PROGRAMME BOOK / LIVRE DU PROGRAMME

ICASA 2021

DURBAN, SOUTH AFRICA

6 -11 DEC. 2021

Africa's AIDS response

The race to 2030 – Evidence. Scale Up. Accelerate

La riposte au Sida en Afrique

Objectif 2030 - Evidence. Passage à l'échelle. Accélération

REPUBLIC OF SOUTH AFRICA

PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATAL

SOCIETY FOR AIDS IN AFRICA
SOCIÉTÉ AFRICAINE ANTI-SIDA
SAA

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

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Welcome Address by ICASA 2021 President

It is my honour, pleasure, and privilege to address all the members of the Society for AIDS in Africa (SAA) in African and the rest of the World, and particularly our potential participants to the ICASA 2021 Conference that will be in Durban, South Africa. Many of you will remember that in 2019 we had a successful conference in Kigali, Rwanda attended by nearly 9000 delegates. It was an exciting conference with many strategies shared, and the efforts to eradicate HIV was progressive. The UNAIDS 90-90-90 HIV and AIDS target by 2030 projection, and there was an assurance that 95-95-95 is achievable. Suddenly the 2020 target was annihilated by the COVID 19 pandemic, which affected our health systems, particularly in Africa, resulting in many deaths.

At Society for AIDS in Africa, our main trust is our contribution towards ending HIV/AIDS and emerging diseases. There is a need to examine the effect of COVID 19 concerning ending HIV. The COVID 19 pandemic has disrupted the provision of life-saving services to vulnerable communities and increased infections. People living with HIV who contracted the COVID 19 found it difficult to manage the two conditions which led to ICASA 2021 Theme "**Africa AIDS response: The race to 2030 – Evidence. Scale-up. Accelerates**", which seeks to consider the impact of HIV and that of COVID 19 and how to lessen the two diseases. Our members and potential participants are assured that ICASA 2021 is a reality. A virtual meeting, held with the Minister of Health, South Africa, Dr Zweli Mkhize, concerning ICASA 2021 conference. We are considering a virtual event in case the pandemic worsens. ICASA 2021 hybrid conference will host 3000 in-person attendees, and the rest of the delegates will join virtually.
The following objectives seek to address HIV and its related diseases such as tuberculosis, hepatitis, malaria, and infectious diseases.

- To strengthen health systems to integrate high impact interventions on comorbidities, emerging infections and NCDs.
- To build, strengthen and invest in Africa's scientific capacity and manufacturing of vaccines, diagnostics and therapeutics.
- To identify in Africa resource tailored interventions for populations most affected, including women, children, adolescents, men and Key Populations.
- To evaluate the impact of COVID-19 on the HIV/AIDS response and share lessons learned in overcoming barriers in maintaining continuity of care for people living with and at risk for HIV infection.
- To amplify national, regional, continental, and global integration to reach epidemic control in Africa: Africa's contributions in the Diaspora.

Comorbidities such as hypertension, diabetes are significant risks to contract COVID 19 infection. COVID 19 vaccines are now being produced, and these vaccines only have the potential to reduce morbidity and mortality. Many Africa nations are finding it difficult to get vaccines. There will be subsequent pandemics, and Africans need to come together and learn to make vaccines. The fight against infections disease is now, and the challenges faced by the population needs attention. There is a need for Africans in the Diaspora to end HIV/AIDS by 2030. Some Africans in the Diaspora have contributed to producing vaccines for COVID 19. Their contribution will be of great value to improve our health system to make our continents free of AIDS.

I assure everyone that ICASA 2021 will come off, and we are looking forward to an exciting conference.

Prof. John Idoko
ICASA 2021 President / SAA President

Allocution de bienvenue du Président de ICASA 2021 (Translation from English to French)

C'est un honneur, un plaisir et un privilège pour moi de m'adresser à tous les membres de la Société Africaine Anti-Sida (SAA), aux africains et au reste du monde, et en particulier aux potentiels participants à laConférence ICASA 2021 qui se tiendra à Durban, en Afrique du Sud. Vous serez nombreux à vous rappeler qu'en 2019, nous avons tenu une conférence à succès à Kigali, au Rwanda, où nous avons enregistré près de 9000 délégués.

Ce fut une conférence passionnante avec de nombreuses stratégies partagées et les efforts pour éradiquer le VIH étaient en progrès. Les objectifs 90-90-90 de l'ONUSIDA sur le VIH et le Sida ciblaient 2030, mais il y avait une assurance que 95-95-95 était réalisable. Soudain, l'objectif de 2020 a été anéanti par la pandémie du COVID 19 qui a affecté nos systèmes de santé, en particulier en Afrique, causant de nombreux décès.

Au niveau de la Société Africaine Anti-Sida, notre

principale objectif est notre contribution à l'éradication du VIH/Sida et des maladies émergentes. Il est nécessaire d'examiner l'effet du COVID 19 sur l'éradication du VIH. La pandémie du COVID 19 a perturbé la fourniture de services vitaux aux communautés vulnérables et augmenté le taux d' infections. Les personnes vivant avec le VIH qui ont contracté le COVID 19 ont eu du mal à gérer les deux conditions ; ce qui nous a conduit au thème de ICASA 2021:

" La riposte au Sida en Afrique: La course vers 2030 – Evidence.Passage à l'échelle. Accélération », qui veut considérer l'impact du COVID19 sur la gestion du VIH et comment élaborer de nouvelles stratégies pour lutter efficacement contre les deux maladies. Nos membres et potentiels participants sont rassurés que ICASA 2021 est une réalité. Une réunion virtuelle s'est tenue avec le précèdent ministre de la Santé d'Afrique du Sud, Dr Zweli Mkhize sur la conférence ICASA 2021. Nous envisageons un événement virtuel au cas où la pandémie s'aggraverait. La conférence hybride de ICASA 2021 accueillera 3000 participants en présentielles et le reste des délégués en virtuel.

Les objectifs suivants visent à lutter contre le VIH et ses maladies associées telles que la tuberculose, l'hépatite, le paludisme et les maladies infectieuses.

- Renforcer les systèmes de santé pour intégrer des interventions à haut impact sur les comorbidités, les infections émergentes et les ISTs.
- Construire, renforcer et investir dans la formation scientifique en Afrique, et la fabrication de vaccins, le diagnostic et la thérapeutique.
- Identifier en Afrique des interventions adaptées aux ressources pour les populations les plus affectées, dont les femmes, les enfants, les adolescents, les hommes et les populations clés.
- Évaluer l'impact du COVID-19 sur la réponse au VIH/SIDA et partager les leçons apprises pour surmonter les barrières au maintien de la continuité des soins au profit des personnes vivant avec le VIH et à risque d'infection par le VIH.
- Amplifier l'intégration national, régional, continental et mondial pour parvenir à la maîtrise de l'épidémie en Afrique : les contributions de l'Afrique de la diaspora.

Les comorbidités telles que l'hypertension, le diabète sont des risques importants pour contracter une infection au COVID 19. Des vaccins contre le COVID 19 sont maintenant produits, et ces vaccins ont seulement le potentiel de réduire la morbidité et la mortalité.

De nombreux pays africains ont du mal à accepter les vaccins. Il y aura des pandémies ultérieures, et les Africains ont besoin de se réunir et d'apprendre à fabriquer des vaccins. Le combat contre les infections, la maladie est pour maintenant, et les défis auxquels la population est confrontée ont besoin d'attention. Il y a un besoin crucial pour les Africains ainsi que ceux de la diaspora d'aider a mettre fin au VIH/SIDA d'ici 2030.

Certains africains de la diaspora ont contribué à produire des vaccins contre le COVID 19. Leur contribution sera d'une grande valeur pour améliorer notre système de santé afin que notre continent puisse arrive à bout du Sida.

J'assure à tous que ICASA 2021 se tiendra et nous attendons impatiemment une conférence passionnante.

Pr John Idoko
Président de ICASA 2021/ Président de la SAA

Welcome Address by Honourable Minister of Health, South Africa

On behalf of the Government of South Africa, we commit to do our utmost best to successfully host the 21st edition of the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA), scheduled to take place at Durban International Convention Centre and online 6–11 December 2021.
We thank the Society for AIDS in Africa (SAA) for their confidence in our ability to host the conference for the second time, barely a decade after having hosted the 17th ICASA conference in 2013, in the "Mother City" (Cape Town) under the theme, Now More Than Ever, Targeting Zero!

We also applaud the SAA for being resolute in ensuring that the HIV response agenda is not relegated to the periphery as the continent and the rest of the globe intensify efforts to arrest the COVID-19 pandemic.

ICASA is driving an integration agenda for COVID-19, HIV, TB and STIs services to ensure a comprehensive and inclusive health response for the continent. The South African Government supports this agenda and vision.
As a continent, we have come a long way over the last couple of decades – the ICASA platform will afford us an opportunity to assess our progress and share good practices to enhance our response.

In the past two years, COVID-19 has significantly derailed our efforts, with some reports painting a bleak picture of the impact of the pandemic on HIV and TB services. The latest UNAIDS Global AIDS Update, Confronting Inequalities, highlights the fact that only 19 countries achieved the 90-90-90 targets by 2020. Most others were already struggling to reach their targets, and that was exacerbated by the disruptions of COVID-19. The Goalkeepers Report by the Gates Foundation says the global health response has been set back by a whopping 25 years and estimates that lockdowns could increase global TB incidence by 6.3 million people and mortality by 1.5 million. Further to that, the TB response could be set back by as much as 5–8 years.

There are glaring signs in our own country that reinforce the scale of these challenges; within the first few months of the lockdown, data from health facilities pointed to a decline in the number of people accessing HIV and TB services. Many patients also missed their treatment collection appointments, and a sizeable number of people were lost to follow-up.

These challenges were not just limited to HIV and TB, as there are also concerns over the Dr. Joe Phaahla RSA Minister of Health number of people accessing services for immunisation and non-communicable diseases, and to access broader health and social services. There's clearly a need to intensify our integration agenda and catch-up plans to mitigate against these setbacks and renew our determination. South Africa, together with many other countries, met at the UN General Assembly in June this year, and committed to a series of new and ambitious targets in the 2021 Political Declaration on AIDS. We agreed on the need to end AIDS by 2030, through an unflinching focus on ending inequalities.

We have a new global AIDS strategy 2021-2026 that provides us with clear objectives, updated areas of emphasis and new ways of working. It reflects the need for political leadership and scientific innovation, while clearly placing communities, key populations and people living with HIV especially, at the centre of our approach.

As we all continue to respond to the challenges of OVID-19, we must rebuild with the deliberate intent of addressing the inequalities that put us all at risk. These inequalities are apparent in our countries, across our region and continent, and internationally, as evidenced in the very unequal distribution of Coronavirus vaccines globally.

As countries, we can rebuild our economies and our health programmes by drawing on lessons learned from the HIV response over the last few decades. We should ground our approaches on human rights principles and drive a truly multisectoral response that is both inclusive and community centred. We should strengthen our health systems by mobilising alliances and reinforcing coalitions. The face of HIV is still overwhelmingly that of a black female, particularly girls and young women in Sub-Saharan Africa who continue to experience new HIV infections at an alarming rate. I look forward to ICASA 2021 focusing on addressing the social and structural drivers of HIV and shining a spotlight on gender inequality and social protection for key populations and vulnerable people.

The conference should also reflect on concrete measures to support women and girls in the context of the COVID-19 pandemic. Ways to arrest gender-based violence and improve access to essential health services should be explored. Governments across Africa need to do much more to empower women and girls. Education, socio-economic opportunities and safety for women and girls

should remain as overarching objectives in our response to HIV.

We call on all African states to rally behind ICASA and participate in the 21st ICASA Conference to be hosted by our country later in the year and, to adopt the integration agenda in order to propel the African continent towards ending AIDS by the year 2030.

Hosting this conference will have a deep and long-lasting impact on our HIV, TB and STIs response in South Africa while benefiting the entire continent.

Dr. Joe Phaahla
RSA Minister of Health

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Discours de bienvenue de l'honorable ministre de la Santé d'Afrique du Sud (Translation from English to French)

Au nom du gouvernement d'Afrique du Sud, nous nous engageons à faire de notre mieux pour accueillir avec succès la 21ème édition de la Conférence Internationale sur le Sida et les infections sexuellement transmissibles en Afrique (ICASA), prévu se tenir au Centre de Convention International de Durban et en ligne du 6 au 11 décembre 2021.

Nous remercions la Société Africaine Anti-Sida (SAA) pour leur confiance en notre capacité d'accueillir la conférence pour la deuxième fois, à peine une décennie après avoir accueilli la 17e conférence ICASA en 2013, dans la « ville mère » (Cap Town) sous le thème; Maintenant plus que jamais, vers l'objectif Zéro !

Nous félicitons également la SAA pour sa détermination à s'assurer que le programme de riposte au VIH n'est pas relégué aux oubliettes alors que le continent et le reste du globe intensifient leurs efforts pour arrêter la pandémie du COVID-19.

L'ICASA dirige un programme d'intégration pour le COVID-19, le VIH, les services de lutte contre la tuberculose et les IST pour garantir une riposte sanitaire complète et inclusive pour le continent. Le gouvernement sud africain soutient ce programme et cette vision.

En tant que continent, nous avons parcouru un long chemin au cours des deux dernières décennies - la plateforme de ICASA nous offrira une occasion d'évaluer nos progrès et de partager les bonnes pratiques pour améliorer notre riposte.

Au cours des deux dernières années, le COVID-19 a considérablement déraillé nos efforts, et certains rapports dressent un tableau sombre de l'impact de la pandémie sur les services de lutte contre le VIH et la tuberculose.

La dernière mise à jour mondiale de l'ONUSIDA, « Confronting inequalities », met en évidence le fait que seuls 19 pays ont atteint les objectifs 90-90-90 d'ici 2020. La plupart des autres pays avaient déjà du mal à atteindre leurs objectifs, et cela, est aggravé par les perturbations du COVID-19. Le Goalkeepers Report, de la Fondation Gates indique que la riposte sanitaire mondiale a été retardée de 25 ans et estime que le confinement pourrait augmenter l'incidence mondiale de la tuberculose de 6,3 millions de personnes et la mortalité de 1 500 000. De plus, la riposte à la tuberculose pourrait être retardée de 5 à 8 ans.

Il y a des signes flagrants dans notre propre pays qui renforcent l'ampleur de ces défis ; dans les premiers mois du confinement, les données des établissements de santé ont indiqué une baisse du nombre de personnes ayant accès aux services de lutte contre le VIH et la tuberculose. De nombreux patients ont également manqué leurs rendez-vous de collecte de traitement et un nombre important de personnes ont été perdues de vue.

Ces défis ne se limitent pas seulement au VIH et à la tuberculose, car pour moi, Dr Joe Phaahla, Ministre de la Santé de l'Afrique du Sud, le nombre de personnes ayant accès aux services de vaccinations et de maladies non transmissibles suscite également des inquiétudes ainsi que ceux pouvant avoir accès à des services sociaux de santé plus vastes. Il y a clairement un besoin d'intensifier notre programme d'intégration et de plans de rattrapage pour atténuer ces revers et renouveler notre détermination. L'Afrique du Sud avec de nombreux autres pays se sont réunis à l'Assemblée générale des Nations Unies en juin dernier et se sont engagés dans une série de nouveaux et ambitieux objectifs dans la Déclaration politique de 2021 sur le Sida. Nous avons approuvé le besoin de mettre fin au Sida d'ici 2030, à travers un accent particulier sur l'éradication des inégalités.

Nous avons une nouvelle stratégie mondiale de lutte contre le sida 2021-2026, qui nous offre des objectifs clairs, des domaines d'intérêt actualisés et de nouvelles méthodes de travailler. Il reflète le besoin du leadership politique et d'innovation scientifique, tout en plaçant clairement les communautés, les populations clés et les personnes vivant avec le VIH en particulier, au centre de notre approche.

Alors que nous continuons tous à relever les défis du COVID-19, nous devons reconstruire avec l'intention

délibérée de régler les inégalités qui nous mettent tous en danger. Ces inégalités se manifestent dans nos pays, dans toute notre région et continent et sur le plan international, comme en témoigne la répartition très inégale des vaccins contre le Coronavirus au niveau mondial.

En tant que pays, nous pouvons reconstruire nos économies et nos programmes de santé en tirant les leçons apprises de la riposte au VIH au cours des dernières décennies. Nous devons fonder nos approches sur les principes des droits de l'homme et conduire une réponse véritablement multisectorielle qui soit à la fois inclusive et centrée sur la communauté. Nous devons renforcer nos systèmes de santé en mobilisant des alliances et en renforçant les coalitions.

Le visage du VIH est encore majoritairement celui des femmes africaines, en particulier des filles et jeunes femmes subsahariennes qui continuent de souffrir de nouvelles infections à VIH à un rythme alarmant. J'ai hâte de voir ICASA 2021 se centrer sur la résolution des facteurs sociaux et structurels du VIH et braquer les projecteurs sur les inégalités entre les sexes et la protection sociale des populations clés et des personnes vulnérables.

La conférence devrait également réfléchir à des mesures concrètes pour soutenir les femmes et les filles dans le contexte de la pandémie du COVID-19. Les moyens d'arrêter la violence basée sur le genre et améliorer l'accès aux services essentiels de santé, devraient être explorés. Les gouvernements africains doivent faire davantage pour rendre les femmes et les filles autonomes. L'éducation, les opportunités socio-économiques et la sécurité pour les femmes et les filles doivent demeurer des objectifs primordiaux dans notre riposte au VIH.

Nous lançons un appel à tous les Etats africains à se rallier à ICASA et participer à la 21ème conférence ICASA qui aura lieu dans notre pays un peu plus tard cette année et d'adopter le programme d'intégration afin de propulser le continent africain vers l'éradication du SIDA d'ici 2030.
Abriter cette conférence aura un impact profond et durable sur notre riposte au VIH, à la TB et aux IST en Afrique du Sud tout en profitant à l'ensemble du continent.

Dr Joe Phaahla
Ministre de la Santé d'Afrique du Sud

Welcome Address by the Premier, Kwazulu-Natal, South Africa

The Leadership of the Society for AIDS in Africa (SAA); Members of the Executive Council of KwaZulu-Natal; The Mayor of EThekwini, His Worship, Cllr Mxolisi Kaunda; The Director-General of the Department of Health, Dr Sandile Buthelezi; The Director-General of KwaZulu-Natal, Dr Nonhlanhla Mkhize; Senior Government Officials; Social Partners; Members of the Fourth Estate; Distinguished Guests; Ladies and Gentlemen;

I take this opportunity to add my voice in welcoming you all to the warm, hospitable, and beautiful city of Durban.

Thank you for taking your time this morning to witness the official signing of the Memorandum of Understanding (MOU) entered by our national government through the Department of Health and the Society for Aids in Africa to host the 21st International Conference for AIDS and STIs in Africa (ICASA) which will take place here at Inkosi Albert Luthuli ICC from the 6th to the 11th of December 2021.

As a hosting province and city, we extend our gratitude to our national government for approving the hosting of this crucial conference. In KwaZulu-Natal, the provincial government endorsed Durban as a host city on the 11th of April 2021.

We look forward to hosting an impactful, memorable conference and to partner with the Society on AIDS in Africa (SAA). Since its founding in 1989, SAA has led from the front in mobilizing stakeholders to attain the vision of an Africa which is free of AIDS, TB, Malaria, and other diseases. We recognize the organisation's significant role in the fight against the stigma and discrimination of People Living with HIV (PLHIV). SAA continues to be visible in campaigns for social justice and expansion of quality treatment, care and support for people living with HIV.

Notwithstanding the constraints brought about by Covid-19, we have no doubt that we will succeed in hosting a successful 21st International Conference for AIDS and STIs in Africa (ICASA). The conference will bring together scientists, policy makers, communities, activists, and people living with HIV as we all rededicate ourselves to the ideal and promise of an AIDS-free Africa.

Holding ICASA 2021 in Durban is important for our

province. We remain the province with the highest burden of HIV in South Africa. In this regard, this conference will help to galvanize all our stakeholders in KZN not to take the eye off the ball while we battle the deadly Covid-19.

We are happy also to host ICASA 2021 because KwaZulu-Natal will also be able to share its many successful stories, many of which are driven by communities themselves at grassroots level to turn the tide against HIV, AIDS, TB, and STIs.

This will be an opportunity also to examine our strategies and impact in reducing HIV infections in key populations as well as the vulnerable groups like girls and women aged between 15 and 24.

As we conclude Women's Month today, we are reminded that gender inequality and patriarchy continue to be part of the structural drivers that fuel the spread of HIV. ICASA 2021 will provide KwaZulu-Natal with an opportunity to look at the economic empowerment opportunities that are designed to improve the economic status of girls and women in an effort to arrest the spread of HIV and STIs.

In memory of our late beloved Isilo, His Majesty King Goodwill ka Bhekuzulu, we also hope to use ICASA 2021 to share experiences with our continent and the world on the crucial role played by ubukhosi, the traditional leadership, in reducing STIs, advancing medical male circumcision, promoting HIV and TB testing, as well as fighting social stigma on HIV and TB. UHlangalomhlabathi, iMbube noma isilele yayikukhuthaza ukuziphatha kahle kwabantwana, ikakhulukazi abantwana bamantombazane.

As KwaZulu-Natal, we offer to deliver a successful conference in partnership with our national Department of Health, the South African National Aids Council (SANAC), as well as SAA. We have already appointed members of the KZN Local Organising Committee (LOC), and they have a clear programme that they are already implementing in preparation for the Conference. We will welcome Africa and the world with the warm and friendly embrace of KwaZulu-Natal. Visitors who will attend in person will experience for themselves the elegance, beauty, culture, and rich heritage of the Zulu Kingdom.

ICASA 2021 could not have taken place at a better venue than this ICC which is named after Africa's first Nobel Peace Laurette, Inkosi Albert Luthuli who received his award exactly sixty years ago.

The fight against STIs, TB, HIV, and stigma are important in building lasting peace in relationships, in homes, in communities, and in societies. As we gather in December, we will again be laying a firm foundation on building lasting peace, creating model citizenry, and in unleashing the full potential of the people of KwaZulu-Natal and Africa.

This is the time for Africa to scale up its response. It's a time to accelerate, to strengthen collaboration, and to use evidence better to reach our targets.

Let us seize the moment and be known as the generation that delivered an AIDS-free Africa.

It is in our hands.

Indeed, better days are ahead of KwaZulu-Natal and the continent of Africa.

Let us work together for a Better Africa and a Better World.

Namukulekile Kwelika Mthaniya, Kwelika Phunga no Mageba.

I thank you.

SIHLE ZIKALALA
Premier, Kwazulu Natal

Discours de bienvenue du Gouverneur du Kwazulu-Natal, Afrique du Sud (Translation from English to French)

Mesdames et Messieurs les membres du Conseil d'administration de la Société Africaine Anti-Sida (SAA) ; chers membres du conseil exécutif du KwaZulu-Natal ; Monsieur le maire d'EThekwini, Révérend Cllr Mxolisi Kaunda ; Monsieur le Directeur Général du ministère de la santé, Dr Sandile Buthelezi ; M. le Directeur général du KwaZulu-Natal, Dr Nonhlanhla Mkhize; Messieurs et madames les hauts fonctionnaires du gouvernement ; chers partenaires sociaux ; chers membres de la quatrième législation ; distingués invités; Mesdames et Messieurs;

Je saisis cette opportunité pour joindre ma voix et vous souhaiter à tous la bienvenue dans la ville chaleureuse, hospitalière et magnifique de Durban.

Merci d'avoir pris de votre temps ce matin pour être témoins de la signature officielle du protocole d'accord (PE) conclu par notre gouvernement national par le biais du Ministère de la Santé et la Société Africaine Anti-Sida pour accueillir la 21ème conférence internationale sur le Sida et les IST en Afrique (ICASA) qui aura lieu ici au Centre de Convention International Inkosi Albert Luthuli ICC, du 6 au 11 décembre 2021.

En tant que province et ville d'accueil, nous exprimons notre gratitude à notre gouvernement national pour avoir accepté abriter cette importante conférence. Au KwaZulu-Natal, le gouvernement provincial a désigné Durban comme ville hôte le 11 avril 2021.

Nous avons hâte d'accueillir une conférence percutante et mémorable et de nous associer à la Société Africaine Anti-Sida (SAA). Depuis sa création en 1989, la SAA est allée de l'avant en mobilisant les parties prenantes pour atteindre la vision d'une Afrique exempte du SIDA, de la tuberculose, du paludisme et d'autres maladies. Nous reconnaissons l'importance du rôle de l'organisation dans la lutte contre la stigmatisation et la discrimination des personnes vivant avec le VIH (PVVIH). La SAA continue d'être visible dans les campagnes pour une justice sociale et l'expansion de la qualité du traitement, des soins et du soutien des personnes vivant avec le VIH.

Malgré les contraintes engendrées par le Covid-19, nous n'avons aucun doute que nous réussirons à organiser la 21ème conférence internationale sur le Sida et les IST en Afrique (ICASA). La conférence rassemblera des scientifiques, des décideurs politiques, des communautés, des activistes et des personnes vivant avec le VIH, alors que nous nous consacrons tous à nouveau à l'idéal et à la promesse d'une Afrique sans Sida.

La tenue d'ICASA 2021 à Durban est importante pour notre Province. Nous demeurons la province avec le plus lourd fardeau du VIH en Afrique du Sud. A cet égard, cette conférence aidera à galvaniser toutes nos parties prenantes dans le KwaZulu-Natal à ne pas perdre de vue le VIH pendant que nous combattons la mortelle pandémie Covid-19.

Nous sommes également heureux d'accueillir ICASA 2021 car le KwaZulu-Natal pourra également partager ses nombreuses histoires à succès, dont beaucoup sont conduites par les communautés elles-mêmes au niveau local pour inverser la tendance du VIH, du sida, de la tuberculose et des IST.

Ce sera aussi l'occasion d'examiner nos stratégies et impact sur la réduction des infections à VIH chez les populations clés, ainsi que les groupes vulnérables comme les filles et les femmes âgées entre 15 et 24 ans.

Alors que nous concluons le mois de la femme aujourd'hui, nous nous rappelons que l'inégalité des sexes et le patriarcat continuent de faire partie des moteurs structurels qui alimentent la propagation du VIH. ICASA 2021 offrira au KwaZulu-Natal l'occasion d'examiner les opportunités d'autonomisation économique qui sont créées pour améliorer la situation économique des filles et femmes dans le but d'arrêter la propagation du VIH et des IST.

A la mémoire de notre regretté Isilo, Sa Majesté le Roi Goodwill ka Bhekuzulu, nous espérons également utiliser ICASA 2021 pour partager des expériences avec notre continent et le monde sur le rôle crucial joué par l'ubukhosi, le leadership traditionnel, en réduisant les IST, en faisant progresser la circoncision médicale, en faisant la promotion du dépistage du VIH et de la tuberculose, ainsi qu'en luttant contre la stigmatisation du VIH et de la tuberculose. UHlangalomhlabathi, iMbube noma isilele yayikukhuthaza ukuziphatha kahle kwabantwana, ikakhulukazi abantwana bamantombazane.

En tant que KwaZulu-Natal, nous promettons offrir une conférence à succès en partenariat avec notre département national de la santé, le Conseil national sud-africain de lutte contre le sida (SANAC) et la SAA. Nous avons déjà désigné des membres du comité d'organisation local (LOC) du KZN, et ils ont un programme clair qu'ils mettent déjà en œuvre dans le cadre de la préparation de la Conférence. Nous accueillerons l'Afrique et le monde avec l'étreinte chaleureuse et amicale du KwaZulu-Natal. Les visiteurs qui assisteront en personne à la conférence expérimenteront par eux-mêmes l'élégance, la beauté, la culture et le riche patrimoine du royaume zoulou.

ICASA 2021 n'aurait pas pu avoir lieu dans un meilleur endroit que ce centre de convention international qui porte le nom du premier prix Nobel de la paix d'Afrique Laurette, Inkosi Albert Luthuli qui a reçu son prix il y a exactement soixante ans.

La lutte contre les IST, la tuberculose, le VIH et la stigmatisation est importante dans la construction d'une paix durable dans les relations, les foyers, les communautés et les sociétés. Des que nous nous réunissons en décembre, nous poserons à nouveau des bases solides de construction d'une paix durable, en créant des citoyens modèles et en libérant le potentiel entier du peuple du KwaZulu-Natal et de l'Afrique.

C'est le moment pour l'Afrique d'intensifier sa réponse. C'est le moment d'accélérer, de renforcer la collaboration et mieux utiliser les évidences pour atteindre nos objectifs. Saisissons le moment et soyons reconnus comme la génération qui a livré une Afrique sans sida.
C'est entre nos mains.

En effet, des lendemains meilleurs sont devant le KwaZulu-Natal et le continent africain.
Travaillons ensemble pour une meilleure Afrique et un

monde meilleur.
Namukulekile Kwelika Mthaniya, Kwelika Phunga non Mageba.
Je vous remercie.

SIHLE ZIKALALA
Premier Kwazulu Natal

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Opening Ceremony Speakers/ Orateurs de la cérémonie d'ouverture

Winnie Byanyima
Executive Director, UNAIDS
Under-Secretary-General, United Nations

WELCOME STATEMENT

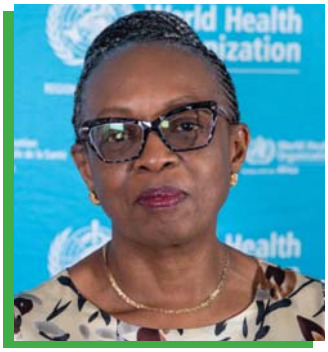
Friends and colleagues,
Welcome to Durban and to ICASA 2021!
Since we last came together for ICASA, the world has been upended by another devastating pandemic. COVID-19 has killed millions of people, ravaged economies, and severely tested HIV responses across the world. Like HIV before it, the response to COVID-19 has demonstrated the gaping inequalities that exist between countries and within them—most starkly reflected by the unjust global distribution of vaccines.

But amid the grief and sadness, I am proud that communities of people living with and affected by HIV leveraged their experience and expertise to fight this new threat, at the same time striving to protect the advances made against HIV. The strength that resides in communities gives me hope.
Now, I am asking you to dig even deeper.

This is a highly significant moment for all of us fighting to end AIDS. In June, the United Nations General Assembly adopted a new Political Declaration on Ending AIDS that puts ending inequalities at the core of our mission to end AIDS as a public health threat by 2030. This is also reflected in the new UNAIDS strategy adopted earlier this year.

Ending AIDS and upholding everyone's right to health depends on governments giving communities of women, young people, and other groups at higher risk of HIV infection the space and resources to lead from the front.
Solidarity, courage, and resilience are the greatest attributes of our movement and they will take us forward into a decade of action to end AIDS.

I wish you all a productive meeting!



Dr. MOETI Matshidiso
WHO Regional Director for Africa

WELCOME STATEMENT

I would like to thank His Excellency, President Cyril Ramaphosa, and the Government and people of South Africa for hosting the 21st International Conference on AIDS and STIs in Africa (ICASA). It is a pleasure for WHO to co-organize this event with the Society for AIDS in Africa. This important Conference is happening at a time when the tremendous progress African countries have made against HIV/AIDS is at risk.

The COVID-19 pandemic has disrupted access to some prevention and testing services and we now know that people living with HIV are more likely to experience severe COVID-19 symptoms than those without HIV. What's more, new HIV infections are not declining fast enough and rates of infection are unacceptably high among adolescent girls and young women. There are significant inequalities in access to services – children and key populations are being left behind.

So, ICASA in 2021, is a much-needed opportunity to share experiences, advocate and innovate, and to come together like never before, to reignite a global movement aimed at generating evidence for, scaling-up and accelerating Africa's actions in the race towards ending epidemics of AIDS by 2030.

Welcome to the 21st ICASA – Let's unite!

ICASA 2021

DURBAN, SOUTH AFRICA | 6-11 DEC. 2021

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The ICASA 2021 Youth Programme Committee leading the planning of youth programme activities at the ICASA 2021 towards Africa's AIDS response.
Le Comité du programme des jeunes de ICASA 2021 dirigeant le planning des activités du programme des jeunes lors de ICASA 2021 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 1,325 Abstracts.

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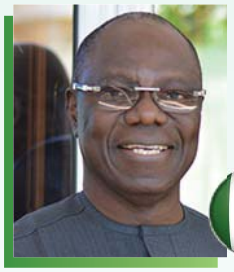

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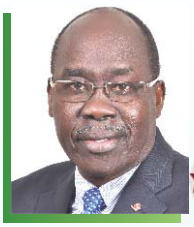

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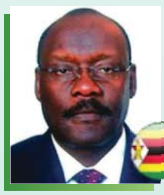

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SCHOLARSHIP

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 several organizations and we use this medium to thank them for their support for delegates attendance.

This year's Scholarship for ICASA 2021 was funded by the ICASA Conference and partners. In addition, the Government of South Africa gave more than 60 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.

Category	Number
Full scholarship	54
Partial scholarship	40
Virtual scholarship	1144
Total Scholarship Awardees	1238

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ICASA 2021 is supported by an excellent and dedicated team of 150 volunteers. The Conference organizers would like to especially thank all who supported volunteer recruitment and management process.

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ICASA 2021 Conference Rapporteurs were sponsored by the conference organizers and their T-shirts were supported by UNFPA

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Ms Phumelele Mngomezulu /Ms Nompumelelo Ntuli	-	Complaints, Compliments and Comments Management
Mr Sibongiseni Ngema / Mr Vincent Ngubane / Malcolm CanHam	-	Disaster Management
Dr Moeketsi Modisenyane	-	Protocols, Programme, Customs and Visa

LA BOURSE

Chaque deux ans, des bourses et d'autres types d'appui financiers sont accordés à un grand nombre de personnes pour leur permettre d'assister, de participer et de présenter leurs recherches à la conférence.

Cela est important pour garantir le maintien de l'équilibre quant à la représentation à la conférence et sa pertinence continue en tant que forum mondial. Pour ce faire, nous comptons sur l'appui financier de plusieurs organisations et nous utilisons ce média pour les remercier pour leur appui à la participation des délégués.

La bourse de cette année pour participer à ICASA 2021 a été financée par la conférence ICASA et ses partenaires. En outre, le gouvernement d'Afrique du Sud a accordé plus de 60 bourses aux participants locaux.

Les bourses accordées ont pris en compte toutes les 5 régions géographiques de l'Afrique. Les bourses ont été accordées à tous les présentateurs oraux et des affiches qui en ont fait la demande.

CATEGORIE	NOMBRE
Bourse entière	54
Bourse partielle	40
Bourse virtuelle	1144
Total bourses accordées	1238

LES BENEVOLES

ICASA 2021 est appuyé par une excellente équipe dévouée de 150 bénévoles. Les organisateurs de la conférence aimeraient remercier spécialement tous ceux qui ont soutenu le recrutement des bénévoles et le processus de gestion.

APPUI DES RAPPORTEURS

Les Rapporteurs de la conférence de ICASA 2021 ont été sponsorisés par les organisateurs de la conférence et leurs T-shirts financés par le FNUAP.

RAPPORTEURS

Col. Dr. Alain Azondekon	Rapporteur principal de la conférence
Mr. Tanguy Bognon	Assistant au rapporteur principal de la conférence
Madam Isabelle Bodea	Appui technique
Dr. David Ouedraogo	Track A
Dr. Raphael Adu-Gyamfi	Track B
Dr. Marie-Huguette Kingbo	Track C
Dr. Cossi Angelo Attinsounon	Track C
Dr. Kinsley Mort	Track D

Mrs. Marijanatu Abdulai	Track E
Miss Olympia Laswai	Track E

SECRETARIAT INTERNATIONAL DE ICASA

M. Luc Armand Bodea	-	Directeur de ICASA
Mme Clemence Assogba	-	Responsable des inscriptions
M. Raymond Yekeye	-	Chargé de Programme sur le site
M. Innocent Laison	-	Chargé des opérations sur le site
Col. Dr. Alain Azondekon	-	Responsable des rapporteurs
Prof. Morenike Ukpong	-	Chargé de Communication
M. Daniel Epeh	-	Responsable du Suivi & Evaluation
Mrs. Margaret Owusu-Amoako	-	Responsable de l'exposition des affiches
Dr. Emil Asamoah-Odei	-	Assistant technique
M. Frank Amoah	-	Comptable du projet
M. Tapiwa Guwindoga	-	Chargé des TI
M. Chris Kwasi Nuatro	-	Chargé du Marketing/ Partenariat
M. Gordon Mwinkoma Tambro	-	Chargé de programme
M. Emmanuel T. Kuadzi	-	Administrateur TI/ Web
Mlle Marie-Noelle Atta	-	Chargée de Marketing/ Partenariat Snr.
M. Leslie Sodjinu	-	Coordinateur Logistique/ Hébergement
M. Felix Apana Okley	-	Assistant TI
M. Alphonse Nengoma	-	Chargé des comptes sur le site
Mme Lillian Yeboaa Oteng	-	Chargée des inscriptions
M. Julius Mortsi	-	Assistant à l'inscription des médias communautaires/ des jeunes
M. Ziberu Abdul Manaf	-	Appui technique
M. Derick Ayitey	-	Chauffeur
M. Augustine Vasco Nyarko	-	Chauffeur
Mlle Gift y Mensah	-	Concierge

General Information / Informations Générales

DURBAN INTERNATIONAL CONVENTION CENTRE, SOUTH AFRICA

The 21st International Conference on AIDS and STIs in Africa is taking place in Durban, at the Durban International Convention Centre (Durban ICC), South Africa.

The full address of the venue is: Follow the N2 Northern Freeway in a Southerly direction. Approaching Durban take the Mt Edgecombe/Umhlanga slip road, heading towards the sea. Follow the signs to Durban and proceed along the Ruth First Freeway M4 (Northern Freeway) past Virginia Airport and Durban North. On approaching Durban, proceed straight over the Sandile Thusi Road (Argyle) intersection and turn right onto Bram Fischer Road (Ordnance Road). The entrance to parking is on the corner of Stalwart Simelane Street (Stanger) and Bram Fischer Road.

View Map/Directions: **https://icc.co.za/contact/map/**
Should you encounter any problems, or require any additional information, please ask any of the conference staff or volunteer, or visit our General Information Desk, which is located in the Registration Area on the ground floor.

CERTIFICATES OF ATTENDANCE
Certificates will be sent virtually to all ICASA 2021 Delegates from Saturday, 11th December 2021.

COMMUNITY VILLAGE
The Community Village is an integral and vibrant element of the ICASA programme. ICASA 2021 Community Village will be an all new and exciting Hybrid Experience. To access ICASA 2021 Virtual community Village, one needs to be register via the ICASA 2021 Virtual Community Village Registration Portal. Due to COVID-19 and its associated restrictions, only a total of 80 people will be allowed into the Community village per session. All who desire to be part of this year's ICASA 2021 Hybrid Community Village must be vaccinated and mut show proof of vaccination (COVID -19 vaccination card). Due to the limited numbers, participation will be on a first come, first serve basis.

The Village will host virtual community village sessions cutting across the 8 ICASA 2021 networking zones, giving conference participants and the general public and the diaspora, the opportunity to interact virtually with Community Leaders, Representatives from Civil Society and government agencies/institutions.

Link to access the Online Community Village Session planner: ***https://bit.ly/3ClOZjC***

The Hybrid ICASA 2021 Community Village will be open from 7th – 10th December 2021.

CONFERENCE REGISTRATION
The Registration area is located on the ground floor and is clearly marked on the conference floor plan.

OPENING HOURS:

Monday, 6th December 2021	8:45 AM – 16:00 PM
Tuesday, 7th December 2021	8:45 AM – 17:00 PM
Wednesday, 8th December 2021	8:45 AM – 17:00 PM
Thursday, 9th December 2021	8:45 AM – 17:00 PM
Friday, 10th December 2021	8:45 AM – 17:00 PM
Saturday, 11th December 2021	8:45 AM – 12:15 PM

Conference delegates must wear their badges at all times in order to gain access to the session rooms and exhibition area. Conference volunteers and the venue security will not allow anyone to enter the conference venue without a valid badge. If you have lost your badge, please contact the registration desk.

Replacement badges will be issued at a cost of $60 each (including VAT). Accompanying adult participants are permitted access to the opening and closing ceremonies. Only children (under 18) registered as accompanying persons will be admitted to all conference sessions.

EXHIBITION
In-Person Exhibition booths are located in the Exhibition Hall at Hall 3A to 4D offering delegates a chance for dynamic interaction with exhibitors. There are plenty of exciting exhibitors at ICASA and delegates are encouraged to visit all stands to discover the latest news from our supporting organizations.

Some exhibitors will give demonstrations in the Exhibition Hall which promises to add an extra level of interest to conference participation. All the stands are marked on the dedicated Exhibition Map to make each booth easy to find.

Access virtual booth via **icasa2021.vfairs.com**

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

INTERNET/WIFI
The Durban ICC wireless internet is available in all conference venues. If you need help to access the internet with your device, please visit the General Information Desk or the help 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 as well as all virtual platforms.

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

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

MEDIA CENTRE
Media registration must be carried out at the dedicated Media Registration Desk in the Registration at Hall 5A. Accredited media will have full access to the Media Centre located on the ground floor. The Media Centre will be open daily from Monday, December 6th to Saturday, 11th December 2021, from 07:00 AM to 19:00 PM.

The Media Centre will be equipped with computers and printers for use by ICASA 2021 for accredited journalists. Information on press conference and briefings will be posted in Media Centre with updated dates and times. Journalists wishing to secure interviews with conference speakers will be assisted in the Media Centre.

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

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

POSITIVE LOUNGE
The Positive Lounge is provided exclusively for people living with HIV as a place where they can rest, refresh themselves, network and take medications.
The Positive Lounge is located at the MR11/12 E, Lower Concourse, and it's open from Tuesday, 7th December to Friday, 10th December, 08:00AM and 7:00PM.

PRESENTERS, SPEAKERS, CHAIRS AND FACILITATORS
The faculty is located at MR 21/22 A, upper concourse (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 confirm their presentation date, time and venue and receive specific security information relevant to their session.

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

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

OPENING HOURS:

Monday, 6th December 2021	10:00 AM – 16:00 PM
Tuesday, 7th December 2021	8:00 AM – 17:00 PM
Wednesday, 8th December 2021	8:00 AM – 17:00 PM
Thursday, 9th December 2021	8:00 AM – 17:00 PM
Friday, 10th December 2021	8:00 AM – 17:00 PM
Saturday, 11th December 2021	8:00 AM – 12:15 PM

POSTER EXHIBITION
The ICASA 2021 Poster Exhibition will be organized virtually throughout the Conference from 7th – 10th December 2021. Poster exbition time is from 11:39 - 12:24. Please refer to the ICASA 2021 Online programme or ICASA 2021 App for an overview of Virtual Poster Exhibition

Access virtual Posters via **icasa2021.vfairs.com**

INSTRUCTIONS FOR POSTER EXHIBITORS/ PRESENTERS:
The posters will be displayed virtually throughout the Conference. During breaks, presenting authors are required to be online to interact and answer questions and provide further information on their study results.

SECURITY

The Safety and Security Office is located on-site and can be contacted on our emergency lines: +27 31 3601007
For security reasons, access to all the Congress venues will be controlled. Access to the session rooms and Exhibition Halls of the Durban ICC 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 Durban ICC 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, associates and subcontractors liable in respect of all cost, claims, demands and expenses as a result of any damage, loss or injury to any person howsoever caused as a result of any act or default of the Conference Secretariat or a person representing the Conference Secretariat, their contractors or guests.

In addition, the conference participant shall take all necessary precautions to prevent any loss or damage to his/her property with special regard to mobile phones, carry/ handbags and computing equipment.

ICASA 2021 ATTENDEE HEALTH AND SAFETY MEASURES

Here's all you need to know for attending ICASA 2021 safely, responsibly, and confidently. Note that some guidelines are mandatory.

