Nana Amoako Acheampong • Learning through young people left behind: Addressing SRHR, HIV and mental health needs of young people living with HIV—Musah Mumumba
16:00 - 17:00	Breakout Sessions	• Let's talk, engage and support one other! A dedicate space for young people living with HIV-- Global Network of young people living with HIV, Y+ Kigali hope Association, KHA (Rwanda young people living with HIV network) - Kosisochukwu Uneh, Cedric Nininahazwe & Alex Karamuna • Word off SBGV & HIV-AfriYAN Ghana & Youth Changers Kenya - Edith Asamani & Venoranda Kuboka • Data dealers in HIV Prevention Advocacy—Teenseed Africa & Athena Network - Winne Obure & Nyasha Sitholi
17:00 - 18:00	Closing Plenary	• Closing remarks • Youth Declaration • Dance performance: T-Queens (Our stories retold

PRE-CONFERENCE DES JEUNES

DAY Lundi 01 Décembre 2019

Time: 14H - 18H **Lieu:** Kigali Room(Main Auditorum)

Modérateurs:
Dr. Cherise Umutoni Gahizi, Medical doctor, King Faisal Hospital
Nii Adjetey Ashiboe-Mensah, ICASA 2019 Youth Committee
Gloria Nawanyaga, Moderateur de la Plénières d'ouverture

Temps	Activité	Personnes en charge
13:00 - 14:00	Inscription	Bénévoles
14:00 - 14:30	Allocution de bienvenue	**Orateurs** • Un représentant des leaders du groupe des jeunes de ICASA 2019 • Président de la SAA • Invités (À déterminer, UNFPA, Fonds Mondial, Première dame du Rwanda) • Ministre de la jeunesse et des TIC du Rwanda • Un invité (À déterminer)
14:30 - 16:00	Plénières d'ouverture	Ministre de la jeunesse et des TIC du Rwanda Youth Friendly Spaces in Africa—Rihab Blidi Raising the next generation to address the HIV Response through Mentorship—Nana Amoako Acheampong • Learning through young people left behind: Addressing SRHR, HIV and mental health needs of young people living with HIV—Musah Mumumba
16:00 - 17:00	Séances de groupes	• Let's talk, engage and support one other! A dedicate space for young people living with HIV-- Global Network of young people living with HIV, Y+ Kigali hope Association, KHA (Réseau des jeunes rwandais vivant avec le VIH)

Temps	Activité	Personnes en charge
17:00 - 18:00	Plénières de clôture	• Session de données de l'UNFPA • Déclaration des jeunes • Performance de danse: T-Queens (Our stories retold)

YOUTH PAVILION ACTIVITIES

ACTIVITY	DATE/TIME	SPEAKERS/ ORGANISERS	FORMAT
Rainbow realities: a sneak peek into the lives of young lgbtiq persons in bulawayo	3/12/2019 10: 45-12:15	NeoteriQ The Sexual Rights Centre (SRC)-Zimbabwe	• Screening • Open Mic session
Our Stories Retold	3/12/2019 12: 45-14:15	• Anna Foundation Uganda • Icebreakers Uganda	• Storytelling • Interpretive Dance • Poetry
The Outspoken Beauty Beauty is not appearance, it is a state of mind...	3/12/2019 14: 45-16:15	UNFPA YoLe Fellows Ghana	Make-up, hair styling and facial therapy sessions.
Orange Farm Dance	3/12/2019 16: 45-18:15	• Orange Farm Dance Theatre • Dinganga Theatre Creation	• Dance session • Cultural Exchange
SLOT FOR YOUNG PEOPLE WITH DISABILITIES	4/12/2019 10: 45-12:15	To Be Determined	• Book reading • Video screening • Interactions
l'importance du dépistage des sujets exposes au VIH a partir d'un cas index	4/12/2019 12: 45-14:15	ALCONDOMS CAMEROUN	Interactive discussion
Human Centered Design Workshop	4/12/2019 14: 45-16:15	UNFPA YoLe Fellows Ghana	• Capacity Building • Ideation
The Power of Creative Performance and Arts	4/12/2019 16: 45-18:15	Public Health Ambassadors Uganda (PHAU)	Creative Dance & Performance Workshop
"Yoga-laxation: Soften the Seroiousness"	5/12/2019 10: 45-12:15	UNFPA YoLe Fellows Ghana	Health & Wellness

Youth Pre-Conference/ Pré-Conférence des Jeunes

ACTIVITY	DATE/TIME	SPEAKERS/ ORGANISERS	FORMAT
Using Sports To Engage Men Around HIV	5/12/2019 12: 45 - 14:15	Grassroot Soccer Zimbabwe	• Sports/Physical Activity • Interactive discussion
The Photo Myriad	5/12/2019 14: 45-16:15	UNFPA YoLe Fellows Ghana	• Augmented reality • Photo Booth
MEN ENGAGE AFRICA	5/12/2019 16: 45-18:15	Sonke Gender Justice and MenEngage Africa Youth	• Community Dialogue • Interactive discussion
Alone Not Alone	6/12/2019 10: 45-12:15	Zimbabwe Men Against HIV and AIDS (ZIMAHA)	• Live Screening
Lunch time is Crunch time	6/12/2019 12: 45-14:15	Athena Network	• Power Talks
Sexually Abused but not Broken: A Sneak Peek and Reading of my New Book " MY STRENGTH"	6/12/2019 14: 45-16:15	People In Need Agency - PINA Uganda	• Book reading • Video screening • Interactions
SRH chat	6/12/2019 16: 45-18:15	Smoooth Chat	• Performaces • Panel Discussion

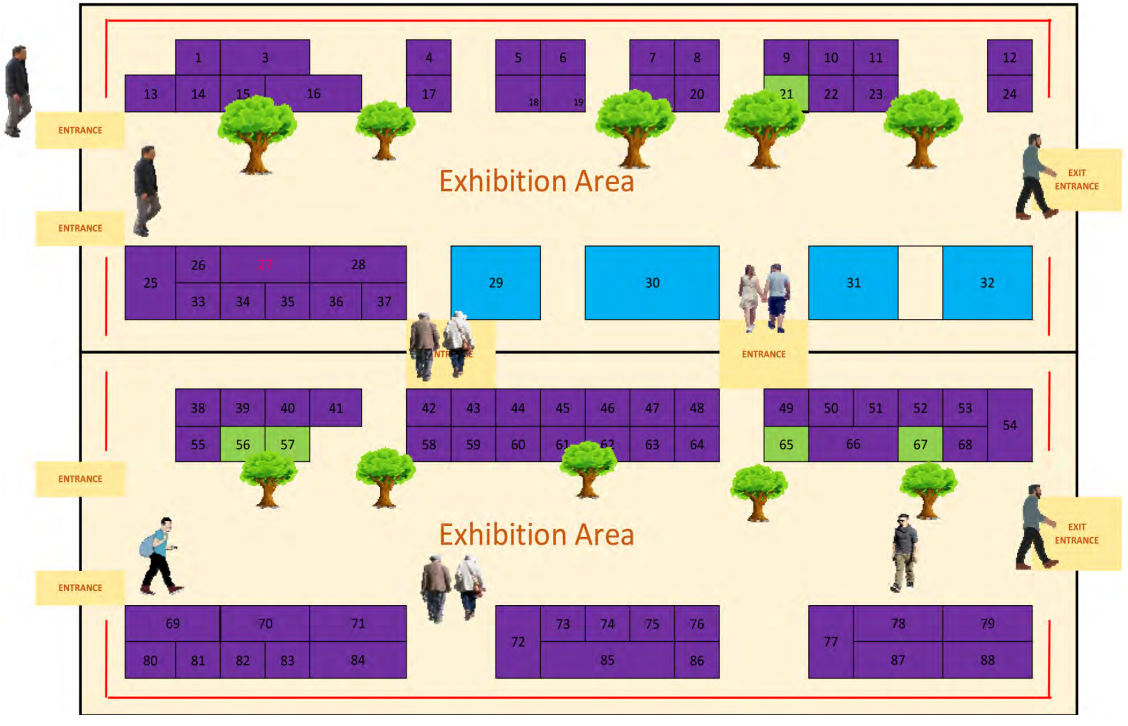
EXHIBITORS / EXPOSANTS

ORGANIZATION/ ORGANISATION	BOOTH NUMBER/ NUMERO DU STAND
Abbott	29
AFRICA BIOSYSTEMS LIMITED	35
AFRICA SYNERGY GROUP PLUS	64
AIDS Healthcare Foundation (AHF)	60
AMSHeR	82
ANCS	45
AUROBINDO PHARMA LTD	77
AVACARE HEALTH	54
AV-Jeunes/eCentre Convivial	68
BD Biosciences	37
Biocentric	50
bioLytical Laboratories, Inc.	75
BIOSYNEX SA	86
Cepheid	26
Chembio Diagnostic Systems, Inc	74
Chemonics International	48
Diagnostics for the Real World Ltd	31
Expertise France	72
FHI 360	8
Gilead	25
Guangzhou Wondfo Biotech Co., Ltd.	87
Health Development Initiative	84
HIV Vaccine Trials Network (HVTN)	91
Hologic	79
Human Gesellschaft fuer Biochemica und Diagnostica mbH	55
Humana People to People	12
Humanitarian Startup Investment	47
HUMENSIS/BELIN INTERNATIONAL	39
IAS	83
ICAP at Columbia University	42
INTEC PRODUCTS, INC (XIAMEN).	36
International Partnership for Microbicides	58
International Treatment Preparedness Coalition	59
Ishtar msm	46
Johnson & Johnson Global Public Health	78

ORGANIZATION/ ORGANISATION	BOOTH NUMBER/ NUMERO DU STAND
KAREX	24
Laurus Labs Limited	32
Le Reseau Eva	52
Ministere de la Sante et de la Population / PNLS - Congo	5
mothers2mothers	33
MSD	18
MSF	1
Mylan	30
National AIDS Control Council-Kenya	22
National AIDS Control Programme - Tanzania	6
National AIDS Council-Zimbabwe	17
National AIDS/STI Control Programme (Ghana Health Service)	11
NASCP	3
Omega Diagnostics Ltd	40
OraSure Technologies Inc	27
Plateforme ELSA	7
Population Council	43
Population Services International	85
Premier Medical Corporation	76
PROGRAMME NATIONAL DE LUTTE CONTRE LE VIH SIDA	66
QIAGEN	34
RBC	62
RCB	61
ROJALNU/BF	53
RwandaAir	23
SADC- SRHR 2030 "Community of Policy and Practice"	9
SAfAIDS	13
Savics	19
Selenium Education and Research Centre	51
Society for AIDS in Africa	16
Sysmex South Africa	73
Tanzania Biotech Products Limited	63
The Female Health Company	41
Trans Smart Trust	44
Trinity Biotech	38
U.S. Census Bureau	49
UGANDA AIDS COMMISSION	14

ORGANIZATION/ ORGANISATION	BOOTH NUMBER/ NUMERO DU STAND
UN Women	81
UNAIDS	70
UNFPA	69
UNICEF	80
University of Oxford, Global Health Network	4
ViiV Healthcare	28
Virology Education	10
WHO	71

EXHIBITION HALL / CENTRE D'EXPOSITION



3mx3m Expo Booths
Expo Mega Booths x7
Seating Area
Poster Area
Slot Not Available

EXHIBITION HALL / CENTRE D'EXPOSITION

Together We Can End HIV

Gilead is committed to
eliminating HIV across Africa.

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GILEAD

Plenary Sessions/ Session Plénière

TIME	08:45 – 10:15 hrs	ROOM	Main Auditorium (Kigali Room)	DATE	Tuesday, 03 December 2019

Chairs: Winnie Byanyima, Prof. Tandakha Dieye and Rokhaya Nguer

Plenary Topic:
Towards developing a globally effective HIV vaccine

Speaker:
Prof. Lawrence Corey,
Professor of Medicine & Laboratory Medicine, University of Washington

Dr. Lawrence Corey is a member of Fred Hutchinson Center Research Center, professor of Medicine and Laboratory Medicine at the University of Washington, and past president and director of Fred Hutch. Dr. Corey is also principal investigator of the HIV Vaccine Trials Network, an international collaboration of scientists and institutions dedicated to accelerating the development of HIV vaccines. His honors and awards include election to the National Academy of Medicine and the American Academy of Arts & Sciences. He is also the recipient of the American Society of Microbiology Cubist Award for lifetime achievement in his role in the development of antivirals for the treatment of herpes viruses and HIV.

Plenary Topic:
African Heads of State towards AIDS Free Africa: What does it take!

Speaker:
Her Excellency Mukabalisa Donatille,
Speaker of the Chamber of Deputies of the Parliament of Rwanda

Her Excellency Mukabalisa Donatille, the Speaker of the Chamber of Deputies of the Parliament of Rwanda is Rwandese by nationality. She has a great experience in political affairs. She also worked in the private sector as well as in the United Nations system.

Since 1981 to 1998, she worked for the United Nations Development Program in Kigali in various positions. Before joining Parliamentary activities in 2000, she was an independent Consultant in project management. Since July 2000, she was a Member of the Rwanda National Transitional Assembly and Deputy Chairperson of the Standing Committee on Economy and Trade up to 2003.

In 2003 there were general parliamentary elections and she was elected Member of the Chamber of Deputies on the list of the Liberal Party and was elected Deputy Chairperson of the Standing Committee on Political Affairs and Gender.

Since October 2011, she was a Senator, Deputy Chairperson of the Standing Committee on Political Affairs and Good Governance (Upper Chamber).

On 4th October 2013, she was elected as Speaker of the Chamber of Deputies/

Parliament of Rwanda and reelected on 19th September 2018.

Plenary Topic:
Health Financing; community and private sector engagement for increased domestic funding

Speaker:
Ms. Rosemary W. Mburu, Mph,
Executive Director for WACI Health

Rosemary W. Mburu, MPH (@rosemarymburu, @WACI_ Tweets) has been a champion for healthy communities for over fifteen years and currently serves as the Executive Director for WACI Health. Mburu is a civil society leader in Africa and has extensively worked on supporting civil society to engage with decision makers at community, national, regional and global levels. She is a civil society organizer working on building and strengthening civil society networks and platforms on health-related advocacy and campaigning in Africa. Her contribution in building spaces that facilitate Africa civil society's engagement and participation in Global Health include, the Civil Society Platform on Health in Africa (CiSPHA), Global Fund Advocates Network (GFAN) Africa Hub, and Africa Free of New HIV Infections (AfNHi).

In her day-to-day work, Ms Mburu works to create political will towards improved health outcomes for all in Africa by engaging with governments, key multilateral and bilateral institutions such as World Health Organization, the Global Fund, the Stop TB Partnership, and the World Bank. Mburu has served on various global health institution's governing structures including the UHC2030 Steering Committee and UNITAID Communities Advisory Group.

Ms. Mburu Holds a Masters in Public Health from Ohio University, a Masters in Business Administration from Frostburg State University, Maryland, and a Bachelor of Education from Kenyatta University, Kenya.

TIME	08:45 – 10:15 hrs	ROOM	Main Auditorium (Kigali Room)	DATE	Wednesday, 04 December 2019

Chairs: Benjamin Djoudalbaye, Dr. Olusegun Odumosu and Prof. Aristophane Tanon

Plenary Topic:
Operationalizing the implementation of innovative biomedical prevention (PrEP, microbicides, and long acting ARVs)

Speaker:
Prof. Linda-Gail Bekker,
COO, Desmond Tutu HIV Foundation

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP(SA), PhD is the Deputy Director of the Desmond Tutu HIV Centre at the Institute of Infectious Disease and Molecular

Medicine, UCT and Chief Operating Officer of the Desmond Tutu HIV Foundation. Linda-Gail is a physician scientist and has a keen interest in HIV, Tuberculosis and related diseases. Her research interests include programmatic and action research around HIV treatment roll out and TB integration, prevention of HIV in a women, youth and men who have sex with men.

She has contributed to a number of publications emanating from the Desmond Tutu HIV Centre on topics relevant to the South African HIV and TB epidemics. In her role in the Foundation, she is passionate about community development. She is also immediate past President of the International AIDS Society.

Plenary Topic:
Promote stronger Community led leadership for ending AIDS in Africa.

Speaker:
Magatte Mbodj
Executive Director of the National Alliance of Communities for Health in Senegal (ANCS)

She has more than 18 years' experience in the management of health programmes, specifically in the fight against STIs and HIV/AIDS, the supervision of civil society organisations and the training of trainers in the fields of sexually transmitted infections and HIV infection, sexual and reproductive health, community system strengthening (CSS), advocacy, organisational development and nutrition. She is coordinating two regional programmes funded by the Global Fund and Intrahealth/USAID in 6 West African countries (Senegal, Burkina Faso, Cote d'Ivoire, Guinea Bissau, Cape Verde and Burundi).

She is a member of Senegal's CCM, as a Civil Society Principal Recipient (PR). She participates, as an HIV expert, in all strategic sessions and meetings at the national and international levels, as well as in the preparation of framework and resource mobilization.

Since 2005, she held the position of Executive Director of the National Alliance of the Communities for Health (ANCS), Principal Recipient of the Global Fund since 2005 for all HIV/AIDS interventions on behalf of civil society organizations.

She hold a Diploma of Advanced Professional Studies (Master) at Léopold S. SENGHOR University, Alexandria, EGYPT, Option: Community Nutrition and a Certificate of Competency for Medium Technical and Vocational Education (C.A.E.M.T.P.) at ENSETP, Cheick Anta DIOP University, Dakar, Senegal, Option: Social and Family Economy (4 years after Bachelor's Degree).

Plenary Topic:
Integrating HIV care with emerging infections, comorbidities, and NCDs.

Speaker:
Prof. Wafaa El-Sadr
Director of ICAP - Columbia University

Wafaa El-Sadr, MD, MPH, MPA is a University Professor of Epidemiology and Medicine at Columbia University, the director of ICAP at Columbia University, and director of the Global Health Initiative at the Mailman School of Public Health.

Dr. El-Sadr founded ICAP, a global health center situated at the Columbia Mailman School of Public Health, which is focused on addressing major global health threats, and health systems strengthening that provides technical assistance, implementation support through strengthening health systems in partnership with governmental and non-governmental organizations in more than 30 countries around the role. In this role, she leads the design, implementation, scale-up, and evaluation of large-scale programs and research including on HIV, tuberculosis, malaria and maternal-child health among other public health challenges.

Dr. El-Sadr is a prominent researcher and has led numerous epidemiological, clinical, behavioral, and implementation science research studies. She is a principal investigator of the NIH-funded HIV Prevention Trials Network (HPTN), which seeks to prevent HIV transmission, globally.

Dr. El-Sadr was named a John D. and Catherine T. MacArthur Foundation Fellow and is a member of the National Academy of Medicine. In 2013, she was appointed University Professor, Columbia's highest academic honor. She is a fellow of the African Academy of Sciences. She also holds the Dr. Mathilde Krim-amfAR Chair in Global Health at Columbia University.

TIME	08:45 – 10:15 hrs	ROOM	Main Auditorium (Kigali Room)	DATE	Thursday, 05 December 2019

Chairs: Dr. Placidie Mugwaneza, Dr. Christine Kaseba Sata and Francois Xavier Karangwa

Plenary Topic:
What will it take to achieve EMTCT and 90-90-90 goals for children in Africa?

Speaker:
Dr. Dorothy Mbori-Ngacha
Senior HIV Specialist, UNICEF

Dr. Dorothy Mbori-Ngacha is the Senior HIV Specialist on Elimination of Mother to Child Transmission and Paediatric treatment for UNICEF's Global HIV/AIDS programmes. She is a medical epidemiologist specializing in paediatrics and child health.

Dr. Mbori-Ngacha brings extensive experience from the public sector, academia,

the NGO community and international organizations. to her current role where she also focuses on inter-agency collaboration within the UN and with other partners to achieve global targets. She holds a Medical Degree and a Master of Medicine in Paediatrics from the University of Nairobi; and a Master's in Public Health from the University of Washington.

Plenary Topic:
Stronger positioning of women leadership in Africa for the HIV response

Speaker:
Tshepo Ricki Kgositau
Executive Director, Accountability International

Tshepo Ricki Kgositau's professional background is in International Relations with a speciality in International Human Rights Law and Diplomacy from Monash University. Ricki is passionate about legal and policy reform within the region as a means to advancing socio-economic justice and accountability; she recently won a constitutional case seeking legal gender recognition in the High Court of Botswana in 2017.

Mrs.Kgositau-Kanza is the former Director of Gender DynamiX; the first and oldest trans focused NGO in Africa and a stalwart in movement building having co-founded a subregional collective of trans organisations called the Southern Africa Trans Forum (SATF).

Ricki is also a 2016 Mandela~Washington Fellow. She is currently the Executive Director of Accountability International; making her the first Black-Young-African-Transgender-Woman to head up an international NGO.

Accountability International's work is focused on holding leaders accountable for human rights, international as well as continental human rights law, policy and developmental commitments they are signatory to; as way to increase accountability towards those still left behind or excluded.

Plenary Topic:
Accessing services for People living with disabilities

Speaker:
Prof. Seni Kouanda,
Medical Epidemiologist

Medical epidemiologist, senior researcher and head of the public health department of "Institut de Recherche en Sciences de la Santé" (IRSS), professor of epidemiology and deputy director of "Institut Africain de santé publique"(IASP), EDCTP senior research fellow.

He has carried out research on various topics including HIV/AIDS, reproductive health,

nutrition, infectious diseases, and health system research. His is widely published in peer review journals with more than 120 journal articles. He has conducted researches for many funders (EDCTP, UNICEF, WB, UNFPA, WHO, USAID, EU, IDRC) in the context of several West African countries.

TIME	08:45 – 10:15 hrs	ROOM	Main Auditorium (Kigali Room)	DATE	Friday, 06 December 2019

Chairs: Dr. Charles Kouanfack, Dr. Natalia Kanem and Daouda Diouf

Plenary Topic:
How to optimize second and third line ARV regimens and prevent HIV drug resistance through differentiated care in Africa

Speaker:
Dr. Tendani Gaolathe
Assistant Program Director, Department of Internal Medicine - University of Botswana

Dr. Tendani Gaolathe is a lecturer in the Department of Internal Medicine. She chairs and serves on the Ministry of Health and Wellness' National HIV/AIDS Treatment Guidelines Committee, and advisory to numerous technical working groups. She also serves as a research associate at the Botswana Harvard AIDS Institute Partnership and is currently assisting Rutgers Global Health Institute in laying the groundwork for collaboration between Rutgers and the University of Botswana.

Through the Botswana Harvard AIDS Institute Partnership's PEPFAR training and capacity building program, Dr. Gaolathe has served as Principal Investigator on two cooperative agreements and led the Botswana Harvard Master Trainer treatment and education effort, which has been instrumental in the successful rollout of antiretroviral treatment clinics, task shifting, laboratory decentralization, and national monitoring and evaluation efforts in Botswana. Previously, Dr. Gaolathe worked at Princess Marina Hospital in Gaborone, first as a specialist in internal medicine. and then as interim director of the facility's antiretroviral drug clinic.

A native of Botswana, Dr. Gaolathe earned her medical degree from St. George's University in Grenada and completed her medical residencies at St. Michael's Medical Center in Newark, New Jersey.

https://www.ncbi.nlm.nih.gov/pubmed/?term=gaolathe

Plenary Topic:
Political Leadership to advance SDG 3 and promote inclusivity of vulnerable populations

Speaker:
Ms Cindy Kelemi
Executive Director, BONELA

Ms Cindy Kelemi is the Executive Director of the Botswana Network on Ethics, Law and HIV/AIDS. Ms Kelemi, is a renowned activist who has impacted the response to HIV/AIDS, in Botswana, regionally and internationally.

While at BONELA, Ms Kelemi coordinated the first ever Treatment Literacy Programme in Botswana, which empowered over 50000 people living with HIV/AIDS with the science of HIV, the benefits of treatment and associated side effects. This became the biggest HIV movement in Botswana, which advocated for access to TB/HIV services, monitoring of drug stock outs and holding duty bearers accountable for service delivery while advocating for inclusive and enabling policy and legal environment. The highlight of her career, was when the organisation she leads, BONELA, successfully petitioned the government of Botswana, through the courts, to ensure provision of HIV treatment to foreign prisoners held within Botswana prisons.

Ms Kelemi joins other activists, to call for an end to dwindling donor support for the AIDS response, complacency, lack of accountability, the rising new infections among AGYW, lack of rights based and community centred approaches, criminalisation of HIV and most at risk and vulnerable groups such as Sex Workers and MSM - among many challenges facing the end of AIDS today.

Plenary Topic:
Community Innovation and Technology to ending AIDS

Speaker:
Dr. Olawale Felix Fadare
Senior Technical Advisor (Outcomes & Evaluation), Caritas Nigeria

Dr. Fadare is a public health physician with 15 years' experience in Nigeria's HIV response. He is currently Senior Technical Advisor in a Caritas Nigeria HIV project delivering ARVs to over 51,000 persons living with HIV through 197 hospitals in southern Nigeria. He leads a 40-person Strategic Information team and is a focal point for the GRAIL (Galvanizing Religious Leaders for Accelerated Identification and Linkage to Pediatric ART) project which uses innovative case identification strategies to identify HIV positive children in faith communities.

He obtained his medical degree from the University College Hospital, Ibadan and has undergone training at the National Postgraduate Medical College of Nigeria, the University of Stellenbosch South Africa as well as numerous certifications specific to the HIV sector. He is presently the Curator for the Society for HIV Care Clinicians in Nigeria (SHCCIN).

TIME	08:45 – 10:15 hrs	ROOM	Main Auditorium (Kigali Room)	DATE	Saturday, 07 December 2019

Chairs: Lillian Mworeko, Julian Kerboghossian and Kemi Gbadamosi

Plenary Topic:
Community based monitoring for quality service delivery.

Speaker:
Wame Mosime
Director of Global Programs and Advocacy

She currently manages all of ITPC's programmatic and strategic pillars - #TreatPeopleRight #WatchWatchMatters #MakeMedicinesAfforable – across global regions (i.e. Latin America and Caribbean, Eastern Europe and Central Asia, Middle East and North Africa, East Africa, West Africa, and Asia).

Ms. Mosime has worked within the civil society and development partner sectors for the over 18 years, and has a wide range of expertise includes resource mobilization, policy development, advocacy, community dialogue, community and health systems strengthening, costing analysis and developing innovative practices that engage non-conventional partners in the HIV-response.

Plenary Topic:
Youth leadership at the centre of the HIV response

Speaker:
Gouem Phadylatou,
Statistician

GOUEM Phadylatou, ingénieur statisticienne gestionnaire de travaux, née le 07 /01/1993 à Ouagadougou avec une malformation congénitale, est une fille handicapée motrice d'une mère ménagère et d'un père homme d'affaire. Passionnée du social, elle s'est lancée dans la vie associative avec l'Association des Elèves et des Etudiants Handicapés du Burkina qu'elle a quitté en 2019 pour fonder l'Association Vivre de Nouveau.

Elle est aussi membre de Pan African Female Youth Leaders/Burkina Faso et de l'Association Flamme d'Espoir pour l'Emergence des Jeunes. Son ambition étant d'apporter le sourire aux autres.

Plenary Topic:
Addressing social structures to increase access to service and agency for Adolescent Girls and young women.

Speaker:
Sandrine Umutoni
Director General, Imbuto Foundation

Sandrine Umutoni, Director General of Imbuto Foundation Sandrine Umutoni is passionate about Rwanda, social studies, the arts, and discovering new cultures. In 2015, Sandrine began her work at Imbuto Foundation, an organisation that aligns its work to the country's priorities, by contributing to the development of a healthy, educated, and prosperous society. Starting from the Communications Unit, Ms. Umutoni was later appointed in 2016, as the Foundation's Director General.

Before joining Imbuto Foundation, Ms. Umutoni worked in education; for various institutions for research; and promoted access to literature and the arts, for diverse members of the community. Ms. Umutoni pursued her education in international relations, communications and translation on three continents, and is also creative at heart, who published her first children's book in 2016.

Notes

20 YEARS
AFTER ABUJA – WHAT NEXT?

DATE: 5TH DECEMBER 2019 | TIME: 10:45 – 12:15

Welcome and Introduction of the Session
Dr. Meskerem Grunitzky/ Dr. Ihab Ahmed

Review of Commitments on HIV Financing (From Abuja to Kigali)
Winnie Byanyima (UNAIDS EXD)
H.E. Amira Elfadil Mohammed Elfadil (Social Affairs Commissioner - AUC)

Thinking outside the commitments: Bringing Accountability to the Fore
Ricki Kgositau (AI EXD)

The role of the Community: Community Asks
Yvette Raphael Alta (AVAC)

HIV Prevention and Testing: What needs to change?
Rosemary Mburu (WACI EXD)

Addressing Key Populations: The Egypt KP Case Study
Amar Anad

Discussions : *Dr. Meskerem Grunitzky/ Dr. Ihab Ahmed*

Conclusions and Recommendations
Dr. Meskerem Grunitzky/ Dr. Ihab Ahmed

Session Room: Prof. Madeleine Okome (MH 3)
Venue: Kigali Conference Centre, Kigali, Rwanda

TIME	10:45 – 11:00	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Tuesday, 03 December 2019

Track A: Basic Science (Biology & Pathogenesis)

HIV Transmission, latency Reservoir and Diagnostic tools

Chair: Cheryl Johnson

TUAA0101 - TRACK A1

Feeding Options and Mother-to-Child Transmission of HIV: Evidence Over Years Support Exclusive Protected Breastfeeding

10:45 – 11:00

Nguefeu Nkenfou Céline[1], Moudourou Sylvie[2], Kamgaing Nelly[1], Fokam Joseph[1], Nanfack Aubin[1], Ngoufack Marie Nicole[1], Mekue Mouafo Linda Chapdeleine[3], Yatchou Laeticia Grace[1], Ndjolo Alexis[1]

[1]Chantal Biya International Center for Research on the Prevention and Management of HIV / AIDS (CIRCB), Yaoundé, Cameroon, [2]CIRCB, Yaoundé, Cameroon, [3]University of Dschang, Dschang, Cameroon

Background: Prevention of mother to child transmission of HIV initiated in Cameroon in 2010 with option A, where HIV infected mother were selectively put on antiretroviral treatment, with recommendations of breastfeeding infant accompanied to NVP prophylaxis. In 2014, national guidelines switched to option B+ where all infected mothers were put on lifelong ART despite the immune state or viral load, with protective breastfeeding. Thus, the effect of feeding option remain incompletely understood in the B+ era. Our objective was to determine the effects of various feeding options on transmission of HIV from mother to child over a 5-years timeframe.

Methods: Retrospective data analysis was carried out on Early Infants diagnosis (EID) data covering maternal treatment history, PMTCT interventions, infant feeding options and HIV status. Data presented as means and percentage, and p-value< 0.05 considered significant using Fisher Test.

Results: Over ten years 39816 mothers were enrolled in the study. Enrolled children include 19668 male and 19706 female. Overall positivity was 8.24%. According to feeding option, cumulated data from the early Infant Diagnosis showed that MTCT is 4.9% (exclusive breastfeeding), 10.82% (mixed feeding) and 3.22%(artificial feeding), p=0.00001. Until 2017, there was a significant difference between the transmission under exclusive feeding and artificial feeding (OR: 1.57 CI 95% 1.126-2.190, p=0.007). But as from 2018, there was no significant difference between the two feeding options in exposed infants (OR: 1.304; CI 95% 0.534-3.188, p=0.559).

Conclusion: Over the years, breastfeeding, is proving to be the best feeding option for infants, and especially in HIV exposed infants as long as WHO recommendations are observed. Advantages of breastfeeding are undeniable; this strengthens the WHO recommendations as ART is been accessible to all, supporting the value of breastfeeding in our context.

TUAA0102 - TRACK A1

Cellular Pathways and Virus-host Interactions Essential for the Emergence of HIV from Latency

11:00 – 11:15

Mbonye Uri, Kizito Fredrick, Karn Jonathan

Case Western Reserve University, Molecular Biology and Microbiology, Cleveland, United States

Background: Inability to eradicate HIV infection in patients adhering to potent antiretroviral therapy has been attributed to persistent reservoirs of transcriptionally latent HIV proviruses in a tiny fraction (approximately 60 per 106) of memory CD4+ T cells in both peripheral blood and lymphoid tissues. Reactivation of latent HIV transcription is mediated by assembly of a super elongation complex (SEC) at the

proviral promoter following recruitment of the host transcription elongation factor P-TEFb from a nuclear transitional complex called 7SK snRNP by the viral accessory protein Tat. The current project was therefore aimed at investigating the biochemical and cellular mechanisms essential for the biogenesis and activation of P-TEFb in memory T cells and its recruitment by Tat to proviral HIV.

Methods: Resting memory CD4+ T lymphocytes or latently infected primary Th17 cells were activated by co-stimulation of the T-cell receptor (TCR) or treated with agonists or inhibitors targeting specific TCR signaling pathways. Immunofluorescence flow cytometry and high resolution microscopy were employed to monitor inducible expression of P-TEFb and the assembly and/or the subcellular distribution of Hsp90/Cdc37/CDK9, 7SK snRNP, SEC, RNA polymerase II, Tat and HIV RNA.

Results: Upon TCR activation of resting memory cells, P-TEFb assembly is initiated by synthesis of the Cyclin T1 subunit of P-TEFb and exchange of the CDK9 subunit from an Hsp90/Cdc37 cytoplasmic complex to 7SK snRNP. Subsequently, there is a nuclear exchange of P-TEFb between the 7SK RNP complex and Tat. These molecular processes are regulated by specific post-translational modifications. PKC agonists produced a significant elevation of P-TEFb in latently infected Th17 cells which correlated with increased proviral reactivation. Calcium ionophore elevated Cyclin T1 expression and was sufficient to induce a noticeable reactivation of latent HIV. Inhibitors of PI3K, mTORC1 and 2, or casein kinase II substantially blocked P-TEFb induction due to TCR activation and partially suppressed TCR-induced proviral reactivation.

Conclusions: Reactivation of P-TEFb and latent HIV are mediated by multiple complementary T-cell signaling pathways. These results highlight the critical role of P-TEFb in the reactivation of HIV and suggest that distinct activators of P-TEFb may need to be developed to target incurable HIV reservoirs in the memory T-cell population of virally suppressed individuals.

TUAA0103 - TRACK A1

Validation du Point of Care (POC) m-PIMA™ HIV-1/2 Viral Load (Abbott) dans la Quantification du VIH-1 pour l'Atteinte des 90-90-90 au Sénégal

11:15 - 11:30

Diop Ndiaye Halimatou[1], Sene Pauline[1], Ndiaye Ousseynou[2], Diallo Sada[1], Ndiaye Kine[3], Ngom Ndèye Fatou[4], Ngom Gueye Ndèye Fatou[3], Raymond Alice[5], Kiernan Brianan[6], Toure-Kane Coumba[7]

[1]Laboratoire de Bactériologie Virologie CHNU Aristide le Dantec, Dakar, Senegal, [2]Institut de Recherche en Santé, de Surveillance Epidémiologique et de Formation (IRESSEF), Dakar, Senegal, [3]Centre de Traitement Ambulatoire, Centre Hospitalier Universitaire de Fann SMIT, Dakar, Senegal, [4]UNICEF, Dakar, Senegal, [5]Clinton Health Access Initiative (CHAI), Dakar, Senegal, [6]Clinton Health Access Initiative, Dakar, Senegal, [7]Institue of Health Research Epidemiological Surveillance and Training (IRESSEF), Dakar, Senegal

Contexte: Dans la perspective de l'atteinte des 3X90 d'ici 2020, l'introduction des POC peut améliorer les délais d'exécution et de rendu des résultats de la quantification de la charge virale (CV) du VIH. Leur utilisation apparait comme une stratégie complémentaire au système de laboratoire conventionnel. Cependant l'évaluation de ces nouveaux tests s'impose afin de garantir la qualité des résultats. L'objectif de cette étude était d'évaluer les performances du test m-PIMA™ HIV-1/2 Viral Load (Abbott) avec le test Abbott HIV-1 Real Time® Assay (Abbott) pris comme référence.

Methodes: L'évaluation du test m-PIMA™ a porté sur un total de 527 échantillons, incluant 427 plasmas choisis sur la base de leur valeur de CV disponible par la technologie de Abbott et 100 échantillons de sang total prélevés de manière prospective chez des patients vivants avec le VIH dans 7 structures de santé de Dakar, Sénégal. Tous les échantillons (plasma et sang total) ont été testés par le m-PIMA™ sur une prise d'essai (pe) de 50µl et les 100 derniers ont également bénéficié d'un test Abbott HIV-1 à partir du plasma (pe=600µl). L'analyse des performances a été faite après une conversion logarithmique des valeurs de CV et le calcul de la différence de

log (D-log) avec un seuil de significativité de D-log supérieure à 0,5. Les performances ont été évaluées par le calcul de la sensibilité (Se), la spécificité (Sp), la corrélation avec la droite de régression ainsi que la concordance par le diagramme de Bland-Altman.

Resultats: Les résultats du test de charge virale m-PIMA™ HIV-1/2 Viral Load et du Abbott HIV-1 Real Time® Assay ont été obtenus pour 519 échantillons (02 résultats invalides avec Abbott et 06 avec m-PIMA™) ; 471 étaient concordants (D-Log≤0,5) et 48 étaient discordants (D-Log>0,5) avec 42 échantillons surestimés par Abbott pour des valeurs de CV>3,0 log copies/ml. Une bonne corrélation et une bonne concordance ont été notées entre les deux techniques avec un coefficient de corrélation r=0,96 et un biais de -0,0089 log10 copies/ml, (IC à 95%=- 0,0115 à 0,0063). La Se et la Sp étaient respectivement de 93% et 99% pour un seuil de détectabilité à 2,9 log10 copies/ml et de 95% et 99% pour un seuil à 3,0 log copies/ml.

Conclusion: Ces résultats montrent que le test m-PIMA™ HIV-1/2 Viral Load présente de bonnes performances malgré le faible volume d'échantillon utilisé. C'est donc un outil prometteur pour la décentralisation de la CV du VIH au Sénégal.:

TUAA0104 - TRACK A1

Evaluation of GeneXpert HIV-1 Qual (Cepheid) and Alere™ Q HIV1/2 Detect (Abbott) to Improve HIV Early Infant Diagnosis in Senegal

11:30 – 11:45

Sow-Ndoye Aissatou[1], Diop- Ndiaye Halimatou[2], Séne Pauline Yacine[2], Diack Aminata[3], Adama Sylvie[2], Diop Khady[2], Ngom Ndeye Fatou[4], Coulibaly Khadidiatou[5], Raymond Alice[6], Kiernan, Briánn[6], Boye Cheikh Saad Bouh[2], Toure-Kane , Coumba[7]

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Background: HIV Early Infant Diagnosis (EID) is a crucial component of Prevention of Mother-To-Child Transmission (PMTCT) programs and therefore necessary to reach the 90-90-90 targets by 2020. In resource-limited settings, the introduction of point-of-care (POC) technologies has the potential to improve turnaround time and as result, improve outcomes for HIV exposed infants. This study aimed to evaluate the performance of the GeneXpert HIV-1 Qual Assay (Cepheid) and Alere™ q HIV1/2 Detect (Abbott) for EID.

Materials and methods: The performance of the GeneXpert assay was evaluated with a total of 175 samples including 88 Dried Blood Spot (DBS) specimens collected retrospectively from a biobank (60 negative and 28 positive samples) and 87 whole blood samples (WBS) collected prospectively in children exposed to HIV from 7 health sites in Dakar, Senegal. The Alere™ q test was evaluated using 87 HIV-1 WBS, 4 HIV-2 WBS and 1 HIV 1 /2 WBS.

The Roche Cobas AmpliPreP/Cobas TaqMan HIV-1 Qual (CAP/CTM) was used as the reference for HIV-1 results using DBS and WBS specimens to determine the performance of GeneXpert and Alere q. The Generic HIV-2 VL (Biocentric) was used as a reference for HIV-2 samples. The analytical performance was assessed using sensitivity (Se), specificity (Sp), positive predictive value (PPV), negative predictive value (VPN) and Cohen kappa coefficient.

Results: For HIV-1 detection, no discrepancies were found with GeneXpert DBS samples (n=88) , GeneXpert WBS (n=87), or Alere q WBS (n=87), showing 100% [95% CI: 93.9-100%] sensitivity, 100% [95% CI:97.5-100%] specificity, 100% [95%CI:93.9-100%] PPV and 100% [95%CI:97.5-100%] NPV. The consistency with CAP/CTM was 100% with a Kappa coefficient of 1 ($p < 0.001$, 95%CI) for both techniques.

For HIV-2 detection, only five samples were tested with Alere q and Generic Biocentric

showing perfect consistency between the two techniques.
Conclusion: These preliminary results confirm the performance of GeneXpert HIV-1 Qual and Alere q HIV1/2 Detect for the detection of HIV-1 and HIV-2 and encourage the scale-up of POC testing to improve access to early infant diagnosis in decentralized settings in Senegal.
Keys words: HIV, Early Infant Diagnosis, Evaluation performance

TUAA0105 - TRACK A1

HIV Drug Resistance in Northern Part of Ghana: Population-based Household Survey

11:45 – 12:00

Mary Addae Fosu
Ussher Polyclinic, Public Health Administration, Accra, Ghana

Background: Antiroviral treatment (ART) programme is the largest globally with >4 million HIV-infected persons receiving standardized treatment regimens. Monitoring levels of HIV drug resistance (HIVDR) is a priority activity for the country. HIVDR testing was included for the first time in the 5th national HIV household survey conducted in 2013.
Method: Multi-stage stratified cross-sectional random sampling was used to select households for participation nationally. Dried blood spots were tested to determine HIV status, estimated recency of infection, exposure to antiretroviral drugs (ARVs), and HIVDR in addition to behavioral data from all household members who agreed to participate. HIVDR testing was conducted on HIV-positive samples with viral load ≥1000 copies/ml using next generation sequencing methodologies.
Result: 1107 HIV positive samples from virally unsuppressed participants, 697 (63%) were successfully amplified by polymerase chain reaction and sequenced. Drug resistant mutations (DRM) were identified in 27.4% (95% CI 22.8-32.6) of samples: 18.9%(95% CI 14.8-23.8) had resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs) only, 7.8% (95% CI 5.6-10.9) had dual resistance to NNRTIs and nucleoside reverse transcriptase inhibitors(NRTIs), and 0.5% (95% CI 0.1-2.1) had resistance to second-line regimens that include protease inhibitors (PIs),NNRTIs, and NRTIs). Table 1 shows HIVDR by exposure to ARVs, sex, and age. NNRTI-only resistance was found in 14.3% ARV+ve and 20.0% ARV-ve samples (p=0.311), while dual NNRTI and NRTI resistance occurred in 40% ARV+ve and 2.1% ARV-ve samples (p< 0.001). Among those who were ARV-ve but self-reported daily ARV use (ARV defaulters; n=41), 75.6% had DRM; 56.4% with NNRTI-only resistance, 14.3% with dual NNRTI and NRTI resistance. There were no significant age and sex differences among either NNRTI-only resistant and dual NNRTI and NRTI resistant samples.
Conclusion: These findings demonstrate high proportions of DRM among virally unsuppressed HIV-infected persons in the northern part of Ghana. While these results include treatment defaulters, potential pretreatment HIVDR levels are concerning. Programmatic implications include stronger adherence support to reduce ARV defaulting, and strengthened first line ART regimens by including integrase strand transfer inhibitors (INSTIs) as a part of first line treatment.

TIME 12:45 – 14:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Tuesday, 03 December 2019

Track E: Health Systems, Economics and Implementation Science

Ending AIDS: Leveraging Community, Engagement, Leadership and Ownership

Chair: Ludfine Bunde

TUAE0201 - TRACK E2

Rock Leadership Programme: Traditional Leaders Championing HIV Response in Eswatini, Malawi, Zambia and Zimbabwe

12:45 – 13:00

Chibukire Ngoni

SAfAIDS, Programmes, Pretoria, South Africa

Issues: Funded by UNAIDS, SAfAIDS implemented the Rock Leadership '90: Strengthening Capacity of Traditional Leaders to Champion the Community Response to Ending AIDS in Africa Project in four countries namely Malawi, Swaziland, Zambia and Zimbabwe programme through traditional leaders leading HIV testing campaign called " Village to Village, I know My Status, Do you know?. Evaluation of the programme was done at the end.

Descriptions: The evaluation used a Cross-sectional Analytic Study Design, employing a mixed method approach based on a combination of qualitative and quantitative techniques to analyse primary and secondary data. Literature from project proposals, mapping reports, project monitoring reports, budgets and other national level documents was reviewed. A total of 397 community members (adults and young people) were met through group discussions, while 606 people were interviewed using the one-on-one questionnaire. Key informants (68) were interviewed from SAfAIDS, implementing partners, health providers, NGOs, community leaders and project champions.

Lessons learned: Traditional leaders are influential in uptake of HIV services. There was an increase in HIV testing at community health centres. The increase in testing reached up to 200% and nurses attributed the increase to the impact made by the Rock '90 project in the community. Regular testing also increased supported by V2V community events which increased service provision awareness. Only 1.1% males and 2.8% females interviewed had never been tested for HIV and ART initiation increased dramatically in health facilities in the intervention communities. A remarkable 89% of respondents knew the status of the youngest child in the household, with 82% of respondents saying a mother in their household received PMTCT support during their last pregnancy. The project was well aligned to global, regional and national priorities. The project was also relevant to communities as those participating suffered from high HIV prevalence, low uptake of HIV services due to lack of knowledge and at times lack of testing services and health facilities. Although challenges differed, there was a general consensus amongst those consulted that the project met a real and ongoing need.

Next steps:

- Scale up the project to saturate communities
- Prioritise index/ targeted testing in farming communities
- Capacitate community leaders
- Strengthen collaboration with partners to ensure adequacy resources

TUAE0202 - TRACK E2

Coping Mechanisms Adapted to Community HIV Services Delivery Following the Transition from PEPFAR to Central Support in Uganda

10:45 – 11:00

Ssegujja Eric[1], Mukuru Moses[1], Zakumumpa Henry[2], Ssengooba Freddie[3]
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Introduction: Psychosocial support critical for HIV care requires a strong community component. The rapid scale up of ART services invested heavily in psychosocial aspects aimed at building health system capacity ready for transition to central support. However the structures to hand over service delivery were not as strong. Even then, the VHT strategy couldn't handle the scope of work as it was during support. Consequently health managers, and community volunteers in whom these capacities were built had to devise ways of moving forward with work through improvision. This paper analyses the coping mechanisms adapted to community HIV services delivery following the transition from PEPFAR to central support during the implementation of geographic prioritization.

Methods: A longitudinal case study was conducted in Uganda with in-depth interviews among health workers, facility managers, district health managers, implementing partners and focus group discussions with individuals receiving HIV care services at the time of the transition. Data was collected using audio digital recorders, transcribed and analysis done using atlas.ti where emerging themes and subthemes formed the results.

Results: Overall results revealed three trends in adjusting community HIV service delivery post-PEPFAR support. HIV care core activities previously offered through community outreaches were recalled and continued being offered at the static clinics. For the non-core HIV care activities that didn't require much financial support to carry on were integrated into routine outreach services supported by MoH while for activities that couldn't go on without funding were terminated. The community volunteers previously engaged that still had morale were recalled to support at the static clinics mostly in administrative roles. Other volunteers like mentor mothers had to migrate to neighboring districts for similar services to retain their financial benefits that had been lost in their districts following the transition to central support.

Conclusions: In the absence of donor support, sub-national health systems adapt to different strategies to cope with a community component necessary in the provision of HIV care services. It is essential to analyze these strategies in order to tap into those that can be scaled up without having to incur a lot of resources which would affect their sustainability.

TUAE0203 - TRACK E2

Global Treatment Access Survey: Community-led Research to Assess Barriers to Quality HIV Care and Services

13:15 – 13:30

Garcia Pedro Trinidad[1], Inghels Maxime[2], Khan Tatyana[3], de León Alma[4], Kaberia Rose5, Boka Raoul[6], Amimi Alia[7], Zelinskyi Yaroslav[8], Dooronbekova Aibar[9], Brito Ceneyda[10], Melendez Ada[11], Ajuna Syrus[12], Dah Elias[13], Abou Diana[14], Thomas Caroline[15], Dang Do Dong[16], Mwareka Tonderai[17], Chilende Clever[18], Etya'ale Helen[19], Mosime Wame[19], Swan Tracy[20]
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Indonesia, [16]VNP+, Hanoi, Viet Nam, [17]Zimbabwe National Network of PLHIV (ZNNP+), Harare, Zimbabwe, [18]Treatment Advocacy and Literacy Campaign (TALC), Lusaka, Zambia, [19]International Treatment Preparedness Coalition Global (ITPC), Gaborone, Botswana, [20]International Treatment Preparedness Coalition Global (ITPC), New York, United States

Background: As access to ART and viral load monitoring expands, HIV services must be responsive to the needs of people living with HIV (PLHIV), especially key populations. Research on access to, and quality of HIV services is especially important in the 'treat-all' context, yet information on the quality and scope of care from the PLHIV perspective is limited.

Methods: The International Treatment Preparedness Coalition (ITPC) conducted a community-led survey to identify gaps in access to and quality of HIV services among 2,777 PLHIV across 14 low-and middle-income countries, eight of which in Africa (Burkina Faso, Côte d'Ivoire, Dominican Republic, Honduras, Indonesia, Kenya, Kyrgyzstan, Lebanon, Morocco, Uganda, Ukraine, Vietnam, Zambia, Zimbabwe). One third of the study participants were members of a key population group (men who have sex with other men, sex workers, transgender people and/or people who inject drugs). The study included a quantitative survey, which evaluated barriers to HIV services among recipients of care (RoC), and a qualitative survey which characterized delivery challenges among health care workers.

Results:

- Late diagnosis (CD4 cell count of < 200 cells/mm3) decreased in the 'treat-all' era, yet 30% of survey participants presented with advanced HIV disease after 2015, and only 83.5% had CD4 cell testing.
- A third of the 1,585 women surveyed reported lacking access to modern contraception (injectables or oral pills). Almost 1 in 5 women reported lack of access to condoms, compared to 7% for men.
- Many ART centres do not have the capacity to diagnose and/or treat opportunistic infections (OI). Up to 73% of RoC did not receive testing, prophylaxis and/or treatment for OI, and 1 in 4 survey respondents reported that testing for OI was unavailable at their healthcare site.
- Over a quarter of survey participants reported suboptimal adherence (< 90% of pills taken) for reasons including stigma, inconvenient clinic hours and/or waiting times.
- Access to viral load testing is increasing, yet nearly 15% of survey respondents with a viral load test (VLT) didn't know the result of their most recent VLT, and 24% had detectable HIV RNA (>1000 copies/mL).

Recommendations: Increased quality of care can only be achieved if RoC are at the centre of designing and providing relevant services. Community-led research provides a critical opportunity to identify treatment and care barriers and highlight opportunities for improvement.

TUAE0204 - TRACK E2

Village Savings and Loan Associations Clip Children Living with HIV to Lifeline; Lessons from 'Towards an AIDS Free Generation in Uganda,' (TAFU) Project

13:30 – 13:30

Bitira David[1], Vrolings Eliane[2], Musinguzi Merian[2,3]
[1]Community Health Alliance Uganda, Programs, Kampala, Uganda, [2]Aidsfonds, Amsterdam, Netherlands, [3]Aidsfonds, Kampala, Uganda

Issue: 30% of 96,000 children under 14yrs living with HIV in Uganda are lost to follow up (LTFU) before and after enrollment in care; and viral suppression is lower among children (39.3%) than adults (59.6%). Concerted effort is required to alleviate discrimination, poverty, poor nutrition, limited childhood HIV care knowledge, lack of transport and frequent medicine stock outs that hamper children retention in care

Description: Community Health Alliance Uganda through TAFU established Village Savings and Loan Associations (VSLA) in Kyenjojo, Mubende and Mityana districts

to improve income, food security and child care of households with children living with HIV to enhance their retention in care and adherence to treatment. 23 VSLAs with 768 members were established and provided financial and technical support. Each member saves 1,000 Uganda Shillings (USD 0.27) weekly. Members borrow from VSLAs to meet basic needs and buy medicines for children under their care and boost their income generating activities. During VSLA meetings, community health workers (CHW) and expert clients coach members on children living with HIV care. Members also deliberate on health needs of children and assign CHW and expert clients to visit families and attend to children that missed refill appointments or are ill. Members also share experiences on caring, feeding and children medication; and support one another cope with stigma

Lesson learned: VSLAs contributed to return of 356 children LTFU into care within a year; and improved their retention in care and treatment adherence. 'I did not have money for transport to take my daughter to ART clinic. I borrowed some from our VSLA and took her to hospital,' (parent, Mubende); VSLAs ensure uninterrupted availability of medicines and enhance children adherence to treatment. 'When I went to health center and there was no septrin, I got a loan from VSLA, bought medicine and saved my son's life,' (caretaker, Mityana); VSLAs raise family incomes to meet children and other family members' needs. Members' empowerment enables them to overcome HIV stigma and improve care for themselves and children living with HIV that increase their treatment adherence

Next steps: Health workers to attend and enrich VSLA education sessions and offer needed expert services;

Organizations to scale-up and strengthen VSLAs as community service delivery points to meet needs of children;

Districts to register and link VSLAs to government programs for sustainability

TUAE0205 - TRACK E2

The Role of the Community Based NPO in Working with Clinics to Find the Lost to Follow ups

13:45 – 14:00

Learmonth Penny

Future Families, Pretoria, South Africa

Issues: South Africa is experiencing high numbers of HIV positive clients who are defaulting on treatment. Future Families has had success in identifying and enrolling HIV positive clients into their program and retaining them on treatment. We look at how at Future Families an NPO joined hands with the health facilities to find the lost to follow up adolescents and re- initiate them on ART.

Descriptions: Future Families currently works with 27 000 OVCA&Y. Entry as an NPO into the clinic environment was not easy and required the intervention of the local district manager and a MOU with the Dept of Health. The Future Families team was required to undergo training on adherence protocols after which afforded them the respect to be integrated in to the facility with the mandate to trace lost to follow up clients, get them back to the clinic to reinitiate treatment and then enroll Children living with HIV into Future Families adherence groups.

Future Families employs a cadre of 150 care workers who are trusted members of the community and who have positive relationships with the clinics and schools. The care workers each receive the details of 10 lost to follow up adolescents and they set out to find them. Using their existing networks they have been successful in finding the adolescents, establishing a relationship, accompanying them to the clinic and then providing ongoing support to the adolescent.

In the first three months, 721 lost to follow ups were referred, 712 were traced, and now 622 are on treatment.

Lessons learned: 1. Parents have not shared the child's status with them and

so while taking treatment they are unaware of the reason and the implications of stopping treatment.2. Stigma remains a critical issue for young people and so they stay away from clinics. 3. The young people report a low self-image and feelings of low self-esteem.

We need a partnership between the health professional and grass root community caregivers to provide holistic care to HIV positive youth

Next steps:

1. Establish multi-disciplinary teams at clinic level.
2. Identify ways to attract youth to clinics
3. Enroll youth in adherence clubs at initiation of ART.
4. Future Families establish ART pick up points in the community.

TIME 14:45 – 16:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Tuesday, 03 December 2019

Track A: Basic Science (Biology & Pathogenesis)

HIV drug Resistance and its impact on 3rd 90

Chairs: Dr. Fausta Shakiwa MOSHA

TUAA0301 - TRACK A3

Dolutegravir Based Regimen in Second Line Treatment in Togo without Resistance Genotyping Tests, Is this Promising?

14:45 – 15:00

Salou Mounerou[1], Butel Christelle[2], Comlan Adjo Seyram[1], Konou Abla Ahouefa[1], Tegueny Kokou[1], Dossim Sika[1], Delaporte Eric[2], Dagnra Anoumou Yaotsè[1], Peeters Martine[2]

[1]FSS/UL, Laboratoire Biolim, Lomé, Togo, [2]IRD, UMI233, Montpellier, France

Background: WHO recommends dolutegravir (DTG) based regimens for HIV-1 infection. Here we evaluated whether blind switch to DTG-based treatment in combination with an optimized NRTI backbone (i.e. AZT or ABC + 3TC) would be effective in case of virological failure (VF) on current antiretroviral therapy (ART) (TDF+3TC+EFV) because genotypic drug resistance testing is not available in Togo.

Methods: HIV-1 infected patients on ART with Viral Load (VL) >1000 copies/ml (ABBOTT m2000rt) were consecutively enrolled from January to September 2018 in Lomé, the capital city. Plasma samples of these patients were sequenced to analyse drug resistance mutations (DRM).

Results: During the study period, 1708 patients (median 40 years [IQR 31- 49], 1161 (68.7%) women) were tested for VL. VL was >1000 copies/ml for 324 (18.9%) patients and 200 (61.7%) were tested for DRMs; 167/200 (83.5%) were on NNRTI-based regimen and 33/200 on PI-based regimen. 181/200 (90.5%) samples were successfully sequenced in RT gene; 140/181(77.4%) were resistant to NRTIs plus NNRTIs, 4/181(2.2%) to NRTI only, 18/181(9.9%) to NNRTI only and 22 (13%) out of 169 successfully genotyped in the protease gene were resistant to PI. Concerning the NRTI that will be used in the second line DTG based regimen, genotyping results showed 137 (75.7%) strains with high (n=130) or intermediate (n=7) resistance to 3TC. Although, they did not receive AZT or ABC, 58 (32%) patients accumulated NRTI mutations that predicted high (n=33) or intermediate (n=25) resistance to AZT, 41 (22.7%) and 99 (54.7%) had intermediate and high resistance to ABC. Regarding integrase inhibitors, 12.3%(22/178) had minor mutations not inducing resistance to DTG.

In case of ART switch to a DTG-based regimen with AZT or ABC and 3TC, only 23.9% of patients will be sensitive to this combination, but 32.2% to 72.5% will be on

monotherapy with DTG, because of high or intermediate resistance to 3TC and AZT or ABC. In case of blind switch of all patients to DTG-based first line ART (TDF+3TC+DTG), 50.9. % will be on DTG monotherapy because of DRMs to 3TC and TDF

Conclusions: Our data highlight the importance of VL testing before switch to DTG and for monitoring of patients on suboptimal DTG based regimens, otherwise large-scale switch to DTG could prevent the achievement of the third 90 of UNAIDS objectives and lead to emergence of resistance to integrase inhibitors in Togo.

Keywords: HIV, Dolutegravir, effectiveness, low incomes countries

TUAA0302 - TRACK A3

Antiretroviral Resistance Patterns in HIV-1 Infected Patients Failing to Second-line in Bamako, Mali

15:00 – 15:15

Traore Fatoumata Tata[1], Maiga Almoustapha I[1,2], Fofana Djeneba B[3], Maiga Abdramane A[1], Dao Dorcas[1], Cisse Mamadou[4], Togo Josue[1], Sangare Samba A[1], Diallo Fodie[1], Diarra Zoumana[4], Dolo Oumar[1], Murphy Robert[5], Calvez Vincent[6], Katlama Christine[6], Marcelin Anne G[3]

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Introduction: Despite the effectiveness of ART (Antiretroviral treatments), virological failures and HIV resistance to ARVs may occur. More than 20 years, patients remained on first-line ARV treatment coupled with a lack of virological follow-up, a late switch in second line which increase the virological failures for second line ART in resource-limited countries. All of these factors could have a negative impact to archive the goal of the last 90% of the UNAIDS in sub-Saharan Africa, particularly in Mali.

Objective: We aimed to evaluate the prevalence of ART resistance patterns in HIV-1 infected patients in second-line virological failure in Mali.

Method: We recruited HIV-1 infected patients who failed to their second-line ART. The patients have been recruited from Bamako clinical care centers from March 2013 to December 2016. Protease and reverse transcriptase genes were sequenced by a commercial (Viroseq) and in house (ANRS) methods. The results were interpreted using the latest versions of Stanford algorithm.

Results: We included 309 patients who failed to their second line treatment (VL ≥ 1000 copies / ml). Female sex was predominant with (%) 227/309, the median age was 35 years [18 and 70 years], the median of viral load was 57086 copies / ml [1040 and 2000000 copies / ml], the median of CD4 count was 194 cells / mm3 [2 and 1660 cells / mm3]. The CRF02_AG was the most predominant HIV-1 subtype with 71% of cases and 62.46% of our patients were exposed to last six ARV molecules. The prevalence of resistance to different classes of ARV was as follows: 65.37% to NRTI, with M184V (61.81%), 61.49 to NNRTI with Y181C / I / V (22.98%), and V82F/T (2, 3%) and L76V (0.05%).

Conclusion: These data show a high prevalence of NRTIs and NNRTI but less than 10% of PI resistance., The LPV remain sensitive in many patients this suggere the use better virological monitoring and good tools for poor adherence detection.

Keywords: HIV-1, virological failure, second-line ARV, resistance patterns

TUAA0303 - TRACK A3

C-Terminal P7(NC) - P6gag Gag Polymorphisms and Protease Drug Resistance Mutations Profile in HIV-1 Infected Patients Failing Protease Inhibitors Treatment

15:15 – 15:30

Teto Georges[1], Tako Desire[2], Fokam Joseph[2], Dambaya Beatrice2, Nka Alex[2], Santoro Maria-Mercedes[3], Colizzi Vittorio[3], Perno Carlo-Federico[3], Ndjolo Alexis[2]
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HIV Gag mutations have been reported to confer PI resistance in B subtypes but very little is known about non-B. Understanding the role of P7 - P6gag in PI resistance and characterize relevant mutational patterns, could help to reduce failures to PI

We conducted at CIRCB a cross-sectional study on 334 individuals (96 on PI). Resistance mutations (RMs) were analyzed in the protease region using the Stanford algorithm v 8.3. Mutations were identified in the P7 - P6gag cleavage sites(CS) (P7/P1 and P1/P6gag) and non-CS of each sequence using HXB2 and Bioedit.7.2.5 software. Each Gag sequence was analyzed for the presence of specific P7 - P6gag RMs known or not to be associated with resistance to PIs. Samples containing a mixture of wild type and mutant were scored as mutants. Statistical analysis was performed using GraphPad Prism 6. Data were analyzed by two-tailed unpaired t-test or ANOVA for multiple comparison. $p \leq 0.05$ was considered significant.

We compared PI exposed patients to not exposed in P7 - P6gag CS and non-CS. In CS we found the already described RMs given as exposed/not exposed frequencies: I437V 0%/0.84%; L449P 73.9%/ 80%; P453L 9.37%/3.36% with the respective p 0.861;0.675;0.04 in P7/P1 CS for the first RM and P1/P6gag CS for the others. In non-CS, we found V467E 84.37%/92.47% (p=0.607) and two new mutations with high entropies Q476K 79.16%/0.84% and E477Q 79.16%/0% (p< 0.0001). Among the 96 (44.31% men, Mean age [IR]=41.21±12.66 [7-70] yrs.) on PI, 76 were failing PI with RMs (38.63% M46I, 7.95% I47IV/V/A, 4.54% I50L, 12.5% I54IM/M, 14.77% L76V, 4.54%, V32F11.36% V82S/T/A/F, 21.59% I84V and 5.68% L90M). We found out the prevalence of RMs in P7 - P6gag in patients with PI-RMs as compared to those with no PI-RMs. The mutations in term of PI-RMs/no PI-RMs were: P453L 55.5%/44.4%; Q476K 43%/55.26%; E477Q 42.10%/53.94% all with p>0.05. No P7 - P6gag RMs was linked to a particular subtype: CRF02_AG (63%), G (4%), F2(4%), A (17%), D (2.63%), CRF11_cpx (11.3%) or CRF09_cpx (1.3%) (p≥0.05).

Our analysis revealed in addition, two potentially important, not yet described, new mutations Q476K, E477Q in P7-P6gag non-CS of non-B Gag, that could have clinical implications. Subtypes and PI-RMs had no impact on these mutations. However, further phenotypic analyses and clinical correlates of drug failure will be needed before such information is suitable for amending existing resistance algorithms that are used for genotyping HIV resistance testing.

TUAA0304 - TRACK A3

Forte Prévalence de la Résistance Transmise du VIH-1 chez les Patients Nouvellement Infectés et Naïfs de Traitement Antirétroviral au Bénin

15:30 – 15:45

Tchiakpe Edmond, Keke Rene Kpemahouton, Moussa Bachabi, Gangbo Flore Armande
Programme Santé de Lutte Contre le SIDA au Bénin, Cotonou, Benin

Introduction: Partant des dernières recommandations de l'OMS pour le remplacement des inhibiteurs non nucléotidiques de la transcriptase inverse par le Dolutégravir, il s'est avéré important d'évaluer le niveau de circulation de la résistance transmise dans la population générale. L'étude a pour but:

Etablir le profil de mutations associées aux antirétroviraux et déterminer les souches du VIH-1 circulants chez les patients nouvellement infectés par le VIH-1 et naïfs de

traitement

Méthodologie: Etude prospective a porté sur 248 patients. La charge virale a été quantifiée à partir des plasmas sur l'équipement Roche COBAS® AmpliPrep/COBAS ® TaqMan® 96. Sur les ARN viraux extraits avec le kit Qiagen, une PCR nichée sur (PR + 240 AA de la TI) a été réalisée. Les amplifiats ont été purifiés avec le kit Qiagen puis séquencés sur le « Genetic Analyser 3500 Applied Biosystem ». Les séquences ont été éditées sur (https://pssm.cfenet.ubc.ca/account/login) puis soumises au site (https://hivdb.stanford.edu/cpr/) pour générer les mutations de type SDRM. L'arbre phylogénétique a été réalisé sur Seaview v4.4.1 pour l'assignement des différents sous-types et CRFs après alignement des séquences nucléotidiques contre des séquences de référence circulant en Afrique de l'Ouest. Les virus recombinants ont été caractérisés par Simplot 2.6 et bootscanning.

Résultats: La moyenne des charges virales était de 5,32 log [IC : 2,82 à 7 log]. Vingt-sept patients portaient au moins une mutation de résistance (10,89% ; 27/248). Au total 42 mutations de résistance ont été identifiées. Les INNTI représentaient 10% (24/248) et se répartissaient comme suit: K103N (14/42), G190A (3/42), Y181C (2/42), les V106A, Y188KL, P225H, Y188L, V106M représentaient chacun (1/42). Les INTI représentaient 6% (16/248) et se composaient de : M184V (8/42) et les D67N, M41L, T215S, K65R, M184I, D67G, K70R, K219Q qui représentaient chacun (1/42). Les IP (I84V et L90M) représentaient chacun 1% (2/248).

Les souches prédominantes étaient CRF02_AG, CRF06_cpx et CRF43_02G (71,8%, 6,8% et 1,2%) respectivement. Une seule séquence portait le CRF01_AE. Les souches pures G, A3 et F1 représentaient respectivement (4,8%, 3,6% et 0,4%). Les formes recombinantes uniques représentaient 9,3% (23/248).

Conclusion et Recommandations: La prévalence de la résistance transmise du VIH-1 est élevée (> 10%), d'où l'impératif adoption des dernières recommandations de l'OMS sur le remplacement de l'Efavirenz par le Dolutégravir.

TUAA0305 - TRACK A3

Prevalence and Diversity of HIV Drug Resistance Mutations in Patients Entering Treatment Programmes in Northern South Africa

15:45 – 16:00

Ogola Bixa[1], Matume Daphney[1], Bessong Pascal[2]

[1]University of Venda, HIV/AIDS & Global Health Research Programme and Department of Microbiology, Thohoyandou, South Africa, [2]University of Venda, HIV/AIDS & Global Health Research Programme, Thohoyandou, South Africa

Background: In September 2016, South Africa introduced the universal HIV treatment programme, that is, 'diagnose and treat.' Transmission of drug resistant viruses complicates the choice of first line treatment regimen at the population level. This study aimed to determine the prevalence and diversity of HIV drug resistance mutations in patients entering HIV treatment programmes in northern South Africa.

Methods: Proviral DNA was isolated from peripheral blood mononuclear cells of 257 of supposed drug naïve HIV-1 infected patients to entering treatment programmes in northern South Africa. A fragment of the HIV pol gene, comprising the complete protease and the first 421 amino acids of reverse transcriptase was amplified by nested PCR. Amplicons were sequenced on an Illumina MiniSeq Next Generation Sequencing (NGS) platform. Consensus sequences were derived with minority variants cut-offs of >20%-5% for each patient using Geneious® software version 8.1.5. HIV-1 drug resistance was inferred using the Calibrated Population Resistant (CPR) tool in HIV drug resistant database. Viral subtypes were determined using SCQUEL and RIP genotyping tools.

Results: Quality sequences were obtained for 253/257 (98.4%) of the patients. About 9.5% (24/253) of the patients harboured at least one surveillance drug resistance mutation (SDRM). The proportion of resistance mutations to NNRTI, PI, and NRTI

were 8.3%, 1.4% and 0.8% respectively. A majority (15/24; 62.5%) of the patients harbouring SDRM were females, between the ages 21-66 years, with median CD4+ cell count of 212/µl (range:50-811) and median viral load of 20,863 copies/mL (range: 20-696 474). The most frequent SDRM was K103N (75%; 18/24), and of these 5/12 were in males (41.7%). K103N is associated with high-level reduction in Nevirapine (NVP) and Efavirenz (EFV) susceptibility. Other mutations observed included: NNRTI: V106M (3/24), K101 (1/24), P225H (3/24); NRTI: 1/24 of each of M41L, K65R, M184V, F77L; PI: G73S (1/24), D30N (2/24), L90M (1/24). All sequences were HIV-1 subtype C on the Pol gene, except one which was HIV-1 subtype G.

Conclusion and Recommendation: These observations from NGS analysis suggest that the study population, entering HIV treatment programmes in northern South Africa, harboured moderate levels of transmitted drug resistance mutations. Drug resistance surveillance studies may be needed to better understand resistance in the drug naïve population in the era of 'diagnose and treat.'

TIME	16:45 – 18:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Tuesday, 03 December 2019

Track A: Law, Human Rights Social Science and Political Science

Communal Mobilization for Access to Services and Suppression of Viral Load

Chair: Helene Badini, UNAIDS RST WCA

TUAD0401 - TRACK D3

Tribune Santé Ados et Jeunes: Une Plateforme pour Renforcer l'Accès des Jeunes aux Informations et Services Grâce aux Réseaux Sociaux

16:45 – 17:00

Tao Oumar
MAJ/ ABBEF/ IPPF, Ouagadougou, Burkina Faso

Questions: Les adolescents et les jeunes sont les couches les plus vulnérables dans la contraction des IST / VIH au Burkina Faso. Comment utiliser les réseaux sociaux pour que les jeunes aient la bonne information afin de se protéger des IST / VIH-SIDA?

Description: C'est dans ce contexte que la fédération internationale pour la planification familiale (l'IPPF) a financé le Mouvement d'Action des Jeunes (MAJ) de l'association burkinabè pour le bien être familiale (ABBEF) pour la mise en œuvre de ce projet innovant dénommé ''Youth connect initiative'';

C'est un projet qui met le focus sur le développement de plateforme (Tribune santé ados et jeunes) sur les réseaux afin de créer et de diffuser des contenus multimédia (vidéos, articles, microprogramme audio etc.) pour renforcer les connaissances des jeunes sur les droits sexuels et reproductifs des adolescents et des jeunes;

Grâce à ce projet, une plateforme dénommée Tribune Santé ado et jeunes a été créée sur les différents réseaux sociaux;

L'objectif étant de donner un espace de dialogue, d'échange en droit et santé sexuelle et reproductive (DSSR), plaider en faveur du soutien envers les jeunes vivants avec le VIH, sensibiliser les jeunes sur différentes thématiques liées aux IST/VIH et pour finir emmener les jeunes à utiliser les réseaux sociaux pour référer leurs pairs vers les cliniques des centres d'écoute pour jeunes de notre association.

Leçons: En une année de mise en œuvre du projet, nous avons enregistré les résultats suivants:

- 59 900 jeunes touchés sur différents thématiques de santé sexuelle et de la reproduction contre 30 000 prévus

- 45 articles rédigés par les jeunes sur les IST/VIH/SIDA et sur la santé de la reproduction en général;
- 05 microprogrammes radios réalisés et diffusés;
- 15 vidéos produites sur des thématiques de la santé sexuelle et reproductive des adolescents et des jeunes
- 70 WhatsApp chat et 45 tweet up avec participation des jeunes de l'Afrique entier;
- 80 jeunes ont eu leurs compétences renforcées de façons directes sur le blogging, l'utilisation des réseaux sociaux, le filmage et montage des vidéos et audio et la rédaction des articles:

Prochaines étapes: Le mouvement prévoit la mise en place d'un site Internet contenant un forum de discussion pour les jeunes. Aussi, un numéro vert est en cours de mise en œuvre ou les jeunes vont directement discuter avec un spécialiste sur les questions de santé de la reproduction et sur les questions d'IST / VIH-SIDA.

TUAD0402 - TRACK D3

L'impact de la Structuration Familiale dans la Gestion du Secret de l'Annonce du Diagnostic de l'Infection à VIH aux Enfants Suivis au Centre de Traitement Ambulatoire (CTA) de Brazzaville

17:00 – 17:15

Bitsindou Parfait Richard[1], Ekat Martin[2], Mahambou Dominique[3], Diafouka Merlin[3], Nzounza Patrick[4], Giraudbit Pierre[4]

[1]Centre de Traitement Ambulatoire (CTA), Brazzaville, Congo, [2]Service des Maladies Infectieuses du CHU de Brazzaville, Brazzaville, Brazzaville, Congo, [3]Centre de Traitement Ambulatoire (CTA), Brazzaville, Brazzaville, Congo, [4]Délégation Croix-Rouge Française en République du Congo, Brazzaville, Brazzaville, Congo

Contexte: Sur une séroprévalence de 2.28% d'enfants de moins de 15 ans au Congo, la transmission verticale reste un maillon faible de la riposte nationale du VIH. La population Congolaise, reconnue croyante à plus de 80% a du mal à intégrer qu'un enfant soit infecté par le VIH. Le recours à l'étiologie sorcière est souvent le moyen d'expliquer cette réalité rendant pénible l'atteinte de l'objectif 90-90-90. L'orphelin se retrouve dans une situation délicate, surtout en cas de remariage du parent en vie. Plusieurs difficultés à l'annonce et au suivi post annonce sont rencontrées à l'heure actuelle, justifiant le taux de morbi-mortalité, ainsi que le premier rapport sexuel très précoce à 11 ans. Dans ce travail, nous voulons montrer comment la structuration familiale influence la gestion de l'annonce de la séropositivité à un enfant.

Méthodes: Il s'agit d'une étude rétrospective portant sur l'annonce de la séropositivité à 79 enfants de 9 à 15 ans réalisée de 2014 au 30 novembre 2017 répartis en 2 groupes : ceux ayant des parents en vie et ceux ayant perdu au moins un p arent et vivant en famille d'accueil ou recomposée. Les entretiens psychologiques triangulaires, individuels, les groupes de parole respectivement des enfants et ceux constitué par leurs familles, ainsi que les ateliers d'expression ont été réalisés pour leur préparation à l'annonce. La grille congolaise du processus d'annonce progressive du statut à l'enfant a été utilisée respectivement pour décider du moment d'annonce complète.

Résultats: Sur les 79 enfants retenus dans cette étude 30 enfants vivant en famille d'accueil ont été stigmatisés et discriminés après l'annonce de leur statut sérologique faute de soutien psychologique de l'entourage et 49 ayant des parents en vie avaient été tardivement informés du fait de la réticence de ceux-ci et 8 enfants orphelins de 13 à 14 ans étaient sexuellement actifs pour récompenser la carence affective et l'ostracisme dont ils étaient l'objet .

Conclusions et Recommandations: L'annonce du statut sérologique de l'infection à VIH aux enfants vivant dans les familles d'accueil ou recomposées pose plus de problème que celle des enfants ayant les parents en vie les activités de soutien psychologique sus indiqués devraient être réalisés par les prestataires prenant en charge lesdits enfants.

TUAD0403 - TRACK D3

Facteurs Associés à la Suppression de la Charge Virale chez les Adolescents sous ARV au Centre d'Excellence Pédiatrique (CEP) du CHU Gabriel Toure

17:15 – 17:30

Coulibaly Yacouba Aba
CHU Gabriel Touré, Pediatrie, Bamako, Mali

Introduction: L'infection à VIH est une pandémie mondiale et les pays en développement y payent le plus gros tribut. Le nombre d'enfants infectés par le VIH atteignant l'adolescence est en constante augmentation.
Objectif: Analyser les facteurs associés à la suppression de la charge virale chez les adolescents séropositifs au CEP du CHU Gabriel Touré.
Question de recherche: Les facteurs socio-démographiques et ceux liés au traitement sont-ils associés à la suppression de la charge virale chez les adolescents infectés par le VIH ?
Méthodes: Il s'agissait d'une étude transversale portant sur 393 adolescents infectés par le VIH et suivis au CEP du CHU Gabriel Touré de 2010 à 2017. L'indétectabilité de la charge virale a été évaluée en fonction du statut orphelin, du schéma thérapeutique, de l'âge à l'inclusion et de la durée de suivi du traitement dans une analyse bivariée puis multi variée (régression logistique). L'analyse a été faite avec SPSS version 21 et R version 2.15.2.
Résultats: L'âge moyen à l'initiation du traitement ARV était de 63.77±44,19 mois; 55,1% étaient orphelins d'au moins un parent. A l'inclusion 67,8% étaient au stade clinique III ou IV OMS ; la dernière charge virale était indétectable dans 51,4%. Les adolescents sous 1ère ligne étaient 2,1 fois plus susceptibles d'avoir une charge virale indétectable par rapport à ceux qui étaient sous 2ème ligne [1,36-3,23]. Les adolescents âgés actuellement d'au moins 15 ans étaient 9 fois plus susceptibles d'être indétectable par rapport à ceux qui avaient moins de 15 ans [0,93-87,91]. Ceux incluent sans déficit sévère étaient 1,6 fois de chance d'être indétectable par rapport à ceux qui incluent avec un déficit sévère [1,05-2,65].
Conclusions et Recommandations: La 1ère ligne thérapeutique, l'âge d'au moins 15 ans et l'inclusion sans déficit sévère sont des facteurs associés à la suppression de la charge virale chez les adolescents.
Les recommandations vont à l'endroit des personnels soignants: Débuter le traitement antirétroviral dès le dépistage; Respecter la régularité du suivi biologique

TUAD0404 - TRACK D3

Analyse des Determinants de l'Observance Antiretroviale au Benin: Cas des Patients des Sites de Dist et de Racines Ong

17:30 – 17:45

Houeto Gbedonou
RéBAP+, Atlantique, Abomey-Calavi, Benin

Introduction: L'atteinte de l'objectif 90-90-90 suppose, entre autres, l'observance antirétrovirale au niveau de chaque personne vivant avec le VIH. Au Bénin, malgré la disponibilité du service VIH, le pari d'accès permanent au traitement antirétroviral n'est pas encore gagné chez la majorité des personnes vivant avec le VIH/SIDA.
Méthodes: A l'aide d'un formulaire, il a été collecté des données quantitatives sur la dispensation des molécules antirétrovirales de janvier 2017 à juin 2018 sur deux sites à Cotonou : Dispensaire des Infections Sexuellement transmissibles(DIST) et de RACINES ONG.
Il a été ensuite collecté des données qualitatives sur ces mêmes sites auprès des populations clés (HSH, UDI, TS) les femmes enceintes et les jeunes de 15 à 24 ans.
Résultats: Sur le site de RACINES ONG la proportion des patients qui se sont approvisionnés mensuellement en ARV pendant douze mois successifs varie de

41,3 à 44,8% tandis que cette proportion varie de 16,7 à 20,0% sur le site du DIST. Il s'en déduit que plus de 55% des personnes vivant avec le VIH/SIDA manquent de s'approvisionner en ARV au moins une fois sur douze sur une période de douze mois. L'analyse des données qualitatives ont permis d'établir que:

- des facteurs sous-jacents tels que le degré de croyance en sa séropositivité au VIH et en l'efficacité du traitement antirétroviral sont fortement explicatifs du degré d'observance antirétrovirale chez le patient ;
- la problématique du respect des droits humains liés aux VIH est catalytique entre la situation socio-économique des patients et leur degré d'observance antirétrovirale.

Conclusions et recommandations: Le patient, pour atteindre la suppression virale et être indétectable, doit affranchir les étapes de la chaîne d'observance antirétrovirale à savoir :

1. Accepter et prendre conscience de sa séropositivité
2. Croire en l'efficacité du traitement antirétroviral
3. Adhérer au traitement antirétroviral
4. Respecter les rendez-vous des consultations médicales et d'approvisionnement mensuel en molécules antirétrovirales
5. S'approprier les indications du médecin en matière de consommation des molécules antirétrovirales
6. Respecter les indications du médecin en matière de consommation des molécules antirétrovirales
7. S'immuniser contre les réactions stigmatisant et discriminatoires de son environnement.
8. Assumer sa séropositivité
9. Faire preuve de combativité pour garantir son bien-être socio économique

TUAD0405 - TRACK D3

Promouvoir la Participation Communautaire comme Moyen de Pérennisation de la Stratégie de Dispensation Communautaire des ARV en Afrique Sub-Saharienne

17:45 - 18:00

Siaheu Kameni Bibiane[1], Nansseu Njingang Richie Jobert[2], Ayuk Tatah Sandra[3], Bigna Jean Joel[4]

[1]Comité National de Lutte contre le SIDA, Ngaoundéré, Cameroon, [2]Ministère de la Sante du Publique du Cameroun, Yaoundé, Cameroon, [3]Department of PediatricsDouala Laquintinie HospitalDoualaCameroon, Douala, Cameroon, [4]School of Public Health, Faculty of MedicineUniversity of Paris Sud XILe Kremlin BicêtreFrance, Paris, France

Problématique: Dans son plan stratégique visant à réduire le fardeau de l'infection au VIH, accélérer et renforcer la fourniture du traitement antirétroviral (TAR) aux personnes vivant avec le VIH (PvVIH), le Cameroun comme d'autres pays d'Afrique a opté pour différentes stratégies dont la dispensation du TAR dans la communauté par le biais d'organisations à base communautaire (OBC) bien identifiées et encadrées. Le financement de cette stratégie repose principalement sur des ressources du Gouvernement mais surtout de ses partenaires au développement dont le Fond Mondial avec le soutien d'UNITAID.Ceci permet aux PvVIH de bénéficier d'un TAR continu, gratuit. Cependant,avec la réduction de ce financement externe,Il est donc plus qu'urgent de réfléchir à des stratégies alternatives et efficaces pour soutenir la lutte contre le VIH par le biais de la dispensation communautaire.

Description: De nombreuses études menées en Afrique ont montré que l'assurance maladie à travers des mutuelles de santé semble être une solution pour améliorer l'accès à des soins de qualité, mobiliser les fonds nécessaires, améliorer l'efficacité du secteur de la santé et le développement social et institutionnel de la société. La mutualisation des associations de PvVIH au Cameroun et dans d'autres pays constituerait donc une stratégie prometteuse devant contribuer à compenser le

retrait du financement des sources extérieures et permettant une appropriation de la lutte contre le VIH.

Leçons apprise: A titre d'exemple et de projection, une cotisation mensuelle de 1 USD par mois des 381.874 PvVIH attendus en 2018,permettra de générer une somme de 4582488 USD. En 2016, la subvention allouée à chaque OBC s'élevait à environ 2835 USD;compte tenu du fait que 63 organisations communautaires ont été recrutées dans tout le pays, le coût total à allouer pour le fonctionnement des OBC serait d'environ 178605 USD par an. Ceci démontre clairement que la participation financière d'associations de PvVIH assurera non seulement la pérennisation de la stratégie de dispensation communautaire mais aussi l'extension du nombre d'associations à travers le pays pour davantage rapprocher les médicaments des populations

Prochaines étapes: D'autres axes de recherche de financement pourraient être explorés dans le secteur économique , l'instauration d'une Loi de Finances consacrée uniquement à la lutte contre le VIH

Mots-clés: VIH / SIDA, dispensation communautaire, pérennisation, mutuelle, Cameroun

TIME 10:45 – 12:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Wednesday, 04 December 2019

Track C: Epidemiology and Prevention Science

Social Epidemiology of HIV

Chairs: Simone Salem, UNAIDS RST MENA

WEAC0501 - TRACK C3

Shifts in Gender Norms and Partner Violence in South Africa's Informal Settlements: Positive Results from a Randomized Controlled Trial of the Community Responses Program

10:45 - 11:00

Pulerwitz Julie[1], *Psaki Stephanie*[2], *Zieman Brady*[1], *Hewett Paul C.*[1], *Beksinska Mags*[3]
[1]Population Council, Washington, United States, [2]Population Council, New York, United States, [3]MatCH Research Unit, Durban, South Africa

Background: We report on the effectiveness of a community-based program (Asibonisane Community Responses (CR)), focused on promoting equitable gender norms, and reducing intimate partner violence (IPV) and HIV risk. CR was implemented in informal settlements, where barriers to reaching the 90-90-90 goals may be exacerbated.

Methods: A stepped-wedge randomized evaluation was conducted in 18 informal settlements in KwaZulu-Natal South Africa. CR program rollout was randomized across sites, allowing for comparisons between control and intervention areas. Using a two-stage random sampling approach, we interviewed 768 women ages 18-24 and 758 men ages 18-35 in early 2017. We conducted two cohort follow-up rounds at seven-month intervals; results are derived from round 3 of data collection. Attitudes towards gender norms were measured by the GEM Scale (e.g., men should be the primary decision-maker in a couple; score range of 1-10.)

Results: Reports of violence were high at baseline relative to national data: 22% of women reported experiencing physical violence from a primary partner, and 10% reported sexual violence, in the last six months. Among men, 15% reported perpetrating physical violence, and 4% sexual violence, against a primary partner. At baseline, there was substantial endorsement of inequitable norms by both men and women, although women were less likely than men to endorse inequitable norms ($p< 0.0001$). At endline, women living in CR intervention communities were less likely to report physical or sexual violence from a primary partner in the previous six months (OR=0.61, $p< 0.05$) than those in control communities, and similarly, men in CR intervention communities were less likely to report perpetrating physical or sexual violence in the last six months (OR=0.45, $p< 0.05$). Both women and men in CR intervention communities were also less likely to endorse inequitable gender norms than in control communities (12% and 7% increase in mean equity score, respectively; both $p< 0.0001$) at endline.

Conclusion: Reports of violence and endorsements of inequitable norms were quite high in these informal settlement settings at baseline. Initial findings show that the community-based CR program had a beneficial effect on attitudes towards gender norms and experience and perpetration of physical and sexual violence, despite the challenging environment.

WEAC0502 - TRACK C3

Predictors of Transactional Sex among Adult Men Living in an Informal Urban Area, South Africa

11:00 – 11:15

Magni Sarah[1,2], Hatcher Abigail[2], Wamoyi Joyce[3], Christofides Nicola[2]
[1]Genesis Analytics, Johannesburg, South Africa, [2]University of the Witwatersrand, Johannesburg, South Africa, [3]National Institute for Medical Research, Mwanza, Tanzania, United Republic of

Background: Transactional sex is a risk factor for HIV in women in sub-Saharan Africa, but relatively few studies have explored this relationship in adult men. The predictors of transactional sex in adult men are important to determine in low-resource, high-HIV settings. The aim of this study is to describe the predictors and patterns of adult men engaging in transactional sex (giving) in an impoverished, peri-urban settlement in South Africa.
Methods: We used data from a cross-sectional study with 2,406 men aged 18-40 years in a peri-urban settlement near Johannesburg. Past year transactional sex was assessed by asking men to self-complete five questions on transactional sex, items on sociodemographics, relationships, the Alcohol Use Disorders Identification Test, and the Sexual Relationship Power Scale. Multi-variate logistic regression in Stata v14 was used to determine associations between transactional sex and sociodemographic, experience, attitudinal and behavioural variables.
Results: Of the respondents who had ever had sex, 47% (n=1,004) reported transactional sex with a casual partner in the past year. Respondents reported providing, or thinking they were expected to provide, the following in exchange for sex: cash, somewhere to stay, family support, and consumables. Controlling for sociodemographics, men who lived in the community longer had higher odds of transactional sex compared to shorter-term counterparts (adjusted odds ratio [AOR]=1.31, 95% confidence interval [CI]= 1.03-1.67). Men reporting controlling behaviours had higher odds of engaging in transactional sex than those without (AOR=1.87, 95%CI=1.43-2.45). Hazardous drinkers had 33% higher odds of engaging in transactional sex than non-hazardous drinkers. Men reporting three or more sexual partners had more than tripled odds of engaging in transactional sex (AOR=3.85, 95%CI=2.92-5.09).
Conclusions and Recommendations: Addressing transactional sex in men remains crucial, especially where men engage in other concurrent risky behaviours. To address HIV risk in relation to transactional sex, future programmes need to address harmful masculinities, including relationship control, multiple partners and hazardous drinking. Programmes should aim to address social norms that men should provide financial support while female partners are expected to provide sex in return. Such programming may be particularly timely in under-resourced settings where HIV incidence remains high.

WEAC0503 - TRACK C3

Establishing Structures for Girls and Young Women to Report Sexual Violence within 72 Hours

11:15 – 11:30

Dhakwa Dominica, Mundingi Renias, Mudzengerere Fungai, Harbick Donald, Tafuma Taurayi
FHI 360, Harare, Zimbabwe

Issues: Adolescent girls and young women (AGYW) face a disproportionately high risk of contracting HIV. Gender Based Violence (GBV) remains one of the key drivers of HIV amongst women and girls in low income settings. 38% of girls and young women aged 15-24 in Zimbabwe experience sexual violence. Thus, girls who experience sexual violence are up to three times more likely to be infected with HIV. Sexual violence is associated with stigma and shame that has resulted in poor help seeking behaviour. Other reasons contributing to low reporting of sexual violence include negative attitudes of health care workers, limited knowledge of consequences and

fear of divorce.
Descriptions: The DREAMS Initiative in Zimbabwe established 72 Hour GBV Desks, a school-based initiative to facilitate GBV reporting, management and referrals. The desk creates linkages with health, social protection and legal services for survivors. A DREAMS Initiative transport voucher system supports learners to access GBV services. A School GBV Oversight Taskforce comprising teachers and learners manages the GBV Desk. GBV concerns include mental, physical, sexual, HIV, STI, and unwanted pregnancies. It also undertakes advocacy with school management and community leaders to address GBV related issues. Given that sexual violence has severe mental and physical consequences, the GBV Desk creates a safe supportive space for girls to discuss and share experiences. Teachers provide basic counselling and mentoring to girls. Through the GBV Desk girls' risk perception on sexual violence, skills and knowledge on identifying, managing and reducing sexual violence are imparted on the girls.
Lessons learned: Out of the total girls reporting sexual violence, 71%, girls referred through the GBV Desk accessed PEP within 72hrs. Participation of learners in selecting teachers that support them in dealing with sensitive issues increased learner interest and retention in program activities. Integration of transport voucher system builds a strong support structure for survivors of sexual violence.
Next steps: Schools and teachers have a key role to play in raising awareness on the medical impact of sexual violence. Thus, participation of learners in building and managing GBV management structures is critical to build confidence given the social barriers to disclosure and response to sexual violence. Linking schools to other service providers is critical for facilitating learner access to GBV services.

WEAC0504 -TRACK C3

Socio-economic Status and HIV Viral Suppression in an Urban Health Center in Rwanda

11:30 – 11:45

Kayihura Aline[1], *Asiimwe-Kateera Brenda*[2], *Hitimana Nadia*[3], *Gonzalez Perez Juan*[2]
[1]Kinyinya Health Center, Kigali, Rwanda, [2]AIDS Healthcare Foundation, Kigali, Rwanda, [3]Tulane University-Rwanda, Kigali, Rwanda

Background: In the HIV epidemic in Sub-Sahara Africa significant efforts have been made to provide the essential package of care and treatment services free of charge. In the context of the UNAIDS 90-90-90 targets, however, little is known about the influence of income level on achieving the 90% target of patients on ART virally suppressed. Here we use the "Ubudehe" socio-economic categories -used by the Rwandan welfare programs and graded on a scale of 1-4 (1 being the most vulnerable) - to look at the association between socio-economic status and viral suppression in people living with HIV (PLHIV) initiated on ART in a public health center supported by the AIDS Healthcare Foundation (AHF).
Methods: Data from all HIV positive adult patients active on ART in June 2017 and with known Ubudehe category were included in the study. Ubudehe category was identified through registers of patients receiving nutritional support (category 1) and subsidized medical insurance (category 2-3). Demographic and clinical data was extracted from electronic medical records. Association between variables of interest and viral suppression were analyzed by multivariate logistic regression.
Results: A total of 845 clients were recruited; 66% were females; 34% were between 40-49 years and 69% were WHO clinical stage 1 or 2. Majority of the patients (46%) belonged to Ubudehe category 3. In multivariate regression analysis, Ubudehe category 3 was inversely associated with viral load < 20copies/ml (Adjusted Odds ratio [aOR]; 0.60, 95% Confidence interval [95%CI]: 0.36-0.99; p=0.05) suggesting that clients in that category had less odds of having viral load suppression compared with clients in Ubudehe category 1. Age 18-24 year (aOR: 0.35, 95%CI: 0.16-0.75; p< 0.01) and baseline CD4 were also associated with undetectable viral load in the study

population.
Conclusions and Recommendations: Our study found that PLHIV in the higher socioeconomic group had an increased risk of unsuppressed viral load. The association could be related to their lifestyle with tight working schedules and job responsibilities (versus a highest percentage of category 1 and 2 clients, unemployed or having temporary jobs) affecting adherence to ART and on time attendance to clinical appointments. The better performance of patients in Ubudehe category 1 could be partly a consequence of the higher social support that these patients receive (nutritional, 100% free medical care) in comparison with the other three categories.

WEAC0505 - TRACK C3

Uptake of a Combination of Behavioural HIV Prevention Methods among Adolescent Girls and Young Women Involved in Sex Work in Kampala, Uganda

11:45 - 12:00

Mayanja Yunia[1], Bagiire Daniel[1], Kamacooko Onesmus[2], Namale Gertrude[1], Seeley Janet[3], Mayaud Philippe[1]
[1]MRC/UVRI & LSHTM Uganda Research Unit, HIV Interventions, Entebbe, Uganda, [2]MRC/UVRI & LSHTM Uganda Research Unit, Statistics, Entebbe, Uganda, [3]MRC/UVRI & LSHTM Uganda Research Unit, Social Science, Entebbe, Uganda

Background: Adolescent girls and young women (AGYW) involved in sex work are at particular risk of HIV and other sexually transmitted infections (STI) and require targeted interventions because the proportion of young people in Sub-Saharan Africa continues to increase. We describe uptake of combination of behavioral HIV prevention methods and associated factors among AGYW in Kampala, Uganda.
Methods: Between 2013 and 2018, we enrolled 1,898 participants 15-24 years at the Good Health for Women Project clinic, which provides services for female sex workers (FSWs) in Kampala. Volunteers < 18 years were mature/emancipated minors. Baseline data were collected on HIV, socio-demographics, sexual behavior, reproductive health, substance use, and intimate partner violence (IPV). The primary outcome was uptake of a combination of behavioral HIV prevention methods (consistent condom use with paying partners in the past month and ever testing for HIV). Associated factors were analyzed using logistic regression.
Results: Participants had a mean age 21 years (SD ±2.2), 53% had lower than secondary education and 42% were separated/ divorced. Mean age at first pregnancy was 17 years (SD ±2.2); 69% had at least one child, 36% reported using reliable contraception (commonly Depo Provera) and 19% had at least one STI syndrome. Most (92%) had ever tested for HIV before enrolling at the clinic, baseline HIV prevalence was 21%, 92% reported paid sex of whom half used condoms consistently with paying partners in the past month. Overall 41% reported uptake of both behavioural interventions. IPV was reported by 44%, mainly with casual partners, 28% were high-risk alcohol drinkers and 34% had ever used illicit drugs commonly marijuana and khat. Uptake of both behavioural HIV prevention methods was less likely among < 18 years (aOR 0.58; 95% CI 0.35-0.95), participants reporting IPV in past 3 months (aOR 0.59; 95% CI 0.47-0.73), those who were not using contraception (aOR 0.79; 95% CI 0.63-1.00) and those who had other jobs besides sex work (aOR 0.38; 95% CI 0.29-0.49).
Conclusions: Uptake of a combination of two behavioural HIV prevention methods was low. Younger FSWs need structural interventions; these should address IPV and improve contraceptive use. Other interventions such as oral pre-exposure prophylaxis are also of benefit to this group.

TIME 10:45 – 12:15 Uhr | ROOM Kigali (Auditorium) | DATE Wednesday, 04 December 2019

Track D: Law, Human Rights Social Science and Political Science, Kigali (Auditorium)

The "Tap Closes": Enhancing the Response of Key Population to HIV: The Imperative for Public Protection, Innovations and Human Rights

Chair: Dr. Etienne Karita

WEAD0601- TRACK D4

Navigating the Gaps Between Initiation and Retention of Key Populations Living with HIV (KPLHIV) on Treatment: Perspectives of Ghanaian KP-Focused Civil Society Organizations

10:45 – 11:00

Kye-Mensah Ebenezer
JSI Research and Training Institute Inc., Accra, Ghana

Issues: Although Ghana has made strides in its HIV and AIDs response, Key Population (KP) individuals living with HIV still face unique barriers at each stage of the HIV continuum of care. Ghana's strategy in achieving the 90-90-90 targets for Men Who have Sex with Men (MSM) and Female Sex Workers (FSWs) relies heavily on local Civil Society Organizations (CSO). An explicit understanding and remediation of the factors that lead to these leakages is essential for achieving the UNAIDS second and third 90 targets. However, the limited literature on the causal factors of the leakages in Ghana typically focuses on the viewpoints of KPs, services providers and policy makers. This paper examines the factors of leakages in linking and retaining KPLHIV in care and the remedies from the unique lenses of local implementing CSOs.
Descriptions: The JSI-implemented USAID/Strengthening the Care Continuum Project is Ghana's flagship KP-focused HIV program. The Project is implemented with 11 CSO partners operating in 12 districts. The Project conducts quarterly Peer Review Meetings (PRM) for staff and CSOs to share performance data, come to a common understanding of the causes of leakage and to discuss successful approaches in navigating these challenges. In June 2019, the Project conducted content analysis of PRM reports from April 2017 to May 2019 to examine successes, trends and replicable practices that have contributed to CSOs improving testing and treatment retention practices.
Lessons learned: CSO's identified two broad categories of causes of leakages: individual and structural levels factors, ranking individual as more influential in affecting drop out. Client-related issues such as denial of HIV status, lack of credible client addresses, self-stigma and misconceptions about the side effects of ARVs were identified. At the structural level, health facility related issues included the lack of privacy and confidentiality, poor service provider attitudes, discrimination and shortage of drugs, and general logistical issues with accessing health facilities with KP clients.
Next steps: There is an intrinsic benefit in exploring the causes of leakages in the continuum of care from the lenses of local implementing Civil Society Organizations. This reflective process serves as an additional incentive for the CSOs to examine and mobilize their diverse resources to ensure that KPLHIV are more effectively linked to and retained in care.

WEAD0602 - TRACK D4

Tracking HIV Prevention Responses among LGBTI Communities through Human Rights-based Advocacy in Rwanda

11:00 – 11:15

Mulisa Tom
Great Lakes Initiative for Human Rights and Development (GLIHD), Human Rights, Kigali, Rwanda

Issues: Rwanda counts between 500,000-1000,000 members of LGBT. The HIV prevalence among Men having Sex with Men is at 4.0%.[1] Stigma and discrimination associated to their gender identity are among factors behind HIV infections.[2] Rwanda counts currently 12 LGBT organizations, but do not benefit from that constitutionally guaranteed right to freedom of association.[3]

[1] National Strategic Plan of HIV response (July 2013-2018)

[2] GLIHD Report (2018). Best Practices and Stories to Track Human Rights Violation among Key Population

[3] Rwanda Constitution of 4th June 2003

Descriptions: In Rwanda there is no legal framework against or protecting LGBT. However, in 2011 Rwanda government signed the UN statement condemning violence against LGBT people. Within this context, through funding of UNAIDS Rwanda office, GLIHD in collaboration with RBC organized in November 2018 a high-level symposium of law enforcement officers on the linkages between HIV prevention and human rights to fast track responses for ending AIDS among key populations.

Lessons learned: Lack of human rights based intervention can fast fuel the spread of HIV and impact of diseases among LGBT. Using this approach is essential in dealing with issues and barriers relating to mechanisms of preventing new HIV infections among key populations.

Next steps:

1. Litigate one case in court to challenge the current policies and laws towards its harmonization for the benefit of LGBT communities (this shall impacts on actual situation of health services delivery to LGBT towards improvement of HIV prevention mechanisms);
2. Create legal-aid posts for LGBTs to report cases. A toll-free line shall also be established;
3. Take the lead to advocate for a specific law on HIV in Rwanda;

The approach will help LGBT to find better pathways towards reduction of the 4% HIV prevalence but also holding the government accountable to different human rights obligations.

WEAD0603 - TRACK D4

LGBT Security Intervention in Kenya

11:15 – 11:30

Njoka Kelly Kigera
Ishtar Msm, Advocay/Admin, Nairobi, Kenya

Background: SOGI security has been a great challenge in Kenya where by majority of the LGBT community have faced a lot of violence cases that are not being reported and documented with the fear of being arrested or detained, tortured, blackmailed or mob justice. Due to such cases/reports, we came up with an online platform called Utunzi Rainbow Security. Utunzi, meaning 'care' in Swahili, it's an online platform that allows individuals and organizations to report and document violations against lesbian, gay, bisexual, trans, intersex and queer (LGBT) individuals; respond to emergency security situations; track violations; and share information. It also provides information on LGBT concerns in Kenya and maintains searchable of recorded violations. It has a member of seven organization hosted by LENANA Cluster which is a part of Gay and lesbian coalition of Kenya (GALCK) and Nyanza, Rift Valley and Western Kenya LGBTnetwork, -NYARWEK

Methods: The Utunzi platform receives violation reports and requests for assistance from LGBTI at risk in Kenya through SMS (short-code 22069); email (report@utunzi.com); twitter @utunzinetwork and utunzi rainbow security application on the Google play store or through direct entry on the website via our reports page.Reports can be made anonymously or if an individual is requesting assistance can be made with a mobile number, email address, Twitter or Facebook account. Reports and requests for assistance are then received by the Utunzi team and responded to directly or through referrals to organizations on the ground. Res-ponders are selected on the basis of geographic location, their expertise and capacity.Utunzi will respond to reported cases of Human Rights violations and abuses on the basis of individuals' perceived and/or actual sexual orientation, gender identity and expression **Results:** Since 2018 we have sensitized members of the LGBT community on how to report cases and empowered them with civil education. We have handled at least 482 cases since June 2018 since utunzi started where by majority of the cases have been violation from the police ,Evictions ,physical violence blackmail of gay men and intimate partner violence ,which has affected our programing. **Conclusions and Recommendations:** There is also need of police sensitization on LGBTI issues and other violates of the SOGI community .There is need of sensitization of law enforcement in issues regards LGBTI introductions of programs that educate community on human rights.

WEAD0604 - TRACK D4

Enhancing Economic Viability to Reduce HIV Mobility among LGBT Persons in Botswana

11:30 – 11:45

Mosweu Onkokame
Men for Health & Gender Justice Organisation, Policy and Advocacy, Gaborone, Botswana

Issues: Increase economic viability of Lesbians, Gay, Bisexual and Transgender (LGBT) persons who are living in low socio-economic status through provision of economic empowerment trainings and creation of support systems in assisting them in starting small businesses to reduce HIV vulnerability and the disease burden. This strategy falls within structural intervention as a means to promoting combination prevention in HIV programming targeting LGBT persons **Descriptions:** Men for Health and Gender Justice piloted the "Rainbow Economic empowerment Programme". The process starts with a call for application to be part of the programme in two districts in Gaborone and Maun which are areas most affected by LGBT people living in low socio-economic bracket of the society, followed by Selection process and a two weeks training programme on Economic empowerment and highlighting how economic freedoms can reduce vulnerability to contracting HIV/AIDS. The trainings are conducted by LGBT persons who are in business with experience in building small businesses and such as it came as a unique peer to peer capacity building process. Monitoring and evaluation tools and processes are followed to ensure growth and positive performance by the LGBT persons trained and small businesses initiated. Results realized so far indicate that a total of 350 LGBT individuals were trained on entrepreneurship/business skills and 320 individuals were supported to start their own small business (138 are living with HIV). Preliminary results have indicated beneficiaries have experienced improved quality of life and reduced vulnerability to HIV infection **Lessons learned:** workable interventions such as economic empowerment are crucial for better health outcomes since vulnerability, in search of income, is highly reduced. This is so critical taking into consideration that this group is a high-risk population as far as HIV morbidity is concerned to achieve HIV cascade 90,90,90 among LGBT persons in Botswana. **Next steps:** The organisation will be sharing the lessons learnt and best practices from this programme with different key populations movements across Botswana and Africa as well as training more LGBT persons on the programme.