NB: All delegates should have their covid test done at least 72 hours prior to departure. It is compulsory to be vaccinated if you are attending in-person

Action to take in advance

Mandatory - badging

To avoid lines, we'll email your Letter of Invitation in advance. You'll need to save it on your phone and bring it with you. Badge holders and/or lanyards will also be available at registration desks.

At Durban ICC - moving in and around the venue

Mandatory - face masks

You must wear a face mask all the time inside Durban International Convention Center (except for medical exemptions). Both venue staff, Security and ICASA 2021 Volunteers are jointly responsible for monitoring face covering compliance and both are authorized to escort people out of the venue in the case of non-compliance.

Mandatory - staff access to booths

Booths with exhibiting partners will have their own dedicated registration desk with a clearly visible reception desk. This will ease traffic flow and minimize contact with attendees at peak times.

Entering the Conference

Traffic flow in and out of the conference will be carefully managed. As far as possible we will ensure one way movement of people and minimal contact. We will also provide plenty of clear signage and extra event staff to guide you on your way.

Exhibition hall density

Wider aisles will be added wherever possible and we'll provide more seating areas in the exhibit hall to reduce crowding and improve traffic flow.

Mandatory - refreshments

The venue will provide an extended range of individually packaged food items and will observe all applicable COVID health and safety standards.

Cleaning standards and special measures during the conference

Mandatory-exhibition Hall cleaning

The convention space will be cleaned regularly including electrostatic spray treatment every night in accordance with ICC standards. Exhibitors will also be required to clean meeting areas between each appointment or meeting.
Mandatory - health and safety monitoring
Staff from ICASA 2021, volunteers and security of the venue will continually monitor the Covid safety procedures across the show to ensure compliance and safety for all attendees.

Hand sanitizer

Hand sanitizer dispensers will be placed throughout the show as well as on many exhibitor booths. Also,
PPE will be provided to all delegates at the registration desk. Attendees are encouraged to sanitize their hands frequently and aft er every meeting.

Meeting/conference rooms

Meeting rooms will be set up in compliance with the current distancing and capacity guidelines in South Africa to ensure you can take part safely in ICASA 2021 sessions.
Other safety standards
The venue has implemented a vast range of health and safety measures which are not detailed on this page but can be viewed on the venue website.
Importantly, the entire Durban -ICC, including the exhibition halls, is equipped with a highly efficient ventilation system that provides full air exchanges per hour and meets the current International Conference

standards.
In case of delegate COVID19 Test exit, is positive the delegate will support all cost related inclusive quarantine.
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SMOKING POLICY

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

SOCIAL MEDIA

Connect with ICASA through our social media platforms and stay abreast with happenings during the conference. Follow us on Twitter (@ICASA2021), like our Facebook page (ICASA2021) and download the ICASA EVENT App (Available on iOS (Apple Devices) and Playstore (Android Devices) via **https://event.crowdcompass.com/** or visit the ICASA 2021 Website to access the ICASA 2021 Online Conference Programme: **https://bit.ly/3vNiMPM**

CENTRE DE CONVENTION INTERNATIONAL DE DURBAN, AFRIQUE DU SUD

La 21ème Conférence Internationale sur le SIDA et les IST en Afrique aura lieu à Durban, au Centre de Convention International de Durban (Durban CCI), Afrique du Sud.

L'adresse complète du lieu est : Suivre la N2 Autoroute du Nord en direction du Sud. À l'approche de Durban, prendre la voie de déviation Mt Edgecombe/Umhlanga en direction de la mer. Suivre les panneaux pour Durban et continuer le long de la Ruth First Freeway M4 (Autoroute du Nord), dépasser l'aéroport de Virginie et Durban North. En approchant de Durban, continuer tout droit jusqu'à l'intersection de la route Sandile Thusi (Argyle) et tourner à droite sur la Route Bram Fischer (route de l'Ordnance). L'entrée du parking est au coin de Stalwart Simelane Street (Stanger) et de Bram Fischer Road.

Voir la carte/l'itinéraire : **https://icc.co.za/contact/map/**
Si vous rencontrez des difficultés ou avez besoin d'informations complémentaires, veuillez vous adresser au personnel de la conférence ou aux bénévoles ou visitez notre bureau d'informations générales situé sur l'aire d'enregistrement au rez-de-chaussée.

ATTESTATION DE PARTICIPATION

Les certificats seront envoyés virtuellement à tous les délégués de ICASA 2021 à partir du samedi 11 décembre 2021.

VILLAGE COMMUNAUTAIRE

Le village communautaire est un élément intégral et dynamique du programme de ICASA. Le village communautaire de ICASA 2021 sera une toute nouvelle et passionnante expérience hybride. Pour accéder au village communautaire virtuel de ICASA 2021, il faut s'inscrire via le portail d'inscription au village communautaire virtuel de ICASA 2021.

En raison du COVID-19 et de ses restrictions, seules 80 personnes au total seront autorisées à entrer au village communautaire par session. Tous ceux qui désirent faire partie du village communautaire hybride de ICASA 2021 de cette année doivent être vaccinés et présenter une preuve de cette vaccination (Carte de vaccination COVID-19). En raison du nombre de place limité, la participation se fera selon le principe du premier arrivé, premier servi.

Le Village accueillera des sessions virtuelles du village communautaire recoupant les 8 zones de réseautage de ICASA 2021, donnant aux participants à la conférence et au grand public, ainsi qu'à la diaspora, la possibilité d'interagir virtuellement avec les leaders communautaires, les représentants de la société civile et les organes/

institutions gouvernementales.
Lien d'accès au programmeur de la session du village communautaire en ligne : **https://bit.ly/3ClOZjC**

Le village communautaire hybride de ICASA 2021 sera ouvert du 7 au 10 décembre 2021.

INSCRIPTION À LA CONFÉRENCE
La zone d'inscription est située au rez-de-chaussée et est clairement indiqué sur le plan de la conférence.

HEURES D'OUVERTURE:

Lundi 6 décembre 2021	8h45 - 16h00
Mardi 7 décembre 2021	8h45 - 17h00
Mercredi 8 décembre 2021	8h45 - 17h00
Jeudi 9 décembre 2021	8h45 - 17h00
Vendredi 10 décembre 2021	8h45 - 17h00
Samedi 11 décembre 2021	8h45 - 12h15

Les participants à la conférence doivent porter leurs badges en tout temps afin d'accéder aux salles de session et à l'aire d'exposition. Les bénévoles de la conférence et la sécurité du site ne permettront à personne d'entrer dans la salle de conférence sans un badge valide. Si vous perdez votre badge, veuillez contacter le bureau d'inscription.

Des badges de remplacement seront émis au coût de 60$ l'unité (y compris la TVA). Les accompagnants des participants adultes sont autorisés à participer aux cérémonies d'ouverture et de clôture.

Seuls les enfants (moins de 18 ans) inscrits comme accompagnants seront admis à toutes les sessions de la conférence.

EXPOSITION
Les stands d'exposition physiques sont installés sur l'aire d'exposition de la salle 3A à 4 D, offrant ainsi aux délégués une opportunité d'interaction dynamique avec les exposants. Il y a beaucoup d'exposants passionnés à ICASA et les délégués sont encouragés à visiter tous les stands afin de découvrir les dernières nouveautés de nos organisations partenaires.

Certains exposants feront des démonstrations dans la salle d'exposition ; ce qui promet offrir un niveau d'intérêt supplémentaire à la participation à la conférence. Tous les stands sont indiqués sur le Plan d'exposition pour rendre facile la localisation de chaque stand.
Accédez au stand virtuel via **icasa2021.vfairs.com**

BUREAUX D'INFORMATION
Un bureau d'informations générales est situé dans l'aire d'inscription. Il y a des guichets d'informations complémentaires spécifiques à chaque zone dans l'aire d'exposition. Les bénévoles seront installés tout au long de la conférence pour aider les participants avec toute demande de renseignements.

INTERNET/WIFI
Le wifi de Durban ICC est disponible sur tout le site de la conférence. Si vous avez besoin d'aide pour accéder à Internet avec votre appareil, veuillez visiter le bureau d'informations générales ou le bureau d'aide de MTN.

INTERPRÉTATION (EN/FR).
Les langues officielles de la conférence sont l'anglais et le français. L'interprétation simultanée de l'anglais au français et du français vers l'anglais sera offerte dans toutes les salles de session, ainsi que sur toutes les plateformes virtuelles.
Si vous souhaitez utiliser les services d'interprétation simultanée, prenez un casque d'écoute avant la session immédiatement devant la salle de session concernée. Les délégués sont tenus de déposer un passeport valide ou 100 $US en espèces pour s'offrir un casque d'écoute. Celui-ci sera restitué lorsque le casque sera remis. Les délégués seront facturés à 100 $US pour les casques perdus, égarés ou endommagés.
Pour éviter la longue attente, veuillez vous procurer des casques pendant la pause avant la session. Veuillez retourner l'équipement à la fin de chaque session pour garantir leur recharge pour l'utilisation du lendemain.

CENTRE DE PRESSE
L'inscription des médias doit être effectuée au bureau d'inscription consacré aux médias dans la zone d'inscription au niveau du Hall 5A. Les médias accrédités auront un accès total au Centre de Presse situé au rez-de-chaussée. Le Centre de Presse sera ouvert tous les jours du lundi 6 décembre au samedi 11 décembre 2021, de 07:00 à 19:00.

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 désirent avoir 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 dans le Guide des médias qui sera délivré à tous les journalistes accrédités pour la conférence.

DIRECTIVES POUR LA PARTICIPATION/CODE DE CONDUITE

La conférence reconnaît 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 sud-africaine sera appliquée.

LE SALON POSITIF

Le Salon Positif est offert seulement aux personnes vivant avec le VIH comme un lieu de repos, de rafraichissement ou pour constituer des réseaux et prendre leurs médicaments. Le Salon Positif est situé au MR11/12 E, Lower Concourse et il est ouvert du mardi 7 décembre au vendredi 10 décembre, de 08:00 à 19:00.

PRÉSENTATEURS, CONFÉRENCIERS, PRÉSIDENTS ET FACILITATEURS

La faculté est située au MR 21/22 A, au-dessus de Concourse (veuillez consulter le plan du lieu de la conférence). Tous les conférenciers, présidents, modérateurs, facilitateurs et présentateurs oraux sont priés de se rendre à la faculté immédiatement après l'inscription pour confirmer la date, l'heure et le lieu de leur communication et recevoir les informations sécuritaires spécifiques à leur session.

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

NB: Ne pas se référer à temps à la faculté pourra amener les organisateurs à désigner des remplaçants.

HEURES D'OUVERTURE:

Lundi 6 décembre 2021	8:00 – 16:00
Mardi 7 décembre 2021	8:00 – 17:00
Mercredi 8 décembre 2021	8:00 – 17:00
Jeudi 9 décembre 2021	8:00 – 17:00
Vendredi 10 décembre 2021	8:00 – 17:00
Samedi 11 décembre 2021	8:00 – 12:15

EXPOSITION DES AFFICHES

L'exposition des affiches à ICASA 2021 sera organisée virtuellement tout au long de la conférence du 07 au 10 décembre 2021. L'exposition d'affiches se fera chaque jour de 11:39 - 12:24. Veuillez vous référer au programme en ligne de ICASA 2021 ou à l'application de ICASA 2021 pour un aperçu des expositions virtuelles des affiches.
Accéder aux affiches virtuelles via icasa2021.vfairs.com

INSTRUCTIONS POUR LES PRESENTATEURS/ EXPOSANTS D'AFFICHES:

Les affiches seront présentées virtuellement tout au long de la conférence. Pendant les pauses, les présentateurs sont tenus de se connecter pour échanger et répondre aux questions et donner des informations supplémentaires sur les résultats de leurs études.

SECURITE

Le Bureau de la Sécurité se trouve sur place et peut être contacté sur nos lignes d'urgence au +27 31 3601007.
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 International de Durban sera accessible uniquement pour les participants inscrits portant des badges de la conférence. Dans l'intérêt d'une sécurité personnelle, les participants doivent présenter leurs badges de conférence seulement dans les locaux du Centre de Convention International de Durban.

Ni le Secrétariat de la Conférence, ni aucun de leurs prestataires contractuels, ne sera responsable de la sécurité des articles apportés 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 de 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.

MESURES DE SANTÉ ET DE SÉCURITÉ DES PARTICIPANTS A ICASA 2021

Voici tout ce que vous devez savoir pour assister à ICASA 2021 en toute sécurité, de manière responsable et en toute confiance. Notez que certaines des directives sont obligatoires.
NB: Tous les délégués doivent faire leur test COVID au moins 72 heures avant leur déplacement. Il est obligatoire d'être vacciné si vous assistez en personne.

ACTIONS À ENTREPRENDRE EN AMONT

Obligatoire - badge

Pour éviter les files d'attente, nous vous enverrons en avance votre lettre d'invitation par e-mail. Vous devrez l'enregistrer sur votre téléphone et l'apporter avec vous. Les porte-badges et/ou cordons seront également disponibles aux bureaux d'inscription.

Au Centre de Convention International de Durban - se déplacer dans la conférence

Obligatoire - masques faciaux

Vous devez porter un masque facial tout le temps à l'intérieur du Centre de Convention International de Durban (sauf pour les dispenses médicales). Le personnel des deux sites, la sécurité et les bénévoles de ICASA 2021 sont conjointement responsables de la surveillance du respect du visage couvert et les deux sont autorisés à escorter les personnes hors de la salle en cas de non-respect.

Obligatoire - accès du personnel aux stands

Les stands avec les partenaires exposants auront leur propre bureau d'inscription avec un bureau de réception bien visible. Cela facilitera la circulation et minimisera les contacts avec les participants aux heures de pointe.

Entrer dans la conférence

Le trafic entrant et sortant de la conférence sera soigneusement géré. Dans la mesure du possible, nous assurerons une seule voie de circulation des personnes et un contact minimal. Nous allons également apporter beaucoup de signalisations claires et du personnel supplémentaire pour vous orienter.

Densité des salles d'exposition

Des allées plus larges seront ajoutées dans la mesure du possible et nous fournirons plus de places assises dans la salle d'exposition pour réduire le surpeuplement et améliorer la fluidité du trafic.

Obligatoire – les rafraîchissements

Le site offrira une gamme variée de produits alimentaires emballés et observera toutes les mesures sanitaires et sécuritaires liées au Covid. Il y aura aussi une aire de restauration et un village de marché à l'extérieur du site du Centre de Convention International.

Normes de nettoyage et mesures spéciales pendant le spectacle

Obligatoire- Nettoyage de la salle d'exposition

L'espace de la convention sera nettoyé régulièrement, y compris le traitement par pulvérisation électrostatique tous les soirs, conformément aux normes du Centre de Convention International. Les exposants devront également nettoyer les espaces de rencontre entre chaque rendez-vous ou réunion.

Obligatoire - surveillance de la santé et de la sécurité

Le personnel de ICASA 2021, les bénévoles et la sécurité du site surveillera en permanence les procédures de sécurité Covid pendant tout le salon pour assurer la conformité et la sécurité de tous les participants.

Désinfectant pour les mains

Des distributeurs de désinfectant pour les mains seront placés partout dans le salon, ainsi que dans de nombreux stands d'exposants. Aussi, le PPE sera offert à tous les délégués au niveau du bureau d'inscription. Les participants sont encouragés à se désinfecter fréquemment les mains et après chaque réunion.

Salles de réunion/conférence

Les salles de réunion seront aménagées dans le respect des directives actuelles en matière de distanciation et de capacité en Afrique du Sud pour vous assurer une participation en toute sécurité aux sessions de ICASA 2021.

Autres normes de sécurité

Le site a mis en place une large gamme de mesures sanitaires et sécuritaires non détaillées sur cette page mais qui peuvent être consultées.

Il est important de noter que l'ensemble du Centre de Convention International de Durban, y compris les salles d'exposition est équipé d'un système de ventilation très efficace qui donne des échanges d'air complets par heure et répond aux normes internationales actuelles en matière de conférence.

Au cas où un délégué est testé positif au COVID 19, ce dernier prendra en charge tous les frais, y compris ceux de la quarantaine.

POLITIQUE DE TABAGISME

Il est interdit de fumer partout dans le bâtiment. Lorsque vous fumez dehors, merci de respecter l'environnement, les collègues délégués et autres invités en éliminant correctement les mégots de cigarettes et autres déchets dans les bacs fournis.

MEDIAS SOCIAUX

Connectez-vous avec ICASA via nos plateformes de médias sociaux et restez informés des événements pendant la conférence.

Suivez-nous sur Twitter (@ICASA2021), aimez notre page Facebook (ICASA2021) et téléchargez l'application ICASA EVENT (disponible sur iOS (appareils Apple) et Playstore (Appareils Android) via https://event.crowdcompass.com/ ou visitez le site web de ICASA 2021 pour accéder au programme de la conférence en ligne de ICASA 2021 : **https://bit.ly/3vNiMPM**

Best Abstract Award Recipients - ICASA 2021

TRACK A

Title of Abstract: Investigating the potential of traditional medicines in reactivation of latent HIV-1

Khanyisile Mngomezulu

South Africa

Khanyisile Mngomezulu is a doctoral candidate in the Discipline of Traditional Medicine, School of Nursing and Public Health at the University of KwaZulu-Natal. She obtained her Masters in Medical Sciences and BSc Honors in Medical Microbiology.

Her doctoral research focuses on finding traditional medicinal plants with the ability to reactivate latent HIV using laboratory models. Her research study is being conducted in collaboration with world class researchers from the Simon Fraser University, University of Pretoria, and the Africa Health Research Institute of the University of KwaZulu Natal.

This research has the potential to resolve one of the last stumbling blocks to treatment of HIV, which is the inability of highly active antiretroviral therapy to clear HIV copies in latently infected immune cells. She has also authored and co-authored papers in peer- reviewed journals.

TRACK B

Title of Abstract: Morbidity and associated factors among patients living with HIV-2 in West Africa

Dr. Simon Pierre Boni

Cote D'Ivoire

Né le 08 Mars 1987, Dr Simon Pierre BONI est ivoirien, marié et père d'une fille. Il fait des études supérieures à Abidjan, Côte d'Ivoire où il obtient en 2016 le diplôme de docteur d'état en médecine. Il est titulaire d'un diplôme d'université en épidémiologie des cancers et d'un master en santé publique option santé internationale obtenus à l'Université de Bordeaux.

Ses domaines de compétences sont l'épidémiologie et la santé globale, l'évaluation de programmes de santé et l'implémentation et la coordination de projets de recherche. Depuis 2017, il coordonne des projets de recherche sur la thématique VIH et cancer au sein du consortium International epidemiology Databases to Evaluate Aids(IeDEA) West Africa et collabore en qualité de chef de projet au Programme PAC-CI, avec d'autres équipes, sur les hépatites virales et le VIH-2. Il est par ailleurs médecin en charge du developpement du Partenariat et de la multisectorialité au Programme National de Lutte contre le cancer en Cote d'Ivoire.

TRACK C

Title of Abstract: Changes In Sexual Behaviour Among Women In Studies Evaluating the Dapivirine Vaginal Ring For HIV Prevention

Kudzai Hlahla

Zimbabwe

Position: Pharmacist of Record University of Zimbabwe Clinical Trials Research Centre (UZ-CTRC)

Kudzai Hlahla, B Pharm (Hons); Post graduate Diploma (HIV) Management, is a research pharmacist based in Harare Zimbabwe. She has 8 years of experience in setting up and implementation of clinical trials in HIV prevention and has participated in seven phase II-IV trials including those involving investigational new drugs (INDs) in women and adolescent women and young girls (AWYG) at risk of HIV acquisition.

She has extensive experience in running clinical site pharmacies including the handling, preparation and dispensing of investigational product including nanosuspensions, long acting injectables, monoclonal antibodies and managing PrEP-based products namely TDF/FTC and the Dapivirine intravaginal ring for HIV prevention.

Her research interests include the epidemiology of infectious diseases including HIV and TB in women and AWYG in Sub Saharan Africa, and the implementation of safe and effective biomedical and behavioral interventions in this population. She is passionate about contributing to the existing body of knowledge through the publication of robust clinical research papers that inform current and future practice and public health policy. As such, Kudzai is in her final year of her Master's in Public Health

TRACK D

Title of Abstract: Social isolation is associated with major depressive disorders among women accessing HIV/AIDS care in Nigeria

Dr. Olumide Adetokunbo Abiodun

Nigeria

Olumide is a Nigeria-based Public Health Physician with over 16 years of experience working in HIV/AIDS, adolescent health, reproductive health, epidemiology of cancer and infectious disease, cancer control, research, education, management, and consultancy. He was a consultant/investigator to the CLIP-Nigeria trial, a multi-million-dollar project funded by the Bill & Melinda Gates Foundation Saving Lives at Birth (through Grand Challenges Canada).

The project aimed to address the excess maternal and perinatal mortality derived from the failure to identify and rapidly manage pre-eclampsia and eclampsia at the community level in LMICs. I have been a member of several professional and management groups. Also, Olumide is involved in capacity development, bespoke training, critical review, and overall project management. His research and consultancy have culminated in several peer-reviewed publications.

Olumide is presently exploring critical contextual factors for designing and implementing effective adolescent suicide behavior interventions in sub-Saharan Africa. He is an Associate Professor in the Department of Community Medicine, Babcock University, Nigeria.

TRACK E

Title of Abstract: Utilizing community-driven strategies to break through barriers to HIV service uptake among people who inject drugs (PWID) in Bayelsa State, Nigeria

Adekunle Emmanuel Idowu

Nigeria

Idowu Adekunle Emmanuel is a public health professional with 9 year's progressive experience in planning, designing, implementing, monitoring, and evaluating public health programs in sexual reproductive health and rights, HIV/AIDs, and TB. He has a bachelor's degree in Pure and Applied Physics from the Ladoke Akintola University of Technology, Oyo state Nigeria and is currently undergoing a master's degree program on data science at Rome Business School Italy.

He is currently working with Achieving Health Nigeria Initiative on the Meeting Targets and Maintaining Epidemic Control (EpiC) project. Under the USAID's key population investment fund (KPIF), EpiC Nigeria is implementing activities with a focus on accelerating current key and priority population programs for female sex workers (FSW), men who have sex with men (MSM), persons who inject drugs (PWID), transgender persons, and prison inmates (PI) in Bayelsa and Niger states. Implementation commenced in December of 2019, and services provided are across the entire HIV/AIDS prevention, care, and treatment cascade for key populations at the community and facility levels. The project maintains well-structured One-Stop-Shop (OSS) and Drop-In Centers (DICs) to offer these comprehensive services seamlessly.

He has worked extensively on PEPPER/USAID-funded projects with various international organizations (FHI360, Heartland Alliance International, Hygeia Foundation) where he provided technical assistance on data use and dissemination through institutional and capacity building, effective partnership, and stakeholder management.
Idowu has previously worked on the FHI360 SIDHAS project in different capacities between 2016-2018. He has broad experience in data analytics, data quality assurance, capacity building, and he is familiar with donor demands. He enjoyed reading and traveling.

Session Coding/Codification des Sessions

ICASA 2021 SESSION CODING

EXAMPLE 1: MOAA01 = MO (WEEKDAY) – (SESSION TYPE) AA – (SESSION ORDER) 01

EXAMPLE 2: MOAA0103 = MO (WEEKDAY) – (SESSION TYPE) AA – (SESSION ORDER) 01 - ABSTRACT ORDER) 03

EXAMPLE 3: FOR POSTER: PEA001 = PE (Poster Exhibition) – (TRACK CATEGORY) A – (ABSTRACT ORDER) 001

WEEKDAY	SESSION TYPE	SESSION ORDER	SPEAKER ORDER
MO (MONDAY)	PL (PLENARY SESSION)		01,02,03
TU (TUESDAY)	SS (SPECIAL SESSION)		
WE (WEDNESDAY)	NAD (NON-ABSTRACT DRIVEN SESSION)		
TH (THURSDAY)	WS (WORKSHOP)		
FR (FRIDAY)	SY (SATELLITE SYMPOSIA)		
SA (SATURDAY)	AA (ABSTRACT DRIVEN SESSION)	01,02,03…etc	01,02,03

SESSION TYPE	COLOR CODE
PL (PLENARY SESSION)	
SS (SPECIAL SESSION)	
NAD (NON-ABSTRACT DRIVEN SESSION)	
WS (WORKSHOP)	
SY (SATELLITE SYMPOSIA)	
AA (ABSTRACT DRIVEN SESSION)	
PE (POSTER EXHIBITION)	

TRACK	POSTER ABSTRACT CODE
TRACK A	PEA001, 2, 3…ETC
TRACK B	PEB001, 2, 3…ETC
TRACK C	PEC001, 2, 3…ETC
TRACK D	PED001, 2, 3…ETC
TRACK E	PEE001, 2, 3…ETC

CODIFICATION DE LA SESSION DE ICASA 2021

EXEMPLE 1 : MOAA01 = MO (JOUR DE SEMAINE) – (TYPE DE SESSION) AA – (ORDRE DE SESSION) 01

EXEMPLE 2 : MOAA0103 = MO (JOUR DE SEMAINE) – (TYPE DE SESSION) AA – (ORDRE DE SESSION) 01 - ORDRE D'ABSTRACT) 03

EXEMPLE 3 : POUR L'AFFICHE : PEA001 = PE (Exposition d'affiches) – (CATEGORIE DE TRACK) A – (ORDRE D'ABSTRACT) 001

JOUR DE LA SEMAINE	TYPE DE SESSION	ORDRE DE SESSION	ORDRE DU CONFERENCIER
MO (LUNDI)	PL (SESSION PLÉNIÈRE)		01,02,03
TU (MARDI)	SS (SESSION SPECIALE)		
WE (MERCREDI)	NAD (SESSION NON CONDUITE AVEC DES ABSTRACTS)		
TH (JEUDI)	WS (ATELIER)		
FR (VENDREDI)	SY (SYMPOSIA SATELLITE)		
SA (SAMEDI)	AA (SESSION CONDUITE AVEC DES ABSTRACTS)	01,02,03… etc	01,02,03

TYPE DE SESSION	CODE DE COULEUR
PL (SESSION PLENIERE)	
SS (SESSION SPECIALE)	
NAD (SESSION NON CONDUITE AVEC DES ABSTRACTS)	
WS (ATELIER)	
SY (SYMPOSIA SATELLITE)	
AA (SESSION CONDUITE AVEC DES ABSTRACTS)	
PE (EXPOSITION DES AFFICHES)	

TRACK	CODE DES ABSTRACTS DES AFFICHES
TRACK A	PEA001, 2, 3…ETC
TRACK B	PEB001, 2, 3…ETC
TRACK C	PEC001, 2, 3…ETC
TRACK D	PED001, 2, 3…ETC
TRACK E	PEE001, 2, 3…ETC

Programme Overview / Guide du Programme

SESSION PLANNER

NON-ABSTRACT DRIVEN SESSIONS

The non-abstract driven sessions address a variety of current viewpoints and issue. 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. This 45-minute 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 2021 features 4 high-quality, targeted professional development **workshops** that promote and enhance opportunities for knowledge transfer, skills development and collaborative learning designed by the Conference Programme Committees. For ICASA 2021 Workshop will be 45 minutes in length and with simultaneous translation in both French and English.

A rapporteur summary session will be held immediately before the closing session on December 11th December from 10:42 to 11:27. 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.

Oral Abstract Sessions - These sessions are organized into themes which address new developments in each of the five scientific tracks or focus on a topic which crosses various tracks. Oral abstract sessions are 45-minute sessions that consist of five oral presentations of ten mutinies followed by a five-minute question and answer session. An interactive moderated discussion, facilitated by the co-chairs, is held at the end of the session.

POSTER EXHIBITION

Organized by track and covering a wide variety of topics, the Poster Exhibition which will be virtual for ICASA 2021 includes approximately 0ver 350 posters. Each poster is displayed throughout the conference from 7th – 10th December 2021 and presenters will interact with delegates virtually at scheduled times to answer questions and provide further information on their study results.

PROGRAMME ACTIVITIES

Programme activities at ICASA 2021 are hosted by individuals, groups and organizations in the Global village area of the conference venue. Accessible to registered conference participants and free of charge to the general public, they offer a unique platform for diverse activities that bridge all areas of science, leadership and accountability and community.

COMMUNITY VILLAGE

The Community Village activities include Panel discussions and debates on cutting-edge HIV issues; Film screenings; Art exhibits; Networking zones focusing on key populations and issues; NGO and marketplace booths showcasing the work and products 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 is located at Hall 5B within the Durban ICC

Additional information about the Community Village and Youth Programme can be found on the conference website at: icasa2021.saafrica.org and the Community village pocket programme.

Stay up to date with everything happening in the ICASA 2021 Hybrid Community Village by following @ICASA2021 on Twitter.

ICASA 2021 COMMUNITY VILLAGE NETWORKING ZONES

- PERSONS LIVING WITH DISBALITY NETWORKING ZONE
- WOMEN NETWORKING ZONE
- PERSONS LIVING WITH HIV NETWORKING ZONE
- YOUTH NETWORKING ZONE
- DIASPORA NETWORKING ZONE
- KEY POPULATION NETWORKING ZONE
- FAITH BASED ORGANIZATION NETWORKING ZONE
- FEMALE SEX WORKERS NETWORKING ZONE

SATELLITE SESSION

Satellite sessions will take place all day on 6th December 2021 only in the morning and from Tuesday, 7th December 2021 to Saturday, 11th December 2021. Satellite sessions take place in the conference center 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 delegate with unique learning experiences through interactive site visits to organizations that work on HIV and AIDS issues in Durban South Africa. The goal is to exchange knowledge, best practice, successes, challenges and innovative solutions through dialogue and hands-on activities. To register visit the registration desk.

SESSIONS SANS RÉSUMÉS

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 parties prenantes.

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 45 minutes engagent grandement tous les participants. Les sessions symposia traitent des questions importantes qui défient les simples solutions. Sur la base d'un thème ou d'une question unique, clairement définie, les conférenciers et les participants partageront leurs expériences, contribueront aux résultats de recherches pertinentes et émettront des idées pour identifier des pistes de progrès.

ICASA 2021 présente 4 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 désignés par les comités de programme de la conférence. Pour ICASA 2021, les ateliers dureront 45 minutes avec une traduction simultanée en Français et en Anglais.

Une session de résumés des rapporteurs aura lieu immédiatement avant la session de clôture le 11 décembre de 10:42 à 11:27. La session de résumés 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 AVEC RESUMES ORAUX

Ces sessions sont organisées en thèmes traitant des nouveaux développements dans chacun des cinq tracks scientifiques ou mettant l'accent sur un sujet qui couvre divers tracks. Les sessions d'abstracts oraux durent 45 minutes qui consistent en cinq présentations orales de dix minutes suivies d'une question-réponse de cinq minutes. Une discussion interactive modérée, facilitée par les co-présidents, se tient à la fin de la session.

EXPOSITION D'AFFICHES

Organisé par track et couvrant une grande variété de sujets, l'exposition des affiches qui sera virtuelle à ICASA 2021 comprend environ plus de 350 affiches. Chaque affiche est affichée tout au long de la conférence, du 7 au 10 décembre 2021 et les présentateurs interagiront avec les délégués de manière virtuelle à des heures programmées pour répondre aux questions et fournir de plus amples informations sur les résultats de leurs études.

ACTIVITÉS DU PROGRAMME

Les activités du programme à ICASA 2021 sont hébergées par des personnes, des groupes et organisations dans l'aire du village global du lieu de la conférence. Accessible aux participants inscrits à la conférence et gratuit pour le grand public, ils offrent une plateforme unique pour diverses activités qui relient tous les domaines de la science, du leadership, de la responsabilité et des communautés.

VILLAGE COMMUNAUTAIRE

Les activités du village communautaire comprennent des discussions de groupe et des débats sur des questions de pointe sur le VIH ; des projections de films; des expositions d'art; des zones de réseautage axées sur les populations clés et les problèmes; des stands d'ONG et de marché présentant le travail et les produits des organisations travaillant dans le domaine du VIH ; et une variété de performances en direct d'artistes locaux et internationaux qui se tiendra sur la scène principale.

La zone du village communautaire est située au Hall 5B à l'intérieur du Centre de Convention International de Durban.

Les informations complémentaires sur le Village Communautaire et le programme des jeunes peuvent être trouvées sur le site web de la conférence : icasa2021.saafrica.org et dans le programme de poche du village communautaire.

Restez informés de tout ce qui se passe dans le village communautaire hybride de ICASA 2021 en suivant @ ICASA2021 sur Twitter.

ZONES DE RESEAUTAGE DU VILLAGE COMMUNAUTAIRE DE ICASA 2021

- ZONE DE RESEAUTAGE DES PERSONNES VIVANT AVEC UN HANDCAP
- ZONE DE RÉSEAUTAGE DES FEMMES
- ZONE DE RÉSEAUTAGE DES PERSONNES VIVANT AVEC LE VIH
- ZONE DE RÉSEAUTAGE DES JEUNES
- ZONE DE RÉSEAUTAGE DE LA DIASPORA
- ZONE DE RÉSEAUTAGE DES POPULATIONS CLÉS
- ZONE DE RÉSEAUTAGE DES ORGANISATIONS CONFESSIONNELLES
- ZONE DE RÉSEAUTAGE DES TRAVAILLEUSES DU SEXE

SESSIONS SATELLITES

Les sessions satellites auront lieu toute la journée du 6 décembre 2021 uniquement le matin et à partir du mardi 7 décembre 2021 au samedi 11 décembre 2021. Les sessions satellites ont lieu dans le centre de conférence, mais sont entièrement organisées et coordonnées par l'organisation hébergeant le satellite.

Le comité de programme examinera le contenu et les conférenciers des sessions satellites pour s'assurer qu'ils respectent les principes scientifiques et éthiques de la conférence.

TOURS D'ENGAGEMENT

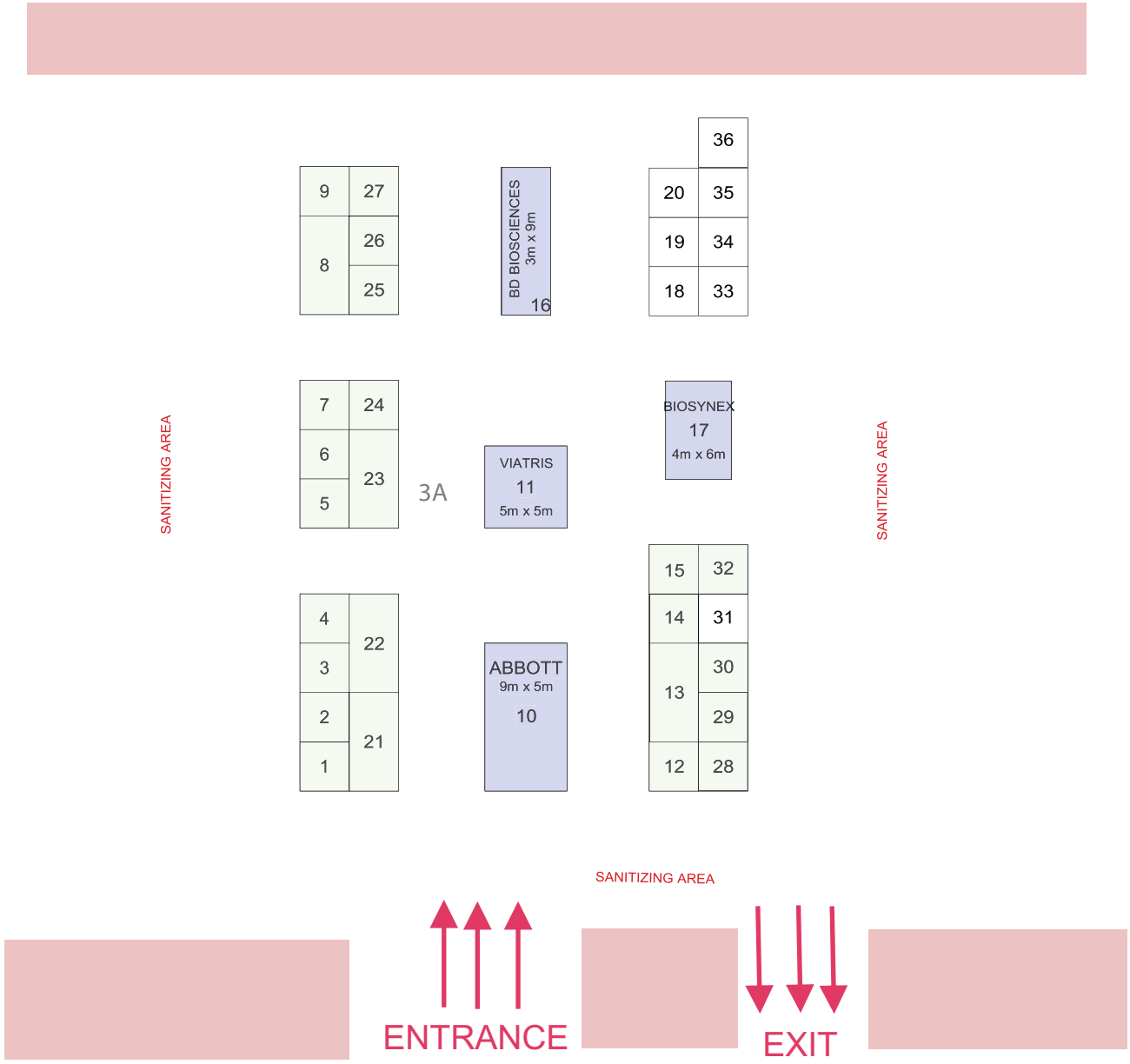
Les tours d'engagement offrent aux participants des expériences d'apprentissage unique par des visites interactives de sites à des organisations travaillant sur les questions liées au VIH et au SIDA à Durban, en Afrique du Sud. L'objectif est d'échanger sur les connaissances, les meilleures pratiques, les succès, les défis et les solutions innovantes à travers le dialogue et les activités pratiques.

Pour s'inscrire, veuillez visiter le bureau d'inscription.

EXHIBITION ORGANIZATION/ ORGANISATION EXPOSANT	BOOTH NUMBERS / NUMERO DE STAND
Society for AIDS in Africa	12
Information Desk	28
FEMNET	31
MSD	9
OraSure Technologies Inc	8
BIOCENTRIC	5
IMMY	6
SAfAIDS	1
BD Biosciences	16
BIOSYNEX SA	17
Guangzhou Wondfo Biotech Co., Ltd	13
HUMAN DIAGNOSTICS WORLDWIDE	7
Chembio Diagnostic Systems Inc	25
Omega Diagnostics	29
Charles R Drew University	3
WHO	21
Save the Children International	2
Chemonics	30
VIIV HEALTHCARE	15
UNFPA	23
ABBOTT	10
VIATRIS	11
Johnson and Johnson Global Public Health	14
The Female Health Company	4
Cepheid	32
The Global Fund	24
UNAIDS	22
Ministry of Health, South Africa	18
KwaZulu-Natal	26
SANAC	33
Zoë-Life Innovative Solutions	27

COMMUNITY VILLAGE BOOTH / STANDS DU VILLAGE COMMUNAUTAIRE	BOOTH NUMBERS / NUMERO DE STAND
EANNASO	34
TORORO FORUM FOR PEOPLE LIVING WITH HIV/AIDS NETWORKS (TOFPHANET)	19
North Star Alliance	20
TASO Tororo	35
Reproductive Health Uganda	36

EXHIBITION FLOORPLAN



COMMUNITY VILLAGE PROGRAMME SESSION PLANNER

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	6-Dec	7-Dec	8-Dec	9-Dec	10-Dec	11-Dec
9:00 AM - 9:45 AM						
9:45 AM - 10:30 AM	SATELLITE SYMPOSIUM	Plenary Session	Plenary Session	Plenary Session	Plenary Session	Plenary Session
10:30 AM - 11:15 AM		Effects of COVID-19 on the health of Female sex workers in Africa0.(FSW Zone) Innovation and Resilience of sex workers on HIV response (Female Sex Worker Zone)	Providing Alternative HIV Prevention Tools For High-risk Populations in Eastern Africa. Dapivirine Ring Could be a Game changer (Women's Zone)	Youth & the UPR: Human Rights to end AIDS (Youth Zone)	Inclusive engagement of PWDs in the fast-track agenda to reach 90-90-90s targets in the city of Kigali and secondary cities (Disability Zone)	
11:15 AM - 11:30 AM		Break	Break	Break	Break	
11:30 AM -12:15 PM		In the Daily Life of Adolescent Girls and Young Women with Disabilities: focusing on SRHR and GBV (Disability Networking Zone)	Mental Wellness (Faith Based Organization Zone)	U=U is an important message for Africa (PLHIV Zone)	How Sex workers living with HIV access HIV services amidst COVID-19. (FSW Zone	
12:15 PM - 12:30 PM		Break	Break	Break	Break	Rapporteur Session/Closing Ceremony
12:30 PM- 13:15 PM		The Proximity Project (Key Population Zone)	YAA Pillow Talks Sessions (Youth Zone)	Harm reduction and drug user-leadership in Africa (KP Zone)	Communities taking the lead in the COVID-19 response (Women's Zone)	
13:15 PM - 13:30 PM		Break	Break	Break	Break	
13:30 PM- 14:15 PM		Raising awareness and mobilizing action for African children during COVID-19 (Faith Based Organization	Early and Unintended Pregnancies among young girls (PLHIV Zone)	)In the Daily Life of Adolescent Girls and Young Women with Disabilities: focusing on SRHR	#DontLet StigmaWin (Diaspora Zone)	
14:15 PM: 14:30 PM		Break	Break	Break	Break	
14:30 PM- 15: 15 PM		Eroe Bambino-Child Heroe (Youth Zone)	Amplifying sex workers voices in HIV response (FSW Zone) Scaling up sex workers-led projects	Community System Strengthening (CSS), CS & Community Engagement in	Let's Talk Sex Work (Diapora Zone)	
15:15 PM - 15:30 PM		Break	Break	Break	Break	
15:30 PM - 16:15 PM		Maintaining the gains on HIV within COVID 19 (PLHIV Zone)	WE ARE NOT ONE THING: BREAKING SILOS. (KP Zone)	Young People and Faith Communities partnering to End AIDS (Faith Based Organization Zone)	Policy Programme that excludes men (Diaspora Zone)	
15:45 PM - 16:30 PM	Opening ceremony					

KEY POPULATION NETWORKING ZONE
YOUTH NETWORKING ZONE
DISABILITY ZONE
DIASPORA ZONE
KEY POPULATION ZONE
FAITH BASED ORGANIZATION ZONE
PLHIV ZONE
WOMEN NETWORKING ZONE

CALL FOR DONATION IN AID OF CONSTRUCTING A SECRETARIAT

The Society for AIDS in Africa (SAA), the custodian of the International Conference on AIDS and STIs in Africa (ICASA), would like to invite you to make a significant contribution towards the construction of its ultra-modern multi-purpose headquarters in Accra, Ghana.

The building of the SAA Headquarters has prompted a need for donations.

For more information kindly contact:

Society for AIDS in Africa Coordinator
Mr. Luc Armand H. Bodea
lucbodea@saafrica.org
Tel: +233 54 374 8781

ICASA 2021 YOUTH PRE-CONFERENCE

Theme:
Accelerating Youth Leadership, Resilience and Innovations towards 2030

Date: Dec. 5th 2021 | **Time:** 9:00AM - 4:00PM

Venue: Durban ICC

Room: 500 Capacity

Moderators: Nii Adjetey Ashiboe-Mensah & Teboho Mohloai

THEME

Africa's AIDS response: The race to 2030 – Evidence. Scale Up. Accelerate

ICASA 2021 OBJECTIVES

- To strengthen health systems to integrate high impact interventions on comorbidities, emerging infections and NCDs.
- To build, strengthen and invest in Africa's scientific capacity and manufacturing of vaccines, diagnostics and therapeutics.
- To Identify in Africa, resource tailored interventions for populations most affected including women, children, adolescents, men and Key Populations.
- To evaluate the impact of COVID-19 on the HIV/AIDS response and share lessons learned in overcoming barriers in maintaining continuity of care for people living with and at risk for HIV infection.
- To amplify national, regional, continental and global integration to reach epidemic control in Africa: Contributions from Africans in the Diaspora.