WEAD0605 - TRACK D4

Access' Barriers and Perceived Quality of Sexual Reproductive Health (SRH), Gender Based Violence (GBV) and HIV Services among Adolescents and Young People (ADYP) in Zimbabwe

11:45 - 12:00

Zimbizi George[1], Mpofu Amon[2], Mutimwii March[1], Nyamucheta Masimba[2], Senzanje Beula[3], Pierotti Chiara[3]
[1]UNICEF Consultant, Harare, Zimbabwe, [2]National AIDS Council, Harare, Zimbabwe, [3]UNICEF Zimbabwe, Harare, Zimbabwe

Issues: Almost half of all HIV new infections in Zimbabwe occur amongst adolescents and young people (ADYP).

Descriptions: In November-December 2018[CP1] , National AIDS Council and UNICEF conducted an Assessment in 6 selected districts on availability, accessibility, quality and barriers to Sexual Reproductive Health (SRH), Gender Based Violence (GBV) and HIV services among AYDP. After ethical approval, 55 Key Informant Interviews with service providers (SPs), 4 Focus Group Discussions with Caregivers and 21 with different ADYP groups were conducted. Thematic content analysis was used for qualitative data while descriptive statistics were generated from U-Report (14,742 ADYP respondents).

Lessons learned: SRH, GBV and HIV services, mainly provided by LNGOs, were available, but not evenly across the districts. Traditional and faith healers were identified as alternative SPs. 66% ADYP reported access to HIV, 59% GBV and 48% SRH services, with difference among districts (36%-74%) and gender (60% girls; 57% boys). NGO were perceived to provide better quality and youth-friendly services (YFS) than public especially for Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI); Young Female and Male Sex Workers (YFSWs, LMSWs) and adolescents living with HIV (ALWHIV). Only YMSWs revealed going to local clinics but as ordinary males. Barriers to services access were: religion; culture; negative masculinity; service fees, long distances; commodities shortage; SPs breaching confidentiality; unfriendly and judgmental SPs attitudes; stigma and discrimination in public facilities towards ALWHIV and adolescents living with disability (ALWD); LGBTI and YFSWs fear to be reported to police; lack of information material for LGBTI and ALWD; lack of SPs' adequate skills to provide services to ALWD, LGBTI and YFSWs; lack of ALWD-friendly infrastructures; caregivers' conservative attitudes.

Next steps: Key gaps to be addresses are: training of SPs particularly in government institutions on YFS to meet the different ADYP groups' diversified needs without feeling judged or stigmatized; scale up SRH and GBV services as ADYP have limited access compared to HIV services; target gender and cultural-related barriers through strengthening male engagement and intensifying parent-ADYP communication; develop SRH information tailored for most vulnerable ADYP; monitor ADYP satisfaction with surveys and routine feedback system (suggestion boxes, social media or SMS platforms).

TIME 16:45 – 18:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Wednesday, 04 December 2019

Track C: Law, Human Rights Social Science and Political Science

HIV / AIDS Prevention Programmes

Chairs: Dr. Almoustapha Maiga

WEAC0701 - TRACK C4

Mise en Place du Programme de « Marrainage „ pour l´élimination de la Transmission du VIH de la Mère à l´enfant dans le District Sanitaire de Guédiawaye

Diouf Maty
Ministère de la Sante et de l'Action Sociale, District Sanitaire de Guediawaye, Dakar, Senegal

La communauté internationale s'est engagée pour mettre fin à l'épidémie du VIH à l'horizon 2030. Pour ce faire, l'élimination de la transmission verticale demeure le premier levier sur lequel les programmes doivent s'appuyer. Malgré les progrès notés, le Sénégal n'a pas atteint les objectifs de l'élimination d'où la nécessité de mettre en place des stratégies innovantes à savoir: Ø le renforcement de la décentralisation de la PTME au niveau des postes de santé Øla délégation des taches (dépistage, PEC et suivi), ØL'intégration des services et l'accompagnement des structures sanitaires . ØC'est ainsi que le DS de Guediawaye a adopté ce programme de « marrainage » afin de capitaliser l'engagement de la sage-femme et de renforcer son apport dans l'atteinte des objectifs de l'eTME et ceci pour mieux booster les indicateurs du programme.
Objectifs: Améliorer l'offre de services offerte par la sage-femme aux femmes enceintes séropositives et à leurs familles en vue de l'élimination de la TME. •Promouvoir un modèle d'engagement de sage-femme dans le programme d'Elimination de la Transmission Mère-Enfant du VIH.
Methodes: la formation•des sages-femmes et des acteurs communautaires sur le paquet de soins à offrir au cople mere enfant le coaching sur site
Resultats: Les acteurs communautaires (n=65) ont été capacités et mobilisés pour la sensibilisation au niveau des zones respectives

- l'offre de services de PTME au niveau des points de prestation est disponible
- les TDR syphilis duo sont disponibles
- Douze femmes enceintes séropositives âgées de 26 à 45 ans sont suivies de janvier 2017 à juillet 2018 au niveau des postes de santé avec deux PDV en 2017 et une en 2018 lesquelles recherchées et retrouvées
- Toutes ont eu une charge virale indétectable et la PCR réalisée à tous les enfants elligibles. est revenue négative
- les outils ont été mis à jour
- Légère hausse des données reportées dans le DHIS2 et le rapport transmis par le point focal PTME
- le programme marainage a démarré dans les postes

Conclusion et Recommandations: L'élimination de la transmission du VIH de la mère à l'enfant est une réalité grâce à la mise en place d'un dispositif de prise en charge intégré et de qualité et d'un engagement fort de la part de tous les acteurs. • Le programme marainage demeure une bonne pratique à documenter afin de le capitaliser et le passer à l'échelle.

WEAC0702 - TRACK C4

Sex Positive Approaches in Delivery of Sexual Reproductive Health & HIV and AIDS Related Education and Information to School Going Adolescents and Young People

13:00 – 13:15

Amina Judy[1], *Mwashi Annete*[2], *Dambalash Ermias*[2], *Singh Arushi*[3]
[1]Kenya SRHR Alliance, Nairobi, Kenya, [2]Family Health Options Kenya, Nairobi, Kenya, [3]Pleasure Project, Goa, India

Background: Although there have been huge improvements in diagnosis and treatment of HIV and AIDS, there are 36.7 million people worldwide living with HIV & AIDS. Sub-Saharan Africa has been hit hardest with 24.7 million living with HIV in 2013.More than half of the world's population 2.9 billion people is under the age of 25 and 80% of all HIV-positive young women (aged 15-24) live in SSA in 2013. Taking into account the HIV prevalence among young people and that young people worldwide are having sex by the average age of 18 years, its ever more critical to deliver engaging safer sex education at a global scale, particularly to those living in low and middle-income countries

Its against this that the Kenya SRHR Alliance through the GUSO program conducted a research dubbed the pleasure audit which was intended to understand and unpack what is meant by an environment that is positive towards young people's sexuality

Methods: Qualitative methods were used for the study with 6 in-depth interviews, 5 focus group discussions with a total of 15 male &13 female respondents (age 13-25) and 1 CSE session observed

The following key research questions were used;

To what extent is CSE under GUSO inclusive of the elements of a sex-positive approach?

How are messages that promote a sex positive view and that move beyond purely prevention of disease expressed in the sexuality curricula and IEC materials? Do facilitators feel comfortable to respond to learners questions on relationships, HIV & AIDS,consent and sex comprehensively and encourage them to be responsible for their sexual well-being by questioning social and gender norms that govern these? Do learners feel more positive about their own bodies and have more sexual self-esteem, are they able to express their sexual expectations and desires in a clear manner?

Results: Despite a socio-cultural and legislative context that curtails the discussion of sex, condoms, contraception, and pleasure among young people, especially those in-school, it is possible to adopt a sex-positive and pleasure-based approach. From the study we learnt that learners want more reliable information on sexual pleasure, safe sex and healthy relationships

Conclusions and Recommendations: Sex education curricula existing in different institutions in general need to have comprehensive and clear information on HIV&AIDS, PeP & PreP, sexual diversity, healthy relationships, enjoyment of body and skills, gender transformative approaches and mental health

WEAC0703 - TRACK C4

Évaluation de l´accès aux Services Complets de Prévention du VIH/SIDA pour les Populations Clés dans le District de Santé de Bamenda

13:15 – 13:30

Nkenjeu Tchiegang Olivier
Affirmative Action Cameroon, Yaoundé, Cameroon

Introduction: Avoir accès aux services de santé de qualité et à des services complets de prévention du VIH / sida font partir des droits fondamentaux pour tous, indépendamment de l'âge, du genre, du sexe et de l'orientation sexuelle. Avoir les services de prévention du VIH accessibles aux populations clés, malgré des obstacles sociaux, religieux et juridiques, contribuera dans une large mesure à réduire l'incidence parmi ces groupes, à améliorer les résultats pour la santé et

à réduire la prévalence du VIH dans la population en général. Malgré l'importance d'accroître l'accès aux services de prévention, la plupart des études ont été consacrées à l'accès aux traitements au détriment de l'accès à la prévention. **L'objectif principal:** de ce résumé était d'étudier dans le district de santé de Bamenda, les obstacles à l'accès aux services de prévention du VIH pour les populations clés (KP) en générale et particulièrement pour les Travailleuses de sexe (TS) et les hommes ayant des rapports sexuels (HS). En particulier, l'étude visait à mener une enquête et ressortir une analyse situationnelle des facteurs de non-accessibilité aux services de prévention du VIH pour les HSH et les TS dans le district de Santé de Bamenda. **Methode:** le résumé se base sur une étude ressente qui pour obtenir des données pour l'étude, à administrer un questionnaire à 373 TS et 199 HSH dans la région de Bamenda. Ceci a permis de faire une évaluation de l'accès des services de prévention et de l'acceptabilité de ceux-ci par les KP dans la région. Les données ont été analysées à l'aide de statistiques descriptives, et des régressions bi variées et multivariées.

Résultats: 29,2% des TS et 55,8% des HSH ayant participé à l'étude avaient accès à des services complets de prévention du VIH. **Leçons apprises:** Des obstacles importants tels que la distance géographique, la non-prise de conscience de l'endroit où obtenir des services, les politiques et lois répressives, les mœurs et coutumes, ainsi que le manque d'informations dans l'utilisation du préservatif étaient tous des facteurs limitant l'accès aux services de prévention. **Conclusions et Recommandations:** Ainsi, pour un meilleur accès aux services de prévention et une bonne appropriation par les KP, les acteurs doivent prendre en compte ces barrières observées, accompagner de méthodes de préventions novateurs.

WEAC0704 - TRACK C4

Targeting Men through Testing Patients with Sexually Transmitted Infections at Kuisebmund Health Centre

13:30 – 13:45

Mangwana Hadrian[1,2], Chirairo Harugumi[2], Hanganda Elia[3], Shaehama Lavinia[4], Johannes Martha[4], Brandt Laura[2], Forster Norbert[2], Barnabee Gena[2], Omalley Gabrielle[2]
[1]Society for Family Health Namibia, Windhoek, Namibia, [2]International Training and Education Center for Health, Windhoek, Namibia, [3]MoH, Namibia, Namibia, [4]MoH, Windhoek, Namibia

Background: In Namibia only 79.6% of males know their HIV status (NAMPHIA 2017), suggesting a considerable gap in diagnosing PLHIV. Sexually transmitted infections (STIs) involve a high HIV risk, hence targeted testing of STI patients may reduce the diagnosis gap. In Kuisebmund Health Centre (KHC), STI patients were not routinely tested for HIV before this intervention. **Methods:** This review includes patients diagnosed with a STI at KHC between October 2017 and September 2018. Each STI patient with unknown HIV status was offered a test and "STI" was noted in the register when tested. Those with negative results were booked for retesting 3 months later and if tested were documented as "STI retest". A retrospective baseline review was carried out to estimate the HIV status of patients with STIs compared to patients without. **Results:** Of 1891 patients treated for STIs 590 (31.2%) were tested for HIV. 68.8% were not tested because of known status, refusal, and presentation during after-hours or weekends (43%). 342 (58%) of tested STI patients and 27 (69%) of HIV positive STI patients were male. The positivity yield was significantly higher in STI compared to non-STI patients (6.6% vs 3.6%, p=0.002). The odds ratio of testing positive was 1.8 (CI 1.3 to 2.5, p=0.001) times higher in STI compared to non-STI patients and after stratifying by sex it was 1.8 (CI 1.1 to 2.7, p=0.008) for men and 1.5 (CI 0.8 to 2.6, p=0.21) for women. Over the last 4 months, 110 initially HIV-negative STI patients were booked for retest. Of these, 42 (38.2%) were re-tested, with 9.5%

(4) testing positive (these clients are excluded from the 39 mentioned above). **Conclusions and Recommendations:** Targeting STI patients for HIV testing and offering re-testing to those initially negative is associated with a higher yield of HIV positive cases and a high proportion of newly diagnosed HIV positive men. Since uptake of routine HIV testing and re-testing for STI patients remains low, offering after hours and weekend testing should be explored.

WEAC0705 - TRACK C4

Assessment of HIV Service Packages for People Who Inject Drugs in 13 African Countries

13:45 – 14:00

Burrows Dave[1], McCallum Lou[1], Falkenberry Haley[1], Parsons Danielle[1], Zhao Jinkou[2]
[1]APMG Health, Washington, United States, [2]The Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria, Geneva, Switzerland

Issues: Design and implementation of HIV service packages for people who inject drugs (PWID).

Description: As part of a larger Global Fund-funded project, APMG Health conducted assessments of the design and implementation of HIV service packages for PWID in 13 countries (Angola, Benin, Cameroon, Kenya, Madagascar, Malawi, Mali, Morocco, Sierra Leone, South Africa, Sudan, Togo and Tunisia), including desk reviews and key informant interviews, site visits, and focus group discussions with PWID in each country.

Lessons learned: Most countries (nine out of 13) assessed have defined packages of services for PWID, though some only partially adhere to the recommended interventions according to WHO guidelines. All countries include condom programming, and half include lubricant; all include behavioral interventions, HIV testing, counseling, treatment, and care services; twelve out of 13 include prevention services for co-infections and co-morbidities; and all but two of the 13 countries assessed include sexual and reproductive health interventions. Most countries fail to include the full suite of harm reduction programs, though some programs exist in half of the countries assessed. Very few countries include supportive laws and policies, ways to address stigma, discrimination, and violence, and community empowerment activities. Coverage rates for PWID in HIV prevention and harm reduction services are scarce, with data only available from half of the countries assessed, without data available on each type of service. Estimates of coverage of HIV prevention packages range from 28% in Sierra Leone to 112.3% in Benin. There was evidence that some HIV programming for PWID is being successfully implemented (in particular in Kenya); however, the evaluation reveals questions on the quality and coverage of services in most assessed countries.

Next steps: Findings of these assessments allow for the analysis of the quality and coverage of services for PWID through several levels of the health system in the countries assessed, with respect to beneficiary experience, implementation and programmatic aspects, and funding. Recommendations are offered for improved adherence to WHO guidelines for packages of services for PWID, including more attention being paid to sub-populations of PWID, including women, youth, and migrant populations who inject drugs, scaling-up needle and syringe programs, and studying barriers to adherence in opioid-substitution therapy.

TIME 12:45 – 14:15 Uhr | ROOM Kigali (Auditorium) | DATE Wednesday, 04 December 2019

Track D: Law, Human Rights Social Science and Political Science

Addressing the Health Needs of Adolescents and Diverse Populations: Migrants, MSM, Sex Worker

Chair: Mr. Ider Dungerdorj

WEAD0801- TRACK D5

Sexual Reproductive Health and Rights (SRHR), HIV Migration Programming across Migration Corridors in Six SADC Countries

12:45 – 13:00

Shingwenyana Ntiyiso[1], *Bwambale-Mulekya Francis*[2], *Ngcobo Nonkululeko*[3]
[1]Save the Children International, SRHR, Pretoria, South Africa, [2]IOM Regional Office, Migration Health/SRHR, Pretoria, South Africa, [3]IOM Regional Office, Monitoring and Evaluation, Pretoria, South Africa

Issues: Migration predisposes to increased SRHR and HIV vulnerabilities. SRHR and HIV among adolescent migrants, young people and migration-affected communities is a worldwide concern that requires urgent attention by governments, development partners and the society. Current regional and national HIV trends reveal an increasing burden of new HIV infections among adolescents and young people aged 15 to 24 years. There are a number of reports linking migration to increased risk for acquisition of HIV and other sexually transmitted infections. In response to the challenges, the "Knows no Borders" consortium implements the SRHR HIV Knows no Borders Project across migration corridors in six SADC countries, described in this paper. **Descriptions:** Implemented in cross border districts of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia. The intervention works at three outcome levels. Level 1 - Demand Creation: In each country, community members representing the AYPs, migrants and sex worker populations were trained to conduct door-to-door health education followed with referrals for services. Level 2 - Increased Access to Services: Service providers, from each of the six countries; both health and non-health, were trained to provide AYPs, migrant and sex worker responsive services. Level 3 - Enabling Environment: Conduct advocacy engagements at district, national and regional levels. **Lessons learned:** 886 trained change agents actively providing services; the program reached 302 897 beneficiaries with SRHR-HIV education, 207 schools providing comprehensive sexuality education, and 851 service providers capacitated. 18930 beneficiaries referred to services, by end of 2018. Achieved 108 community dialogues, 107 forums for the beneficiaries to advocate for their rights and 46 inter-sectoral collaborations through which 1818 local, national and regional level policy makers; gatekeepers and influencers have been sensitized. 1. Capacity building improves access to services. 2.Positive outcomes (income generation, school for child sex workers, community savings by sex workers)3. Effective continued care achieved through cross border forums **Next steps:** Continue strengthening community engagement and participation, also leverage collaboration and partnerships with government and other stakeholders for beneficiaries to access health facilities, communities and schools with SRH-HIV services and information. Scale up to high prevalence SADC countries.

WEAD0802 - TRACK D5

Addressing the Mental Health Status of ALHIV Aimed at Improving Adherence at Rafiki Clinic

13:00 – 13:15

Munyoro Dennis[1,2], Otieno Brian[3], Nyandiko Winston[2,4], Apondi Edith[2,4], Scanlon Michael[5], Chemon Jane[4], Aluoch Josephine[4]

1Ampath Center, Pediatric Research, Eldoret, Kenya, 2Moi University, College of Health Sciences, School of Medicine, Department of Child Health and Pediatrics, Eldoret, Kenya, 3Alfajiri Network CBO, Nairobi, Kenya, 4Academic Model Providing Access to Healthcare (AMPATH), Eldoret, Kenya, 5Icahn School of Medicine at Mount Sinai, New York, United States

Introduction: According to the World Health Organization, most mental health disorders manifest around the age of 14, affecting an estimate of 12.3 global population, thus making adolescents particularly vulnerable to poor mental health which has a significant impact on physical and psychosocial development. In Kenya, the National Bureau of Statistics reported only 412 mental health-related deaths in 2018 among adolescents and young people. This is likely a significant under-estimation due to a variety of factors, including poor and late diagnoses, stigma associated with mental health, poor knowledge of mental-health, weak monitoring and reporting systems. Rafiki Clinic, located at Moi Teaching and Referral Hospital- Eldoret, hosts 887 ALHIV is an adolescent-focused comprehensive care center, which includes providing care in all aspects of HIV for ALWIH, including clinical care and psychosocial and peer support programs. Adolescent peer mentors and educators form a core component of the Rafiki care model **Methodology:** Safe spaces were established for adolescent clients that are led by trained peer mentors to facilitate conversations about mental health and create a forum for adolescents to share their experiences during "health talks." A linkage and referral system was established for severe cases or where professional medical attention was needed for psychiatry and psychology programs at MTRH. In collaboration with psychiatry and psychology teams, reporting tools was created to facilitate linkage to further care if necessary. Finally, we established a buddy bench and mental buddies among adolescent clients themselves. **Results and Findings:** We examined changes in the viral load suppression rates determining if in-cooperating mental health in the care package will improve suppression rate among adolescents living with HIV. Between January and April 2019, a total of 138 ALHIVs aged 10 to 24 years of age participated in the implemented programs. During this time, there was an increase in viral load suppression from 76.7% to 79.3%. During this period 5 adolescents were identified with mental disorders and were linked to treatment. **Conclusion:** Mental health being among the package of care in the UHC package launched recently by His Excellency Uhuru Kenyatta, it's important to have this as a package of care in primary health care

WEAD0803 - TRACK D5

Using Strategic Care Programs to Improve Adherence to Treatment among Men Who Have Sex with Men (MSM) in Nigeria

13:15 – 13:30

Nnolum Chukwuebuka[1], Aka Abayomi[2], Ashiri Daniel[1]

[1]International Center for Advocacy on Right to Health, Care and Support, Abuja, Nigeria, [2]International Center for Advocacy on Right to Health, Management, Abuja, Nigeria

Issues: A large number of HIV infected men who have sex with men (MSM) live with clinical depression and do not have a positive attitude to life. There is huge burden of stigma and discrimination which leads to various mental health issues ranging from depression to suicidal thoughts and attempts. This also contributes to non-adherence to clinical appointments and ART, thus affecting treatment progress, viral suppression and retention to HIV care. **Descriptions:** The International Center for Advocacy on Right to Health (ICARH) manages a specialized one stop shop (OSS) clinic that provides free comprehensive HIV care and other Sexually Transmitted Infection (STI) treatment services to sexual minorities

and key populations in Abuja, FCT and its environs. It was established in the year 2011 with support from Institute of Human Virology Nigeria (IHVN). ICARH currently has over 800 HIV positive key populations (KP) in care with over 70 female sex workers in care. **Lessons learned:** From 2011 - 2017, ICARH recorded total of 415 MSM in HIV care who routinely passed through adherence, nutritional, psycho-social and economic counseling and assessment at the ICARH OSS Clinic on different appointment dates. Report showed that 43% [178] was clinically depressed, 15% [62] nutritionally malnourished, and 35% [145] are economically challenged. This made retention in care challenging reducing it to from 60% as at December 2016 - 40% in December 2017 with 3 deaths within a period of 12 months. In the January 2018, ICARH initiated a strategic care program for HIV positive MSM in FCT to address issues of adherence and retention in care. The program provided community based support group services, nutritional and psycho-social support, skill acquisition training and empowerment, Home based HIV care, Human Rights trainings, community based prevention awareness outreach and friendly community centre furnished with indoor and outdoor games and access to internet. In December 2018, ICARH recorded a total 475 KP currently on Antiretroviral Therapy (ART) with a reduction rate of 15% [71] in clinical depression, 5% [24] on nutritional malnourishment, and 10% on economic challenges. Clinical evaluation report also recorded 80% [380] on retention rate and 70% [332] on viral suppression with 1 death. **Next steps:** There is need to adopt and integrated services models that anticipates and addresses psychological and socioeconomic challenges of MSM living with HIV to achieve retention in care.

WEAD0804 - TRACK D5

Systems Analysis and Improvement Approach to Optimize Sexual and Reproductive Health Services Uptake among Young Women who Sell Sex in Kilifi County, Kenya

13:30 – 13:45

Manguro Griffins[1], Langat Lillian[2], Okoro Dan[2], Temmerman Marleen[3]
[1]International Centre for Reproductive Health Kenya, Mombasa, Kenya, [2]UNFPA, Nairobi, Kenya, [3]Aga Khan University, Nairobi, Kenya

Issue: Poor uptake of HIV services among young sex workers remains a major challenge for key population programs in Kenya. Sex workers have high HIV prevalence; 29% compared to 4.9 % for the general population. Young sex workers are a priority because of higher vulnerabilities from low self-perception of risk, little SRH knowledge and high rates of sexual violence. They do not readily seek available services as they may not identify as sex workers and experience greater self-stigma. Additionally, approaches outlined in the Kenya national guidelines do not identify or address the needs of young sex workers. There is therefore need for evidence-based interventions to promote service uptake for young FSW. **Description:** Between January and December 2018, we applied an iterative five-step systems analysis and improvement approach to test simple, cost-effective interventions to optimize service uptake among young sex workers in Mtwapa, Kenya. Step one comprised focused-group discussions with sex workers aged 15 to 20 years to identify needs, barriers and facilitators. In step two, young sex workers charted a process map and identified modifiable bottlenecks to service uptake. In step three, we proposed adaptations to the process flow to eliminate the bottlenecks. In step four and step five, the proposed interventions were implemented, with three-monthly assessments to evaluate the success of the interventions and make changes where necessary. **Lessons learnt:** Bottlenecks identified were: age-related barriers between young sex workers and peer educators, young sex workers were reluctant to visit the sex worker clinic, and the clinic only provided HIV services. To eliminate these bottlenecks, we: recruited younger peer educators (15 to 18 years), did twice-a-month outreaches at hotspots, increased the range of services, introduced counselling for alcohol and drugs and set-up psychosocial support for HIV positive sex workers. Of an estimat-

ed 1,800 young sex workers in Mtwapa, 288 (17%) received SRH services between October to December 2017 compared to 1481 (82%) between October to December 2018. Likewise, of 408 FSW who initiated oral pre-exposure prophylaxis, month three continuation rates improved from 36% before intervention to 70% after intervention. **Next steps:** Findings emphasize the utility of a program learning approach with strong community involvement to optimize HIV services. such approaches can improve HIV service uptake for other key population groups.

WEAD0805 - TRACK D5

People Living with HIV Navigating Disengagement and Back to Art Care: Lessons from Community Outreach Services in Cape Town, South Africa

13:45 – 14:00

Dubula-Majola Vuyiseka[1], White-Ndwanya Takiyah[1], Sishuba-Zulu Masibulele[2], Pokolo Sivuyile[3], Mayekiso Noxolo[3], Melani Nonqaba[3], Stofile Akhona[3], Mabhulu Sikhangele[4], Oyiya Siphokazi[4], Obose Busisiwe[2], Klauze Jean Jacques[1]

[1]Stellenbosch University, Africa Centre for HIV/AIDS Management, Cape Town, South Africa, [2]Activist Education and Development Centre, Cape Town, South Africa, [3]Movement for Change and Social Justice, Cape Town, South Africa, [4]Sonke Gender Justice, Cape Town, South Africa

Disengagement from care appear to be increasing especially those not initiated ART and those have been on ART. Evidence suggests that adolescents, people who have not disclosed their HIV status, men, and pregnant women withdraw from care struggle more than other. Therefore, the fast track goals will not be met. One major challenge is missed appointments which are inevitable in the lifelong journey of those living with HIV. Combined humanistic approaches must include minimizing barriers upon re-entry to care including creating unique patient identifier to facilitate migration, reduce loss of patient folders, reduce time waiting for care , improve health worker attitudes , introduce after hour ART services, increase support for the newly diagnosed to prevent long-term disengagement.

Through a consortium of community based organisations in partnership with the academic institution, we collected qualitative and quantitative data to understand these challenges.

A total 31 489 people of whom 49% males and 47% females utilizing HIV Rapid tests and HIV saliva test (Ora-quick) in the City of Cape Town. New 998 positive found and (68%) linked to care. Reasons for refusing ART including lack of readiness to start ART,need more counselling support, being afraid to disclose their HIV-positive status to family members or sexual partners until the boyfriend is tested, lack of permission from employer and lack of after hour services .

Community outreach trackers travelling outside the health facilities clinics to locate patients in the community. 669 people defaulting out of those 414 were linked to care. Various reasons were found including missed appointments/visits, no transfer letter, long queues, migration, Change of clinics , fear of punishment in health facilities, missing folder and poor health services. Self-reported ART defaulters use mobile testing services as pathways for back to care. 342 self-reported positives that came and out of those we successfully linked 224 back to care.

Minimise barriers to patient re-entry into care such as transfer letters. Introduce unique patient identifier to facilitate people moving from clinic . Community outreach HIV services are essential in both tracking and supporting people who have disengaged in care. Engaging employers through the workplace policies needs to be revisited.

Efforts to prevent missed clinic visits will need combined approaches that include minimizing barriers to back to health system challenges.

WEAD0806 - TRACK D5

Violence Victimization and Viral Load Failure among HIV-positive Adolescents and Young Adults in Ndola, Zambia: A Mixed Methods Study

14:00 – 14:15

Merrill Katherine[1], Campbell Jacquelyn[2], Decker Michele[3], McGready John[3], Burke Virginia[3], Mwansa Jonathan[4], Miti Sam[4], Frimpong Christiana[4], Kennedy Caitlin[3], Denison Julie[3]

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Background: Virtually no studies have examined violence victimization and viral load (VL) failure among adolescents and young adults (AYA) living with HIV in sub-Saharan Africa. We examined this relationship using data from Project YES! (Youth Engaging for Success), a randomized controlled trial among HIV-positive AYA, ages 15-24 years, in Ndola, Zambia. **Methods:** Baseline trial data were analyzed from four HIV clinics. Multiple logistic regression was used to obtain crude and adjusted associations between VL failure (>=1,000 copies/ML) and past-year violence victimization, measured in five modalities: any violence (physical violence, psychological abuse, or forced sex), frequency/severity of violence, type of violence, perpetrator group, and polyvictimization (2+ violence types). In-depth interviews were conducted with 41 trial participants (17 male, 24 female) and thematic analysis performed. Results were triangulated across methods. **Results:** Of 272 AYA included in analyses (59.3% female, 72.9% perinatally infected), 73.5% (n=200) experienced any past-year victimization and 36.7% (n=100) had VL failure. In adjusted models, higher odds of VL failure were observed among those reporting: high frequency vs. no violence victimization (adjusted odds ratio, AOR: 2.63; 95%CI: 1.06-6.51; p< 0.05); high frequency vs. no psychological abuse victimization (AOR: 4.70; 95%CI: 1.64-13.45; p< 0.01); and any vs. no violence from a non-caregiver family member (AOR: 2.65; 95%CI: 1.49-4.74; p< 0.001). Some but not all interviewees qualitatively described how violence influenced their VL. For instance, several experienced psychological abuse due to their HIV status, which spurred thoughts of suicide and hampered medication adherence: "My being HIV-positive has brought me trouble at this home…Each time they [insult and ridicule me], I just think of killing myself. I even..stop[ped] taking my medication…for two months." **Conclusions and Recommendations:** Past-year violence victimization was highly prevalent and associated with VL failure. AYA described multiple pathways through which victimization related to VL failure. Addressing the frequency, type, and perpetrator of violence against HIV-positive AYA may be critical to preventing VL failure and mitigating the spread of HIV. HIV interventions for AYA must account for frequent exposure to psychological abuse, which may be an important but overlooked barrier to viral suppression.

Keywords: Violence, viral load failure, youth, Zambia

TIME 14:45 – 16:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Wednesday, 04 December 2019

Track C: Epidemiology and Prevention Science

Basic HIV Epidemiology

Chairs: Dr. Stephen Ayisi Addo

WEAC0902 - TRACK C5

An Assessment of Drug Use among People in Prisons: The Nigerian Experience

13:00 – 13:15

Anenih James[1], Ashefor Greg[1], Ikomi Esther[1,2], Stople Oliver[3]

[1]National Agency for Control of AIDS (NACA), FCT Abuja, Nigeria, [2]UNODC, FCT Abuja, Nigeria, [3]Nigerian Prison Service, FCT Abuja, Nigeria

Background: People in prisons (PIP) are key populations not only for HIV and other sexually transmitted infections (STIs) but also for tuberculosis (TB) and Hepatitis B (HBV) and C (HCV). Penal institutions all over the world are considered environments for fast and uncontrolled spreading of HIV and Hepatitis B due to many risk factors including unsafe sexual practices as well as poor health care and living conditions. We assessed prevalence of HIV/AIDS and presumptive TB among PIP, and drug use among the people in Nigerian prison. **Methods:** A cross-sectional descriptive study was employed for the assessment. The study covered twelve prisons across the six geopolitical zones. HIV was assessed using single algorithm while TB was assessed using clinical screening of symptoms. Descriptive statistics with 95% confidential interval was conducted for key outcome variables while Chi Square test was used to assess differences between categorical variables. Ethical approval was obtained from the National Health Research Ethics Committee. **Results:** A total of 2,511 people in prisons participated in the study with 92% male proportion. About 50% of the respondents were aged 25 - 35 years. Overall, 55% had a lifetime history of drug use prior to confinement. The most common drugs used in Nigerian prison were cannabis (51%) and opiates (tramadol 23% and codeine 19%). Males reported higher drug use than females. Both injecting and non-injecting drug use were reported by people in prisons. About 50% of respondents had a lifetime history of use of cannabis. For non-medical use of opioids it was 16% among people in prison compared to 5% among the general population. Estimated proportion of people who inject drugs in prison was about 2.5% and about 2% of respondents reported initiating injecting drug use in prison. **Conclusions and recommendations:** This study demonstrates the use of drugs among people in Nigerian prisons and showed that majority of the drugs used are of the non-injecting type. Given the high rate of infectivity for both HIV and hepatitis via direct inoculation through contaminated needles, evidence based strategies are required to eliminate needle sharing, targeted intervention to male prisoners while also controlling both injecting and non-injecting drug use within prisons.

Keywords: Assessment, Drug, prisons, use

WEAC0903 - TRACK C5

A Mixed-Method Study Exploring the Clinical and Social Status of Young Mothers Living with HIV and Their Children in Zimbabwe

14:00 – 14:15

Mupambireyi Zivai[1], Simms Victoria[2], Willis Nicola[3], Cowan Frances[4,5]

[1]Centre for Sexual Health & HIV Research Zimbabwe, Children and Adolescent, Harare, Zimbabwe, [2]London School of Hygiene and Tropical Medicine, London, United Kingdom, [3]AFRICAID Zvandiri Programme, Harare, Zimbabwe, [4]Liverpool School of Tropical Medicine, Liverpool, United Kingdom, [5]Centre for Sexual Health & HIV Research Zimbabwe, Harare, Zimbabwe

Background: The success of ART means that an increasing number of perinatally HIV infected adolescent girls and women are reaching adulthood and becoming pregnant. We investigated the clinical and social situation of young mothers living with HIV and their children using a mixed-methods study. **Methods:** Participants were HIV positive young women aged 15-24 years and their infants from two districts in Zimbabwe. Mothers completed a structured interview, had a full clinical examination and a psychological assessment. Children had a clinical assessment and completed the Malawi Developmental Assessment Tool. Additionally, a sub set of mothers took part in in-depth interviews (n=16), audio diaries (n=10) and agreed for their partners to be interviewed (n=7). Quantitative data were analysed descriptively and with chi square tests using STATA 15 and qualitative data were analysed using thematic analysis. **Results:** 177 mothers and 176 children were enrolled. The median age of children was 12 months (IQR 5-27 months, range 0-101 (8 years)). 35.0% of mothers were perinatally infected. Most women (68.4%) were married, and 76.3% were unemployed. The study found high rates of viral suppression (86.9% with viral load< 1000 copies/ml) and few infants (6.2%, n=11) were HIV infected; all were on ART. Mental disorder symptoms were common with over half of women scoring above the cutpoint for risk of common mental disorder and depression. Symptoms of poor mental health were significantly associated with poor adherence and with experience of violence. There was strong evidence of association between experiences of violence and risk of depression. 65.1% of mothers who reported experiencing physical violence had 8 or more common mental disorder symptoms using the SSQ-14 compared to 37.2% who never experienced violence. Onward disclosure of HIV status was limited, only 44.1% had disclosed to their partners. Mothers reported that they feared spousal disruption and being blamed for introducing the infection to the relationship. Out of 173 children who completed the MDAT, 12.7% were at risk of developmental delay. **Conclusion:** Young women living with HIV regardless of mode of transmission confront a number of a challenges which affects their health and that of their children. Given the high risk of common mental disorders, and the impact of this on maternal adherence (and likely child development) targeted mental health interventions for mothers need to be scaled up.

WEAC0904 - TRACK C5

Assessment of HIV Prevalence among Children Born to HIV-Infected Female Sex Workers in Rwanda

15:30 – 15:45

Mushimiyimana Marie Josee[1], Mazzei Amelia[1], Muriisa Grace[2], Mugwaneza Placidie[3], Twahirwa Rwema Jean Olivier[4], Mwanyumba Fabian[2], Mukarurema Edith[1], Unyuzimana Marie Aimee[1], Sinabamenye Robertine[1], Ingabire Rosine[1], Ng'oma Kondwani[2], Nsanzimana Sabin[3], Karita Etienne[1]

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Background: Female sex workers (FSW) in Rwanda are disproportionally affected by HIV, with a prevalence proportion as high as 51%. Many studies have suggested that FSW have poor health seeking behavior, and little is known on their uptake of PMTCT services and on the prevalence of HIV among their children. We assessed the prevalence of HIV among children born to HIV-infected FSW in the Kigali and Western provinces of Rwanda **Methods:** HIV-infected FSW enrolled in care and treatment services at 29 health centers in Kigali City and the Western Province were invited to bring their children below 18 years old to the clinic for HIV status assessment and linkage to care and treatment services. They were asked about antiretroviral (ARV) use during pregnancy and whether they delivered in a maternity setting. HIV testing was offered to children with unknown HIV status or previous HIV negative results. All children

found to be HIV-infected were immediately linked to care and treatment services. **Results:** Between August 2017 and October 2018, we enrolled 3011 children born to 1385 HIV-infected FSW. 320 children (11%) were less than 2 years old, 590 (19%) were in the 2-5 years age group, 899 (30%) were in the 6-9 years age group, and 1202 (40%) were 10 years and above. The proportion of children born to mothers who received ARV treatment during pregnancy increased over time: from 23% among children born between 2000 and 2004, to 41% in 2005-2009, 68% in 2010-2014, and 88% in 2015-2018. A similar trend was also found for deliveries in a maternity setting: the proportion of children who were born in a maternity service increased from 70% in 2000-2004, to 80% in 2005-2009, 90% in 2010-2014, and 95% in 2015-2018. We ascertained the final HIV status for 2963 of the 3011 children (98%): 115 children were known to be HIV-infected and were all receiving ARV treatment, and 18 new HIV-infected children were identified. The overall HIV prevalence was 4.4% (95% CI: 3.7-5.2), and it decreased over time, from 5.4% among children born between 2000 and 2004, to 4.8% in 2005-2009 and 2010-2014, and 2.4% in 2015-2018. All newly identified HIV-infected children were successfully linked to care and treatment services. **Conclusion:** Our data indicate that the uptake of PMTCT services by FSW increased over time, and the prevalence of HIV among their children decreased over time. Elimination of vertical transmission of HIV is a realistic goal even among high-risk populations

WEAC0905 - TRACK C5

HIV/AIDS, Tuberculosis and Health Services Situation in Nigerian Prisons

15:15 – 15:30

Amanze Ogbonna[1], Ashefor Greg[2], Anenih James[2], Ikomi Esther[2], Aguolu Rose[2], Zachariah Kums ThankGod[2], Eluwa George[3]

[1]National Agency for the Control of AIDS (NACA), Abuja, Nigeria, [2]National Agency for the Control of AIDS (NACA), Research, Monitoring and Evaluation, Abuja, Nigeria, [3]United Nations Office on Drugs and Crime (UNODC), Abuja, Nigeria

Background: In sub-Saharan Africa, extraordinary high rates of HIV have been documented in prison populations: South Africa (41%), Cote d'Ivoire (27.5%) and Zambia (27%). Prisoners are key populations for HIV, other sexually transmitted infections (STIs) and Tuberculosis (TB) because of the prevalent conditions in prisons- unsafe sexual practices, as well as poor health care and living conditions. No previous HIV/AIDS/TB studies in Nigeria had included prison inmates. Therefore, this study aimed at determining the current prevalence of HIV and Tuberculosis, and the availability of HIV prevention and treatment services in Nigerian prisons. **Methods:** A mixed methods approach was used. This involved qualitative methods (interviews and focus group discussions). The quantitative method was a cross-sectional study design using interviewer-administered structured questionnaire. Data collection occurred between August to December 2018.The study population comprised of 2,511 prison inmates (males and females) and prison staff. The study took place in 12 prisons spread across the 6 geo-political zones of Nigeria. Furthermore, there was voluntary screening for HIV and TB for the inmates in the prisons that participated in the study. STATA 15 and NVivo 12 were used for data analyses. **Results:** Of the 2511 respondents, 92% were males; about 50% were aged 25-35 years; about 20% had secondary level education; and about two-thirds were single. HIV prevalence was 2.8% (which is double of 1.4% reported for the general population). HIV prevalence was significantly higher among female prisoners (6.9%) than male prisoners (2.7%). It was highest among those with no formal education (3.8%) and those older than 45 years (8.1%). Positive TB screening was 46% and this was the same for both males and females, and higher among older inmates compared to younger ones. Less than 66% of the respondents reported the availability of HIV prevention, treatment, sexual and reproductive health services in the prisons. Only 37% of the respondents were satisfied with the quality of services received at the prisons' health facilities **Conclusions and Recommendations:** HIV prevalence was significantly higher among

prisoners than among the general population. There is a need to improve HIV/TB prevention interventions, and availability of sexual and reproductive health services for prison inmates in Nigeria.

TIME	14:45 – 16:15 Uhr	ROOM	Kigali (Auditorium)	DATE	Wednesday, 04 December 2019

Track C: Epidemiology and Prevention Science, Kigali (Auditorium)

HIV / AIDS Prevention Programmes

Chairs: Eva Kiwango (UNAIDS Mozam)

WEAC1001 - TRACK C1

Assessment of the Design and Implementation of HIV Service Packages for Men Who Have Sex with Men in 13 African Countries

14:45 – 15:00

McCallum Lou[1], Burrows Dave[1], Falkenberry Haley[1], Parsons Danielle[1], Zhao Jinkou[2]
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Issues: Design and implementation of HIV service packages for men who have sex with men (MSM).

Description: As part of a larger Global Fund-funded project, APMG Health conducted assessments of the design and implementation of HIV service packages for MSM in 13 countries (Angola, Benin, Cameroon, Kenya, Madagascar, Malawi, Mali, Morocco, Sierra Leone, South Africa, Sudan, Togo, and Tunisia), including desk reviews and key informant interviews, site visits, and focus group discussions with MSM in each country.

Lessons learned: All countries included in this assessment recognize MSM as a key population and have designed packages of HIV prevention and treatment services to meet their needs. While the specifics of these service packages vary, all provide male condoms, HIV testing and counseling, and HIV treatment and care; 92% provide services for sexual and reproductive health and the prevention and management of co-morbidities and 85% provide behavioral interventions and lubricant as part of condom distribution. None of the countries assessed systematically account for critical enabler activities specific to MSM. No countries provide MSM-specific services to address stigma/discrimination or services to prevent violence; one country provides MSM-specific services to address supportive laws and policies and services to promote community empowerment. The average coverage of HIV prevention programs among MSM is low: 39.7%. Little data are available on linkages of new HIV cases to care, and average ART coverage among MSM ranges from 11.9% in Sudan to 94% in Malawi.

Next steps: Despite providing robust service packages, progress remains slow in many of the assessed countries, implying that there are mitigating factors that act as barriers to service access for MSM. Country packages are designed without MSM-specific critical enabler services, and the assessment process revealing that stigma, fear of violence and criminalization are the biggest barriers to service access for MSM and other key populations in the assessed countries. By not providing services to address the socio-political context surrounding MSM, these countries ignore and invalidate the challenging and often dangerous environment MSM face when attempting to access services. Recommendations for service package design and incorporating community empowerment activities are provided to decrease stigma, legal barriers and violence, and thereby better serve MSM populations and improve coverage.

WEAC1002 - TRACK C1

Implementation of an Index Testing Strategy in a Community-Based Clinic Providing Health Services to Female Sex Workers: SOUTOURA Clinic in Bamako

15:00 – 15:15

Alitiny Almahdy Ag[1], Tall Madani[2], Lambert Andrew[3], Sidibe Fadiala[1], Bore Djibril[2], Hamdallah Myriam[3], Sacko Souleymane[4], Ranebennur Virupax[3], DiCarlo Meghan[3], Cooper Emilie[3], N'Tossama Diarra[5], Bashi Jules[2]

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Background: In Mali, identification of new HIV cases remains a great challenge to achieving UNAIDS' first 90 goal. To improve efficiency, the USAID- and PEPFAR-supported LINKAGES project developed an index testing strategy to identify people at high risk for HIV among female sex workers (FSWs) and their contacts. This approach contributes to improved HIV case-finding. We conducted an analysis of program data to determine HIV case-finding performance when an index testing strategy is implemented among FSWs in an urban community-based clinic. **Method:** Program activities were conducted in SOUTOURA Clinic of Bamako, which serves FSWs. The index testing strategy used was the assisted partner notification approach. This enabled the program team to focus on a high-risk group of contacts identified by index clients: sexual partners (both male partners and other FSWs sharing the same regular clients) and biological children. FSWs were requested to voluntarily disclose theirs contacts with the aim of providing HIV testing and enrolling those who tested positive on treatment. Reasons for refusing to share contacts were collected. Contacts were traced using several referral options: client referral, contract, provider, and dual. HIV tests were conducted using the national algorithm to confirm contacts' status. **Results:** Data from 106 HIV-positive FSWs were collected for this analysis. Among them, 27 (25%) were unreachable after three attempts. Of the 79 (75%) who were reachable, 25 (32%) had no contacts, 34 (43%) had contacts but refused to share, and 20 (25%) accepted to disclose their contacts. A total of 33 contacts were identified, representing a ratio 1:1.7 contacts per FSW index case. All contacts (100%) were traced and accepted HIV testing: 25 (76%) males, three (9%) FSWs, and five (15%) children. Using HIV rapid test kits, seven (21%) contacts tested HIV positive: two (67%) FSWs and five (20%) men. Refusal to disclose contacts was related to fear of violence, stigma, and discrimination (22; 65%) and cessation of relationship (12; 35%). **Conclusions:** Index testing is feasible in a community-based clinic providing health services to FSWs. High HIV case-finding was observed among sexual partners and other FSWs. Refusal to voluntarily disclose contacts is high due the potential for direct social impact on FSWs' lives.

WEAC1003 - TRACK C1

Uptake of HIV Self-testing and Linkage to Care among Female Sex Workers in Nairobi: A Pilot Programme Using Peer-based Distribution of Graquick HIV Self-testing Kit

15:15 – 13:30

Achieng Josephine

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Background: Female sex workers (FSW) are disproportionately affected by HIV, yet their engagement in HIV services does not reflect this heightened risk. Kenya launched HIV Self-testing operational manual in 2017 paving way for Implementation of HIV Self -testing (HIVST) as an additional strategy towards achieving the 1st 90 of the UNAIDS 90:90:90 targets. HIVST seeks to address barriers to HIV diagnosis among Female Sex by offering an alternative to facility-based HIV testing services due to FSWs fear of accessing because of stigma, discrimination and criminalization of sex work in Kenya. **Methods:** This study piloted an intervention to distribute HIVST kits to FSW through peer

educators in Ruaraka Sub County (Nairobi, Kenya) from July 2018 to September 2018. We recruited "models" who are the peer educators that we engage in various hotspots. The models were trained in HIVST and asked to distribute up to seven kits to their peer networks. The peers contacted with HIVST information were given all necessary instructions required including a referral and linkage channel back to the Drop in center or service provider. The accuracy of HIVST was measured against a confirmatory test conducted by a registered clinical officer. We conducted client based feedback survey to assess the experience with peer-distributed HIVST against provider initiated tactic. Results: Thirty models offered HIVST kits to 210 sex workers and 181 (86.2%) accepted the offer. No model reported hardships except for one model who reported incidences of intimate partner violence among one of their peers. Among the engaged peers, 163 tested (90%) out of which 11 peers (7%) were first time testers. 4 sex workers living with HIV learned their status through peer-distributed HIVST and were all able to visit BHESP drop in center for a confirmatory test preceding linkage.(Reporting positivity rate of 2%). Out of the 163 peers who performed a test, 153 reported that they would recommend HIVST to their sexual partners and family. All HIVST models stated that they would accept acting as peer distributors again. **Conclusions and Recommendations:** Peer-based distribution model of HIVST is safe and has high uptake. Participants showed high willingness to use HIVST due to its confidentiality/privacy and convenience compared to testing in government facilities, where stigmatization of key populations is common.

WEAC1004 - TRACK C1

Index Testing and Intensified Case Finding for Efficiency in HIV Testing in Rwanda

13:30 – 15:45

Remera Eric[1], Gentille Musengimana[2], Janise Richard[3], Dieudonne Sebuhoto[2], Samuel Sewava Malamba[3], Augustin Mulindabigwi[4], Elise Tuyishime[3], Placidie Mugwaneza[5], Eugenie Kayirangwa[3], Jared Omolo[3], Suthar Amithab[6], Mac Donald[3], Sabin Nsanzimana[5]

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Background: The scale up of HIV testing in Rwanda has been facilitated by a wide diversification and simplification of HIV testing modalities. As the country inches closer to the UNAIDS HIV first 90 of knowing one's HIV status, finding the remaining positives may be difficult using passive methods. Therefore, Rwanda initiated the implementation of Case Surveillance system, which involves Active Case Finding through index testing with partner notification services (PNS) and family testing. This abstract describes the overall cascade for index testing using different approaches. **Methods:** Since October 2018, Active HIV Case finding (ACF) is implemented as part of Case Surveillance (CS) system in 23 health facilities in Kigali city. The cases identified through ACF are linked to care and followed up longitudinally in CS to document their HIV sentinel events in the routine HIV prevention and treatment program. Paper forms and electronic Case Report Forms (eCRF) hosted within the DHIS2 system are used for data collection, management, analysis and storage. The data were extracted from the eCRFs and exported to Microsoft Excel and STATA version 15 for analysis. **Results:** Between October_2018 and June 2019, 2598 index cases were registered. Of them, 1792, 624, 156 and 26 Index cases were registered from VCT, PIT, ANC and Maternity respectively. From the total index cases, 2316 (89.1%) provided partner's information for the last 12 months with an index case to partner ratio of 1.5 (3844, mean=1.5, median=1). Of those, 3,344 (86.9%) partners were successfully contacted; 37% were reached through client referral, 32% by provider and 31% by contract referral. Of all partners contacted, 2833 (84.7%) came to the health facility for HIV testing and 118 (4.2%) were already aware of their HIV positive status. Of those who pre-

viously tested negative or never tested , 2,442 (86.1%) were tested for HIV. 218 (8.9%) were tested HIV positive and 203 (93.1%) of them were linked to treatment. **Conclusion:** There is need to adopt strategies to effectively identify PLHIV who do not know their HIV status and examine most successful Case Finding Strategy such as partner notification that can be adopted to identify most at risk sexual partners . All three index-testing approaches provided important contributions to epidemic control and will be translated to national policy for routine program implementation.
Keywords: Index testing, Case finding, HIV

WEAC1005 - TRACK C1

Cibler le Dépistage VIH/SIDA des Personnes Handicapées pour Atteindre les "90 90 90" au Sénégal

15:45 – 14:00

Dieng Ousmane[1], Walou Benoît Joseph[1], Keita Faly[1], Busière Sandrine[2], Miele Corinne[3]
[1]Humanité & Inclusion, Ziguinchor, Senegal, [2]Humanité & Inclusion, Dakar, Senegal, [3]Humanité & Inclusion, Lyon, France

Description: Au Sénégal, la prévalence du VIH est plus élevée chez les personnes handicapées (PH) (1,9%) que dans la population générale (0,5%) selon l'enquête bio comportementale réalisée en 2015 par le Conseil National de Lutte contre le VIH/SIDA au Sénégal (CNLS). Néanmoins, l'absence de stratégies de lutte adaptées à leurs besoins spécifiques persiste. Dans le cadre du projet INCLUSIPH, une approche de dépistage VIH et de suivi ciblant les PH et leurs familles dénommée « Activités d'Initiatives Locales » (AIL) a été développée dans les régions de Ziguinchor, Kolda et Sédhiou au Sénégal en partenariat avec Santé Service Développement. Elle a consisté à :

- L'identification, la sélection et le financement d'organisations de PH à forte capacité de mobilisation sociale ;
- Au renforcement de capacité des leaders de ces organisations sur les thématiques VIH/SIDA, droits humains, techniques de communication et mobilisation sociale ;
- La mise en réseau des organisations de PH avec les équipes de dépistage et de prise en charge VIH des districts sanitaires ;
- Au financement de 33 campagnes de mobilisations sociales suivies de dépistage du VIH avec un objectif minimum de 100 personnes à dépister dont 80% de PH par campagne ;
- L'appui au référencement des cas positifs et leur enrôlement dans les activités d'accompagnement psychosocial et de prise en charge communautaire.