THEME

La riposte au Sida en Afrique: objectif 2030 - Evidence. Passage à l'échelle. Accélération

OBJECTIFS ICASA 2021

- Renforcer les systèmes de santé pour intégrer les interventions à impact considérable sur les comorbidités, les infections émergentes et les MNT.
- Mettre en place, renforcer et investir, dans la recherche scientifique et la fabrication de vaccins, le diagnostique et les produits thérapeutiques en Afrique.
- Identifier en Afrique, des interventions adaptées aux ressources domestiques pour les populations les plus touchées, y compris les femmes, les enfants, les adolescents, les hommes et les populations clées.
- Évaluer l'impact du COVID-19 sur la riposte au VIH / Sida et partager les bonnes pratiques pour surmonter les obstacles liés au maintien de la continuité des soins pour les personnes vivant avec le VIH et à risque d'infection par le VIH.
- Amplifier l'intégration nationale, régionale, continentale et mondiale pour le contrôle de l'épidémie en Afrique: contributions des Africains de la diaspora.

Plenary Sessions/Sessions Plenière

TIME	ROOM	DATE
09:45 - 10:30	Plenary Room	Tues. 7 Dec. 21

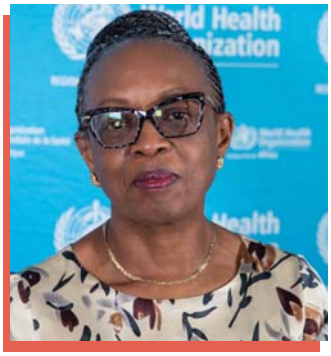
Plenary Topic: To build, strengthen and invest in Africa's scientific capacity and manufacturing of vaccines, diagnostics and therapeutics

Dr. Malebona Precious Matsoso

Director Of the Health Regulatory Science Platform, A Division Of The Wits Health Consortium At The University Of The Witwatersrand

Precious Matsoso is currently an Honorary Lecturer at the University of the Witwatersrand, Department of Pharmacy & Pharmacology and the Director of Health Regulatory Science Platform, a division of the Wits Health Consortium. She was the Director General of Health for nine and a half years, She was the World Health Organisation Director for five and a half years. She has also been in a leadership role of the South African medicine regulatory agency. She has served in a number of advisory bodies both locally and internationally, which include the Independent Panel on Pandemic Preparedness and Response; the UN High level Panel on Access to Medical Technologies; the Independent Oversight and Advisory Committee on Emergencies; the International Advisory Board of the Global Health Centre of the Graduate Institute of Geneva. She chaired the Southern African Development Community regulatory initiative. She chaired the Ministerial Advisory Committee on eHealth, and developed eHealth and digital health strategies. She rolled out a massive Health Patient Registration System with enrolment of over 44 million patients and healthcare users. She has led the World's largest HIV/AIDS programme with over 5 million people on treatment contributing to improved life expectancy in South Africa. She served as the Chair of the Executive Board of the World Health Organisation. She created the Public Health Enhancement Fund, a public private partnership for research capacity development, undergraduate medical training, health management and leadership training

Plenary Topic: Sustaining the gains during COVID-19.



Dr. Matshidiso Rebecca Moeti

Regional Director for Africa World Health Organization (WHO)

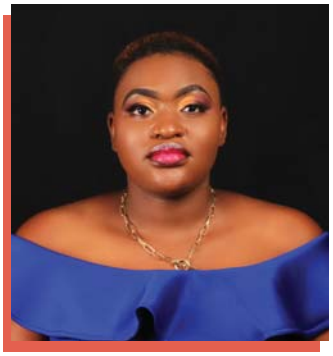
Dr Matshidiso Rebecca Moeti is the World Health Organization (WHO) Regional Director for Africa and the first woman to occupy this position. In February 2020 she was confirmed by the WHO Executive Board after her resounding re-election for a second term. Over the past five years, Dr Moeti has led a Transformation Agenda that is widely acknowledged to have improved WHO's performance and effectiveness and to have informed the global WHO Transformation.

Under Dr Moeti's leadership tremendous progress has been made, including interruption of wild poliovirus transmission in the WHO African Region – this is the second disease to be eradicated from the Region after small pox 40 years ago. Capacities to respond health emergences like COVID-19 and Ebola have also improved significantly improved. Through the regional flagship programme on Universal Health Coverage, WHO is supporting countries to ensure people can access to needed care without financial hardship.

Dr Moeti is a medical doctor and public health expert, with more than 40 years of national and international experience. She has worked with the WHO Regional Office for Africa, where she has held several senior positions, since 1999. Dr Moeti successfully led WHO's "3 by 5" Initiative in the African Region, which aimed to expand access to antiretroviral therapy in countries. Prior to joining WHO, Dr Moeti worked with UNAIDS as the Team Leader of the Africa and Middle East Desk in Geneva, with UNICEF as a Regional Advisor, and with Botswana's Ministry of Health in various capacities.

In recognition of her excellent service to humanity, Dr Moeti has received many accolades including an Honorary Fellowship from London School of Hygiene & Tropical Medicine, an Honorary Doctorate of Science from the University of Health and Allied Sciences in Ghana, Honoris Causa Doctorate by Instituto de Higiene e Medicina Tropical, Universidade NOVA de Lisboa, COVID-19 Heroine by Ellen Johnson Sirleaf President Center for Women and nominated Women of 2020, Financial Times. She is a great champion for women in leadership in global health.

Plenary Topic: Epidemic Control in Africa: Response from the Diaspora.



Miss. Doreen Moraa Moracha

HIV ACTIVIST

My name is Doreen Moraa Moracha, a young woman living with HIV from Kenya, founder of I AM A BEAUTIFUL STORY, Social influencer championing HIV/AIDs stigma, Award winner of the Stigma Warrior award 2020 awarded by The International Stigma Conference, Organized the international Session of the 11th International stigma Conference where I was also a panelist speaking about using HUMAN Centered Design to fight HIV/AIDS stigma. I have been a panelist in different engagements such as the African Stigma Forum, The Young Africans Unite: Claiming our Rights to health and Social Justice webinar by the Ready Movement and Global, I was part of the COVID 19 and Young people Project by UNICEF and Y+ Global and currently I'm working with GNP+ on developing tools to be used for implementation of UHC among communities of people Living with HIV where I am the Project manager and Peer consultant for my country Kenya. I also represent the HIV constituency in the Beijing +25 youth task force by UN-Women, I'm also a member of the Beyond Living Life force under GNP+,ICW and Y+Global,In 2019,I was highlighted by WHOAFRO as one of the youth champions for their campaign "Tea on HIV" which was showcased at ICASA 2019,I was also a panelist in the Inter-Generational session of the 4th STC on Gender Equality and women empowerment in Addis Ababa Ethiopia I also gave a short speech at the African Union and I was also a speaker in the YWCA council in Johannesburg for the Intergenerational panel.

My initiative I AM A BEAUTIFUL STORY is meant to create hope and awareness and also encourage people living with HIV that there is a beautiful life even after a HIV positive diagnosis. I am using my story of living with HIV to encourage other people living with HIV like me that HIV is a manageable health condition. What keeps me going is that one day I want to see a stigma free society and that starts with normalizing the HIV conversation in our daily lives.

TIME	09:45 - 10:30	ROOM	Plenary Room	DATE	Wed. 8 Dec. 21

Plenary Topic: Africa leadership to take to lead in ending AIDS in Africa: Abuja Declaration: where we are?

Dr. Mathume Joseph Phaahla

Minister of Health of South Africa

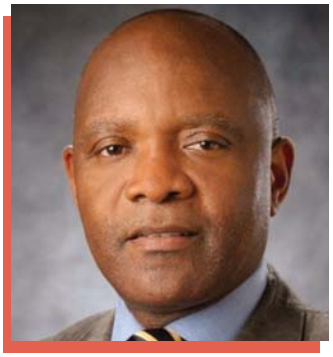
Appointed as Deputy Minister of Health from 25 May 2014, Appointed as Deputy Minister of Arts and Culture from 1 November 2010, Appointed as Deputy Minister of Rural Development and Land Reform on 11 May 2009 Sworn in as Member of Parliament for the ANC first week of May 2009.

Head of the ANC Presidency responsible for coordinating the office of the President, Deputy President and National Chairperson during election campaign from November 2008 to 30 April 2009. Elected to the National Executive Committee of the ANC in December 2007, Former Director-General 2010 FIFA World Cup Government Coordinating Unit 2005-2008 CEO of the S.A. Sports Commission which was the overall coordination and regulator of all Sports Federations from 2000-2005.

The Sports Commission paved the way for the current S.A. Sports Confederation and Olympic Committee –SASCOC. Member of Provincial Executive Committee of ANC in Limpopo Province 1991-2001, Before unbanning of ANC in 1990 served in leadership positions in various mass democratic movement structures including in the NEC of the United Democratic Front MEC Education, Sports and Culture in Limpopo Province 1997-2000.

First MEC for Health and Social Development in Limpopo Province from 1994-1997, Qualified as a Medical Practitioner MBCHB 1983 University of Natal and practised in various hospitals in KZN, Gauteng, Mpumalanga and Limpopo till April 1994

Plenary Topic: Management of COVID 19 in Africa: Impact & Way forward



Dr. John Nkengasong

Director, Africa Centres for Disease Control And Prevention African Union Commission

Dr. John Nkengasong currently serves as Director of the Africa Centres for Disease Control and Prevention, a specialized technical institution of the African Union.

In early 2020, he was appointed as one of the WHO Director-General's Special Envoys on COVID-19 Preparedness and Response. In addition, Dr Nkengasong was most recently awarded the Bill and Melinda Gates Foundation's 2020 Global Goalkeeper Award for his contributions to the continental response in fighting the COVID-19 pandemic in Africa.

Prior to his current position, he served as Acting Deputy Principal Director of the Center for Global Health and Chief of the International Laboratory Branch, Division of Global HIV and TB for the US Centers for Disease Control and Prevention (CDC).

Dr Nkengasong holds a master's degree in tropical biomedical science from the Institute of Tropical Medicine in Antwerp, Belgium, and a doctorate in medical sciences (virology), from the University of Brussels, Belgium.

Dr Nkengasong has received numerous awards for his work including Sheppard Award, the William Watson Medal of Excellence, the highest recognition awarded by the US CDC. He is also recipient of the Knight of Honour Medal by the Government of Cote d'Ivoire, was knighted in 2017 as the Officer of Loin by the President of Senegal, H.E. Macky Sall, and Knighted in November 2018 by the government of Cameroon for his significant contributions to public health. He is an adjunct professor at the Emory School of Public Health, Emory University, Atlanta, GA.

He serves on several international advisory boards including the Coalition for Epidemic Preparedness Initiative (CEPIT) and the International AIDS Vaccine Initiative (IAVI), among others. He has authored over 250 peer-review articles in international journals and published several book chapters.

Plenary Topic: HIV prevention is everyone's Business: The pathway to stemming new infections in Africa.

Dr. Natalia Kanem

United Nations Under-Secretary-General and Executive Director Of The United Nations Population Fund (UNFPA)

Dr. Natalia Kanem is United Nations Under-Secretary-General and Executive Director of the United Nations Population Fund (UNFPA), the United Nations sexual and reproductive health agency. Appointed by United Nations Secretary-General António Guterres in 2017, Dr. Kanem has more than 30 years of strategic leadership experience in the fields of preventive medicine, public and reproductive health, social justice and philanthropy. She started her research career with the Johns Hopkins and Columbia University schools of medicine and public health.

Dr. Kanem joined the United Nations in 2014 as UNFPA Country Representative in the United Republic of Tanzania. In 2016, she was named Assistant Secretary-General and Deputy Executive Director in charge of programmes. Previously, she served as founding president of ELMA Philanthropies, Inc., and as senior associate of the Lloyd Best Institute of the West Indies.

At the Ford Foundation from 1992 to 2004, she funded pioneering work on women's reproductive health and human rights, serving first in West Africa and eventually as Deputy Vice-President for peace and social justice programmes in Africa, Asia, Eastern Europe, Latin America and North America.

She holds a medical degree from Columbia University in New York, and a Master's degree in Public Health with specializations in epidemiology and preventive medicine from the University of Washington in Seattle. She is a magna cum laude graduate of Harvard College in history and science.

In 2019, Dr. Kanem presided over the Nairobi Summit on ICPD25, which marked the 25th anniversary of the International Conference on Population and Development. Dr. Kanem is recognized for her powerful advocacy for the rights and choices of women and girls and as a key influencer and thought leader in the formulation of global policy on sexual and reproductive health and rights in the Sustainable Development Goals era and has been listed on the Gender Equality Top 100.

A member of the United Nations Senior Management Group, a high-level body chaired by the Secretary-General, she is also a member of the United Nations System Chief Executives Board for Coordination; the United Nations Secretariat Management Performance Board; the H6 Partnership for global health; and the UNAIDS Committee of Cosponsoring Organizations, which she has chaired. She is also a Governor of the United Nations System Staff College and a member of the Honorary Advisory Council of the Dag Hammarskjöld Fund for Journalists.

Dr. Kanem advocates for the rights of women and girls on the Inter-Agency Standing Committee, an international forum for humanitarian partners, and as co-chair of the Reference Group of Family Planning 2020-2030, a global partnership for investing in rights-based family planning. She has made leadership contributions to the Secretary-General's organizational transformation initiatives towards reform of the United Nations development system, including co-chairing the Strategic Financing Group of the United Nations Sustainable Development Group, and as a member of the High-Level Steering Groups on Gender, Youth, the System-wide Response to Sexual Exploitation and Abuse and the global response to COVID-19.

Dr. Kanem is the fifth Executive Director of UNFPA since the Fund became operational in 1969.

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UNFPA, the United Nations sexual and reproductive health agency, aims to end the unmet need for contraception, end preventable deaths in pregnancy and childbirth, and end gender-based violence and harmful practices in all forms, including child marriage and female genital mutilation, basing its efforts on high-quality population data to ensure that no one is left behind.

TIME	09:45 - 10:30	ROOM	Plenary Room	DATE	Thurs. 9 Dec. 21

Plenary Topic: Political leadership and partnerships to promote and accelerate access to innovation prevention & care.

H.E. Marisol Touraine

Former Minister Of Health, France

Board Chair of UNITAID

After studying at the Ecole normale supérieure (ranking first or in the top 3 French schools in all international rankings) a degree in economics and social sciences, Marisol Touraine studied at the Institut d'études politiques of Paris and at the prestigious Harvard University in the United States.

Advisor to the Prime Minister from 1988 to 1991 on geostrategic issues, she became a member of the Conseil d'Etat in 1991. She then served at political positions at local level and within the French Parliament for several years before being appointed Minister of Social Affairs, Health and Women's Rights (2012-2017). Her support to authorize and to assure financial coverage for innovative preventive HIV treatments were particularly recognized at this position as well as her fight for the neutral cigarette pack, acknowledged by the WHO prize in 2016.

Mrs Touraine is now a senior member of the Conseil d'Etat and an international consultant for social policies. In June 2019, she was elected Chair of the Unitaid's Executive Board.

Plenary Topic: The new Global strategy to end AIDS by 2030: what do we need to do differently in Africa.

Dr. Shannon Hader

Deputy Executive Director of Programme at UNAIDS And Assistant Secretary General At The United Nations

Shannon Hader, MD MPH, is currently the Deputy Executive Director of Programme at UNAIDS and Assistant Secretary General at the United Nations. She's trained in pediatrics, internal medicine, and infectious

diseases, and has worked in a variety of roles in the HIV fight across the world: clinical, uniformed services, local health department, private sector, US Centers for Disease Control and Prevention, and United Nations. She has a strong focus on delivering results for people, promoting investments in community-led responses, and driving innovation and change.

Plenary Topic: Health System Strengthening: The funding Landscape: health financing and Domestic Resource Mobilization.

Solange L. Baptiste

Executive Director, ITPC

Solange Baptiste is Executive Director of the International Treatment Preparedness Coalition (ITPC). She leads community activists and allies across the globe to deliver ITPC's mission to enable people in need to access optimal and affordable HIV treatment through treatment education, demand creation, community-led monitoring and interventions to make medicines more affordable. Solange has over 15 years of global program management and advocacy experience and specializes in monitoring and evaluation. She has a depth of knowledge in social epidemiology, health financing and community systems strengthening in the developing world through her work on USAID/PEPFAR health and development, and other bilateral and multi-country initiatives across Africa and Asia. She earned a Bachelor of Science in Biology from Tuskegee University and her Master of Science in Population and International Health from the Harvard School of Public Health. Solange is committed to ensuring that the voice of affected communities contributes to and influences the decisions and policies that affect their lives.

TIME 09:45 - 10:30 | ROOM Plenary Room | DATE Fri. 10 Dec. 21

Plenary Topic: HIV, TB & other co-infections: The journey ahead.

H.E. Eric Goosby

Founding director of the Ryan White Care Act

Eric Goosby, M.D., is an internationally recognized expert on infectious diseases, with a specialty in HIV/AIDS clinical care, research, and policy. During the Clinton Administration, Dr. Goosby was the founding director of the Ryan White CARE Act, the largest federally funded HIV/AIDS program in the U.S. He went on to become the interim director of the White House's Office of National AIDS Policy. In the Obama Administration, Dr. Goosby was appointed Ambassador-at-Large and implemented the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), which significantly expanded under his tenure life-saving HIV treatment to millions in Sub Saharan Africa, SE Asia, and Eastern Europe.

After serving as the U.S. Global AIDS Coordinator, he was appointed by the UN Secretary-General as the Special Envoy on Tuberculosis, where he focused on the first-ever UN High-Level Meeting on TB in 2019. Most recently, he served as a member of President Biden's COVID-19 Advisory Board. He is currently a Professor of Medicine at the UCSF School of Medicine and leading the Center for Global Health Delivery, Diplomacy and Economics, Institute for Global Health Sciences. He is a member of the Western States Scientific Safety Review Workgroup, and serves on the San Francisco Dept. of Public Health, Policy Group for the COVID-19 Response.

Plenary Topic: Implementing person centered Key population programming at scale.

Mr. Roberto Paulo

Executive Director, LAMBDA

Roberto Paulo is a Mozambican citizen, aged 42 years old. Currently, he is working as the Executive Director of LAMBDA – a non-profit Mozambican Association For Sexual Minorities, the unique Mozambican LGBTI organization, established in 2006. He has a degree in Psychology and Pedagogics and 22 years of experience in activism on HIV and Human Rights. He has been advocating for several years to guarantee the massification of ART (Anti-Retroviral Treatment) in Mozambique, and presently a member of CCM (Country Coordination Mechanism for the Global Fund) representing Key population.

His work at Lambda, includes leading several initiatives to guarantee and influence more inclusion in terms of country's policies, laws and guidelines, as well as opportunities for equal treatment for LGBTI communities and Key Population as a whole.

Over the past 5 years, he has been conducting capacity building programs on Sexual Orientation and Gender Identity Expression (SOGIE) for government officers at different levels (i.e. police officers, secondary teachers, health providers, etc), and also officers from the USG (United States Government) agencies, Implementation Partners and other key stakeholders.

To date, he has been sitting as member of the Key Population Technical Working Group at The Ministry of Health, and also at the Key Population Technical Working Group at the National AIDS Council. Recently, he was nominated as a member of the Technical Council of Executive Secretariat of National AIDS Council.

Plenary Topic: Impact of COVID on HIV Services

Mr. Daouda Diouf

Executive Director, ENDA SANTE

Daouda DIOUF is the Executive Director of ENDA Santé an international organization based in Dakar, Senegal that works in 12 countries in West and Central Africa region in the area of public health with a focus on country and regional programs focused HIV, adolescent and youth, maternal and child health, marginalized populations, sexual and reproductive health and human rights in Africa.

Daouda is the CEO of the Civil Society Institute for HIV and Health in West and Central Africa, a platform of 80 NGO from 18 countries.

Social economist and specialist in health and development programs, Mr DIOUF plays leading role in African civil society networks on HIV / AIDS and global health. In contributing to science, Mr DIOUF is the author and co-author of several scientific articles and publication on HIV, key populations, sexual health, sustainable development in Africa.

TIME	09:45 - 10:30	ROOM	Plenary Room	DATE	Sat. 11 Dec. 21

Plenary Topic: Adolescent girls, young women & men: Key to achieving the end of AIDS in Africa in 2030.

Dr. Thato Chidarikire

Director for HIV Prevention Programmes

Currently Dr Thato Chidarikire is the Director for HIV Prevention Programmes in the National Department of Health. Her Portfolio includes management of HIV Prevention Programmes including but not limited to HIV Testing Services (HTS), Pre exposure Prophylaxis (PreP), Youth HIV Prevention, Post Exposure Prophylaxis (PEP), Condoms, STI management,

Communication and Stake holder management.

She has over 20 years professional experience gained in Academia, Public Health Sector and Research Units and Parastatals. With 17 years in the HIV field, her vast experience includes Policy and guideline development, HIV Prevention intervention programmes, Research and Clinical Trials.

She has co-chaired the WHO HTS guideline development group, the national PFIP prevention work stream and the national HIV Think Tank. She is a PHD graduate from Wits University, with a specialty in Virology.

Plenary Topic: HIV Pediatrics: how far did we relieve the burden on children and what is the perspective towards 2030?

Dr. Chewe Luo

Director for HIV Prevention Programmes

Dr. Luo is a paediatrician and scientist from Zambia with extensive clinical, research and programme management expertise. Currently she is the Global Chief of HIV and Associate Director in Programme Division of UNICEF at Headquarters in New York. While at UNICEF headquarters, she has also worked as the technical lead for HIV country programme scale-up efforts and as senior advisor for Maternal Child Health.

Dr. Luo has over 20 years of experience in advancing child health as a clinician and a researcher at the University Teaching Hospital in Zambia; as a clinician for National Health Service in the United Kingdom; and as programme lead with UNICEF at country, regional, and headquarter levels. She has worked with with several governments, academic and research institutions, multilateral organisations and funders and has several publications in peer reviewed journals.

Dr. Luo has a Masters of Medicine in Paediatrics from the University of Zambia, School of Medicine and a Masters in Tropical Paediatrics and a PhD from the Liverpool School of Tropical Medicine, Liverpool University, School of Medicine, in the United Kingdom. Dr. Luo is also a fellow of the Royal College of Physicians, Edinburgh, Scotland.

Plenary Topic: Addressing the needs of People who Use Drugs to achieve epidemic control.

Richard Nininahazwe

Africa Coordinator, NPUD

Richard NININAHAZWE est le coordinateur d'AfricaNPUD, Africa Network of people who use drugs. En 2016, il est le co-fondateur de BAPUD, Burundi Association of people who use drugs. L'année suivante, après l'agreement de BAPUD comme ONG, il participe à la première étude sur les usagers de drogues au Burundi. Cette étude met un nouveau visage sur l'usage de la drogue et la séroprévalence. Il va occuper le poste de représentant des populations clés au CCM Burundi, avant de rejoindre Nairobi pour coordonner le réseau régional. Comme hobby il pratique les arts martiaux et il est le père de deux fils.

WE CAN FIGHT CORONAVIRUS TOGETHER

VIRUS PREVENTION IS IN OUR HAND!

Wear a Mask

Wash Your Hand

Contactless

Avoid Crowds

Abstract Driven Sessions/Sessions dirigées

TIME	ROOM	DATE
10:42 - 11:27	100 Capacity Room	Tues. 7 Dec. 21

Track A: Basic Science (Biology & Pathogenesis)

Drug Development & Resistance

Chairs : Prof. Almoustapha Maiga (Mali)
Dr. Nokukhanya Msomi (South Africa)

TUAA0101 - Investigating the potential of traditional medicines in reactivation of latent HIV-1

PRESENTING AUTHORS

K. Mngomezulu , N. Gqaleni , M. Ngcobo

University of KwaZulu-Natal, Traditional Medicine, Durban, South Africa, Africa

Health Research Institute (AHRI), Durban, South Africa

BACKGROUND

The pathogenesis of HIV-1 involves the infection and replication in CD4 + T lymphocytes, macrophages and dendritic cells. There is no cure for HIV, but it is possible to treat and control the virus. Combination antiretroviral therapy (cART) can target various stages of the HIV-1 life cycle, successfully suppressing viral replication to below detectable levels and stops disease progression, allowing people infected with the virus to live longer. However, cART does not cure HIV infection since the virus persists within latently infected CD4 + T cell reservoirs. Thus, new strategies to eradicate these viral reservoirs are of importance. Traditional medicines (TM) offer potential opportunities to identify viable treatments that could complement cART and eliminate these viral reservoirs. This study aims to investigate a plant-based TM product as a potential agent to reactivate resting CD4+ T cells and induce transcription of latently infected HIV-1.

METHODS

The TM was obtained from a traditional healer (TH) residing in KwaZulu-Natal. The traditional medicine is used as an infusion of four medicinal plants. The identities of the plants used are the intellectual property of Messrs. Nkabinde but are known by researchers in this study. They are referred to as CML-4, MGN-3, SDK-2 and SPN-1. The in vitro effective doses of the TM and the SDK-2 extract in normal peripheral blood mononuclear cells (PBMCs) were established using the ATP cell viability assay. Based on initial research, this study uses the combination TM and a single plant extract (SDK-2), which has been shown to have the highest anti-HIV activity.

RESULTS

The IC of the water extract of the TM was established at 325,3 µg/ml. SDK-2 had an IC concentration of 106.4 µg/ml. In preliminary anti-HIV assays, the combination TM extract was shown to have an IC doses of 3.47 µg/ml (pNL-NF inhibition, tested in transfected 293T cells + reporter cells SXR5) and 70.83 µg/ml (pNL-BaL inhibition, tested in transfected 293T cells + reporter cells SXR5). These effective doses will then be used to evaluate HIV-1 reactivation in latently infected cell models.

CONCLUSION

Alternative HIV therapies that can become permanent cures are vital in resource limited settings affected by HIV/AIDS and this study will hopefully provide these new approaches.

TUAA0102 - Profil de mutation de résistance aux inhibiteurs de protéase chez les enfants sous traitement antirétroviral depuis au moins 6 mois à Abidjan (Côte d'Ivoire)

PRESENTING AUTHORS

J.-J.R. DECHI , T.d. TONI , J.-L.P. N'DIN , J.F. N'GUESSAN , E. BROU , A. AGUIA , K. KOUAKOU , H. CHENAL , M. CAMARA-CISSE

Centre Intégré de Recherches Biocliniques d'Abidjan (CIRBA), Abidjan, Cote D'Ivoire, Centre National de Transfusion Sanguine (CNTS), Abidjan, Cote D'Ivoire, Laboratoire de Biochimie/Faculté des Sciences Médicales, Abidjan, Cote D'Ivoire

CONTEXTE

Les inhibiteurs de protéase (IP) du VIH sélectionnent plus de mutations que toute autre classe d'antirétroviraux (ARV). L'accumulation de ces mutations induit une résistance aux IP ou une résistance croisée. En Côte d'Ivoire, seulement 2 IP sont disponibles pour les enfants, ce qui est un véritable défi en pratique clinique dans un contexte où les tests génotypiques de résistance (TGR) sont inexistants. L'objectif de notre étude était de déterminer les mutations mineures et majeures sur le gène de la protéase du VIH-1 qui pourraient diminuer l'efficacité des IP chez les enfants.

MÉTHODES

La population étudiée était constituée d'enfants issus d'une cohorte nationale prospective au CIRBA de 2012 à 2013. Ils avaient une sérologie positive pour le VIH-1 ou dual, un âge inférieur à 18 ans et une charge virale supérieure à 1000 copies/mL. La détermination des mutations mineures et majeures sur le gène de la protéase du VIH-1 et leurs interprétations ont été réalisées avec les techniques et algorithme de l'ANRS

(www.hivfrenchresistance.org). Les arbres phylogénétiques ont été réalisés avec MEGA 7.

RÉSULTATS

A partir d'une cohorte de 260 enfants, 61 ont été inclus dans l'étude (23%). L'analyse phylogénétique a montré que le CRF02_AG représentait 85% des sous-types. Nous avons retrouvé aussi les sous-types A (10%), CRF06_cpx (3%) et CRF09_cpx (2%). La fréquence de résistance aux IP était de 13%. Les mutations mineures fréquentes étaient M36I et K20I (100%), H69K (88%), L89M et I54V (75%) et G16E (50%). Les mutations majeures étaient V82A (75%), M46I (63%), L90M (38%) et L76V (13%). Aucune résistance à Tripanavir/Ritonavir (TPV/r) et Darunavir/Ritonavir (DRV/r) n'a été observée.

CONCLUSION ET RECOMMANDATIONS

L'étude a permis de déterminer les mutations sur le gène de la protéase du VIH-1 associées à la résistance aux IP chez les enfants et a confirmé la prédominance du CRF02_AG en Côte d'Ivoire.

Lopinavir/Ritonavir (LPV/r) et Atazanavir/Ritonavir (ATV/r) sont les 2 IP utilisés. La mutation majeure responsable de la résistance à LPV/r était L76V. La combinaison de mutations fréquemment associées à l'inefficacité des 2 IP était I54V-V82A-L90M-M46I pour LPV/r et G16E-L90M-M46I pour ATV/r. L'étude a ainsi montré la nécessité d'accès accru à des options de 3 ligne idéalement guidées par les TGR. En prévision, des efforts doivent être déployés pour réduire les prix des ARV et acquérir d'autres IP comme TPV/r et DRV/r pour les enfants en Côte d'Ivoire.

TUAA0103 - Potential implications of C-terminal p7 (NC)-p6 Gag genetic variants in the emergence of protease drug resistance mutations among HIV-1 non-B subtypes: a case-control analysis in Cameroon

PRESENTING AUTHORS

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BACKGROUND

In resource-limited settings (RLS), long-term exposure to first-line antiretroviral therapy (ART) has led to increasing burdens of HIV drug resistance (HIVDR), and a growing switch to ritonavir boosted protease inhibitors (PI/r)-based second-line ART. Of note, mutations in HIV-1 Gag and Pol genes compensate for a loss of viral fitness caused by highly mutated patterns among B-clade. There is limited knowledge among non-B clades. We therefore sought to determine P7(NC)-P6 HIV-1 Gag gene variants selected under PI/r pressure and their co-variations with protease (PR) mutations among HIV-1 non-B clades.

METHODS

This is a case-control study conducted from January 2018 through December 2020 among 362 HIV-infected individuals in Cameroon: control-arm (101 ART-naïve) versus case-arms (143 on PI/rbased and 118 on reverse-transcriptase inhibitors, RTI). Partial Gag (P7(NC)-P6) and the entire PR were sequenced and analyzed using Seqscape v.2.6 and Stanford HIVdb algorithm v8.9-1; comparison in the frequency of Gag variants between the control versus each of the case arms was performed using chi-squared tests of independence, with $p<0.05$ considered significant.

RESULTS

Out of the 362 participants (mean age: 39±12 years; 63% female), a broad diversity of HIV-1 non-B clades were found, driven by CRF02_AG (54.69%), subtype A (13.53%), D (6.35%); and G (4.69%). The overall rate of PR-DRMs among PI/r-experienced was 19.5% (28/143), driven by M46I (15.38%; 22/143), I84V (7.69%; 11/143) and I54V (7.69%; 11/143). Eighteen Gag variants were significantly higher in PI/r-exposure versus ART-naïve, and classified in three groups: group1 ($p<0.0001$): L449F, I479G, D480E, Y484P; group2 ($p<0.001$): E460A, S465F, V467E, Q474P, E482G, L483Q; group3 ($p<0.01$): R464G, P453L, S462L, I479K, I479R, D480N, T487A, T487V. Furthermore, three Gag variants (I479R, Y484P and L449F) were also significantly higher in RTI-exposure versus ART-naïve ($p<0.05$). Of the 8 Gag variants that showed a positive correlation with PR-DRMs, L449F clustered with four PR-DRMs (I54V, L90M, M46I and V32I); while P453L clustered with seven PR-DRMs (I54L, I54V, I84V, L33F, M46I, V82A and V82T).

CONCLUSIONS AND RECOMMENDATIONS:

This case-control analysis suggests the co-emergence of Gag P7(NC)-P6 variants with PR-DRMs, essentially among patients failing PI/r-based ART. Cohort-studies are needed to confirm the clinical significance of these Gag-variants on response to PI/r-based regimens.

TIME	14:30 - 15:15	ROOM	100 Capacity Room	DATE	Tues. 7 Dec. 21

Track A: Basic Science (Biology & Pathogenesis)

Diagnostics tools development

Chairs : Dr. Fausta Mosha (Congo)
Dr. Nokukhanya Msomi (South Africa)

TUAA0201 - Infections génitales basses chez les femmes infectées par le VIH-1 suivies à l'hôpital de jour du CHU Sanou Sourô de Bobo-Dioulasso

PRESENTING AUTHORS

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INTRODUCTION

L'infection génitale basse (IGB) de la femme reste un problème de santé publique dans les pays en développement. Le VIH entraine une fragilisation et une réduction des moyens de défense de l'organisme favorisant ainsi la survenue des IGB. Nous décrivons les caractéristiques des IGB chez les femmes infectées par le VIH-1 sous traitement ARV à l'hôpital du jour (HDJ) adulte de Bobo-Dioulasso.

MÉTHODOLOGIE

Étude prospective à visée descriptive du 24 Octobre 2016 au 31 Janvier 2017. Ont été incluses toutes les patientes infectées par le VIH-1 sous traitement ARV à l'hôpital de jour adulte de Bobo-Dioulasso en consultation de suivi et ayant donné leur consentement éclairé.

RÉSULTATS

306 patientes y étaient incluses. L'âge moyen était de 41,6 ans ±8,4 ans avec des extrêmes allant de 15 à 74 ans. Les signes cliniques prédominant étaient les pertes blanches (45,42 %).

Deux cent quarante (78,43%) patientes avaient un nombre de lymphocytes CD4 > à 500 cellules/µl ; 290 avaient une charge virale indétectable ; 198 (64,71%) des leucorrhées épaisses, et 4 des leucorrhées filantes. Le pH était basique chez 221 (72,22%) patientes. Le Sniff test était positif chez 171. Le score de Nugent était intermédiaire chez 43 (14,05%) ; 188 (61,44%) avaient une IGB. Les germes isolés étaient : candida spp, Gardnerella vaginalis et trichomonas vaginalis.

CONCLUSION

Cette étude montre l'existence des IGB chez les femmes infectées par le VIH-1 au Burkina Faso bien qu'elles soient sous traitement ARV avec une charge virale indétectable.

Mots clés : Infection génitales basses, VIH, Charge virale, Bobo-Dioulasso, charge virale indétectable.

TUAA0202 - Comparison of Ampfire and MY09/11 assays for HPV genotyping in anogenital specimens of Rwandan men who have sex with men

PRESENTING AUTHORS

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BACKGROUND

The AmpFire HPV Genotyping Assay is a relatively inexpensive and rapid method to detect high-risk human papillomavirus (HPV) genotypes in anogenital specimens and is a potentially useful method for HPV genotyping in low-resource settings. However, there are few data documenting its performance. We compared Ampfire to MY09/11 L1 PCR, a validated test that can detect over 40 HPV genotypes and which has been used for many research studies in the past and using anal and penile HPV specimens from a cohort study of HIV- and HIV+ men who have sex with men (MSM) in Rwanda, we determined the agreement between MY09/11 and AmpFire at the University of California San Francisco (UCSF) and AmpFire inter-laboratory agreement at UCSF and Rwanda Military Hospital (RMH).

METHODS

We tested 338 anal and penile swab specimens collected from HIV- and HIV+ MSM, from March 2016 to September 2016 for HPV using the two technologies at UCSF. The RMH research laboratory tested the same specimens using AmpFire. Cohen's kappa coefficient was used to test for reproducibility; $k > 0.75$ was considered excellent and $0.4 \leq k \leq 0.75$ good reproducibility.

RESULTS

Overall, comparing MY09/11 and AmpFire done at UCSF, for anal specimens 13% and 20.7% (k= 0.73) were positive for high-risk HPV (hrHPV), respectively; for penile specimens 26.3% and 32.6% (k=0.67) were positive for hrHPV, respectively. For anal specimens, good reproducibility was found for types 16 and 18 with k=0.69 and k=0.71 respectively and excellent reproducibility was found for HPV 31, k=0.79. For penile specimens, good reproducibility was found for types 16 and 18 respectively with k=0.50 and k=0.72 and excellent reproducibility was found for types (68, 51, 31 and 53) k= 0.76-0.79. Inter-laboratory results using AmpFire at UCSF and RMH: among anal specimens, positivity for hrHPV was 20.7% for both laboratories (k=0.87) while for penile specimens, positivity was 34.9% vs 31.9% (k=0.89), respectively. For anal specimens excellent reproducibility was found for types 16 and 18 with k=0.80 and k=1.00. For penile specimens, excellent reproducibility was found for types 16 and 18 with k=0.85 and k=0.91.

CONCLUSION

MY09/11 and AmpFire assays have good reproducibility while the AmpFire had excellent inter-laboratory reproducibility. These results show that AmpFire is feasible for HPV genotyping in low- and middle-income countries.

KEY WORDS

MSM, MY09/11, AmpFire, hrHPV

TUAA0203 - Covid-19: diagnostic différentiel en cas de suspicion de paludisme en zone impaludée, cas du Cameroun.

PRESENTING AUTHORS

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INTRODUCTION

Depuis le début de la pandémie de la COVID-19, le Cameroun est confronté à une double épreuve : protéger ses citoyens contre les risques de santé publique existants, comme le paludisme et contre les risques émergents, comme la COVID-19. Le virus responsable de cette récente maladie peut causer des symptômes retrouvés en cas du paludisme. Notre étude avait pour objectif de déterminer la prévalence et facteurs associés à la COVID-19 en cas de suspicion du paludisme chez les patients.

MÉTHODES

une étude transversale analytique a été menée au Centre Médical le Jourdain pendant 8 semaines du 19 Avril au 13 Juin 2021. Le recrutement était consécutif ; étaient inclus, les patients avec suspicion de paludisme après une consultation médicale, ayant donné leur consentement éclairé ou leur assentiment parental. Avaient été exclus, ceux présentant des signes respiratoires tels que toux, difficultés respiratoires et rhinorrhée. Un prélèvement nasopharyngé a été réalisé à la recherche d'antigène du SRAS-CoV 2 grâce au kit STANDARD Q COVID-19 Ag de SD BIOSENSOR. La confirmation du paludisme était faite à l'aide de la goutte épaisse colorée au Giemsa comme gold standard avec lecture en double aveugle avec troisième lecture en cas de discordance. Les données recueillies ont été analysées à l'aide des logiciels SPSS version 28.0 et EPI INFO version 7.0. Le test Khi-deux a été utilisé pour rechercher l'association entre les variables qualitatives avec pour valeur statistiquement significative p<0,05.

RÉSULTATS ET DISCUSSION

ont été retenus dans notre étude, 211 patients majoritairement de sexe féminin (112 ; 53,1%). L'âge variait de 2 à 76 ans avec une moyenne d'âge de 34.5 (± 18) ans. Le paludisme était confirmé dans 33,2% (74) des cas. La prévalence de la COVID 19 était de 7,11% (15). Il y avait 2 (0,9%) cas de coinfection COVID-19/Paludisme. Aucune association statistiquement significative n'a été retrouvée entre le paludisme et la COVID-19. Les signes cliniques décrits en cas de COVID-19 étaient la fièvre (86,7%), les céphalées (66,7%), l'asthénie (40,0%), les myalgies/arthralgies (13,3%), l'hypo/agueusie (26,66%) et l'hypo/anosmie (6,66%). Conclusion et recommandation : en cas de suspicion du paludisme en zone impaludée, il parait non négligeable de rechercher une infection au SRAS-CoV 2.

MOTS-CLÉS

SRAS-CoV 2, COVID-19, paludisme, prévalence.

TIME	12:36 - 13:21	ROOM	300 Capacity Room	DATE	Tues. 7 Dec. 21

Track E: Health Systems, Economics and Implementation Science

Socio Economics

Chair : Ms. Beatrice Mutali (South Africa)

TUAA0301 - Transitioning the HIV workforce from PEPFAR contracts to the Uganda government payroll

PRESENTING AUTHORS

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INTRODUCTION

Although increasing public spending on health worker recruitments could reduce HIV workforce shortages in Sub-Saharan Africa, effective strategies for achieving this are still unclear. We aimed to understand the process of transitioning health workers (HWs) from PEPFAR (President's Emergency Plan for AIDS Relief) to Government of Uganda (GoU) payrolls and to explore the facilitators and barriers encountered in increasing domestic financial responsibility for absorbing this expanded workforce.

METHODS

We conducted a multiple case-study of 10 (out of 87) districts in Uganda which received PEPFAR support between 2013 and 2015 to expand their HIV workforce. We purposively selected eight districts with the highest absorption rates ('High absorbers') and two with the lowest absorption rates ('Low absorbers'). A total of 66 interviews were conducted with high-level officials in three Ministries of Finance, Health and Public Service (n=14), representatives of PEPFAR implementing organizations (n=16), District Health Teams (n=15) and facility managers (n=22). Twelve focus groups were conducted with 87 HWs absorbed on GoU payrolls. We utilized the Consolidated Framework for Implementation Research (CFIR) to guide thematic analysis.

RESULTS

At sub-national level, facilitators of transition in 'high absorber' districts were identified as the presence of transition 'champions', prioritizing HWs in district wage bill commitments, host facilities providing 'bridge financing' to transition workforce during salary delays and receiving donor technical support in district wage bill analysis-attributes which were absent in 'low absorber' districts. At national-level, multi-sectoral engagements (incorporating the influential Ministry of Finance), developing a joint transition road map, aligning with GoU salary scales and recruitment processes emerged as facilitators of the transition process.

CONCLUSION

Our case-studies offer implementation research lessons on effective donor transition and insights into pragmatic strategies for increasing public spending on expanding the HIV workforce in a low income setting.

TUAE0302 - Socio-economic inequality and access to Antiretroviral Treatment for peoples living with HIV

PRESENTING AUTHORS

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BACKGROUND

The number of people living with HIV(PLHIV) in Cameroon is estimated at 520 000 individuals. In 2016, the country started to scale up Antiretroviral therapy by adopting WHO recommendations suggesting that PLHIV should start ART irrespective of their CD4 cell count. By the end of 2018, 52% of the said HIV population were on treatment in-country. But these results are still far away from the UNAIDS 90-90-90 target adopted by the country. International research suggests that lower economic status was closely related to delayed ART initiation, adherence, and outcome. The aim of this study is to evaluate the impact of socioeconomic inequality on the access to ART for PLHIV in Cameroon.

METHOD:

A cross-sectional study was conducted in the 10 regions of Cameroon between October and December 2017. The eligible patients were those aged 15-49 who started ART less than six months before the study period. People who were visiting the selected health facility during the period of study were invited to participate in the study. Multivariate analysis was used to determine factors associated with access to ART.

RESULT

A total of 3 074 PLHIV on TAR were recruited in the study, 59.6% were women and the main age was 38.8[38:3-39.2] years old. Most of the patients (61.3%) were enrolled in urban areas, 38.7% had a primary school level and 42.8% attended secondary school. More than 22% of patients reported that ART is not accessible in Cameroon and

30.5% reported ever have missed their appointment to refill their medication. Residing in rural areas was associated with poor access to ART services (OR=0.60; P<0.000). The patient expenses for transport to the health facility (0.99, P<0.002), the distance between the household and the health facility (0.87, P<0.001), as well as the patient income (OR=1.1, P<0.027) were strongly associated with poor access to ART. As compare with civil servants, ART services are more accessible to patients working in the private sector (OR=1.6, P<0.014) and those self-employed (OR=1.4, P<0.026). In the multivariate analysis peoples living in rural areas and paying the high cost of transport were less likely access to ART as well as those with lower income.

CONCLUSION

This study reveals that socio-economic inequality has an impact on the accessibility of treatment. This suggests the ART program should develop a better strategy to reach the more vulnerable groups, especially people living in rural areas.

TUAE0303 - Cash paying patients for ART in South Africa: Purses and wallets contributing to treatment targets

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BACKGROUND

South Africa's public antiretroviral treatment (ART) programme has grown to one of the world's largest since its initiation in 2003. By 2020 the country had reached 93-73-88 against the 90-90-90 targets. With performance against the 2 90 presenting the greatest challenge, South Africa must increase ART coverage for adult men by 565 349, adult women by 368 020, and children by 74 662. The South African National AIDS Council (SANAC) monitors ART coverage from two data main sources. Firstly, public sector ART statistics, including by far the largest proportion of people on treatment. Secondly, Council of Medical Schemes data on private clients. Thus far, monitoring has excluded a third group: patients who pay cash for their ART.

METHOD

In 2020, SANAC collaborated with IQVIA to extract patient level pharmacy data on ARV drugs dispensed from April 2017 to March 2022, in line with the National Strategic Plan for HIV, TB & STIs 2017-2022. These data have been analysed to ascertain the demographics, geographical distribution and time trends of cash-paying patients, and have been compared with public sector and Council of Medical Schemes ART coverage data.

RESULTS

A total of 183 195 individual patients have paid cash for ART between April 2017 and May 2021. In contrast to the national public sector programme where male patients are substantially under-represented, cash paying patients are almost exactly equally male and female. In a distribution similar to the public sector, almost half of all cash paying ART patients fall into the 35-49 age band. The number of cash paying patients has more than doubled between 2017 and 2020, with 64 069 patients paying directly for their ART by 2020, up from 29 234 in 2017. This represents a steady annual increase from 0.76% of people on ART in 2017 to 1.21% in 2020. Although this is a small percentage of the total treatment programme, it will make a substantial contribution to the treatment gap as the country closes in on targets.

CONCLUSION

Cash paying patients contribute both to total ART provision, and to a seamless continuum of care. Patients may initiate their treatment privately, and later transition into private health insurance or the public sector, or may use cash as a fall-back to avoid treatment interruptions. A detailed analysis of cash paying patients will provide an understanding of this hitherto excluded contribution to closing the HIV treatment coverage gap, crucial to ending the HIV pandemic.

TIME	14:30 - 15:15	ROOM	300 Capacity Room	DATE	Tues. 7 Dec. 21

Track E: Health Systems, Economics and Implementation Science

Differentiated Service Delivery

Chairs : Prof. Morenike Ukpong (Nigeria)
Mr. Jimmy Wilford (Zimbabwe)

TUAA0401 - Comparative analysis of community- and facility-based differentiated service delivery implementation

PRESENTING AUTHORS

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A. Oduola3, J. Egwuagu-Pius6, G. Akro7, M. Bateganya8, H. Khamofu3, S. Raj Pandey3 1Achieving Health Nigeria Initiative, Nigeria (AHNi), Akwa Ibom, Nigeria, 2FHI 360, Akwa Ibom, Nigeria, 3FHI360, Abuja, Nigeria, 4Achieving Health Nigeria Initiative, Nigeria (AHNi), Cross River, Nigeria, [5]Achieving Health Nigeria Initiative, Nigeria (AHNi), Abuja, Nigeria, 6USAID, Nigeria, Abuja, Nigeria, 7Ministry of Health, Akwa Ibom State, Nigeria, 8FHI 360, Abuja, Nigeria

BACKGROUND

The HIV surge implementation in Akwa Ibom State led to an increase in the number of people on antiretroviral therapy (ART) from 34,274 in 2018 to 122,528 in 2021. To program for these numbers, the Strengthening Integrated Delivery of HIV/AIDS Services project, funded by PEPFAR through USAID, implemented both community-based (CB) and facility-based (FB) differentiated services delivery (DSD) models. We compared treatment outcomes from CBDSD and FBDSD models implemented in the state.

METHOD

We conducted retrospective analysis of routine program data from 36 health facilities. Two client cohorts were analyzed: active clients on first-line regimen devolved into FBDSD or CBDSD model between January and April 2020. The FBDSD model includes Fast-Track — a differentiated services delivery model — that caters to clients at least six months on ART with records of good adherence and no opportunistic infections; and adolescent refill clubs designed to provide differentiated care for adolescents. CBDSD includes community ART refill clubs where clients obtain refills during club meetings in the community. Outcomes assessed in both cohorts 12 months post-devolvement were: viral load (VL) test done, VL suppression (<1000 copies/ml), and continuity on treatment (COT) with no ART interruption, within the period. Chi-square test was used to examine differences in outcomes using SPSS ver. 26.0.

RESULTS

Of the 3,595 clients, 838 were devolved to the FBDSD while 2,757 to the CBDSD model. Proportion of male to female was 28% (235/838) and 72% (603/838) in FBDSD compared to 33.5% (924/2,757) and 66.3% (1,833/2,757) in CBDSD (p=0.003). Median (IQR) age was 34 years (23–42) and 34 years (29–41) in the FBDSD and CBDSD, respectively (p=0.013). Clients in the FBDSD were 1.8 times more likely to have VL test than those in the CBDSD 93% (779/838) vs. 87.9% (2,424/2,757); aOR=1.814; 95%CI 1.36-2.42, p<0.0001). However, there was no difference in viral suppression rate 97% (756/779) vs. 98% (2,376/2,424); aOR=0.66; 95%CI 0.40-1.10; p=0.109) or COT 99.3% (832/838) vs. 99.0% (2,730/2,757); aOR=1.37; 95%CI 0.56-3.33; p=0.48) across both models.

CONCLUSION

Irrespective of the DSD model implemented, client COT and viral suppression were achieved. However, there is a need to scale up strategies to improve VL testing in community settings.

TUAE0402 - Does a Youth Intern Program Strengthen HIV Service Delivery in South Africa? A Time-Series Analysis

PRESENTING AUTHORS

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BACKGROUND

Since 2018, Youth Health Africa (YHA) has placed unemployed young adults in one-year internships in non-clinical roles at health facilities to support HIV services. While YHA is designed to improve employment prospects for youth, it also strives to strengthen the health system. Hundreds of YHA interns have been placed in program (e.g., HIV self-screening promoters) or administrative (e.g., data clerks) roles across South Africa, but their impact on HIV service delivery has yet to be evaluated.

METHODS

Using routinely collected data from 10/2017 to 3/2020, we conducted an interrupted time-series analysis to explore the impact of YHA on HIV testing, treatment initiation, and retention in care. We analyzed data from facilities in Gauteng and North West Provinces where Aurum is the implementing partner and where interns were placed between 11/2018 and 10/2019. We used linear regression accounting for facility-level clustering and time correlation to compare trends for six HIV service indicators related to HIV testing, treatment initiation, and retention in care before and after interns were placed. Outcomes were measured monthly at each facility. Time was measured as months since the first interns were placed at each facility. We conducted three secondary analyses per indicator, stratified by region, number of interns at the facility, and intern role.

RESULTS

Based on 207 facilities hosting 604 interns, presence of YHA interns at facilities was associated with significant improvements in monthly trends for the numbers of people tested for HIV (change: +19.9; 95% CI: 16.8, 22.9), lost to follow-up (-0.5; -0.7, -0.3), completing viral load (VL) testing (+0.8; 0.5, 1.1), and virally suppressed (+0.7; 0.4,

0.9). We found no difference for number of new treatment initiations (+0.1; -0.1, +0.2), and decreases in monthly trends for new positive cases (-0.5; -0.7, -0.4) and number initiated on treatment within 14 days of diagnosis (-0.6; -0.8, -0.4). Change in HIV testing and VL testing/suppression was most pronounced where there were program interns and a higher number of interns; change in loss to follow-up was greatest with administrative interns.

DISCUSSION AND RECOMMENDATIONS

Placing interns in facilities to support non-clinical tasks seems to strengthen HIV service delivery by increasing HIV testing and improving retention in care, either through direct patient contact or improving decision making and follow-up based on patient records.

TUAE0403 - Defining Person-Centered Care within the HIV Treatment Continuum in Sub Saharan Africa: A Systematic Review

PRESENTING AUTHORS

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BACKGROUND

Person-centered care meets the needs of individuals by increasing convenience, making services supportive and accessible, providing friendly services to diverse populations, and engaging communities and stakeholders. While evidence demonstrates that person-centered care approaches can lead to clinical improvements across the HIV care continuum, person-centered care has not yet been well defined or measured.

METHODS

A study team from John Snow, Inc. undertook a formal systematic review process (PROSPERO CRD42021246011) aiming to define person-centered care practices for HIV in sub Saharan Africa. Findings will inform a tool to assess person-centered care provided in diverse clinical settings. The team searched PubMed and CINAHL for studies that described HIV treatment service delivery in sub Saharan Africa; defined elements of person-centered care that facilitate service access, adherence, and retention; included health outcomes; were in English and published from January 2016 to present. Content analysis led to theme and sub-theme development. The Effective Public Health Project Practice tool for quantitative studies assessed the quality of included studies.

RESULTS

Thirty-one studies from 12 countries met the inclusion criteria, including 56,586 study participants (females ranging 42% - 100%; males ranging 0% - 58%). Major theme 1: Human resources with sub-themes staff composition, staff availability, and staff competency. Major theme 2: Organizational processes with sub-themes client feedback mechanisms, service efficiency and integration, convenience and access, and differentiated treatment models. Major theme 3: Technology with sub-themes integration and security of information, information technology to support health workers, and information technology to support clients. Major theme 4: Client support and agency with sub-themes community support, incentives, and client agency. Twenty-five of the person- centered interventions resulted in improvements in linkage to care, treatment retention, and/or viral suppression.

CONCLUSIONS AND RECOMMENDATIONS

The study team is developing a tool to assess the level of person-centered care using the major themes and sub-themes from this systematic review. The validation process will take place in select countries in SSA among diverse populations and clinical settings. Further scale-up of person-centered care practices may contribute to closing the 95-95-95 gap.

TIME	13:33 - 14:18	ROOM	500 Capacity Room	DATE	Tues. 7 Dec. 21

Track A: Basic Science (Biology & Pathogenesis)

A2 - Host Genetics, Immunology & Co-Infections

Chairs : Prof. Laurent Belec (France)
Prof. Thumbi Ndungu (South Africa)

TUAA0501 - Epidemiological and viral characteristics of undiagnosed HIV infections in Botswana.

PRESENTING AUTHORS

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BACKGROUND

HIV-1 is highly endemic in Botswana. The country's most significant challenge is improving HIV testing and identifying undiagnosed people. We evaluated factors associated with undiagnosed HIV infection using genetic, behavioral and socio-demographic data.

Methods: As part of the Botswana Combination Prevention Project, at least 20% of individuals across 30 villages in Botswana were randomly tested for HIV from 2013 to 2018. A total of 12,610 participants were enrolled, 3,596 (29%) were HIV-positive at enrolment and 147 participants became HIV-positive during the trial. Extensive socio-demographic and behavioral data were collected from all participants and next-generation sequences were generated for all HIV positive cases. Here, we compared three groups: those previously known to be HIV-positive (n=2,995), those newly diagnosed at the start of the trial (n=601) and those who became HIV positive during the trial (n=147). We searched for differences in demographic and behavioural data between groups using logistic regression. Next, we compared the topology of each set of cases in HIV-1 phylogenies and used a genetic diversity-based algorithm to classify infections as < or > 1 year.

RESULTS

We identified demographic factors, such as being male, young and married as associated with undiagnosed HIV infection ($p<0.001$). Behavioral factors such as inconsistent condom use, multiple sexual partners and spending time away from home increased the odds of harboring undiagnosed HIV infection, while knowing the HIV status of a partner significantly decreased those odds ($p<0.001$). Results from the genetic diversity-based classifier were concordant with epidemiological data. The probability of being classified as recent infection was high among incident infections ($P=0.847$), low among known infections ($P=0.005$) and intermediate for new diagnoses ($P=0.252$) ($p<0.001$).

CONCLUSION

Taken together, our results indicate that those with undiagnosed infections are young, educated, married, men who spend a proportion of time away from home and do not consistently use condoms with their partners. Notably, these men are aware of their risk – they test frequently, and a sizeable proportion had infections likely to be recent based on a genetic- diversity based classifier. In the era of "Test and Treat all", the identified predictors may help better prioritize groups for prevention and testing.

TUAA0502 - FORTE PREDOMINANCE DE L'INFECTION AUX HPV ONCOGENES ET DES GENOTYPES CIRCULANT CHEZ LES FEMMES VIH SEROPOSITIVES A OUAGADOUGOU, BURKINA FASO.

PRESENTING AUTHORS

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INTRODUCTION

Cette étude s'est particulièrement intéressée au statut VIH et au papillomavirus humain (HPV) responsable du cancer du col de l'utérus. L'objectif était d'étudier le profil et la prévalence génotypique du HPV chez les femmes infectées et non infectées par le VIH.

MÉTHODES

L'étude a été menée à Ouagadougou et a porté sur 421 femmes : 183 femmes séropositives (VIH+) et 238 femmes séronégatives (VIH-). La PCR/hybridation et la PCR en temps réel ont été réalisées pour la détection des génotypes du HPV à haut et à faible risque.

RÉSULTATS

Les deux populations de femmes différaient par leurs caractéristiques socio-économiques, comportementales et sexuelles. La prévalence du HPV était de 24,8% et 63,9%, respectivement, chez les femmes VIH- et VIH+. Sauf pour HPV16, HPV52, HPV58 et HPV6, qui étaient plus élevés chez les femmes séropositives par rapport aux femmes séropositives, c'est l'effet inverse qui a été retrouvé pour les autres génotypes. Nous avons trouvé beaucoup plus de cas de co-infection avec trois génotypes ou plus chez les femmes VIH+ par rapport aux femmes VIH-. L'utilisation de contraceptifs et un faible taux de CD4 étaient associés à l'infection au HPV chez les femmes séropositives ($p < 0,05$). Les paramètres tels que la tranche d'âge, l'état matrimonial, la profession, le niveau d'éducation, les antécédents d'infection gynécologique et l'utilisation du préservatif différaient selon le statut VIH ($p < 0,05$).

CONCLUSION

Grâce à cette étude, nous avons constaté que les HPV sont très répandus chez les femmes séropositives au Burkina Faso. Cependant, compte tenu de la forte prévalence de génotypes de HPV autres que 16 et 18, dans notre étude, un autre type de vaccin doit être envisagé pour les couvrir. En attendant, les résultats de cette étude pourraient être un tremplin pour l'introduction de vaccins contre les HPV déjà existants au Burkina Faso.

MOTS CLÉS
VIH, HPV, Génotypes, Femmes, Vaccin, Burkina Faso.

TUAA0503 - *In vitro* effects of product Nkabinde on immune response and HIV replication capacity

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BACKGROUND
Although the upscale of antiretroviral therapy has dramatically reduced the global numbers of new HIV infections, emergence of drug resistance has become a serious public health concern. Traditional medicine (TM) has been proposed as a promising alternative intervention to prevent HIV infection and transmission. However, the mechanism by which TM induces immunological response against HIV remains unclear. Here, we evaluated the in vitro effects of TM Product Nkabinde (PN) on mucosal and systemic immune responses and HIV replication.

METHODS
PN was supplied by local Traditional Health Practitioner. The IC50 concentration of standardized extract on isolated peripheral blood mononuclear cells (PBMCs) was established using the cell viability assay over 24hrs of incubation. Luminex and flow cytometry assays were used to measure cytokine and cellular levels in PBMCs stimulated with PN and/or PHA over 24, 28 and 72hrs, respectively.

RESULTS
The IC50 concentration of the PN for the PBMC was 325 µg/ml. In PBMCs treated with PHA, percentages of HLA-DR+ and CD38+ cells were elevated in both CD4+ and CD8+ T cells compared to PBMCs treated with PN, irrespective of incubation period. There were no differences in percentages of CCR5+ cells in both T cell subsets. At 24hr incubation, PN treated PBMCs had elevated concentrations of pro- (IL-1a, IL-1b, and TNF-a) and anti-inflammatory (IL-10) cytokines, chemokines (MIP-1a and MIP1b) and growth factors (GM-CSF) compared to unstimulated PBMCs.

CONCLUSION
We conclude that product Nkabinde possess immunomodulatory properties that may impact activation and recruitment of HIV susceptible cells. More studies using PN are needed to further understand key parameters mediating induction, expression, and regulation of the immune response in the context of HIV.

TIME	10:42 - 11:27	ROOM	600 Capacity Room	DATE	Tues. 7 Dec. 21

Track E: Health Systems, Economics and Implementation Science

E2 - Technology

Chair : Mr. Sydney Hushie (Ghana)

TUAA0601 - Getting to 90-90-90 using data analytics and dashboards to identify gaps and set actionable targets for Operation Phuthuma across districts in South Africa.

PRESENTING AUTHORS
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ISSUES
In 2019 the South African National Department of Health (NDOH) launched Operation Phuthuma – a strategy that leverages data sources and analytics with increasing granularity to inform targets and track progress towards 90-90-90 at district-level across the country.

DESCRIPTION
Prior to Operation Phuthuma, national and provincial HIV estimates were used to inform district targets but quarterly monitoring and poor coordination hindered action and progress. Operation Phuthuma recognised the need to set district targets disaggregated by age and gender, which could be applied at facility-level and used operationally to inform resource allocation and implementation to accurately target gaps. The team redefined HIV cascades, identified and triangulated relevant data sources and communicates results to provinces, districts and sub-districts through dashboards at weekly and monthly review meetings.

LESSONS LEARNED
By using targeted analytics NDOH have been able to accurately identify 'Front-runner' districts, those close to or achieving 90-90-90, and 'Turn-around' districts where

further prioritisation is needed. Frequent data review at all levels and triangulation of multiple data sources has improved data quality and reduced discrepancy between sources. Using more granular analytics (i.e. facility level, disaggregated by age and gender); consistent messaging and communication through dashboards; and setting targets actionable for those controlling implementation (e.g. by giving hard numbers rather than percentages) has resulted in clear, tangible guidance on the gaps for facilities and districts. By the end of May 2021, 6 (of the 52) districts had achieved 90-90-90 with another 6 set to achieve 90-90-90 within the second half of 2021.

NEXT STEPS

Using this targeted analytics process, Operation Phuthuma has been able to set clear actionable targets for the HIV programme and set the course for many districts and facilities to achieve 90-90-90 in 2021.

TUAE0602 - Use of workplace vending machines to increase access to HIV self testing in Kenya

PRESENTING AUTHORS

M. Mugambi1, O. Njathi2, E. Kahn-Woods3, N. Karuthiru2, A. Kinyanjui4, E. Kimenju5 1National AIDS and STI Control Programme, Nairobi, Kenya, 2OraSure Technologies, Nairobi, United States, 3OraSure Technologies, Boston, United States, 4Farmer's Choice Limited, Nairobi, Kenya, 5Majid Al Futtaim Hypermarkets Limited (Carrefour), Nairobi, Kenya

BACKGROUND

Despite progress in scaling access to HIV testing in Kenya, disparities persist, especially by gender. Kenya's National AIDS & STI Control Programme (NASCOP) has recognized oral fluid HIV self testing (HIVST) as a convenient, confidential, and empowering way to increase access to HIV testing for key populations.

In November 2020 and May 2021, Farmer's Choice Limited (FCL), Majid Al Futtaim Hypermarkets Limited (Carrefour), NASCOP, and OraSure embarked on introducing the OraQuick Health Check vending machine (VM) into the workplace. The VM pilot saw the FCL and Carrefour staff receive the OraQuick HIVST at no cost.

METHODS

The primary objective of the pilot was to evaluate the feasibility of using a VM to increase access to and awareness of HIVST. The secondary objective was to assess the effectiveness of HIVST VM in reaching priority populations. FCL and Carrefour were selected as key sites to introduce HIVST VM due to their established HIV wellness program and large, predominantly male workforces.

VM were placed in strategic locations (eg., outside the cafeteria) at FCL and Carrefour, enabling easy access for staff. Posters were made to instruct users on how to operate the VM and where to obtain further information on testing and counseling. "Wellness champions" were recruited from the workforce, who were trained to pass on HIVST information to the staff.

RESULTS

Workplace VM was successful in increasing access to HIV testing and raising awareness about the convenience of HIVST:

- Access: In 7 months, 1,426 HIVST kits were distributed (900 at FCL, 526 at Carrefour)
- Priority populations:
  1. 58% of kits were distributed to men (60% at FCL and 56% at Carrefour),
  2. 21% of testers were first-time testers (20% at FCL and 23% at Carrefour), and
  3. 69% were either first time testers or hadn't been tested in the past year (80% at FCL and 51% at Carrefour)
- Acceptability: Staff valued that no blood was required for the oral fluid HIVST and encouraged others to get tested, especially after receiving a negative result

CONCLUSIONS

NASCOP, FCL, and Carrefour successfully increased access to HIV testing for priority populations by offering convenient access to oral fluid HIVST through workplace VM. Clear instructions and marketing are critical to increasing uptake. Workplace VM HIVST can be an effective method for national testing programs and private sector companies to scale access to HIV testing by bringing services to end users in an easy and confidential setting.

TUAE0603 - Optimization of a Web-Based Ushauri Platform for Client Appointment Management in Health Facilities: Homabay County, Kenya

PRESENTING AUTHORS

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BACKGROUND

Appointment management is an effective strategy to ensure continuity in treatment and minimization of interruptions for persons living with HIV. Virtual appointment management systems provide additional flexibility and a pre-determined system of engagement

and reminders for clients. The Ushauri Platform, stemming from a Swahili word meaning provision of information, is a web-based appointment management mobile application that provides information through an electronic appointment diary that sends automated SMS reminders and motivational messages to clients 2 weeks, 1 week and 3 days prior to, the day of a clinic appointment, and immediately after a missed appointment. It tracks and provides daily appointment trends.

METHODS

In collaboration with the Ministry of Health, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) utilizes the Ushauri platform for appointment keeping and engaging clients at supported health facilities in Kenya. The impact of Ushauri implementation at 27 selected facilities with electronic medical records (EMR) in Homabay County from March to November 2020 was assessed. Trends in appointment keeping and re-engagement after missing appointments were analyzed over this period. The proportion of appointments kept and proportion of clients re-engaged in care within 7 days of a missed appointment before (March-June 2020) and after Ushauri implementation (July-November 2020) were calculated. Data was further disaggregated by age (0-9 years, 10-19 years, 20+ years).

RESULTS

Over 34,000 clients on HI/V care were enrolled into the Ushauri platform after providing written informed consent between March 2020 and November 2020. Increased rates of appointment keeping were experienced across different ages; 67% to 79% among 0-9-year-old clients, 74% to 82% among 10-19-year-old clients and 73% to 81% among clients 20 years or older. In addition, the proportion of clients re-engaged in care within 7 days after a missed appointment improved from 52% to 71% on average among 0-9-year-old clients, 45% to 71% among 10-19 years-old clients and 53% to 73% among clients 20 years or older. The median number of days' clients were re-engaged in care within 7 days of a missed appointment decreased overall across the different ages and sex.

CONCLUSION

The use of digitally-based appointment management systems supports treatment continuity for clients living with HIV.

TIME	12:36 - 13:21	ROOM	Plenary Room	DATE	Wed. 8 Dec. 21

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

D5 - Innovation, Adolescents, Young People and HIV

Chair : Beatrice Mutali (South Africa)

TUAA0701 - Prevalence of Gender-Based Violence (GBV) and HIV among Adolescent and Young People (AYP) living in the selected Internally Displaced Persons (IDPs) Camps In Borno State, Nigeria.

PRESENTING AUTHORS

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INTRODUCTION

Sexual and Gender-based violence (SGBV) is a common occurrence in populations affected by conflicts such as the insurgency in northeast Nigeria in which some AYP can be vulnerable and infected with HIV through sexual assault and rape. However, the prevalence of SGBV is typically difficult to measure in such conflict affected populations. AYP at risk often face significant challenges in accessing services, including medical services such as clinical management of rape, HIV counselling and testing, PEP, legal aid and psychosocial support. Empirical studies with displaced persons in Nigeria's IDP camps have also shown that AYP are still vulnerable to sexual assault, exploitation in camps and HIV.

AIM

This research will examine the prevalence of violence and HIV in IDPs camp in Maiduguri, Borno State and utilization of GBV services including HIV counselling and testing at the One Stop Centre (OSC) in Borno State

MATERIALS AND METHODS

The study adopted a mixed-methods research design incorporating Focus group discussion (FGD) and Key information interviews (KII). To estimate the prevalence of violence/HIV and assess young people's attitudes and knowledge, we conducted a FGD among AYP in the general population. Also, Stakeholder knowledge, and

attitudes towards VAW and HIV were assessed through KII research methods. Additionally, KII was conducted with the case worker to assess the utilization of HIV testing and counselling at the OSC by AYP

RESULTS

Almost half the respondents in the survey (30.5%) reported they had experienced violence at some time. This included: emotional violence (52.9%), physical violence (23.8%), sexual violence (28.6%) and economic violence (16.7%). Being physically forced to have sex was the most prevalent act of sexual violence (35.7%), while being forced to do something humiliating or degrading (14.3%) or to engage in sex in order to receive cash, food, clothes, etc. (35.7%) were less common. 40% of the respondent has low knowledge of HIV counselling and testing and do not know where to receive the services. Response from the OSC (service provider) shows that 8% of the raped GBV survivors were HIV.

CONCLUSION

From the survey, it was found that close to one half of AYP (30.5%) reported experiencing violence in their lifetime and some of them have low knowledge of HIV counselling and testing. These high percentages reflect the broad range of abuse, stigma, and exclusion to which AYP are subjected at all ages.

WEAD0702 - Prevalence and predictors of high-risk sexual behaviours among young adults at a state university in Zimbabwe

PRESENTING AUTHORS

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BACKGROUND

The highest number of new HIV infections in Zimbabwe are recorded in the 20-29 age group, with most being through heterosexual transmission. University students are a sub- population within this age group and are key in HIV prevention. This study sought to determine the prevalence of high-risk sexual behaviours among undergraduate university students at a state university in Zimbabwe, and determine the predictive value of alcohol use, childhood sexual abuse, and sexual debut for each high-risk sexual behaviour.

METHODS: The research adopted an analytical survey design, and data were collected using a self-administered questionnaire given to a sample of 381 students (65.6% females and 34.5% males) selected using clustered random sampling. Logistic regression analyses were done to determine the significance of each predictor variable.

RESULTS

Findings indicate that 65.62% (165 females and 85 males) of the students in the sample had some sexual experience, with most reporting inconsistent condom use (70%) and multiple sexual partnerships (10.4%). Transactional sex and intergenerational sex were less prevalent among the students. A higher frequency of alcohol consumption was associated with a greater likelihood of multiple sexual partnerships (OR=1.931, p=0.016) and intergenerational sex (OR=2.014, p=0.001), while more frequent heavy episodic drinking predicted inconsistent condom use (OR=1.630, p=0.028) and transactional sex (OR=1.445, p=0.042). Childhood sexual abuse predicted multiple sexual partnerships (OR=2.328, p=0.015), and increased the likelihood of intergenerational sex by seven times and transactional sex by four times. Lower age at sexual debut was associated with a higher likelihood of inconsistent condom use (OR=0.734, p=0.026), and multiple sexual partnerships (OR=0.697, p=0.005).

CONCLUSIONS AND RECOMMENDATIONS

The risk factors identified were consistent with problem behaviour theory in which early sexual debut among adolescents is associated with other problem behaviours. Findings emphasise the necessity of sexual and reproductive health programs targeting teenagers to prevent early sexual debut. Screening for childhood sexual abuse would be useful in HIV prevention, and there is a need for interventions designed specifically for students who consume alcohol.

WEAD0703 - Influencing youth demand for HIV prevention services through social media

PRESENTING AUTHORS

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1Networking HIV & AIDS Community of Southern Africa - NACOSA, Adolescent Girls and Young Women, Cape Town, South Africa, 2Networking HIV & AIDS Community of Southern Africa - NACOSA, Communications, Cape Town, South Africa

ISSUES

Young women are one of the populations most vulnerable to HIV in South Africa. The My Journey Adolescent Girls and Young Women programme, funded by the Global Fund, aims to decrease HIV incidence. The COVID-19 pandemic has accelerated the risks for young women. Restrictions have seen a reduction in the uptake of HIV

and post-violence care services.

DESCRIPTION

The Influencer project identified 30 young women on the My Journey programme to be social media influencers. The young women were recruited to reflect the diversity of female programme beneficiaries in terms of age, HIV status, sexual orientation and gender identity, in and out of school. The Influencers engaged with their peers on social media platforms (Facebook, Instagram, WhatsApp) to drive demand for HIV and other SRH services and to empower other young women. Influencers were given phones and data and trained in the basics of HIV and SRHR, digital advocacy, social media and content creation. They were also mentored and provided with key health messaging. Weekly Facebook LIVE sessions further supported them and created a sense of community. From January-June 2021, Influencers posted regularly on issues like HIV testing, PrEP, relationships, GBV, sexuality, mental health and STIs. The programme reached 41645 Facebook and 4016 Instagram accounts.

LESSONS

Social media peer education increases the reach of HIV prevention work and improves access to services for young women. Creating a community of peers engaging on sexuality, health and gender issues is a powerful platform to address myths. Mental health issues and experience of violence were a significant factor, requiring additional psycho-social support. An holistic developmental plan should be considered, so that Influencers can develop beyond their current roles. Promoting behaviour change in girls and young women, without including the voices of boys and young men was identified as a gap.

NEXT STEPS

The project is being continued with a focus on further diversifying the Influencers to include adolescents in all their diversity to consider: gender, (dis) ability, and learners in TVET colleges. The training will be expanded to include: mental health awareness and self-efficacy and content creation. A professional development plan will be created to help Influencers transition out of the project. A key messaging content framework will be developed, as well as exploring other social media platforms: TikTok & YouTube.

TIME	13:33 - 14:18	ROOM	100 Capacity Room	DATE	Wed. 8 Dec. 21

Track B: Clinical Science, Treatment and Care

B2 - COVID -19 & HIV

Chairs : Dr. Hugues Lago (Congo)
Prof. Mosa Moshabela (South Africa)

TUAA0801 - Integration of Differentiated Model of Care (DMOC) on HIV/AIDS and Non-Communicable Diseases treatment refills in and outside health facilities in South Africa during Covid-19.

PRESENTING AUTHORS

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ISSUES

South Africa has the largest ART program in the world. Currently, 5.1 million people are on antiretroviral treatment. The overall prevalence of hypertension was 14.3% in 2017, while the overall prevalence of diabetes was 3.2% in 2017. The massive expansion of the ART program in recent years and the rising burden of NCDs in South Africa are placing considerable strain on health care services, presenting challenges of maintaining high-quality public health services. Adherence to HIV, TB, and NCD treatments is an increasing challenge, and non-adherence to long-term therapies results in poor health outcomes.

DESCRIPTION

Differentiated Models of Care (DMOC) aims to strengthen linkage, adherence, and retention using a patient-centered approach throughout the treatment cascade. It makes provision for the three DMoCs (Facility Pick Up Points (FAC PuP), External Pick-Up Points (EX-PuP), and Adherence Clubs (AC) both at facility and community based) for those who are stable and living with HIV and/or hypertension and/or diabetes.

LESSONS LEARNED

2735 Central Chronic Medicine Dispensing and Distribution (CCMDD) external PUPs have been contracted by end of May 2021. The FAC-PuP model allows for direct and quick access to the pharmacy for healthy and stable clients on treatment. AC is facility and community-based and allows stable patients to be grouped together, voluntarily for

routine check-ups. EX-PuP model takes various forms, but all involve the patient collecting their treatment supply individually outside of the facility or from an automated system. Thus, including from private pharmacies, lockers, etc. As of end-March 2021, the data by the DMOC and type of patient showed a significant number of clients decanted (2 634 684). EX-PuP showed a high proportion of 60% (1 486 684) followed by FAC-PuP 25% (658 671) and lastly, the AC at 15% (500 590).

NEXT STEPS

Covid-19 inspired and expedited service delivery innovations. We, therefore, seize the opportunity and optimize responses to scale up the integration of HIV/AIDS and NCDs medicine refills using the DMOCs. South Africa is planning to conduct a comprehensive review of ART & AGL Policy Guidelines - in view of soliciting the scale-up of DMOC. We need to optimize the realization of 4th 90 – "A long and healthy life for people living with HIV". "We need to see DSD as the new normal, "If this is how people want their care, it is a right, not a luxury".

WEAB0802 - HIV care during COVID pandemic in Africa: experience from DREAM Programme

PRESENTING AUTHORS

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BACKGROUND

Experts have expressed concern about the impact of COVID-19 on the disruption to HIV programmes, leading to reduced care seeking for new patients, and to interruption of treatment for patients on care.

DREAM is a program for treatment and care of PLWH implemented by the Community of Sant'Egidio (CSE), based on some pillars: free of charge access to a package of essential services, use of Information Technology, development of laboratory services, patient and community empowerment.

Since the beginning of the pandemic crisis, CSE put in place measures to reduce impact for the health care in the countries where it operates, based on three levels: community awareness and involvement, measures to protect health centers (training, proper PPE delivery, symptom screening, rescheduling of appointments), strengthening of molecular biology laboratory.

Objective of the present work is to describe impact of COVID pandemic on HIV services implemented by CSE in 5 African countries during the first pandemic wave.

METHODS

We carried out a retrospective study in order to evaluate impact of pandemic and restrictions measures on different parameters of HIV care. Electronic files of patients accessing 8 DREAM centers in Malawi, 7 in Mozambique and in 5 West/Central Africa (Cameroon, RDC, Guinea) were reviewed in order to compare: new patients starting ART, lost to follow up (LTFU), deaths and respect of appointments for drugs refill in two periods: April- September 2019 and April-September 2020. Respect of appointments was calculated as the percentage of: number of executed appointments /number of scheduled appointments, based on data routinely registered on software used in the health centers.

RESULTS

Overall number of PLWH in ART at the beginning of the two periods was 46.181 and 47.393. New initiations of ART declined by 47% (1832 to 975). Mortality slightly declined (0,7% in 2019, 0,5% in 2020), and so did rate of LTFU (1,5% in 2019, 1% in 2020). Scheduled appointments for drug refills in the period were recorded for 42337 patients in 2019 and 37761 in 2020. Attendance to scheduled appointments slightly declined but was high in both periods (100% attendance for 82% of the sample in 2019, for 80,6% in 2020).

CONCLUSIONS

Our data indicate a reduction of new initiations of ART in the considered period. The multi-level intervention of CSE seemed to be successful in maintaining HIV patients in care despite the disruption of daily life in the countries.

WEAB0803 - Influence du COVID-19 sur l'accès aux ARV dans la Zone de Santé de Mumbunda de mars-décembre 2020 à Lubumbashi, RDC.

PRESENTING AUTHORS

A. SAIDI SALIMA1, J. KABWIMA1, C. MUTONKOLE2, F. NTAMBWE3, E. TELWA4, M.-P. BAKELE5

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CONTEXTE
L'accès aux ARV est l'un des déterminants de la suppression de la charge virale (CV) chez les PVVIH. Le réapprovisionnement individuel du stock d'ARV des patients se fait à travers les modèles différenciés des soins. Ceci a permis d'atteindre une suppression de la CV de 89% en Décembre 2019 dans la zone de santé (ZS) de Mumbunda. En Mars 2020 avec le COVID-19, le PNLS avait instruit aux formations sanitaires (FOSA) d'approvisionner les PVVIH en ARV pour plus d'un mois quelle que soit la stabilité des patients afin d'éviter une rupture de stock. La présente étude veut démontrer une éventuelle influence du COVID-19 sur l'accès en ARV.

OBJECTIF
Evaluer l'accessibilité aux ARV dans la ZS de Mumbunda pendant la période de Mars à Décembre 2020 dû au COVID-19.

MÉTHODES
Une étude rétrospective a été menée dans 4 FOSA qui prennent en charge 80% des PVVIH dans la ZS de Mumbunda de Mars à Décembre 2020. Une revue documentaire des fiches de prise en charge, les registres des médicaments, les fiches de stock des ARV, les bons de commande et de livraison des ARV a été réalisée. Nous avons analysé la disponibilité des ARV dans les sites de prise en charge, le respect des rendez-vous par les PVVIH pour le retrait de leurs ARV, les quantités d'ARV remises aux PVVIH et l'accès au prélèvement de la CV.

RÉSULTATS
Au total 200 dossiers (133F-67H) ont été revus dans 4 FOSA. Sur 947 visites réalisées, 599 l'ont été à la date prévue. La moyenne de mois prescrit était de 1.7. Et celle de jours sans TAR était de 14. Sur les 169 CV prévues et réalisées, 54 (32%) étaient dans le délai.
Au trimestre 1 (T1) le besoin en TLD s'élevait à 1052 boites et le stock disponible (SD) servi était de 380 boites (36%). En LPV/r: 88 boites et SD servi=35 boites (37%). En ABC+3TC : 444 boites et SD servi : 340 boites (76%). Au T2, le besoin en TLD était de 1659, SD servi=1769 boites (106%). En LPV/r : 41 boites et SD servi=56 boites (136%). En ABC+3TC : 94 boites le SD servi=53 boites (56%). Au T3 le besoin en TLD : 973 boites et SD servi=973 soit (100%). En LPV/r: 261 boites et SD servi=358 (112%). En ABC+3TC :744 boites et SD servi=740 boites (99%).

CONCLUSION ET RECOMMANDATIONS
Le COVID-19 a influencé l'accès de PVVIH par une faible disponibilité des ARV, le non-respect des rendez-vous des PVVIH pour l'approvisionnement en ARV et la faible réalisation de la CV. Une bonne prévention des épidémies augmente l'observance et accélère la lutte contre la pandémie.

MOTS CLÉS :ARV, COVID-19

TIME	10:42 - 11:27	ROOM	300 Capacity Room	DATE	Wed. 8 Dec. 21

Track C: Epidemiology and Prevention Science

C5 - COVID -19

Chair : Prof. Samuel Kalluvya (Tanzania)

TUAA0901 - CONTINUITY OF HIV CARE SERVICES RELATED TO HIV INFECTION STUDY, IN THE CONTEXT OF THE COVID-19 PANDEMIC, SENEGAL - 2021.

PRESENTING AUTHORS
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BACKGROUND
The COVID-19 pandemic response measures would favor concentration on the latter to the detriment of routine services, including the follow-up of people living with HIV (PLHIV), the major risk of which would be the discontinuity of services. This is why the National Epidemic Management Committee had the objective of studying the continuity of health care services related to HIV infection in the context of the COVID-19 pandemic in Senegal.

METHODS
A mixed (quantitative+qualitative), structural, cross-sectional, descriptive, and analytical study was carried out (03/01/2020-02/28/2021) using a combination of stratified, elemental random, and systematic sampling. Data were collected by telephone (not to expose PLHIV to COVID-19). Univariate, bivariate, and multivariate analyses were carried out using simple logistic regression (with Excel2010®, EPI Info7.2.4.0®, StataSE/15.1® and R3.6.3® including the IRaMuTeQ© interface). Anonymity and free and informed consent were in use, and the infection, prevention, and control. The approval of the National Ethics Committee for Health Research was obtained.

RESULTS
There were 504 PLHIV surveyed, predominantly female (67%), with 8.28% pregnant or recently delivered, 53.57% of whom delivered in hospital, 89.29% on ART, and 57.14% PCR (87.5% negative). The mean age was 43.2 ±13 years

with the extremes being 16 and 80 years. Stage I was more represented (90.28%) than Stage III (2.38%). Tuberculosis co-infection (TB) was detected in 76.79% of cases (positive in 2.33%). Viral load (VL) was found in 67.26% of cases, 71.68% of which were undetectable. The study found a 2.38% gap in the continuity of follow-up services for PLHIV in the pandemic context and statistically significant associations: (i) In bivariate analysis, with the source of energy (p=0.001), the existence of television (p=0.025), the cost of transport (p=0.028) and of consultation (p=0. 015), as well as VL, haemoglobin, blood glucose level and TB testing ; (ii) In multivariate analysis, with the existence of television (p=0.037: ORadj = 3.475 [1.076-11.225]) and transport costs (p=0.026: ORadj = 0.495 [0.267-0.919]). Finally, the qualitative analysis showed the barrier of the high cost of care services and the benefit of awareness.

CONCLUSION

COVID-19 pandemic has reduced the supply-demand of follow-up services for PLHIV and is an opportunity to prepare for other health crises by developing continuity of service plans based on the results found

WEAC0902 - Differences in detection of recent infections among persons newly diagnosed with HIV in Eswatini before and during COVID-19, July 2019 - December 2020

PRESENTING AUTHORS

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BACKGROUND

COVID-19 caused severe global interruptions in HIV Testing Services (HTS), and more specifically, recent infection surveillance, leaving many countries with limited data to detect areas of ongoing HIV transmission. In Eswatini, however, surveillance of recent infections (acquired within last 12 months) continued throughout the pandemic. Eswatini utilizes a recent infection testing algorithm (RITA) based on a Rapid Test for Recent Infection (RTRI) and viral load result >1,000 copies/mL to classify recent infections more accurately. We assessed the effects of the pandemic on the frequency of recent infections detected in Eswatini from July 2019-December 2020.

METHODS

Eswatini's recent infection surveillance data were analyzed to evaluate differences in RITA recent infection status among clients >15 years newly diagnosed with HIV before (July 2019- March 2020) and during (April-December 2020) the COVID-19 pandemic. Facilities with >1 RTRI conducted per month, each month, throughout the study period were included. Data were pooled in these two 9-month periods. We performed logistic regression to compare the odds of RITA recent infections before and during the pandemic, adjusting for age, sex, and modality.

RESULTS

19 of 128 facilities in Eswatini providing HTS met inclusion criteria, accounting for 29.6% of HIV diagnoses over the 18 months (enrollment fluctuated from 64%-96%). Among the 19 facilities, 4,262 newly-diagnosed clients enrolled from July 2019 - December 2020, 56.6% pre-pandemic (n=2,410). Among the 256 RITA recent infections, 72% (n=184) were before the pandemic. Infections had a 2.1 times higher odds of being detected as recent before, compared to during, the pandemic (adjusted-OR=2.13, CI, 1.58, 2.87). Facilities were treated as a random effect within the model. This association did not vary significantly by sex, age group, or modality.

CONCLUSIONS & RECOMMENDATIONS

Among newly HIV diagnosed clients at this subset of 19 facilities, recent infections were more likely to be detected before the pandemic. These findings suggest a potential shift in access to testing for all age groups and sexes. This delay may be related to COVID-19 mitigation efforts, limited availability of HTS and/or client mobility. These findings provide important information for tailoring Eswatini's public health response post-pandemic as the country continues to scale-up recent infection surveillance.

KEYWORDS: HIV, recent infection, COVID-19, Eswatini

WEAC0903 - The Impact of COVID-19 Prevention Measures on the SRHR of Young People, including Young People(Y/P) Living with HIV (YPLHIV) in Uganda

PRESENTING AUTHORS

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BACKGROUND

With a global estimate of 1.8 million YPLHIV, 30% of new infections occur among youth aged 15-24. Uganda counts

nearly 170,000 YPLHIV with figures expected to rise as more youth remain at risk of infection. Uganda's efforts to reduce the HIV incidence have been hindered by COVID-19 as access to prevention services remained remarkably low in 2020, with a drop in April citing the deterrent of STI/HIV prevention initiatives including HCT services. This study aimed at discovering the effects of COVID-19 prevention measures on YP's SRHR in Uganda.