Leçons apprises: Cette approche a permis d'obtenir les résultats suivants de Mars-2018 à Juin-2019 :

- 3370 personnes dépistées dont **72%** de PH et **56%** de femmes en 33 campagnes dans les 3 régions.
- **65 cas** positifs dépistés référés pour une confirmation soit une prévalence de 1,93%.
- Parmi les cas positifs, on retrouve **77%** de PH dont **62%** de femmes.
- Parmi les PH, 74% ont une déficience physique, **12%** une déficience mentale, **10%** une déficience visuelle et **2%** une déficience auditive.
- La moyenne de **2** cas positifs dépistés par campagne confirme la haute vulnérabilté des PH au VIH.

Prochaines étapes:

- Accompagnement personnalisé des cas positifs pour une suppression virale après plus de 6 mois de traitement ARV.
- Plaidoyer pour une meilleure prise en compte des PH dans les programmes de lutte contre le VIH/SIDA.

- Restitution des résultats aux réunions techniques avec les régions médicales, le CNLS en vue d'un reclassement des PH dans les populations à cibler en priorité.

Mots clés : Activités initiatives locales ; Plaidoyer ; Accompagnement personnalisé ; Dépistage ciblé

TIME	16:45 – 18:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Wednesday, 04 December 2019

Track D: Law, Human Rights Social Science and Political Science

Addressing Needs of Transgender Individuals for Education, Services and Prevention

Chair: Berry Nibogora

WEAD1101 - TRACK D2

Transgender Women Combating HIV & AIDS through Artivism (Experiences from Tanzania)

1645 – 17:00

Moffat Marvellous
House of Empowerment and Awareness in Tanzania, Dar es Salaam, Tanzania, United Republic of

Issues: It's evidential that the prevalence of HIV & AIDS amongst transgender women is higher (48%) compared to other groups within the LGBTI communities globally. In Africa this has been mainly caused by stigma and discrimination that comes from two strong aspects of culture and religion whereby in most African culture a man has more value than that of a woman and therefore being a man who identifies or presents as a woman in the society is very odd, unacceptable and considered an immoral act/practice subjecting this particular community into greater challenges which has led to effect of high HIV infections and transmission. For example through lack of employment due to their gender identities issues majority of transgender women have ended up engaging into the Sex working industry as means for their survival were they face alot of sexual abuse such as rape, high unprotected sex tendecies for good money and sharing of clients who happen to be cisgender men mostly spreading diseases such as HIV & STI's to the larger population. **Descriptions:** This being a major problem in most African countries in this case Tanzania organizations such as House of Empowerment and Awareness in Tanzania (HEAT) pioneering in dealing with transgender women & transgender women sex workers issues, came up with innovative ways of trying ending this chronic problem facing transgender women through strategic ways by the use of ART which has brought a big change/impact in so many ways such as in their economic lives, improving their self esteem, improvement intheir physical and mental health together with more awareness, advocacy skills etc. **Lessons learned:** After introducing and employing such strategic interventions we have experienced positive changes in their attitudes especially on their well being and self protection as well as awareness that has lessened the risks of exposing themselves into HIV & AIDS infections and transmissions but at the same time improving their standard of living as well as marketing themselves into greater opportunities such competence into the Art Industry, employment opportunities etc. **Next steps:** Positive experiences that we are encountering in Tanzania through this innovative intervention are the ones we introduce and share to potential platforms such as ICASA and others so that they may be applied in combating and finally ending HIV & AIDS in Africa going to the global level. **Keywords:** Artivism, Empowerment, Innovativeness, Transgender women

WEAD1102 - TRACK D2

Advocacy for Increased PrEP Access and Uptake for MSM and Transgender Women: An AVAC Advocacy Fellowship Project (April 2018 to April 2019)

17:00 – 17:15

Matongo Deloune Comfort[1,2,3], Matsikure Samuel[4]
[1]Gays and Lesbians of Zimbabwe, Harare, Zimbabwe, [2]Lund University, Social Medicine and Global Health, Lund, Sweden, [3]AVAC, Advocacy and Partnerships, New York, United States, [4]Gays and Lesbians of Zimbabwe, Programs, Harare, Zimbabwe

Issues: Zimbabwe has very high HIV incidence (.48) and prevalence (14%). The HIV burden in Key populations (KPs) like MSM and transgender women (TGW) is even higher with MSM prevalence at 23.5%. In 2016 the government introduced PrEP to the pool of prevention options with the aim to reduce incidence rate by 50% by 2020. However, by 2018, when the AVAC project commenced, PrEP was available in only in 6 sites country wide which was not adequate to facilitate PrEP increased accessibility hence there was low uptake. The one-year AVAC Advocacy Fellowship project thus came in to influence the government to put in place structures that would facilitate increased availability, accessibility and uptake of PrEP.
Descriptions: Upon introduction of the project, the fellow made efforts to engage strategic partners in biomedical HIV prevention and in KP programming. The Fellow sensitized and mobilized stakeholders to support the advocacy. Also engaged with the AIDS council and the health ministry through advocacy meetings. The project also advocated for a seat in the National KP forum and the PrEP Technical Working Group, which were strategic for the project.
By the end of the project:
Number of sites offering PrEP increased from 6 to 24
Developed Health Worker training manual and job aid
Developed the first ever KP minimum service package, with PrEP priority
Trained 350 health workers on KP friendly service provision
Developed the first edition of the National KP implementation Plan
Conclusion: The AVAC fellowship project significantly contributed to the increase in number of sites offering PrEP, Capacity building of Health staff provide quality services to MSM and TGW and the creation of strategic policy documents all of which facilitates increased availability and accessibility of PrEP for MSM and TGW.
Lessons learned: Functional Partnerships: Advocacy pursuits ought not to be solo projects. The forging of networks, coalitions, synergies and complementary efforts among advocates, CSOs, development Agencies and Government are key to advocacy success.
Knowledge and Evidence: Advocacy is only powerful when backed by authentic evidence.
Being Opportunistic: Advocacy requires paying attention to negligible windows *of opportunity that at times can change the trajectory of the whole project. Flexibility:* Advocacy landscape is constantly changing, advocates need to equally adapt.
Next steps: Fellow continues to advocate for strengthened demand generation initiatives for PrEP.

WEAD1103 - TRACK D2

Attracting Hard to Reach Trans Women to HIV Programming in Luanda, Angola by Attending to Their Gender Identity Needs As Trans Women

17:15 – 17:30

Pimenta Yuca1, Baltazar Sandra1, Diaz Ana[2], Goggin-Kehm Molly[3], Bashi Bagendabanga Jules[4]
[1]Management Sciences for Health (MSH), Trans Women Group Mulheres de Coracao, Maianga, Angola, [2]Management Sciences for Health (MSH), LINKAGES Project, Maianga, Angola, [3]FHI 360, LINKAGES Project, Washington DC, United States, [4]FHI 360, Bamako, Mali

Issues: Trans women have health needs tied to their gender identity as women that differ from men who have sex with men. Before meeting these needs, the LINKAGES

program had difficulty attracting high risk Trans women to HIV testing services.
Descriptions: From April 2016 to March 2018, LINKAGES used traditional outreach approaches to reach Trans women: mobile teams of peer educators and HIV counsellors would be sent to bars, brothels and discotheques to offer condoms, lubricants and onsite HIV testing. However, only 42% (106/255) of the Trans women would agree to test for HIV onsite or later at a health facility or community center. Focus groups revealed that they wanted to have their own safe space where they could meet and discuss specific topics such as hormone therapy and job opportunities. In April 2018, the project engaged a Trans peer educator and a nurse to mobilize trans women through peer referrals, to attend meetings once a month at a community center where gender-specific topics would be discussed and HIV testing offered.
Lessons learned: By June 2018, the proportion of Trans women reached through the new method who agreed to test for HIV rose to 76% (68/98). Additionally, the case finding rate also increased significantly from 12% (13/106) to 41% (28/68) suggesting that this second approach is attracting Trans women who may be at higher risk for HIV.
Next steps: In addition to proving an effective outreach method to encourage HIV testing among high risk Trans women, the new outreach approach has allowed the Trans women to develop a collective identity.

WEAD1104 - TRACK D2

HIV Status Disclosure by HIV-infected Nigerian Men who Have Sex with Men and Transgender Women

17:30 – 17:45

Tiamiyu Abdulwasiu B[1,2], Lawlor John[3,4], Kokogho Afoke[1,2], Charurat Manhattan E[5], Robb Merlin L[3,4], Adebajo Sylvia[6], Eluwa George[6], Njab Jean[6], Ake Julie A[3], Baral Stefan D[7], Nowak Rebecca G[5], Crowell Trevor A[3,4], The TRUST/RV368 Study Group
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Background: Men who have sex with men (MSM) and transgender women (TGW) are disproportionately impacted by HIV and may face pressure to conceal their diagnosis, particularly in settings where same-sex sexual practices are stigmatized. We evaluated HIV status disclosure to sexual partners, HIV treatment outcomes, and stigma patterns of Nigerian MSM and TGW.
Methods: TRUST/RV368 is a prospective observational study of adult MSM and TGW recruited via respondent-driven sampling in Abuja and Lagos, Nigeria. Previously-diagnosed, HIV-infected participants who enrolled from March 2013 to May 2018 were asked, "Have you told your (male/female) sexual partners (MSP/FSP) that you are living with HIV?" In separate analyses by partner gender, robust Poisson regression models were used to estimate risk ratios (RRs) and 95% confidence intervals (95% CIs) for characteristics associated with HIV status disclosure to no vs. some/all MSP and FSP. Self-reported stigma indicators were also compared between groups.
Results: A total of 529 MSM and TGW were enrolled with median age 25 (interquartile range 22-29) years, including 158 (29.9%) who had disclosed to MSP. Among 227 participants with FSP, 36 (15.8%) had disclosed their HIV status. Factors independently associated with HIV status disclosure to MSP included living with a man (RR 6.27 [95% CI 1.71-23.02], compared to single/unmarried), disclosure to a healthcare provider (RR 2.72 [95% CI 1.45-5.08]), disclosure to FSP (RR 3.99 [95% CI 1.79-8.92]), ART prescription (RR1.76 [95% CI 1.09-2.83]), and viral suppression < 50 copies/mL (RR 1.90 [95% CI 1.18-3.07]). Factors independently associated with disclosure to FSP included being married/living with a woman (RR 12.57 [95% CI 4.28-36.90], compared to single/unmarried) and disclosure to MSP (RR 4.77 [95% CI 1.94-11.70]). No differences in self-reported stigma indicators were observed between participants who had and had not disclosed to MSP. Participants who disclosed to FSP were more likely than those

who had not to report ever having felt afraid to walk around (18.2% vs. 5.0%, p=0.04). **Conclusions and Recommendations:** Though uncommon among Nigerian MSM and TGW, HIV status disclosure to sexual partners was associated with improved likelihood of ART use and viral suppression with little change in self-reported stigma indicators. Strategies to encourage HIV status disclosure should be pursued in these marginalized populations with a high burden of HIV.

WEAD1105 - TRACK D2

Exploring Provsion of Gender Affirming Care for Transgender and Retention in Care

17:45 – 18:00

Akanji Michael[1], *Umoh Paul*[2], *Ojemeiri Airoje Karl*[1]

[1]Heartland Alliance International, Abuja, Nigeria, [2]Health Alliance International, Abuja, Nigeria

Issues: It has been noted that the provision of services to transgender individuals need to function effectively for their retention in care to achieve the universal goal. Nigeria as a country does not include transgender in its definition of key populations, hence provision of comprehensive HIV interventions is limited to services provided for mem who have sex with men. Using the programmatic data from Integrated Most at Risks population HIV intervention prevention program (IMHIPP) of Heartland Alliance in Nigeria, explored the provision of gender-affirming care information for transgender individuals. **Description:** Using the IMHIPP programmatic data, for a cohort of 1421 individual transgender accessing HIV testing service from October 2017 to June 2109. 105 persons were diagnosed living with the virus which is about 7.5% prevalence, more than 5 times higher than the national prevalence rate of 1.4 %. For the 105 people, gender-affirming care information was included in their treatment plan and 73% (105 treatment new and 77 currently on treatment) retention rate was recorded among transgender. **Lessons learnt:** Transgender individuals have a higher prevalence rate than general population and provision of comprehensive services for transgender individuals should be an integral part of HIV services and service providers need to refer transgender individuals to facilities that provided gender-affirming care **Next steps:** Advocacy for the inclusion of transgender in the Nigerian definition of key population, and to develop a national guideline for interventions for Transgender individuals to achieve the UNAIDS 95-95-95 target and leave no one behind.

TIME	10:45 – 12:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Thursday, 05 December 2019

Track E: Health Systems, Economics and Implementation Science

HIV, Mental Health and Integrated Care Across Africa

Chair: Prof. Oche Agbaji

THAE1201 - TRACK E6

Is It OK to Not Be OK in HIV Care? Mental Health Resources and Screening in HIV Care Environments in 24 Districts of Zimbabwe

10:45 – 11:00

Webb Karen[1], Page-Mtongwiza Sara[1], Patel Diana[1], Mbetu Patricia[1], Chinyanga Tinashe[1], Apollo Tsitsi[2], Rwafa Chido[3]

[1]Organisation for Public Health Interventions and Development (OPHID), Harare, Zimbabwe, [2]Ministry of Health and Child Care, AIDS & TB Unit, Harare, Zimbabwe, [3]Ministry of Health and Child Care, Mental Health Unit, Harare, Zimbabwe

Issues: People living with HIV (PLHIV) are more than twice as likely to experience a mental health disorder. With an HIV prevalence of 14.1%, to strengthen mental health services for PLHIV, the Ministry of Health and Child Care (MOHCC) recommends mental health screening of all clients in HIV care annually. However, little is known about the integration of mental health services within HIV care and treatment in practice.

Descriptions: In March/April 2019, OPHID conducted a mental health in HIV care program scoping assessment with the objective of documenting existing mental health resources within HIV care and treatment services in the 24 districts where the FACE-HIV program operates. Mixed-method health systems evaluation approach, using a standardized questionnaire administered with relevant District-level MOHCC staff. Completed forms were entered electronically into MS Forms. Descriptive analysis was conducted using MSExcel and StataV13.

Lessons learned: Among 24 Districts serving a population of 424 352 people living with HIV on ART, only 3 practicing psychiatrists were identified. The majority of Districts (75%;18/24) reported having a District Mental Health Focal person, and 92%(22/24) reported nurses trained in mental health in post (N=275). Only 37% (9/24) of Districts reported that they were actively conducting mental health screening in HIV care as recommended. The most frequently cited reasons for failure to screen clients in HIV care being lack of: health care worker confidence, screening tool awareness and weak referral networks. Health system stakeholders, however, perceive the prevalence of mental health disorders to be high, with depression and anxiety perceived as the most frequently observed mental health conditions among PLHIV.

Next steps: The findings of this scoping exercise indicate 4 key actions required to strengthen mental health service integration with in HIV care in Zimbabwe:

1. Decentralise basic mental health service capacity to primary care level;
2. Support health care workers with simple, evidence-based tools and guidance on 'if, then' for mental health screening, treatment and referral to build health care worker confidence and capacity;
3. Conduct more granular District-level mapping to identify all existing interventions, resources and partners for development of context-relevant referral networks;
4. 'Upskill' existing cadres providing HIV care in evidence-based mental health screening, treatment and referral pathways.

THAE1202 - TRACK E6

Mental Health Another Pain to HIV

11:00 – 11:15

Opiyo Faith
University of Nairobi, Nairobi, Kenya

Background: 60% of the Kenyan population are young people aged 10-24 years with 1 in every 4 persons being an adolescent. This population is considered vulnerable as the period of adolescence is characterized by physical, social and psychological changes. Kenya ranks fourth highest in new HIV infections among young people living with HIV/AIDS, according to National Aids Control Council (NACC) there are 435224 young people living with HIV, with half of these number being adolescent. These forms more than 60% of people currently on antiretroviral therapy
However, many adults lack the patience and even time to indulge the young people at this stage especially on mental health; most of them regard mental health as "the disease of the rich" or fall back on religion and culture to validate mental illness. Having no guidance and feelings of neglect young people living with HIV get withdrawn get depressed experience anxiety and may end up committing suicide. Young people living with HIV who have mental illness are at a risk of making irrational decisions regarding their reproductive health, they can wallow in drugs and alcohol abuse translating to unsafe sex which is responsible for the increased new HIV infections among young people.
Methods: Advocating for integration of mental health in the health management systems. Establishment of a monitoring and evaluation system for evaluating the improvements in adolescent health also the health gaps.
Desk review of existing data on SRHR among young people participating in comprehensive sexuality education.
Results: The results indicate that Youth friendly center within the countries have at least 2 trained counselors.
There is need of follow up after first counselling session with the infected Youth.
Conclusions and Recommendations: Governments champion for multi sectoral collaboration and young people involvement in holding robust discussions on mental health to cohort who are both infected and affected.
Policy makers should advocate for comprehensive contextualization of mental health within the national adolescent Sexual and Reproductive Health Policy.
Ministry of health youth friendly counselors at every facility where young people go to take drugs from.

THAE1203 - TRACK E6

Prevalence and Factors Associated with Psychological Distress among Key Populations in Togo, 2017

11:15 – 11:30

Gbeasor-Komlanvi Fifonsi Adjidossi[1,2], Tchankoni Martin[2], Sewu Essèboè[2], Zida-Compaore Wendpouire Ida Carine[2], Alioum Ahmadou[3], Bitty-Anderson Alexandra[4], Salou Mounerou[5], Dagnra Claver Anoumou[5], Ekouevi Didier Koumavi[1,2,3]
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Background: Mental health is a largely neglected issue among in Sub-Saharan Africa, especially among key populations. The aim of this study was to estimate the prevalence of psychological distress and to assess the factors associated among males who have sex with males (MSM), female sex workers (FSW) and drug users (DU) in Togo in 2017.
Methods: A cross-sectional bio-behavioral study was conducted in August and September 2017 using a respondent-driven sampling (RDS) method, in eight cities in

Togo. A standardized questionnaire was used to record sociodemographic characteristics and sexual behaviors. The Alcohol Use Disorders Identification Test(AUDIT) and a subset of questions from the Tobacco Questions for Survey were used to assess alcohol and tobacco consumption respectively. PD was assessed with the Kessler Psychological Distress Scale. A blood sample was taken to test for HIV. Descriptive statistics, bivariate and multivariate ordinal regression model were used for analysis.
Results: A total of 2044 key populations including 449 DU, 952 FSW and 643 MSM with a median age of 25 years, interquartile range (IQR) [21.0-32.0] were recruited. The overall prevalence of mild PD among the three populations was 20.0% (95%CI= [18.0-22.0]) and was 19.0% (95%CI= [17.0-21.0]) for severe/moderate PD. HIV prevalence was 13.7% (95%CI = [12.2-15.2]). Age 25 years and over [aOR = 1.24 (95% CI: 1.02-1.50)], being HIV positive [aOR = 1.80 (95% CI: 1.31-2.48)], hazardous alcohol consumption [aOR = 1.52 (95% CI: 1.22-1.87)] and having a secondary [aOR = 0.52 (95% CI: 0.42-0.64)] or higher [aOR = 0.46 (95% CI: 0.32-0.64)] education level were factors associated with PD. FSW [OR = 0.55 (95% CI: 0.43-0.68)] and MSM [OR = 0.33 (95% CI: 0.24-0.44)] were less likely to report PD compared with DU.
Conclusions and Recommendations: The present study indicates that mental health care must be integrated within health programs in Togo with a special focus to key populations through interventions such as social support groups.
Keywords: Psychological distress, Key populations, HIV, Associated factors, Togo

THAE1204 - TRACK E6

Impact of the Integration of a Depression Screening and Treatment Program into Routine HIV Care on HIV and Mental Health Outcomes in Malawi

11:30 – 11:45

Udedi Michael[1,2], Pence Brian[3], Stockton Melissa[3], Gaynes Bradley[3], Mphonda Steve[4], Kulisewa Kazione[2], Hosseinipour Mina[3,4]
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Issues: Depression is highly prevalent among patients newly starting antiretroviral treatment (ART) in Malawi and many other countries. Unrecognized and untreated depression at the time of ART initiation can increase the likelihood of loss to HIV care and viral failure. Effective approaches to screen for and treat depression, even in low-resource settings, are well understood in a research context but rarely applied in the real world.
Descriptions: We integrated a depression screening and treatment program into two public-sector HIV primary care clinics in Lilongwe, Malawi, using existing general clinical personnel with support and training by mental health specialists. We trained HIV post-test counselors to screen for depression, HIV clinicians to confirm diagnosis and manage treatment, and lay health workers to provide brief problem-solving therapy. We evaluated the program's impact using a multiple-baseline design with a screening-only phase (with referral to existing treatment pathways) and a program implementation phase. The primary evaluation outcome was HIV treatment success (retained in care and virally suppressed 6 months post-initiation). Secondary outcomes included 6-month ART appointment attendance and depression remission.
Lessons learned: From April 2017-November 2018, 2,204 patients newly starting ART were screened for depression (screening phase: 1,143; program phase: 936). Of these, 503 (24%) had at least mild depressive symptoms (Patient Health Questionnaire-9 score ≥5) and 131 (6%) had at least moderate depressive symptoms (PHQ-9 score ≥10). Overall, only a quarter of patients achieved HIV clinical success; only 26% of patients from the screening phase and 22% of patients in the active phase. By the 6-month appointment window only 36% and 35% attended an appointment during the screening and active phase, respectively. The results of this study provide import-

ant evidence about the impact of a real-world depression treatment program on HIV outcomes.

Next steps: With careful attention to the implementation process, HIV care providers can successfully screen individuals initiating HIV care for depression. To successfully implement the integration program, efforts should foster local ownership by the facility, support health facility capacity, and prioritize ongoing mobilization of human resource and medical supplies. To have an impact on HIV outcomes there is a need to sustain adequate treatment for depression.

THAE1205 - TRACK E6

Integration of Mental Health into HIV/AIDS Community Care and Support Guidelines in Nigeria

11:45 – 12:00

Falola-Anoemuah Yinka, Ade-Yusuf Taiwo Ali, Ogundipe Alex

National Agency for Control of AIDS, Community Prevention and Care Services, Abuja, Nigeria

Issues: Mental Health (MH) is that state of well-being in which an individual is able realize his or her own potential and can positively cope with the normal stresses of life. There is evidence that people living with HIV are more likely than the general population to have multiple long-term conditions such as poorer mental health and poorer sexual health due to the impact of living with a stigmatized, chronic medical condition and traumatic life events. Findings from Nigeria, indicate that the prevalence of mental health problems among PLHIV range from 21.5% to 59.1% including 15.1% suicidal ideation; 5.8% active plans to commit suicide; while 3.9% had made a suicidal attempt in the past. There are strong indications that MH conditions in PLHIV are under-diagnosed and undertreated (WHO 2001). Not only does mental ill-health negatively affect quality of life, it can complicate clinical care e.g. disengagement from healthcare systems, non- adherence to ART and so on. Given the potential impact of MH problems on the overall care and support of PLHIV indicated in the compromising physical health and heightening risk of onward HIV transmission, there is the need for comprehensive response that integrates MH including its identification and management in the continuum of care support services for PLHIV in Nigeria.

Descriptions: The intervention was designed to integrate of mental health into HIV/AIDS community care and support components of the national HIV/AIDS response in Nigeria.

The National Agency for the Control of AIDS (NACA) led a multi-sectorial team for the task. The process included review of literature, secondary data collection and analysis of care and support program documents. The process included series of consultative and technical meetings with large array of stakeholders including PLHIV, development and implementing partners and academia. The entire process was resourced by government of Nigeria and concluded in six months.

Lessons learned: Identification of gaps in the management of MH in HIV program was useful for the integration of MH in the HIV/AIDS community care and support program in the country. The meetings also promoted awareness among stakeholders for the opportunities to improve MH and HIV programming in Nigeria.

Next steps: The new Guidelines is being rolled-out to improve MH and HIV control in Nigeria especially for better patient outcomes towards achieving global target to end the epidemic of AIDS and other diseases by 2030.

TIME 12:45 – 14:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Thursday, 05 December 2019

Track E: Health Systems, Economics and Implementation Science

Championing Male Involvement and Engagement in HIV Service

Chair: MarieRose Kayirangwa

THAE1301 - TRACK E4

Zambia Male Characterization Study: Who Are the Sexual Partners of DREAMS Adolescent Girls and Young Women - AGYW?

12:45 – 13:00

Cicciò Luigi[1], *Beal Katherine*[2], *Chikuba-McLeod Muka*[1], *Chisashi Mercy*[1], *Chungulo Peter*[1], *Fullem Andrew*[2], *Illingworth Sarah*[3], *Madevu-Matson Caitlin*[2], *Musonda Musonda*[3], *Njelesani Mwansa*[1], *O'Bra Heidi*[3], *Watson Kim*[1]

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Background: Women in Zambia are disproportionally more vulnerable to HIV. Particularly, the annual HIV incidence among adolescent girls and young women (AGYW) is significantly higher (1.07%) than the incidence in males of the same age group (0.08%). The purpose of the Zambia male characterization study (MCS), conducted by the USAID DISCOVER-Health project implemented by JSI, was to characterize and understand the male sexual partners of adolescent girls and young women (AGYW) at risk of HIV, in order to better target and improve HIV programs for males, and reduce HIV transmission among AGYW.

Methods: The mixed methods study was conducted sequentially in 2017/18 in three urban DREAMS districts. A quantitative survey among AGYW characterized their male sexual-partners. A subsequent qualitative survey among 123 males 20-34 years old (15 focus-group-discussions and 9 in-depth-interviews), defined men's health-seeking behaviours and the interventions required to increase their access to and utilization of HIV services, including testing, treatment (ART), circumcision, and condoms.

Results: Of the 808 sexually-active AGYW respondents, 258 (32%) were 15-19 years old and 550 (68%) were 20-24 years old. They characterized their male sexual partners: Most (97%) were older (20% 1-2 years older, 31% 3-4 years older, 37% 5-9 years older, and 8% ≥10 years older), with 92% estimated to be between 20 and 34 years old. Additional male partner information showed that: 65% were single; 68% had attained secondary education; 65% had a formal or informal job; 63% lived in the same community/neighbourhood as the respondent; 58% were circumcised; 62% had disclosed their HIV sero-status; and 39% were known or presumed to have concurrent sexual relationships with other women. Although 77% of the AGYW stated that they were free to ask for condom use, only 40% had used a condom in their last sexual intercourse. Notably, 26% of AGYW respondents reported coerced/forced sex by their male partner (s) in the last 12 months.

Conclusions: The profile of the male sexual partners of AGYW, particularly age range and socio-economic status, was key to identifying potential male HIV/health service beneficiaries and engaging them to obtain insights from about their HIV service access/utilization, in order to inform tailoring to increase their service access/utilization, for their own health, for the health of their sexual partners and families, and towards HIV epidemic control in Zambia.

THAE1302 - TRACK E4

Improving the Quality of Male Circumcision Services through Continuous Quality Improvement in Malawi

13:00 – 13:15

Byabagambi John[1], Moyo Tiwonge[2], Mjuweni Stephano[2], Chabwera Nephtary[2], Kapito Martin[3], Mwandi Zebedee[4], Odek James[5], Kiggundu Valerian[6]
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Issues: Key to implementation of voluntary medical male circumcision (VMMC) is the need to assure that high quality service delivery standards are met. Continuous Quality Improvement (CQI) has been scaled up in several countries and HIV service programs but best practices are not widely shared. The Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project started providing technical support in CQI in Malawi to MOH and four implementing partners; PSI, Jhpiego, Malawi Defense forces and Project IQ. The goal was to ensure that VMMC service delivery meets WHO, national and PEPFAR service quality standards.

Descriptions: Between January and May 2018 AIDSfree conducted a baseline CQI assessment at 31 health units to determine the level of service quality. The assessment covered; 1) management systems, 2) supplies and equipment, 3) registration of clients and group education, 4) counselling for HIV 5) surgical procedure, 6) monitoring and evaluation and 7) infection prevention and control practices. The processes of care including linkage of HIV positive clients into ART care, and improving post-operative review were also assessed. Health units were supported to form CQI teams. AIDSfree trained the teams on application of the CQI approach, provided them with monthly onsite coaching, and supported them to convene in quarterly peer to peer learning sessions to promote inter team and inter partner learning. Quarterly CQI re-assessments were conducted and data was summarized using dashboards (score of less than 50% = poor, >50 to less than 80% =fair and greater than 80=Good). Improvements in processes of care was documented using trend charts.

Lessons learned: A total of 142 services providers were trained on CQI,178 attended learning sessions, and 5 rounds of CQI re-assessments were completed. By November 2018, Jhpiego sites had improved from an average of 59% to 92%, PSI from an average 87% to 94% and Project IQ from an average 75% to 81%. Post-operative follow-up at day 7 improved from an average of 21% to 72% while linkage into ART care improved from an average of 24% to 100%.Gaps faced by VMMC teams can be effectively addressed by the service providers if appropriately supported. The CQI approach provides a successful framework for addressing gaps and maintaining high quality VMMC services.

Next steps: We recommend that all VMMC service providers are supported to apply the CQI approach as a way of sustaining good VMMC service delivery.

THAE1303 - TRACK E4

Involvement of Partners of Male Pregnant Women in the Prevention and Transmission of HIV Services from Mother to Child (PMTCT) in Haiti: A Mixed Cross-sectional Study

13:15 – 13:30

Ngangue Patrice[1], Fleurantin Middle[2], Adekpedjou Rheda[2], Gagnon Marie-Pierre[2]
[1]Université de Sherbrooke, Sherbrooke, Canada, [2]Université Laval, Québec, Canada

Background: The objectives of this study were to determine the level of involvement of male partners of pregnant women living with HIV in the prevention of mother-to-child transmission (PMTCT) services and identify associated factors and barriers that may influence their involvement in PMTCT services.

Methods: From May to June 2018, a mixed cross-sectional study was conducted among pregnant women living with HIV, followed in the antenatal clinic (ANC) of two

health institutions of the UAS of Saint-Marc. A questionnaire was used to measure the level of partner involvement in prenatal services, as reported by pregnant women. Descriptive, correlation and multiple linear regression analyses were conducted as part of quantitative analyses. Audio-recorded semistructured interviews with pregnant women were also conducted and content analysis was performed.

Results: A total of 102 pregnant women living with HIV responded to the questionnaire. According to the information reported by these women, 47% of their male partners had an index of involvement in high PMTCT (scores of 4 to 6). The results revealed that 90% of male partners were financially supporting their pregnant women, and 82% knew the appointment date of their wives to ANC. In contrast, just one-quarter (25%) of partners accompanied their spouses to ANC, and an even smaller proportion 19% routinely used a condom during intercourse during pregnancy.

Predictors of male involvement in PMTCT were being married (b= 0.78; p = 0.022), sharing HIV status with her male partner (b= 0.64; p = 0.022). Concerning male partner' characteristics, having a positive HIV status (b= 1.12; p = 0.004) was the predictor of male involvement in PMTCT. Content analyses of interviews revealed several barriers that may hinder the involvement of partners in these services including the conflict between the hours of operation of the ANC and the work schedule of the partners, the high waiting time in the provision of ANC services to pregnant women, and the perception attributed to maternal care as women domain.

Conclusions and Recommendations: Overall male partners involvement in PMTCT services is moderate. Several obstacles related to gender relations, socio-cultural beliefs, and the organization of care are likely to hinder this involvement. Establishing contextually and culturally accepted strategies in PMTCT services for male partners of pregnant women is likely to strengthen their involvement in the PMTCT program.

THAE1304 - TRACK E4

No Longer "Hard-to-Reach Men" in Zambia; a Micro Targeted Prevention Approach Helped in Reaching At-risk-Men

13:30 – 13:45

Siame Charity[1], Phiri Arlene[2], O'bra Heidi[3], Musimwa Kate[4], Ko Shirley[4], Ventimiglia Tom[4], Thoya Jackson[1]

[1]Pact Zambia, USAID Z-CHPP, Lusaka, Zambia, [2]Pact Zambia, Lusaka, Zambia, [3]USAID, Lusaka, Zambia, [4]Pact USA, Washington DC, United States

Issue: HIV prevalence in Zambia peaked at 28% in late 1990s & declined to 13.5% in 2009 & 12% in 2016. Prevalence among 15-49 years is 14.3% for females & 8.3% for males. ZAMPHIA 2016 indicated over 2/3 of HIV positive men (25-29 years) were not aware of their status. Scale-up of HIV testing services is an effective national strategy in Zambia. Test & treat was launched in 2018. Evidence shows that misconceptions & fear of negative consequences are major barriers of testing. Many at-risk men are mobile, not able to access health services outside working hours. HIV education has been shown to improve testing uptake. A 2015 study showed 33% of male truck drivers had >3 sexual partners. Condom use was at 77% with non-regular, 63% with a regular partner & 7% with their wives.

Description: USAID Z-CHPP contributes to reduction of new HIV infections by adoption of high-impact HIV services & protective behaviors among priority populations. It implements a combination prevention strategy in 14 high burden districts. Micro targeted approaches using geographic hot spot mapping, risk assessment before testing to profile high risk men & behavioral & biomedical interventions, contributed to high uptake of testing & care services among men ages 25+.

Lessons learned: Following the micro targeted approach, average positivity yield reached 33.9% for index & 26.9% for targeted mobile testing among men aged 25+. Linkage to care reached 98% because of volunteers escorted referral approach using bicycles. High impact services uptake has significantly increased (3.5 million con-

doms distributed in FY19).
The narrative "men are hard to reach" is no longer a story for USAID Z-CHPP. Proportion of men >25years (mobile populations) who received standard HIV prevention messages were higher than other priority population categories (58%). More mobile men 25+ were reached with HTS service with positivity rate of 38% next to discordant couples (53%) in FY19. Positivity among men 25+ was as low as 6% in 2016. But, full-fledged implementation of micro targeted approach & combination prevention interventions, brought average positivity to 33% & linkage to care 98% by June 2019.
Next steps: To maintain high positivity from index testing, Pareto's 80/20 principle will be reinforced whereby 80% of tests will come from index & 20% from mobile. Work with traditional leaders & Faith-Based Organizations will address misconceptions, GBV & harmful practices.
Men/ Hot Spots/Positivity

THAE1305 - TRACK E4

Augmentation de la Détection des Cas Positifs aux VIH par l'Approche du Dépistage Indexé Grâce à l'Implication des Relais Communautaires et des Médiateurs de Santé

13:45 – 14:00

Niyoncuti Evangéline[1,2], Rwimo Patricia[1,2], Kabugubugu Martine[1,2], Annequin Margot[2]
[1]Association Nationale de Soutien aux Séropositifs et Malades du Sida (ANSS), Bujumbura, Burundi, [2]Laboratoire de Recherche Communautaire, Coalition PLUS, Pantin, France

Questions: Depuis 2010 au Burundi, les nouvelles infections VIH ont diminué de 54% et le taux de prévalence VIH en population générale était de 0,9% en 2017. Afin de prolonger les efforts entamés, l'Association Nationale de Soutien aux séropositifs et malades du Sida « ANSS » a développé un dispositif de notification aux partenaires dans le cadre du dépistage VIH, en impliquant les relais communautaires « RC »et les médiateurs de santé « MDS ».
Description: De janvier 2018 à mars 2019, Tout patient dépisté VIH positif ou avec une charge virale élevée était mis en lien avec un MDS. Lors d'un entretien personnalisé et confidentiel, le patient listait ses partenaires sexuels en renseignant les coordonnées. Les partenaires sexuels étaient alors contactés par les MDS soit par téléphone soit à domicile. Le MDS informait le partenaire qu'une personne avait renseigné ses coordonnées lors d'une sensibilisation au dépistage du VIH, sans divulguer la personne qui avait donné le nom du partenaire et proposait un dépistage VIH.
Dans la communauté, les RC, à l'aide d'un outil d'évaluation des risques proposaient un dépistage VIH via autotest aux personnes hautement exposées au risque de transmission. Dans le cas d'un test réactif, les RC amenaient les personnes pour confirmation au centre et par la suite les liaient aux soins.
Leçons apprises: De janvier 2018 à Mars 2019, 253 partenaires ont été listés, 144 hommes et 109 femmes, parmi eux 26 hommes et 17 femmes ont été dépistés VIH positifs, soit 18 % des partenaires masculins et 15,5% parmi les partenaires féminines listées.
En 2017, le taux de détection de positif était de 3,7% (508 cas positifs/13 555 tests), en 2018 Avec l'instauration de la notification aux partenaires, le taux de détection de positif était de 5,22% (674 cas positifs/12 893 tests). Au premier trimestre 2019, le taux de détection était de 8,86% (125 cas positifs/1365 tests).
Prochaines étapes: Les stratégies de dépistage incluant la notification aux partenaires sont des stratégies efficaces pour augmenter le nombre de personnes qui connaissent leur statut sérologique. La mise à l'échelle au niveau national de cette stratégie permettrait de prolonger la baisse de la séroprévalence déjà entamée dans la population burundaise.

TIME 14:45 – 16:15 Uhr | ROOM Prudence Mabele (MH 2+ Corridor) | DATE Thursday, 05 December 2019

Track E: Health Systems, Economics and Implementation Science

Young People Bridging Divides; Through Innovations and Partnerships

Chair: Dr. Kalada Green

THAE1401 - TRACK E3

Co-financing Social Protection Interventions for Adolescents in South Africa: Moving towards Multi-sectoral Contributions

14:45 – 15:00

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[1]National Agency for Control of AIDS (NACA), Policy, Planning and Coordination, Abuja, Nigeria, [2]London School of Hygiene & Tropical Medicine, London, United Kingdom

Background: Social protection interventions (SPIs) are designed to address the social, economic and cultural factors that increase the predisposition of adolescents to HIV-risk behaviors. Traditional economic evaluations on SPIs conducted from single-sector (HIV) perspective tend to exclude benefits to other sectors (e.g sexual and reproductive health (SRH), social development (SD)).
Objectives: The first part of the study assesses the cost-effectiveness (CE) of Cash+-Care SPIs among adolescent South African girls (10-18yrs) from the perspectives of HIV, Education, SD and SRH sectors. The second part explores the potential of the program for Co-financing by these benefiting sectors and the extent to which each would be willing to contribute.
Methods: The Cash+Care SPIs were assessed using sector-specific CE and cost-utility analyses. Two financing approaches were considered. The first was Silo financing whereby each budget holder considers the CE of the interventions evaluated against their specific CE threshold (CET). The second Co-financing approach estimates the maximum amounts each sector would contribute to the intervention based on their specific CET, these amounts are then summed-up so the total costs are covered with all the sectors willing to contribute. A Fair-sharing Analysis (FSA) to estimate the amounts each sector should contribute to the total cost is then demonstrated.
Findings: From the Silo analyses, the Interventions were CE only for the HIV and SRH sectors and they would be willing to fund the program. However, with Co-financing, the program became CE for all four sectors and the combined willingness-to-pay (WTP) amounts exceed the total cost. The FSA shows the incremental CE ratios become more cost-effective, further supporting the Co-financing initiative.
Conclusions: SPIs are less likely to be considered efficient and CE when evaluated from individual-sector perspectives, making them less likely to be financed or scaled-up. The Co-financing approach provides an approach to evaluate the program benefits more holistically. Additionally, the FSA prescribes a methodology with which governments can incorporate them into planning and budgeting.
Recommendations: There may be challenges during negotiations for 'fair' sharing of costs; some sectors could try to downplay benefits to them or lower their WTP estimates. Agreements would be needed on program components that are crucial to performance of sector-specific outcomes.

THAE1402 - TRACK E3

Building Bridges - Improving Adolescent HIV Service Delivery through South to South Learning

15:00 – 15:15

Ricotta April[1], Willis Nicola[1], Johnson-Feltham Karen[2], Ameyan Wole[3], Penazzato Martina[3], Doherty Meg[3], Lule Frank[4], Apollo Tsitsi[5]

[1]Africaid, Harare, Zimbabwe, [2]Shenandoah University, Winchester, United States, [3]World Health Organization, Department of HIV and Global Heptatitis Programme, Geneva, Switzerland, [4]HIV/AIDS Treatment and Viral Hepatitis Programme, Regional Office for Africa, World Health Organization, Brazzaville, Congo, [5]Ministry of Health and Child Care, Harare, Zimbabwe

Issues: Sub-Saharan Africa is home to 85% of the 1.8 million adolescents living with HIV. Despite global efforts to end the HIV pandemic, adolescents continue to bear the burden of new infections,morbidity and mortality, thus creating a roadblock to achieving global HIV epidemic control. As a sub-population, adolescents require a service delivery approach calibrated to their needs. Countries must be mentored in successful differentiated service delivery (DSD) models, permitting rapid adoption, adaptation, implementation and scale-up. To be effective, the models must be developed and implemented with the input of adolescents themselves.

Description: The Zvandiri model, implemented by Zimbabwe's Ministry of Health and Child Care (MoHCC) and Africaid is an evidence-based strategy for providing community based peer support to adolescents living with HIV (ALHIV). Uptake of HIV testing and treatment, viral suppression and improved psychosocial well-being have been demonstrated among ALHIV in Zvandiri. With support from The ELMA Foundation and UNICEF, the World Health Organization, respective Ministries of Health (MOH) and Africaid held technical working groups in ten AIDS Free priority countries. A multi-sector approach involving MOH, implementing partners (IPs), donors and adolescents was used. The workshops focused on developing national plans for implementation and scale up of services for ALHIV highlighting the Zvandiri model.

Lessons learned: Sharing best practices among MOH and IPs encouraged country teams to learn and plan together. A marketplace-style exhibition of the Zvandiri Model highlighted the support required for adolescent centred DSD at scale. This approach emphasized adolescent engagement and their role in planning and implementation. Following the meetings, six of the ten countries have either adapted the Zvandiri model, planned a site visit to Zimbabwe or increased their meaningful engagement between IPs, adolescents and MOH.

Next steps: The workshops represent a unique model of south-to-south learning, prioritizing sustainability and collaboration in the countries most affected by HIV. Africaid and Zimbabwe's MoHCC will continue providing technical assistance to other countries, allowing them to adapt the Zvandiri model to their respective contexts. Through sharing of best practices and ideas, stakeholders have an unprecedented opportunity to provide adolescent friendly health services, save lives and contribute towards ending the HIV pandemic.

THAE1403 - TRACK E3

Improving Retention among Adolescents Living with HIV Using Inter-generational Hangout - Experience from North Central Nigeria

15:15 – 15:30

Adeleye Taofeek[1], Popoola Victor[1], Ijezie Echey[1], Ojamuge George[2], Lutung Penninah[2], Edith Babarinde, Chinelo Achebe

[1]AIDS Healthcare Foundation-Nigeria, Abuja, Nigeria, [2]AIDS Healthcare Foundation - Uganda, Kampala, Uganda

Issues: Large disparities in treatment outcome of adolescents living with HIV(ALHIV) as interventions that improved treatment among adults is yet to be fully adapted to adolescent care, partly because most programs lump up their interventions, leading to unwanted outcomes and poor retention in care. Inter-generational hangout pro-

vided insight towards understanding the specific issues affecting retention in care and overall treatment outcome among ALHIV.

Description: Multi-center focused group discussions was conducted for 195 persons (40 parents and 95 ALHIV). Discussions were in 2 stages of three different groups, ALHIVs and their parents, the parents only while the third group was the ALHIVs. Discussion guide was used to moderate and open conversations were encouraged. Key issues include challenges with ART, factors affecting adherence and retention, care perception and improvement, peer support, among others. The ALHIV involved in this activity were monitored over 6months for improved adherence, treatment literacy, participation in support group activities, communication with parents, disclosure and retention.

Lessons learned: Of the 40 parents, 8 were Males and some had more than one ALHIVs. The mean age of the ALHIV was 17 and only 50% knew their HIV status. Key concerns from the parents were socio-economic issues, poor communication with ALHIV, limiting effect of their wards HIV status and difficulties with disclosure. ALHIV were more concerned with treatment fatigue and education. The parents were enthusiastic to learn from each other, understanding that a child's HIV status has no correlation with their future accomplishments and they demonstrated openness to more communication and disclosure. Significant improvement in clinic activities including support group meetings and adherence. Improved treatment literacy with 96% participants retained in care.

Next steps: Interventions such as intergenerational hangouts can provide a very useful avenue to break significant care barriers as it encourages communication, facilitates peer learning and provides support for disclosure, adherence and retention. It is recommended that this intervention be considered as a programmatic tool to improve retention and overall treatment outcome among adolescents living with HIV.

THAE1404 - TRACK E3

Linking in and out of School Clubs to Health Facilities and Community in HIV Prevention: Experience from 10 Years of Adolescent Sexual Reproductive Health (ASRH) Project in Rwanda

15:30 – 15:45

Hagenimana Felix, Musonera Grace Kaneza, Rurangwa Amanda, Rugamba Olivier, Kayiranga Eric, Mukamurara Helene R., Akimana Rachel, Kalisa Isabelle, Umutesi Geraldine, Umutoni Sandrine

Imbuto Foundation, Health, Kigali, Rwanda

Issues: Rwanda has made substantial progress in increasing access and utilization of reproductive health services. Although this progress has led to overall improvements in sexual and reproductive health, a significant proportion of adolescents are sexually active before age of 18 (23.6% of girls and 28.1% of boys). Furthermore, there is limited "comprehensive knowledge" about HIV transmission and prevention among adolescents (62% of girls and 60 % of boys) aged 15-19 years. The ASRH project intervention aimed at introducing a new approach, pairing in and out-of-school youth to health facilities and community to improve HIV prevention and ASRH-related knowledge, attitudes and practices, and increase the utilization of youth friendly services in Rwanda.

Descriptions: Since 2010, Imbuto Foundation has implemented the ASRH project in four districts and featured three interrelated components: Establishment of youth ASRH clubs to facilitate peer-to-peer learning and communication; pairing of youth clubs with nearby health facilities, training health facility staff on the delivery of youth-friendly ASRH services; and organizing Parent and adolescent Communication (PAC) forums and outreach campaigns. Data were collected using Project monitoring tools on quarterly basis. The descriptive statistics was used to generate programme features, using SPSS version 23.

Lessons learned: The project successfully created a network of 263 peer educator clubs (107 school clubs and 156 out-of-school clubs) and trained 6,183 peer educators on disseminating HIV prevention and ASRH information. In total, 190 health care providers were trained to provide ASRH youth friendly services and 293,652 young people accessed ASRH services including HIV and STI screening and treatment. Additionally, 1,115 families took part in PAC forums that aimed at stimulating ASRH related conversation between parent and child. The linkage between in and out of school youth, health care providers and community has influenced youth perceptions and improved exposure to ASRH information and knowledge of HIV prevention by 92.4% among club members. However, use of youth friendly services is still at 65.5%.
Next steps: The experiences of the ASRH project implementation can be scaled up to others districts with high rate of HIV and ASRH related issues. Greater efforts are required in raising awareness on use of youth friendly services and encourage parental involvement in PAC dialogues with their children.

THAE1405 - TRACK E3

Evaluation of Interventions for Increasing Access to Sexual and Reproductive Health and HIV Services among Young People: The Youth Enterprise Model (YEM) in Uganda

15:45 - 16:00

Ogolla Rachel[1], *Tomusange Penninah*[2], *Kindyomunda Rosemary*[1]
[1]United Nation Population Fund Uganda, HIV/AIDS and SRH, Kampala, Uganda, [2]United Nation Population Fund Uganda, Adolescent and Youth, Kampala, Uganda

Background: The Youth Enterprise Model (YEM) project designed by United Nations Populations Fund (UNFPA) in 2012 aimed at increasing knowledge of adolescents and young people aged (10-24) on Sexual and Reproductive Health (SRH) and HIV. YEM used three major access points to target young people in business: Community, Institutions where young people go for either financial services or skills development and health facilities in two districts of Uganda: Kampala and Mubende. YEM has reached over 700,000 young people, helping shape better health seeking and financially responsible behaviors.
Methodology: A mixed methods approach was used to assess YEM validity in Mubende and Kampala between May and June 2018. Quantitative data was collected through questionnaires completed by 1,261 young people aged 10-24 (655 male and 605 female). This included; information on knowledge, attitudes, practices and experiences of young people related to SRH/HIV services and information. Qualitative data was collected through institutional capacity assessments and key informant interviews. In-depth interviews were conducted with project stakeholders.
Findings: Results showed; that knowledge of HIV prevention was slightly higher in the two intervention districts of Kampala and Mubende compared to control districts of Mityana and Wakiso (OR=1.31, P=0.029),10% increase in the proportion of young people who hold favorable opinion that a young person who is not sexually active need information about SRH/HIV from 65% at baseline to 75.7% at end line and 18% point increment in young people who hold favorable opinion about women initiating condom use was recorded with the intervention districts recording higher scores compared to control districts ((OR=2.51, P=0.002). Analysis of qualitative data showed that financial institutions acknowledged that they have not only gained knowledge but also the skills to share with the young people whilst other financial institutions have made further steps to incorporate SRH/HIV issues in their policies.
Conclusion and recommendation: End-line survey confirmed validity of the model, which is proving that by marrying business and health, we can unleash young people's true potential. This is a promising approach that requires increased investment in strengthening advocacy efforts with financial institutions and youth economic empowerment programs for full integration of SRH/HIV information.

Keywords: Youth Empowerment, Condom use, integration

TIME	16:45 – 18:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Thursday, 05 December 2019

Track E: Health Systems, Economics and Implementation Science

Missing Technology to Improve Prevention, Access and Monitoring of the HIV Response

Chair: Dr. Emmanuel Alhassan

THAE1501 - TRACK E1

eLearning Platform Combats Traditional Challenges to VMMC Provider Training in East and Southern Africa

16:45 – 17:00

Mwandi Zebedee[1,2], Chandler Kim[2,3], Letsoalo Andiswa[4], Maziya Vusi[5], Aupokolo Mekondjo[6], Gold Elizabeth[2,3], Soldati Yazabantu[7,8], Broekhuysen Erin[2,3], Sallet Jackie[2,3], Choge Isaac[9], Amzel Anouk[10], Kiggundu Valerian[10]

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Issues: Competent health care workers are needed to deliver safe, efficient, high-quality voluntary medical male circumcision (VMMC) services. Conventional classroom training presents challenges to busy providers; trainees must spend hours away from work and rely upon non-standard, sometimes outdated curricula.

Descriptions: The VMMC Online Training Hub (OTH) is an eLearning platform designed to overcome the challenges of conventional classroom training. The OTH provides a standardized VMMC training curriculum using smart phones or computers from anywhere, with or without internet access. The OTH covers didactic VMMC training traditionally learned through in-person workshops. Learners complete and pass the online theoretical course before proceeding to an in-person clinical practicum, if required. The OTH's learning management system (LMS) provides access to updates, support supervision, refresher training and questions (when applicable). The process uses "Connect," a media platform in which learners communicate with each other and with moderators

Lessons learned: From August 2017 to July, 2019, the OTH enrolled more than 2,000 VMMC staff from 13 countries, and over 50% completed the curriculum. 38% of trainees were VMMC providers and 17% were assistant providers. South Africa, Lesotho, Namibia, and Eswatini have endorsed the OTH platform as their standard for training VMMC providers. Using the LMS, the OTH has documented 379 providers completing training for the dorsal slit procedure, the practice recommended for adolescents by WHO. The OTH provides significant cost savings, as it eliminates travel expenses and time associated with in-classroom training. The average OTH training time is 18 hours, compared to 14 days (112 hours) for traditional classroom workshops. The OTH captures students' progress and guides them through the course. Real-time reports can display success and determine future training needs. Because the training is standardized and accessed online, new content and updates can easily be added and learners are immediately informed of the latest VMMC content. Through the eLearning platform and Connect, news or curriculum changes can be shared quickly.

Next steps: Since its launch, the OTH has seen massive uptake and is widely accept-

ed. This accessible and high-quality training platform should expand to additional countries to advance the adoption of safe, high-quality VMMC.
Keywords: VMMC, online training, AIDSFree, circumcision providers

THAE1502 - TRACK E1

Getting the Message: Low-cost SMS Tool Improves ART Adherence and Viral Suppression in Central America

17:00 – 17:15

Mendizabal-Burastero Ricardo[1], Ortiz Jose[1], Gall Andrew[2], Villaseñor Yadira[1]
[1]Intrahealth International, Guatemala, Guatemala, [2]Intrahealth International, Washington, United States

Issues: In Central America, antiretroviral therapy (ART) clinics need to improve their services to increase adherence to ART and clinical follow-up. Currently, few interventions to address missed appointments have been implemented in the region. Evidence-based interventions with low cost and high potential for scale up can close this gap. Since 2016, with funding from USAID, IntraHealth International has been implementing a low-cost SMS reminder system for clinical appointments in four countries—the first such use of SMS by ART clinics in Central America

Descriptions: IntraHealth conducted a cohort analysis of HIV patients linked to 20 ART clinics in Guatemala (n=6), El Salvador (n=5), Honduras (n=3) and Panama (n=6). Data collection began between 2016-2018, through March 2019. Patients were offered SMS clinical appointment reminders by trained health workers and data on patients who agreed to enroll or did not enroll were included in the analysis. 10,560 patients on ART enrolled, most in Guatemala (51%, n=5,395). 57.5% of patients were male, with the highest male-to-female ratio in Panama (3.2) and lowest in Honduras (1.0). Most patients were over 25 years old (68% between 25-49). Overall, 86% of patients accepted SMS reminders, the highest in Panama (99%) and lowest in Honduras (78%). Comparing by self-identity, men who have sex with men (MSM)/bisexuals had higher acceptance than heterosexuals (92% vs. 85%, $p< 0.001$). Data were collected onsite with a tablet using Dimagi's CommCare HQ. Weekly synchronization with cloud-database was performed. Data were exported as a plain CSV file. Univariate, bivariate, and multivariate analysis, adjusting for self-identity and country, was performed on STATA 14, SPSS 25, and R 3.5.3

Lessons learned: Patients receiving SMS reminders showed a significant increase of T cell CD4+ recovery ($p< 0.001$). Time to achieve viral suppression varied; in El Salvador most of the cohort achieved viral suppression in 6 months, and in Guatemala almost 12months. Patients receiving SMS messages had increased odds (OR = 1.75 (IC95% 1.5-2.0) of achieving viral suppression. Patients self-identified as MSM had higher odds to achieve viral suppression (2.9, IC95% 1.4-5.7, p:0.0003).

Next steps: This proof-of-concept shows the potential of expanding this SMS tool to improve HIV service gaps regarding viral suppression and retention at ART sites in Central America.

THAE1503 - TRACK E1

Using Data Visualization to Drive Decision-making, Address Data Use Challenges, and Strengthen Health System Responses for HIV/AIDS: Lessons Learnt from Zambia, Uganda and Cote d'Ivoire

17:15 – 17:30

Efronson Emilie[1], Sims Jacob[1], Soko Nyewani C.[2], Sikazwe William[2], Mwale John[2]
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Background: 36.9 million people globally were living with HIV with an estimated 1.8 million new infections in 2017. Domestic policymakers and development partners in Africa have channeled resources into HIV/AIDS prevention and treatment programs, however, their efforts have been hindered by limited or no access to timely and dis-

aggregated data on HIV/AIDS prevention, treatment and investments. Equipping decision-makers with access to an intuitive decision-support-tool (DST) to analyze and understand data is critical to the HIV/AIDS response so that resources can be allocated effectively and customized solutions are created for populations with the greatest need. Without access to timely, accurate, and digestible information countries will fall short of both curbing new infections and reaching UNAIDS 90-90-90 targets.
Description: We interviewed decision-makers in the HIV response in Zambia, Uganda, and Cote d'Ivoire around the current state of data and desired features in a future data system in order to develop a customized DST for Zambia and Cote d'Ivoire and provide recommendations in Uganda. Local decision-makers drove DST design to determine indicators and interactive visualizations for inclusion, level of disaggregation, which data sources to integrate, and GIS and location data to include. Together with our in country collaborators we developed customized training materials and a training of trainers curriculum.
Lessons: Establishing a formal decision-making body that meets regularly to discuss tool development is critical to ensuring response to local demand and sustainability throughout the DST development process. Stakeholders identified 3 qualities in a future DST: desire for open-source/ web-based interactive visualizations, cross comparisons with other relevant data systems, and use of GIS and location data. Additionally, when deploying a national level DST, utilizing a training of trainers approach to reach system users in all districts is cost effective and critical to reach and empower data users with the tools they need.
Conclusions: Ensuring sufficient capacity building and stakeholder buy-in so that decision-makers and end-users are equipped with the skills to both interpret and use data to drive decision-making in the national HIV/AIDS response is critical for system sustainability. By doing so, the DST will address a gap in the current data landscape and improve the effectiveness in both the immediate and long-term response to HIV/AIDS.

THAE1504 - TRACK E1

Providing End-to-End Stock Data Visibility through Open Source Technologies: Case Study of Monitoring PEPFAR-led Transition to TLD

17:30 – 17:45

Borse Nagesh[1], Bem Julia[2], Payne Katelyn[3], Lin Chia-Ying[3], Lari Nasim[3], Metzger Michael[3], Iqbal Harris[3]
[1]USAID Global Health Supply Chain Program - Procurement and Supply Management, Arlington, United States, [2]USAID Bureau of Global Health, Washington, United States, [3]USAID Global Health Supply Chain Program: Procurement and Supply Management, Arlington, United States

Issues: Transitioning patients to a superior first-line antiretroviral (ARV) regimen of tenofovir/lamivudine/dolutegravir (TLD) requires careful management of ARV drug stocks and visibility into stock status at all levels of the health system. In low-resourced countries, raw data may be available to provide a summary of stock status, but it is often not fully utilized. The USAID Global Health Supply Chain Program-Procurement and Supply Management (GHSC-PSM) project works to ensure a reliable supply of health commodities for patients in U.S. President's Emergency Plan for AIDS Relief-supported countries. It also helps countries and other donors draw down legacy ARV regimens, minimizing waste.
Description: GHSC-PSM has implemented two initiatives for greater data visibility and analyses of country-level stock availability and distribution to the lowest level of the supply chain.

1. Procurement Planning and Monitoring Report-HIV: collects data from 59 central and regional warehouses in 18 countries
2. Supply Chain-Facility-level AIDS Commodity Tracking: collects data from 14,000+ health facilities in 12 countries

Data dashboards for these initiatives are used to:

- Visualize central and regional data on stocks of first- and second-line ARVs and HIV rapid test kits
- Triangulate facility-level stock and patient data to understand whether the facility has enough ARVs to meet patients' needs

Lessons learned: On a monthly basis, data and analysis are shared with USAID, the Office of the U.S. Global AIDS Coordinator, and countries to ensure availability of medicines, including:

- TLD stock levels
- TLD expiry dates
- Status of legacy ARV draw-down

In one case, this analysis allowed a donor to cancel Nevirapine-based ARV orders that would have slowed the transition of patients to TLD. Additionally, monitoring the TLD transition at the patient level has enabled supply chain staff to:

- Observe changes in stock levels over time
- Monitor draw-down of products being substituted or removed from the market
- View distribution of products across various facilities
- Identify potential distribution issues
- Evaluate distribution of products per patient and identify incongruencies

Next steps: The online dashboards create linkages across different data sources using open source technologies, increasing visibility into warehouse and facility stock levels at the last mile. They have potential to provide decision-support for a broader audience and can be scaled-up across other commodity groups.

THAE1505 - TRACK E1

Understanding Gaps in the HIV Treatment Cascade in 11 West African Countries: Findings from the Regional Community Treatment Observatory

17:45 – 18:00

Oberth Gemma[1], Baptiste Solange[2], Mosime Wame[3], Manouan Alain[4], Garcia Pedro[4], Taro Trisa[5], Gueye Omar Ben Khatab[4], Traore Anta Mariam[4], Murara Joelle[4], Boka Raoul[6]

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Background: In West and Central Africa, 48% of people living with HIV (PLHIV) are aware of their status, 40% are accessing antiretroviral therapy (ART), and 29% are virally suppressed. Progress is stymied by drug stock-outs, weak health systems, human rights barriers, and low quality of care. In February 2017, the International Treatment Preparedness Coalition (ITPC) established the Regional Community Treatment Observatory in West Africa (RCTO-WA) to increase accountability for the 90-90-90 targets.

Methods: ITPC trained and supported national networks of PLHIV to collect and analyze facility-level data along the HIV treatment cascade from 103 health centers in 11 West African countries. From July 2017-June 2018, the RCTO-WA conducted 538 health center visits, 279 key informant interviews, and 110 focus group discussions. In this paper, we share the first year of RCTO-WA community monitoring findings, analyzed using the 'Five As' framework— availability, accessibility, acceptability, affordability and appropriateness.

Results:

Availability: ART stock-outs were recorded during 23.4% of health facility visits (95% confidence interval [CI] 19.8%-27.0%), lasting an average of 40.5 days (95% CI 34.2-46.7). Stock-outs were less common for HIV tests and viral load supplies.

Accessibility: Long distances to health centers was the top cited barrier to HIV testing and ART. Linkage to care was high overall (4,692 positive tests; 4,354 ART initiations),

but was lower among key and vulnerable populations, and countries without test-and-treat. Among 81,817 people on ART, 16,491 viral load tests were performed.
Acceptability: One third of participants rated the quality of services a 3 or less out of 5. A quarter of viral load test results were returned from the lab within 2 weeks, with faster turnaround time associated with improved viral suppression ($p < .05$).
Affordability: Payment was not cited as a major barrier to services, despite high out-of-pocket expenditure in the region.
Appropriateness: Key and vulnerable populations made up 16% of positive HIV tests but just 7% of people on ART. Young men were less likely to access services than young women.
Conclusions and Recommendations: To achieve the 90-90-90 targets, ongoing community monitoring is critical. The RCTO-WA highlights key access gaps along the HIV treatment cascade. National and regional advocacy should focus on expanding differentiated service delivery and removing gender- and human rights-related barriers.

TIME	10:45 – 12:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Friday, 06 December 2019

Track B: Clinical Science, Treatment and Care

Viral Load and Linkage

Chair: Dr. Oni Idigbe

FRAB1601 - TRACK B1

HIV Virological Failure Management: Give the Chance to the Patient, Not to the First Line ART!

10:45 – 11:00

Breton Guillaume[1], Billaud Anthony[2], Sié Dionou[3], Karemera Francine[4], Koita Youssouf[5], Karemangingo Saidi[6], Agaman Jean Claude[7], Mbangue Madeleine[8], Zana Daniel9, Temgoua Edith10, Laborde-Balen Gabrièle[11,12], OPP-ERA Study Group

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Background: Even though access to HIV viral load (VL) has increased in resource-limited settings, its clinical use remains challenging. The OPP-ERA project has allowed performing more than 180000 VL from 2014 to 2019 in Burundi, Cameroon, Côte d'Ivoire and Guinea. However, in case of VL≥1000 cp/mL, less than 15% of patients have benefited from a VL control, as recommended by national guidelines, and switch to 2nd line is anecdotal. We investigated the factors associated with low use of 2nd line.

Methods: We performed surveys of prescribers' VL knowledge and perceptions of the factors associated with low use of 2nd line in the 4 countries in 2019. Qualitative data were collected during clinical trainings.

Results: The knowledge survey included 71 participants, 58% had a good knowledge of VL however the 1000cp/mL threshold was respected by only 23% of them for a clinical case with a decrease in VL after adherence strengthening (p< 0,01).

The main reasons perceived as associated with low use of 2nd line were structural (fear of 2nd line shortage 42%, low availability of 3rd line 50%) and organizational (slow turnaround of VL test results 80%, work load 60%). Individual reasons were perceived as secondary (low VL knowledge 23%, difficulty explaining viral failure to patients 39%).

In qualitative survey, the fear of over-use of expensive 2nd line appears as a concern for HIV program manager. Therefore, ensuring that adherence has been sufficiently strengthened before switching to 2nd line seems crucial but difficult to evaluate. VL seems then often considered as an objective measure of non-adherence and those especially since patients in virological failure suffer from negative representation. Moreover, even a modest decrease in VL after adherence strengthening is considered as a success, which often leads to repeated adherence intervention and VL control to "give a chance to the 1st line" in the hope to reach a VL< 1000 cp/mL, with very low and late switch to 2nd line.

Conclusions and Recommendations: The VL guidelines are known, but their interpretation seems complex. Ensuring that adherence has been properly reinforced, compliance with the 1000 cp/mL threshold, cost and availability of 2nd line and a slow turnaround of VL test results seems to be factors associated with the low use of the 2nd line. Significant capacities building seem necessary to increase the best use of VL to improve patient's care.

Key words: Virological failure, 2nd line, VL guideline

FRAB1602 - TRACK B1

Impact of Peer Mentoring on Viral Suppression and Internalized Stigma among HIV-positive Adolescents and Young Adults in Ndola, Zambia: Project YES! Youth Engaging for Success RCT Results

11:00 – 11:15

Denison Julie A.[1], Burke Virginia M.[1], Miti Sam[2], Frimpong Christiana[2], Merrill Katherine G.[1], Abrams Elizabeth A.[1], Mwansa Jonathan K.[2], Nonyane Bareng A.S[1]
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Background: Youth-led strategies remain untested in clinic-based programs to achieve viral suppression (VS) and reduce internalized stigma among HIV-positive adolescents and young adults (AYA) in sub-Saharan Africa. In response, Project YES! drew upon Positive Youth Development and Social Cognitive Theory to place trained and paid HIV-positive youth peer mentors (YPMs) in HIV clinics in Ndola, Zambia.
Methods: A randomized controlled trial was conducted in one children's hospital, one adult hospital, and two primary care facilities. Consecutively recruited AYA, ages 15 to 24 years, were randomly assigned to either an intervention arm, consisting of monthly one-on-one and small group sessions with a YPM and optional caregiver support groups, or the usual care arm. Survey data and blood samples were collected at baseline and midline. GEE models adjusted for age, sex and clinic and evaluated the effect of study arm over time on VS and internalized stigma. Internalized stigma was assessed as feelings of worthlessness, shame and guilt due to living with HIV.
Results: Enrolled participants (n=276) were predominantly female (60%). Most intervention AYA (95%) attended an orientation meeting with the YPM, health care provider and, if invited by the youth, their caregiver. Seventy-four percent of Project YES! clients in the intervention arm attended at least 5 of the 6 YPM one-on-one meetings. Significant improvements in VS occurred in both arms between baseline and midline [OR 1.49, 95% CI (1.08, 2.07)]. In a stratified analysis, the children's hospital intervention participants versus the comparison participants experienced a relative increase in the odds of VS by a factor of 4.7 [interaction term OR 4.66, 95% CI.84, 11.78]. By midline, internalized stigma was significantly reduced by a factor of 0.39 (OR 0.39, 95% CI 0.21, 0.73) in the intervention arm relative to the reduction in the comparison arm.
Conclusions and Recommendations: Project YES! provides an effective clinic-based approach to engage both female and male AYA and improve VS in pediatric settings and reduce internalized stigma across all settings. HIV-positive youth are an underutilized resource to address HIV-outcome inequities experienced by adolescents and young adults in sub-Saharan Africa.

FRAB1603 - TRACK B1

Virological Rebound among Re-suppressed Patients after Failing Second-line HIV Therapy in Johannesburg, South Africa

11:15 – 11:30

Shumba Khumbo[1], Onoya Dorina[2], Nattey Cornelius[2], Levin Jonathan[1], Goeieman Bridgette[3]
[1]School of Public Health, University of Witwatersrand, Faculty of Health Sciences, Johannesburg, South Africa, [2]Health Economics and Epidemiology Research Office, Department of Internal Medicine, School of Clinical Medicine,Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa, [3]Right to Care, Johannesburg, South Africa

Background: While reports suggest that some HIV-infected patients on protease inhibitor-based second-line antiretroviral therapy (from here forth referred to as second-line ART) achieve re-suppression after experiencing virological failure, their risk of virological rebound (subsequent virological failure) is unclear. We estimated incidence rates of and examined predictors of, virological rebound among these patients.
Methods: We used a retrospective cohort study design to analyse routinely collected data for adult (≥18 years) patients, who switched to second-line ART between 1st Jan-

uary 2012 and 31st December 2016 at Themba Lethu Clinic in Johannesburg , South Africa. Analysis was restricted to patients who re-suppressed (viral load < 400 copies/mL) within 6 months after experiencing first virological failure. Patients were followed up for 24 months and were right censored. Baseline patient characteristics were summarised stratified by sex. Incidence rates and survival probabilities were estimated using Kaplan-Meir survival analysis methods. Predictors of virological rebound were investigated using Cox proportional hazard modelling.

Results: Out of 2371 patients on second-line ART, a total of 242 patients (57.4% males and 42.6% females) re-suppressed in a median (IQR) of 3.7 (2.8-4.6) months after initial virological failure. Overall, the incidence rate of virological rebound was 23.20 per 100 person-years (PY) (95% CI: 18.38-29.27), and this was higher for males (Males: 24.39/100PY; [95% CI: 17.15-34.68] vs. Females: 22.35/100PY; [95% CI: 16.39-30.47]). Risk of virological rebound was higher among underweight patients (Body mass Index [BMI]:< 18.5kg/m2) compared to those with a normal BMI (BMI: 18.5-24.9 kg/m2), (aHR: 3.08; [95% CI:1.16-8.13]). Patients with low CD4 count (< 350 cells/µl) had a higher risk compared to those with a higher CD4 count (>500 cells/µl), (aHR: 3.68; [95% CI:1.10-12.33]). Receiving at least five enhanced adherence counselling sessions reduced the risk by 89% compared to receiving less than five (aHR: 0.11; [95% CI:0.06-0.20]).

Conclusions and Recommendations: The incidence rate of virological rebound is high among patients on second-line ART who re-suppress after experiencing initial virological failure. Enhancing patient-centred interventions to improve ART adherence, CD4 count and BMI in these patients, may reduce switches to more expensive and limited third-line regimens.

FRAB1604 - TRACK B1

Prevalence of Undetectable HIV Viral Load in Pregnant Women Initiating Option B+ in Kampala and Mityana, Uganda

11:30 – 11:45

Gabagaya Grace[1], Rukundo Gordon[1], Amone Alexander[1], Wavamunno Priscilla[1], Malamba Samuel[2], Matovu Joyce Namale[1], Lubega Irene[1], Nakabiito Clemesia[1], Namukwaya Zikulah[1], King Rachel[3], Nolan Monica[1], Fowler Mary Glenn[4], Musoke Philippa[1,5]

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Background: Viral load (VL) monitoring is key in monitoring adherence and documenting treatment response. However, as per HIV treatment guidelines in Uganda, the first VL is done 6 months after initiation of antiretroviral therapy (ART). Undetectable VL (uVL) at ART initiation can result in over-estimation of treatment efficacy/ adherence. We analyzed the baseline VL study data at 0 months after ART initiation from a cohort of HIV positive pregnant women enrolled in the Friends for Life Circles for Option B+ study.

Methods: HIV-positive pregnant women ≥18 years old and newly initiated on ART for Option B+ in Kampala and Mityana Districts were enrolled into the study. Each participant had whole blood samples collected on enrolment day for assessment of baseline plasma HIV-RNA. VL testing was conducted using COBAS Ampliprep /COBAS Taqman whose lower limit of detection was 20 copies/ml. Samples with 1-19 copies/ml were reported as < 20 copies/ml while 0 copies/ml were reported as undetectable. Participants with uVL had repeat rapid antibody testing to confirm HIV diagnosis and if negative, had HIV DNA PCR testing done.

Results: Nineteen (3.6 %) of 532 newly identified HIV-positive pregnant women enrolled in the study had uVL at baseline; 10 (1.9%) had < 20 copies/ml; without history of prior ART use. The mean duration from date of ART initiation to time of sample collection for baseline VL assessment was 4 days (SD =4). The median age in years for

participants with and without uVL at baseline was 26(23, 30) and 25(22, 30) respectively; p=0.62. In addition, there was no association between parity, marital status, mean monthly income, educational level attained, disclosure of HIV status to partner or any other person and uVL at baseline (p=0.88, p=0.69, p=0.26, p=0.59, p=0.42 and p=0.066 respectively).

Conclusions and Recommendations: A small proportion of Ugandan pregnant HIV-positive women initiating ART (Option B+) had uVL at baseline, and were presumed "elite controllers"; or unreported ART use. Further studies are needed to better understand the biologic mechanisms of elite controllers; as well as considering screening for baseline drug levels in self-reporting ART naïve pregnant women with uVL to better inform treatment efficacy.

Keywords: HIV, ART naïve, Viral load Monitoring, Elite control, Uganda

FRAB1605 - TRACK B1

Real Time Medication Monitoring Improves Virological Outcome among People Living with HIV on Antiretroviral Treatment in Moshi, Tanzania

11:45 – 12:00

Ngowi Kennedy Michael[1,2], Pima Francis M[1], Mmbaga Blandina T[1,3], Nieuwkerk Pythia T[2], Aarnoutse Rob E[4], Marion Sumari-De Boer[1,5]

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Background: People living with HIV (PLHIV) have problems with adherence to treatment. Interventions should address a variety of factors. Mobile phone coverage in Tanzania is high (>80%) and is an ideal way to use mobile health (mhealth) for reminding and monitoring medication intake. The aim of this study is to investigate the effect of reminder cues and tailored feedback, using two mhealth strategies, on adherence to treatment among PLHIV in Moshi, Tanzania.

Methods: We performed a randomized three-armed clinical trial among PLHIV on ART in two treatment centers in Moshi, Tanzania. One arm received the Wisepill device for real time medication monitoring (RTMM). If medication from the device is not taken on time, the participant receives a short message service (SMS) reminder text. In the second arm, participants receive a reminder SMS on three random days a week, followed by a question SMS to which they have to reply whether they took medication. Visual reports are used to give tailored feedback on adherence. The third arm receives standard care only. Virological outcome (copies/ml) was measured at study entry and at 48 weeks and compared between the three arms using chi-square tests. A result of < 20 copies/ml was considered undetectable.

Results: Preliminary analyses of 86 participants who finished follow-up showed that 50 (58%) were women and median age was 40[IQR:31-52]. There were 32 (37%) in the RTMM arm, 25 (29%) in the SMS arm and 29 (34%) in the control arm. At study entry, there was no difference in virological outcome with 47% being undetectable in the RTMM ar, 52% in the SMS arm and 46% in the control arm (p=0.90). At 48 weeks, the viral load was undetectable in 72% in RTMM, 68% in SMS and 55% in the control arm (p=0.36). There was no difference between male and female participants in undetectable viral load at 48 weeks (p=0.56). The percentage of participants having a high viral load of 400 copies/ml or more was 13% in the RTMM arm, 24% in the SMS arm and 31% in the control arm (p=0.21).

Conclusions and Recommendations: Preliminary results show a trend of participants in the RTMM arm having better virological outcomes, although not significant. The number of participants who finished the study is still low. We believe the trend might continue and lead to a significant result once all participants have finished follow-up. Therefore, we conclude that RTMM is a promising way of improving treatment outcome among PLHIV on ART.

TIME	12:45 – 14:15	ROOM	Prof. Madeleine Okome (MH 3)	DATE	Friday, 06 December 2019

Track A: Basic Science (Biology & Pathogenesis)

HIV Co-infections and Emerging pathogens

Chairs: Dr. Frank LULE

FRAA1701 - TRACK A2

Mortality Still Fivefold Higher in HIV-infected MDR-TB Patients after Shortening of Delays in Rwanda

12:45 – 13:00

Ngabonziza Jean Claude Semuto[1,2], Decroo Tom[3,4], Torrea Gabriela[2], Habimana Yves Mucyo[5], Migambi Patrick[5], Ivan Emil[1], Zolfo Maria[3], Mazarati Jean Baptiste[6], Rigouts Leen[2,7], de Jong Bouke Catherine[2]

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Background: HIV co-infection is a known predictor of rifampicin-resistant tuberculosis (RR-TB) mortality. It is unknown how much mortality can be reduced by shortening delays in initiating appropriate MDR-TB treatment. Since 2006, the TB programme intensified programmatic efforts to rapidly diagnose and treat RR-TB, particularly among HIV-coinfected patients. In this national study we sought to evaluate whether delays were shortened more among HIV-coinfected patients and its effect on mortality.

Methods: Retrospective analysis of individual level data for patients diagnosed with RR-TB between 01/07/2005 and 31/12/2016 in Rwanda. Delay was calculated as the number of days between sputum sample collection for RR-TB diagnosis and MDR-TB treatment initiation. The equality-of-medians test was used to compare medians. Logistic regression was used to estimate predictors of mortality.

Results: This analysis included 730 (83.3%) of 876 RR-TB patients notified. HIV co-infection was documented for 698 (95.6%) RR-TB patients, of whom 291 (41.7%) were HIV-coinfected. Between 2006 and 2016, the overall median delay in initiating MDR-TB treatment decreased from 156 days(d) (IQR:112-212d) to 5d (IQR:3-11d; p< 0.001), and was significantly shorter among HIV-coinfected (median=53d; IQR:9-105) compared to HIV negative patients (median=78d;IQR:15-109;p< 0.001). Simultaneously, the overall RR-TB mortality significantly decreased from 30.8%(95%CI:19.9-43.4) in 2006 to 6.9%(95%CI:2.3-15.5) in 2016 (p< 0.001). HIV-coinfection (aOR 2.3, 95%CI:1.4-3.8) was associated with RR-TB mortality. A delay in starting MDR-TB treatment of at least 100d was significantly associated with RR-TB mortality among HIV-negative patients (aOR 2.9, 95%CI:1.1-7.7), but not among HIV-coinfected patients (aOR 2.1, 95%CI:0.9-4.6). Moreover, in 2016, RR-TB mortality was five times higher among HIV-coinfected (12.5%; 95%CI:3.5-29.0) than HIV-negative patients (2.5%; 95%C:0.1-13.2%), albeit with wide confidence intervals.

Conclusion and Recommendations: This unique nationwide study covering more than 10 years, showed a successful reduction of delays, resulting in an important reduction of mortality. Even though HIV-coinfected patients were starting MDR-TB treatment faster compared to HIV negative patients, they were still five times more at risk of dying. How to reduce RR-TB specific mortality, beyond reducing delays, should be explored further among HIV/MDR-TB co-infected patients.

FRAA1702 - TRACK A2

The Effectiveness of Nutrition Supplements to Improve Sputum Conversion, Treatment Completion and Weight Gain among TB & HIV+/- Patients: A Systematic Review and Meta-analysis

13:00 – 13:15

Nambajimana Abidan[1], Ndishimye Pacifique[1], Mpabuka Etienne[2], Rusisiro Byiringiro[2], Karame Prosper[1], Musabyimana Jean Pierre[1], Nshimiyimana Ladislas[2], Feyissa Garumma Tolu[3], Musanabaganwa Clarisse[4], Migambi Patrick[2], Umutesi Condo Jeanine[2]
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Background: Nutrition, immunity, and infection interact together in a complex and dynamic way and patterns. Previous studies have shown that tuberculosis and the human immunodeficiency virus (HIV) are associated with malnutrition, reduced appetite, low dietary intake, malabsorption and increased caloric demand. Nutritional deficiencies caused by TB may worsen the disease, or delay recovery by depressing important immune functions. In the present review, we have investigated the effectiveness of nutrition supplements to improve sputum conversion, treatment completion and weight gain among TB patients to effectively inform decision makers on designing the potential interventions to ascertain how best to deliver economic support to those suffering from and susceptible to TB in lower and middle-income countries.
Methods: This review has considered studies that include adult and children receiving treatment for pulmonary TB (both HIV positive and HIV negative) and who were supplemented with nutrition in lower and middle-income countries. This review also considered studies that evaluate the effectiveness of multivitamins, nutrients and minerals supplements provided for TB patients during the course of treatment. Studies that measured sputum conversion, treatment completion and weight gain were also included in the review.
Results: Of 779 references initially identified from PubMed, sciences.gov and other sources, only 18 studies met the inclusion criteria. The minerals and other multivitamins were found to have no effect on treatment completion among HIV+ and HIV- (both combined). The findings showed that nutrition supplement on TB patients under treatment has an effect on weight gain among TB HIV- alone. No statistically significant benefits on sputum conversion have been demonstrated.
Conclusion: More research projects are still needed to know whether routinely providing nutrition supplements can improve tuberculosis treatment outcomes in HIV+/-, but it probably improves weight gain in some settings.

FRAA1703 - TRACK A2

Genital Co-infection with High-risk Human Papillomavirus (HPV) and HIV among Sex Workers in Burkina Faso

13:15 – 13:30

Zohoncon Theodora Mahoukede[1,2], Ilboudo Régine[3], Ouédraogo Charlemagne[4], Simpore Jacques[3]
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Background: Genital human papillomavirus (HPV) infection, the most common sexually transmitted infection among women, is potentially serious because of its associated high risk of cervical cancer. HIV co-infection increases the risk. The aim of this study was first to determine the prevalence of carrying HPV / HIV and second to characterize high-risk HPV genotypes among females sex workers in Ouagadougou, Burkina Faso.
Methods: This study was specific for female sex workers. HIV testing has been done. During 1 months, 200 females sex workers voluntarily accepted endocervical swab

collection. Real-time PCR was used to identify HPV genotypes.
Results: HIV seropositivity was found in 4.5% of female sex workers (9/200). High-risk HPV carrying prevalence was 41.5%: 106 females sex workers were positive for at least at one high-risk HPV genotype. Fourteen genotypes corresponding to 225 infections were characterized: HPV68 (33/225), HPV31 (27/225), HPV52 (21/225), HPV51 (20/225), HPV56 (17/225), HPV66 (17/225), HPV58 (16/225), HPV35 (16/225), HPV39 (14/225), HPV18 (14/225), HPV45 (13/225), HPV59 (7/225), HPV16 (6/225), HPV33 (4/225). Multiple infection, statistically associated with females sex workers' age ($p < 0.001$), was detected in 53,8% of the infected females sex workers. While the number of sexual partners was statistically associated with carrying of HPV ($p < 0.001$; OR = 2.0; 95% CI : 0.56-7.14), the early beginning of the sexual intercourses and recent change of partners were not.
Conclusions and Recommendations: This study has shown that the prevalence of high-risk HPV genotypes is high and shows the need to strengthen the means of control against this disease. This study also notes HIV / HPV co-infection among sex workers. The genotypes here identified are different from those targeted in the currently available prophylactic vaccines. A broader study to chart the high-risk HPV genotypes circulating in West Africa is necessary to tailored vaccine.

FRAA1704 - TRACK A2

Evaluation of the Efficacy of Hepatitis B Virus Vaccine in PLHIV in Rwanda

13:30 – 13:45

Umutesi Justine[1,2], *Remera Eric*[1]
[1]Rwanda Biomedical Center (RBC), Kigali, Rwanda, [2]Helmholtz Center for Infection Research(HZI), Braunschweig, Germany

Background: Vaccination against HBV is still the most effective measure to prevent HBV infection and its consequences. However, persons living with human immunodeficiency virus (PLHIV) have a reduced response to HBV vaccination due to the inability of the body to produce the antibodies required for future protection against the virus. We aimed to evaluate the efficacy of the HBV virus vaccine in PLHIV in Rwanda, determination of full vaccination coverage rate and factors associated with immune or non-immune response
Methods: During the year 2015, HIV positive and negative individuals have been vaccinated against HBV from different health facilities. From March to May 2017, a blood specimen was taken to test for Hpatitis B Surface Antibodies (HBsAb) and patients information recorded on a laboratory request form. A threshold of < 10 IU/L anti-HBs titer is used to determine whether someone has been successfully vaccinated.
Results: For a total of 11,523 individuals with available information on HIV status, HBsAb test results and number of HBV vaccines received, 5410(46.94%) were HIV positive. 7312(63.09%) were female and 3,876(33.60%) were aged between 35-44. 10699(92.3%) received three HBV vaccine doses (5616{91.40%} and 5083{93.3%}) in HIV-negative and positive respectively. 8,667(74.80%) had Anti-HBs titer below 10 IU/L; 5028 (81.80%) in HIV-negative and 3639 (66.80%) in HIV positive. In multivariate analysis, comparing with people aged between 35-44 year, people under 15 were more likely to be not protected (anti-HBs titer above 10 IU/L) Adjusted Odds Ratio (AOR)=1.5; 95%Confidence Interval (CI)= 1.04-2.38). Comparing with female, males were less protective (AOR=1.35 CI =1.16-1.57). Comparing with Eastern province, people from the City of Kigali were less protected (AOR= 2.1; CI 1.46-3.06). Receiving 3 doses and above and being on NonTDF based ART regimen were protective AOR=0.39; CI=0.30 and AOR= 0.51; CI= 0.54 - 0.73.
Conclusions and Recommendations: This is a first step to understand the vaccine efficacy among HIV negative and positive. In deep analysis and further researches are needed to understand the vaccine efficacy among youth.

FRAA1705 - TRACK A2

APOBEC3G Polymorphisms and HBV Co-infection in a HIV Seropositive Population of Burkina Faso

13:45 – 14:00

Compaore Tegwinde Rebeca[1,2], Ouedraogo Henri Gautier[1], Sagna Tani[1,2], Ouattara Abdoul Karim[2,3], Soubeiga R. Serge Theophile[1,2], Kouanda Seni[1], Simpore Jacques[2]
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Background: Apolipoprotein B mRNA editing enzyme catalytic polypeptide-like 3G (APOBEC3G) is a potent host defense factor, which interferes with HIV-1 and HBV. Our study had for objectives, to screen a population of HIV-1 infected patients in Burkina Faso for HBV, to screen the population for APOBEC3G variants rs6001417, rs8177832, and rs35228531 previously described, and to analyze the effect of these three variants on HIV/ HBV co-infection in Burkina Faso.
Methods: HBV detection was performed on samples from HIV-1 infected subjects using rapid detection tests and real-time PCR. APOBEC3G genotyping was done by the TaqMan allelic discrimination method. McNemar corrected test, Odds ratio (OR), confidence intervals (CI) at 95%, Linkage disequilibrium (LD) summary statistics were determined.
Results: HBV prevalence was 56.7% among HIV-1 positive patients in our study. Genotype E was the genotype of HBV present in our hepatitis B positive samples. The genotypes CC, GG of rs6001417, AA and GG of rs8177832, and TT of rs35228531 were associated with an increased risk of being co-infected with HBV. In fact, the respective odds ratios were for rs6001417 genotype CC OR= 2.43, 95% CI (1.57-13.76), p=0.000058 and for genotype GG OR=3.81, 95% CI (2.40-6.04), p=10-10. For genotype AA and GG the odds ratios were respectively OR=2.39, 95% CI (1.54-3.70), p=0.000086 and OR=4.23, 95% CI (2.6-6.9), p=10-10. Only genotype TT of the variant rs35228531 was associated with HBV co-infection with OR=15.29, 95% CI (6.69-34.92), p=10-10. The linkage disequilibrium between APOBEC3G's 3 variants studied were slightly higher among HIV mono-infected compared to HIV/HBV co-infected patients.
Conclusions and Recommendations: This study shows that there is a significant difference between HIV mono-infected individuals' genotypes compared to co-infected HIV/HBV individuals', in a population from Burkina Faso. APOBEC3G should be more investigated in a HIV/HBV co-infection context.

TIME	12:45 – 14:15	ROOM	Prof. Madeleine Okome (MH 3)	DATE	Friday, 06 December 2019

Track B: Clinical Science, Treatment and Care

Anti-Retroviral Therapy

Chair: Dr. Meg DOHERTY

FRAB1801 - TRACK B2

Prevalence of Advanced HIV Disease at Antiretroviral Therapy Initiation for Children and Adolescent 5-14 Years of Age in Tanzania, 2015-2018

12:45 – 14:15

Masenge Theopista Jacob[1], Antelman Gretchen[2], Van de Ven Roland[3], Kimambo Sajida Julius[4], Songoro Juma[5], Kimario Chrispine[6], Kashindye John[7]
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- Tanzania, Training and Capacity Building Officer, Dare Salaam, Tanzania, United Republic of

Background: As antiretroviral therapy (ART) is scaled up and countries adopt the WHO-recommended "Teatment for All" policy, prevalence of advanced HIV disease (AHD) at ART initiation for individuals age ≥15 years has decreased between 2004 and 2015 in 10 high burden countries. However, there is scarcity of data for children/adolescents age 5-19 years in these countries, including Tanzania. We reviewed the prevalence of advanced HIV disease at ART initiation for children and adolescents age 5-19 years in Tanzania to inform the need for implementing a differentiated care package for advanced HIV disease at ART initiation in this age group.

Methods: A retrospective review was conducted from the national care and treatment database (CTC2) for 420 facilities in 6 regions from January 2015-December 2018. WHO clinical stage and CD4 count within 6 months before or 3 months after ART initiation was assessed; advanced HIV disease was defined as WHO clinical stage 3 or 4 or CD4 count < 200. We evaluated the outcomes of children/adolescents with advanced disease at ART iniation, classified as deceased, lost to follow-up (LTFU), in care, and last viral load result status. Patients coded as "opting out" of ART were classified as LTFU, and patients transferring out were excluded.

Results: A total of 6426 children and adolescents 5-19 years old initiated ART in the study sites from 2015-2018 with a documented baseline WHO stage. The mean proportion with WHO stage 3 or 4 at ART initiation was 30%; this decreased from 37% in 2015 to 23% in 2018 (p-value trend< .0001), similar to what has been observed among adults. Only 1779 (28%) new children/adolescents had a baseline CD4 performed, and 24% were CD4< 200. Those with WHO stage 3/4 at ART initiation had significantly more deaths (9% vs 3%, p< .0001) and LTFU (19% vs 24%, p< .0003) outcomes compared to those stage 1/2. Viral suppression (< 1000 c/mL) was also lower among those initiated at WHO stage 3/4 (70%) compared to stage 1/2 (77%, p< .0001). Similarly, in the subgroup with CD4 count availability, there were significantly more deaths (13% vs 2%, p< .0001), LTFU (22% vs 18%, p=.004), fewer currently in care (65% vs 80%, p< .0001), and less viral suppression (68% vs 74%, p=.053) in those with CD4 < 200 vs >200 at ART initiation.

Conclusions and Recommendations: Despite the widespread implementation of "Treatment for All", almost one-third of children/adolescents aged 5-19 years present with AHD at ART initiation by WHO clinical staging and one-quarter have CD4 < 200. Coverage of CD4 testing is declining over time, hindering proper classification of AHD patients at ART initiation. There are more deaths and LTFU and less viral suppression among children/adolescents who present with AHD, illustrating the need for adoption of the WHO AHD care package, including evaluation for opportunistic infections (OI) and provision of OI prophylaxis for children/adolescents with AHD in our setting.

Key words: Advanced HIV disease, antiretroviral therapy (ART), treat all, CD4

FRAB1802 - TRACK B2

Concurrent Use of Ocimum Gratissimum and Fixed Dose Combination of Zidovudine, Lamivudine and Nevirapine Reduces Plasma Concentration of Nevirapine

13:00 – 13:15

Njan Anoka[1], Yusuf Olalekan[1], Oyediran-Ahmad Azeezat[1], Olaoye Solomon[2], Erdogana Ozlem[3], Ofigbele Mathew[4]

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Background: Approximately 64% of individuals ingest herbs concomitantly with orthodox medications in Nigeria. This is particularly common among people living with HIV and AIDS (PLHA). The burden of the interaction of these herbs with antiretroviral drugs (ARV) might not have been elucidated. Anti-retroviral treatment (ART) centres administer Nevirapine (N) for prophylaxis and treatment of HIV. This study investigat-

ed the effect of concomitant ingestion of the commonest ingested herb and ARVs on steady state serum concentration of Zidovudine (Z), Lamivudine (L) and Nevirapine in PLHA at the University of Ilorin Teaching Hospital, Kwara state, Nigeria.
Methods: An initial cross-sectional descriptive study was conducted among 60 herbalist and 300 (male: female; 81:219) PLHA at the UITH HAART clinic to ascertain the common herbs ingested alongside ARVS in the region. Data was gathered with a semi-structured, interviewer-administered questionnaire and analysed with the Microsoft excel software. A quantitative analysis of ethno-pharmacological data was carried out by determining familiarity index (Fi) of the herbs. 20 clients (female: male; 15:5), randomly divided into two groups of 10 each, were carefully selected from the pool of patients on ZLN. After a one herbs-free month, Group A took only ZLN while group B took O. gratissimum with ZLN. Liquid-liquid extraction was used for drug extraction and a validated high performance liquid chromatography used to determine the plasma concentration of the individual drugs. Plasma concentration was determined using linear regression and statistical group analysis was performed with SAS 9.1 software using one way analysis of variance and Duncan multiple range test.
Results: Ocimum gratissimum had the highest familiarity index (41%) of all herbs ingested in PLHA in the region. There was statistically significant decrease in serum concentration of Nevirapine (423.9+/-117.5ng/ml vs 1435.9+/-689.1ng/ml) in PLHA that took O. gratissimum with ARVs compared to those that took only ZLN which may imply a sub therapeutic steady-state concentration of Nevirapine.
Conclusions and Recommendations: The sub therapeutic concentration of ARVs associated with intake of Ocimum gratissimum may encourage viral resistance and increase the pool of virally-unsuppressed PLHA. We, therefore, recommend a more aggressive public health campaign against combination of herbs and ARVs.
Keywords: Nevirapine, Herbs, Subtherapeutic, Unsuppressed

FRAB1803 - TRACK B2

Profile of Elderly Adults Living with HIV Infection in Kigali City: A Descriptive Study

13:15 – 13:30

Rukundo Gilbert[1], Remera Eric[2], Ng'ang'a Loise[3], Ndahimana Jean D'Amour[4]
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Background: As in other Low Income Countries (LICs) in sub-Saharan Africa, the number of Human Immunodeficiency Virus (HIV) infected individuals receiving antiretroviral therapy (ART) in Rwanda is steadily increasing. Although, the proportion of children (< 15 years) and adults (15-49 years) of people living with HIV in Rwanda are known (0.2% and 3.1%), the corresponding proportion in old adults (50+ years) is still unknown and less attention has been given to knowing their profiles in the context of HIV. In this study, we described the demographic, clinical and medication profiles of older people living with HIV (PLWHIV) in the capital city of Rwanda.
Methods: We conducted an exploratory, retrospective descriptive analysis using routinely collected data of all people living with HIV collected using the Electronic Medical Record system (EMR) in 29 health facilities providing ART services in the City of Kigali. We restricted our analysis to a subset of elderly adults who are still alive, aged 50 and above by the time of data extraction, June 2018, and are on ART Different variables including age, sex, marital status, Body mass index (BMI), ART regimen, Time on ART, CD4 count, and viral load (VL) were collected. We performed descriptive statistics analysis to summarize the treatment details, clinical and demographic characteristics of the above group of patients.
Results: We analyses EMR data of 13,860 patients on ART aged 50 years and above. Of them 60.8%(8,428) were female. The median (interquartile range: IQR) time on ART

was 7 (4; 10) years and 43.5%(6,035) were married/cohabitating. 59.7% (8,273) had a normal body mass index (BMI) (18.5-24.9), while 29.6%(4,103) were overweight or obese. The majority 42.3%(5,084) were on TDF+3TC+EFV cART and 52.9%(7, 330) were still having this cART as their first-line regimen. We observed that 91.3%(12,654) and 83.4%(10,554) of these patients had a treatment success (most recent VL < 1000 copies/mL) and undetectable VL (< 20 copies/mL).
Conclusions and Recommendations: Our data indicate that, Access to ART in Rwanda has drastically improved survival and life expectancy thus leading to an increase in the aging population of PLHIV. HIV program in Rwanda should start to emphasize and implement a differentiated care model for younger and older adults to ensure optimal long-term survival outcomes in the group of patients in this age group.

FRAB1804 - TRACK B2

Évolution de la Qualité des Soins et du Traitement Antirétroviral des Personnes Vivant avec le VIH au Burkina Faso de 2014 à 2017

13:30 – 13:45

Yonli Bapougouni Philippe Christian[1], Guiré Abdoulaye[2], Ouédraogo Théophile[2], Meda Zinglé Clément[3], Ki Célestine[1], Ouédraogo Smaila[4,5,6]
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Contexte de l'Étude: L'utilisation des antirétroviraux (ARV) à grande échelle pour le traitement des personnes vivant avec le VIH (PVVIH) s'accompagne d'un développement de résistance au VIH. Nous avons analysé l'évolution des facteurs programmatiques associés à un risque élevé d'émergence de résistance dans 24 centres de soins et de traitement des PVVIH au Burkina Faso de 2014 à 2017.
Méthodes: Nous avons réalisé une étude de cohortes rétrospectives pour analyser l'évolution de trois (3) indicateurs d'alerte précoce de l'émergence de résistance du VIH aux antirétroviraux (Retrait des ARV dans les délais, Rétention sous TARV à 12 mois et pratiques de prescription) recommandés par l'OMS de 2014 à 2017 dans 27 (25%) centres de soins et traitement ARV (CSTARV) dont 23 publics, deux confessionnels et deux associatifs au Burkina Faso. Le fichier électronique HIV_DR_EWI_TOOL_EN_Updated_210213fr(Neil_fixed)_MJreviewed14May_2014 développé par l'OMS a été utilisé pour l'extraction et l'analyse des données obtenues à partir des fichiers de dispensation des antirétroviraux de ces CSTARV.
Résultats: Sur l'ensemble des 27 CSTARV, la médiane [intervalle interquartile] des patients qui ont retiré le traitement antirétroviral dans les délais a évolué respectivement de 61% [54%-70%] en 2015, 60% [48%-66%] en 2016 et de 58% [49%-67%] en 2017. Aucune structure n'a atteint le seuil de qualité d'au moins 95% recommandé par l'OMS dans les cohortes de 2014 et 2015. Un seul centre l'a atteint en 2016. La médiane [intervalle interquartile] de la rétention sous traitement antirétroviral à 12 mois pour les cohortes de 2014, 2015 et 2016, a été de 70% [61%-73%], 69% [58%-78%] et 65% [55%-76%] respectivement. Le seuil de rétention dans le traitement ARV à 12 mois d'au moins 85% recommandé par l'OMS pour éviter l'apparition de résistance n'a été atteint que dans les deux (2) centres communautaires au cours de la période sous revue. La prescription des antirétroviraux est restée conforme aux directives nationales dans tous les centres évalués.
Conclusion: La qualité des soins et du traitement antirétroviral des PVVIH a régressé de 2014 à 2017 dans les centres de soins et traitement ARV évalués avec un risque élevé d'émergence de résistance du VIH aux antirétroviraux. Pour minimiser ce risque, un programme d'éducation thérapeutique des patients et un système efficace de recherche des perdus de vue aux rendez-vous doit être mis en place.
Mots Clés: IAP, résistance VIH, qualité soins

FRAB1805 - TRACK B2

Transition from Efavirens to Dolutegravir Based Regimen

13:45– 14:00

Uwungutse Marie Madeleine, Tuyishime Ntaganda Isabelle, MUSENGIMANA Gentille, Muhayimpundu Ribakare

Rwanda Biomedical Center (RBC), HIV/AID&OBBI, Kigali, Rwanda

Issues: Since 2016, WHO has included Dolutegravir (DTG) as an alternative first line treatment for HIV. DTG is more effective, better tolerated and more protective against treatment discontinuation from adverse drug reactions than Efavirens (EFV). DTG, when combined with 2 other medicines in a single fixed-dose combination pill, is considered to be among the best current treatments for HIV. Rwanda HIV program introduced DTG in the national HIV treatment guideline as the first line regimen option for newly diagnosed HIV+ patients. The guideline also recommends transition from Efavirens based regimen to DTG for existing patients on ART since April 2019.

Descriptions: We conducted countrywide shifted clinical mentorship to speed scale up of new National HIV treatment guideline changes with focus on transition to Dolutegravir (DTG) as new and effective molecule. Clinical mentors from all hospitals were invited for an orientation meeting, where guidance and required tools and materials were provided. Teams were established by coupling a medical doctor and nurse where possible.Supervisors from Rwanda Biomedical Center were also appointed to support and coordinate clinical mentor's activities. Clinical mentors had the responsibility to provide all necessary information to Health Care Providers related to new changes and collect data from registers and patient files in accordance with the tool developed in advance. Clinical Mentors helped their mentees to select People Living with HIV (PLHIV) who were eligible to be shifted to DTG. The daily report was sent to supervisor for compilation and providing feedback. However, 81,211(44,8%)of all patients on ART who were receiving a NNRTI (Non-Nucleoside Reverse Transcriptase Inhibitor)-based regimen were eligible to be shifted on DTG based regimen

Lessons learned: The transition from Efavirens based regimen to DTG for patients on ART fulfilling the criteria for shifting required the estimation of the proportion of patients eligible to DTG for planning and quantifications purposes. Site by site, this exercise was done to know how many patients were eligible for the transition on DTG. Clinical mentorship facilitated onsite training of Health care providers.The scale-up of DTG-based regimen is going on without any challenge.

Next steps: The transition from a NNRTI-based regimen to a DTG-based regimen will continue and will be scaled up to include women in the reproductive age group.

TIME	12:45 – 14:15 Uhr	ROOM	Kigali (Auditorium)	DATE	Friday, 06 December 2019

Track B: Clinical Science, Treatment and Care

None-Communicatable Diseases and Palliative Care

Chair: Dr. Henry Nagai

FRAB1901 - TRACK B4

Rapid Scale up of Cervical Cancer Screening in Women Living with HIV (WLHIV) in the Partnership to End AIDS and Cervical Cancer: PEPFAR, the George W. Bush Institute, UNAIDS, and Merck

12:45 – 13:00

Watts Heather[1], Albertini Jennifer[1], Cazier Crystal[2], Kuzmich Holly[2], Prainito Amber[1], Marks Lauren[1], Shakarishvili Anna[3], Hofmann Regan[4], Birx Deborah[1]

[1]U S Department of State, Office of the Global AIDS Coordinator, Washington, United States, [2]George W. Bush Institute, Dallas, United States, [3]UNAIDS, Geneva, Switzerland, [4]UNAIDS, Washington, United States

Background: Women living with HIV (WLHIV) have an increased risk of developing invasive cervical cancer (ICC). Our objective was to assess the rates of cervical pre-cancers and suspected ICC among women in the first year of screening in HIV treatment settings.
Methods: The Partnership to End AIDS and Cervical Cancer was launched in May 2018. PEPFAR provided support in eight countries with HIV prevalence > 10% in women (Botswana, Eswatini, Lesotho, Malawi, Mozambique, Namibia, Zambia, and Zimbabwe) for rapid scaling of biannual screening with visual inspection with acetic acid for women aged 25-49 or per national guidelines and one-time screening for women over 49 not previously screened, with treatment for pre-invasive lesions and referral for evaluation of suspected ICC. Data tracked included number and type of screening (first, rescreen, or follow up), findings, and treatment for precancerous lesions (cryotherapy, LEEP - Loop Electrosurgical Excision Procedure, thermal coagulation). Data are reported semi-annually. Scale up began in Q4 of FY2018 although some sites had pre-existing programs.
Results: During FY2018, 108,993 WLHIV and during the first half of FY2019, 144,846 WLHIV were screened, for a total of 253,839. Of those, 199,046 (85%) were first time screens, 31,200 (13%) repeats, and 2683 (1%) follow up after treatment. Of the total, 233,532 (92%) screened negative, 14,546 (5.7%) had abnormalities not suspected as ICC, and 4700 (1.9%) were referred for evaluation of suspected ICC. The rate of suspected ICC increased with age, ranging from 0.8% under age 20 years to 4.4% over age 49 years. So far, 9140 women (63%) have undergone treatment for pre-invasive lesions including cryotherapy 6634 (73%), LEEP 1966 (22%), and thermal coagulation 540 (6%).
Conclusions and recommendations: Integration and rapid scale up of cervical cancer screening in settings providing HIV treatment to WLHIV is feasible, but more intensive follow up is needed to assure that women with abnormalities receive appropriate evaluation and treatment. The number of sites providing treatment continues to increase.