METHODS

Mixed-methods participatory research coordinated by Rutgers was conducted in October 2020, using a mobile web survey to gather quantitative data among 640 respondents (326 males;314 females, aged 18-30), and Focus Group Discussions (FGDs) to gather Qualitative data among 39 YP (14 males, 22 females, 3 non-binary youth) in 4 selected districts in Eastern Uganda. Participants included YPLHIV, LGBTQI, Teenage Mothers and Youth in school. It looked at COVID-19 prevention measures' effects on access to SRH services and information. Participants for the FGDs were chosen purposively based on their gender, marital and educational status. Quantitative data analysis was done using descriptive statistics while qualitative data was analysed using a grounded theory approach that allowed identifying the common patterns and salient themes.

RESULTS

The impact of COVID-19 on YPLHIV worsens existing inequalities. Most YPLHIV reported that taking COVID-19 preventive measures were sometimes perceived as meaning that they were infected with COVID-19. Such accusations are likely to be hard to bear given the already existing stigma attached to HIV-positive people. 65% of participants reported that they needed information on STIs/HIV, and YPLHIV needed ART services but couldn't access them, mostly due to constricted transportation means. Other respondents who needed STI or HIV services (56% males; 55% females) reported failures due to fear of being infected with COVID-19.

CONCLUSIONS

The pandemic paused many negative effects on YPLHIV. Some of those concern the double stigma that may arise if they also test positive for COVID-19 and the increased psychosocial afflictions resulting from stress and isolation. YPLHIV are at risk of experiencing additional barriers that inhibit access to care. Thus, these challenges and barriers need to be addressed, to maintain continuity of care and strong psychosocial support systems.

TIME	10:42 - 11:27	ROOM	500 Capacity Room	DATE	Wed. 8 Dec. 21

Track C: Epidemiology and Prevention Science

C1 - COVID -19

Chair : Dr. Izukanji Sikazwe (Zambia)

WEAC1001 - Impact of COVID-19 on HIV Index Case Testing in Ethiopia.

PRESENTING AUTHORS

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BACKGROUND

Since the first confirmed case of coronavirus disease (COVID-19) on March 13, 2020 in Ethiopia, COVID-19 has negatively impacted HIV index case testing (ICT) by decreasing patient flow, decreasing availability of health workers due to infection or exposure, and conversion of health facilities to COVID-19 treatment centers. To mitigate the impact of COVID-19, HIV programs implemented virtual phone counseling, cyber education, virtual monitoring, and HIV self-testing. We evaluated the effect of COVID-19 on Ethiopia's HIV ICT program.

METHODS

We analyzed US President's Emergency Plan for AIDS Relief Monitoring, Evaluation, and Reporting HIV ICT data from FY20Q1 (October–December 2019; pre-COVID-19) to FY21Q2 (January–March 2021). A total of 1,492 facility and community sites, which represent huge majority of the ICT results in Ethiopia, were included in this analysis. Aggregate data on the number of clients who received HIV ICT services in FY20Q2 and FY20Q3 were compared with the pre-COVID-19 period. Quarterly results from FY20Q4 to FY21Q2 were compared with FY20Q3 (April-June 2020), the quarter most affected by COVID-19. The FY21Q2 results were also compared with Pre COVID-19 period.

RESULTS

In FY20Q1, 19352 clients were offered ICT and 16140 tests were conducted. Compared with the pre-COVID-19 period, HIV ICT offering in FY20Q2 dropped to 13357 (-31%). Index testing results also decreased to 14048 (-13%). In FY20Q3, index offered and tested further declined by 10077 (-52%) and 84591 (-52%) respectively. Compared to FY20Q3, ICT

offered increased to 10616 (+15%) in FY20Q4, to 15352 (+65%) in FY21Q1 and to 25600 (+176%) in FY21Q2. The corresponding test results also showed increment to 11482 (+49%) in FY20Q4, to 18496 (+141%) in FY21Q1 and to 33869 (+341%) in FY21Q2. In FY21Q2, index offered and tested increased to 25600 (+32%) and 33869 (+109%) respectively, compared to the pre COVID-9 Period.

CONCLUSION AND RECOMMENDATIONS:
HIV ICT in Ethiopia declined considerably starting March 2020 and recovered to pre-COVID-19 level by year end. Results surpassed the pre-COVID level by beginning of 2021. Virtual phone counseling, cyber education, virtual site-level monitoring, and HIV self-testing facilitated HIV ICT and helped mitigate the impact of COVID-19 on ICT services. These strategies are key for early case finding, treatment, prevention of HIV transmission and epidemic control.

KEYWORDS
COVID-19 impact, mitigation measures, Index Testing, Ethiopia

WEAC1002 - Potential Reductions in HIV and STI risks during COVID-19; a cross sectional study among female sex workers in Southwestern, Uganda.

PRESENTING AUTHORS
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BACKGROUND
The first case of COVID-19 in Uganda was reported on March 21st, 2020, and new infections continue to be reported every day. The government of Uganda has introduced measures like suspension of public gatherings, closure of non-essential business, discontinuation of public transport and enforcement of a national curfew to mitigate spread of the virus. These measures potentially have considerable impact on the income and general livelihoods of certain populations. Female sex workers are a high-risk group that maybe highly affected due to the close contact nature of their sex work. This study interacted with FSWs on PrEP to assess the impact of COVID-19 on risky sexual behaviours.

METHODS
This cross-sectional study was carried out among 524 FSWs using pre-exposure prophylaxis (PrEP) in Southwestern Uganda between February to June 2021. We administered a brief survey regarding access to health services, sex work, PrEP adherence, sexual behaviours, mental health and COVID-19 awareness and precautions. Responses were analyzed using descriptive statistics.

RESULTS
All 524 FSWs in the study were aware of COVID-19, and the majority (93.1%)were worried about getting infected. Most of them (88.6%) did not have any difficulty in obtaining PrEP medications due to COVID-19 related restrictions. However most (85.9%) of the FSWs in this study reported decreased clients seeking sex in the last 3 months.

CONCLUSIONS
FSWs were aware of COVID-19 and its risks, and most were concerned about being infected. Women generally could still access PrEP. Client number markedly reduced, and the subsequent reduction in income is a concern. The reduction in partner numbers may result in a reduction in new STI diagnoses and new HIV infections. We recommend tailored messages and information for reducing the risk of COVID-19, additional socio-economic protections due to lost income for this vulnerable population and focus on maintaining access to sexual health services during the COVID-19 pandemic.

WEAC1003 - COVID-19 Lockdown: Impact on facility-based HIV Testing Services and proposed mitigation strategies to combat future restrictions in Delta State Nigeria

PRESENTING AUTHORS
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BACKGROUND
People living with HIV (PLHIV) have better outcomes with early diagnosis and commencement of antiretroviral treatment. Anecdotal information suggests that the COVID-19 pandemic lockdown impacted HIV testing programs. We, therefore, assessed the impact of COVID-19 lockdown on facility HIV testing services (HTS) in secondary and tertiary health facilities and identified potential mitigation strategies from health workers in Delta State, Nigeria.

METHOD
The study utilised mixed methods. A secondary analysis of data from 53 HIV care sites (37 government-owned and

16 private, 34 rural and19 urban), to assess the impact of COVID-19 lockdown on HIV testing services (number of people tested (HTH_TST), and positive cases (HTS_POS) identified) and linkage to treatment. Outcomes during the lockdown period (Apr – May 2020) and post lockdown period (Jun – July 2020) and mean differences were derived. In-depth interviews were conducted among 63 health-care-workers and 21 community case managers to explore the challenges of providing HTS during the lockdown and identify strategies for mitigating the effect of potential future lockdowns. Data was analysed using a thematic approach.

FINDINGS

We reported 71,847 facility HIV tests done (2,352 positives with a 98.9% linkage rate) during the lockdown period and 85,980 (4,488 positives with a 100% linkage rate) post-lockdown period. There was a 19.7% and 90.8% increase in HIV testing and positive cases identified during lockdown and post lockdown, respectively. The average number of tests done by the facilities during and post lockdown was 1355.6 ± 198.0 and 1622.3 ± 243.0, respectively. The mean difference in tests was 266.6 ± 201.1 Similarly, the mean number of positives in lockdown, post lockdown and difference were 44.4 ± 8.5, 84.6 ± 20.2 and 40.3 ± 14.2. Three themes were extracted related to challenges; transportation problems, fear of infection and quarantine in the hospitals and financial difficulty. The themes identified for mitigation of future lockdowns were expanding testing options, providing incentives, and protecting staff.

CONCLUSION AND RECOMMENDATIONS:

COVID 19 lockdowns adversely impacted HIV testing in Delta State. Efforts to create system resilience could include community-based testing, patient incentives, expanding HTS services to Primary Health Centers, private labs, and pharmaceutical stores, in addition to special protections like dedicated transport systems for staff during lockdowns.

TIME	14:30 - 15:15	ROOM	500 Capacity Room	DATE	Wed. 8 Dec. 21

Track E: Health Systems, Economics and Implementation Science

E5 - COVID 19 & HIV

Chair : Prof. Seni Kouanda (Burkina Faso)

WEAC1101 - QuickRes maintains HIV services for key populations under COVID-19 lockdowns in Namibia.

PRESENTING AUTHORS

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ISSUES

The COVID-19 pandemic has forced governments to impose lockdown restrictions on people's movement to curb the spread of the virus. This has resulted in the physical closure of hotspots, impacting the routine delivery of HIV prevention services and linkage to clinical services for key populations (KPs) in Namibia. The already marginalized KPs stand to suffer even further marginalization from society, facing an increasingly fragile economy and accelerating health disparities due to COVID-19.

DESCRIPTION

To reduce gaps in service delivery during lockdowns, the KP-STAR project, funded by PEPFAR through USAID and implemented by IntraHealth Namibia, adapted QuickRes in August 2020 and rolled it out to 10 priority geographical areas (PGAs). Developed by FHI 360, QuickRes is an online application originally created to ensure continuity in HIV prevention interventions for KPs including linkage to ART, pre-exposure prophylaxis (PrEP), and follow-up services for viral load (VL) suppression and those who interrupt treatment. QuickRes allows clients to book HIV services online and allows case managers to monitor clients on ART and PrEP, provide phone-based support, track clients, and schedule and plan client refill appointments remotely, minimizing face- to-face interaction.

Between January-June 2021, 37 of 72 clinics mapped into QuickRes were active for KPs to make bookings and risk assessments and for case managers to capture data on HIV testing, PrEP, and ART services across the 10 PGAs. Staffed by 21 case managers equipped with tablets, we observed 2863 total users; 1083 completed risk assessments and

1328 directly booked appointments. 2502 (72%) arrived at clinics, 1549 (62%) received HIV tests with 242 (15.6%) testing HIV positive; 592 initiated PrEP (45.3%). 160 (66%) enrolled in ART; 52.9% are virally suppressed clients on ART with documented VL done in last 12 months.

LESSONS

KPs can be reached through QuickRes and encouraged to access HIV prevention interventions, treatment, and retention in care, contributing to achieving VL suppression under lockdowns and reaching clients that cannot be reached face-to-face.

NEXT STEPS: Future benefits of QuickRes include extending the online application to the Ministry of Health and Social Services for complete online coordination with health workers and case managers.

KEY WORDS

QuickRes- An online booking platform.

WEAC1102 - Multi-Month Dispensing of Antiretroviral Therapy and Viral Load Suppression for Children Living with HIV Before, and During the COVID-19 pandemic in Nigeria, Tanzania, and Zambia

PRESENTING AUTHORS

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BACKGROUND

Implementation of multi-month dispensing (MMD) of antiretroviral therapy (ART), historically reserved for adults, was expanded for children above two years living with HIV (CLHIV) during COVID-19 to ensure continuity of treatment. In Nigeria, Tanzania, and Zambia, the Faith-based Action for Scaling up Testing and Treatment for the Epidemic Response (FASTER) project provided above-site and on-site support to Ministries of Health to implement MMD for CLHIV, including routine ART stock monitoring, virtual data review meetings, and MMD mentorship for healthcare workers, in addition to site level support already provided by the President's Emergency Plan for AIDS Relief (PEPFAR) implementing partners. We assessed MMD uptake and viral load suppression (VLS) over time in FASTER sites to monitor impact of programmatic shifts in ART service delivery.

METHODS

Our analysis used PEPFAR Monitoring, Evaluation and Reporting data for children (0-14 years) attending PEPFAR facilities receiving additional FASTER support that implemented MMD between October-December 2019 and October-December 2020 in Nigeria, Tanzania, and Zambia. We calculated the percent change in overall proportion of clients on ART by MMD category; <3 months (n=153 facilities), 3-5 months (n=154 facilities) and ≥ 6 months (n=95 facilities), difference in median VLS (≤1,000 copies/ml) rates across facilities (n=156 facilities), and percent change in the proportion of facilities with overall VLS above 80% (n=109 facilities).

RESULTS

Across the three countries, the overall proportion of ART dispensed as <3 months MMD decreased (53% to 26%), 3-5 months MMD increased (41% to 61%), and ≥ 6 months MMD increased (6% to 13%). Median VLS rates increased (75% to 85%). Additionally, the proportion of facilities with VLS above 80% increased (27% to 70%). All results varied within +/-2% when disaggregated by sex, except for ≥6 months where MMD uptake was higher for girls than boys (128% vs. 106%).

CONCLUSIONS

Although there were observed increases over time in MMD uptake and VLS, direct associations cannot be made due to confounding factors and lack of patient-level data, including age disaggregation. Future work is needed to examine direct associations between MMD uptake and VLS in a cohort of CLHIV, alongside other factors including ART regimen optimization.

WEAC1103 - Experiences and Outcomes of Home delivery of ART as an Innovative Strategy to Ensure Continuity of HIV/SRHR Services amidst the COVID 19 Pandemic in Alive Medical Services Kampala, Uganda.

PRESENTING AUTHORS

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BACKGROUND

In response to the COVID 19 pandemic, Government of Uganda implemented a nation-wide lock down in 2020 and 2021. Whereas the strong mitigation measures of lockdown were seen to be controlling COVID-19 transmission, they were also affecting health service delivery posing a significant threat for people living with HIV/AIDS. The abruptness of the restrictions and lock down caught majority of people unaware with low ART stocks. Alive Medical Services (AMS) a non-profit HIV clinic in Uganda serving clients with integrated and comprehensive HIV care and treatment free of charge used innovative strategies including home delivery of ART to promote access and continuity of services for all clients.

DESCRIPTION

A variety of strategies were used with a modified community DSDM approaches for all PLHIV. All children, adolescents, adults, vulnerable and marginalised populations are being served. Multi- month refills of 3-6 months were being prescribed for all PLHIV.

Peer to peer deliveries: Expert peers used bicycles to deliver the medications for adolescents and young people (15-24 years) who would prefer to receive ARVs at an agreed place by peers they know.

Motorcycle Riders: Well packaged parcels are delivered by public motorcycle riders at their homes within 50KM radius due to its low cost, swiftness, and confidentiality.

Courier services and post office: Medication can be sent as parcels to the clients living beyond 50KM radius with telephone contacts.

Virtual psychosocial support: Offered to those with unsuppressed viral loads, on TB medication, depression.

LESSONS LEARNED

Between March and July 2020 734 clients were able to get their refills with in one week's appointment. ARVS can be delivered by courier services and motorcycles ART deliveries are cheaper to deliver medicines to stable clients. For the unstable clients who are not able to return to the clinic monthly, it is possible to do follow-up IACS virtually.

CONCLUSIONS

Despite the difficulty in accessing HIV care and treatment services during this COVID19 period as a result of stringent government directives and lockdown, it is still possible to continue providing lifesaving HIV care/treatment through various innovative aspects like AMS has done so as to maintain the gains that the nation has this far achieved. Lock down increased structural barriers for Key Populations to access services so this was a great benefit to them.

KEY WORDS: Home delivery, HIV, COVID 19, innovations, Multi month

TIME	14:30 - 15:15	ROOM	600 Capacity Room	DATE	Wed. 8 Dec. 21

Track E: Health Systems, Economics and Implementation Science

D4 - The Challenge of maximizing food quality & life during colliding pandemics

Chair : Mr. Niyi Ojuolape (Nigeria)

WEAD1201 - Access to HIV Treatment, Prevention and Sexual and Reproductive Health Services for Adolescent Girls and Young Women in Kenya during the COVID-19 Pandemic

PRESENTING AUTHOR

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BACKGROUND

The onset of COVID 19 significantly affected access to services at Kenyan health facilities, as services were either abridged or inaccessible. Health facilities have reportedly been scaling down other services including for SRH/HIV to prioritize on COVID 19. With the scale down, SRH and HIV services targeting Adolescent Girls and Young Women (AGYW) have also been affected, with the limiting of movement and mandatory COVID 19 symptoms checks at the health facilities creating an unfriendly environment for AGYW. Frequent stockouts of SRH/HIV products had been reported at some facilities, slowing down HIV and SRH integration during the pandemic period.

METHODS

An online survey targeting 39 AGYW aged 15 to 24 living

with HIV in 9 counties of Kenya, namely Turkana, Mombasa, Kilifi, Kisumu, Siaya, Nairobi, Machakos, Kakamega and Homabay, was conducted in late 2020 to find out how the COVID-19 pandemic had affected the SRH/HIV services they received at health facilities. In addition to the online survey, a series of Focused Group Discussions (FGDs)was undertaken with the participation of 44 AGYW in Kilifi (24 participants) and Kakamega (20 participants)counties.

RESULTS

87% of the participants, both online survey and FGDs, noticed changes in service delivery at health facilities during the pandemic, with activities like psychosocial support group sessions suspended, scaling down of operations and limiting visits as per COVID 19 guidelines. 71% of the participants preferred phone calls as a mode of client follow-up by health facilities. More than 65% of the participants preferred the integration of CCCs with the outpatient departments. They also preferred community refills through peer mentors and counsellors as a means of receiving health products during the pandemic. They advocated for the designation of days exclusively for SRH/HIV services at the facilities, as a strategy for increasing the uptake of SRH and HIV products during the pandemic.

CONCLUSION

An all-inclusive approach, one that involves health workers, program and policy implementers and the client (AGYW), appears to be the solution to the success of integrating SRH and HIV services for AGYW during the COVID-19 pandemic. Aggressive information dissemination about the new pandemic is key to debunk myths and misconceptions that stifle access to health services at the facilities by the AGYW. SRH and HIV services integration must be client-centred for it to achieve the desired results.

WEAD1202 - The risk of contracting yet another virus: dilemmas faced by young people living with HIV during COVID-19

PRESENTING AUTHORS

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BACKGROUND

Evidence shows that HIV-related stigma combined with the burden of living with a chronic illness can lead to depression and anxiety. Additionally, people living with HIV may experience socioeconomic and environmental stressors that may trigger or exacerbate pre-existing mental health conditions. Young people are highly vulnerable to poor mental health due to the demanding dynamics of transitioning from childhood through adolescence into adulthood. Poor mental health can lead to adverse knock-on effects on health, education, livelihood, and the formation of relationships. Therefore, it is imperative to understand and address the impact of COVID-19 on the mental health of young people living with HIV (YPLHIV).

METHODS

A sample of 166 YPLHIV aged 18-29 years participated in a global survey exploring barriers to mental health access and integration between April and June 2020. Eleven per cent of the YPLHIV were from Africa, 68% from Latin America, 15% from Europe and 6% from Asia and the Pacific. Sixty-eight per cent were male (including transgender men), 16% were female (including transgender women), and 13% identified as non-binary. Sixty per cent were between the ages of 25 and 29, 38% were between 20 and 24 years, and 5% were between 18 and 19 years. Three researchers independently performed a content analysis of 109 in-text responses in which young participants explained their fears regarding COVID-19.

RESULTS

Two-thirds of the participants (64%) agreed with the statement: "I feel anxious about COVID-19 due to my HIV status." Respondents lacked information and were concerned about their bodies' ability to cope with COVID-19, especially in the case of poorly managed HIV. Beliefs about higher vulnerability to COVID-19 meant that respondents were concerned about their health and posing a threat to loved one. COVID-19-related restrictions and fear of contracting COVID-19 while accessing ART were a barrier to service access. Shielding was associated with fear of job lay-offs. Respondents also expressed concerns that the supply of HIV treatment, which was already insufficient before COVID-19, would be further compromised. Three respondents were indifferent regarding COVID-19, citing that HIV was worse than anything else that could happen to them.

CONCLUSIONS AND RECOMMENDATIONS

The study shows that COVID-19 intensified YPLHIV's HIV management-related worries and anxieties. Findings highlight a need for credible information and support for YPLHIV

WEAD1203 - Social isolation is associated with major depressive disorders among women accessing HIV/AIDS care in Nigeria

PRESENTING AUTHORS

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INTRODUCTION

HIV infection is associated with a four-fold increase in the occurrence of major depressive disorders. The burden of depression in HIV is worst among women living with HIV in resource-poor settings. The lack of a partner and communal support that is prevalent among HIV-infected further aggravates the burden of depression among HIV-positive women. The current study aimed to assess the relationship between social support and major depressive disorder (MDD).

METHODS

This was a cross-sectional study of 458 adult women accessing HIV care in Nigeria, who were selected by systematic random sampling. Data was collected through structured interviews using validated scales for measuring social support and depression. Bivariate and multiple regression analyses were used to evaluate the relationship between social support and MDD.

RESULTS

The prevalence of MDD, requiring intervention, was 5.9%. More than half (52.6%) of the participants were socially isolated. Regression analysis showed that the likelihood of MDD increased by 5% for every point reduction in social support scores (adjusted Odds ratio = 0.950, 95% Confidence interval = 0.918-0.983). Also, time since HIV diagnosis had an inverse relationship with MDD (adjusted Odds ratio = 0.984, 95% Confidence interval = 0.971-0.998).

CONCLUSION AND RECOMMENDATION

Social isolation is common among women living with HIV. Social support might protect against major depressive disorders, requiring treatment. Social support may, therefore, be a critical success factor for interventions, whether support–focused or broader intervention for major depressive disorders among women living with HIV.

TIME	12:36 - 13:21	ROOM	Plenary Room	DATE	Thurs. 9 Dec. 21

Track E: Health Systems, Economics and Implementation Science

E7 - Integration and Case findings

Chair : Prof. Mosa Moshabela (South Africa)

THAE1301 - Index testing and HIV case-finding rates among partners of people newly diagnosed with HIV and PLHIV with unsuppressed viral load

PRESENTING AUTHOR

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ISSUES

While studies have shown that index testing (IT) is highly effective in identifying previously undiagnosed persons living with HIV (PLHIV), anecdotal evidence shows that PLHIVs are not always willing to name their sexual partners. Little evidence exists on characteristics distinguishing those PLHIV who agree to IT and those who do not. Understanding these differences can assist programs to identify and address barriers to IT among subgroups of PLHIV.

DESCRIPTION

Burundi's USAID-funded RAFG Project sought to determine differences in IT acceptance and HIV case-finding rates among PLHIV Newly Diagnosed Positive (PNDP) and PLHIV with Unsuppressed Viral Load (PUVL). De-identified data for all PLHIV ≥ 15 years offered IT in 4 high-burden provinces during October 2019–September 2020 were extracted from the project database. Acceptance rates (AR) were compared among people of different sex and age. Difference in proportions and means were calculated by the X2 test and Student's t-test, respectively. Stratified analyses were used to control for confounding. P-values of <0.05 were considered significant.

LESSONS LEARNED

Our analyses included 3,107 index cases (2,420 PNDP, 687 PUVL). Compared to PUVL, PNDP were more likely to accept IT (96.3% vs. 55.9%, p<0.01), report more partners (2.5 vs. 1.9, p<0.05), less likely to have partners who got tested (80.2% vs. 92.1%, p<0.01), and a higher HIV case-finding rate (27% vs. 25%, p<0.01) among partners.

PUVL's low AR merits attention. Among PUVL: males were more likely to accept than females (OR=1.84, p<0.01) and acceptance varied by age: 44.4% among those ≤24 years, 74.4% for 25–39 years, and 43.4% for ≥40 years (p<0.01). Among those PUVL ≤24 years, males were less likely to accept than females (OR=0.43, p<0.05); among those ≥25 years, males were more likely to accept (OR=2.7, p<0.0001). PNDP's high AR shows that IT works for them. PUVL's low AR, particularly among younger males and older females, highlights that different communication approaches may be needed.
Next steps: This study is one of few on PLHIV characteristics associated with IT uptake. Anecdotal evidence from care providers suggests that PUVL are reluctant to elicit partners due to fear of being judged responsible for HIV transmission and for not adhering to their treatment regimen. Given the substantially lower acceptance of IT among PUVL, as well as sex and age differences in uptake, qualitative research should explore PUVL's barriers to IT.

THAE1302 - Integrated Family Planning and ART Resupply Model for Women Living with HIV in Zimbabwe

PRESENTING AUTHOR

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ISSUES

Suboptimal contraceptive access for HIV positive women of childbearing potential (WOCBP) in Zimbabwe has been a barrier to uptake of DTG-based regimens, such as TLD. While March 2020 national guidelines recommend DTG use and effective counselling for WOCBP, addressing ground-level Family Planning (FP) and antiretroviral therapy (ART) access issues remain critical.

DESCRIPTION

An integrated FP/ART resupply model was piloted to dually promote uptake of TLD and contraceptives. In 10 high volume sites, 45 healthcare workers (HCWs) were trained on enhanced FP counselling and transitioning women to TLD. The FP/ART patient pathway was optimised using referral slips to track clients, should the required FP/ART services not be found at points of entry. Baseline and pilot routine clinical datasets were used for a pre-post quantitative analysis in Microsoft Excel, while HCW interviews provided qualitative insights.

LESSONS

A total of 847 WOCBP aged 15-49 years accessed FP/ART services during the pilot. The proportion of WOCBP on TLD increased [10% to 52%]. Most women accessed contraceptives through the OI/ART clinic (67.8%), while others accessed through family and child health, antenatal care, and outpatient departments. The contraceptive prevalence rate increased [64.7% to 99.2%], with stronger preferences for short-term methods. The use of contraceptive pills increased [18.2% to 64.7%], while condom use significantly reduced [36.0% to 0.1%]. Only 1.2% switched from short- to long-term methods, while the 5.8% who had never used contraception took up a method of choice.

Despite challenges related to data capturing, loss to follow-up, FP commodity supply and COVID-19 interruptions, uptake of both contraceptives and TLD increased. Service integration reduced patient travel burden, while enhanced counselling by trained HCWs empowered women to make informed decisions. Quality documentation was critical for measuring integration, including tracking of referrals. Further, constant supply of FP commodities of choice was confirmed to be critical to uptake.

NEXT STEPS

The modelled integration of FP/ART services can be extended to other HIV service delivery areas, including differentiated service delivery, towards equitable access to healthcare services. Future work could explore the use of digital inter-departmental tracking methods to mitigate the risk of referral leakages.

KEYWORDS

service integration; family planning; dolutegravir; Zimbabwe

THAE1303 - Investigation of intimate partner violence and links to viral suppression among women on antiretroviral treatment in northern Nigeria

PRESENTING AUTHOR

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BACKGROUND

Globally, evidence suggests that Intimate Partner Violence (IPV) is a common occurrence, with lifetime risk ranging from 36% to 71%. According to the Nigerian Demographic

and Health Survey (2013), only 31% of married women participated in decision making concerning their health care, major household purchases, and visits to their family/relatives. Despite improvements in antiretroviral therapy (ART) coverage, from 360,000 in 2010 to over 1,000,000 in 2018, viral suppression rates among people living with HIV (PLHIV) in Nigeria remains challenging (45.3% in women aged 15–49, NAIIS 2019). Various studies reveal that IPV might be associated with reduced condom use, higher HIV incidence and poor ART adherence. Centre for Integrated Health Programs, a local PEPFAR funded non-governmental organization, which provides HIV care and treatment services to over 170,000 PLHIV (65% being women), explored the associations between IPV and viral suppression among women on ART in 4 health facilities (HF).

DESCRIPTION

Between September–December 2019, 214 virally unsuppressed PLHIV were identified for IPV screening across 4 HF in Northern Nigeria. Health facility selection criteria includes (1) availability of adherence counselors, (2) available post gender-based violence (GBV) care services and (3) client load. Adherence counselors were trained on IPV routine enquiry using an adapted screening tool. IPV survivors identified received clinical/non-clinical post GBV services based on a minimum care package and were bled for viral load (VL) post IPV focused adherence sessions. Interventions offered to survivors include assisted disclosure, safety plan development, couple counselling and referrals for financial empowerment.

LESSONS LEARNED

Of the 214 virally unsuppressed women screened for IPV, nearly a third of the women -77 (36%) experienced one form of IPV. Following post EAC/IPV sessions received, 94% achieved VL suppression (<1,000 copies/ml). Major contributing factors associated with poor ART medication adherence include lack of disclosure due to fear of violence, patriarchal societal norms, and cultural beliefs, limiting access to resources for medication pickup and health visits.

CONCLUSION

Integrating routine IPV screening as a component of clinical service package for virally unsuppressed women and providing post IPV care interventions could improve adherence to ART medication, enhance HIV VL suppression and spur progress towards epidemic control.

TIME	13:33 - 14:18	ROOM	Plenary Room	DATE	Thurs. 9 Dec. 21

Track C: Epidemiology and Prevention Science

C3 - HIV/AIDS PREVENTION PROGRAMMES & HIV/AIDS SURVEILLANCE M&E

Chair : Shawn Malone (South Africa)

THAC1401 - Use of Social Marketing for promoting HIV Self-Testing Services among Adolescents and Young People in Lagos, Nigeria: A case study of SMARTPACK Intervention

PRESENTING AUTHORS

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KEY WORD

HIV Self-Testing, SMARTPack, Value Added Commodities, AYP, Lagos.

BACKGROUND

Adolescents and Young People (AYP) are under-served by the traditional HIV Testing Services due to social stigma and inadequate youth-friendly services in Nigeria. Only 1 out of 5 AYP (15-24 years) is aware of their HIV status; thus, the need for innovative testing strategies targeting AYP. HIV Self-Testing (HIVST) is a promising approach towards fast-tracking the 95-95-95 UNAIDS target by 2030. However, we are not aware of implementable and sustainable strategies of HIVST among AYP in Lagos, Nigeria. This study explored the use of SMARTPack intervention to increase uptake of HIV testing services by AYP.

METHODS

The OraQuick HIVST kit was re-branded and repackaged as “SMARTPack” with value added commodities including: male and female condoms, wrist bands and STI services following a peer-led approach by AYP and for AYP. It was then marketed to AYP in Lagos State from August, 2019 to March, 2020. Data on socio-demographic, sexual history,

and previous HIV testing were collected using structured questionnaires at baseline and after 6 months, follow-up. Information on SMARTPack perception in relation to affordability and stigma reduction were also collected. Descriptive statistics using mean, standard deviation and proportion were employed.

RESULTS:

A total of 114 AYP comprising 60 males (52.6%) with mean age 21.0±2.9years were reached. At follow-up, 91% had undertaken a second HIV self-test and 71% had been linked to Youth Friendly Health Center (YFC) irrespective of their HIVST result. Forty-six percent of AYP diagnosed with STI at the YFC received treatment. Also, 85% agreed that SMARTPack reduced social stigma associated with HIV testing; 59% were willing to disclose their result to a caregiver. About half (52%) of AYP could afford SMARTPack every 6 months at a mean price of N1,225.35(USD3.22)±N GN803.86(USD2.11).

CONCLUSIONS

AYP in Lagos perceived SMARTPack as a discreet and affordable HIVST option which could improve testing rate and referrals. Scaling up strategies SMARTPack could support efforts to achieve the 95-95-95 UNAIDS targets in Lagos state.

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THAC1402 - Have we met before? Understanding predictors of repeat HIV testing in Eswatini using HIV-1 recent infection surveillance data.

PRESENTING AUTHORS

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PURPOSE

Repeat HIV testing among people living with HIV (PLHIV) already diagnosed and initiated on anti-retroviral therapy (ART) complicates identification of new HIV infections, and monitoring HIV epidemic control in sub-Saharan Africa. We assessed viral load suppression (VLS) among PLHIV testing recent on a rapid-test for recent infection (RTRI) assay to estimate non-disclosure of ART use among PLHIV initially classified as newly HIV-diagnosed.

METHODS

The Eswatini HIV-1 Recent Infection Surveillance (EHRIS) program uses a recent infection testing algorithm (RITA) that combines an RTRI assay and viral load (VL) testing among newly diagnosed PLHIV. PLHIV who test RTRI recent and have VL ≥1000 copies/mL are considered recently infected. PLHIV who tested recent on RTRI and had VL <1000 copies/ml were considered misclassified as recently infected. We used data collected between July 1, 2019–April 15, 2021 among PLHIV 15-years and older, and performed univariable and multivariable log-binomial regression to estimate the relative risk of misclassification by time-period (pre-, post-March 24, 2020 COVID-19 "stay-at-home" guidance), sociodemographic and behavioral characteristics.

RESULTS

Of 936 RTRI recent infections with VL reported during this period, 358 (38.3%) were misclassified. The adjusted relative risk (ARR) of misclassification among RTRI recent infections was higher if testing was done on or after "COVID-19 stay-at-home" guidance was issued on March 24th, 2020 (ARR=1.3, 95%CI=1.1–1.5), age ≥25 years (ARR=1.4 95%CI=1.1–1.6) and among those testing at community sites (ARR=1.6, 95%CI=1.3–1.9).

CONCLUSION

Over one-third of RTRI recent PLHIV in our analysis were misclassified as recent infections., This suggests that retesting among previously diagnosed PLHIV is common, underscoring the importance of VL testing for accurate classification of recent infections. PLHIV tested after "COVID-19 stay-at-home" guidance, at community settings, and in older age-groups had higher probability of being repeat testers. Understanding motivations for retesting will help sharpen HIV service responsiveness and counselling to meet client needs and may reduce retesting.

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THAC1403 - Successful return of clients results after an HIV self-test: the role of peer educators in mbeya, tanzania
Abel Ngwalle (Tanzania)

PRESENTING AUTHORS

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Military Medicine, Clinical, Bethesda, United States, 5U.S. Military HIV Research Program (MHRP, Clinical, Silver Spring M.D, United States

ISSUE

Based on the World Health Organization's guidelines on HIV self-testing (HIVST) from 2016, Tanzania adopted HIVST as an integrated approach to national HIV testing services (HTS). HIVST is being scaled up as a safe and effective strategy to reach undiagnosed populations. While HIVST has the potential to increase uptake of HTS and help detect early HIV infection, monitoring the utilization of HIVST kits and outcome of end users remain challenging.

DESCRIPTION

Following a protocol-driven pilot project on HIVST in-country, Tanzania's government amended the HIV/AIDS Prevention and Control Act to allow people to self-test for HIV. HJFMRI implemented a peer-led HIVST model at community level, targeting hotspots for kit distribution. 82 trained peers screened clients and those eligible were offered HIVST kits. Upon request, clients received extra kits for their contacts, accompanied with written instructions on proper test use and follow-up. Clients' contact information were recorded in the HIVST register for follow-up. Within 2 days, peers called clients to inquire about kits and unreachable clients were traced physically. Clients with reactive results were referred to a nearby clinic for confirmatory testing. Newly diagnosed positives were escorted for antiretroviral therapy (ART) initiation.

LESSONS LEARNED

From February to June 2021, peer educators distributed 19,918 HIVST kits, with 10,486 (53%) clients preferring directly assisted HIVST, including 8,672 females and 1,814 males; 9,432 clients (5,922 females and 3,510 males) opted for unassisted self-testing. Overall, 15,987 (80%) clients returned their kits, and among them, 359 (2%) clients had a reactive result. Follow-up testing using the national testing algorithm confirmed 351 (98%) as HIV-positive, 350 (99.7%) of whom were linked to ART. During the reporting period, HIVST contributed to 8% (351/4,204) of total new positives identified through community testing strategies.

NEXT STEPS

Integrating HIVST to facility-based HTS may increase frequency of testing and improve case finding, particularly among those who would be missed by traditional testing approaches. The peer-led HIVST delivery model reported a high accuracy and acceptable HIV performance, with high return rate of distributed kits. HIVST is a worthwhile investment and countries should consider using a similar monitoring system to actively track used kits and users, considering the high unit cost of kits.

TIME	10:42 - 11:27	ROOM	100 Capacity Room	DATE	Thurs. 9 Dec. 21

Track B: Clinical Science, Treatment and Care

B3 - ART

Chairs : Dr. Frank Lule (Uganda)
Prof. Ayesha Kharsany (South Africa)

THAB1501 - High performance of integrase genotyping on diverse HIV-1 clades circulating in Cameroon: toward a successful transition to dolutegravir-based regimens in low and middle-income countries

PRESENTING AUTHOR

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BACKGROUND

Transition to dolutegravir-based as preferred first-line antiretroviral therapy (ART) is underway in low and middle income countries (LMICs). Given the broad diversity of HIV-1, a successful transition requires a thorough routine monitoring of integrase drug-resistance for a long-term effectiveness of these drug-regimens.

METHODS

We developed an in-house integrase-genotyping Sanger assay on plasma-samples from HIV-infected patients, seen routinely from February 2019 throughout January 2021. Sequence quality was validated following WHO operational framework and phylogeny done using MEGAv.7. Desirable and acceptable sequencing rates were set at ≥80% and 60-79% respectively; performance was stratified by viremia.

RESULTS

Of the 193 samples processed, with a median [IQR] viremia of 23,574 [518-109,235] copies/mL, 126 had >1000 copies/mL (i.e. WHO-threshold for genotypic-resistance-testing in LMICs). Following WHO-threshold, sequencing performance was 82.54% (104/126). According to

viremia, sequencing performance was 84.62% (66/78) with ≥100,000 copies/mL versus 76.67% (23/30) with 10,000–99,999 copies/mL (p=0.24); 83.33% (15/18) with 1,000–99,999 copies/mL (p=0.56); 73.68% (14/19) with 500–999 copies/mL (p=0.21); 50% (13/26) for 200–499 copies/mL (p=0.0007) and 36.36% (8/22) for <200 copies/mL (p<0.0001). Overall, 17 different subtypes were found within the 139 integrase-sequences obtained: 72 (51.8%) were CRF02_AG, 36 (25.9%) pure subtypes and 31 (22.3%) other recombinant forms. One patient exposed to raltegravir and dolutegravir, harboured major integrase-resistance mutations (E138KQ/G140A/Q148R/S147G).

CONCLUSION AND RECOMMENDATIONS

The developed in-house integrase-genotyping is highly effective, with acceptable performance even at low-level viremia (500-999 copies/mL). Additionally, its wide subtype coverage makes it a useful tool in monitoring the emergence of integrase-resistance mutations and to support the scale-up of dolutegravir-based regimens in LMICs and beyond.

KEYWORDS

HIV-1, Integrase-genotyping, viral clades, dolutegravir, Cameroon.

THAB1502 - Effectiveness of tele-EAC on viral suppression in the covid-19 pandemic era in Kaduna, Nigeria

PRESENTING AUTHORS

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BACKGROUND

The World Health Organization recommends Enhanced Adherence Counseling for HIV seropositive people on antiretroviral therapy (ART) with unsuppressed viral load (VL) (≥1000 copies/ml). Enhanced adherence counseling (EAC) is an intervention that consists of at least 3 adherence counseling sessions geared towards improving viral suppression and reducing subsequent treatment failure. In the pre-Covid-19 era, EAC sessions were primarily delivered face-to-face with the patient but the Covid-19 pandemic era brought about contactless healthcare services, and the advent of telephone EAC. But little is known of the effectiveness of this EAC modality. The objective of this study was to examine the effectiveness of tele-EAC on HIV viral suppression among PLHIV on ART during the Covid-19 pandemic era.

METHOD

A retrospective comparative cohort study was conducted in June 2021 amongst two cohorts of PLHVs on ART with unsuppressed VL (≥1000 copies/ml) who had EAC sessions in Kaduna, Nigeria. The first cohort included 661 PLHIV who underwent face-to-face EAC sessions between March 2019 and February 2020 (pre-Covid-19 era), while the second cohort comprised 1207 PLHIVs who underwent tele-EAC sessions between April 2020 and March 2021 (Covid-19 era). The post-EAC viral suppression rate for both cohorts was determined.

RESULTS

In the first cohort of 661 PLHIV who underwent face-to-face EAC, 645 (97%) had repeat VL tests; 637 results were received, out of which 445 (70%) were suppressed. VL suppression was higher in females (68%; n=301) than in males (32%; n=144). Similarly in the second cohort of the 1207 PLHIV who were enrolled for telephone EAC, 1004 (83%) had repeat VL test after at least 3 consecutive months of good adherence assessment. 727 repeat VL results were received with 509 (70%) achieving VL suppression. The proportion of viral load suppression was also higher among females (70%; n=356) than in males (30%; n=153). A higher probability of VL suppression was characterized by undergoing at least 3 consecutive sessions of good adherence (≥95%).

CONCLUSION AND RECOMMENDATION:

The study showed that tele-EAC is effective to achieve desirable viral suppression even in the COVID 19 era. It is therefore recommended that service providers can provide EAC services virtually to prevent missed opportunities and the spread of COVID 19 in the hospital setting.

KEY WORDS

Enhanced Adherence Counseling, Tele-EAC, Covid-19 pandemic, Viral Suppression

THAB1503 - Virological response to third-line antiretroviral therapy according to HIV genotypic resistance profile at initiation in Yaoundé-Cameroon

PRESENTING AUTHORS

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BACKGROUND
In order to limit the emergence of HIV drug resistance in a context of limited antiretrovirals (ARV) options, we sought to evaluate the efficacy of third line regimens according to HIV genotypic resistance profile at initiation of third line in Cameroon.

METHODS
A cohort study was conducted from January-September 2020 among third line's patients at the Yaoundé Central Hospital. HIV-1 protease (PR) and reverse transcriptase (RT) mutations were analyzed using the Stanford HIVdb v8.3 algorithm. Virological success (viral load [VL] <390 copies/mL) was assessed after 12 months on third line regimens using OPP-ERA platform. Statistical analyses were performed using Epi Info software version 7.2.2.6 with p<0.05 considered statistically significant.

RESULTS
Out of 38 eligible patients (42% (16/38) female; median age 49 [IQR: 39-57] years), median CD4 count and VL at third line initiation were 173 [34-374] cells/mm3 and 169,322 [30,382-551,826] copies/mL, respectively. At baseline, 100% (38/38) of the patients were resistant to reverse transcriptase-inhibitors (RTI) and 66% (25/38) to protease-inhibitors (PI/r), although 63% (24/38) were still effective on darunavir/r. The preferred third line regimen was dolutegravir+darunavir/r+tenofovir+lamivudine (51%); and the median duration on third line was 21 [17-32] months. The virological success rate on third line was 89% (34/38). However, the virological response on third line was similar regardless of ARV treatment (p=0.87) and baseline CD4 count (p=0.34).

CONCLUSION AND RECOMMENDATIONS:
Despite a previous multidrug resistance profile, switching to third line was accompanied by virological success in the majority of patients. This high efficacy, probably due to the high genetic barrier of main third line molecules, requires prolonged long-term monitoring for evidence-based decisions in resource-limited countries with similar settings.

KEYWORDS: HIV; Antiretroviral therapy; Drug Resistance; Third line; Virological response; Cameroon

TIME	14:30 - 15:15	ROOM	100 Capacity Room	DATE	Thurs. 9 Dec. 21

Track B: Clinical Science, Treatment and Care

B1 - Diagnostics, Clinical course of HIV Co-infection

Chairs : Prof. Jean-Cyr Yombi (Belgium)
Prof. Nombulelo Magula (South Africa)

THAB1601 - Morbidity and associated factors among patients living with HIV-2 in West Africa

PRESENTING AUTHOR
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BACKGROUND
HIV-2 infection is characterized by a slower disease progression than HIV-1 infection. However, there is limited data on morbidity among patients living with HIV-2 (PLHIV-2) in the era of universal access to antiretroviral treatment (ART). This study aimed at describing morbidity and associated factors among PLHIV-2 in Côte d'Ivoire.