FRAB1902 - TRACK B4

Prévalence et Facteurs Associes à l'Infection Génitale à HPV à Haut Risque de Malignité, aux Dysplasies et au Cancer du Col de l'Utérus dans une Cohorte de Femmes Infectées par le VIH au Sénégal

13:00 – 13:15

Ba Selly[1], Sow Papa Salif[1], Dembele Boubacar[2], Toure Macoumba[1], Sy Marie P[1], Traore Fatou[1], Sall Fatima[1], Seydi Moussa[1], Gottlieb Geoffrey S[3], Kiviat Nancy B[3], Hawes Stephen E[3]
[1]Service des Maladies Infectieuses de Fann, Dakar, Senegal, [2]Institut Curie, Dakar, Senegal, [3]Université de Washington, Seattle, United States

Les programmes de dépistage visant à prévenir le cancer du col de l'utérus chez les africaines infectées par le VIH font défaut. l'objectif de l'étude est de déterminer la prévalence de l'infection à HPV à haut risque de malignité et des dysplasies du col de l'utérus chez les femmes séropositives et d'en décrire les facteurs associés.
Méthodologie: Il s'est agi d'une étude descriptive longitudinale analytique et prospective ayant duré sept ans durant la période allant d'octobre 2005 à septembre 2012. Était incluse toute femme âgée de 18 ans et plus, infectée par le VIH, consentante à participer à l'étude en dehors de toute grossesse. Après l'inclusion , ces femmes bénéficiaient tous les quatre mois d'examens hémato immunologique, anatomo cytopathologique (Frottis cervico vaginal et biopsie si FCV anormal) d'une sérologie HPV avec un PCR et un génotypage
Résultats: 209 femmes infectées par le VIH (VIH-1: 79% (n = 167), VIH-2: 14% (n = 29), VIH-1 et 2 : 7% (n = 13)) . L'âge médian était de 41 ans [extrêmes : 20-66 ans], 54% étaient mariées et 84% n'utilisaient aucune méthode contraceptive. Le taux médian de CD4 était de 375 cellules / mm3 et la durée médiane du suivi était de 2,45 ans. A

l'inclusion, l'ADN de l'HPV a été détecté dans 73% des cas (n= 147) , parmi lesquels 118 (78%) avaient une séropositivité pour plusieurs types d'HPV. Les HPV à haut risque détectés étaient HPV-16 (14%), HPV-58 (16%), HPV-52 (17%) et HPV-18 (10%), HPV-33 (10%), HPV-35 (15%), HPV-51 (11%) . Soixante-deux femmes (30%) avaient des anomalies cytologiques (VIH-1 (33%), VIH-2 (25%), VIH -1,2 (23%), p = 0,7), dont 6% d' ASCUS, 12% de lésions de bas grade, 4% de lésions de haut grade, 4% de carcinome in situ (CIS) et 4% de cancer invasif (ICC).les facteurs associés à HPV à haut risque de malignité et aux dysplasies du col étaient le jeune âge aux 1ers rapports sexuels (p=0 ,001) , le multi partenariat sexuel(p=0 ,001 l'immunodépression sévère(p=0 ,001) et le stade avancé d'infection à VIH (p=0 ,001)

Conclusion: L'association de l'infection génitale à HPV ,des dysplasies du col de l'utérus et de l'infection à VIH n'est pas rare . Ce qui suggère la nécessité de promouvoir des actions de prévention comme le dépistage précoce des dysplasies du col, voire la vaccination contre l'HPV chez les séropositives

FRAB1903 - TRACK B4

Glucose Metabolic Disorder and Associated Inflammatory Markers among HIV Patients in Tanzania

13:15 – 13:30

Memiah Peter[1], Nkinda Lillian[2], Majigo Mtebe[2], Zuheri Aisha[3], Stafford Kristen[4], Kingori Caroline[5]

[1]University of Maryland, Baltimore, United States, [2]Muhimbili University of Health and Allied Sciences, Daresalaam, Tanzania, United Republic of, [3]Infectious Disease Clinic, Daresalaam, Tanzania, United Republic of, [4]University of Maryland School of Medicine, Baltimore, United States, [5]Ohio University, Colombus, United States

Background: Ongoing chronic inflammation among people living with HIV (PLHIV) is correlated with the increased risk of GMD. However, the availability of data on inflammation and GMD within this group in sub-Saharan Africa (SSA) is limited. Extrapolating findings from high income countries to SSA is hampered by ethnic and social-economic difference. Therefore, we assessed inflammatory markers and their association with GMD among PLHIV in Tanzania.

Methods: A cross sectional study was conducted in Dar es salaam, Tanzania from March to December 2018. A total of 407 HIV patients who had an overnight fast and on antiretroviral therapy were recruited. The World Health Organization stepwise approach for non-communicable disease surveillance was used for data collection. Fasting blood glucose and blood glucose after 75g oral glucose load was measured. Enzyme-linked immunosorbent assay was used for inflammatory markers; C - reactive protein (CRP) Interleukin-6 (IL-6), interleukin-18 (IL-18), soluble tumor necrosis factor receptor-1 (sTNFR-I) and sTNFR-II. Bivariate and Multi-variate analysis was conducted to examine association between inflammatory markers and GMD. A p-< 0.05 was considered statistically significant.

Results: The prevalence of GMD was observed to be 67.6%. Among them, 93.4% had impaired fasting glucose, 86%, impaired Glucose Tolerance and 100% presented and diabetes mellitus. Being older p< 0.001 (>55 years) and initiating smoking at age >28 years were significantly associated with GMD (p = 0.05). Engaging in moderate activities significantly reduced the risk of GMD (p = 0.04). Having CD4 count of 351-500 cells/ µl reduced the odds of GMD by 66.7%. Comparing the highest to the lowest quartile at multivariate level, only CRP showed an independent significant association with GMD (adjusted OR 1.9 CI 95%: 1.03 - 3.57). Despite the lack of significant association, other biomarkers provided an indicative linear relationship with GMD.

Conclusion: High CRP and low CD4 are important predictors of GMD among PLHIV in the Tanzanian setting. These findings highlight the need to integrate routine screening of GMD among the HIV population. More rigorous studies are required to establish causality of hyperglycemia among PLHIV.

FRAB1904 - TRACK B4

Palliative Care Community-based Treatment for Chronically-Ill AIDS Patients in Lagos

13:30 – 13:45

Onigbogi Olanrewaju[1], Onigbogi Modupe[2]
[1]College of Medicine, University of Lagos, Community Health, Lagos, Nigeria, [2]University of Texas Health Science Centre, Epidemiology, Houston, United States

Background: With the introduction of Highly Active Anti-retroviral Therapy, more HIV/AIDS patients live longer in our communities. This study was conducted to assess the willingness of people in Lagos to participate in setting up palliative care treatment centers for these patients.
Methods: Self administered questionnaires were completed by 251 respondents. SPSS version 17 data editor was used to analyze data. Univariate odds ratios and 95% confidence intervals (95 % CI) were used to evaluate the correlates of willingness to participate (WTP).
Results: A total of 72% of the respondents reported that they will be willing to participate in palliative care for the HIV patients. Higher willingness was associated with prior contact with higher education (OR = 1.23, 95% CI: 1.02-1.73), present employment (OR = 1.55, 95% CI: 1.45-1.82) and a potential for financial incentives (OR = 1.59, 95% CI: 1.32-1.77). Decreased WTP was associated with concerns about social stigmatization (OR = 0.35, 95% CI: 0.13-0.81) and possibility of rejection by the patients (OR = 0.81, 95% CI: 0.56-0.91).
Conclusions and Recommendations: A high level of WTP indicates that there may be some success if organizers provide incentives as a part of the take-off of this community based program.

FRAB1905 - TRACK B4

Utilisation de Médicaments Traditionnels et Complémentaires chez les Personnes Infectées par le VIH en Côte d'Ivoire: Étude Transversale

13:45 – 14:00

Mariam Mama Djima[1], Ekouevi Koumavi Didier[2], Moisan Jocelyne[3]
[1]Côte D'ivoire Pasteur Institute, Abidjan, Côte d'Ivoire, [2]PACCI, Treichville, Côte d'Ivoire, [3]Faculté de Pharmacie de l'Université Laval, Quebec, Canada

Introduction: En Côte d'Ivoire, les personnes vivant avec le VIH (PVVIH) ont un accès gratuit au traitement antirétroviral (TARV) et au cotrimoxazole. Cependant, elles peuvent avoir recours à d'autres types de traitement notamment ceux issus de la médecine traditionnelle et complémentaire (MTC), pour le traitement du VIH ou des infections associées. Il existe peu de données sur l'usage de la MTC par les PVVIH sous TARV en Afrique. Cette étude a pour objectif de décrire l'usage de la MTC et d'identifier les facteurs associés à cet usage chez PVVIH sous TARV en Côte d'Ivoire.
Méthodes: Une étude transversale a été menée dans six cliniques de prise en charge du VIH en 2016. Les adultes infectés par le VIH-1 et recevant un traitement antirétroviral depuis au moins un an étaient admissibles. Un questionnaire standardisé a été utilisé pour collecter les données démographiques, les caractéristiques du VIH, l'usage de médicaments et l'usage de la MTC. Les facteurs associés ont été identifiés à l'aide d'une régression multivariée de Poisson.
Résultats: Au total, 1458 PVVIH (73,4 % de femmes), d'âge médian de 81 mois sous TARV ont été enrôlés. L'usage de la MTC au cours des 12 mois et des 30 jours précédant l'interview des participants étaient respectivement de 64,5 % et de 53,2 %.
Parmi les 776 utilisateurs de la MTC à 30 jours, 77,8 % des PVVIH étaient très satisfaits de l'utilisation de produits issus de la MTC. Les sources d'informations les plus rapportées ayant motivé le recours aux produits issus de la MTC étaient à 60,0 %) les parents. Parmi les utilisateurs de la MTC, 49 (6,3%) ont informé les professionnels de santé de l'usage de produits issus de la MTC. Les facteurs associés à l'usage de la MTC, des 12 derniers mois jours, ont été : le fait d'être une femme , d'avoir une mau-

vaise perception de son état de santé; de rapporter la consommation d'au moins un médicament non ARV. Être sans emploi ou étudiants et travailler dans un secteur informel ont été associé inversement à l'usage de la MTC à 12 mois.
Conclusion: L'usage de la MTC touche plus de 50% des PVVIH sous TARV quel que soit la période d'estimation de l'usage de la MTC. Le renforcement de la sensibilisation des patients VIH et des autorités nationales pour un meilleur usage est essentiel pour réduire la survenue d'effets indésirables et d'interaction médicamenteuse

TIME	14:45 – 16:15	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Friday, 06 December 2019

Track B: Clinical Science, Treatment and Care

Co-Mobility and Tools

Chair: Dr Athanase Kiromera

FRAB2001 - TRACK B3

Linkage to Care in the Rwanda Population-based HIV Impact Assessment (RPHIA)

14:45 – 15:00

Kayigamba Felix[1], Kamanzi Collins[2], Mugisha Veronicah[2], Nsanzimana Sabin[3], Mugwaneza Placidie[3], McLeod Natasha[4], Kayiramgwa Eugenie[5], Gatesi Sandrine[1], Umutoni Silvie[1], Rwabasigari Dieudonne[1], Tafadzwa Dzinamarira[1], Gallican Rwibasira[1], Sasi Jonnalagada[6], Hoatian Cai[5], Malamba Samuel[7], Muhayimpundu Ribakare[3]
[1]ICAP at Columbia University, Kigali, Kigali, Rwanda, [2]ICAP at Columbia University, Kigali, Rwanda, [3]RBC-MOH, Kigali, Rwanda, [4]ICAP at Columbia University, New York, United States, [5]CDC Rwanda, Kigali, Rwanda, 6CDC Atlanta, Atlanta, United States, [7]ICAP at Columbia University in Kigali, Kigali, Rwanda

Background: The Rwanda population-based HIV impact assessment was conducted from October 2018 to March 2019, this provided an important opportunity to integrate service delivery, HIV testing and active linkage to care (ALTC), into a household survey. ALTC of all participants diagnosed with HIV was prioritized during this survey to reduce untreated infections and strengthen the HIV continuum of care. This abstract describes the RPHIA linkage to care experiences of those who self-reported being unaware of their HIV status.
Methods: A total of 39,243 individuals from 11,227 randomly selected households were tested for HIV using a serological rapid diagnostic testing algorithm. Consent to share the participant's contact information with a health facility (HF) of choice was obtained and were defined as consented for linkage to care. Participants who were prioritized for ALTC were those who reported as not being aware of their HIV+ status. ALTC forms were delivered to HFs by RPHIA technical team within 2-3 days of survey completion in a given enumeration area. Monitoring visits were conducted to assess whether participants whose ALTC forms were delivered to HFs have visited, initiated on ART or lost to follow up.
Results: A total of 958 individuals (2.4%) were found to be HIV+, of which 239 (24.9%) self-reported to be unaware of their HIV+ status. Out of those that are unaware,189 (79.1%) visited HFs (82 were already in care but did not disclose, 87 were linked and initiated on treatment and 20 were linked but they either refused to initiate on treatment or did not initiate due to other reasons). Of the 50 individuals who did not visit the HFs, 3 (6.0%) changed residence, 13 (26.0%) refused to visit HFs after all attempts to link them and 34 (68.0%) the HFs were not able to contact them. The mean duration from household testing to initiation of treatment was 45 days.
Conclusions and Recommendations: Failure to ensure appropriate linkage to care has been a major source of criticism for household surveys. Here we demonstrate the feasibility and importance of active linkage to care and treatment for HIV and the

operational challenges encountered. We recommend that the HFs prioritize active tracking of those not yet initiated on treatment.

FRAB2002 - TRACK B3

Atteintes Neurologiques Associées au VIH/SIDA à Ouagadougou au Burkina Faso

15:00 – 15:15

Diallo Ismaël[1], Dabilgou Alfred Anselme[2], Ouédraogo Eliane[3], Sawadogo Abdoulaye[4], Zoungrana Jacques[5], Diendéré Eric Arnaud[6], Sondo Apoline K[7], Savadogo Mamoudou7, Sangaré Lassana[8], Drabo Youssouf Joseph[9], Ndour Cheikh Tidiane[3]

[1]Hôpital de Jour (Prise en charge VIH)/Service de Médecine Interne, Centre Hospitalier Universitaire Yalgado, Médecine, Ouagadougou, Burkina Faso, [2]Service de Neurologie, Centre Hospitalier Universitaire Yalgado Ouedraogo, Ouagadougou, Burkina Faso, Médecine, Ouagadougou, Burkina Faso, [3]Service de Maladies Infectieuses, Hôpital Fann de Dakar, Sénégal, Médecine, Dakar, Senegal, [4]Service de Maladies Infectieuses, Centre Hospitalier Universitaire Yalgado Ouedraogo, Ouagadougou, Burkina Faso., Médecine, Ouagadougou, Burkina Faso, [5]Service de Maladies Infectieuses, Centre Hospitalier Universitaire Souro Sanou, Bobo-Dioulasso, Burkina Faso, Médecine, Bobo-Dioulasso, Burkina Faso, [6]Service de Médecine Interne, Centre Hospitalier Universitaire de Bogodogo, Ouagadougou, Burkina Faso, Médecine, Ouagadougou, Burkina Faso, [7]Service de Maladies Infectieuses, Centre Hospitalier Universitaire Yalgado Ouedraogo, Ouagadougou, Burkina Faso, Médecine, Ouagadougou, Burkina Faso, 8Service de Bactérioloie-Virologie, Centre Hospitalier Universitaire Yalgado Ouedraogo, Ouagadougou, Burkina Faso, Médecine, Ouagadougou, Burkina Faso, [9]Hôpital de Jour (Prise en charge VIH)/Service de Médecine Interne, Centre Hospitalier Universitaire Yalgado Ouedraogo, Ouagadougou, Burkina Faso, Médecine, Ouagadougou, Burkina Faso

Contexte: Les atteintes neurologiques associées au VIH sont encore à ce jour une des circonstances de découverte de l'infection à VIH dans les pays à ressources limitées. Nous avons donc voulu étudier les caractéristiques épidémiologique, clinique et paraclinique des personnes infectées par le VIH et présentant des atteintes neurologiques dans la ville de Ouagadougou.

Méthodes: Etude transversale, descriptive réalisée du 1er janvier au 31 décembre 2016. Ont été inclus, les patients infectés par le VIH, âgés de 18 ans et plus, présentant une atteinte neurologique centrale et/ou périphérique (clinique et/ou radiologique), hospitalisés dans l'une des trois structures de référence de prise en charge de l'infection à VIH à Ouagadougou durant la période d'étude.L'analyse statistique des données a été effectuée grâce au logiciel SPSS version 17.

Résultats: Soixante-sept patients d'un âge moyen de 43,2 ± 8,7 [25 - 61] ans, pour un sex-ratio de 0,6 ont été inclus dans l'étude. Le VIH de type 1 était le plus retrouvé (89,5%). Le taux moyen de lymphocytes TCD4 était de 159,6 cellules/mm3. Le déficit moteur (64,1%), l'altération de la conscience (35,8%) et le syndrome méningé (17,9%) étaient les manifestations neurologiques les plus fréquentes. Les atteintes neurologiques centrales (95,5%) étaient dominées par la toxoplasmose cérébrale (34,3%) et les atteintes neurologiques périphériques par la neuropathie périphérique (3%). La charge virale plasmatique moyenne (n=35) et la charge virale mesurée dans le LCR (n=26) était respectivement de 645626,6 et 1083,7 copies/mm3.

Quarante-sept patients (70,1%) étaient sous traitement antirétroviral dont 68,1% en première ligne. Parmi ces patients sous traitement la CV était réalisée chez 57,5% montrant un taux d'échec virologique de 72%. Une prophylaxie contre les infections opportunistes était effective chez 18 patients. Le taux de mortalité au cours de l'étude était de 35,8%.

Conclusions: La toxoplasmose cérébrale demeure à ce jour la première atteinte neurologique associée au VIH, relevant l'importance de la chimioprophylaxie au cotrimoxazole, la mise sous traitement antirétrovirale systématique et l'éducation thérapeutique.

FRAB2003 - TRACK B3

Characterization and Antibiotic Susceptibility Patterns of Bacteria Associated with Pelvic Inflammatory Disease (PID) among Women Attending Private Hospitals in Nigeria

15:15 – 15:30

Egwuatu Tochukwu
University of Lagos, Department of Cell Biology and Genetics, Lagos, Nigeria

Background: Pelvic inflammatory disease (PID) is an infectious and inflammatory disorder of the upper female genital tract including the uterus, fallopian tubes and adjacent pelvic structures. PID is initiated by infection that ascends from the vagina and cervix into the upper genital tract.

Methods: Of the one hundred and fifty (150) High Vaginal Swab (HVS) specimens collected from sexually active young women between the ages of below 20-40 years diagnosed with PID in Yaba environment, one hundred and thirteen (113) organisms were isolated from the specimens representing six genera of pathogens upon determination by morphological, biochemical characteristics and microscopic examination. The pathogens isolated included the following: Escherichia coli, Candida albicans, Klebsiella spp., Proteus spp., Staphylococcus aureus and Streptococcus pyogenes. E. coli was the most predominant 54 (47.8%) followed by S. aureus 25 (27.1%), Candida albicans 10 (8.8%), S. pyogenes 10 (8.8%), then Proteus spp. 8(7.1%) while Klebsiella spp. had the least isolation of 6 (5.3%).

Results: Out of the 113 isolates, 103 were subjected to antibiotics susceptibility test against Gram-positive and Gram-negative antimicrobial drugs. Staphylococcus aureus was sensitive to Ceftazidine (100%), and resistant to Chloramphenicol, (40%). Streptococcus pyogenes was sensitive to Ciprofloxacin (90%) and resistant to Amoxicillin and Clavulanic acid, (92%). Escherichia coli was sensitive to ceftazidine (83.3%) ciprofloxacin (90%), meropenem (85.2%)and resistant to amoxicillin and clavulanic acid (50%). Klebisiella spp. was sensitive to Ciprofloxacin (90%), Ceftazidime (100%) and Meropenem (60%) and resistant to Amoxicillin and Clavulanic (40%) . Proteus spp. was sensitive to Ciprofloxacin (87.5%), Chloramphenicol (87.5%), Ceftazidine (87.5%) and resistant to Meropenem (75%). The age distribution of the females diagnosed with PID showed that females within the age group of 21-25 years 30 (40%) had the highest incidence of PID followed by 26-30 years 24 (32%), 31-35 years 12 (16%) and 16-20 years 9 (12%). The use of intrauterine devices (IUDs) by the females diagnosed with PID showed that females that used IUDs (52.7%) were more than non-users of IUDs (47.3%). The users of IUDs were diagnosed for PID more than the non-users.

Conclusion and Recommendations: Routine screening and treatment of females for lower genital tract infection to minimize their role in PID is recommended.

FRAB2004 - TRACK B3

Difference in Grading of Biological Anomalies Between Countries: The End of a Large Problematic!

15:30 – 15:45

MERCIER Noémie[1], *Diallo Alpha*[1], *Assoumou Lambert*[2]
[1]ANRS, French Agency for Research on AIDS and Viral Hepatitis, Service de Vigilance des Recherches Cliniques, Paris, France, [2]CMG-U1136, site Pitié, Paris, France

Introduction: The collection of biological data with different normal values in multicenter studies is a real problem. This point concerns both inclusion criteria and safety analysis of biological data, the improvement and the harmonization of this gradation has become essential nowadays. The aim of this study is to present a numerical tool allowing research teams to balance biological data observed in different countries for a specific study.

Methods: We have developed a numerical tool allowing each site to weight the observed biological values and, in a second step, to scale them according to table de-

fined by the protocol. For this, we digitized the following formula described by Tinazzi A which takes into account, for each observed biological value (x), the standards of local laboratory Lx (low limit) and Ux (upper limit) as well as those called "standards" Ls and Us.
s = Ls + (x-Lx) (Us-Ls) / (Ux-Lx) where s is the new estimated biological value
For this purpose, a digital application has been created. Thus, before grading a biological anomaly, the investigator can, using this tool, weight the observed value before determining grade according to the table defined in protocol.
Results: We tested our weighting tool with data extracted from the clinical trial ANRS12136 TEMPRANO. We targeted our test on neutrophil values among biological data collected. To information, in this trial, Grade 4 neutropenia was classified as Serious Adverse Event (SAE) and so required an immediate SAE notification to sponsor. Before the weighting, 17 collected neutrophils count grade 4 were observed, according to the grading scale available in the protocol. After the weighting, we observed 16 neutrophils count grade 3. Thus, the weighting tool permitted to downgrade 16 values. The use of this tool would therefore have allowed the decrease the number of SAEs notifications, this time-saving would have allowed to the investigators to devote themselves fully to the care of their patients.
Conclusions and Recommendations: The weighting of biological values will permit to harmonize values in multicentric trials where the biological standards values are different. This tool will facilitate statistical analysis and interpretation of the study results. This tool could be used in large clinical trials: multi-country, multi-center and also in monocentric trials with difference in standards observed between extra-hospital labs (private labs) and intra-hospital clinical sites.

FRAB2005 - TRACK B3

"It's a Big Problem to Take that Pill before You Feel Ready": ART Initiation Challenges under Treat All in Rwanda

1545 – 16:00

Ingabire Charles[1], Umwiza Francine[1], Gasana Josephine[1], Munyaneza Athanase[1], Murenzi Gad[1], Anastos Kathryn M.[2], Adedimeji Adebola[2], Ross Jonathan[2]
[1]Rwanda Military Hospital, Research and Clinical Division, Kigali, Rwanda, [2]Albert Einstein College of Medicine, Department of Medicine, Montefiore Medical Center, Bronx, United States

Background: In 2016, Rwanda implemented a Treat All guideline to provide antiretroviral therapy (ART) to all people living with HIV (PLHIV) within 7 days of diagnosis. Few studies in sub-Saharan Africa have examined patient perspectives of initiating ART quickly under Treat All. We sought to understand barriers to and facilitators of initiating ART under Treat All.
Methods: We conducted semi-structured individual interviews at two health centres in Kigali from October 2018-January 2019. Interviews were conducted in Kinyarwanda with PLHIV ≥18 years to explore experiences of HIV diagnosis and initiating ART soon after diagnosis. Interviews were recorded, transcribed, and translated to English. We used a modified grounded theory approach to identify major themes.
Results: Of 37 participants, 73% were female, 40% were aged 18-24 years, and 81% enrolled in care after Treat All was implemented. Major themes included being overwhelmed by the HIV diagnosis, difficulty accepting it, a lack of readiness to initiate ART, but also support for initiating ART while healthy. Participants reported a high degree of emotional distress following HIV diagnosis: "When they told me that I am infected with HIV, I became afraid and anxious…I felt like I was not going to be alive anymore". Participants also described difficulties in accepting their diagnosis: "I had not accepted my status yet. I was afraid to be seen by people, wondered what people will say, doubted the result." Because of these experiences, many participants did not feel ready to start medication immediately: "I wish that they must first of all let the person accept the status, accept starting medication, and let him come after some time when he feels ready to start medications. Starting medications immediately is

like forcing him to take medications." However, despite challenges in initiating ART, participants felt that early ART was beneficial because it kept them healthy:"The Treat All program made it easier because they started to treat me before I developed any health problems. Till now, I did not have any problems related to HIV infection."
Conclusions and Recommendations: Although study participants appreciated the benefits of Treat All, the emotional distress and difficulty of accepting an HIV diagnosis were substantial barriers to initiating ART soon after diagnosis. Treat All ART initiation guidelines should account for the emotional distress of HIV diagnosis and patient readiness to start medication.

TIME	14:45 – 16:15 Uhr	ROOM	Kigali (Auditorium)	DATE	Friday, 06 December 2019

Track C: Epidemiology and Prevention Science

Epidemiology of HIV Co-Morbidity and Emerging Infections

Chair: Prof. Seni Kouanda

FRAC2101 - TRACK C2
Prevalence and Determinants of Hepatitis B and C in Rwanda

14:45 – 15:00

Mugisha Nakyanzi Veronicah[1], Remera Eric[2], Serumondo Janvier[2], S. Winterhalter Frieda[3,4], Uwizihiwe Jean Paul[2], Kabanda Alice[2], Karame Prosper[2], Ntaganda Fabien[5], Mwesigwa Richard[6], Kayirangwa Eugenie[7], Kamanzi Collins[8], Rwibasira Gallican[8], Nsanzimana Sabin[2]
[1]ICAP at Columbia University Rwanda, Kigali, Saint Lucia, [2]Ministry of Health, Rwanda Bio-Medical Center, Kigali, Rwanda, [3]ICAP at Columbia University, Kigali, Rwanda, [4]ICAP at Columbia University, New York, United States, [5]Rwanda Military Hospital, Kigali, Rwanda, [6]US Centers for Disease Control and Prevention, Kigali, Rwanda, [7]U.S Centers for Disease Control and Prevention, Kigali, Rwanda, [8]ICAP at Columbia University Rwanda, Kigali, Rwanda

Background: Hepatitis B (HBV) and C (HCV) continue to be major public health concerns globally[1]. In 2011, Rwanda initiated a robust Viral Hepatitis control program. There was, however, no comprehensive national data on the prevalence of hepatitis. Strategic planning relied on estimates and small-scale surveys. The first national estimate of HBV and HCV was done as part of the Rwanda Population Based HIV Impact assessment. The data herein is from the survey conducted October 2018 to March 2019.
Methods: RPHIA, a cross-sectional household (HH)-based survey covered 39,328 persons (10-64) from 11,219 randomly selected HH.HBV tested in HH using HBV surface antigen (HBsAg) and HCV at National Reference Laboratory using antibody rapid test, then HCV Viral RNA Polymerase Chain Reaction (PCR) to confirm active infection. Weighted prevalence and odds ratio calculated to account for associated risk factors.
Results: All HIV positive participants and HIV-negatives from a 10% random sample of HHs tested for HBV and HCV. Overall prevalence of HBV and HCV was 2.3%(95%,CI:1.6-3.0) and 1.2% (95%CI:0.7-1.6) respectively. HBV prevalence was twice in males (3.1%,95%CI:1.9-4.2) compared to females (1.6%,95%CI:0.9-2.3); but the difference was not significant. HBV prevalence varied from 2.7% in the East province to 0.9% in the North. Prevalence of HBV was 5.9% (95%CI:4.2-7.7) and 1.8% (95%CI:1.2-2.4) in HIV+ and HIV- individuals, respectively. HCV was lowest in Kigali (0.5%) and highest in the South (1.8%). There was no significant difference in prevalence of HCV between HIV+ and HIV- persons; prevalence 2.6% (CI:1.3-3.9) and 1.0% (CI0.6-1.4) respectively. In multi-variable analyses, odds of HCV infection greater in ages 45-64 compared to 10-24 (AoR12.1,95%CI5.2-28.2).HIV+ persons more likely to be infected with HBV compared to HIV- ones (AoR4.1,95%CI:2.4-6.8).In contrast to HCV, there was no significant difference between HIV+ and HIV- participants for HCV(AoR2.1,95%CI:1.3-3.3).

HCV demonstrated a high risk of infection among the older population age 45-64 (AoR12.1, 95%CI 5.2-28.2) compared to younger population (10-24).
Conclusions and recommendations: Both HBV and HCV pose significant health risks for HIV positive individuals, but HBV was significantly higher in HIV+ as opposed to HCV. This data highlights the importance of a control program that targets HIV+ individuals for HBV control, while HCV control initiatives may be independent of HIV status.
Keywords: Hepatitis, Prevalence, RPHIA Survey
[1] Global Hep report 2018

FRAC2102 - TRACK C2

A15: Evaluation de la Co-infection VIH, Hepatites (B, C) et Syphilis chez les Donneurs Benevoles de Sang en RCA: Cas du Centre National de Transfusion Sanguine de Bangui d'Avril à Juin 2019

15:00 – 15:15

Lenguetama Kodia Régina Edwige
Ministère de la Santé et de la Population, Bangui, Central African Republic

Introduction: Le dépistage des agents infectieux représente une étape dans le processus de la qualification biologique des dons de sang. Les virus hépatotropeset la bactérie responsable de la Syphilis partagent les mêmes voies de transmission que le VIH, d'où l'existence d'une fréquence élevée de coïnfection par les virus de l'hépatite B ou C ou dela Syphilis chez les patients infectés par le VIH. Bien que l'étude de la coinfectionVIH/hépatites B et hépatite Cfaitl'objet de nombreuses publicationsen Afrique,la situation chez les Donneurs Bénévoles de Sang en RCA reste inaperçue.L'objet de cette étude est d'évaluer la coïnfection des hépatites B et C et de la syphilis chez les donneurs bénévoles de sang vivant avec le VIH à Bangui en RCA.
Méthode: C'est une étude transversale couvrant la période d'Avril à Juin 2019, au Centre National de Transfusion Sanguine. La population d'étude était composée des personnes tout venantes de deux sexesde plus de 18 ans se présentant pour un don de sang. Les données étaientcollectées à partir des fiches de renseignements des donneurs et des résultats de l'analysebiologique. Les méthodes immuno-chromatographique avec des antigènes fixés sur gel ont été utilisées suivant l'algorithme de l'OMS. Les variables mesurées étaient l'âge, le sexeainsi que les résultats de sérologiesAgHBs, HCV, Syphilitique et VIH.Le test de Chi deux étaitutilisé pour mesurer l'association entre les variables qualitatives significative pour une valeur dep-value< 5% avec un intervalle de confiance de 95%.
Résultats: Au total 117 cas d'infection à VIH étaient enregistrés sur 3555 échantillons inclus dans l'étude soit une prévalence de 3,29%. Le sexe masculin était majoritaire à 85,47% (100/117).La tranche d'âge de 18-25 ans était la plus touchées avec 52,13% (61/117) suivi de 26-44 ans avec 43,6% (51/117).
Les coïnfections étaient respectivement de11, 11% (13/117) entre VIH et hépatite B ;de 2,56%(3/117) entre HIV et hépatite C et de 2,56% (3/117) entre HIV et RPR.Aucun cas de triple infection n'a été enregistrédurant la période del'étude.
Conclusion: Cette étude nous a permis de montrer que l'infection à VIH est souvent associée aux autres marqueurs (HBS, HCV, RPR). La sensibilisation et la prise en charge médicale des Donneurs Bénévoles de Sang restent les moyens efficaces pour la prévention des infections à VIH et les autres IST.

FRAC2103 - TRACK C2

Unraveling the Burden of (Major) Depressive Disorders among People Living with HIV in Africa

15:15 – 15:30

Nansseu Jobert Richie[1,2], Tounouga Dahlia Noelle[3], Bigna Jean Joel[4,5]

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Background: Depression constitutes one of the most prevalent mental disorders and leading cause of disability worldwide. People living with HIV (PLHIV), due to their status, are highly at risk of presenting depressive disorders, which can negatively impact the course of HIV infection. It is therefore important to accurately estimate its burden among PLHIV, especially in Africa the epicenter of HIV infection, with the aim of deriving efficient and evidence-based related health policies, locally.

Methods: The authors carried out a systematic review with meta-analysis of studies published between January 2000 and February 2018 on the prevalence of (major) depressive disorders among people living with HIV in Africa. They searched PubMed, Embase, Web of Science, African Journal Online and Africa Index Medicus, supplemented by a manual search; no language restriction was applied. A random-effects meta-analysis model served to pool studies together, complemented with a multivariable meta-regression analysis to identify potential sources of heterogeneity, if existent.

Results: A total of 118 studies representing 61,125 patients and 19 countries were retained. Methodological quality assessment revealed that 64 (54.2%), 49 (41.5%) and 5 studies (4.3%) had a low, moderate or high risk of bias, respectively. Most studies used the Centre for Epidemiology Studies Depression Scale to diagnose depression. The pooled prevalence estimates of depressive disorders and major depressive disorders were 36.4% (range 4.0-67.7; 95% confidence interval (CI): 32.1-40.7) and 15.6% (range 0.0-68.5; 95%CI: 12.6-18.9), respectively. These estimates were significantly higher in Northern than in sub-Saharan Africa; contrariwise, the study setting, site, CD4 cell counts, age, sex, and proportion of people with undetectable viral load did not influence these estimates.

Conclusions and Recommendations: The burden of depressive and major depressive disorders is very high among people living with HIV in Africa, hence deserving more attention and implication from all local actors. HIV-bound health care providers should be trained to routinely screen and rapidly identify depressive disorders among PLHIV, and address adequate care in order to avoid their negative impact on HIV progression. Furthermore, local tools to diagnose depression among PLHIV in Africa should be developed. Further studies are warranted in Africa to better depict all factors driving depression among PLHIV.

FRAC2104 - TRACK C2

Improved Quality of Life in Patients after DAA Treatment for Hepatitis C: Results from SHARED Study in Rwanda

15:30 – 15:45

Umutesi Grace[1], Van Nuil Jennifer Ilo[1], Rurangirwa Akashi Andrew[2,3], Shumbusho Fabienne[1], Dushimimana Jean De Dieu[1], Muvunyi Claude Mambo[2], Mbituyumuremyi Aimable[4], Kabahizi Jules5, Musabeyezu Emmanuel[2], Nsanzimana Sabin[4], Grant Philip[6], Kateera Frederick[1], Gupta Neil[1,7,8]

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Background: The World Health Organization (WHO) estimates that 71 million people are chronically infected with hepatitis C virus (HCV) which accounts for 400,000 annual deaths worldwide. Roughly, 15% of these cases occur in Sub-Saharan Africa (SSA). In Rwanda, the HCV prevalence is 4.7% among people living with HIV and varies from 2.6 - 6.4% among other groups. Direct acting antiviral (DAA) therapy has been shown to be safe and highly effective in chronic HCV patients resulting in decreased fibrosis, cancer, and mortality. Nevertheless, little is known about the psychosocial impact of HCV treatment in low and middle-income countries.
Methods: We assessed the quality of life of participants enrolled in the SHARED study, an open-label clinical trial to assess the safety and efficacy of ledipasvir/sofosbuvir in treatment of patients with chronic HCV in Rwanda. We included participants with HCV genotypes 1 and 4, including people living with HIV who had been taking approved antiretroviral therapies for at least six months. In total 300 participants were enrolled from February to September 2017. We adapted the 35-question Medical Outcome Survey validated in Rwanda for HIV. We administered this survey to assess the perception of physical and mental health of participants before and after treatment i.e. at day 0 and week 24, respectively. We used R software for descriptive and inferential statistics.
Results: The mean age was 61.9 (SD+/- 13.9) and 61.1% of the participants were female. Overall, the physical health summary (PHS) score increased from 55.6% at baseline to 60.4% at week 24 (p-value< 0.001) and the mental health summary (MHS) score increased from 53.5% at baseline to 60.8% after 24 weeks (p-value< 0.001). There were no significant differences in PHS or MHS based on treatment success/failure, gender, or HIV status, but those with advanced fibrosis or cirrhosis (APRI score > 1.5) at enrollment had statistically significant improvements in PHS after treatment (p-value = 0.0109).The prevalence of depression decreased from 8.2% before treatment to 2.1% after treatment.
Conclusions: These findings suggest a positive impact of DAAs on quality of life among HCV infected patients, which has not been measured previously in SSA. Participants expressed a perceived improvement of not only their physical but also their mental quality of life. Our results underscore the urgent need for improved accessibility of DAA treatment for HCV infected patients.

TIME	16:45 – 18:15 Uhr	ROOM	Prof. Madeleine Okome (MH 3)	DATE	Friday, 06 December 2019

Track E: Health Systems, Economics and Implementation Science

Why Every Woman's Health Matters

Chairs: Ms Winnie Byanyima, UNAIDS
Niyi Ojuolape

FRAE2202 - TRACK E5

The Costs of Initiating and Retaining Women on Oral PrEP in Zimbabwe

16:55 – 17:10

Mangenah Collin[1], Nhamo Definate[2], Gudukeya Stephano[3], Gwavava Emily[3], Gavi Chiedza[1], Muleya Polite[1], Chidawanyika Sandra[1], Chiwawa Progress[1], Sithole Justice[3], Johnson Carey[3], Dhlamini Roy[3], Chinake Obey[3], Mutede Blessing[3], Taruberekera Noah[3], Maponga Brian[3], Madidi Ngonidzashe[3], Bara Hilda[4], Mahaka Imelda[5], Napierala-Mavedzenge Sue[6], Dunbar Megan[5,7], Hoke Theresa[7], Ncube Getrude[8], Cowan Frances[1,9], Terris-Prestholt Fern[10]

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[8]Ministry of Health and Child Care Zimbabwe, Harare, Zimbabwe, [9]Liverpool School of Tropical Medicine (LSTM), Liverpool, United Kingdom, [10]London School of Hygiene and Tropical Medicine (LSHTM), London, United Kingdom

Background: In 2016 Zimbabwe began rolling out oral PrEP for individuals at high risk of HIV infection. To inform PrEP implementation and scale-up, policymakers urgently need evidence on resource costs. This micro-costing study estimated full economic costs of PrEP delivery and demand creation for 7 sites. 6 were PSI New Start Centre (NSC) clinics where incentivised mobilisers generated demand during routine outreach whilst a public sector gender-based violence (GBV) clinic provided PrEP though not actively creating demand.

Methods: Using a provider perspective, resource use and cost data were collated from expenditure records, supplemented by field observations. Staff time allocation was analysed through time and motion. Total cost and unit cost were estimated per person initiated and per person retained at 3 and 6 months. A sensitivity analysis tested the impact of key assumptions on unit costs.

Results: Over the 12-month period (January-December 2018) 4,778 clients initiated oral PrEP at NSC's, (range 351 at a small-town site to 1,694 in a large city facility). 2,209 (46%, range 11%-79%) and 1,209 clients (25%, range 7%-47%) were retained on PrEP at 3 and 6 months post-initiation in the PSI facilities. The GBV facility initiated 62 clients on PrEP retaining 17 (27%) and 5 (8%) at 3 and 6 months respectively. The total annual cost was $1,059,965 across the 6 PSI facilities and $8,477 at the public sector GBV clinic. Demand creation, including mobilizer incentives (35%) and human resources (31%),were key cost contributors. Unit costs per person initiated on PrEP ranged from $206 at the largest PSI facility in Harare, to $377 at the small-town facility and was $137at the GBV clinic. Due to variable retention, unit cost per client retained ranged from $254 to $2,930 at 3 months and $439 to $4,395 at 6 months in the PSI sites. Sensitivity analysis identified humanresources as a main driver of cost variation across the sites.

Conclusions and Recommendations: In this study PrEP delivery costs varied substantially by site and delivery model for both initiation and retention with higher volume sites reflecting lower unit costs. However results show higher costs per person associated with poor retention. Further research could identify why clients fail to return for refills as this will help better support client retention and improve efficiency by spreading the high fixed costs of initiation over more months of PrEP protection and ultimately lower costs per person.

FRAE2203 - TRACK E5

Limited Use of Dual Contraception among Women of Reproductive Age in Eswatini

17:10 – 17:25

Ndungwani Rumbidzai[1], Ngcamphalala Cebisile[1], Gwebu Nontobeko[1], Ndlangamandla Mpumelelo[1], Hlophe Londiwe[1], Sahabo Ruben[1], Mnisi Zandile[2], Nuwagaba-Biribonwoha Harriet[1]

[1]ICAP in Eswatini, Mbabane, Eswatini, [2]Ministry of Health, Mbabane, Eswatini

Background: Use of dual contraception is recommended for protection against pregnancy, HIV and sexually transmitted infections (STIs) among all women of reproductive age (15-49 years). In a high HIV/STI prevalence settings, dual protection remains critical. We analyzed uptake and predictors of dual contraception among women of reproductive age in Eswatini.

Methods: Data from the second Swaziland/Eswatini HIV Incidence Measurement Survey 2 (SHIMS2) was analyzed. Data on self-reported contraceptive use was collected. Dual contraception was defined as use of both hormonal methods and condoms to prevent pregnancy and HIV/STIs. Analysis was restricted to women 15-49 years who were aware of their HIV status and reported current contraception use and sexual activity in the preceding 12 months. We compared characteristics of women on dual to

those on single contraception (one hormonal method or condoms) using descriptive statistics and logistic regression model adjusting for age, urban/rural residence, region, education, HIV status, parity, marital status and most recent partner's HIV status
Results: Of 5158, 49% (n=2548) were sexually active and reported contraceptive use. Only 7% (n=180) reported dual contraception use. The majority, 93% (n=2368), reported using single contraception: 58% (n=1362,) were using condoms only and 42% (n=1006) were using hormonal contraception only. Of the 7% (n=180) on dual contraception, 55 % (n=101) were living with HIV (LHIV) and 45% (n=79) were HIV negative. Of 2368 on single contraception 41% (n=971) were LHIV, and 59% (n=1397) were HIV-negative.
Compared to those LHIV, HIV negative women had higher odds of single contraception use (AOR 2.5, 95% CI 1.7-3.6). Married/cohabiting women had higher odds of single contraception compared to single women (AOR 4.3, 95% CI 2.9-6.3). Odds of single contraception use were lower among nulliparous than uniparous women (AOR 0.3, 95% CI 0.2-0.7), para 2 (AOR 0.2, 95% CI 0.1-0.5), and para 3 (AOR 0.3, 95% CI 0.1-0.7). We found no statistically significant associations with age, urban/rural residence, region and most recent partner's HIV status
Conclusions and Recommendations: Most women of reproductive age were using single contraception particularly HIV negative women and married women, leaving most women at high risk of acquiring HIV and STIs. Given the high HIV prevalence in Eswatini, efforts should be made to increase uptake of dual contraception and promote use of pre-exposure prophylaxis (PrEP).

FRAE2204 - TRACK E5

Care &Treatment to Women Genocide Survivors Raped and Infected with HIV, as a Human Right & HIV Response - A Lesson from Rwanda

17:25 – 17:40

Umutesi Geraldine, Hagenimana Felix, Akimana Rachel, Kalisa Isabelle, Vugayabagabo Jackson, Umutoni Sandrine, Ndejuru Radegonde
Imbuto Foundation, Health, Kigali, Rwanda

Issues: The UN Security Council Resolution 1820 adopted on 19th June 2008, recognized the rape as a war crime. During the 1994 Genocide against the Tutsi in Rwanda between 250,000 and 500,000 women who survived were systematically raped, with the intention to infect them with HIV and 20,000 children born of these mass rapes.As women were not comfortable to access HIV services due to stigma around rape,it was of paramount importance to find a suitable solution to address this issue.This paper highlights a model that can be used as a Human Right and HIV response in the post conflict environments.
Descriptions: Under the leadership and advocacy of H.E. Madam Jeannette Kagame, the First lady of Rwanda, a five year program “Care & Treatment Project”(CTP) has been launched in 2005 by Imbuto Foundation in partnership with Survivors'Fund, through 4local NGOs namely: Avega-Agahozo, Solace Ministries, Rwanda women'Netowork.
The long term project objective was to improving the living conditions of HIV+ women survivors raped during the 1994 genocide. The project offered a community based care with ART and comprehensive services to 2,500 HIV+women and their families” by providing services in a safe and supportive environment through four special clinics serving for that purpose.
The project outputs aimed at enhancing the capacity of 4 local NGOs' clinics to offering HIV/AIDS and other medical care to conform to the national norms of HIV/AIDS care. Data were collected using program monitoring and evaluation tools on quarterly basis. Descriptive analysis have been generated using Microsoft Excel.
Lessons learned: The program reached over 2500 HIV+ women aged between 18 to 59 years. A total of 1,892 (75.68%) women accepted to be enrolled in the ART program in other Health centers. All four clinics have a community-based and women initi-

ated 22 income generating activities to cover their other social needs. Around 1496 Secondary beneficiaries received psycho social,trauma management & education support.

Next steps: The safe spaces and holistic services addressing individual, household and community needs, have helped the women raped to live positively with HIV and integrated in the national HIV programs.The four special clinics have been integrated in the pool of health centers offering the ART Services in Rwanda. This model can serve as a model of providing HIV quality services by addressing stigma around HIV related to rape and violence in post conflict countries.

FRAE2205 - TRACK E5

Integration of Maternal and Child Health Intervention and Adolescent Girls' Program within HIV Intervention Setting in FCT, Abuja by CTEO Nigeria

17:40 – 17:55

Ogundare Yemisi[1], Onife Olokunde[1], Obande Obande Peter[1], Ndukwe Walter[1], Mulero Emmanuel[2], Benjamin - Laniyi Tunde[2]

[1]Community Transformation & Empowerment Organisation, Abuja, Nigeria, [2]RCCG The Throne Room, Transcorp Hilton, Abuja, Nigeria

Issues: Maternal and child health interventions as well as programs for Adolescent girls have remained a crucial aspect of community interventions that have been neglected across in Nigeria. This is evident with high rate of maternal and child mortality for HIV and non HIV population, number of pregnant women lacking required knowledge about MNCH and poor menstrual health hygiene for girls across rural communities. The community transformation and empowerment organization (CTEO) a faith-based organization established by the RCCG Throne Room parish in Abuja conducted interventions for pregnant women and adolescent girls across project communities during HIV program interventions. This assessment sought to review the integration of maternal and child health and Adolescent girls' programs conducted by CTEO between December 2018 - July 2019.

Descriptions: HIV prevention programs are part of CTEO core interventions areas in select communities. Alongside HIV counselling and testing conducted in project communities, CTEO conducted advocacy, community sensitizations, capacity building and counseling for pregnant women with focus on PMTCT. Menstrual hygiene education, counselling and distribution of sustainable reusable sanitary packs were provided to girls in the communities and mother baby packs distributed to pregnant women. During these interventions CTEO conducted pre and post capacity building assessment and qualitative assessments through Key informant discussions and focus group discussions with selected target beneficiaries and community leaders to assess outcome of the interventions

Lessons learned: Results from the assessment shows significant knowledge gained about mode of transmission of HIV, importance of HIV testing and HIV treatment centers, specifically from mother to child and general population. Significant knowledge gained was evident in the pre and post capacity building sessions for pregnant women and adolescent girls from 40% - 70%. Poverty and lack of access to adequate health care & HIV services for specific groups was still identified as a challenge from the respondent, as most preferred group learning

Next steps: Explore working with community leaders to design more affordable HIV program interventions, facilitate the integration of community HTS & MCH/Adolescent girl clubs programs with in rural community clubs and extend messages and services to extended facilities within rural communities.

TIME	16:45 – 18:15 Uhr	ROOM	Prudence Mabele (MH 2+ Corridor)	DATE	Friday, 06 December 2019

Track B: Clinical Science, Treatment and Care

Adherence

Chair: Dr. Anita Asiimwe

FRAB2301 - TRACK B5

Challenges Young People Living with HIV Face in Adhering to ART in Second Cycle Institutions in the Ashanti Region of Ghana

16:45 – 17:00

Lodonu Roseline Edna Ama[1], Adu-Ampong Daniel[2], Ayeh Elsie[3], Porekuu Patricia[4], Amendah Djesika[5], Senoo Cecilia[6], Gyamfi Maame Serwaa[2]

[1]Hope For Future Generations (HFFG), Programmes, Kumasi, Ghana, [2]Hope For Future Generations (HFFG), Monitoring Evaluation and Learning, Accra, Ghana, [3]Pan African Positive Women's Coalition PAPWC, Programmes, Kumasi, Ghana, [4]Hope For Future Generations (HFFG), Programmes, Accra, Ghana, [5]AIDSPAN, Policy, Nairobi, Kenya, [6]Hope For Future Generations (HFFG), Management, Accra, Ghana

Issues: In Ghana, young people living with HIV (YPLHIV) who are in school face numerous challenges in adhering to their Anti-retroviral drugs regimen. They include stigmatization in their schools, lack of treatment literacy and lack of dedicated adolescent friendly services for those living with HIV. Even the national youth policy of Ghana does not specifically address the unique needs of YPLHIV. As part of the Global Fund, Community Systems Strengthening project, Hope for Future Generations, a local NGO in Ghana, commissioned a study which sought to explore the effects of these challenges on the well-being of YPLHIV registered in second cycle institutions in Ghana and ways to mitigate those challenges

Descriptions: Four (4) focused group discussions with a total of thirty-two (32) YPLHIV aged 15-24 who were in second cycle institutions were conducted in April, 2019 in the Komfo Anokye Teaching Hospital in the Ashanti Region of Ghana. This hospital is the second largest and the main referral hospital for the northern part of Ghana. YPLHIV who attended the adolescent clinic at the time of the study were recruited through purposive sampling for the study.

Lessons learned: The discussions revealed that stigma--illustrated by fear of being seen by friends, fear of adhering to strict drug schedules, skin conditions—non-disclosure by parents to their wards, low level of HIV knowledge among teachers and misconceptions about the condition have negatively impacted on them. They have had to devise strategies to avoid stigma. The most common was changing the packaging of the medication to avoid easy detection but still taking the medication as recommended: some pour drugs into gum/toffee containers and hide in washrooms to take the medication. A second common strategy was telling lies when they are seen by their peers taking their drugs. A third strategy that is dangerous is skipping the medication altogether.

Next steps: The study highlighted YPLHIV drug adherence challenges. Some recommendations are to identify context specific interventions like integrating ART services into existing youth friendly corners, intensify psycho-social counselling and support for YPLHIV and identify Young Positive Ambassadors to follow up to these schools. At the policy level, it would be expedient to include the needs of adolescents in the review and development of Ghana's National Strategic Plan in order to enhance the country's chances of ending the HIV epidemic.

FRAB2302 - TRACK B5

The Feasibility of Diagnosing and Treating Acute HIV Infection in a Resource Limited High HIV Incidence Setting in Eswatini

17:00 – 17:15

Kerschberger Bernhard[1], Aung Aung[1], Mpala Qhubekani[1], Ntshalintshali Nombuso[1], Mamba Charlie1, Mthethwa-Hleza Simangele[2], Sibandze Dumile[3], Maphalala Gugu[3], Dube Lenhle[2], Kashangura Rufaro[4], Obulutsa Thomas[1], Tombo Marie Luce[1], de la Tour Roberto[5], Calmy Alexandra[6], Telnov Alex[5], Rusch Barbara[5], Gonzalez Alan5, Ciglenecki Iza[5]

[1]Medecins Sans Frontieres (OCG), Mbabane, Eswatini, [2]Ministry of Health (SNAP), Mbabane, Eswatini, [3]Ministry of Health (NRL), Mbabane, Eswatini, [4]Ministry of Health (Nhlangano Health Centre), Nhlangano, Eswatini, [5]Medecins Sans Frontieres (OCG), Geneva, Switzerland, [6]University Hospital (HIV/AIDS Unit), Geneva, Switzerland

Background: The diagnosis of acute HIV infection (AHI) is hardly performed in Africa. However, delaying HIV diagnosis and care after the establishment of chronic infection may impair epidemic control. This study is one of few assessing the feasibility of AHI care from a high HIV incidence setting.

Methods: From March to July 2019, adults (16-49 years) were enrolled prospectively into the study at Nhlangano secondary care outpatient department in Eswatini (formerly Swaziland) if 1) they had symptoms suggestive of AHI (fever/ sore throat/ symptoms of STIs) and tested HIV-negative on the rapid diagnostic point of care tests (RDT) Alere Determine™ and Uni-Gold™, or 2) had an inconclusive RDT test result, or 3) were referred from the pre- (PREP) and post- (PEP) exposure prophylaxis programme as a presumptive AHI case. A confirmed AHI case was defined as a patient with a RDT-negative or inconclusive test result who had two viral loads (VLs) ≥40 or one VL≥10,000 (4 log10) copies/mL, performed on the Cepheid Xpert HIV-1 assay. All patients with AHI were offered same-day antiretroviral therapy (ART) initiation and partner notification services.

Results: Of 426 patients tested with RDTs, 311 (73%) were eligible for VL testing because of 1) symptoms suggestive of AHI and a negative RDT test result (n=303; 97%), 2) an inconclusive RDT result (n=6; 2%), 3) or being referred as a PEP patient (n=2; 1%). Of these patients (n=311), 264 (85%) received a VL test, of whom 6 (2.3%) had a detectable VL at the median of 4.96 log10 (minimum log10 3.53; maximum log10 6.43) copies/mL. Three patients were women, median age was 30 years and median CD4 was 269 cells/mm3. Four patients initiated ART within 24 hours of diagnosis, 1 within 72 hours, and 1 declined treatment. Of 4 patients with sufficient follow-up time, 3 had a suppressed VL (< 1,000 copies/mL) at 2 weeks and all 4 patients were virally suppressed at 4 weeks. Three of these patients showed an increase in their CD4 of more than 50% within one month. Five patients disclosed 5 sexual partners, of whom 3 presented to the clinic. One partner presented RDT-positive and was treatment naïve, and 2 were HIV-negative and initiated PREP.

Conclusions and Recommendations: AHI testing can contribute to HIV diagnosis in outpatient departments in resource limited settings. Yet partner tracing and rapid linkage to care are critical components that need to be better addressed.

FRAB2303 - TRACK B5

Implementing an Innovative Evidence-based Mobile Health (mHealth) Intervention to Improve Engagement and Adherence to HIV Prevention and Care Services in Rwanda

17:15 – 17:30

Lester Richard[1], Nsanzimana Sabin[2], Benekigeri Chantal[3], Serafini Gabrielle[4], Umuhoza Justine[3,5], El Joueidi Samia[1], Babili Abdulaa[4]

[1]University of British Columbia, Infectious Disease - Faculty of Medicine, Vancouver, Canada, [2]Rwanda Biomedical Center (RBC), Kagali, Rwanda, [3]WE-ACTx for Hope Clinic, Kagali, Rwanda, [4]WelTel International mHealth Society, Vancouver, Canada, [5]WelTel International mHealth Society, Kagali, Rwanda

Background: Suboptimal adherence to antiretroviral therapy (ART) and inadequate

engagement in prevention activities hinder achieving the 90-90-90 UNAIDS HIV targets. In Rwanda, adolescents with HIV lack access to care and are especially vulnerable to poor adherence. WelTel is a leading digital health solution that uses 2-way SMS messaging which has previously been demonstrated in randomized controlled trials to improve ART adherence, viral suppression, quality of life scores, and cost-effectiveness by WHO standards.

Description: In 2018, the WelTel SMS mHealth service was successfully implemented in the WE-ACTx for Hope Clinic in Kigali City. Based on needs assessments conducted in 2017 in Kigali, this clinic was chosen due to the high number of adolescents/youth who are being lost to follow up. Since the service's inception, 1000+ patients have been enrolled on the platform and 70,000+ SMS messages have been exchanged. The service includes a weekly check-in message that provides a communication link between out-patients and their healthcare providers (HCP). Regular community discussions were held to collect information about barriers faced by adolescents, youth, and other patients living with HIV. Results were used to adapt and evolve the technology to meet the needs of the populations who are least likely to engage in HIV prevention and care services.

Lessons learned: Since the service's implementation, positive changes have been observed by patients and HCPs. Patients attending the clinic reported that using WelTel was a lifeline and made them feel cared for. As a result of enhanced patient to HCP communication and engagement, optimal adherence to ART, improved retention in care, and attendance at the clinic were observed. HCPs reported having a more effective and efficient system to manage, monitor, and follow-up with many out-patients. This aligns with Rwanda's “Treat All” strategy that aims to increase HCP's capacity to deal with larger patient loads efficiently, potentially contributing to differentiated care models. Additionally, improved pharmacy and laboratory visits have been reported by clinic staff.

Next step: WelTel is a success in the We-ACTx for Hope clinic, improving the healthcare experience for patients and HCPs. This success has ignited our ambition and desire to expand the service into 2 new sites; the Remera and Gikondo Health Centers in the Gasabo and Kicukiro Districts, respectively.

FRAB2304 - TRACK B5

Factors Affecting ART Adherence and Client Satisfaction in Ethiopia: The Case for Differentiated Service Delivery

17:30 – 17:45

Tefera Ambachew, Abraham Dawit, Nigatu Frehiwot, Tekeste Asayehegn
Project HOPE Ethiopia, Addis Ababa, Ethiopia

Background: Ethiopia observed a decline in HIV burden. Interventions were scaled up and improved access to comprehensive HIV services. Recently, the country started implementing “appointment spacing model” of differentiated service delivery allowing clients to collect ARVs bi-annually. However, there are still gaps for optimal adherence and retention in care.

Methods: A cross sectional facility based mixed method study conducted from July to August 2018 among randomly selected adult PLHIVs in 30 health facilities to examine the status of HIV service delivery. Data entered into EPI INFO7, analyzed using STATA14.1. NVIVO11 was used for the quantitative data analysis. Bivariate and multivariate analysis done to identify the factors affecting adherence and client satisfaction.

Results: 1153 adult PLHIV (749 female) interviewed with a response rate of 99.4%. 12.1% had ever missed a dose of ART. Of these, 43.1% reported missing their doses sometimes, while 4.9% did so often. The reason was while trying to conceal the tablets from other people. 86.2% pick their medication without interruption and 78.8% followed prescriptions. The 7 and 3 days self-reported adherence was 94.0% and 94.9% respectively. In the bivariate analysis, educated PLHIVs were more likely to adhere to ART (X2=4.38, p-value=0.036) than the uneducated and those obtaining

ART within their town were more likely to adhere to ART (X2=18.1, p-value < 0.0001). In multivariate analysis, the associations remained significant for education (AOR: 1.85; 95%CI; 1.10-3.12) and place of ART refill (AOR=2.86; 95%CI: 1.73-4.72). Out of the interviewed, 314 (27%) reported quality problems of services they are receiving, 89.0% saying these were important factors with potential to prevent them from attending care. Late service starting hours (36.8%) and long waiting time (36.5%) were more common while unavailability of services out of working days and hours, mistreatment by staff, shortage of staff were also reported. 69.2% were either satisfied or very satisfied while 30.7% were neutral or dissatisfied.

Conclusions and Recommendations: Existing gaps in service quality and accessibility are negatively affecting adherence to ART and user satisfaction. Implementation of various differentiated service delivery models are recommended to address these gaps. Strong community based interventions with targeted adherence education schemes are required to address adherence related gaps, especially for uneducated PLHIV.

FRAB2305 - TRACK B5

Factors Affecting Retention in Care and Treatment Clinics among People Living with HIV in Zanzibar

17:45– 18:00

Khalid Asha, Khalid Farhat, Mohamed Sophia, Mwendo Emmanuel, Damian Damian
Zanzibar Integrated HIV, Hepatitis, TB and Leprosy Programme, Zanzibar, Tanzania, United Republic of

Background: Sub-Saharan Africa (SSA) remains the worst affected region with HIV/AIDS globally. Unlike many SSA countries, Zanzibar is characterized with a concentrated HIV epidemic, having very low HIV prevalence in the general population (0.4%); with 86.6% of the clients enrolled on ART. Retention in HIV care reduces risk of HIV transmission, AIDS morbidity and mortality and increases life expectancy among people living with HIV (PLHIV). The adoption of test and treat strategy makes retention in ART programs of a paramount importance. This study aimed at determining factors affecting retention in HIV care among PLHIV in Zanzibar.

Methods: This was a cross-sectional study conducted in 12 Care and Treatment Clinics (CTCs) in January 2017. PLHIV were randomly selected from the appointment register and invited to participate in the study. Retention to care was defined as attending regular follow up appointments, scheduled laboratory tests and other monitoring activities as prescribed by the health care provider in the past 12 months prior to the survey.

Result: In total, 682 PLHIV on ART were enrolled in this study. Almost three-quarters were females (74.2%). The median age at enrollment was 40 years (IQR: 34-47). More than half PLHIV (58.1%) were on ART for about 5 years or more. Retention on HIV care was estimated to be 90%. Males were twice more likely to miss scheduled appointments compared to their female counterparts (16.5% vs. 7.7%; OR=2.30, 95%CI: 1.28-4.11; p=0.001). Furthermore, PLHIV who have disclosed their HIV status were 75% less likely to miss scheduled appointments juxtaposed those who did not (29.3% vs. 8.7%; OR=0.23, 95%CI: 0.11-0.52; p< 0.001). The major reasons reported for missing a scheduled visit included witchcraft beliefs (51.4%); believing on traditional medicine (37.2%), believing they already cured (10.0%) and drug side effects (9.0%).

Conclusion: Retention in HIV care in Zanzibar was high. Sex and HIV status disclosure were factors affecting retention in HIV programme. Negative believes, drugs side effects were the commonly reasons for missing scheduled visits. Strategies to improve retention in HIV care should focus on offering comprehensive health benefits of HIV treatments and provision of medical supports among clients experiencing side effects. Moreover, targeted interventions focusing on females and clients who have not disclosed their status should be initiated to improve long-term retention in this setting.

TIME	16:45 – 18:15 Uhr	ROOM	Kigali (Auditorium)	DATE	Friday, 06 December 2019

Track D: Law, Human Rights Social Science and Political Science

Social Media and Their Innovative Communication Mechanism

Chair: Kunle Adeniyi

FRAD2401 - TRACK D1

Acceptance and Use of Social Media for Reaching Key Populations with HIV Programming in Ghana

16:45 – 17:00

Mensah Ebenezer K[1], Avle-Gavor Rita Emefa[1], Kodua Nyano Angelina[1], Rahman Yussif Ahmed Abdul[1], Adiibokah Edward[1], Kowalski Mark[2], Nagai Henry[1]

[1]JSI Research and Training Institute Inc., Accra, Ghana, [2]JSI Research and Training Institute Inc., Boston, United States

Background: Social media use increases HIV testing rates, especially among men who have sex with men (MSM) and female sex workers (FSW) in high-income countries, as it enables providing information and counseling discretely in high-stigma environments. However, KP-focused local civil society organizations (CSOs) in Ghana are yet to fully understand and utilize it as an intervention tool. This study sought to understand social media acceptance and use among CSOs and the facilitating conditions for integrating it as a tool for KP HIV programming in Ghana

Methods: The USAID/Strengthening the Care Continuum Project is Ghana's flagship KP-focused HIV program implemented by JSI in collaboration with Population Council. The project is implemented with 11 CSO partners. From February to April 2019, the project adapted the Technology Acceptance Model (TAM) for a cross-sectional mixed methods study. 55 purposively selected CSO field staff reported basic demographics, social media sites in use, perceived usefulness and personal fit in the use of social media. We collected qualitative data from FSWs and MSM via 22 one-on-one interviews (11FSWs and 11MSM) and group discussions (2 FSWs and 2 MSM)

Results: Ten of 11 CSOs use social media in urban areas; 7 of the 10 are MSM focused CSOs; 3 are FSW focused, and 3 focus on both KP types. Widely used social media sites were Facebook, Whatsapp, Grinder, Instagram for both; Tinder for FSWs, and Planet Romeo for MSM. Most CSOs utilize multiple social media platforms concurrently. MSM CSOs are early adopters in integrating social media, however it has taken more time for FSW CSOs to connect with high-risk FSW online. CSOs in urban metropolitan settings have been more effective at initiating social media KP HIV interventions than in semi-urban or rural areas. 10 out of the 11 CSOs indicated social media use contributes to a higher HIV positive testing yield among hard to reach and high-risk KPs and their networks

Conclusions and Recommendations: It takes time to build trust online, so CSOs should consider working through networks of high profile KPs, and use social media handles as an entry point in connecting with riskier KPs. Social media interventions should be complimented with participatory community engagement approaches in transitioning of KPs reached online for physical contact HIV services. CSOs staff need to continuously undertake risk profiling of sites a to reduce associated risks to project MSM

FRAD2402 - TRACK D1

Utilisation des Médias Sociaux pour Sensibiliser le Public au VIH et aux IST: Expérience de Humanity First Cameroun avec des Hommes Ayant des Rapports Sexuels avec des Hommes Vivant à Yaoundé

17:00 – 17:15

Olongo Ekani Antoine Silvère

Humanity First Cameroon, Programs, Yaoundé, Cameroon

Context: Most sub-Saharan Africa countries have a generalized HIV epidemic in the general population and a concentrated one among key populations. The latest IBBS study conducted in 2016 in Cameroon found an HIV prevalence of 20% among men who have sex with men and Transgender. Efforts to prevent HIV remain insufficient to reverse this trend, as stigma and discrimination prevent hard-to-reach beneficiaries from up taking services offered by community based organizations (CBO). It is therefore in order to reach these hidden MSMs that Humanity First Cameroon has developed online sensitization through social media as part of its package of activities for HIv prevention.

Methods: As part of the implementation of the CHAMP project (Continuum of prevention, care and treatment with populations in Cameroon) of USAID, we recruited from the period of October 2017 to September 2018 an expert in charge of online prevention activities. We created a user profile in the following applications: Facebook, Grindr, Whatsapp group, Badoo and Planetromeo. Through this activity, we reached a large number of people connected to give them up-to date information about HIV and STIs and especially we referred them to our CBO for furthers services such as HIV testing. At the end, we assessed the number of new person referred for a HIV test and calculated the yield of HIV among them calculated them.

Results: Between October 2017 and September 2018, we sensitized through this activity 825 MSMs. Of them, 400 who were not familiar to our services previously were referred to the CBO for HIV testing. 35(8, 7%) were tested positive and were linked to treatment and has currently suppressed their viral load.

Conclusion and Recommandations: The results show us that this intervention effectively increase the uptake of prevention services and it helps us reach hidden MSM with high HIV yield. It is therefore important to maintain this activity in the package of HIV prevention services if we want to test at least 90% of MSM living with HIV and end AIDS.

FRAD2403 - TRACK D1

Affected or Infected; An Exhibition Showcasing the History of HIV in Uganda

17:15 – 17:30

Nalungu Ruth[1], Kyomugisha Eunice[1], Blackmore Kara[2], Asiimwe Bena Diana[1], Matovu Sylvia[3], Candiru Susan[4], Byonanebye Dathan[1], Kajubi Phoebe[1], Parkes-Ratanshi Rosalind[1,5], King Rachel[6]

[1]Infectious Diseases Institute, Makerere University College of Health Sciences, Kampala, Uganda, [2]London School of Economics, London, United Kingdom, [3]The AIDS Support Organisation(TASO), Kampala, Uganda, [4]Uganda AIDS Commission, Kampala, Uganda, [5]University of Cambridge, Institute of Public Health, Cambridge, United Kingdom, [6]University of California San-Francisco (UCSF), San Francisco, United States

Issues: Since 1984 when the first case of HIV/AIDS became known in Uganda, the disease has metamorphosed from being a death sentence to a chronic disease. The change is attributable to evolution of HIV prevention and treatment strategies towards effective and accessible treatment. The journey of HIV response is an important lesson for response to emerging infectious diseases. We held an exhibition on the History of HIV/AIDS in Uganda and documented experiences and perceptions of the exhibition.

Description: We collaborated with responsible government agencies (National Museum of Uganda, Uganda AIDS commission) to develop an HIV exhibition detailing the journey of HIV response in Uganda. Stakeholder engagements comprising re-

searchers, academicians, politicians, HIV activists, historical figure-heads and PLHIV extensively reviewed audio-visual and print material, artefacts and library collections from government agencies, HIV organizations and private archives. Participatory curation led to development of six themes: unknown, knowing, believing, caring, remembering, surviving (testing, treatment and prevention) and advocacy. The exhibition targeted youths who have not witnessed the days when there was no treatment.
Lessons learnt: Over 100,000 materials were collected in digital form from different achieves were collected and compiled into one digital archive. An exhibition catalogue was produced on newsprint. The exhibition showcased gender inclusive IEC materials, art works, photographs, films, ARVs, condoms, art works and artefacts, herbal and biomedical treatments. There was a display of literature including newspapers, drama scripts, policy and guideline documents. In addition to the digital archive, new audio-visual materials such as talking boxes with client testimonies in different languages, video testimonies from experts and a video of the exhibition experience were developed. The exhibition attracted 2,202 participants (994 females,1208 males, 290 foreigners, 946 students). 913 people were screened for HIV testing eligibility, 356 were tested and 8 (2.2%) were HIV positive and linked to care.
Next steps: We developed a successful exhibition that engaged the wider community with the history of HIV in Uganda and encouraged HIV testing. We aim to take the exhibition around Uganda to engage with and collect more materials from regional and rural communities. We have also been offered a permanent space in the National Museum of Uganda for the exhibition.

FRAD2404 - TRACK D1

Enhancing HIV Awareness and its Prevention among Youth through Music in Rwanda

17:30 – 17:45

Marthe Mukamana[1,2], *Iyamuremye Severin*[1]
[1]Uyisenga Ni Imanzi, Make Music Program, Kigali, Rwanda, [2]University of Rwanda, African Center of Data Science, Kigali, Rwanda

Issues: The 1994 genocide against Tutsi in Rwanda that took more than one million of Tutsi's live resulted in multiple negative psychosocial, community and public health consequences including HIV-associated challenges. The Government of Rwanda has setup strategies to fight against HIV in youths via distribution of condoms, community mobilization, formation of anti-AIDs clubs in schools, post prophylaxis drugs and expansion of male circumcision services.Despite these efforts, there are still gaps among some categories of people whom these messages don't effectively reach like street children. Make Music Program at UYISENGA NI IMANZI (UNM) a non-governmental organization complements the government strategies by establishing free spaces for healing, talents detection and production of youths' songs to enhance HIV awareness and its prevention among youths as most of them are interested in entertainment mostly music.
Descriptions: Since 2014, UNM, Make Music Program has helped to develop tools for HIV prevention and trauma healing among youths. These are song writing, music production and entertainment programs. These have become channels for spreading messages on HIV transmission and prevention and a shelter for those who are HIV+. Within UNM studio, on a quarterly basis, we produce 20 audio songs providing HIV prevention messages, training and healing on trauma. The songs are also spread through electronic and social media like local radio and websites.
Lessons learned: Music and arts play a big role in treatment (psychological, adherence) and prevention of HIV in youths. Data from 326 direct program beneficiaries. A sample of 179 shows that on entry, have little knowledge on transmission means of HIV except unprotected sex and contaminated blood transfusion, which is 100% known. On exit phase, there is a lot of improvement, 95% to 100% are aware on transmission routes and preventive measures of HIV and also, youth peers can influence

each other positively.

Next steps: We're planning to increase the number of direct beneficiaries from 20 to 40 quarterly through group and individual sessions. We will also enhance participation in music production and access to studio for songs production. We also plan to increase the number of community concerts from 2 to 5 quarterly which will provide a good opportunity for program beneficiaries to share their experiences, talent and spreading the message on awareness of HIV to the youth of the same generation.

FRAD2405 - TRACK D1

U-report Zimbabwe: Engaging Adolescents and Young People through a Mobile Platform to Increase their Access to HIV and Sexual Reproductive Health Prevention and Treatment Services

17:45 - 18:00

Pierotti Chiara, Gwatiwa Joneck, Senzanje Beula, Mutsiwegota Shepherd
UNICEF Zimbabwe, Harare, Zimbabwe

Issues: In Zimbabwe, decline of new HIV infections among adolescent and young people (ADYP) has been slow and is projected to remain the same unless innovative, engaging and interactive interventions, including ways of dissemination of prevention information are implemented.

Descriptions: U-Report was introduced by UNICEF Zimbabwe in 2015 and implemented with line Ministries. It's a free SMS through RapidPro platform to/from 176,238 voluntary registered U-reporters (46% Female; 36% ADYP) for real-time monitoring, community engagement and communication.

Lessons learned: May 2018-July 2019, an average of 27,413 ADYP U-Reporters per poll were reached with 10 polls of 5-11 questions. 7 polls to understand ADYP views and knowledge on HIV-related topics to inform Radio Shows; 2 to assess perceived quality of SRH and HIV prevention services and 1 to assess ARVs impact by Cyclone Idai confirming high lost (63%). Analysis showed wide (14%-95%; 23% average) response rate according to topics; higher among girls (59%) and 20-24 age group (70%). 72% ADYP (more among girls 74% and in 20-24 73%) reported access to HIV testing services and 66% to ASRH, only 13% to prevention information on condom use and 4% on STI, particularly among the youngest (15-19) and boys. 57% of 15-19 group don't seek health services because “did not feel like going” or 43% “did not feel comfortable going” due to health workers' attitudes. Knowledge on ARV medication was high in terms of definition (73%), what can affect adherence like drugs/substance abuse (92%), poor nutrition (48%) or fear of disclosure status (48%), lack of privacy for storage in school (33%), poor confidentiality (19%). Few ADYP “knew all three definitions of stigma” (36%; 39% girls and 32% boys) and discrimination (33%), but only 37% will not tell family and friends if tested HIV positive. ADYP reported that mobile technology helped them to speak out freely and know that they are not in isolation. In addition, 55,792 ADYP living with HIV were reached through U-report for counselling and 14% were referred to services as needed.

Next steps: U-report is a game changer for reaching ADYP, especially youngest, with information on prevention and on access to services. U-report can be used for data triangulation and real-time monitoring of ADYP programme, including tracking referral and service utilization. Involvement of ADYP in the preparation of the polls' questions is key to get higher response rate.

TUPEA002 - Evolution of Subtypes of the Human Immunodeficiency Virus Type 1 in Kinshasa over the Last 30 Years: Documentary Review from 1985 to 2015

Kamangu Erick

TUPEA003 - Bridging the Gap for Lost Opportunities

Iho Grace

TUPEA004 - Emergence of Novel HIV Polymerase Mutations Associated with Treatment Intensification in Cameroon

Bimela Chrysantus, Tiencheu Bernard

TUPEA005 - Involvement of the Genetic Diversity of HIV-1 in the Virological Treatment Failure of First Line Antiretroviral in Kinshasa

Kamangu Erick

TUPEA006 - Molecular Epidemiology of Human Immunodeficiency Virus Type 1 and Therapeutic Monitoring of Patients Treated in Kinshasa/Democratic Republic of the Congo

Kamangu Erick

TUPEA007 - Frequencies of Molecular Markers of Resistance to Non-nucleotide Inhibitors of Reverse Transcriptase in Treatment-naive HIV-infected Patients in Kinshasa

Kamangu Erick

TUPEA008 - Non-CRF02_AG HIV-1 Infections Dominated by URFs In, and Absence of Transmission Links between Three Selected Neighboring Coastal Countries of West-Africa: Senegal, Guinea, Mauritania

Aristid Ekollo Mbange

TUPEA009 - Genetic Diversity and Detection of HIV-1 Resistance to Protease Inhibitor in Nigeria

Oladipo Elijah Kolawole

TUPEA010 - Modelling HIV/AIDS Disease Progression: A Parametric Semi-Markov Model with Interval Censoring

Asena Tilahun

TUPEA011 - The Role Played by the National Biorepository in HIV Patient Management and Clinical Research in Uganda

Semanda Patrick, Nansumba Hellen

TUPEA012 - Maraviroc and HIV-1 Subtype C Predicted Co-receptor Usage in Africa: An Individual Sequence Level Meta-analysis

Matume Daphney

TUPEA013 - Dynamic and Geographical Distribution of HIV-1 Subtypes in Africa

Diouara Abou Abdallah Malick

TUPEA015 - Potential of Interleukin 7 (IL-7) and CD4/CD8 Ratio as Markers of Immune Reconstitution in HIV Patients on Antiretroviral Therapy in Yaoundé, Cameroon

Happi Mbakam Cedric, Okomo Assoumou Marie Claire, Agueguia Azebaze Franklin, Messembe Martha, Lyonga Emilia, Mondinde Ikomey George

TUPEA016 - Analysis of CD4+Foxp3+ Regulatory T Cells (Tregs) and Immune Status of HIV Infected Patients under Antiretroviral Therapy

Ndishimye Pacifique

TUPEA017 - Natural Killer Cells Kir Genes Profile Implicated in HIV-1 Disease Progression in the Context of Anti-retroviral Naïve HIV-1 Infection

Sake Ngane Carole Stéphanie, Bimela Jude , Tchadji Jules Colince, Lissom Abel

TUPEA018 - Low-level CD4+ T Cell Activation among Seronegative Partners in HIV-1 Heterosexual Serodiscordant Couples Is Associated with Increased Condom Use

Camara Makhtar, Diallo Abdou Aziz, Diaw Papa Alassane, Mboup Souleymane, Ndiaye Dieye Tandakha

TUPEA019 - Factors Influencing Non-VL Suppression among PLHIV in Borno State: A Case of USUMH

Fadoju Sunkanmi

TUPEA020 - Is Retesting an Approach to Be Implemented in All Settings? An Experience from a Pilot Conducted in Mozambique

Amane Guita, Chicuecue Noela, Couto Aleny

TUPEA021 - HIV-P24 Antigen among HIV Antibody Seronegative Pregnant Women Attending Adeoyo Maternity Teaching Hospitals (AMTH), Ibadan, South Western Nigeria

Oluremi Adeolu

TUPEA022 - HIV Seroprevalence, Self-reported STIs and Associated Risk Factors among Men who Have Sex with Men: A Cross-sectional Study in Rwanda, 2015

Shema Eliah, Saba Ntale Roman, Rutayisire Gad, Mujyarugamba Pierre, Greatorex Jane, Frost Simon David William, Kaleebu Pontiano

.

TUPEA023 - Impact of Peer to Peer Mechanism in Increasing Access of Pregnant Women to E-MTCT/PMTCT Services in Nigeria

Izuchukwu Amah Fortune

TUPEA024 - Key Population, a Major Driver of HIV Epidemics in Abia State Nigeria

Ajike Eme

TUPEA025 - Seroreversion in Infants Born to HIV Seropositive Mothers

Metoudou Anselme, Olivier Ngono

TUPEA026 - Early Sexual Debut and Associated Risk Factors among Youth in Rwanda, 2015

Umutesi Justine

TUPEA027 - Positive Predictive Value for HIV Mother to Child Transmission, in Area with Limited-resources, Bilene-Mozambique

Osorio Dulce

TUPEA028 - Predictors for Virological Non-suppression among HIV Infected Pregnant Women in Lira, Northern Uganda: A Cross-sectional Study

Agnes Kasede

TUPEA029 - Enhancing HIV Prevention among Girls by Fighting Child Marriage and Sexual and Gender Based Violence

Kauluka Shora Manuel

TUPEB030 - Characteristics of HIV Infected Children Dying before ART Initiation in Eswatini

Masuku Thembie

TUPEB031 - Feasibility and Challenges of Mobile Phone Peer Mentoring and Education Support in Nigeria (an Ongoing Project by APYIN with Support from IHVN)

Blessing Ogodo Gloria

TUPEB032 - Access to Sexual Reproductive Health Service for MSM and Transgender Women in Harare, Zimbabwe

Kuyala Raymond

TUPEB033 - Relation entre le Réservoir Viral et le Succès Thérapeutique chez des Adultes Ayant Initié Précocement les Traitements Antirétroviraux (TARV)

N'takpé Jean Baptiste, Gabillard Delphine

TUPEB034 - Rapprocher des Jeunes l'Information et les Services de Santé Sexuelle et Reproductive, y Compris de VIH/SIDA, à Travers le Numérique

Dzola God-Abel, Nzickou Dyobaltine Claude Emmanuelle

TUPEB035 - Présentation Tardive aux Soins des Adultes Séropositifs au VIH et Facteurs Associés à Abidjan (Côte d'Ivoire) a l'Ere du ''Test and Treat''

Dossou-Yovo Senan Gatien Aurele, Ouedraogo Abdoul Gafourou Arsene

TUPEB036 - Qualitative Detection of Proviral-DNA of HIV-1 in Infants to Determine the Efficacy of Antiretroviral Therapy in the Prevention of Vertical Transmission of HIV-1 in the Gambia

Cham Lamin B

TUPEB037 - HIV Testing and Linkage to Care in Rwanda, Assessment Made in 5 Selected Sites for the Period of July 2018 to May 2019

Gasana Michael, Musengimana Gentille, Mutunge Elise

TUPEB038 - Facteurs Associés à la Dysfonction Sexuelle Féminine chez les PVVIH de Novo au Burkina Faso

Traoré Solo, Guira Oumar, Tieno Hervé, Zoungrana Lassane, Bognounou Réné, Drabo Joseph Youssouf

TUPEB039 - Expérience d'Alliance Côte d'Ivoire dans l'Amélioration du Taux d'Enrôlement des PVVIH dans les Soins dans 39 Districts Sanitaires

Tietio Zogba Jean Baptiste, Koussan Ives Roland

TUPEB040 - Prevalence of HIV Status Disclosure among Young Adolescent Enrolled on ART in Johannesburg

Chadyiwa Martha

TUPEB041 - The Effectiveness of Pictogram Intervention in the Identification and Reporting of Adverse Drug Reactions in Naïve HIV Patients in Ethiopia

Abegaz Tadesse Melaku

TUPEB042 - Impact d'un Paquet Minimum d'Interventions sur le Succès Thérapeutique au Long Terme et la Mortalité sous Traitement ARV dans les Pays à Ressources Limitées

Bognon Tanguy, Ladjouan Mohamed, Challa Sylvie, Incho Marie Noelle, Semondji Hervé Loic, Azondékon Alain

TUPEB043 - Caractéristiques Épidémiologiques et Cliniques des Personnes Vivant avec le VIH (PVVIH) Décédées en 2018 dans les Structures Sanitaires au Burkina Faso

Ouedraogo Smaila

TUPEB044 - IRIS Associated with Thrombocytopenia in a Patient Living with HIV

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FRPED276 - Documentation of Cultural, Social and Gender Factors that Lead to Low Retention and Participation of Adolescent Girls and Young Women Living with HIV in HIV Prevention, Care and Treatment Services

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FRPED279 - Special Needs and Sign Language Training for Primary Counsellors in Zimbabwe

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FRPED280 - Attitudes and Knowledge Regarding HIV/STDs amongst Migrant and Transactional Sex Workers in Goma DRC

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FRPED281 - Levels and Determinants of Knowledge of HIV/Aids amongst Women in South Africa

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FRPED294 - Use Sexual and Reproductive Health Services, Including HIV/AIDS, by Adolescent Refugees in Mahama Camp, Rwanda

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FRPED298 - Engaging Discordant Couples through Psychosocial Support Services to Address Gender Based Violence at AIDS Information Centre (AIC), Uganda

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FRPED304 - GBV Survivors Opt out from Holistic Care: Findings from a Review of Post GBV Response in Health Facilities in Southern Nigeria

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FRPED305 - The Effect of Intimate Partner Violence on Implementation of HIV Services: A Cross-sectional Analysis of HIV Infected Women in Coastal Kenya

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FRPED306 - Impliquer La Population Générale dans la Riposte du VIH chez les LGBTQ et Respect des Droits Humains

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FRPEE311 - Engagement of and Collaboration with State Stakeholders: Key to the Success of the Nigerian AIDS Indicator and Impact Survey

Aguolu Rose, Edward Chigozie, Ashefor Gregory

FRPEE312 - Scaling-up Viral Load Testing in Treatment Monitoring of HIV/AIDS Clients on Combined Antiretroviral Therapy in Project Concern International Supported Defense Force Zambia Health Facilities

Tembo Aaron K., Musonda Shebba E., Kafweta Cunningham, Mulenga Yvonne

FRPEE313 - Stakeholder Engagement in Changing the Narratives around Issues Affecting Lesbian Gay Bisexual Transgender and Intersex (LGBTI) Communities in Nigeria

Nnolum Chukwuebuka, Alubumgu Basiru

FRPEE314 - Strengthening Collaborative Partnerships: Role and Impact of Research Partners in Creating a Conducive Policy Environment for Key Populations in Kenya
Owino George Victor1

FRPEE315 - Evidence-based Behavioral Change Communication Materials as Effective HIV Peer Education Interventions among Female Sex Workers

Addison-Fynn Mary, Appiah Evans

FRPEE316 - Management Stratégique du Programme de Lutte contre le VIH/SIDA dans les Forces Armées au Sénégal

Toure Mor Talla1, Diallo Gorgui Sene

FRPEE317 - Domestic Financing towards Ending HIV&AIDS in Uganda through Voluntary Contribution of One Dollar to the Private Sector Led Fund

Tamale George

FRPEE318 - The Impact of PMTCT Intervention in Private Health Facilities Rivers State Nigeria, in Reducing Mother to Child Transmission of HIV

Aneke Chukwunonye

FRPEE319 - Leveraging Mobile Technology & Creative Storytelling to Enhance HIV Prevention, Care and Treatment for Children and Adolescents Using the Kidzalive Talk Tool Mobile Application

Mutambo Chipo

FRPEE321 - Empowering Zambia Millennials: Tapping into Technology to Meet their Sexual Reproductive Health and Rights/ HIV Needs

Meda Kudzai

FRPEE322 - Artificial Intelligence to Improve Access and Task Shifting for HIV Services

Popoola Victor Oluwatobi, Popoola Eunice Oluwadamilola, Abikoye Oluwakemi Christiana

FRPEE323 - Impact of Provision of Mobile Phones for Communication Between Healthcare Workers and People Living with HIV in Sierra Leone

Amahowe Franck, Ngwatu Brian, Jalloh Memuna

FRPEE324 - Unlocking Rwanda's Genomic Research Potential towards Delivery of Individualised HIV Diagnosis, Treatment and Surveillance: Bio Banking, Genomics and Virtual Sequences Model (BRT BioGenomics)

Karame Prosper, Ndishimye Pacifique

FRPEE325 - Continuous HIV Data Quality Improvement through Use of Facility Champions and Adoption of Electronic Medical Records in EMR Supported Hospitals in Kericho County, Kenya

Ronoh Patrick

FRPEE326 - Impact of Electronic HIV Testing Services (eHTS) on Uptake and Documentation of HIV Testing Services; A Data Quality Assessment of Electronic Data in Kisumu, Western Kenya

Omondi Felix

FRPEE327 - Experience from Scale-up Integrated Testing of HIV-1 Qual and MTRIF GeneXpert Assays in 69 Health Facilities in Ethiopia

Abate Zelalem, Assaye Biruhtesfa, Bellete Bahrie

FRPEE328 - Using RADA Mobile App to Reduce the Rates of HIV Prevention among University Students: A Case of University of Nairobi, Kenya

Kivuvani Mwikali

FRPEE329 - Impact of Prioritized Community Symptomatic Testing (P-COST) Model; An Approach for Improving HIV Fast Track Strategy (FTS) in Rural Communities in North-Central Nigeria

Nwabueze Emmanuel, Poopola Victor, Nedu Austin, Abiaziem Greg

FRPEE330 - Enhancing Transmission of Laboratory Results Using Mobile Technology to Reduce Turnaround Time for Delivery of Care to People Living with HIV/AIDS: Experience from SMS Printers to mLab in Kenya

Mudogo Collins, Mwangi Cathy

FRPEE331 - Application of Mobile Money Payment Solutions in HIV/AIDS Program Management: Community Health Workers in Zambia

Mulumba Clive, Monze Muleya, Francis Kasonde

FRPEE332 - Mobile Clinic Reaches Men who Have Sex with Men (MSM) with HIV Testing and Linkage to Care: A Case Study from Ghana

Darko Mensah Matilda, Vanderpuye Naa Ashiley, Sorensen Guro, Ayeh Kissedu Phinehas, Cole Jazmin, Effah Solomon, Kowalski Mark

FRPEE333 - Leveraging Online Spaces to Increase MSM HIV Program Access: Lessons Learnt from Key Population Virtual Mapping Study in Nigeria

Ezirim Idoteyin, Adebanjo Tosin, Ashefor Greg

FRPEE334 - The Contribution of Treatment as Prevention among MSMs and Male Sex Workers Living with HIV in Nairobi, Kenya

Gathatwa James, Mathenge John, Irungu Pascal, Angote Priscah, Njue Kenneth, Maina John, Chege Wanjiru

FRPEE335 - Cascading HIV Awareness and Prevention Program to Key Populations in Nigeria through Micro-planning - Lessons Learnt in FCT & Ekiti State

Chukwuebuka .C. Ejeckam

FRPEE336 - Leaving Noone Behind: Addressing the Unique Needs of Men who Have Sex with Men in Mutare, Manicaland Province, Zimbabwe

Nyamasoka Moses

FRPEE337 - Scaling up HIV Prevention Programmes for and with Adolescent and Young Key Populations through an Online Toolkit

Faugli Bente, Zhukov Ilia

FRPEE338 - Stratégie d'Approche Communautaire Intégrée dans l'Atteinte des 90-90-90 chez les Usagers de Drogues (UD) Précaires d'Abidjan (Côte-d'Ivoire)

Boulet Renaud, Kouadio Denise, Agnimel Armande, Koné Hamidou, Diomandé Masséni, Toha Marie Julie, Hié Mathieu

FRPEE339 - Partnership to Break Structural Barriers to Access to Sexual Reproductive Health /HIV and Gender-based Violence Services: Role of Inter Religious Council of Uganda

Ogolla Rachel

FRPEE340 - Violence against Male, Female and Transgender Sex Workers in Kenya; Sex Worker-led Research into Risks, Mitigation and Access to SRHR

Groot Anna Maria

FRPEE341 - The Nexus: Programming with Legal Facilitators and Improved Overall Case Finding and ART Uptake among Key Populations who Are Victims of Violence in Nasarawa State

Uji Rudolf Oche ,Zakka Timothy

FRPEE342 - Young Women who Sell Sex (YWWSS) in Bangui, Central African Republic: A Neglected Group Highly Vulnerable to HIV

Longo Jean De Dieu

FRPEE343 - Consistent and Correct Use of Condom Usage as a Factor to Reduce the Spread of New HIV Infections among MSM in Oyo State, Nigeria

Onumabor Jude, Efa Obono, Kingsley Ajana

FRPEE344 - Involving Grassroots Authorities in Addressing HIV/AIDS and Discrimination against Key Populations

Gapira Jean Faustin

FRPEE345 - Accelerating Viral Load Suppression among Gay Men, Men who Have Sex with Men and Male Sex Workers in Mombasa County through Community Led Initiatives

Kyana Martin

FRPEE346 - Moonlight HCT the Way to Go for MSM in Tororo/Malaba-Uganda Border

Ayoo Proscovia

FRPEE347 - HIV Treatment Enrollment and Adherence for Key Populations (SW, MSM, TG and PWID) at the Stand Alone Drop in Center Operated by PSI, Liberia

Freeman, W S Josephine

FRPEE348 - Increasing Access to HIV, SRHR Andother Healthcare Services for Intersex People in Zimbabwe

Zuze Ronika

FRPEE349 - Reaching Hard to Reach Men who Have Sex with Men (MSM) in Ghana through Traditional Healers: A Case Study of Maritime Life Precious Foundation

Acquah Robert Kobina, Ekem-Ferguson George, Owusu Asante Mark K, Wosornu Senyo, Kwofie , Edward

FRPEE350 - Etude Pilote sur l'Accès au Dépistage de l'Infection à VIH et au Traitement Antirétroviral chez les Populations Clés dans le District Sanitaire d'Oussouye, Région de Ziguinchor

Diatta Diombraise Gabriel

FRPEE351 - The Uptake of Sexual Reproductive Health and Rights (SRHR) Services among Adolescent Girls and Young Women in Kaduna State, Nigeria

Sunday Haruna Aaron

FRPEE352 - Le Dépistage du VIH/SIDA Fait par les Communautaires MSM

Bah-Bi Boti Elise, Njaboue Philippe Gesvais

FRPEE353 - La Problématique de la Grossesse Non Désirée chez les TS a l'USAC de Kayes

Bane A, Dembele Bintou, Bah D1, Fomba Y

FRPEE355 - Sexual and Reproductive Health Knowledge, Attitude and Practice among Young Persons with Disabilities (PWD); A Case Study of Three Clusters in Lagos

Oluwa Enitan Sophie

FRPEE356 - Early Changes in Family Planning Uptake among HIV-negative Female Sex Workers Initiating Oral Pre-exposure Prophylaxis (PrEP) in Kenya

Waruguru Gladys, Manguro Griffins

FRPEE357 - Treatment as Prevention and Pre-exposure Prophylaxis for Female Sex Workers: Service User Costs of Care in Cotonou, Benin

Cianci Fiona

FRPEE358 - Stratégies d'identification et de Rétention des HSH dans les Soins VIH dans un Centre de Traitement Ambulatoire (CTA) en Afrique de l'Ouest

Gueye Mamadou

FRPEE359 - Barriers and Facilitators of HIV Care Provision for HIV-positive Men who Have Sex with Men in Ghana: The Perspectives of HIV Care Providers

Gyamerah Akua O.

FRPEE360 - Premières Données sur l'Infection à VIH en Milieu Carcéral à Bangui

Mossoro-Kpindé Christian Diamant, Mossoro-Kpindé Hermione Dahlia

FRPEE361 - Delivering Integrated Package of HIV Prevention for Adolescents: Experience from Two Years of First Time Young Mothers Project in Rwanda

Hagenimana Felix, Mukamurara Helene R., Musonera Grace Kaneza, Akimana Rachel, Kalisa Isabelle, Umutesi Geraldine, Umutoni Sandrine

FRPEE362 - Effect of Time Change on Adolescent and Young People Accessibility to AYFHC in Akure, Ondo State, Nigeria

Aiwanfo Onesimus

FRPEE363 - Scaling Up Undetectable = Untransmittable Campaigns within Key Population Drop-in Centers in Kilifi and Mombasa Counties, Kenya

Owira Patricia, Manguro Griffins

FRPEE364 - Dépistage Communautaire au Cameroun: La Solution pour Toucher les HSH «Hard to Reach» de la Ville de Yaoundé ?

Olongo Ekani Antoine Silvère

FRPEE365 - L'Impact du DIC (Drop in Center) sur la Prise en Charge des LGBTIQ au Togo

Avouglan Kodjo Sena

FRPEE366 - Peer-based Distribution of HIV Self-test Kits among Key Population at Work Places in Kampala, Uganda

Kirungi Gloria

FRPEE367 - Micro-planning with Sex Workers: Peer Education for Sex Worker Health Service Provision within the Public Health Sector. This Documentation Relates to the Midlands Province in Zimbabwe

Manyika Jeremia

FRPEE368 - Family Characteristics and Health-related Quality of Life of Persons Living with HIV/AIDS Attending a Comprehensive Treatment and Care Centre in Southwest Nigeria

Adebayo Ayodeji

FRPEE369 - Evaluation Quantitative de l'Impact des Médiatrices Communautaires dans l'Atteinte de l'Objectif 90-90-90 chez les Travailleuses du Sexe Séropositives au Centre Médical Oasis au Burkina Faso

Traore Abdoulazziz Soundiata

FRPEE370 - La Stratégie des Médiateurs : Un Modèle de Participation Communautaire pour Améliorer l'Accès des PVVIH surtout Populations-clé aux Services de Santé

Ndiaye Serigne Cheikh

FRPEE371 - 'The Clinics Are Unsafe': Contextualising Access to Healthcare for Young Gay Men in Southwestern Nigeria

Ekerin Olabode

FRPEE372 - Outreach Initiation and Management (OIM): The HIV Care Cascade in the Community

Zokufa Nompumelelo, Keene Calire, Lebelo Keitumetse, Cassidy Tali, Gwashu Fanelwa, Sibanda Berly, Trivino Duran Laura, López Paola

FRPEE373 - The First Key Population-competent Healthcare Worker Training in Namibia Improved Knowledge and Attitudes

Abang Roger, Goyti Stephen, Oladapo Gbenga Austen

FRPEE374 - Prise en Charge des Pathologies Anales dans le Cadre des Services en Santé Sexuelle chez les HSH au Cameroun. Implications pour la Dé-Stigmatisation de la Santé Anale pour tous

Ntetmen Mbetbo Joachim

FRPEE375 - Cartographie et Évaluation des Sites Fréquentés par les Populations Clés en Guinée Bissau

Ba Ibrahima

FRPEE376 - Non-Communicable Diseases and HIV: Costs, Effects and Efficiency of Integrated Screening and Testing Services for Men in Democratic Republic of Congo (DRC)

Adetunji Oluwarantimi, Gill Michelle, Mukherjee Sushant

FRPEE377 - Blood Pressure Self-monitoring Is Feasible and Acceptable for Adults with HIV and Hypertension in the Kingdom of Eswatini

Schaaf Andrea, Zech Jennifer

DAY	Tuesday	03 December 2019

Session Title:	EBOLA
Venue:	Kigali (Auditorium)
Time:	10:45 -12:15 hrs
Speakers:	Dr. Ibrahim Socé Fall & Dr. Augustin Karumba
Session Chair:	Prof. Myung Lee
Session Co-Chair:	Dr. Sabin Nzanzimana

Session Title:	What is new in HIV Prevention?
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	12:45 – 14:15 hrs
Speakers:	Dr. Gambo Gumel Aliyu, Prof. Quarraisha Abdool Karim, Julia Samuelson and Prof. Helen Rees
Session Chairs:	Prof. John Idoko and Dr. Anthony Nsiah-Asare

Session Title:	Differentiated Service Model (DSDM) Treatment Strategies – Does it meet the needs women and AGYW and other Key Populations?
Venue:	Joel Nana (AD 10)
Time:	16:45 -18:15 hrs
Speakers:	Dr. Mpundu Ribakare, Dr. Camille Anoma & Dr. Peter Preko
Session Chair:	Dr. Aliou Sylla

Session Title:	“Nothing for us without us: The realities of youth, adolescent girls and women leading the HIV response in Africa”
Venue:	Kigali room (Auditorium)
Time:	16:45 -18:15 hrs
Speakers:	Amb. Deborah Birx, DREAMS/PEPFAR, Nyasha Sithole - Athena Network & Janet Bhila - Global Network of Young People Living with HIV (Y+ Network)
Session Chair:	Winny Obure

Session Title:	Meaningful Youth Engagement towards an AIDS Free Africa; Youth Lead the Way
Venue:	Kigali room (Auditorium)
Time:	16:45 – 18:15 hrs
Speakers:	Yordanos Tewolde, Dr. Jane Okrah & Dollarman Fatinato
Session Chair:	Georgina Obonyo

DAY	Wednesday	04 December 2019
	Session Title:	20 years after Abuja, what next?
	Venue:	Prof. Madeleine Okome (MH 3)
	Time:	10:45 -12:15 hrs
	Speakers:	Winnie Byanyima, H.E Amira El-Fadil, Ricki Kgositau, Rosemary Mburu, Amar Anad & Raphael Yvette Alta
	Session Chair:	Dr. Meskerem Grunitzky
	Session Co-chair:	Dr. Ihab Ahmed

DAY	Thursday	05 December 2019
	Session Title:	Effective Engagement of CSO and Key populations in the Funding Mechanisms (PEPFAR and GLOBAL FUND) - what has been achieved, and what needs to be done?
	Venue:	Jeanne Gapiya (MH 4)
	Time:	10:45 – 12:15 hrs
	Speakers:	Allan Maleche, Augustin Dokla, Richard Lusimbo & Margarate Happy
	Session Chair:	Berry Nibogora
	Session Co-chair:	Serge Douomong

	Session Title:	Role of local community leaders in the HIV response and developing resilient communities.
	Venue:	Jeanne Gapiya (MH 4)
	Time:	12:45 – 14:15 hrs
	Speakers:	King Oyo Nyimba Kabamba Iguru Rukidi IV, Sage Semafara, Bishop Gasatura Nathan & Imam Cissé Djiguiba
	Session Chair:	Lois Chingandu

	Session Title:	SAA, WHO AFRO & MOH Rwanda: Scaling up Testing and Access to Treatment for Viral hepatitis in Africa Vs Promoting Hepatitis B & C testing and treatment in Africa
	Venue:	Joel Nana (AD 10)
	Time:	12:45 -14:15 hrs
	Speakers:	Hon. Dr. Al-Hassany, Dr. Donald Kaberuka, Dr. Olufunmilayo Lesi, Dr. Sabin Nsanzimana, Dr. Djoudalbaye Benjamin & Dr. Craig McClure
	Session Chair:	Hon. Dr. Diane Gashumba

Session Title:	Avenues to better prevention (including PrEP) and Zero Transmission: The role of, Young people, Key Populations, Family Community, Program Services and Government Innovation or Sustainable Implementation: How to improve services to reach the global targets (90-90-90)
Venue:	Kigali room (Auditorium)
Time:	12:45 – 14:15 hrs
Speakers:	Nicholas Niwagaba, Catherine Sozi, Nandi Putta & Brian Kanyemba
Session Chair:	Chilufya Kasanda

Session Title:	Youth leadership to end HIV epidemic
Venue:	Kigali room (Auditorium)
Time:	16:45 – 18:15 hrs
Speakers:	King Oyo Nyimba Kabamba Iguru Rukidi IV, Euphrasie Coulibaly, Audrey Nosenga, Alain Patrick Fouda & Emelia Awinebuno Anogya
Session Chair:	Akosua Agyepong

DAY Friday 06 December 2019

Session Title:	Strengthening Community and Faith-based organizations Leadership in HIV/TB Prevention and care: An important action step
Venue:	Prof. Madeleine Okome (MH 3)
Time:	10:45 -12:15 hrs
Speakers:	Dr. Daniel Sarr, Rev. Phumzile Mabizela & Olive Mumba
Session Chair:	Dr. Saidi Mpendu

Session Title:	Mental Health and HIV, children and adolescents: A key strategy to achieve and maintain the third 90
Venue:	Kigali room (Auditorium)
Time:	10:45 – 12:15 hrs
Speakers:	Caroline Yonaba, Baylor Initiative & EVA Network
Session Chair:	Cheick Tidiane Tall

Session Title:	HIV, Migration, the Diaspora and Cultural Competence: Who is getting care and where?
Venue:	Jeanne Gapiya (MH 4)
Time:	14:45 -16:15 hrs
Speakers:	Kwaku Adomako. Cheikh Traore & Brizan Were
Session Chair:	Dr. Marsha Martin
Session Co-chair:	Richard K Matlhare

Session Title:	Facing the Law: Breaking Legislative and Cyber Barriers to HIV/SRHR Services for Young People

Key Issues:

1. The Law as a hurdle to the access of SRHR by Gender Diverse Youth: A Case of Zimbabwean Legislation - Zimbabwe Men against HIV and AIDS (ZIMAHA)/ Advocacy and Research for Men in Zimbabwe (ARMZ)/ The Sexual Rights Centre (SRC)/NeoteriIQ
2. The Age of Consent for adolescents and young people to access HIV and other SRH services: Let's have an African Regional Dialogue - Education as a Vaccine against AIDS (EVA), Nigeria/Uganda Network of Young People Living with HIV (UNYPA)/Association of Women living with HIV in Nigeria (ASHWAN) and Zimbabwe Young Positives (ZY+)
3. Ending SRHR/HIV related Stigma on Social Media and Other Online Spaces - UNFPA Yole Fellows Ghana

Venue: Joel Nana (AD 10)

Time: 12:45 – 14:15 hrs

Speakers: Dr. Karusa Kiragu, Prosperity Ndlovu, Toyin Chukwudozie & Sherifa Awudu

Session Chairs: Dr. Karusa Kiragu & Elizabeth Talatu Williams

Workshop/ Atelier

DAY	Tuesday	03 December 2019
	Session Title:	How to write an Abstract
	Venue:	AD 10 (Joel Nana)
	Time:	12:15 - 16:15 hrs
	Organization:	SAA

DAY	Thursday	05 December 2019
	Session Title:	Transition to Dolutegravir (DTG) regimen: what are the strategies
	Venue:	Kigali room (Auditorium)
	Time:	14:45 – 16:15
	Organization:	PEPFAR Rwanda

	Session Title:	Harm reduction programmes in Africa: policies & progress
	Venue:	Prof. Madeleine Okome (MH 3)
	Time:	12:45 – 14:15 hrs
	Organization:	KANCO, Kenya & PILS, Mauritius
	Speakers:	Naomi Burke Shyne, Kassim Khamis Nyuni, Shaun Shelly, Dr. Michael Katende & Maria-Goretti-Ane

	Session Title:	Prevention of cervical cancer in Africa women living with HIV
	Venue:	Jeanne Gapiya (MH 4)
	Time:	14:45 – 16:15 hrs
	Organization:	Jphiego, Rwanda

	Session Title:	Clinical trials and HIV research: ethics, human rights
	Venue:	AD 10 (Joel Nana)
	Time:	14:45 – 16:15 hrs
	Organization:	MTEK SCIENCES

DAY	Friday	06 December 2019
	Session Title:	Microbiomes and its implications for HIV prevention
	Venue:	Jeanne Gapiya (MH 4)
	Time:	12:45 -14:15 hrs
	Organization:	Nestle Ghana