METHOD
A retrospective analysis was conducted using data of patients enrolled in the IeDEA West Africa HIV-2 and dual cohort. All HIV-2 confirmed mono-infected adult patients were considered for this analysis. Data on clinical, immunologic and virologic characteristics during follow-up visits were retrospectively extracted in patients' medical records and the IeDEA HIV-2 database, from the last visit until the date of HIV diagnosis. Morbidity was defined as the occurrence of both opportunistic infections (OIs) and non-communicable diseases (NCDs). A logistic regression analysis was used to determine factors associated with morbidity.

RESULTS
A total of 266 HIV-2 patients were included, with a

median age of 53 [47-60] years. Protease inhibitor and Dolutegravir-based ART regimen were received by 226 (84.9%) and 11 (4.1%) participants respectively. After a median followed up duration of 9 [6-12] years, 173 (65%) patients remained in care, 93 (35%) were dead or LTFU. Viral load was detectable (>100 copies/mm3) in six (10.3%) patients, CD4 count was <500 cells/mm3 in 110 (41.3%), and 42 (24.3%) presented with WHO clinical stage III/IV at their last visit. Overall, 55 (20.7%) patients experienced a total of 57 morbid events, dominated by OIs in 42 (15.8%) participants. The main OI were skin affections in 16 (38.1%) and pulmonary tuberculosis in nine (21.4%). NCDs were reported in 13 (4.9%) patients, including 10 hypertensions (8 controlled with treatment and 2 dead), six renal failures (4 controlled and 2 dead), four diabetes (2 under control; 2 dead), one breast and one prostatic cancer (both successfully treated). After adjusted on age and HIV follow up characteristics, only baseline CD4 count<200 cells/mm3 [aOR= 3.8; CI95% (1.71– 8.39), p=0.001] remains associated with morbidity.

CONCLUSIONS

PLHIV-2 are facing high morbidity rate dominated by OIs. NCDs including hypertension have also a significant prevalence and must therefore be systematically prevented and investigated.

KEYWORDS: Morbidity, Opportunistic infections, Non-communicable diseases, HIV-2, West Africa

THAB1602 - Prevalence of viral rebound and associating factors in people with diagnosed HIV in Nigeria

PRESENTING AUTHORS

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BACKGROUND

Antiretroviral therapy (ART) allows for suppression of viral load and increased life expectancy of HIV-positive persons. However, in some people, viral rebound occurs after initially becoming undetectable. The Strengthening Integrated Delivery of HIV/AIDs Services project, funded by USAID and led by FHI 360, provides comprehensive HIV treatment for over 134,269 people living with HIV (PLHIV) in Akwa Ibom and Cross River states. The analysis aims to estimate the prevalence of viral rebound and associated factors among people diagnosed with HIV in the two states.

METHODS

We conducted a retrospective cohort study using secondary data from the electronic medical records (EMRs) across 96 health facilities providing ART in the two states. Data collection involved line-listing of all virally suppressed (<1000 copies/ml) clients identified as of December 2018 to determine viral rebound and its associated factors. To determine viral rebound—defined as detectable VL test result >1000copies/ml after an initial suppression, people with two or more viral load tests within a two-year period (January 2019–December 2020) were included. The analysis was done to identify factors—age, sex, ART duration, and enrollment in differentiated care—independently associated with viral rebound using logic regression on SPSS version 26.

RESULTS

Among 11,228 PLHIV with initial viral suppression, median (IQR) age was 39 years (IQR=32–47), 70.8% (7,951/11,228) were females, 96% (10,789/11,228) were on first-line antiretroviral drugs (ARVs), and 20% (2,272/11,228) were on ART for 0–12 months. Of the total, 5.7% (643, Xage=38 years) had documented viral rebound, and 10,585 (Xage=40 years) had documented sustained viral suppression during the 24-month period. Rebound rate was 5.8% (461/7,951) among females, 5.6% (182/3,277) among males (p=0.77), 7.7% (34/439) among clients on second-line ARVs, and 5.6% (609/10,789) among those on first-line ARVs (p=0.06). Increasing age (aOR=1.02,95%CI=1.01-1.02, p<0.001); Increasing duration on ART (aOR=1.08,95%CI=1.05-1.11, p<0.001); and non-enrollment on a differentiated model of care [non-DMOC=530/7,219 (7.3%) vs. DMOC=113/4,009 (2.8%); aOR=2.73,95%CI=1.05-1.11, p<0.001] was significantly associated with increased probability of rebound.

CONCLUSION

Findings showed up to a 5.4% rebound rate among PLHIV in the study setting. This is a call to action for policymakers and program implementers.

TIME	14:30 - 15:15	ROOM	300 Capacity Room	DATE	Thurs. 9 Dec. 21

Track C: Epidemiology and Prevention Science

C2 - HIV /AIDS PREVENTION PROGRAMMES

Chair : Dr. Carlos Toledo (United States)

THAC1701 - Increasing access to HIV services while minimizing potential exposure to COVID-19 among men who have sex with men (MSM) in Ghana.

PRESENTING AUTHOR

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ISSUE

Ghana experienced and continue to experience disruptions in providing HIV services to MSM as a result of Covid-19. Factors such as social distancing which restricts large group outreaches; reduced demand for services because of fear of Covid-19 transmission in facilities; and reduced availability of services as providers are assisting with the pandemic response affect delivery of HIV services for MSM. Maintaining uninterrupted access to essential prevention, testing and treatment services for MSM during the pandemic require using integrated and community-based strategies that minimizes potential risk for COVID-19 exposure.

DESCRIPTION

MLPF introduced various community-based approaches to HIV service delivery for MSM during the pandemic in 3 districts. Peer educators were trained to provide education on COVID-19 during their community outreach activities. Authorization was sort for outreach workers in lockdown areas and provided with PPEs during delivery of physical outreaches. Flexible strategies were implemented to preserve access to HIV services and promote the safety of staff and peers: (1) Online platforms were used to engage peers for HTS and support PLHIV through virtual case management; (2) Testing and treatment took place at homes and safe locations identified by peers; (3) Condoms, lubricants and HIV self-test kits were made available at community-led DICs and outlets for easy access; (4) Multi-month dispensing of ART and PrEP was promoted to eliminate clinic visits

LESSONS LEARNED

Introduction of community-based strategies reached out to more MSM across the 3 districts. HIV positive yield also increased across the 3 districts after the introduction of innovative strategies. During the pandemic between February to April 2020, 445 new MSM were reached and tested for HIV; 32 were diagnosed positive. After the introduction of community-based strategies, between May and July, 634 new MSM were reached; 89 were diagnosed positive.

NEXT STEPS

CSOs can adopt tailored community-based approaches that can be integrated into HIV programs to improve results in reaching, testing and linking MSM in times of a pandemic. There is a need to invest in newer approaches of HIV programming that takes into account changing times.

Scaling up community-based approaches to HIV service delivery can help safeguard the hard-fought gains of the global HIV response. If these solutions are sustained beyond the pandemic, they may help modernize key population programming.

THAC1702 - Factors associated with sexual exploitation and transactional sex among adolescent girls and young women: results from the Zimbabwe Violence Against Children Survey (VACS 2017)

PRESENTING AUTHORS

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BACKGROUND:

Transactional sex is non-marital, non-commercial sexual acts motivated by implicit assumption of an exchange of material support or other benefits for sex. In sub-Saharan Africa, adolescent girls and young women (AGYW) who are sexually exploited minors (<18 years) or who have ever engaged in transactional sex are 50% more likely to be HIV-positive. In 2017, the nationally representative Zimbabwe Violence Against Children Survey (VACS) was conducted to estimate the prevalence of violence among Zimbabwean youth and characterize the relationship between violence during childhood and HIV.

METHODS

Using cross-sectional VACS data from 5,105 AGYW, aged 16-24 years, who participated in the survey and had complete data, we explored associations between sociodemographic and behavioral characteristics and reports of ever being sexually exploited or engaging in transactional sex. Logistic regression analysis, accounting for the survey design, was used to explore factors associated with transactional sex. Factors significantly associated with transactional sex ($p<0.05$) on bivariate analysis were included in a multivariable model. Analyses were performed using SAS v9.4.

RESULTS

Of this sample of AGYW respondents, 2.5% reported ever having transactional sex. While controlling for education, marital status, early pregnancy, experiences of sexual abuse or violence, STI history, and early sexual debut in the final regression model, the following had significant associations with transactional sex engagement: having engaged in work for at least one hour in the previous week (aOR, 1.69 [95% CI: 1.08-2.65]), history of mental illness (aOR, 1.55 [95% CI: 1.02-2.34]), having multiple sexual partners in the previous 12 months (aOR, 8.00 [95% CI: 3.97-16.16]), experience of any violence in their lifetime (aOR, 2.69 [95% CI: 1.58-4.55]), HIV-positive status (aOR, 2.77 [95% CI: 1.29-5.96]), infrequent condom use in the previous 12 months (aOR, 3.81 [95% CI: 2.20-6.60]), and ever pregnant (aOR, 3.73 [95% CI: 1.61-8.65]).

CONCLUSIONS

Strengthening programs for prevention of new HIV infections among AGYW in Zimbabwe could decrease sexual exploitation, transactional sex, and HIV risk behaviors. For example, scale-up of PEPFAR's Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program throughout Zimbabwe could help address the factors we identified and empower AGYW by offering alternatives to transactional sex as a result of economic hardship.

THAC1703 - Social Harms related to PrEP use among Adolescent Girls and Young Women participating in a PrEP Demonstration Project in Uganda

PRESENTING AUTHORS

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BACKGROUND

Pre-exposure Prophylaxis (PrEP) is a proven HIV prevention strategy in high risk populations. Like other biomedical interventions, PrEP implementation may result in social harms from inadvertent disclosure of its use. Identifying and pre-emptively addressing social harms could promote PrEP use.

METHODOLOGY

This prospective cohort study was conducted December 2017 - July 2019. Eligible HIV-negative participants were initiated on daily oral PrEP (Tenofovir/Lamivudine). Scheduled follow up was done at months 1, 2, 3, 6, 9 and 12. At every visit, data on participants' health status, adverse events, adherence, and sexual behavior was collected, while testing for HIV and STIs was performed at the quarterly visits. Reports of potential social harm events were collected at scheduled and unscheduled visits or via phone calls from participants. Social harm was defined as any event related to study participation that occurred in the participant's social life/interactions and resulted in psychological or physical harm. We describe the social harms that occurred in this study and their impact on study participation.

RESULTS

Among 848 enrolled participants, 11 (incidence: 3.10 per 100 person-years (95% CI: 1.72, 5.60) reported PrEP-related social harm events subsequent to someone mistaking PrEP for antiretroviral treatment and suspecting that the participant was HIV-infected. The events included physical assaults (n=4), verbal assaults (n=4), stigmatization by peers (n=1), and loss of regular sexual customers (n=1). One participant reported loss of income from reduced productivity due to PrEP side effects. Five participants who suffered social harm chose to exit the study. The other participants were able to continue the study without further incident. All were provided with counseling services.

CONCLUSION

Despite thorough counseling provided at enrollment and follow-up visits, social harm events, some of them severe, did occur in this study. Most events were related to confusion between PrEP medication and antiretroviral treatment for HIV, as the active molecules in both products are antiretrovirals. Programs implementing PrEP need to focus on this aspect by creating broader social awareness about PrEP and, whenever possible, ensure that PrEP medication is packaged distinctively, to minimize confusion. Campaigns aimed at destigmatizing PrEP can further reduce the incidence of harmful events

among users.

TIME	ROOM	DATE
10:42 - 11:27	600 Capacity Room	Thurs. 9 Dec. 21

Track E: Health Systems, Economics and Implementation Science

E1 - Youth

Chair : Daughtie Ogutu (Kenya)

THAE1801 - Viral suppression among children and adolescents with high viral load following implementation of a standardized enhanced adherence counseling package in Homa Bay and Turkana Counties, Kenya..

PRESENTING AUTHORS

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BACKGROUND

Viral suppression (VS) among children and adolescents on antiretroviral therapy (ART) is sub-optimal in Kenya. Enhanced adherence counselling (EAC) is provided for patients with high (≥1,000 copies/ml) viral load (HVL). However, implementation of EAC is not standardized. We describe the implementation and evaluation of a standardized EAC (SEAC) package.

METHODS

We implemented a SEAC package based on the National ART guidelines. The package included standard procedures operationalizing EAC process, training of providers on psychosocial support and communication skills for children and caregivers, mentoring on EAC processes and individualized case management.

We conducted a pre-post evaluation of the package in six purposively selected facilities. Children and adolescents, 0-19 years with HVL were enrolled. Pre-intervention data were retrospectively collected from patient records between October 2016 and September 2018. Prospective data were collected from February 2019 to August 2020. EAC uptake, time to initiation and completion of the minimum 3 sessions and VS pre-post- SEAC were determined. comparisons used Wilcoxon-Mann-Whitney and Pearson's Chi-square tests at 5% level of significance. Multivariate logistic regression was used to identify factors associated with VS.

RESULTS

Overall, 741 patients, median duration on ART of 6.6 years, IQR, 3.4-9.1 were enrolled, mean age of 11.1 years (SD=4.3). Uptake of EAC was 83% and 100% among EAC and SEAC groups respectively, p<0.001; 403 (81%) EAC and 133(91%) SEAC groups completed 3 sessions, p=0.004. Time to EAC decreased from 49 to 41 days, p=0.006. Time to complete 3 sessions reduced from 59 to 47 days, p=0.002. VS increased from 44% to 55%, p=0.023. Patients who received 1-2 EAC sessions were more likely to be virally suppressed on repeat testing, OR, 1.8 (95% CI; 1.1-2.9) compared to those with ≥3. In multivariate adjusted analysis, patients receiving SEAC were 1.6 (95% CI; 1.1-2.3) times more likely to be virally suppressed on repeat testing compared to those not receiving SEAC. Receiving 1-2 sessions remained significant; AOR, 2.2, (95% CI; 1.3-3.5), as did receiving services in Homa Bay county, AOR, 2.3 (95% CI; 1.3-4.1).

CONCLUSION

Implementation of SEAC improved VS, uptake and time to interventions for children and adolescents with HVL. Two EAC sessions were more effective in achieving VS than the recommended 3. Despite improvement in VS after SEAC, overall suppression was sub-optimal.

THAE1802 - A consultative assessment of Adolescent and Young People (AYP) intervention optimization needs for HIV and SRH services in South Africa

PRESENTING AUTHORS

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Statistics SA (2020) has indicated that the total number of Adolescent and Young People (AYP) aged 15-24 is approximately 9.57 million, of which 720 000 of them are living with HIV. In addition, research has found that AYP have an exacerbated risk of new HIV infections. The characterization of AYP as one of the vulnerable populations prompted the need to prioritize youth engagement and increase access to HIV and Sexual and reproductive health (SRH) services. The Global Fund to fight AIDS, Tuberculosis and Malaria has served as one

of the funding mechanisms that enable the optimization of access to HIV, TB and SRH services while promoting meaningful youth participation.

The South African National AIDS Council engaged a total of 137 AYP with representatives from all provinces through consultative meetings in April 2021. The consultations sought to ascertain the gaps and challenges faced by AYP in accessing SRH, HIV, STI and TB services. It also sought to identify their priorities, best practices for scale-up, opportunities for strengthening community engagement and identify mechanisms to ensure the inclusion and meaningful participation of diverse youth in the upcoming grant.

Biomedical challenges such as lack of access to ART, contraceptive stock-outs and lack of integrated health services were found to contribute to low treatment adherence and high pregnancy rates. The structural challenges found were stigma and discrimination, negative health worker attitudes, access to SRH services without parental consent, GBV, high youth unemployment and early child marriages. Behavioural aspects such as risky sexual behaviour, substance abuse and low adherence to available prevention tools increase the risk of HIV and pregnancy. This is worsened by the lack of adequate psychosocial counselling and engagement of male partners of AGYW and existing knowledge gaps in current policies addressing SRHR.

The meeting proposed concrete recommendations towards strengthening and increasing access to health services and identify priority areas that respond to Biomedical, Behavioural and Structural thematic areas. One of the key proposed outcomes of the consultations was to ensure sustainable solutions by positioning AYP at the centre of their sexual health needs. This can be achieved through continued engagement, promotion of youth-led approaches which place AYP not only as beneficiaries but also key contributors to programmes at design, planning, and implementation stages.

THAE1803 - Pink day youth friendly services: promoting uptake of sexual reproductive health / Human Immuno- deficiency Virus (HIV) services for adolescent girls and young women in Zambia

PRESENTING AUTHORS

K.P. Poho1, K.P. Poho1 Charles R. Drew University of Medicine and Science, Zambia, Data Department, Lusaka, Zambia

About 32% of adolescents aged 15-17 years and 60% of those aged 18-19 years are sexually active in Zambia, and therefore face risks to HIV and other STIs, especially as only 40% report condom use after their last sexual intercourse. Charles Drew University (CDU) with PEPFAR funding through Health Resources and Services Administration (HRSA) implemented the RiseUp! Project in Zambia to address the root causes of HIV risk behavior among adolescent girls and young women (AGYW) with the aim to address youth specific challenges related to adherence to antiretroviral treatment and low viral suppression of HIV. In enhancing this, CDU introduced a day called the Pink day where all the HIV positive girls (pink girls) would meet at a RiseUp house (safe space) for SRH/ HIV and pyscho-social support activities provided in a youth friendly manner.

CDU, in collaboration with first level hospitals under the Ministry of Health in Lusaka, Zambia are implementing a high impact, integrated SRH services. AGYW that visit the RiseUp houses on the Pink days access comprehensive HIV and SRH information and services provided through peer-to-peer sensitizations and focus group discussions. The provision of SRH/HIV service at the RiseUp houses promotes the uptake of services among AGYW as it is provided in a youth friendly manner.

LESSONS LEARNED

By May 2021, the program increased enrollments from 9,602 AGYW to 15,811 (61% increase) AGYW with negative or unknown status into the RiseUp! Program and screened for HIV risk. After screening, a total of 8,506 AGYW were eligible for HIV testing and were tested of which 3309 tested HIV positive (39% yield) and linked to care and treatment. With continuous follow-up and adherence support, from RiseUp! Team and health care providers, 3,184 out of 3309 (96%) of the AGYW on antiretroviral therapy are currently virally suppressed.

NEXT STEPS

The use of demand creating activities results in an increase in the uptake of SRH/HIV information and services by the adolescents' girls and young people. There is a continued need to strengthen the delivery of integrated SRH and HIV services to enhance the one-stop-centres for SRH and HIV services targeting AGYW. Use of a capacity building approach for AGYW care, using a cascading model, will strengthen the ability of Zambia Ministry of Health and implementing partners to expand youth friendly service provision at grassroots level.

KEY WORDS: Youth Friendly Services, Pink day, AGYW, HIV, RiseUp

TIME	13:33 - 14:18	ROOM	Penary Room	DATE	Fri. 10 Dec. 21

Track C: Epidemiology and Prevention Science

PrEP (CROSS SECTION)

Chair : Prof. Morenike Ukpong (Nigeria)

FRAC1901 - Preference for and Uptake of Oral Pre-exposure Prophylaxis among Adolescent Girls and Young Women in Kampala, Uganda

PRESENTING AUTHORS

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INTRODUCTION

Oral pre-exposure prophylaxis (PrEP) has been scaled up however data on product preference, uptake and adherence in real world settings are limited among adolescent girls and young women at risk of HIV infection in sub-Saharan Africa.

METHODS

We conducted a prospective cohort study among 14-24-year-old HIV-negative volunteers who were followed for 12 months in Kampala, Uganda. Within 14 days of enrolment, they received two education sessions including demonstrations on five biomedical interventions that are; available (oral PrEP), likely to be available soon (long-acting injectable PrEP, anti-retroviral vaginal ring), and in development (ARV implant, HIV vaccine). Information included mode and frequency of delivery, potential side effects, method availability. Volunteers ranked interventions, 1=most preferred to 5=least preferred. Oral PrEP was "preferred" if ranked 1 or 2. All were offered oral PrEP and determinants of uptake assessed using Poisson regression with robust error variance. Adherence was assessed using plasma tenofovir levels and self-reports.

RESULTS

Between January and October 2019, 532 volunteers were screened; 285 were enrolled of whom 265 received the two education sessions. Mean age was 20years (SD±2.2), 92.8% reported paid sex, 20.4% reported ≥10 sexual partners in the past 3months, 38.5% used hormonal contraceptives and 26.9% had chlamydia, gonorrhoea and/or active syphilis.

Of 265 volunteers, 47.6% preferred oral PrEP. Willingness to take PrEP was 90.2%, however uptake was 30.6% (n=81). Following enrolment, 51.9% started PrEP on day 14 (same day PrEP offered), 20.9% within 30 days and 27.2% after 30 days. PrEP uptake was associated with more sexual partners in the past 3months: (aRR=2.36, 95%CI: 1.20-4.63) for 2-9 partners and (aRR=4.70, 95%CI: 2.41-9.17) for ≥10 partners, oral PrEP preference (aRR=1.53, 95%CI: 1.08-2.19) and being separated (aRR=1.55, 95%CI: 1.04-2.33). Of 100 follow up samples, 19 had quantifiable Tenofovir levels, considered not protective (>10µg/L). Protective levels (>40µg/L) were only seen in the first quarter, among 3 of 42 volunteers despite 33 having reported optimal (>90%) adherence.

CONCLUSIONS

Half of AGYW preferred oral PrEP, uptake and adherence were low, uptake was associated with higher risk sexual behavior and preference for oral PrEP . Demand creation should be intensified and, access to alternative biomedical products expedited to those for whom daily oral PrEP is not feasible.

FRAC1902 - Willingness to Take PrEP Among High Risk HIV-Negative Adolescent Boys and Young Men in Masese Fishing Community, Jinja District, Uganda

PRESENTING AUTHORS

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INTRODUCTION

High uptake and retention of Pre-Exposure Prophylaxis (PrEP) against HIV is an evidence based intervention to prevent HIV. However, the willingness of high risk groups such as adolescent boys and young men (ABYM) in fishing communities to take PrEP needs to be studied. We therefore sought to determine willingness to take PrEP among high-risk HIV-negative ABYM and explore their understanding of PrEP in the context of HIV prevention within in a Fishing community at the shores of Lake Victoria in Eastern Uganda.

METHODS

We conducted a convergent parallel mixed methods study in Masese Fishing community, Eastern Uganda between October and November 2020 among high-risk HIV-negative adolescent boys and young men in the

general population. Using semi structured questionnaires to determine the willingness to take PrEP and associated factors, we interviewed 479 participants and conducted four audio recorded focus group discussions (FGDs) to explore ABYM understanding of PrEP. We presented willingness to take PrEP as a percentage and determined factors associated with willingness using modified poisson regression analysis at 0.5% significance level. We transcribed the FGDs verbatim and analyzed using thematic content analysis.

RESULTS

Eighty two percent (n/N= 393/479) of ABYM were willing to take PrEP. The significant factors associated with willingness were education level attained (Primary aPR (adjusted prevalence ratio)=1.28, CI: 1.01, 1.63: Secondary aPR=1.36, CI: 1.08, 1.71 and tertiary aPR=1.35, CI: 1.01, 1.79), monthly income >500,000/=UGX (aPR=0.67, CI: 0.50, 0.91), personal risk estimation of not at risk (aPR=0.75, CI: 0.64, 0.87) and not having had an HIV test in the last 12 months (aPR=0.9, CI: 0.83, 0.98).

Qualitative findings showed that the understanding of PrEP was low though most of the ABYM had heard of PrEP, knew that it was taken by HIV negative individuals and would recommend PrEP to others.

CONCLUSION

Despite the low understanding of PrEP, there is high willingness of 82% to take PrEP among ABYM. The factors associated with Willingness to take PrEP were monthly income, education level, testing for HIV and risk perception. The ABYM were also willing to recommend PrEP to other users.

KEY WORDS: PrEP, Willingness, Adolescent Boys and Young men, HIV prevention, Fishing community.

FRAC1903 - Transition d'un essai clinique au programme national "Expérience de l'essai NAMSAL au Cameroun"

PRESENTING AUTHORS

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L'essai NAMSAL ANRS 12313 a débuté en 2016, avait pour objectif de mesurer l'efficacité, la tolérance et le risque d'apparition à long terme de résistance en comparant deux traitements pour l'infection par le VIH – le Dolutégravir et l'Efavirenz à faible dose – en conditions de vie réelles au Cameroun. Cet essai multicentrique à inclus 613 patients adultes naïfs de traitement antirétroviral, suivis pendant quatre ans. Le conseil des organisations internationales des sciences médicales (CIOM), notifie que les chercheurs et les promoteurs doivent prendre des dispositions en termes de transition des participants vers une prise en charge médicale après la fin de la recherche. Ces recommandations sont souvent négligées lors de la rédaction des protocoles de recherche.La fin d'un essai clinique est toujours une course contre la montre pour les équipes de recherche où l'acteur principal est souvent délaissé. L'équipe NAMSAL a élaboré un processus d'accompagnement des participants des essais cliniques vers les programmes nationaux, appelé « Yes, YOU can ». Cet abstract présente leur expérience.

Ce processus de transition, est composé d'un ensemble d'étapes: un questionnaire Q1 (15 items) à passer avant ou pendant le groupe de parole, un groupe de parole (animé par le chargé de projet et le médecin d'étude clinique), un flyer informatif, deux questionnaires, Q2 et Q3 (14 items), à passer à un mois et trois mois après la date de sortie par téléphone pour connaitre l'évolution de sa transition. Le participant est contacté par téléphone au moins un mois avant sa date de sortie. L'équipe l'informe qu'il est invité à un groupe de parole pour expliquer la transition. Il est libre d'accepter.

Entre le 3 février et le 21 juillet 2021, 276 participants ont répondu au questionnaire Q1. Parmi eux 174 (63 %) ont participé aux groupes de parole. La majorité était des femmes (73%) et l'âge médian était de 42 ans (22-67). 20 groupes de parole ont été réalisés. Un groupe de parole était composé en moyenne de 9 personnes et durait en moyenne 1h15.

Les participants qui ont pris part à ce processus, nous ont partagé un retour positif et ont affirmé que cet accompagnement les avait aidés dans la transition vers le programme national. La mise en œuvre de ce processus nécessite une équipe complète, multidisciplinaire, motivée et impliquée pour la réussite de celui-ci. Ce processus doit être pensé en amont lors de la rédaction du protocole.

TIME	12:36 - 13:21	ROOM	100 Capacity Room	DATE	Fri. 10 Dec. 21

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

D6 - Prioritizing vulnerabilities in hard to reach populations

Chairs : Berry Didier Nibogora (Burundi)
Ms. Steve Letsike (South Africa)

FRAD2001 - Risk Factors for Physical and Sexual Violence against Female Sex Workers in Ghana

PRESENTING AUTHORS

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BACKGROUND

Violence against female sex workers (FSWs) is a widespread phenomenon induced primarily by the pervasive worldview that sex work is a contravention of morality. It is however necessary to dismantle the barrier posed by violence against FSWs in order to reach them with HIV services due to the pivotal role they, their clients and partners of their clients play in reinforcing the HIV epidemic. This study sought to assess the risk factors for violence against FSWs in Ghana.

METHOD

The study used secondary data from the 2015 IBBSS among FSWs (n=4,279) and their non-paying partners conducted by Ghana AIDS Commission (GAC). Bivariate, and multiple logistic regression analyses were done to establish factors associated with violence against FSWs. Statistical significance was set at a p-value<0.05.

RESULTS

The study established the prevalence of physical and sexual violence as 10.12% and 24.75% respectively. Physical violence was perpetrated mainly by one-time paying clients (50.58%) and regular paying clients (30.95%). A similar trend was reported for sexual violence. As established by the study, the predictors of physical violence are type of FSW (p-value<0.01), current age of FSW (p-value=0.02), region (p-value<0.01), whether FSW has ever used drugs (<0.01) and whether FSW had ever used alcohol before sex in the past six months preceding the survey (p-value<0.01). Sexual violence on the other hand was predicted by current age of FSW (p-value=0.02), marital status (p-value<0.01), number of living children (p-value=0.04), where FSWs take clients for sex (p-value <0.01), region (p-value<0.01), whether FSW has a history of drug use (p-value <0.01), and whether FSW has ever used alcohol before sex in the past six months (p-value<0.01). Both physical and sexual violence had negative consequences on consistency of condom use and condom failure among FSWs.

CONCLUSION

Violence against FSWs is pervasive in Ghana and it is influenced by a myriad of factors. There is the need for tailored interventions focusing on age, Region of residence, history of drug and/or alcohol use, marital status, and number of living children among other relevant variables to address the menace in order to reach FSWs effectively with HIV services.

FRAD2002 - Contexte humanitaire et prévention du VIH chez les populations les plus vulnérables et à accès difficile: le cas des Pygmées en Republique Centre Africaine

PRESENTING AUTHORS

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CONTEXTE

La République Centrafricaine (RCA) est caractérisée par une épidémie de type généralisé du VIH, avec une prévalence estimée à 3,6% chez les 15- à 49 ans. Malgré les défis liés au contexte social, politique et humanitaire, l'UNFPA s'est engagée auprès du Gouvernement dans son mandat de prévention du VIH en faveur des populations clés et les populations les plus vulnérables dont ceux à accès difficile pour l'atteinte des objectifs de 2030. C'est dans ce contexte que des actions spécifiques ont été appuyées par l'UNFPA/RCA et réalisées au mois de juin 2021 par les partenaires d'exécution en faveur de l'une des populations à accès difficile et plus vulnérables que sont les Pygmées (Aka) au niveau de la ville de Mbaïki et ses environs dans la région Sanitaire N°1.

MÉTHODOLOGIE

Pour toucher cette cible, deux grandes activités ont été réalisées à savoir : la formation des relais Communautaires Pygmées et la sensibilisation des communautés Pygmées (Aka) couplées avec la distribution gratuite des condoms masculins par les Relais dans la ville et les villages environnants. L'approche par les pairs utilisés a permis aux Relais Communautaires (Réco) de transmettre les

messages en langage propre des Aka.

RÉSULTATS

Au terme de ces activités, 25 Relais Communautaires ont été identifiés et formés. Pour un objectif attendu de sensibilisation de 100 pygmées, 269 ont été finalement sensibilisés dont 99 hommes et 170 femmes de la ville de Mbaïki et des villages de Toukoulou (14 km), Tomboki (12 km) et Boto (05 km). Les relais communautaires ont pu convaincre leurs pairs à l'acceptation de port correct de condoms. C'est ainsi que 86 400 condoms ont été distribués dans ces 4 localités. Les lauréats aux jeux-concours ont bénéficié des polos, des morceaux de savon…

CONCLUSION

La population Pygmées constitue une nouvelle cible pour l'expérimentation de la prévention du VIH parmi les populations les plus vulnérables et à accès difficile en RCA. Ces activités ont connu une forte affluence et appréciation des Pygmées qui ont transformé leur timidité en curiosité pour mieux apprendre sur comment éviter le VIH, les IST et mieux planifier les naissances. Cela donne des pistes pour renforcer la prévention au sein de cette population à travers des stratégies efficaces et adaptées.

FRAD2003 - HIV and key populations in West and Central Africa: experiences, service provision, policies and best practices

PRESENTING AUTHORS

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BACKGROUND

The HIV low prevalence in West and Central Africa (WCA) contrasts with Africa Southern and Eastern region with 1.4% and 6.7% in respectively. Also, HIV prevalence in the key populations (KP) in WCA, due to specific higher-risk behaviors, are high: sex workers (8.7%), MSM (13.3%), people who inject drugs (3.4%), transgender (13.5%) and prisoners (2.2%). sought to better understand and respond to the needs of KP by supporting initiatives and providing technical assistance to 23 countries in WCA. The purpose of this research initiated by UNFPA WCA Regional Office (WCARO) was to capture a realistic picture of the existing efforts to provide integrated HIV/STIs, and SRHR services to KP in WCA.

METHODS: A desktop review was first conducted, which included journal articles, reports, national and international policies, strategies and guidelines, and other gray literature. An online questionnaire was also carried out (English, French, and Portuguese) administered via SurveyMonkey. With four themes the questionnaire had multiple choice questions, and related open-ended questions: service provision for KP, policies, strategies and best practices to support KP. The online questionnaire was emailed to 377 stakeholders in 23 countries.

Results: Responses from 93 participants (59,28,6 in French, English and Portuguese respectively) were analyzed by SurveyMonkey. National Strategic Plans that include KP in 22/23 countries with 4/23 that include transgender people. KP still face high levels of stigma and discrimination, even from healthcare workers (HCWs) restricting them access to health services. Most HCWs still lack appropriate skills. Funding for KP services and programs heavily depend on external donors and limited domestic funding. Many felt that more effort is needed to share best practices and innovations under the leadership of WCARO and national platforms.

CONCLUSIONS

Continuous advocacy support for HIV/STIs, SRHR and SGBV programs and services for KP in WCA is needed, and UNFPA WCARO should play a central leadership role. UNFPA WCARO is encouraged to set up a platform for exchanges with KP to define the strategies to be implemented to strengthen the existing population support systems. This roadmap must involve the mobilization of additional human and financial resources to support countries, programs, networks and associations of KP, to better boost HIV prevention interventions.

TIME	10:42 - 11:27	ROOM	300 Capacity Room	DATE	Fri. 10 Dec. 21

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

D1 - Addressing norms and the culture of sex among African Youth

Chair : Mr. Niyi Ojuolape (Nigeria)

FRAD2101 - The social economic impact of Covid-19 on People who Use Drugs in Uganda

PRESENTING AUTHORS

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ISSUE

The COVID-19 pandemic has taken its toll on public health and the public health measures have undoubtedly impacted the majority of the population and including vulnerable populations, such as people who use drugs (PWUD), many of whom rely heavily on health and social services.

DESCRIPTION

In May 2020, Uganda Harm Reduction Network (UHRN) conducted a rapid assessment in the Kampala Metropolitan Area to explore the impact of COVID-19 on issues related to accessibility and availability of services, including any changes to service design and delivery which may have impacted the health and well-being of PWUD in Uganda. The assessment consisted of PWUDs participating in one-on-one, semi-structured telephone interviews and total of 215 PWUD participated. The sample was comprised of 54% males. The services most impacted included harm reduction services, legal services, psycho social /self-help groups, UHRN drop-in centers, health care providers and PWUD housing and food availability.

LESSONS

Results show an enormous impact of covid-19 service delivery. 69% of participants who used harm reduction services identified negative changes in service delivery amid COVID-19 which included; shut down of public transport which affected access to services and health facilities. The earlier gains in behavior change communication were compromised as a result of reduced interventions. Community Psychosocial support meetings reduced yet the rate of psychological distress among PWUDS surged. 39% of people who use drugs on HIV treatment indicated a relapse due to restriction in movements for drug refills and psycho social support sessions. There were challenges of stock-outs of commodities like condoms, self-testing kits and family planning methods among others since most of the partners that supplied these commodities had closed due to shut down. Besides, lack of commodities, there was human rights violations with an 11% increase in illegal arrests of PWUDs in ghettos.

NEXT STEPS

There is need to scale up advocacy and coordination among the CSOs and engagement with public sector and international partners to support harm reduction services. This can be done through the establishment of the network of harm reduction champions among drug users, CSO leaders and development partners.

FRAD2102 - What HIV prevention means to us: perceptions of rural Botswana adolescents on political commitment to end AIDS.

PRESENTING AUTHOR

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BACKGROUND

Botswana is one of the countries highly affected by HIV and AIDS. Young people, especially adolescent girls and young women aged 15 - 24 years account for 25% of new infections and this continues to pose a challenge in terms of ending AIDS by 2030.

OBJECTIVE

The main objective of this survey was to find out from young people in the rural areas what information they have about HIV and what they expect their leaders to do in terms of HIV prevention for youth.

METHODS

Five (5) Focus group discussions were conducted among adolescents or young people aged 10 to 15 years, in four different villages in the Central District of Botswana. Altogether there were 59 young people, 23 young men and 36 young women. They were all school going and mostly in grade 4 to 9. An open-ended questionnaire was used for the discussions.

FINDINGS

All adolescents felt that not enough was being done to reduce HIV infections among young people. Four main areas were cited as barriers: Lack of Knowledge about HIV and AIDS. As some of them said “We know that Botswana adopted the strategy of Comprehensive Sexuality Education but we in the rural schools are not being empowered with education and skills to protect ourselves from HIV.” Limited Access to Services was cited as another barrier, “ HIV prevention is needed in places such as cars, bedrooms, bars, hotels, even the bush but right now even supplies of condoms are only in health centres,” Poverty and violence against women were seen to result in lower use of condoms and barriers to negotiating safer sex. “How do you refuse sex with a blesser when he is the one who buys you food and toiletries?”

CONCLUSIONS

Three decades of HIV prevention have taught us that reducing new HIV infections among young people requires Comprehensive Sexuality Education and strong community HIV prevention responses. There is need for

youth-led prevention and engagement of both men and women in HIV prevention activities.

KEY WORDS
Adolescents, HIV Prevention, Gender Based Violence, Sexuality Education, Botswana.

FRAD2103 - CULTURE OF SILENCE IN SEXUAL MATTERS.

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INTRODUCTION
There is a culture of silence when it comes to sexual matters. Sex is not a topic that is discussed and there is a shame associated with speaking about sex. This has led to the normalization of silence and this silence hurts the community as sexual violence cases are rarely reported. Sexual violence is linked to new HIV/AIDS infection cases that could be avoided if the cases are reported immediately.

AIM
KKANCO has constantly engaged stakeholders and the community in continuous discussion which seeks to empower women, girls and boys with the agency to claim their rights, receive quality education, enjoy healthy lives and take measures to protect themselves from HIV which is a requisite component of combination HIV prevention structural change that reflects the interconnected nature of the sustainable development goals.

LESSON LEARNT
Social norms and taboos relating to gender and sexuality can create a culture of silence, particularly among adolescent girls and boys, which prevents them from asking about issues relating to their sexual and reproductive health and rights. The lack of a confidential and judgment free environment can also be a barrier to both girls and boys obtaining SRHR information and expressing their concerns. The young boys and girls living with HIV are mostly stigmatized, this makes some of them to hide their status. Some refuse to seek treatment at the health facilities because of the secluded clinics and lack of privacy. Not revealing their HIV status may lead them to contribute to new infections which could be easily prevented by being transparent.

CONCLUSION: There is need to get more involved in teaching comprehensive sexuality education because of the way our society hides information on sexuality. Growing up in an era where our parents said sitting next to a girl at school one would make her conceive. The current generation should not to go through what we went through. We know the critical steps that must be taken on the path to gender equality, and we must scale up and invest in what works for boys and girls in the context of HIV and AIDS. This includes empowering boys and girls, particularly those living with HIV, advancing their leadership; eliminating barriers and constraints to girl's access to prevention treatment and care services; eradicating gender based violence; and ensuring adequate financing for both girls and boys needs and priorities in the AIDS response.

TIME	13:33 - 14:18	ROOM	300 Capacity Room	DATE	Fri. 10 Dec. 21

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

D3 - Addressing SGBV and gender inequality to respond and eradicate HIV/AIDS

Chairs : Prof. Sheila Tlou (Botswana)
Dr. Nolwazi Dlamini (South Africa)

FRAD2201 - The forms of violence against sex workers in Mali: a qualitative study

PRESENTING AUTHORS
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INTRODUCTION
Sex workers of Bamako are more affected by Human Immunodeficiency Virus (HIV) than the rest of the population and their vulnerability to the problem is explained by a number of factors including violence which can take several forms, subtypes and manisfestations. This study tried to capture and describe these forms, subtypes and manisfestations by using a qualitative approach.

METHODS
An exploratory qualitative study, involving individual and group interviews, was conducted between December 2018 and May 2019 with 31 sex workers, 13 taxi drivers, 13 clients of sex workers, 13 regular intimate partners of sex workers, seven representatives of the police, six representatives of

town halls, four managers of sites for sex work, two social and health workers, and three managers of adapted services. Interviews were taped, transcribed and their content coded thematically using the NVivo 12 software.

RESULTS

The results show that SWs suffer from verbal, physical, psychological, sexual, economic, and administrative violence. The subtypes of verbal violence, which were identified, were insults and quarrels. Those of physical violence were poisoning, assault and battery. The subtypes related to psychological violence were stigma, discrimination, psychological harassment and social exclusion. Those related to sexual violence were rape, violent sexual intercourse, voluntary withdrawal or breakage of a condom, sexual harassment and sexual exploitation. The subtypes of economic violence included confiscation of money or property, damage to property, embezzlement, fraud, and economic exploitation, breach of commitments, work disruption, extortion, overbilling and theft. Finally, that of administrative violence included the confiscation of administrative or travel documents.

DISCUSSION

The results of this study will contribute to improving knowledge of violence against SWs. By contributing to this, they will participate in improving strategies to combat violence. By helping to improve these strategies, they will help reduce violence. By reducing violence, they will help reduce the spread of HIV and improve the health and well-being of SWs. This will help improve the health and well-being of the general population.

FRAD2202 - USE OF PARALEGALS TO INCREAS SGBV CASES

PRESENTING AUTHOR

M. Mwangi1

1Golden women empowerment and support program {Muranga stars}, Muranga, Kenya

Sexual and Gender Based Violence (SGBV) remains a leading form of gender inequality and discrimination in Kenya. It is a highly prevalent and persistent human rights violations disproportionately affecting women as a result of the imbalanced power between men and women. SGBV has devastating effect on families, communities and the society. Women from poor economic background, those living with disability, those from minority communities, young and older women are particularly highly vulnerable to SGBV. Many cultures tolerate SGBV and inaction in a number of institutions also strengthens it. Kenya has made progress towards the realization of gender equality and women empowerment in line with the MDGs and recently SDGs. However, women and young girls still suffer tremendous levels of discrimination and violence. Kenya has also stated in her various legislations and policy frameworks that the elimination of SGBV and protection of survivors remains one of her topmost human rights agenda. Golden women empowerment & support program [Muranga stars] has also put in place the provision of comprehensive response to SGBV as one of its strategies for addressing SGBV among women and young girls. Among its response strategies lies the use of paralegals in outreaches to increase the reportage for SGBV cases by survivors.

Golden Empowerment & Support Program(Muranga stars) in its effort to address SGBV is among women and young girls is training sex workers, WSW, women using drugs as paralegals. The paralegals act as a bridge between community members, law enforcement officers and the organization. Ther education and outreach model of programming to allow trained peer paralegals to work with their peers at the community level. Paralegals are influential amongst their peers and command great respect from them. Peer paralegals also undertake peer education responsibilities where they educate, advise, counsel, offer legal aid, and refer their peers to service delivery points including clinics and sometimes accompanying SGBV survivors to report their SGBV ordeals to the respective law enforcement officers as well as help them appear in court. The trained peer paralegals also work closely with sensitized law enforcement officers to ensure that survivors of most of the reported SGBV cases get justice.

FRAD2203 - SEXUAL AND GENDER-BASED VIOLENCE (SGBV) IN GHANA: WHAT SUPPORT IS AVAILABLE?

PRESENTING AUTHORS

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BACKGROUND

Sexual and Gender-Based Violence (SGBV) occurs worldwide regardless of economic, religious, or social contexts. Men are the main perpetrators of violence against women and girls. In Ghana, studies have shown that 33% to 37% of women have experienced domestic violence within intimate partner relations (WHO, 2021). During pandemics such as COVID19, support systems that protect women and girls, both institutional and community

structures are weakened, broken down, or become non-existent. Instituting solid national institutions and community-level structures and systems that can identify, prevent and respond to Gender Based Violence and other harmful practices during a humanitarian crisis is critical.
UNFPA, in partnership with the Ministry of Gender, Children and Social Protection (MoGCSP), established the Orange Support Center (OSC). which is aimed to provide a well-coordinated, multi-sectoral service for victims of SGBV in Ghana while coordinating support systems and structures for victims and survivors of SGBV.