Non Abstract Driven Sessions/ Sessions Non-Dirigées

DAY	Tuesday	03 December 2019

Session Title:	Political leadership in upscaling services for vulnerable hard-to-reach groups to end AIDS and STIs in Africa
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	14:45 -16:15 hrs
Speakers:	Prof. Miriam Were, Jeanne Gapiya & Rev. Prof. Gideon Byamugisha
Session Chair:	TIta Issac

Session Title:	The evolution of the AIDS response in Africa in a changing context: A call for new leadership, systems for health and financing
Venue:	Prof. Madeleine Okome (MH 3)
Time:	14:45 – 16:15P hrs
Speakers:	Dr. Karusa Kiragu, Dr. Sabin Nsanzimana, Dr. Nduku Kilonzo & Rosemary Mburu
Session Chair:	Dr. Muhammad Pate

Session Title:	Confronting the nexus: sexual risks, drug users, GBV & HIV
Venue:	MH 4 (Jeanne Gapiya)
Time:	16:45 – 18:15 hrs
Speakers:	Sylvia Ayon, Renaud Boulet & Ana Ture
Session Chair:	Steve Letsiki

Session Title:	HIV in uniform services: Re-energizing Armed forces HIV program in the environment of security challenges
Venue:	Kigali room (Auditorium)
Time:	12:45 – 14:15 hrs
Speakers:	Col. Serge CHABI, Col. Babacar FAYE, Major Dr. Abdul Nyanzi, Col. Dr. Floyd Malasha & Dr. Col. Jean Kagimbana
Session Chair:	Col. Dr. Alain Azondekon

DAY	Wednesday	04 December 2019

Session Title:	Community health workers at the frontline: from HIV to integrated health
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	10:45 – 12:15 hrs
Speakers:	Dr. Sabin Nsanzimana, Daouda Diouf, Dr. Ephrem Mensah & IFRC
Session Chair:	Prof. Abebe Bekele

Non Abstract Driven Sessions/ Sessions Non-Dirigées

DAY	Thursday	05 December 2019

Session Title:	Assessing Success of the HIV Prevention and Services Roadmap: Countries report accomplishments; what will it take to get serious about addressing the needs of women and young girls?
Venue:	Kigali room (Auditorium)
Time:	10:45 – 12:15 hrs
Speakers:	Therese Kabale Omari, Yvette Raphaelle & Brenda Facie
Session Chair:	Dr. Marsha Martin
Session Co-chair:	King Oyo Nyimba Kabamba Iguru Rukidi IV

Session Title:	Partnering to Address Stigma and Discrimination: Implementing the Global Action Plan
Venue:	Prof. Madeleine Okome (MH 3)
Time:	10:45 – 12:15 hrs
Speakers:	Cedric Nininahazwe, Sohaila Bensaid & Samuel Matsikure
Session Chair:	Adrienne Munene
Session Co-chair:	Chilufya Kasanda

Session Title:	Key Populations Organizing in Africa; community resilience and Leadership transition for a sustainable HIV Response
Venue:	Kigali (Auditorium)
Time:	10:45 – 12:15 hrs
Speakers:	Lala Mathy, Yves Yomb, Danilo Da Silva, Happy Hassan, Beyonce Karungi
Session Chairs:	Daughtie Ogutu and Frantz Mananga

DAY	Friday	06 December 2019

Session Title:	Young people leadership, participation and access to services: where are we and how do accelerate progress?
Venue:	Jeanne Gapiya (MH 4)
Time:	10:45 – 12:15 hrs
Speakers:	Aaron Sunday, Rodrigue Koffi, Mubanga Chimumbwa & Sandrine Umutoni
Session Chair:	Nicholas Niwagaba
Session Co-chair:	Kunle Adeniyi

Session Title:	Across the continent: East - West/North - South dialogue: Analyzing effective Prevention interventions for Young People
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	16:45 – 18:15 hrs
Speakers:	Yvonne Mpambara, Issac Moses & Audrey Nosenga
Session Chair:	Sibulele Sibaka
Session Co-Chair:	Tochi Akwarandu

Session Title:	The private sector's contribution in domestic financing: myth or reality?
Venue:	Jeanne Gapiya (MH 4)
Time:	16:45 – 18:15 hrs
Speakers:	Prof. Vinand Nantulya, Katie Gilbert & Jasper Klapwijk
Session Chair:	Caroline Yonaba, Baylor Initiative & EVA Network
Session Co-chair:	Cheick Tidiane Tall

HIGH LEVEL SESSION ON VIRAL HEPATITIS

Session Title:
Scaling up Testing and Access to Treatment for Viral Hepatitis in Africa

Organizers: SAA, WHO AFRO & MoH Rwanda

Date: 5th December, 2019

Session room: Joel Nana (AD 10)

Time: 12:45 -14:15

Session Content

Interactive didactic presentations, shared country experiences and high-level panel discussions

Expected outputs:

1. Update on the Viral Hepatitis situation and progress made in its control in Africa
2. Innovative financing solutions for Viral Hepatitis
3. Lessons learnt in Africa
4. Upcoming AU political declaration on Viral Hepatitis

Expected Impact:

1. Saving lives in Viral Hepatitis by screening and treatment
2. Accelerating Hepatitis screening and treatment in Africa
3. Up-scaling Viral Hepatitis for public health impact in Africa

Satellite Symposia

DAY	Monday	02 December 2019
	Session Title:	Paediatric HIV
	Venue:	Joel Nana (AD10)
	Time:	08:30 - 10:30 hrs
	Organisers:	DNDi, Sidaction, MSF
	Session Title:	Leadership of African First Ladies in the fight against HIV and AIDS
	Venue:	Cheick sidy Modibo Kane (MH 1)
	Time:	08:30 - 10:30 hrs
	Organiser:	OAFLAD
	Session Title:	Stigma and Discrimination – How to win the battle
	Venue:	Prof. Madeleine Okome (MH 3)
	Time:	08:30 - 10:30 hrs
	Organiser:	VIROLOGY EDUCATION
	Session Title:	Multi-disease integrated testing, treatment and care innovation
	Venue:	Jeanne Gapiya (MH 4)
	Time:	08:30 - 10:30 hrs
	Organisers:	ASLM, CHAI, EGPAF, UNICEF, Unitaid
	Session Title:	Putting people at the center of SRHR/HIV Integration
	Venue:	Prudence Mabele (MH 2+ Corridor)
	Time:	08:30 - 10:30 hrs
	Organiser:	UNFPA
	Session Title:	Leading Together: The important of HIV self-testing
	Venue:	Joel Nana (AD10)
	Time:	10:45 - 12:45
	Organiser:	OraSure Technologies
	Session Title:	The Role of Faith-Based Organisations for an AIDS Free Africa: the Caritas Internationalis GRAIL Project and the UNAIDS-PEPFAR FBO Initiative
	Venue:	Cheick sidy Modibo Kane (MH 1)
	Time:	10:45 – 12:45 hrs
	Organiser:	CARITAS INTERNATIONALIS

Session Title:	FINANCING FOR GENDER EQUALITY IN THE HIV/AIDS RESPONSE
Venue:	Prof. Madeleine Okome (MH 3)
Time:	10:45 - 12:45 hrs
Organiser:	UN Women

Session Title:	Satellite Symposia
Venue:	Jeanne Gapiya (MH 4)
Time:	10:45 - 12:45 hrs
Organiser:	

Session Title:	WHO/ HE2RO skills building session: Using economic analysis to plan and budget for your HIV testing and PrEP programmes
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	10:45 - 12:45 hrs
Organisers:	Health Economics and Epidemiology Office (HE2RO)

Session Title:	Advanced HIV Disease in Africa: The laboratory driver
Venue:	Joel Nana (AD10)
Time:	13:00 - 15:00 hrs
Organiser:	GHIG

Session Title:	Amplifying our gains in HIV Prevention for Men: Increasing the Impact and Sustainability of Voluntary Medical Male Circumcision in 2020 and beyond
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	13:00 - 15:00 hrs
Organisers:	UNAIDS, WHO, PEPFAR and Jhpiego

Session Title:	DREAMS: Adolescent Girls and Young Women on the Frontlines Against HIV/AIDS
Venue:	Prof. Madeleine Okome (MH 3)
Time:	13:00 - 15:00
Organiser:	PEPFAR

Session Title:	May the force be with you: Empowering stakeholders with evidence to strengthen the HIV response
Venue:	Jeanne Gapiya (MH 4)
Time:	13:00 - 15:00 hrs
Organiser:	Project SOAR/Population Council

Session Title:	Youth driven solutions to multi-faceted HIV risks and vulnerabilities.
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	13:00 - 15:00 hrs
Organiser:	UNFPA

Session Title:	H L session
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	17:00 - 20:30 hrs
Organiser:	H L session

DAY Tuesday 03 December 2019

Session Title:	Multi-Disease Integrated Solutions: Taking yesterday's investments into the future
Venue:	Joel Nana (AD10)
Time:	07:00 - 08:30 hrs
Organiser:	Roche Diagnostics

Session Title:	Adolescent/Youth HIV
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	07:00 - 08:30 hrs
Organiser:	Elizabeth Glaser Pediatric AIDS Foundation

Session Title:	Pathways to self-reliant indigenous partnerships in HIV
Venue:	Prof. Madeleine Okome (MH 3)
Time:	07:00 - 08:30 hrs
Organiser:	CHEMONICS

Session Title:	Providing PrEP as part of comprehensive sexual and reproductive health services for Adolescent Girls and Young Women in South Africa: Lessons and reflections on integration and retention
Venue:	Jeanne Gapiya (MH 4)
Time:	07:00 - 08:30
Organisers:	Unitaid and Wits RHI

Session Title:	General and Key Population Surveys: Why are they needed and what can they teach us?
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	07:00 - 08:30 hrs
Organiser:	ICAP AT COUMBIA UNIVERSITY

Session Title:	
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	10:45 - 12:15 hrs
Organiser:	MYLAN RESERVED

Session Title:	Innovation and Disruption to End AIDS: New thinking is needed to address the crisis in HIV prevention
Venue:	Prof. Madeleine Okome (MH 3)
Time:	10:45 - 12:15 hrs
Organiser:	FRONTLINE AIDS

Session Title:	Session on Prep Costing
Venue:	Jeanne Gapiya (MH 4)
Time:	10:45 - 12:15 hrs
Organiser:	FHI 360

Session Title:	Achieving the 1st 90 - The Key to Ending AIDS in Africa by 2030
Venue:	Joel Nana (AD10)
Time:	14:45 - 16:15 hrs
Organiser:	GNPBH

Session Title:	MDR TB in HIV and non HIV infected individual: implications for HIV/TB coinfections management
Venue:	Jeanne Gapiya (MH 4)
Time:	12:45 - 14:15 hrs
Organiser:	WHO

Session Title:	Quel est le rôle des communautés pour garantir un leadership politique et impacter durablement les stratégies de santé dans les pays ?
Venue:	Prof. Madeleine Okome (MH 3)
Time:	14:45 - 16:15 hrs
Organiser:	Expertise France

Session Title:	The Global Partnership for Action to Eliminate HIV-related Stigma and Discrimination
Venue:	Jeanne Gapiya (MH 4)
Time:	14:45 - 16:15 hrs
Organiser:	UNAIDS

Session Title:	Accelerating UHC on Ending the Epidemics of HIV, TB and Malaria and other Communicable Diseases
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	Leaving no one behind: Accelerating the HIV/AIDS response in West and Central Africa. (IST-C/WA)
Venue:	Prof. Madeleine Okome (MH 3)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	SESSION ON HIV CURE
Venue:	Joel Nana (AD10)
Time:	18:30 - 20:30 hrs
Organiser:	IAS

Session Title:	Implementation of HIV case surveillance
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	18:30 - 20:30 hrs
Organiser:	WHO

Session Title:	Communities at the centre of the response
Venue:	Prof. Madeleine Okome (MH 3)
Time:	18:30 - 20:30 hrs
Organiser:	UNAIDS

Session Title:	
Venue:	Jeanne Gapiya (MH 4)
Time:	18:30 - 20:30 hrs
Organiser:	RBC

Session Title:	Differentiated service delivery to HIV positive adolescents
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	18:30 - 20:30 hrs
Organiser:	CeSHHAR Zimbabwe

Session Title:	HIV drug resistance (HIVDR) survey implementation in Africa: implementation experience and evidence for policy decisions
Venue:	Kigali (Auditorium)
Time:	18:30 – 20:30 hrs
Organisers:	ICAP and Rwanda Biomedical Cente

DAY Wednesday 04 December 2019

Session Title:	Engaging Men and Boys in the SGBV and HIV Prevention Response
Venue:	Joel Nana (AD10)
Time:	07:00 - 08:30 hrs
Organiser:	Sonke Gender Justice

Session Title:	Differentiated Service Delivery and Advanced HIV Disease
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	07:00 - 08:30 hrs
Organiser:	ICAP at Columbia University

Session Title:	Differentiated ART delivery approaches for West and Central Africa: From pilots to plans for scale-up
Venue:	Prof. Madeleine Okome (MH 3)
Time:	07:00 - 08:30
Organiser:	IAS

Session Title:	Satellite Symposia
Venue:	Jeanne Gapiya (MH 4)
Time:	07:00 - 08:30 hrs
Organiser:	
Session Title:	Lessons learnt from implementing Global Fund AGYW interventions in Zimbabwe
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	07:00 - 08:30 hrs
Organiser:	Zimbabwe National AIDS Council

Session Title:	Milestones, new platforms and strategies for HIV and TB vaccines research - an EDCTP overview
Venue:	Joel Nana (AD10)
Time:	10:45 - 12:15 hrs
Organiser:	EDCTP

Session Title:	No time to wait: Kick-starting integration of HIV testing in family planning in east and southern Africa
Venue:	Jeanne Gapiya (MH 4)
Time:	10:45 - 12:15 hrs
Organiser:	WHO
Session Title:	Innovative technologies and Healthcare
Venue:	Joel Nana (AD10)
Time:	12:45 - 14:15 hrs
Organiser:	WHO

Session Title:	Leveraging differentiated ART delivery models to facilitate contraceptive care and TPT completion
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	12:45 - 14:15 hrs
Organiser:	IAS

Session Title:	THE LAST MILE FIRST – MAKING UHC WORK FOR KEY AND VULNERABLE POPULATION
Venue:	Prof. Madeleine Okome (MH 3)
Time:	12:45 - 14:15 hrs
Organiser:	FRONTLINE AIDS

Session Title:	The Case for Scaling up Provision of Comprehensive SRHR services for the 2030 agenda
Venue:	Jeanne Gapiya (MH 4)
Time:	12:45 - 14:15 hrs
Organiser:	UNFPA GHANA

Session Title:	HIV Self-Testing Looking Forward: Targeted, Scalable and Sustainable, Models for Africa
Venue:	Joel Nana (AD10)
Time:	14:45 - 16:15 hrs
Organiser:	PSI

Session Title:	Testing for 2030: New WHO guidelines on HIV testing services – strategies for reaching the undiagnosed
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	14:45 - 16:15 hrs
Organiser:	WHO

Session Title:	Rights, Evidence, Action: Responding to Human Rights Violations to Ensure Access to HIV Services
Venue:	Prof. Madeleine Okome (MH 3)
Time:	14:45 - 16:15 hrs
Organiser:	FRONTLINE AIDS

Session Title:	Ending the HIV epidemic among Adolescent girls and young women in Africa: what will it take
Venue:	Jeanne Gapiya (MH 4)
Time:	14:45 - 16:15 hrs
Organiser:	UNICEF

Session Title:	What's new, what's hot and what's happening in viral hepatitis
Venue:	Joel Nana (AD10)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	Optimising the selection of diagnostic tools to address challenges with epidemic control in key populations
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	16:45 - 18:15 hrs
Organiser:	ABBOTT

Session Title:	TB Preventive Therapy in Persons living with HIV
Venue:	Prof. Madeleine Okome (MH 3)
Time:	16:45 - 18:15 hrs
Organiser:	The Aurum Institute

Session Title:	Bringing innovation to the patient: SAMBA POC for HIV and Hepatitis
Venue:	Joel Nana (AD10)
Time:	18:30 - 20:30 hrs
Organiser:	Diagnostic for the real world

Session Title:	Making Differentiated Service Delivery Work at Scale for Children, Adolescents and Young People - Lessons Learned from Zimbabwe
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	18:30 - 20:30 hrs
Organiser:	Africaid

Session Title:	Integration: Services for HIV and Cervical Cancer Prevention and Control
Venue:	Prof. Madeleine Okome (MH 3)
Time:	18:30 - 20:30 hrs
Organiser:	UNAIDS

Session Title:	Filling the gaps in HIV prevention
Venue:	Jeanne Gapiya (MH 4)
Time:	18:30 - 20:30 hrs
Organiser:	UNAIDS

Session Title:	Key populations and generalized HIV epidemics: New mathematical models to estimate the contribution of unmet HIV prevention needs of key populations to HIV epidemics across sub-Saharan Africa
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	18:30 - 20:30 hrs
Organiser:	Johns Hopkins Bloomberg School of Public Health

Session Title:	Persons with disabilities and access to HIV / AIDS prevention, sexual and reproductive health, and GBV services
Venue:	Kigali (Auditorium)
Time:	18:30 - 20:30 hrs
Organisers:	UNFPA West and Central Africa Regional Office

DAY	Thursday	05 December 2019
Session Title:	Routine Cascade Data Reviews to Accelerate Progress Towards 90-90-90: Effective models, use of standards, best practices, and new tools and innovation.	
Venue:	Joel Nana (AD10)	
Time:	07:00 - 08:30 hrs	
Organiser:	WHO	

Session Title:	Data for a difference: lessons learned from the implementation of the Regional Community Treatment Observatory (RCTO) in West Africa
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	07:00 - 08:30 hrs
Organiser:	ITPC

Session Title:	Faire de la lutte contre le VIH autrement a travers l'inclusion des Personnes Handicapees pour l'atteinte des 3X90
Venue:	Prof. Madeleine Okome (MH 3)
Time:	07:00 - 08:30 hrs
Organiser:	Ministere de la Solidarite et de la Lutte contre la Pauvrete

Session Title:	Supporting TLD transmission through health systems stregtherning and stakeholder coordination
Venue:	Jeanne Gapiya (MH 4)
Time:	07:00 - 08:30 hrs
Organiser:	USAID Global Health Supply Chain Program

Session Title:	Closing the gap on reaching men: Time for action
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	07:00 - 08:30 hrs
Organiser:	IAS

Session Title:	The drive to thrive – How are the children and adolescents HIVexposed yet uninfected doing?
Venue:	Joel Nana (AD10)
Time:	10:45 - 12:15 hrs
Organisers:	IAS, CIPHER

Session Title:	Less HIV More You: Thriving with HIV
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	10:45 - 12:15 hrs
Organiser:	VIIV HEALTHCARE

Session Title:	Enhancing Pediatric Service Delivery: A key to closing the treatment gap for children
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	12:45 - 14:15 hrs
Organiser:	UNICEF

Session Title:	HIV Prevention: Assessing progress and gaps of national HIV prevention responses from a community perspective
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	14:45 - 16:15 hrs
Organiser:	FRONTLINE AIDS

Session Title:	Offre de Sante sexuelle envers les populations clees
Venue:	Prof. Madeleine Okome (MH 3)
Time:	14:45 - 16:15 hrs
Organiser:	Coalition Plus

Session Title:	Community Organizing to end HIV
Venue:	Kigali Room (Auditorium)
Time:	14:45 - 16:15 hrs
Organiser:	Open Society Foundations

Session Title:	How to adopt and implement WHO recommended HIV testing strategies and transform your HIV programme for 2020
Venue:	Joel Nana (AD10)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	HIV and Emerging new viral infection: challenges in prevention and treatment
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	Tuberculosis preventive therapy in Africa: Translating UNHLM rhetoric into reality. (TUB)
Venue:	Prof. Madeleine Okome (MH 3)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	New Treatment Guidelines, Paediatric treatment and Strategies for Transition to DTG regimen
Venue:	Jeanne Gapiya (MH 4)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	Leading Together: How diverse communities can unite to drive the HIV funding agenda
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	18:30 - 20:30 hrs
Organiser:	VIIV HEALTHCARE

Session Title:	SAA General Assembly
Venue:	Prof. Madeleine Okome (MH 3)
Time:	18:30 - 20:30 hrs
Organiser:	SAA

Session Title:	Testing and Linkage to Prevention and Treatment Services
Venue:	Jeanne Gapiya (MH 4)
Time:	18:30 - 20:30 hrs
Organiser:	World Council of Churches-Ecumenical Advocacy Alliance(WCC-EAA)

Session Title:	Parliamentarians Protecting the Sexual and Reproductive health Rights for Key Populations: The case of SADC Parliamentary Forum
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	18:30 - 20:30 hrs
Organiser:	UNFPA

Session Title:	On the roadmap to achieving the 2030 SDG Goals: Issues and Consequences in HIV Prevention and Treatment
Venue:	Kigali (Auditorium)
Time:	18:30 - 20:30 hrs
Organiser:	MSD

DAY	Friday	06 December 2019

Session Title:	U=U Celebrating the Science
Venue:	Joel Nana (AD10)
Time:	07:00 - 08:30 hrs
Organiser:	Prevention Access Organisation

Session Title:	HIV vaccine prevention trials in Africa: understanding the present, planning for the future
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	07:00 - 08:30 hrs
Organiser:	IAS

Session Title:	Strategies de Ã©rinisation de l'integration des services SR/ VIH pour les adolescents, jeunes et Population clees
Venue:	Prof. Madeleine Okome (MH 3)
Time:	07:00 - 08:30 hrs
Organiser:	International Planned Parenthood Federation Africa Region

Session Title:	This Is How We Do It!: Innovations and achievements in communityled delivery of HIV prevention and treatment services by sex workers, gay and bisexual men in East Africa
Venue:	Jeanne Gapiya (MH 4)
Time:	07:00 - 08:30 hrs
Organiser:	UHAI EASHRI

Session Title:	Sustaining the AIDS response: leadership, finance and accountability
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	07:00 - 08:30 hrs
Organiser:	UNAIDS

Session Title:	STI is critical in HIV and Sexual & Reproductive Health Programs: Current Challenges and Opportunities
Venue:	Joel Nana (AD10)
Time:	10:45 - 12:15 hrs
Organiser:	WHO

Session Title:	Triple Elimination of Mother-to-child transmission HIV, syphilis and Hepatitis B and Involvement of African First Ladies - updates
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	10:45 - 12:15 hrs
Organiser:	WHO

Session Title:	Preventing STIs/HIV and unsafe abortion in adolescents and young women - HIV and Hormonal Contraception
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	12:45 - 14:15 hrs
Organiser:	WHO

Session Title:	Promoting a total market approach to sustainable condom programming in the context of a changing financing landscape.
Venue:	Joel Nana (AD10)
Time:	14:45 - 16:15 hrs
Organiser:	UNFPA

Session Title:	Addressing barriers to services for adolescents and young people for achieving universal health coverage – FRH/TAC-Ado)
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	14:45 - 16:15 hrs
Organiser:	WHO

Session Title:	Data-driven tailored programming for the Last Mile to eMTCT
Venue:	Prof. Madeleine Okome (MH 3)
Time:	16:45 - 18:15 hrs
Organiser:	UNICEF

Session Title:	Preventing, monitoring and responding to HIV drug Resistance in Africa: what are the current data
Venue:	Joel Nana (AD10)
Time:	16:45 - 18:15 hrs
Organiser:	WHO

Session Title:	Adolescent.e.s et Jeunes vivant avec le VIH, nous sommes là ! Pair-éducation et mobilisation en Afrique de l'Ouest et du Centre
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	18:30 - 20:30 hrs
Organiser:	Sidaction/Reseau Grandir Ensemble:

Session Title:	Achieving the 90-70-90 Cervical Cancer Goals in Vulnerable Populations
Venue:	Prof. Madeleine Okome (MH 3)
Time:	18:30 - 20:30 hrs
Organiser:	Jhpiego

Session Title:	Key Population
Venue:	Jeanne Gapiya (MH 4)
Time:	18:30 - 20:30 hrs
Organiser:	ANCS

Session Title:	NAIIS 2018: Getting to Zero
Venue:	Prudence Mabele (MH 2+ Corridor)
Time:	18:30 - 20:30 hrs
Organisation:	University of Maryland Global Initiatives Corporation Nigeria

Session Title:	A Partnership for Progress: The Critical Role of Community Engagement in Strengthening HIV Treatment Programs
Venue:	Kigali (Auditorium)
Time:	18:30 - 20:30 hrs
Organisers:	Clinton Health Access Initiative (CHAI), AfroCAB, and Unitaid

DAY Saturday 07 December 2019

Session Title:	Reframing Rights Equality for Transgender Movements' in Africa: the role of community action in delivering SDGs
Venue:	Joel Nana (AD10)
Time:	07:00 - 08:30 hrs
Organiser:	Trans Alliance

Session Title:	HIV-sensitive Social Protection
Venue:	Cheick sidy Modibo Kane (MH 1)
Time:	07:00 - 08:30 hrs
Organisers:	WFP/ILO/UNAIDS

Session Title:	Innovation, Community, and Political Leadership
Venue:	Prof. Madeleine Okome (MH 3)
Time:	07:00 - 08:30 hrs
Organiser:	UNAIDS

Session Title:	Condom Stigma: Facts or Myths? Lessons From the Community
Venue:	Jeanne Gapiya (MH 4)
Time:	07:00 - 08:30 hrs
Organiser:	National AIDS Control Council - Kenya

Abbott

Abbott is a global leader in in vitro diagnostics with one of the broadest portfolio of businesses spanning nearly every segment – point of care, immunoassay, clinical chemistry, hematology, blood screening, molecular, and informatics. Abbott's life-changing tests and diagnostic tools provide accurate, timely information to better manage health. We're empowering smarter medical and economic decision making to help transform the way people manage their health at all stages of life.

AFRICA BIOSYSTEMS LIMITED

We are a Biotechnology Company incorporated in Nairobi, Kenya since 1999. Our mission & vision is to be a ready, reliable and ethical partner of choice in life science solutions to make a safer, peaceful and productive society in the region. We are committed to increasing exposure of product lines, build capacity and enhance knowledge within emerging Eastern Africa markets to use life science technology to improve research and commercial activities. We are driven by the principles of ethical practices, integrity and dedication to customer service.

We have regional presence in Kenya, Uganda, Tanzania, Rwanda, Burundi, Eriteria, Ethiopia, South Sudan & Somalia.
We distribute the following product range from Thermo Fisher Scientific:

1. Life Science Group (LSG) Instruments, reagents and other consumables
2. General Laboratory products - Laboratory Product Group Division
3. Anatomical Pathology Division
4. Laboratory Information Management System

We also provide service & support of instrumentation by factory trained and certified engineers. We are also a member of the United Nations Compact Group. The UN Global Compact is a principle- based framework for businesses, stating ten principles in the areas of human rights, labour, the environment and anti-corruption.

AHF
AIDS HEALTHCARE FOUNDATION

What's Yo Style? Fun, Bold, Creative & Safe
As part of innovative approaches to address the spate of new HIV infections among young people, the AIDS Healthcare Foundation launched its hugely successful 'STYLE UP' campaign. At the 2019 International Conference on AIDS and STIs in

Africa (ICASA), AHF's exhibition booth will fly the 'STYLE UP' campaign flag, with young people at the centre.

Interactions will focus on what Style means to young people within the context of HIV Prevention, Sexual Reproductive Health and Positive Masculinity. Join us to learn what message speaks their language.

AUROBINDO
Committed to healthier life!

Aurobindo Pharma Ltd, one among the largest ' Vertically Integrated ' pharmaceutical companies in India, has the robust product portfolio spread over major product areas encompassing Anti-Retroviral, CVS, CNS, Antibiotics, Gastroenterologicals, Anti-Diabetics and Anti-Allergic with approved manufacturing facilities by USFDA, UKMHRA, WHO, MCC-SA, ANVISA-Brazil for both APIs & Formulations.
Aurobindo Pharma is one of the major suppliers of ARVs, transforming lives of nearly 5 million PLHIVs.
With 3 decades of experience, 27 manufacturing facilities, 7 R & D centres and more than 20000 plus employee base, Aurobindo is one of the fastest growing generic companies in the world.

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avacarehealth
caring for africa

Avacare Health Group is an integrated innovative Healthcare Company providing holistic healthcare solutions in Africa, the Middle East and India. We provide specialized health services; Manufacture, Market, distribute and supply essential medicines, medical devices and consumables, and consumer health products.

Our team is comprised of talented and dedicated individuals, passionate about the realization of our vision. We have a diverse set of knowledge, skills and competencies. We believe in education and the development of people within our Group and across the Continent. We utilize evidence-based, interdisciplinary team approach and collective vision to inspire our Group to continue to deliver exceptional results.

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eCentre Convivial

L'Association des Volontaires pour la promotion des Jeunes (AV-Jeunes) est une structure de jeunes créée depuis 15 ans pour prendre en compte prioritairement les problèmes de santé sexuelle et reproductive des Jeunes et Adolescents au

Togo. Prestataire de la subvention TGO-H-PMT n°1467 financée par le Fonds mondial, AV Jeunes est également en collaboration respectivement avec UNFPA qui apporte sa contribution pour la prise en charge partielle de l'implémentation et du fonctionnement de la plateforme eCentre Convivial ; ONUSIDA et PNUD ont conjointement financé ponctuellement le développement du dispositif du suivi de la grossesse et vaccinal de l'enfant ; l'Ambassade des Etats Unis a financé ponctuellement l'enrôlement des jeunes filles pour le suivi du cycle menstruel et le CRL YALI Dakar a apporté son appui technique pour le développement de l'application.

BD Biosciences offers solutions that provide both absolute and percentage results of CD4 T lymphocytes to stage progression of HIV/AIDS. These results are used to guide treatment decisions for HIV-infected persons and to evaluate the effectiveness of therapy. Our commitment to help prevent, diagnose, and treat HIV/AIDS goes beyond the application of technology. We actively collaborate across public and private sectors to create effective and sustainable programs to build healthcare capacity.

Biocentric, concepteur et fabricant français de solutions de diagnostic in vitro dans le domaine des maladies infectieuses, offre une gamme complète de tests PCR et d'instruments (thermocycleur en temps réel, extracteur d'acides nucléiques). Sa gamme de réactifs, dénommée « Generic Charge Virale », est réputée pour sa fiabilité et son rapport qualité-prix imbattable et couvre les besoins en suivi virologique des infections à VIH-1, VIH-2 et VHB.

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bioLytical Laboratories Inc. based in Richmond, BC, Canada is a privately-owned Canadian company focused on the research, development and commercialization of rapid, point-of-care in vitro medical diagnostics using its proprietary INSTI® technology platform. With a world-wide footprint of regulatory approvals including US FDA approval, Health Canada approval and CE mark, bioLytical sells its INSTI® HIV test globally and INSTI HIV/Syphilis Multiplex test in Europe. In addition, bioLytical launched its INSTI® HIV Self Test in Europe and Africa this year. The INSTI product line provides highly accurate test results in 60 seconds or less.

BIOSYNEX's 100 word exhibitor/company/product profile:

BIOSYNEX based in Strasbourg is specialized in in vitro diagnostic. Our R&D department and state of the art manufacturing facilities are dedicated to continuously answering new needs in the medical area by offering a wide range of innovative products:

- Rapid diagnostic tests
- Amplix: molecular biology qRT
- Cellscheck: 1st parasitology instrument
- Serology parasitology (Haemaglutination)

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, sexual health, genetic diseases, virology and cancer.

Chembio Diagnostic Systems, Inc. is a leading point-of-care diagnostics company focused on detecting and diagnosing infectious diseases. The company's patented DPP® technology platform, which uses a small drop of blood from thefingertip, provides high-quality, cost-effective results in minutes. Learn more at www.chembio.com

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Founded in 1975, Chemonics is one of the world's leading international development consulting firms. In 76 countries globally, our network of approximately 4,000 specialists pursue a higher standard to help clients, partners, and beneficiaries achieve results. As a multidisciplinary organization, we leverage our expertise to

design innovative solutions that control the spread of HIV. Working hand-in-hand with national governments and communities, we build the capacity of partners to introduce, lead, and institutionalize HIV services in local contexts. The result is locally-driven, accessible, cost efficient, and sustainable approaches that prevent the spread of HIV/AIDS, and improve the lives of those infected.

Diagnostics for the Real World (DRW) was established in 2003 as a spin-out from the Diagnostics Development Unit (DDU) at the University of Cambridge. DRW was founded to bridge the gap between the cutting-edge research conducted by the DDU and the patients who could really benefit from it. Our mission is to serve the large, unmet need in resource-limited settings and provide innovative, high performance, easy to use diagnostics to support clinical services for people in real need. Our SAMBA platforms provide a fast, accurate and cost-effective method for testing and diagnosis when and where it is most needed.

Expertise France is the French public agency for international technical assistance. It aims at contributing to sustainable development based on solidarity and inclusiveness, mainly through enhancing the quality of public policies within the partner countries. Expertise France designs and implements cooperation projects addressing skills transfers between professionals. The agency also develops integrated offers, assembling public and private expertise in order to respond to the partner countries' needs.

Gilead Sciences, Inc. is a research-based biopharmaceutical company that discovers, develops and commercializes innovative medicines in areas of unmet medical need. The company strives to transform and simplify care for people with life-threatening illnesses around the world. Gilead has operations in more than 35 countries worldwide, with headquarters in Foster City, California.

HDI Striving for a healthy society

Health Development Initiative is Rwandan non-governmental organization founded in 2005 with the aim of working towards a society where every person enjoys the highest standards of health and wellbeing. HDI's mission is to empower individuals, communities and institutions to promote community health and development. Through a rights-based approach, HDI builds sustainable alliances to advocate for and support health-friendly policies and services for every Rwandan regardless of social, cultural, or economic status.

HOLOGIC® The Science of Sure

An innovative medical technology company primarily focused on improving women's health and well-being, Hologic enables healthier lives everywhere, every day, with clinical superiority that delivers life-changing diagnostic, detection, surgical and medical aesthetic products rooted in science and driven by technology. Hologic: The Science of Sure in action.

Human Diagnostics Worldwide

For almost 50 years, HUMAN has been offering high-quality products, solutions and services in the field of laboratory diagnostics. Many years of international experience, a unique network of local partners in over 160 countries and regional offices around the globe ensure that HUMAN meets customer and market requirements. More than 400 products, from reagents to automated systems, cover the core areas, autoimmune and molecular diagnostics of modern laboratories and hospitals. Our customers can rely on a comprehensive range of continuously updated IVD products, perfectly matching diagnostic system solutions and excellent service and support through our extending sales and support network.

HUMANA PEOPLE TO PEOPLE

Humana People to People is a network of 30 non-profit associations engaged in international solidarity, cooperation, and development, rooted in a commitment to tackling some of the world's major humanitarian, social and environmental challenges, by working as a collective, supporting people to make changes, improve their lives and help solve the issues they are facing.

Since 2000, the Humana People to People's HIV and AIDS programme, Total Control of the Epidemic (TCE), has reached over 20 million people across 12 countries in Africa and Asia, with community mobilisation, HIV testing, tuberculosis screening, referrals to treatment, and support for treatment adherence.

The International AIDS Society (IAS) leads collective action on every front of the global HIV response through its membership base, scientific authority and convening power. Founded in 1988, the IAS is the world's largest association of HIV professionals, with members in more than 170 countries. Working with its members, the IAS advocates and drives urgent action to reduce the impact of HIV. The IAS is also the steward of the world's most prestigious HIV conferences: the International AIDS Conference, the IAS Conference on HIV Science, and the HIV Research for Prevention Conference.

ICAP is a global leader in HIV and health systems strengthening. Founded in 2003 at Columbia University's Mailman School of Public Health, ICAP has supported more than 6,000 health facilities across more than 30 countries. Over 2.5 million people have received HIV care through ICAP-supported programs. Learn more online at www.icap.columbia.edu

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I NTEC PRODUCTS, INC is a world leader in infectious disease diagnostics with a focus on screeni ng at the point of care. InTec HIV & HCV rapid tests are WHO PQ listed in May 2019 . W e strive for continual improvement through partnership s with health authorities and experts in the management of infectious diseases.

It is our vision that through close cooperation with these global stakeholders, InTec will continue to be a key contributor to reaching the goals of hepatitis elimination, HIV 90 90 90, and other ambitious targets set by the foremost authorities in public health IPM is a nonprofit organization dedicated to developing new HIV prevention

tools like the dapivirine ring and other sexual and reproductive health technologies for women, and making them available in developing countries. IPM has offices in South Africa, the United States and Belgium. Please visit www.IPMglobal.org

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ITPC
INTERNATIONAL TREATMENT PREPAREDNESS COALITION

Community-based monitoring holds the potential for increased domestic oversight and advocacy for improved HIV treatment and access, particularly for key populations. Affected communities utilize ART services but usually lack the needed capacity and information to participate meaningfully in decision-making that shape treatment programs that directly impact their lives. The Global Fund awarded ITPC a 3-year grant to support the development of Community Treatment Observatories in 11 West African countries, empowering networks of people living with HIV to systematically collect and analyze qualitative and quantitative data on barriers to HIV treatment access. We share and discuss emerging findings and lessons learnt.

Johnson & Johnson

Johnson & Johnson is the largest and most diversified healthcare company in the world. We are 134 000 employees in 60 countries, united by a common purpose: to change the trajectory of health for humanity. We have been caring for people for over 130 years. This heritage of delivering trusted products and services drives our three business segments: Consumer, Medical Devices and Pharmaceutical. Charting a bold new, self-sustainable approach, Johnson & Johnson Global Public Health is pushing boundaries as the first fully-dedicated organization within a healthcare company that combines Research & Development, novel access programs & business model innovation, in-country operations, advocacy and the power of multi-sectoral partnerships to ensure that innovative treatments and technologies are available, affordable and accessible for the world's most underserved populations. We have been operating in Africa for nearly 90 years and are committed to delivering innovative solutions to help address unmet global public health needs on the continent.

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karex

Karex is the global leader in condom manufacturing with an annual capacity in excess of 5 billion pieces, offering an unparalleled reach with the ability to export our products to more than 140 countries around the World. Karex began manufacturing condoms in 1988, providing us with more than 30 years of unsurpassed experience in the industry.

For more than a century, MSD has been inventing for life, bringing forward medicines and vaccines for many of the world's most challenging diseases. Today, MSD continues to be at the forefront of research to deliver innovative health solutions and advance the prevention and treatment of diseases that threaten people and animals around the world.

Mylan

Better Health for a Better World

Mylan is a global pharmaceutical company committed to setting new standards in healthcare. We offer a growing portfolio of more than 7,500 marketed products around the world, including antiretroviral therapies on which more than 40% of people being treated for HIV/AIDS globally depend. We market our products in more than 165 countries and territories. We are one of the world's largest producers of active pharmaceutical ingredients. Every member of our approximately 35,000-strong workforce is dedicated to creating better health for a better world, one person at a time.

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mothers2mothers®

mothers2mothers (m2m) is an African not-for-profit that employs and trains women living with HIV as Community Health Workers. These 'Mentor Mothers' provide services in health clinics and communities. They educate and support women and their families to overcome barriers to medical care, and ensure they receive the medication and health services they need, and stay in treatment. From an initial focus on preventing mother-to-child transmission of HIV, today m2m Mentor Mothers provide a range of services from pregnancy and childhood to adolescence. m2m works in eight African nations, and has reached over 11M women and children since 2001. More: www.m2m.org

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Omega DIAGNOSTICS LTD

Omega Diagnostics are pleased to support the 20th ICASA Conference in Kigali, we bring over thirty years of industry experience to improve human health and well-being through innovative diagnostics and global partnerships. Come by and meet us

to learn about the benefits our products VISITECT® CD4 and VISITECT® CD4 Advanced Disease, the world's first instrument-free, semi-quantitative, rapid and disposable lateral flow CD4 tests, improving patient outcomes in people living with HIV and advanced HIV disease.

OraSure Technologies, Inc.

"OraSure Technologies is a leader in rapid point-of-care infectious disease testing products as well as products to collect and stabilize biological samples. Its first-to-market, innovative products include rapid tests for the detection of antibodies to HIV and HCV on the OraQuick® platform. OraSure's portfolio of products is sold globally to various clinical laboratories, hospitals, clinics, community-based organizations and other public health organizations, research and academic institutions, distributors, government agencies, physicians' offices, commercial and industrial entities and consumers. The Company's products enable healthcare providers to deliver critical information to patients, empowering them to make decisions to improve and protect their health. "

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e l s a

Forte de 4 ONG françaises basées à Paris (Sidaction, Solidarité Sida, Solthis et Planning Familial) et de plus de 80 associations partenaires basées dans 26 pays africains, la Plateforme ELSA a pour but de contribuer à l'efficience et à la diffusion des expertises des acteurs associatifs français et africains de lutte contre le sida et de promotion des droits et santé sexuelle et reproductive (DSSR) en Afrique francophone. Plus d'informations : www.plateforme-elsa.org

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USAID FROM THE AMERICAN PEOPLE

PEPFAR

POPULATION COUNCIL Ideas. Evidence. Impact.

PROJECT SOAR SUPPORTING OPERATIONAL AIDS RESEARCH

Project SOAR conducts HIV implementation science research around the world to identify practical solutions to improve HIV prevention, care, and treatment services. This collaborative six-year project (2014–2020), funded by PEPFAR and USAID, also helps strengthen the skills of local research institutions and individuals to conduct and use high-quality research to improve HIV programs and policies. SOAR's portfolio consists of 70+ research activities in 21 countries (19 in Africa).

SOAR is led by the Population Council, a nongovernmental, nonprofit organization headquartered in New York with offices in sub-Saharan Africa and elsewhere. Through

biomedical, social science and public health research, the Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives.

In addition to the Council, the SOAR consortium includes Avenir Health, Elizabeth Glaser Pediatric AIDS Foundation, Johns Hopkins University, Palladium, and The University of North Carolina at Chapel Hill.

HIV SELF-TESTING AFRICA INITIATIVE

HIV SELF-TESTING AFRICA (STAR) INITIATIVE

The STAR Initiative is a Unitaid funded project currently working in six countries in sub-Saharan Africa - Eswatini, Lesotho, Malawi, South Africa, Zambia, and Zimbabwe, that sets to achieve direct public health impact by reducing the number of new HIV infections and averting deaths due to HIV infection by increasing demand for and access to HIV Self-Testing and onward treatment and prevention services. STAR supports national governments in establishing an enabling environment for HIVST scale-up, strengthening supply and delivery by ensuring the adoption of cost-effective distribution models that reach vulnerable, underserved and key populations effectively.

Premier Medical Corporation is the leading manufacturer of WHO prequalified and CE marked rapid tests, First Response HIV, HIv+syphilis Combo and Malaria Pf, Pf/PAN and Pf/Pv tests. PMC also manufactures CE marked Hepatiti C, HBV, and Syphilis tests. PMC had developed HIV recency tests that will be launched by the end of 2019.

Mission: A centre of excellence that promotes effective and ethical development responses to SRH, HIV and TB integrated with livelihood strategies; through advocacy, communication and social mobilization (ACSM)

Vision: Ensure that ALL people in Africa realize their sexual and reproductive health and rights and are free from the burden of HIV, GBV, TB, and their inter-linkages with other health and developmental issues.

Our 4 state-of-the-art manufacturing facilities are located across Malaysia and Thailand, close to the freshest high-quality rubber sources, and are staffed by almost 3,000 dedicated employees. Our vision is to continuously build an organization that responds to the changing views of sexual health and wellness, by developing products that inspire people to make better, healthier choices. We champion social responsibility and sustainability, not just as moral imperatives but to build stronger, long-lasting relationships with our customers.

Le RESEAU EVA est un réseau de pédiatres et d'équipes de soins, spécialisés dans la prise en charge du VIH pédiatrique.

L'objectif de ce réseau est d'améliorer la qualité de la PEC et la couverture de l'accès au TARV chez les enfants et adolescents en Afrique francophone.

Le Réseau intervient actuellement dans 12 pays d'Afrique francophone que sont le Bénin, le Burkina Faso, le Burundi, le Cameroun, le Côte d'Ivoire, le Mali, le Maroc, le Niger, la RCA, le Sénégal, le Tchad et le Togo. Il représente à lui seul une file active de plus de 6000 enfants traités.

SAfAIDS priorities are HIV and TB prevention, care and treatment; Integration of HIV and SRHR services, linkages between HIV, culture and GBV; rights of marginalised communities (LGBTI, people living with HIV and sex workers to access health services.

« Savics is a social and international enterprise, that has been working with government authorities and developmental partners at local, national and international levels in

improving public health and social outcomes across the globe. We leverage existing technologies, and field knowledge to improve health systems, disease surveillance, individualized patient care, and healthcare management.
We have developed a suite of highly innovative applications that interconnects laboratories, addresses supply chain challenges, allows for timely detection, and improves the patient experience. We also provide consulting services to health ministries, physicians and other public health stakeholders, while serving the most vulnerable groups in rural communities. »

The Selenium Education and Research Centre (SERC) in Johannesburg educates the HIV/TB communities concerning the central role selenium plays in immunity, HIV, cancer, chronic disease and general health.
SERC reviews existing scientific knowledge concerning selenium and urges its application to increase CD4 count, reduce disease burden and improve health.
Selenium supplements improve HIV therapy, reduce opportunistic infections and chronic disease. High-dose selenium reduces death from Ebola. Selenium helps prevent active tuberculosis and should improve TB treatment.
SERC searches for gaps in knowledge where selenium might prove effective. It works to coordinate and advance research against disease to improve international health.

The Society for AIDS in Africa (SAA) was established in Kinshasa in October 1990 during the 5th International Conference on AIDS and Associated Cancers in Africa, a precursor to the International Conference on AIDS and STIs in Africa (ICASA).
The formation of SAA with the support of the World Health Organization (WHO) brought to an end, the practice of organizing the International Conference on AIDS in Africa, outside the African continent. At the same time, it empowered Africans to address and respond to the challenges posed by HIV/AIDS on the continent.

The SAA envisions an HIV free Africa with capacity to confront HIV/AIDS and its consequences as well as its related diseases (such as Tuberculosis and Malaria).
The Society also promotes positive environment and research on HIV and its related diseases. The SAA is governed by an Executive Council drawn from South, North, East, West and Central Africa.
SAA partners and collaborates with range of NGOs and it enjoys the support of the UN-System, as well as various International organizations, including the International AIDS Society (IAS). The Society for AIDS in Africa, is the organizer of ICASA. The next ICASA will be organized in 2021. The host country will be announced soon.

For more information, kindly visit our website at: www.saafrica.org/ www.icasa2019rwanda.org
Please contact: Society for AIDS in Africa Permanent Secretariat, P.O. Box AF2072, Plot Container 58, Otano Estate Behind NHTC, Adjiringanor, East Legon, Accra, Ghana
Tel: +233(0)303 93 68 14/ +233(0)303 93 68 15 , Email: info@saafrica.org www.saafrica.org

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sysmex

Sysmex South Africa Ltd are the distributor and support network for Sysmex Automated Haematology and Haemostasis analysers, reagents and Information Systems for laboratories and healthcare facilities within Southern, Eastern and Western Africa.

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY & CHILDREN
NATIONAL AIDS CONTROL PROGRAM

The National AIDS Control Program (NACP) is a Program established in 1988 under the Ministry of Health Community Development Gender Elderly and Children (MOHCDGEC) in Tanzania, located under the Directorate of Preventive Services.

NACP envision an HIV-free society where new infections are halted and people living with HIV or affected by HIV and AIDS receive quality services and support.

The goal is to increase the coverage of HIV and AIDS services in the general population and sub-populations to ensure that by 2020, 90% of people living with HIV know their HIV status, 90% of all HIV positives receive efficacious HAART and 90% of those on ART attain sustainable viral suppression.

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fc2 FHC

The Female Health Company (“FHC”) manufactures, markets and sells the FC2 Female Condom, the only currently available product under a woman’s control that is approved by both the U.S. Food and Drug Administration (FDA) as well as WHO. FC2 provides dual protection against unintended pregnancy and sexually transmitted infections (“STIs”), including HIV/AIDS. The FC2 female condom has been shipped to 150 countries worldwide.

Trinity Biotech

Trinity Biotech specialises in the development, manufacture and marketing of diagnostic test kits. Our success is based on consistency standards of excellence in the quality of all we do.

Test kits manufactured are used in the clinical laboratory and point-of-care segments of the diagnostic market, to detect infectious diseases, sexually transmitted diseases, autoimmune disorders, haemoglobin disorders, and in the detection, monitoring and control of diabetes. We are also a significant provide levels of raw material to the life sciences industry.

Quoted on the NASDAQ exchange, and with facilities spanning Europe and America, our products are sold in more than 110 countries. We reach our customers worldwide by combining the skills of our own sales force with a network of international distributors and strategic partners.

United States™ Census Bureau

First developed in 1987 by the U.S. Census Bureau in consultation with the U.S. Agency for International Development (USAID), the HIV/AIDS Surveillance Data Base is an international compilation designed to provide users with HIV prevalence and incidence data from various sources. The Data Base includes all areas of the world with at least 5,000 population, with the exception of Northern America and U.S. territories.
Through the Data Base interface, available information for population groups in a selected country can be easily retrieved and displayed on the computer screen, and printed or saved to a .pdf or .csv file.

UN WOMEN

UN Women is the United Nations entity dedicated to gender equality and the empowerment of women. A global champion for women and girls, UN Women works to develop and uphold standards, and create an environment in which every woman and girl can exercise her human rights and live up to her full potential.
UN Women brings gender equality and human rights perspectives to its work on women and HIV and AIDS. We spearhead strategies that make clear links to factors propelling the epidemic, such as violence against women, denial of legal rights and women's limited participation in decision-making. In Rwanda, UN Women`s work on HIV and AIDS is implemented under the ONE UN Joint Programme on HIV.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners towards ending the AIDS epidemic by 2030 as part of the Sustainable Development Goals. Learn more at unaids.org and connect with us on Facebook, Twitter, Instagram and YouTube.

UNFPA is the United Nations sexual and reproductive health agency. Our mission is to deliver a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled. We work towards the achievement of the following transformative results, ambitions that promise to change the world for every man, woman and young person: ending unmet need for family planning, ending preventable maternal death, ending gender-based violence and harmful practices, and ending the HIV pandemic.

Across more than 190 countries and territories, UNICEF works for every child, everywhere, to build a better world for everyone. The survival of girls and boys, especially the most marginalized and those living in countries where there is a humanitarian crisis, depends on high-impact health interventions, adequate nutrition for them and their mothers, and protection from HIV. Ending AIDS as a global public health threat has been at the centre of UNICEF's work for more than two decades and is essential to improving children's ability to survive and thrive. Learn more at https://www.unicef.org/hiv. Follow us on Twitter / Facebook / Instagram.

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Working together in HIV

"ViiV Healthcare is a global specialist company 100% focussed on HIV. Through our broad ARV portfolio and patient-centred approach to research and development, we are committed to addressing the significant gaps and unmet needs of people living with and at risk of HIV. 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."

Virology Education is the leading provider of top quality and accredited programs for scientific interchange, knowledge sharing, and education for the healthcare professionals. With nearly 20 years of experience, Virology Education is committed to supporting the healthcare community in the process of discovering, researching, treating, and ultimately curing viruses and infectious diseases.

Virology Education organizes meetings in Africa in close collaboration with local societies that aim to empower African healthcare. We strive to create a platform that provides a unique opportunity for clinicians, researchers, policymakers, industry representatives, and other healthcare professionals in the African region to exchange knowledge on the latest clinical developments.

National AIDS Council Zimbabwe Exhibition

Objectives:

1. To provide an interactive platform for sharing knowledge and ideas
2. To show case successes made by Zimbabwe in the national response to HIV and AIDS (Domestic funding, Decline in HIV Incidence and Prevalence)
3. To provide platform for networking among stakeholders
4. To provide a platform for coordination of Zimbabwe delegates to the conference

Scope of the Exhibition

The following information will be shared through display, print material, electronic material and interpersonal communication

- HIV incidence and prevalence according to regions
- HIV and AIDS domestic funding
- Achievements towards the 90 90 90
- Zimbabwe HIV and AIDS strategic documents
- Programme achievements and coverage (DREAMS, SASA, brother2brother, sista2sista etc)
- Selected abstracts
- Live streaming of selected presentations
- Update the NAC website and social media platforms with conference updates

For author index, visit
https://bit.ly/2QFKCL9

Notes

SOCIETE AFRICAINE ANTI-SIDA

SOCIETY FOR AIDS IN AFRICA

S A A

Who wins the Bid to Host ICASA 2021

To follow up on ICASA 2021.
Kindly, visit: www.saafrica.org

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SOCIETY FOR AIDS IN AFRICA
ORGANIZER OF THE ICASA

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www.icasa2019rwanda.org