The OSC leverages the technology of mobile phones to place phone calls through a toll-free line (0800 111 222). It uses digital platforms, such as the BoaMe SGBV mobile application, to enable users, victims, and survivors of SGBV to receive professional support on counselling and other paralegal services from experts including professional volunteers, clinical psychologists, lawyers, and medical professionals.

ACHIEVEMENTS OF THE OSC

Since the launch and inception of the Orange Support Centre on 30th June 2021, the OSC has received over 1448 calls of which 162 were active, sensitive cases on abuse and child neglect. The way forward is scaling up the Support Centre and the BoaMe App Innovations across the 16 regions and to Ghana Health Service to address Maternal Health Issues.

WAY FORWARD

Scaling Up The Orange Support Centre And BoaMe App Innovations to address issues related to key population in Ghana especially in the area of SGBV and increase contraceptive uptake.

TIME	14:30 - 15:15	ROOM	300 Capacity Room	DATE	Fri. 10 Dec. 21

Track E: Health Systems, Economics and Implementation Science

E4 - Key Population

Chair : Dr. Bannet Ndyanabangi (South Africa)

FRAE2301 - Utilizing community-driven strategies to break through barriers to HIV service uptake among people who inject drugs (PWID) in Bayelsa State, Nigeria

PRESENTING AUTHORS

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ISSUES

In Nigeria, 9% of new HIV infections reported annually are among people who inject drugs (PWID); however, identifying cases of HIV in this key population is challenging. The USAID/PEPFAR-funded EpiC project in Bayelsa State, Nigeria, experienced initial resistance from the PWID community as stigma associated with drug use, mistrust of service providers, and fear of risking criminal sanctions impeded case identification efforts, including contact tracing of needle-sharing partners and provision of related services. After three months of implementation, only 100 PWID had been reached with HIV testing services (HTS), with four testing positive.

DESCRIPTION

To overcome this slow start, the project sought the support of local drug lords/barons on encouraging PWID to access the targeted HIV services available, including case identification and linkage to treatment. Community-specific messages on the importance of knowing one's HIV status were developed and popularized among PWID using IEC materials and group discussions, and PWID community members were recruited and trained to be peer navigators and support people living with HIV to enrol in care. Advocacy and sensitization meetings were also held with law enforcement agencies such as the

Nigerian police force, civil defence, immigration officers, and correctional officers to secure their support for project activities.

LESSONS LEARNED

The implementation of community-driven strategies, especially community sensitization, helped reduce barriers such as stigma and discrimination. Engagement with the drug barons helped establish relationships and build trust. As trust was gained, these barons mobilized and linked their PWID networks to HIV testing and other services. Engaging security officials reduced clients' and providers' fears of being arrested while receiving or providing services. Compared to the three months prior to these interventions, in the three months post-intervention the number of PWID tested for HIV increased from 100 to 5195 and the number newly diagnosed increased from four to 569. This represents an increase in the case finding rate from 4% to 11%. All those newly diagnosed with HIV were initiated on antiretroviral therapy.

NEXT STEPS

Engagement of critical stakeholders and the use of a peer-to-peer approach led to improvements in uptake of HIV services among PWID. Plans are underway to scale up these interventions in Bayelsa and other states.

FRAE2302 - Acceptability of self-sampling for HIV/STI testing in MSM

PRESENTING AUTHOR

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BACKGROUND

Regular HIV/STI testing in men who have sex with men (MSM) is recommended for promoting HIV/STI prevention and enabling timely treatment. It is hypothesized that self-sampling may increase the uptake of testing on a regular basis. This study aimed to assess the acceptability of the self-sampling process in MSM.

MATERIAL AND METHODS

In a one-year cohort study in Hong Kong, participating MSM were asked to test for HIV/STI at 3-monthly intervals. At each visit, participants self-collected urine, pharyngeal and rectal swabs for nucleic acid amplification testing for Chlamydia trachomatis (CT) and Neisseria gonorrhoeae (NG). With the assistance of research staff, participants self-collected fingerprick samples for syphilis point-of-care tests and dried blood spots (DBS) for HIV antibody tests. Through a monthly survey, participant's perception of the self-sampling process was scored (between 1 as "strong disagree" and 10 as "strongly agree") for its convenience, level of discomfort, confidence in performing self-sampling correctly, and accuracy of the self-collected sample in reflecting the true infection status. Correlations between perception items and with time (testing episode) were examined using Spearman's rho. Results: Between August 2019 and December 2020, we recruited 207 MSM, including 449 person-time followups. A totalof 433 (99.3%) rectal swabs, 433 (99.8%) pharyngeal swabs, and 430 (99.8%) urine specimens were correctly collected by self-sampling for laboratory testing. The average (±standard deviation) self-sampling scores reported in the corresponding month was 7.1 ±2.6 (n=188) for convenience, 7.0 ±2.6 (n=187) for confidence, 7.2±2.6 (n=186) for accuracy, and 4.0 ±2.7 (n=183) for discomfort. The score of each perception item was not significantly correlated with time. However, convenience was positively correlated with confidence ($r=0.85$, $p<0.001$), and accuracy ($r=0.80$, $p<0.001$).

CONCLUSIONS

Self-sampling for HIV/STI testing is feasible and generally acceptable. Despite discomfort during self-sampling, participating MSM were confident in collecting specimens correctly, felt the process was convenient, and believed that the test results from self-collected specimens could show their true infection status. Their perception was supported by the high proportion of correctly collected samples.

FRAE2303 - Effects of the COVID-19 pandemic on the mental health, Socio-Economic and access to HIV services Among Gay Men, Bisexual Male, Transgender and other MSM in Rwanda: Evidence-Based Assessment, Nov 2020

PRESENTING AUTHOR

S. MUHIRWA1

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BACKGROUND

The COVID-19 pandemic and its control measures have impacted socio-economic, health, and healthcare provision at various levels. Lock-down, limited/restricted movement, Physical distancing measures, for instance, may affect mental health, impacting access to HIV prevention supplies, access to treatment, human rights violations, and increasing feelings of unsafety, and weakening community support ties. These effects can

be worsened among socially marginalized groups, such as gay men, bisexual males, men who have sex with men (MSM), and transgender women (TGW). The assessment aimed to investigate the effects of the COVID-19 pandemic on mental health, Socio-Economic, and access to HIV services Among Gay Men, Bisexual Male, Transgender, and other MSM in Rwanda.

METHODS

Utilizing a respondent-driven sampling and mixed-method approach, Amahoro Human Respect Organization (AHR) conducted an assessment examining the impact of COVID-19 response on the individuals 'members of stated groups (n=493) residing in three districts of Kigali City and other two districts of Southern and Western Provinces, Rwanda. Data collection methods included in-depth interviews, focus groups, and a survey conducted from July to November 2020.

RESULTS

Category of respondents: gay men 272 (55.3%), Bisexual with 173 (35.1%), transgender women 27 (5.5%) and Lesbian 21 (4.3%). Experienced homophobia during the COVID-19 period was 19.3% sometimes, 36.5% most of the time, 31.6% always, and (1.4%) non-response. 26.0% and 24.9% of participants reported lack of lubricants and condoms respectively, 19.9% failed to reach a health facility, 4.7% left with no medicine while 11% missed their medical appointments On mental health, felt helpless 324 (65.7%), felt afraid 311 (63.1%), felt loneliness 252(51.1%), alcohol and drug abuse (13%), additionally, 36 (7.3%) with suicidal ideology and 12 (2.4%) suicidal attempting. On socio-economic effects: 43.6% lost their jobs, 9.7% closed their business, 24.9% their income was reduced, 3.4% their hours of work reduced while 18.3% reported nothing change.

CONCLUSIONS AND RECOMMENDATIONS

COVID-19 pandemic responses should be inclusive, without discrimination, and facilitate socially marginalized and key populations to fully enjoying access to HIV and AIDS and mental health services. Economic support interventions for Socio-economic recovery.

KEYWORDS: COVID-19, HIV, and AIDS, Gay men, transgender women, Bisexual male, Rwanda

TIME	14:30 - 15:15	ROOM	300 Capacity Room	DATE	Fri. 10 Dec. 21

Track C: Epidemiology and Prevention Science

C6 - SOCIAL EPIDEMIOLOGY OF HIV/ EIPDEMIOLOGY OF HIV CO-MORBIDITY AND EMERGING DISEASES/HIV/AIDS PREVENTION PROGRAMMES

Chair : Prof. Halimatou Diop Ndiaye (Senegal)

FRAC2401 - Outcomes of provider initiated anal consultation in key populations in Cameroon.

PRESENTING AUTHORS

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PROBLEM

Anorectal symptoms are disproportionately high, yet less documented in key population. Due to the taboo on anal health, most patients do not seek medical consultations and are not comfortable discussing these issues with the doctor, even in case of suffering. On the other hand, most general practitioners do not spontaneously interrogate patients on anal symptoms, mostly because they lack training on anal consultation and would not ask questions on matters they don't master. Hence, patients present with diseases in advanced stages that could be handled easily if presented earlier. Following this observation ALTERNATIVES-Cameroun (AC) included provider initiated techniques in the proctology training it offered to 12 community based organizations (CBOs) that render HIV/sexual health services to key population all over Cameroon.

DESCRIPTION

Training sessions and internships included 20% theory and 80% practice. The practical part involved consultations of mobilized patients and provider initiated anal consultations for patients coming with different complaints. To monitor who initiated consultation, a proctology consultation sheet was designed to include an item on whether the consultation was initiated by client or provider. This variables were also entered in a national data base we designed to collect information on all anal consultations provided.

LESSONS LEARNED

The 25 trained personnel initiated 73% of 2000

consultations offered in 2020 with 50% of pathologic cases among men and 43% among women. There is a significant rise in total number of anal consultations as compared to those before the training. Since the training, AC has received more than 60 referrals from CBOs opposed to 0 documented in 2019, hence patients are diagnosed and treated earlier. Moreover, patients and providers are both more comfortable discussing anal health issues.

NEXT STEPS

This projects second phase aims to extend to 20 CBOs in all regions of the country and sharing our expertise with hospitals as well. Provider initiated consultations will be the key of proctology services. Even peer educators and counsellors will be trained to initiate consultations, by asking basic questions on anal symptoms: Anal pain-bleeding or mass. We will gradually build advocacy for more training on proctology in undergraduate and postgraduate teaching, and also welcome interns in CBOs offering these services.

KEY WORDS

Anal disease, Provider initiation, key population

FRAC2402 - Changes In Sexual Behaviour Among Women In Studies Evaluating the Dapivirine Vaginal Ring For HIV Prevention

PRESENTING AUTHORS

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BACKGROUND

Novel HIV prevention technologies are often met with questions about the possibility of risk compensation. The Dapivirine vaginal ring (DVR) was demonstrated to be safe and effective for reducing HIV incidence in two phase III, randomized, double blind, placebo-controlled trials (RCTs), MTN-020/ASPIRE and IPM 027/The Ring Study. It is unclear if sexual behaviors among those enrolled in an RCT changes once efficacy is demonstrated. This analysis compares sexual behaviors in ASPIRE participants who subsequently enrolled in MTN-025/HOPE, an open label extension (OLE) of the DVR and were informed of the product's phase III safety and efficacy results for HIV prevention.

METHODS

Both ASPIRE and HOPE enrolled healthy, sexually active, HIV-negative individuals assigned female sex at birth from Malawi, South Africa, Uganda, and Zimbabwe. Longitudinal data on participants' sexual behaviors were compared between studies, including having a sex partner other than their primary sex partner in the past 3 months, and use of male or female condoms at the last vaginal sex act. Conditional logistic regression models were used to evaluate associations by study with sexual behaviors at enrolment and quarterly visits during the first 12 months of study follow-up.

RESULTS

Of 2629 individuals enrolled in ASPIRE, 1456 (55%) subsequently participated in HOPE. At enrolment in each study, the proportion of participants who reported sex with a non-primary partner in the past three months (ASPIRE=16.9% vs HOPE=18.7%) and condom use at last vaginal sex act (ASPIRE=45.0% vs HOPE=43.3%) did not substantively differ by study. Across all quarterly follow-up visits, sex with a non-primary partner was less frequent in ASPIRE (range across quarterly visits 10.7%-12.6%) compared to HOPE (13.9%-18.7%); adjusted OR=1.47, 95% CI 1.24-1.75. There was no difference in condom use at the last vaginal sex act across all quarterly follow-up visits in ASPIRE (36.5%-42.7%) vs HOPE (43.6%-46.7%); adjusted OR=1.05, 95% CI: 0.94-1.18.

CONCLUSION

Among women who participated in ASPIRE and HOPE, we observed a higher proportion of women reporting sex with non-primary partners in addition to their primary partner in HOPE, with little change in condom use over time between the two studies. Understanding if and how sexual behaviors change with the use of different HIV prevention methods is important for evaluating HIV prevention options and designing counselling guidelines for users.

FRAC2403 - Mobile phone use and HIV risk behaviours among adolescents in South Africa: associations and possible mediators

PRESENTING AUTHORS

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BACKGROUND

Access to and use of mobile phone present new opportunities for addressing adolescents' sexual and reproductive health issues in developing countries. We aimed to investigate the pathways through which mobile phone access and use are associated with HIV risk behaviours among adolescents in South Africa.

METHODS

We analysed two waves of the Mzantsi Wakho longitudinal dataset including interviews with 1392 adolescents and youth aged 10-24 in the Eastern Cape province of South Africa. We assessed two measures of mobile phone use: content use (search for information related to health or HIV) and platform use (using SMS, Facebook, or WhatsApp regularly). Study outcomes of the study included sex on substances, unsafe sex, age-disparate sex, and multiple partnerships. We tested several possible mediators: positive peer norms, self-efficacy scale, and sexual and reproductive health (SRH) knowledge. We first fit both univariate (where outcomes are considered as independent of each other) and multivariate (where outcomes are considered as related to one another) mixed-effects logistic regression models of HIV risk behaviours on mobile phone access and use, mediators, and control variables (HIV status, gender, age, rural residence, and informal housing). Then, we quantified the contribution of the mediators to the effects of mobile phone access and use on HIV risk behaviours.

RESULTS

Mobile phone use for health and HIV-related content was associated with lower risks of sex on substances (average marginal effects (AME): –0.66, 95% CI: –1.26; –0.07, p=0.030) and lower risks of unsafe sex (AME: –0.53, 95% CI: –0.97; –0.11, p-value=0.015). In contrast, mobile phone use for SMS and social media was associated with higher risks of unsafe sex (AME: 0.40, 95% CI: 0.09; 0.86, p-value=0.015). We found similar direction and significance levels associations using the multivariate approach. Positive peer norms, self-efficacy and correct SRH knowledge mediated the effect of mobile phone content use on sex on substances and unsafe sex.

DISCUSSION AND CONCLUSION

Mobile health use – with evidence-informed adolescent-accessible content – can support adolescents to engage in safer sexual practices, by improving the effect of positive peer norms, self-efficacy and correct SRH knowledge. However, use of mobile phones for communications and accessing social media may hamper this possible positive effects.

TIME	12:36 - 13:21	ROOM	600 Capacity Room	DATE	Fri. 10 Dec. 21

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

D2 - Approche Communautaire

Chair : Dr. Bannet Ndyanabangi (South Africa)

FRAD2501 - The impact of Covid-19 on healthcare provision and support services for PLHIV in Antananarivo: ANRS CoVIH-OI qualitative study initial results (2021)

PRESENTING AUTHORS

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BACKGROUND

The Covid-19 crisis and the measures taken by States to limit the spread of the virus have had a significant impact on HIV screening, access to medical care, follow-up and social support systems for people living with HIV (PLHIV).

OBJECTIVES

The ANRS CoVIH-OI (COVID-HIV-Indian Ocean) study has a two-fold objective. Firstly, to study the impact of the Covid-19 pandemic on PLHIV's medical follow-up, by documenting therapeutic pathways, healthcare provider and non-profit initiatives to uphold services, and any reconfiguration of HIV healthcare or support related activities. The second objective is to transfer the knowledge gained from the study. The CoVIH-OI study focuses on Madagascar and Mauritius, two countries with contrasting socio-economic conditions, where PLHIV remain highly

stigmatized. This paper presents initial results of the study conducted in Antananarivo, Madagascar, between February and May 2021.

METHODS

The preliminary results of this qualitative study are based on 55 in-depth interviews with 30 PLHIV, 20 care providers (from the medical and non-profit sectors) and 5 HIV coordinating bodies.

RESULTS

The fear of catching Covid-19, mobility restrictions during lockdown and the fear of stigmatization led to a decrease in the use of HIV health facilities and related services provided by the non-profit sector. Some PLHIV have been able to continue their antiretroviral treatments, sometimes after a break, thanks to the efforts of non-profit workers and health workers to deliver ARVs closer to patients' homes and in larger quantities. However, health professionals have pointed out that some patients have been "lost to follow-up" (having possibly moved outside of the capital and no longer receiving care or receiving care elsewhere).

PLHIV feel particularly vulnerable to Covid-19 because of their HIV infection. This has led to increased trust in ARVs and in caregivers, as both are seen as a means to be better face a potential Covid-19 infection.

CONCLUSION

Opportunities for knowledge transfer have emerged from these results:

1. Compiling ARV distribution guidelines specific to an epidemic context
2. Formulating key messages to facilitate the use of care and health facilities by PLHIV in an epidemic context
3. Promoting the democratization of knowledge about HIV/AIDS and the effectiveness of ARVs in order to encourage testing and to fight stigmatization of PLHIV.

FRAD2502 - La veille communautaire comme outil de réduction de la sigmatisation et de la discrimination des populations clés dans les formations sanitaires.

PRESENTING AUTHORS

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BACKGROUND

Le Cameroun fait partie des pays les plus touchés par le VIH dans la région Afrique de l'Ouest et du Centre, avec une prévalence nationale de 2,7% (CNLS, 2019) chez les populations clés en general, et de 20,6% chez les Hommes ayant des rapports sexuels avec d'autres hommes (HSH) avec des pics de 45% et de 24% respectivement dans les villes de Yaoundé et Douala (Étude IBBS 2016) en particulier.

Ces populations font face à la stigmatisation et à la discrimination dans les Formations sanitaires (FOSA). Cette étude de cas met en évidence une approche de surveillance communautaire en utilisant des patients témoins pour documenter la stigmatisation et la discrimination dans les FOSA.

METHODOLOGIE

La méthodologie s'appuie sur la participation effective des HSH et les Personnes Transgenres (TG) qui sollicitent des soins et traitements sous le vocable de patients témoins (PT). Cette méthodologie a permis la collecte des données dans les services de prise en charge du VIH/Sida de 3 FOSA grâce à une Grille d'observation issue d'une Consultation nationale des Populations clés.

28 PT ont été formés à la surveillance de la qualité des services de santé. Chaque PT est descendu 01 fois par mois pendant 12 mois dans chaque FOSA et a renseigné systématiquement la grille.

RESULTATS

162 descentes ont eu lieu dans les postes du circuit de prise en charge du VIH/SIDA. Il est à noter que 40% des observations ont porté sur l'accès aux services de santé des TG et 60% a concerné les HSH. La collecte des données a permis l'élaboration d'un Rapport d'observation d'indice Sigma CMR.

120 prestataires de santé onte été sensibilisés et à l'issue des rencontres de sensibilisation, un plan d'actions correctives, un Spot de sensibilisation à l'attention des prestataires de santé. et un Guide pratique d'accueil et de prise en charge des HSH et TG dans les FOSA ont été élaborés.

Les réponses aux témoignages des PT comprenaient l'établissement de nouvelles politiques de santé et le plaidoyer pour que la sensibilisation soit incluse dans les programmes de formation des prestaires de santé.

CONCLUSION

A la lumière des observations faites et remontées des FOSA, les actes de stigmatisation à l'endroit des HSH et TG persistent et seraient encore des freins à la prise en charge des personnes vivant avec le VIH/Sida. Les données de la présente étude mettent en évidence les éléments de stigmatisation, des postes où ils ont été observés et les acteurs qui en sont des auteurs.

FRAD2503 - Grande vulnérabilité des LGBT au Bénin due à la violence et à la discrimination : l'expérience du Réseau Bénin Synergies Plus

PRESENTING AUTHORS

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CONTEXTE

Les LGBT du Bénin sont victimes de nombreuses atteintes à leurs droits humains. Ces violations souvent perpétrées par la population générale du fait des pesanteurs socio-culturelles, limitent leur bien être social et sanitaire. Selon la veille réalisée par le Réseau BESYP en collaboration avec le Comité de veille juridique du projet NMF de l'Organisation du Corridor Abidjan-Lagos, il est enregistré en moyenne, 15 à 20 cas de violences subies par les LGBT par trimestre, le long de la traverse béninoise du Corridor. Bénin Synergies Plus (BESYP) créé en 2010, est l'une des anciennes associations au Bénin revendiquant ouvertement l'orientation sexuelle de ses membres et intervient dans la prévention et le dépistage du VIH, l'orientation médicale, la défense des droits et dénonce les cas de discrimination.

OBJECTIF

Améliorer la qualité de vie des minorités sexuelles en œuvrant pour un environnement non discriminant.
Méthode: Recueil des témoignages de violence et discrimination au cours des années 2019 et 2020. Le Réseau se mobilise ensuite pour apporter un appui, orienter vers les soins et dénoncer les atteintes aux droits humains.

RÉSULTATS

Les types de violences et de discrimination en 2019 et 2020 se résument en ces points :
15 arrestations sans emprisonnement qui ont provoqué stress et humiliation pour les victimes;
118 cas de violences physiques et verbales : intrusions à domicile, agressions dans les lieux publics. 22 % de ces 118 cas ont fait objet de plaintes déposées mais toutes classées sans suite ;
15 cas de discrimination dans l'accès aux soins, faisant état du rejet du personnel soignant, conduisant parfois à l'abandon du traitement ARV pour les LGBT séropositifs ;
10 cas de discrimination dans l'accès au travail ou au logement.

RÉPONSES APPORTÉES

158 cas de VBG (violences verbales, psychologiques, physiques et discrimination) ont bénéficié d'un appui psychologique ;
02 victimes de violence physique ont bénéficié d'un appui juridique ;
Identification des centres de santé non discriminants qui accueillent les LGBT séropositifs sans discrimination, avec l'implication des médiateurs LGBT.

CONCLUSION

La situation discriminante des LGBT aggrave leur précarité et renforce leur vulnérabilité, notamment au VIH. BESYP a entamé une démarche de documentation de ces situations afin de pouvoir y apporter les réponses adaptées en s'appuyant notamment sur les réponses existantes.

MOTS CLÉS

Vulnérabilité – LGBT – Discrimination - BESYP

TIME	14:30 - 15:15	ROOM	600 Capacity Room	DATE	Fri. 10 Dec. 21

Track C: Epidemiology and Prevention Science

C4 - SOCIAL EPIDEMIOLOGY OF HIV & HIV/AIDS PREVENTION PROGRAMMES & DIVERSIFIED PREVENTION TOOLS

Chair : Dr. Gina Dallabetta (United States)

FRAC2601 - Black People Don't Get Sad': The Impact of Depression on PrEP Uptake Among Black Men Who Have Sex With Men

PRESENTING AUTHORS

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BACKGROUND

Pre-exposure prophylaxis (PrEP) has been shown to be highly effective in reducing risk of acquisition of HIV. However PrEP uptake among key populations, particularly Black men who have sex with men (Black MSM) remains alarmingly low. Additionally, research has shown men who have sex with men are at elevated risk of adverse mental health outcomes, including depression, anxiety, illegal drug use, suicidality. However there is limited data examining the impact of depression on PrEP uptake among Black MSM. Methods: Utilizing data

from the ViiV ACCELERATE! Initiative, a community based HIV prevention targeting Black MSM, we examined the association between depression and uptake of PrEP among a sample of HIV-negative Black MSM ages 18-65 years (N=170) residing in Mississippi, the poorest state in the country. Between January 2016 and September 2017, participants were invited to take a computer-assisted self-interviewing (CASI) survey which assessed sociodemographic characteristic, sexual risk behavior, depression and PrEP use. Results: Of the 321 participants, 170 PrEP eligible; 42% (n = 72) had taken PrEP in the past 12 months; 46.5% (n = 79) reported they had never taken PrEP. Next we assessed the prevalence of depression among our sample of African-American/Black MSM. Over a third (38.9%) of respondents indicated they were depressed. We found those who were not on PrEP where nearly twice as likely to report depression compared to those who were using PrEP, 52.6% vs 27.42%. Our findings showed those who reported depression were significantly less likely to use PrEP (O.R. 0.43; C.I. 0.21-0.86), after controlling for socioeconomic factors. Also SES was a significant factor in explaining PrEP uptake. Respondents who reported living below the poverty level were 53% less likely to use PrEP (O.R. 0.47; C.I. 0.21-0.89).

CONCLUSIONS

Black MSM experience high rates of depression which can exacerbate HIV vulnerability. We found depression was a significant factor in explaining PrEP uptake. Given the low uptake of PrEP among Black MSM, there is an urgent need for the development and implementation of combination HIV prevention interventions that incorporate access to mental health services among this highly stigmatized and marginalized population.

FRAC2602 - The Effect of Depression on Pre-Exposure Prophylaxis Adherence among Female sex Workers on Pre exposure prophylaxis in Southwestern, Uganda

PRESENTING AUTHORS

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BACKGROUND

Oral pre-exposure prophylaxis is highly efficacious in preventing HIV transmission, but low adherence undermines effectiveness. Mental health disorders particularly depression may be a barrier to consistent Pre-Exposure Prophylaxis (PrEP) use. In Uganda, depression is a common mental disorder among Female Sex Workers (FSWs); almost 43.2% of the FSWs have suffered from depression. Given the considerable burden of depression among FSWs, there is very little research evaluating depression and PrEP adherence among FSWs. We evaluated the association between depression and PrEP adherence among a group of female sex workers (FSWs).

METHODS

We analysed data collected from 524 FSWs on PrEP living in rural southwestern Uganda. Participants were eligible if they were ≥18 years, sexually active and had traded and exchanged sex for money or gifts in the past 3 months and were currently dispensed PrEP for at least 6 months. FSWs interviewed live in highway towns and landing sites along the Lake Victoria basin. Depression was assessed using the nine item self-reported Patient Health Questionnaire (PHQ-9). A sum score of ≥10 indicated depression. PrEP adherence was measured using pill count and dichotomized into poor (<6 pills taken in last week) and good adherence (6 or 7 pills in last week). This study evaluated the associations between depression and adherence using regression models.

RESULTS

Of the 524 women, median age was 26 (IQR=25-29), 43.5% (228/524) had a PHQ-9 score consistent with depression and 71% (372/524) had good PrEP adherence . FSWs with good adherence were less likely to have depression compared to women with poor adherence (adjusted odds ratio [aOR] 0.74; 95% confidence interval [CI] 0.495 - 1.12;). there was no association between depression and adherence (p=0.164). Residence of FSWs was associated with increased depression (aOR 2.20, 95% CI 1.031 - 4.724, p=0.001).

CONCLUSION

Depressive symptoms were high in this sample of FSW on PrEP in Uganda. Integration of mental health services into PrEP programmes offer a useful way to connect HIV negative women to mental health services. If mental health was incorporated into PrEP services, then many more women may be able to get help than they otherwise would.

FRAC2603 - Barriers to providing HIV PrEP services to men who have sex with men and transgender persons in South Africa

PRESENTING AUTHORS

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BACKGROUND

Men who have sex with men (MSM) and transgender persons (TG) have critical needs for effective HIV prevention tools. Beyond Zero, a Global Fund Principal Recipient has scaled-up access to HIV pre-exposure prophylaxis (PrEP) for MSM in nine districts and TG in four districts. Such a scale-up requires investigation into existing barriers that prevent healthcare workers from effectively providing those services. This study identified perspectives of peer educators and target beneficiaries on the needs for, barriers to, and challenges with pre-exposure HIV prophylaxis (PrEP) for MSM and TG in South Africa.

METHODS

We collected qualitative data through a cross-sectional study. We conducted three focus group discussions (FGDs) with 24 peer educators and 2 FGDs with 13 target beneficiaries in March 2021. Participants were purposively selected from all districts implementing the Global Fund programme. We inductively examined the data with a content analytic approach to construct descriptive categories.

RESULTS

The major barriers to scaling up HIV PrEP among MSM and TG reported include the following: reluctance to take a daily oral tablet for prevention; medication side effects; availability of other HIV prevention options, e.g., condoms; stigma related to the labelling of PrEP medicines associated with antiretroviral therapy; stigma associated with HIV PrEP being marketed as an intervention for "key populations"; negative healthcare worker (HCW) attitudes at primary healthcare facilities (PHC); HIV PrEP seen as an intervention driven by partners; medicine stock-outs; and fear about being outed and having to come out in public to seek PrEP. Additionally, lack of clinical and sensitisation training for the Department of Health HCWs leads to the reluctance of PHC staff to provide HIV PrEP or referral for initiation.

CONCLUSION

Training, mentoring, and providing HCWs with guidelines on how to deliver key population-focused HIV care have the potential to address many of the barriers to the scale-up of HIV PrEP for MSM and TG. However, educating target beneficiaries on the benefits and the management of potential side effects is equally important. Additionally, there is a need to rebrand HIV PrEP as a preventative approach for all populations, including repackaging to differentiate from ARVs. On-going community campaigns to address the stigma around HIV PrEP are also required as part of scale-up plans.

HIV; PrEP; MSM; transgender;

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PEA002 - DÉPISTAGE DE MASSE DE LA COVID-19 DANS UNE COMMUNAUTÉ UNIVERSITAIRE D'OCTOBRE À DÉCEMBRE 2020: CAS DE L'UNIVERSITÉ DE YAOUNDE I, CAMEROUN

E. Voundi Voundi

PEA003 - Trend in HIV prevalence among tuberculosis patients in two states of Nigeria, 2017–2020.

I. Onyekwelu

PEA004 - HIV-1 Gag gene Genotypic profile among vertically infected adolescents failing protease inhibitor treatment without major resistance mutations in the protease gene: A snapshot from Cameroon.

A.D. Nka

PEA005 - Prévalence de Staphylococcus aureus résistant à la Méticilline isolées chez les personnes vivantes avec le VIH au Centre Hospitalier Universitaire - Bogodogo, Burkina Faso.

N. HIEN

PEA006 - Structural basis of potential inhibitors targeting SARS-CoV-2 main protease

H.M. Mengist

PEA007 - Respect du suivi virologique des PVVIH en routine en contexte à ressources limitées : cas de la Côte d'Ivoire

T.C. AKA

PEA008 - Evaluation de l'efficacité du Dolutegravir chez les patients infectés par le VIH à Dakar au Sénégal

M. FALL

PEA009 - Evaluation expresse de 2 tests antigéniques avec lecteurs en vue d'une utilisation urgente dans la détection du SRAS-COV-2 à l'INSP de Bamako

E. Coulibaly

PEA010 - Infection par le VIH et Expression d'APOBEC3G au Burkina Faso

T.R. COMPAORE

PEB001 - Clients and Providers Factors Militating Against ART Retention: Need for Community-Focused Remedies.

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PEB002 - People with disabilities and HIV: A cohort followed up at day hospital in UHC of Ouagadougou in Burkina Faso

M. BAZONGO

PEB003 - HPV Positivity and Risk of Cervical Cancer according to HIV-Infection: A comparative evaluation of Cameroonian women

M.C. TOMMO TCHOUAKET

PEB004 - Facteurs prédictifs de la réponse immuno-virologique chez les adolescents infectés verticalement par le VIH au Cameroun

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PEB005 - High-level of cross-resistance to 2nd generation non-nucleoside reverse transcriptase inhibitors in patients failing antiretroviral therapy in Cameroon: Implications for future ART-regimens in Africa

D.H. Gouissi Anguechia

PEB006 - Improving pediatric viral suppression rates using health systems strengthening approach

O. Majekodunmi

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J. Kangethe

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V. Botte

PEB011 - Particularités diagnostiques, étiologiques et pronostiques des méningo-encéphalites lymphocytaires chez les patients hospitalisés au CHU de Treichville d'Abidjan de 2011- 2019.

H. ABESSOLO ABESSOLO

PEB012 - The impact of National Integrated Sample Referral Network (NISRN) on the Expansion of Client Access to Laboratory Services in Nigeria.

V. Obianeri

PEB013 - ASSESSMENT OF EARLY WARNING INDICATORS (EWI) FOR HIV DRUG RESISTANCE TO ARVS IN GUINEA, 2020

K.J.-J.O. KADIO

PEB014 - Improving viral suppression by optimizing ART among HIV-positive children and adolescents in Uganda

A. Mugisa

PEB015 - Ensuring uninterrupted access to ART during COVID-19 pandemic in Cross River, Nigeria

P. Agada

PEB016 - Ensuring viral suppression among children on ART enrolled in South Sudan's orphans and vulnerable children program

P. Mawora

PEB017 - Ensuring viral suppression among children on ART enrolled in South Sudan's orphans and vulnerable children program

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PEB018 - Gastrointestinal parasitic infections and immunological status of HIV/AIDS coinfected individuals in Nigeria

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PEB022 - Determinants of poor adherence to antiretroviral therapy among orphans and vulnerable children living with HIV in Tanzania

B. Amani

PEB023 - Improving viral suppression of children and adolescents using client-centric care in Nigeria

J. Ashivor

PEB024 - Impacts of COVID-19 in the diagnosis of HIV and TB across some testing laboratories within Abuja Nigeria; cross-sectional survey

I. Egbulefu

PEB025 - Supporting a Quality Control System for COVID-19 testing in Nigeria; a success story of public-private collaboration in HIV treatment and care

Z. Gwa

PEB026 - Increasing case finding in low prevalence populations: Using unsuppressed viral load and treatment interruption to guide index testing in Ghana

M. Owusu

PEB027 - Integrating Psychosocial Support services in a school-based HIV Prevention Programme in a time of COVID-19.

K. Mangoale

PEB028 - Embracing technology to enhance behavioral change communication and improving access to Sexual Reproductive Health Rights information and services

R. Awori

PEB029 - Cytomegalovirus retinitis screening in patients with advanced HIV disease in a referral primary health centre in Mozambique

A.G. Gutierrez

PEB030 - Accès au diagnostic et au suivi virologique du VIH au Sénégal : état des lieux, enjeux et perspectives

K.D. Coulibaly

PEB031 - LIMITATIONS FONCTIONNELLES ET IMPACT PSYCHO-SOCIAL DU VIEILLISSEMENT CHEZ DES PATIENTS VIVANT AVEC LE VIH SUIVIS AU CHU DE TREICHVILLE, ABIDJAN

N. Etoundi

PEB032 - La rareté des formulations pédiatriques : obstacle persistant à l'observance thérapeutique chez les enfants et adolescents vivant avec le VIH au Sénégal en 2020.

O. Kantom-Fall

PEB033 - Weight-based ART Monitoring: A Successful Driver of Pediatric and Adolescent HIV Treatment Optimization

C. Nwafor

PEB034 - Growth of children who are HIV-exposed but uninfected: a systematic review and meta-analysis

G. Ekali

PEB035 - Les « point of care » (POC) : Une réponse locale d'appui à la réalisation des CV au Sénégal

K. Bousso

PEB036 - Lessons learnt from paediatric treatment optimization implementation in four counties in western Kenya

L. Nyabiage

PEB037 - Hepatitis C incidences and risk behaviors among people who inject drugs accessing harm-reduction services in Mombasa -Kenya:

A. Karisa

PEB038 - PEB038 - SUIVI INDIVIDUALISE DES ENFANTS ET ADOLESCENTS VIH+ A VIREMIE ELEVEE POUR LA SUPPRESSION DE LEUR CHARGE VIRALE

K. TIENE, P.D. TOURE

PEB039 - HIV Treatment outcomes among newly initiated men in pre and during COVID-19 in Malawi: Case of Neno District

C. Trapence, C. Kachimanga, J.C. Dimitri, E. Connolly

PEB040 - Lessons learnt from ART optimization of children failing protease inhibitor-based regimens in four counties in western Kenya

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PEB041 - Implementing the WHO package of care for patients with advanced HIV disease: the experience of a large antiretroviral therapy (ART) facility in Lagos, Nigeria

R. Oladele, S. Akanmu, M. Odofin

PEB042 - High prevalence of cryptococcal meningitis among ART-experienced patients with advanced HIV in Maputo, Mozambique

R. Deiss, A.G. Gutierrez

PEB043 - Community antiretroviral drug refills and continuity on treatment during COVID-19 pandemic in Cross River State, Nigeria

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PEB044 - Exploring the prevalence and associated risk factors for LTBI among Health workers in HIV care and treatment centres in north central Nigeria

E. Okpokoro, C. Osa-Afiana, F. Bada, U. Okwor, G. Odonye

PEB045 - Association of APOBEC3G polymorphisms and chronic hepatitis B virus carriage in a population of Burkina Faso

T.R. COMPAORE, T. SAGNA

PEB046 - Enhanced Postnatal Prophylaxis for HIV-exposed infants in the AIDS FREE priority countries: A Policy Review

I. Kasirye, M. Kaggwa

PEB047 - Targeted HIV testing based on self-reported level using risk-assessment tools in Eswatini

P. Dlamini, B. Sithole, L. Muzart, M. Matsebula, B. Phiri, N. Dlamini

PEB048 - Diagnostic tardif de l'infection par le VIH : Prévalence, facteurs associés et mortalité chez les patients inscrits dans le Système de Notification des Cas de VIH (SENCAS) au Sénégal

A. Thiam, K. BOUSSO, C.T. NDOUR

PEB049 - A comparative analysis of Dolutegravir quantification in plasma using spectrophotometric, TLC and LCMS methods

E. Onyemata, E. Okpokoro, C. Abone

PEB050 - Weight Trends with Introduction of Dolutegravir among Adults in Lao People's Democratic Republic

J. Campbell, M. Prescott

PEB051 - HAART, DOTS and renal disease of patients co-infected with HIV/AIDS and TB in the South West Region of Cameroon

J.C.N. Assob

PEB052 - Monitoring Virologic Suppression among Children of Female Sex Workers in Southern Malawi

J. Abubakar, C. Trapence, V. Kanje, C. Mhango, A. Mganga, A. Mtimuni, A. Chapendama, R. Demarco, A. Kasote, C. Lau

PEB053 - Understanding Viral Load Suppression in Children Living with HIV in Malawi, Uganda and Zimbabwe

G. Chipungu

PEB055 - Contribution de l'éducation thérapeutique du patient (ETP) dans la prise en charge de l'infection à VIH: cas de la région de la Kara au Togo

A. KATIN, B. AYELOU, A.E. NOKU

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G.C.M. Kalla, V.-G. Mve Mve, N. Kamgaing Noubi, M.N. Ehouzou Mandeng, F. Monebenimp

PEB057 - Improving tuberculosis treatment adherence with mobile phones among women with tuberculosis and tuberculosis-HIV co-infection in Greater Accra Region, Ghana

C. Badzi

PEB058 - Factors associated with loss of follow-up of HIV positive patients on ART in Cameroon

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PEB060 - Scaling up Retention and Adherence Among PLHIV in Western Region, Ghana

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U. Atu, C. Okorie, P. Mohammed

PEB062 - Personalized HIV medicine improves antiretroviral treatment outcomes among adolescents in Cameroon: experience from the EDCTP READY-Study

W.L. Togna Pabo, D. Takou, D. Njume, M.L. Mpouel, C. Chenwi, V. Tala, G. Beloumou, E. Semengue Ngoufack, A.D. Nka, G. Teto, B. Dambaya, S. Djupsa, V. Colizzi, C.F. Perno, A. Ndjolo, J. Fokam

PEB063 - Ensuring an Effective System for the Availability, Analysis and Use of Quality Data for HIV Management.

M. Rengshwat, V. Agu

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I. Elechi, L. Nyang, U. Akpan, K.-A. Ukpong, O. Eloghosa

PEB065 - Barriers to NIMART implementation for Children and Adolescents Living with HIV in five districts in Uganda: A cross sectional study

M. Elang

PEB066 - Improving viral load coverage and suppression in DRC during the COVID-19 pandemic

A. Loando Mboyo, M. Eyenga, D. Tshishi, B. Malenga, Y. Matumona, B. Mboma, F. Banzadio, D. Ingala

PEB067 - Acquired drug resistance patterns and implications on tenofovir-lamivudine-dolutegravir (TLD) use as second- or third-line regimens: evidence from real life experience in Cameroon

C. Chenwi, J. Fokam, B. Dambaya, S. Djupsa

PEB068 - Pre-treatment HIV Drug Resistance in Cameroon: Geographical Disparities and Implications on Dolutegravir- based regimens

C. Chenwi, J. Fokam, V. Tala

PEB069 - Determinants of poor immune recovery among patients with undetectable viremia in Cameroon: Men at higher risk of opportunistic infections

A.D. Nka, Ngoufack Jagni Semengue, D. Takou, G. Teto, M.C. Tommo Tchouaket, G. Angong Beloumou, A. Abba, V. Colizzi

PEB070 - Effect of HIV-1 Genetic Diversity on Immune-virologic response among Adolescents in Cameroon: Experience from the EDCTP READY-Study

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PEB071 - Sonographic evaluation of intima-media thickness of the carotid artery in patients with HIV and healthy controls in Ile-Ife South-West Nigeria.

M.U. Elendu, C.M. Asaleye, A.D. Omisore, B.R. Ayodele, M.R. Elendu, O.O Ayoola

PEB072 - Impact of Moringa oleifera leaves supplementation on quality of life of people living with HIV: A double blind randomized controlled trial

A. Gambo

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H. Koné, B.A. Bahi, L. Nzi

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A.S. TRAORE, AM. RAJAONARIVELO, M. Tapsoba, S. Kindo, P. TIENDREBOGO, A. Ouelgo/Simpore, S. Kouama, I. NIKIEMA, L. OUEDRAOGO, M. TOHON, I. TIENDREBEOGO

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PEB077 - L'échec thérapeutique chez les enfants/ adolescents vivant avec le VIH hors de Dakar : conséquence d'une configuration structurelle défavorable

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A. GBADEBO, O. SHOLEYE, F. GBADEBO

PEB081 - Contribution des « point of care » (POC) dans le diagnostic précoce (DP) des enfants nés de mère séropositives au Sénégal

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PEB082 - Impact of virtual treatment support services on ART Retention in the Covid-19 era: the WhatsApp support group system in Nigeria

O. Angela Omohape

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A.G. KOUAKOU

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C.A. ATTINSOUNON

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A. Thiam, K. Bousso, M.N. FAYE, S. Traore, D. Sy

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H. Mugauri, M. Tshimanga, D.J. Chirenda

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M. Phiri, L. Sigande, M. Simwinga, M. Simuyaba, S. Belemu

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A. Munyaneza, G. Murenzi, C. Ingabire, G. Kubwimana

PEC053 - Bridging the Gap between the Communities and Clinics in HIV Care Using Existing Structures in Taraba State, Nigeria.

A. Dadi, G. Omoregie, J. Anyanti, C. Onyezobi, O. Adeoye, E. Okeke

PEC054 - Increasing visibility, uptake and retention of Pre-Exposure Prophylaxis (PrEP) users among men who have sex with men (MSM) in Nairobi through Let's Get Real Events (LGR).

P. Hagono

PEC055 - Effectiveness of different recruitment methods of adolescent girls and young female commercial sex workers into a PrEP demonstration study in Uganda.

J. Nawatti, M. Ssekitoleko, J. Nanyondo, S. Mugamba, F. Kiweewa, G. Mirembe, D. Kibirige, B. Mwesigwa, E. Musingye, J. Kato, H. Kibuuka

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C. Ejeckam, K. Green

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A. Loando Mboyo, R. Musarandega, M. Eyenga, D. Tshishi, B. Malenga, Y. Matumona, B. Mboma, F. Banzadio, D. Ingala

PEC061 - Génotypage moléculaire comparatif du Papillomavirus humain (HPV) chez les femmes VIH- et les femmes VIH+ au Sénégal.

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S. Tonen-Wolyec, C. Kayembe Tshilumba, S. Batina-Agasa, A. Tagoto Tepungipame

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O. Chidera, C. Obulu

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A.C. Ka'e, J. Fokam, M.C. Tommo Tchouaket, A. Abba, C.A. Chenwi1, D. Gouissi, W. Togna Pabo, N. Fainguem, G. Beloumou, S. Djupsa, N. Kamgaing, C. Nkenfou, A. Ndjolo

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S. Simelane, C. Ngcamphalala, P. Mkhabela, R. Sahabo

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B. Ojwang, H. Ngeso, E. Atieno, W. Otieno, E. Otieno

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B. Mwesigwa, E. Musingye, A. Nakirijja, H. Kibuuka

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C. Nwangeneh, U. Akpan, O. Aliu, E. Nwanja, I. Elechi, I. Sunday, H. Nwaba, B. Gana

PEC097 - A composite risk score to guide strategic targeting of HIV prevention programs for Adolescent Girls and Young Women

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S. OGUNLADE, T. Omoniyi, O. Sholeye

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R. Bulamu

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R. Kareodu

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A. Simamuna, T. Deglee

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S.X. Alger, D. Bogere, T. Nsubuga-Nyombi, L.J. Nelson, A.G. Fitzmaurice

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M. Mahaso, L. Casey, A. Schneider

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A. Tama, E. Mutisya, J. Wambua, D. Pahe, P. Mutinda

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D. Owino

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P. Yikpotey, H. Nagai, Y. Ahmed Abdul Rahman

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I.G. Buki, J. Icyimpaye, V. Sabagirirwa

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S. Bernays, A. Batchelor, J. Lariat

PEE026 - Rapid Expansion of Multi-Month Dispensing to Support Retention of People Living with HIV on Antiretroviral Therapy during the COVID-19 Pandemic in South Sudan.

K. Hartsough, H. Ayalneh, S. Aragaw, F. Bayoa, A. Kidane, O. Ukaejiofo, H. Sethna, M. Semira, J. Najohapa, S. Michaels-Strasser

PEE027 - Modelling One-stop-shop Integration of Family Planning and HIV Services in Zimbabwe, 2021.
H.D. Mugauri, G. Ncube, O. Mugurungi, I. Chikondowa

PEE028 - Zero Violence: Harnessing Art to break the silence on Gender Based Violence among Adolescent Girls and Young Women in Nigeria.
G. Gara

PEE029 - Effective community based interventions for people who inject drugs in Ekurhuleni, Gauteng, South Africa
L.N. Casey

PEE030 - Improving the sex work programme using data analytics.
R. Saker, Y. Andrews

PEE031 - Integrating Female Genital Schistosomiasis into HIV routine Programs Among Rural Communities in Gembe Ward, Homa Bay, Western Kenya.
K. Abidha Achola

PEE032 - A qualitative needs assessment for peer support among caregivers of children living with HIV in Nigeria.
G. Obadiah, N. Torbunde, L. Ezekwe, E. Amadosi

PEE033 - Ensuring supply chain continuity of essential HIV services in the context of COVID-19.
Y. Derib, M. Legesse, H. Tesfaye, F. Abebe, F. Alemu, E. Ejigu, T. Seifu

PEE034 - A Community-Led Assessment: COVID-19 Quarantine Measures Effects on Key Population Communities Organizing, Financing and Advocacy Efforts in Kenya.
P. Irungu

PEE035 - Realigning community HIV services structure in the context of donor transition. Experiences from Uganda
E. Ssegujja, M. Mukuru, H. Zakumumpa, F.P. Ssengooba

PEE036 - Technical assistance through the governance graduation model improves district-level HIV programming in rural Uganda.
F. MUWAYI

PEE037 - Prevalence of Psychological Disorders among the Key Populations and their Partners Living with HIV: Lesson from One Stop Shop Centers in South-South and South- East Nigeria.
O. Onyedinachi, R. Aguanunu, G. Jimbo, G. Odutuga, R. Adedoyin, E. Essien, N. Okoye, A. Eyo, S. Robson

PEE038 - Impact de l'approche Amélioration Qualité (AmQ) des données sur la qualité de services offerts aux personnes vivant avec le VIH (Cas du 2ème 90 dans la zone de santé Bunkeya).
S. MUSOYA KABULO

PEE039 - Using the support group and differentiated model of care as an approach to retain female sex workers in Antiretroviral Care in Akamkpa Local Government Area of Cross River State.
E. Ogar1, A. Osilade

PEE040 - Maintaining HIV commodity security in the COVID era: experience from the Nigeria HIV programme
U. Atu

PEE041 - The impact of COVID-19 on access to HIV and Harm Reduction services among the Key population in Mombasa and Taita Taveta Counties.
A. Karisa

PEE042 - ETUDE DES COUTS DE PRISE EN CHARGE CHEZ LES PATIENTS VIVANT AVEC LE VIH/SIDA SUIVIS A L'HOPITAL RÉGIONAL DE KAOLACK EN 2018.
F. Ly

PEE043 - Innovative Approaches to Provide Comprehensive ASRH information and HIV Services to Youth: Lessons from iAccelerator Project in Rwanda.
O. Rugamba, M. Mukamana, N. Tuyishimire, F. Hagenimana

PEE044 - "I know little about mental health": opportunities and challenges of integrating mental health and HIV services in Ghana.
E. Adiibokah, W. Tun, H. Tagoe

PEE045 - Integration of prevention of mother to child transmission services into existing community-based health Services to reach underserved communities in Ghana
A. Kodua Nyanor, E. Bruce, H. Nagai, M. Kwashie, O. Dotse, C. Agyapong, Y. Abdul Rahman

PEE046 - From Rooms to the Web: Community Involvement in Streamlining PLHIV Care during the COVID-19 Pandemic in Africa
J. Wambui

PEE047 - A Mobile Application Designed to Act as a Link to Services Providers for the Marginalized Implemented by Key Populations Uganda among Key Populations

I.F. Kasonko

PEE048 - HIV-self test, a modality to scale up HIV services for men who sell sex to men in Cross river state, Nigeria.

A. Lubem

PEE049 - Impacts of a Pilot of Community Antiretroviral Group Initiative on HIV-Positive Patients in a Tertiary Health Facility in Abuja, North Central Nigeria

H. ONYEGBUTULEM

PEE050 - 'Nobody can know that you are HIV positive': a formative qualitative study to inform a social network-based HIV self-test distribution strategy among Kenyan fishermen.

S. Lebu, M. Getahun, J. Lee

PEE051 - Socio-Economic, Political and Human Right Impact of COVID-19 in Africa: Case of Ghana.

J.T.-K. Teye

PEE052 - Innovations to support increased gender-based violence case reporting in Montserrado County, Liberia

C.K. Kerbay, G. Kamanga, R. Lyimo

PEE053 - Pratiques simultanées et résilientes en prise en charge du VIH/Sida en périodes anormales : cas de la période de COVID-19

P.F. AKETA

PEE054 - Multi-Month ART Dispensing for Children and Adolescents living with HIV in Ethiopia during COVID-19.

M. Bereda, T. Abamo, G. Aschale, M. Mergia, A. Silesh

PEE055 - Assessing the impacts of COVID-19 on people living with HIV in Uganda: results from a PLHIV-led participatory study.

R. Hodes

PEE056 - Ensuring sustainability of state-led MMC services and demand creation using behavioural economics HIV prevention; medical male circumcision; demand creation; behavioural economics; primary healthcare.

J. Swart, S. Brown, S. Amoils, A. Kwarteng, L. Mulenga

PEE057 - La couverture maladie universelle, une opportunité dans la prise en charge des personnes vivant avec le VIH (PVVIH): Expérience de l'association BOKK YAKAAR de Fatick au Sénégal.

O. NDIAYE, I. BA, M. KA

PEE058 - Decentralized commodity management and its effect on commodity security in Akwa Ibom State.

M. Dakwat, A. Idemudia, O. Guobadia

PEE059 - The importance for MSM to be in a relationship supersedes the desire for HIV prevention and healthcare engagement.

L. Zakwe

PEE060 - Why Daily Situation room meetings matter for achieving HIV epidemic control: lessons from the Nigeria SHARP TO 1 Project.

O. David Ekele, R. Eddichukwu, O. Alimi, T. Adesina

PEE061 - Moving towards a sustainable Voluntary Medical Male Circumcision (VMMC) program in Zambia

J. Masiye, R. Kamboyi, B. Musonda, T. Chisenga, P. Lukonde, A. Kaonga, M. Siame, A. Silumesii, R. Mwanza, J. Chinyonga, K. Malama

PEE063 - Valuing our work: Understanding the Social Return on Investment (SROI) of the Resilient, Empowered Adolescents and Young People (READY+) programme.

C. Dziwa, I. Komanyane

PEE064 - COVID-19 associated changes in HIV service delivery over time in Central Africa: Results from facility surveys during the first and second waves of the pandemic.

R. Ajeh

PEE065 - Donor transition and sustainable financing for HIV/AIDS and COVID-19 in Côte d'Ivoire.

Z.O. KOUDOU

PEE066 - Assessing the readiness of the current system for increased multi-month dispensing in South Africa.

W. Chinogwenya, S. Landman, L. De Kock

PEE067 - The adoption of Differentiated Service Delivery (DSD) in South Africa: Proven effective measure to optimize patient-centered approach and increased retention in care.

M. Manganye, Z. Pinini, L. Seshoka, L. Malala, D. Gavhi, T. Molewa, M. Mkhize, M. Kgokolo, T. Nyawasha, T. Dladlama, M. Pilusa

PEE068 - Strategies for optimizing HIV testing services for female people who Inject drugs in calabar south LGA of

cross river state, Nigeria.

N. Gwan, A. Osilade

PEE069 - Does organizing around transaction cost economics matter for cost minimization? An examination of alternative institutional arrangements for delivery of HIV&AIDS services in Uganda.

S. Khanakwa

PEE070 - Strengthening HIV Viral Load (VL) laboratory supply chains and network performance through a sustainable, replicable, data-driven approach.

Y. Johansen, Y. Ma, J. Recchia, R. Schmittgen

PEE071 - Comparison of age-based estimation with the actual weight of children of the key population aged 1-12 years in three USAID/HALD supported Nigerian Statea (Akwa Ibom, Cross River, and Lagos).

A.A. CHIGERE, P. UMOH, E. GODWIN, E. UGWUIKE, N. AKUTO

PEE072 - Impact of Covid pandemic in provision of HIV services to Female sex workers in Taita Taveta County.

A. Karisa

PEE073 - Current state of prevention of mother-to-child transmission of HIV (PMTCT) among informal health care providers (IHPs) in Cameroon.

L.A. AMBOUA SCHOUAME

PEE0955 - Using mobile clinics to rev up service delivery!

Y. Andrews, R. Saker

PEE075 - Increased efficiency in HIV testing and linkage to ART through faith-engaged community posts in Harare Zimbabwe.

T. Maphosa, M. Melchior

PEE076 - Building South Africa's capacity to resume and scale-up VMMC services during the COVID-19 pandemic.

A. Kwarteng, L. Mulenga, B. Dube

PEE077 - "Community Led Monitoring; Delivering Evidence and Action from Communities for improved HIV/TB service delivery"

B. Ajonye, L. Mworeko, H. Mutabarura

PEE078 - HIV index testing: a cost-efficient strategy with higher-yield in Mozambique.

M. Songane, C. Magaia, N. Dengo, A. Cassamo, R. Nhantumbo, C. Mahumane, A. Mabote, S. Mikusova, N. Bhatt

PEE079 - RECUEIL DES BONNES PRATIQUES DES ORGANISATIONS COMMUNAUTAIRES DANS LA LUTTE CONTRE LE SIDA DANS LES ÉTATS FRAGILES

I. SIKITU, B. MUNEZERO, J.M. MUTIMA

PEE080 - Barriers to keeping clinic appointments among HIV-positive clients in rural Uganda.

P. Amutungire, J.B. Baluku, B. Bukenya Nambuusi, J. Nakawesi, C. Senyimba, B. Mukasa

PEE081 - Citizen Science, Art and HIV.

A. Makombe

PEE082 - Index testing through antenatal clinics as a strategic approach to HIV case finding among men in Malawi during the COVID-19 pandemic: Malawi EMPOWER experience.

N. Lungu, M. Mkandawire, B. Maket, L. Muyumbu, Y. Nyondo, M. Kankhulungo, L. Magombo, P. Gwaza, M. Ruberintwari

PEE083 - COVID-19 impact on gender-based violence amongst women in South Africa during lockdown: A Narrative Review.

S.M.S. Ndlovu, M.A. Mulondo, J. Tsoka-Gwegweni, J. Ndirangu

MIND THE GAP

AFRICAN HIV FINANCING SCORECARD

DATE: 7TH DECEMBER 2021 | TIME : 15:27- 17:00

Session Objectives

The overall goal is to increase the level of engagement and awareness of all stakeholders in Africa, Government, parliament , philanthropes, Civil Society Organizations, private sector and other decision-makers on domestic funding to sustain the gain towards elimination perspective of HIV in 2030.

Brief presentation of the Africa HIV Financing scorecard

Phillipa Tucker

Panel of Guest speakers:

Brian Kanyemba, Peter Sand (Global Fund), Prof. Mthuli Ncube (Minister of Finance Zimbabwe)

Q & A from the audience

Closing remarks

100 CAPACITY ROOM

Special Sessions / Sessions Spéciales

DATE Tuesday, 6 December 2021

The HIV Policy Lab: Examining How National Laws/Policies Impact the Global AIDS Respons

Room: 100 Capacity
Time: 11:35 - 12:15
Speakers : Irene Mukui, MBBS, MPH(Kenya)
Janki Tailor, MPH(USA)
Jetina Juliet Tsvaki, MS (Zimbabwe)
Session Chair Dr. Matthew Kavanagh (USA)

DATE Tuesday, 7 December 2021

The Key Role of the Faith Sector Leadership in the HIV response in Africa

Room: 600 Capacity
Time: 12:36 - 13:21
Speakers : Rev. Jane Nganga (Kenya)
Rev. Prof. Gideon Byamugisha (Uganda)
Imam Harouna Kone (Cote D'Ivoire)
Session Chair : Mr. Paul Sagna (Senegal)
Session Co-Chair : Rev. Godson Lawson (Togo)

HIV and COVID 19: Challenges in Africa

Room: 500 Capacity
Time: 14:30 - 15:15
Speakers : Prof. Seni Kouanda (Burkina Faso)
Prof. Serge Eholie (Cote D'Ivoire)
Prof. Samuel Kalluvya (Tanzania)
Session Chair : Prof. John Idoko (Nigeria)
Session Co-Chair : Dr. Nokukhanya Msomi (South Africa)

DATE Wednesday, 8 December 2021

HIV Prevention, Treatment and Care among People Who Use Drugs and People in Prison in Africa

Room: Plenary Room
Time: 10:42 - 11:27
Speakers : Mr. Elie Aaraj (Lebanon)
Ms. Doreen Gaura (South Africa)
Ms. Fariba Soltani (Iran)
Joseph O. Ike (Nigeria)
Session Chair : Mr. Raphael Tuhafeni Hamunyela (Namibia)
Session Co-Chair : Dr. Khadija Shikely (Kenya)

2021 Political Declaration on AIDS – how to accelerate implementation

Room: 100 Capacity
Time: 10:42 - 11:27
Speakers : Dr. Angeli Achrekar (United States)
Ms. Doreen Moracha (Kenya)
Session Chair : Cindy Kelemi (Botswana)

Impact of COVID-19 on the TB/HIV response

Room: 100 Capacity
Time: 12:36 - 13:21
Speakers : Thembisile Xulu (South Africa)
Dr. Zuki Pinini (South Africa)
Session Chair : Dr. Nonhlanhla Makhanya (South Africa)

COVID 19 Management: South Africa, East Africa, West Africa

Room: 600 Capacity
Time: 12:36 - 13:21
Speakers : Dr Jeremy Nel (South Africa)
Dr. Warren Naamara (Uganda)
Prof Abdoul-Salam Ouedraogo (Burkina Faso)
Session Chair : H.E. Marisol Touraine (France)
Session Co-Chair : Prof. Francois-Xavier Mbopi-Keou (Cameroon)

COVID 19 Management: EMRO Region, Egypt, Central Africa

Room: 300 Capacity
Time: 13:33 - 14:18
Speakers : Dr. Rana Hajjeh (Lebanon)
H.E. Prof Hala Zaid,
Minister of Health (Egypt)
Prof. Francois-Xavier Mbopi-Keou (Cameroon)
Session Chair : Prof. Michel E. Kazatchkine (France)
Session Co-Chair : Prof. John Idoko (Nigeria)

COVID 19 vaccination in HIV infected patients.

Room: 500 Capacity
Time: 13:33 - 14:18
Speakers : Prof. Jean-Cyr Yombi (Belgium)
Prof. Stefano Vella (Italy)
Prof Thumbi Ndung'u (South Africa)
Session Chair : Prof Mosa Moshabela(South Africa)
Session Co-Chair : Prof. Tandakha Dieye(Senegal)

Progress on the COVID-19 vaccine rollout in South Africa (Challenges, Successes and Lessons Learned)

Room: 100 Capacity
Time: 14:30 - 15:15
Speakers : Dr. Nicholas Crisp (South Africa)
Dr. Jeremy Nel (South Africa)
Session Chair : Ms. Steve Letsike (South Africa)

Rapid Tests/Auto tests: HIV & COVID-19

Room: 300 Capacity
Time: 14:30 - 15:15
Speakers : Prof. Laurent Belec (France)
Carmen Figueroa (Switzerland)
Prof. Mathildah M Mokgatle (South Africa)
Session Chair : Prof. Mireille Dosso (Cote D'Ivoire)
Session Co-Chair : Prof. Gérard Grésenguet (Central African Republic)

DATE Thursday, 9 December 2021

A People's Vaccine for COVID-19: No ending AIDS without it

Room: 300 Capacity
Time: 10:42 - 11:27
Speakers : Ms. Winnie Byanyima (Uganda)
Lios Chingandu (Zimbabwe)
Tian Johnson (South Africa)
Session Chair : Christine Stegling (United Kingdom)
Session Co-Chair : Madam Solange L. Baptiste (South Africa)

Domestic Financing: The Critical factor to sustainable financing for the HIV response in Africa

Room: 300 Capacity
Time: 12:36 - 13:21
Speakers : Mr. Jaime Atienza (Spain)
Hon. Prof. Mthuli Ncube (Zimbabwe)
Prof. Kalipso Chalkidou (Greece)
Session Chair : Dr. Mark Blecher (South Africa)
Session Co-Chair : Dr. Justice Nonvignon (Ghana)

Reaffirmation of the ESA Commitment: Accelerating progress towards Agenda 2030

Room: 100 Capacity
Time: 13:33 - 14:18
Speakers : Nyaradzai Gumbonzvanda (Zimbabwe)
Levi Singh (South Africa)
Session Chair : Prof. Sheila Tlou (Botswana)
Session Co-Chair : Remmy M. Shawa (South Africa)

Conducting 2nd Generation surveillance during a pandemic in Nigeria: lessons learnt.

Room: 300 Capacity
Time: 13:33 - 14:18
Speakers : Dr. Gambo Aliyu (Nigeria)
Dr. Akudo Ikpeazu (Nigeria)
Chukwuebuka Ejeckam (Nigeria)
Session Chair : Prof. John Idoko (Nigeria)
Session Co-Chair : Lillian Mworeko (Uganda)

Failure of 2nd line HIV regimens: What should be done?

Room: 500 Capacity
Time: 14:30 - 15:15
Speakers : Prof. Kholeka Mlisana (South Africa)
Prof. Yunus Moosa (South Africa)
Session Chair : Prof. Serge Eholie (Cote D'Ivoire)
Session Co-Chair : Dr. Gloria Maimela (South Africa)

What went wrong: The surge in teenage pregnancies and the implication on ending AIDS in Africa

Room: 600 Capacity
Time: 14:30 - 15:15
Speakers : Prof. Quarraisha Abdool Karim (South Africa)
Dr. Ruth Laibon-Masha (Kenya)
Beatrice Savadye (Zimbabwe)
Session Chair : Ms. Marie-Evelyne Petrus-Barry (Guinea)
Session Co-Chair : Innocent Modisaotsile (South Africa)

DATE Friday, 10 December 2021

Will the global AIDS strategy end inequalities for key populations?

Room: 100 Capacity
Time: 10:42 - 11:27
Speakers : Ricki Kgositau-Kanza (Botswana)
Cynthia Mwase
Session Chair : Hon. Dr. David Parirenyatwa (Zimbabwe)
Session Co-Chair : Daughtie Ogutu (Kenya)

Addressing the needs of People who Use Drugs in achieving " AIDS free-Africa"

Room: Plenary Room
Time: 12:36 - 13:21
Speakers : Prof. Isidore Obot (Nigeria)
Charity Monareng (South Africa)
Richard Nininahazwe (Burundi)
Session Chair : Maria-Goretti Loglo (Ghana)
Session Co-Chair : Seyi Kehinde (Nigeria)

Community Intervention on HIV prevention: Experience from the Field

Room: 100 Capacity
Time: 14:30 - 15:15
Speakers : Koketso Mukobane (South Africa)
Prof. Monique Marks (South Africa)
Angela McBride (South Africa)
Session Chair : Julie Mac Donnell (South Africa)
Session Co-Chair : Stacey Doorly-Jones (South Africa)

Workshop / Atelier

DATE Tuesday, 7 December 2021

How to write an Abstract

Room: Plenary
Time: 11:39 - 12:24
Speaker : Prof. Seni Kouanda (Burkina Faso)
Session Chair : Mr. Luc Armand H. Bodea (Benin)

DATE Wednesday, 8 December 2021

HIV programming during COVID-19: Sustaining the gains and building back better for women, children and adolescents

Room: 500 Capacity
Time: 12:36 - 13:21
Speakers : Lilian Otiso (Kenya)
Maria Vivas Alicia (Lesotho)
Ministry of Health (Laborotary Systems/Diagnostics)
Ministry of Health, ART Services
Session Chair : Rikke Le Kiregaard

Towards elimination of Mother to Child Transmission of HIV, Syphilis and Hepatitis B virus and care for children: Africa case studies and certification of "Path to Elimination"

Room: 600 Capacity
Time: 13:33 - 14:18
Speakers Dr. Mogomotsi Matshaba (Botswana)
Speakers : Dr. Jorge Noel Barreto (Cabo Verde)
Dr. Naemi Shoopala (Namibia)
Dr. Linda Kisaakye Nabitaka (Uganda)
Session Chair : Dr. Françoise Bigirimana (Congo)

DATE Thursday, 9 December 2021

Biomedical HIV prevention for men in a time of a pandemic: Amplifying our gains and increasing in scale, impact, and sustainability of Voluntary Medical Male Circumcision (VMMC) beyond 2021.

Room: 500 Capacity
Time: 13:33 - 14:18
Speakers : Lycias Zembe, Geneva
Wole Ameyan, Geneva
Carlos Toledo, USA
Valerian Kiggundu, USA
Session Chair : Dr. Frank Lule (Uganda)

DATE Friday, 10 December 2021

HIV and Aging population

Room: 500 Capacity
Time: 14:30 - 15:15
Speakers : Prof. Stephen Tollman (South Africa)
Session Chair : Prof. Mosa Moshabela (South Africa)

Non-Abstract Driven Sessions / Session non-dirigée

DATE Tuesday, 7 December 2021

No Prevention, No End. Taking the lead in implementing the 2025 HIV Roadmap

Room: 300 Capacity
Time: 10:42 - 11:27
Speakers : Dr. Julitta Onabanjo (South Africa)
Samuel Matsikure (Zimbabwe)
Session Chair : Prof. Sheila Tlou (Botswana)
Session Co-Chair : Nyasha Sithole (Zimbabwe)

Drug Policy Reform in Africa: a core component to achieving the SDG targets

Room: 500 Capacity
Time: 10:42 - 11:27
Speakers : Adeolu Adebiyi (Nigeria)
Charity Monareng (South Africa)
Kunal Naik (Mauritius)
Session Chair : Ifeanyi Okechukwu (Nigeria)
Session Co-Chair : Adeniyi Moronfolu (Nigeria)

Leading the fight back for HIV prevention.

Room: 100 Capacity
Time: 12:36 - 13:21
Speakers : Grace Kumwenda (Malawi)
Moses Mulindwa (Uganda)
Jane Nganga (Kenya)
Session Chair : Christine Stegling (United Kingdom)
Session Co-Chair : Nyasha Sithole (Zimbabwe)

Countering the Opposition to Comprehensive Sexuality Education: Perspectives from Africa

Room: 100 Capacity
Time: 13:33 - 14:18
Speakers : Patricia Machawira (Zimbabwe)
Mercy Niyibeshasho (Nigeria)
Rosette Nanyanzi (Uganda)
Session Chair : Lois Chingandu (Zimbabwe)
Session Co-Chair : Dr. Haley McEwen (South Africa)

Implementing the New Global AIDS Strategy 2021-2026: the importance of a resilient Primary Health Care

Room: 300 Capacity
Time: 13:33 - 14:18
Speakers : Dr. Yogan Pillay (South Africa)
Florence Anam(Kenya)
Dr. Aboubacar Kampo (Mali)
Session Chair : Hon. Dr. David Parirenyatwa (Zimbabwe)
Session Co-Chair : Emmanuel Ndlangamandla (South Africa)

DATE Thursday, 9 December 2021

HIV self-testing: lessons learned and perspectives.

Room: 500 Capacity
Time: 10:42 - 11:27
Speakers : Dr. Thato Chidarikire (South Africa)
Dr. Serges Tonen-Wolyec (Congo (Democratic Republic))
Cheryl Johnson (Switzerland)
Session Chair : Prof. Francois-Xavier Mbopi-Keou (Cameroon)
Session Co-Chair : Prof. Jeanne Ngogang (Cameroon)

DATE Friday, 10 December 2021

PrEP in Africa: Success and challenges in Africa

Room: Plenary Room
Time: 10:42 - 11:27
Speakers : Dr. Rachel Baggaley (United Kingdom)
Dr. Moherndran Archary (South Africa)
Session Chair : Sihaka Tsemo (Ethiopia)
Session Co-Chair : Dr. Safiatou Thiam (Senegal)

Emerging new viral infection and HIV: interactions and treatment.

Room: 500 Capacity
Time: 10:42 - 11:27
Speakers : Dr. Andrew Kambugu (Uganda)
Lucy Nganga (Kenya)
Session Chair : Prof. Thumbi Ndung'u (South Africa)
Session Co-Chair : Prof. Jean-Cyr Yombi (Belgium)

HIV, TB and COVID 19 co-infections

Room: 300 Capacity
Time: 12:36 - 13:21
Speakers : Dr. Bethrand Odume (Nigeria)
Dr. Lucica Ditiu (Romania)
Dr. Nathan Ford (Switzerland)
Session Chair Prof. Mosa Moshabela (South Africa)
Session Co- Chair : Prof. Jean-Cyr Yombi (Belgium)

The Road to meeting societal enabler targets by 2026: Time to promote rights and end all forms of HIV discrimination

Room: 100 Capacity
Time: 13:33 - 14:18
Speaker : Rachel Ndaya (Congo)
Dr. Tlaleng Mofokeng (South Africa)
Dr. Ahmed Abbadi (Morroco)
Session Chair : Mr. Daouda Diouf (Senegal)
Session Co-Chair : Felicita Hikuam (South Africa)

The use TB screening tools in TB case notifications: successes and challenges.

Room: 500 Capacity
Time: 13:33 - 14:18
Speakers : Kevin Cain(United States)
Dr. Yael Hirsch-Moverman (United States)
Session Chair : Prof. Frank Cobelens (Netherlands)
Session Co-Chair : Prof. Richard Lessells (South Africa)

Satellite Symposia / Satellite

DATE Monday, 6 December 2021

Putting people at the center: Designing, implementing, and measuring impact of person-centered HIV care

Room: 100 Capacity Room
Time: 09:45 - 10:30
Organizer : JSI

Addressing STIs through innovation Challenges for STI control and new technology and strategies to overcome those challenges

Room: 300 Capacity Room
Time: 09:45 - 10:30
Organizer : Global Antibiotic Research and Development Partnership

Delivering Comprehensive SRHR services for marginalised groups in the context of COVID19 Pandemic

Room: 500 Capacity Room
Time: 09:45 - 10:30
Organizer : UNFPA GHANA

Scaling up Innovative HIV diagnostic in Children

Room: 600 Capacity Room
Time: 09:45 - 10:30
Organizer : UNICEF

Clinical Science, Treatment and Care

Room: 100 Capacity Room
Time: 10:40 - 11:25
Organizer : PSI

Addressing STIs through innovation Challenges for STI control and new technology and strategies to overcome those challenges

Room: 300 Capacity Room
Time: 10:40 - 11:25
Organizer : Global Antibiotic Research and Development Partnership

Johnson and Johnson Global Public Health

Room: 500 Capacity Room
Time: 10:40 - 11:25
Organizer : JOHNSON & JOHNSON

Differentiated service delivery for HIV treatment: Updated WHO recommendations and implementation in Africa

Room: 600 Capacity Room
Time: 10:40 - 11:25
Organizer : IAS WITH WHO

HIGH LEVEL MEETING (UNAIDS contribution to RATESA and ESA commitment)

Room: 300 Capacity Room
Time: 11:35 - 12:15
Organizer : UNAIDS

Ending AIDS by 2030 by full integration with the Cervical Cancer Elimination Initiative- (CCEI)

Room: 500 Capacity Room
Time: 11:35 - 12:15
Organizer : WHO

Pathway to PrEP: Expanding Access to HIV Prevention Options for Adolescent Girls and Young Women in Kenya through Integration with Family Planning Services

Room: 600 Capacity Room
Time: 11:35 - 12:15
Organizer : FHI 360

BHPF Pre-Conference

Room: 100 Capacity Room
Time: 12:25 - 13:10
Organizer : BHPF Pre-Conference

HIGH LEVEL MEETING UNAIDS contribution to RATESA and ESA commitment)

Room: 300 Capacity Room
Time: 12:25 - 13:10
Organizer : UNAIDS

Abbott

Room: 500 Capacity Room
Time: 12:25 - 13:10
Organizer : Abbott

Meet the Ring: Product overview and provider/user perspectives on the dapivirine vaginal ring

Room: 600 Capacity Room
Time: 12:25 - 13:10
Organizer : PROMISE Collaboration

BHPF Pre-Conference

Room: 100 Capacity Room
Time: 13:20 - 14:05
Organizer : BHPF Pre-Conference

Analyzing the Quality of Care provided to people living with HIV in selected Fast-Track Cities

Room: 300 Capacity Room
Time: 13:20 - 14:05
Organizer : IAPAC

Towards Universal Healthcare coverage through Diagnostics testing integration

Room: 500 Capacity Room
Time: 13:20 - 14:05
Organizer : Abbott

Launching PrEP-it 2.0 – a multi-functional online tool for planning, monitoring, and evaluation of all forms of PrEP

Room: 600 Capacity Room
Time: 13:20 - 14:05
Organizer : PROMISE Collaboration

BHPF Pre-Conference

Room: 100 Capacity Room
Time: 14:15 - 15:00
Organizer : BHPF Pre-Conference

COVID-19 - Strengthening Africa's vaccine manufacturing capacity through the South African mRNA technology transfer hub

Room: 300 Capacity Room
Time: 14:15 - 15:00
Organizer : Medicines Patent Pool

Final Mile

Room: 500 Capacity Room
Time: 14:15 - 15:00
Organizer : Final Mile

The Dapivirine Vaginal Ring: national planning experience from three countries

Room: 600 Capacity Room
Time: 14:15 - 15:00
Organizer : PROMISE Collaboration

DATE Tuesday, 7 December 2021

Global Network of Young people living with HIV

Room: 100 Capacity Room
Time: 08:45 - 09:30
Organizer : Global Network of Young people living with HIV

Chemonics International

Room: 300 Capacity Room
Time: 08:45 - 09:30
Organizer : Chemonics International

Advanced HIV Disease: Improving access to same-day CD4 testing, from laboratory to community

Room: 500 Capacity Room
Time: 08:45 - 09:30
Organizer : OMEGA DIAGNOSTICS

Abbott Rapid Dx International Limited

Room: 600 Capacity Room
Time: 08:45 - 09:30
Organizer : Abbott Rapid Dx International Limited.

WHO New consolidated HIV prevention and treatment guidelines

Room: Plenay Room
Time: 10:42 - 11:27
Organizer : WHO

Au-delà de populations clés : la distribution secondaire de kits d'autodépistage du VIH en Afrique de l'Ouest Beyond key populations: secondary distribution of HIVST kits in West Africa.

Room: Plenary Room
Time: 12:36 - 13:21
Organizer : Solthis-Projet ATLAS

A new Partnership Approach

Room: 500 Capacity Room
Time: 12:36 - 13:21
Organizer : Frontline AIDS

WHO Guidelines for the management of symptomatic STIs

Room: Plenary Room
Time: 13:33 - 14:18
Organizer : WHO

What Women Know and Want: A gendered approach to realizing an AIDS free Africa

Room: 600 Capacity Room
Time: 13:33 - 14:18
Organizer : WomenLift Health

Impact of COVID-19 on HIV, STI and other health services

Room: Plenary Room
Time: 14:30 - 15:15
Organizer : WHO

Aligning countries' response to reduce inequalities, improve equitable access and quality of HIV, viral Hepatitis and STI services to key populations

Room: 600 Capacity Room
Time: 14:30 - 15:15
Organizer : WHO

UNAIDS RESERVED

Room: Plenary Room
Time: 15:27 - 16:12
Organizer : UNAIDS

HIGH LEVEL MEETING SAA & ACCOUNTABILITY INTERNATIONAL: MIND THE GAP AFRICAN HIV FINANCING SCORECARD.

Room: 100 Capacity Room
Time: 15:27 - 16:12
Organizer : SAA/ACCOUNTABILITY INTERNATIONAL

HIGH LEVEL MEETING (UNAIDS contribution to RATESA and ESA commitment)

Room: 300 Capacity Room
Time: 15:27 - 16:12
Organizer : UNAIDS

Technology transfer hubs for boosting local production of medical products in Africa.

Room: 500 Capacity Room
Time: 15:27 - 16:12
Organizer : WHO/SAA

Partnering for Progress in Paediatric HIV

Room: 600 Capacity Room
Time: 15:27 - 16:12
Organizer : VIIV HEALTHCARE

DATE Wednesday, 8 December 2021

Southern Africa Litigation Centre: Breastfeeding, HIV and the law'

Room: 100 Capacity Room
Time: 08:45 - 09:30
Organizer : Southern Africa Litigation Centre

Patient centered diagnostics

Room: 300 Capacity Room
Time: 08:45 - 09:30
Organizer : CEPHEID

Accelerate and expand HIV screening/ testing with OraQuick HIV Self-Test

Room: 500 capacity Room
Time: 08:45 - 09:30
Organizer : OraSure

Abbott Rapid Dx International Limited

Room: 600 Capacity Room
Time: 08:45 - 09:30
Organizer : Abbott Rapid Dx International Limited

L'annonce du VIH/sida aux enfants et aux adolescents : Bonnes pratiques et défis dans les pays francophones d'Afrique de l'Ouest et du Centre

Room: 600 Capacity Room
Time: 10:42 - 11:27
Organizer : WHO

The Global Fund to Fight AIDS, Tuberculosis and Malaria: The Global Fund: 20 years later: A forward-looking dialogue on the fight against HIV, tuberculosis and malaria and the challenges that lay ahead

Room: Plenary Room
Time: 11:39 - 12:24
Organizer : The Global Fund

Beyond Reaching the first 95: HIV Self-Testing, new experiences from the Unitaid STAR Project

Room: 300 Capacity Room
Time: 12:36 - 13:21
Organizer : PSI

Towards Elimination of Mother-To-Child Transmission of HIV, syphilis and viral Hepatitis B: African case studies and validation of 'Triple Elimination

Room: Plenay Room
Time: 13:33 - 14:18
Organizer : WHO

Progress towards implementation of Africa Regional Action Plan for Preventing and Responding to HIV Drug Resistance 2019 – 2023

Room: Plenay Room
Time: 14:30 - 15:15
Organizer : WHO

UNAIDS

Room: Plenay Room
Time: 15:27 - 16:12
Organizer : UNAIDS

Integrating SRHR and HIV lessons from East and Southern Africa

Room: 100 Capacity Room
Time: 15:27 - 16:12
Organizer : UNFPA

IAS

Room: 300 Capacity Room
Time: 15:27 - 16:12
Organizer : IAS

A new agenda for Malaria in Africa

Room: 500 Plenary Room
Time: 15:27 - 16:12
Organizer : WHO / SAA

Open discussion on HIV Prevention experience

Room: 600 Capacity Room
Time: 15:27 - 16:12
Organizer : VIIV HEALTHCARE

DATE Thursday, 9 December 2021

Long acting technologies and HIV

Room: 100 Capacity Room
Time: 08:45 - 09:30
Organizer : Medicines Patent Pool

HIV Prevention

Room: 300 Capacity Room
Time: 08:45 - 09:30
Organizer : Department of Basic Education

Differentiated service delivery for HIV in Africa during COVID-19

Room: 500 Capacity Room
Time: 08:45 - 09:30
Organizer : IAS

Satellite Symposia

Room: 600 Capacity Room
Time: 08:45 - 09:30
Organizer : Satellite Symposia

Integrated people-centred HIV, STI and TB services and health system strengthening

Room: Plenary Room
Time: 10:42 - 11:27
Organizer : WHO

PEPFAR

Room: Plenary Room
Time: 11:39 - 12:24
Organizer : PEPFAR

Expanding HIV PrEP for Pregnant and Breastfeeding Populations: Lessons learned from expanding PrEP within MNCH service delivery settings in Lesotho.

Room: 100 Capacity Room
Time: 12:36 - 13:21
Organizer : JHPIEGO

University of Maryland Baltimore

Room: Plenary Room
Time: 14:30 - 15:15
Organizer : University of Maryland Baltimore

The importance of the UN Decade of Healthy Ageing 2021-2030 in addressing STIs and HIV in older people in the African region towards UHC

Room: 600 Capacity Room
Time: 12:36 - 13:21
Organizer : WHO

Comorbidities, emerging infections and NCDs

Room: 500 Capacity Room
Time: 13:33 - 14:18
Organizer : WHO

Guidelines for elimination validation

Room: Plenary Room
Time: 14:30 - 15:15
Organizer : WHO

UNAIDS

Room: Plenary Room
Time: 15:27 - 16:12
Organizer : UNAIDS RESERVED

SAA

Room: 100 Capacity Room
Time: 15:27 - 16:12
Organizer : SAA

Go Further on Integrated Approaches to Care – The Path Towards HIV and Cervical Cancer Elimination in Sub-Saharan Africa

Room: 300 Capacity Room
Time: 15:27 - 16:12
Organizer : MSD

Promoting Hepatitis B PMTCT in Africa, advocacy of the First Ladies

Room: 500 Capacity Room
Time: 15:27 - 16:12
Organizer : WHO/SAA

The role of faith communities in supporting programmes for children and adolescents living with and affected by HIV: A qualitative analysis of promising interventions in sub-Saharan Africa

Room: 600 Capacity Room
Time: 15:27 - 16:12
Organizer : UNAIDS - PEPFAR faith Initiative

DATE Friday, 10 December 2021

Strengthening Response Systems: providing support to sexual and gender-based violence in Ghana.

Room: 100 Capacity Room
Time: 08:45 - 09:30
Organizer : UNFPA GHANA

HIV Prevention

Room: 300 Capacity Room
Time: 08:45 - 09:30
Organizer : Department of Basic Education

Capacity Building - looking back and learning for the future

Room: 500 Capacity Room
Time: 08:45 - 09:30
Organizer : IAS

Implementation of 2019 HIV Testing Services : From 2 test to 3 test HIV testing strategy

Room: 600 Capacity Room
Time: 10:42 - 11:27
Organizer : WHO

Scaling up action to end TB deaths among people living with HIV

Room: 600 Capacity Room
Time: 13:33 - 14:18
Organizer : WHO

Access to SRHR services for key populations and persons with disabilities: experience in west and Central Africa Region

Room: 100 Capacity Room
Time: 15:27 - 16:12
Organizer : UNFPA

Support across the generations: Scaling up multisectoral programming for adolescent and young mothers living with HIV

Room: 300 Capacity Room
Time: 15:27 - 16:12
Organizer : UNICEF

Ending TB in West and Central Africa by 2030: Bringing high burden countries on track towards End TB strategy targets by 2025

Room: 500 Capacity Room
Time: 15:27 - 16:12
Organizer : WHO/SAA

Using innovation and technology to accelerate HIV prevention among adolescents and young people

Room: 600 Capacity Room
Time: 15:27 - 16:12
Organizer : UNFPA

DATE Saturday, 11 December 2021

Positive Young Women Voices: Young Women and Girls Leadership

Room: 100 Capacity Room
Time: 08:45 - 09:30
Organizer : Positive Young Women Voices

Satellite Symposia

Room: 300 Capacity Room
Time: 08:45 - 09:30
Organizer : Satellite Symposia

UNFPA LED SESSION

Room: 500 Capacity Room
Time: 08:45 - 09:30
Organizer : UNFPA LED SESSION

Satellite Symposia

Room: 600 Capacity Room
Time: 08:45 - 09:30
Organizer : Satellite Symposia

Sponsors & Exhibitors / Sponsors & Exposants

Abbott is a global leader in in vitro diagnostics with one of the broadest portfolios 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.

Based in Sunnyvale, Calif., Cepheid is a leading molecular diagnostics company that is dedicated to improving healthcare by developing, manufacturing, and marketing accurate yet easy-to-use systems and tests. The company's solutions deliver a better way for institutions of any size to perform sophisticated molecular diagnostic testing for organisms and genetic-based diseases. Cepheid is focusing on those applications where accurate, rapid, and actionable test results are needed most. For more information, visit http://www.cepheid.com.

BD is a purpose-driven company, advancing the world of health™ by developing fundamental medical devices and sophisticated technologies that doctors, nurses, researchers and caregivers rely on to improve the lives of patients. As partners on the front lines, we've helped the world face down viral diseases for decades, from polio, smallpox and measles to HIV and the annual flu.
For Advanced HIV patients with weakened immune systems, continued monitoring and care is especially important given the risk of opportunistic infections. CD4 testing is a reliable diagnostic tool to assess the co-infection risk of HIV patients, proving that CD4 still counts.

For more than 20 years, Biocentric has been Africa's partner in the fight against AIDS with one of its main products, the GENERIC HIV Charge Virale test.
Biocentric now offers a wide range of PCR tests not only for HIV-1 viral load monitoring, but also for HIV-2, HBV, HIV-1 reservoir and for the diagnosis of tuberculosis and antibiotic resistance.
Furthermore, Biocentric offers innovative solutions in the field of in vitro diagnostics, adapted to the needs of the various stakeholders in medical biology, hospital laboratories and private analytical testing laboratories.

Based in Alsace, BIOSYNEX develops, manufactures, and markets medical devices for screening, diagnosis and prevention in a constant quest for excellence.
A major player in the European market, BIOSYNEX covers the French market and over than 70 countries.
BIOSYNEX focuses its development and distribution choices on market-specific, world-class niches through home-made products with high added value (RDTs, women's health, treatment monitoring, medical assistance, etc).
BIOSYNEX is listed in The Global Fund and is a supplier of WHO. Moreover, BIOSYNEX plays an important role when it comes to the humanitarian actions, as it supplies diverse Foundations, NGOs and Governments.

Charles R. Drew University of Medicine and Science (CDU) is one of the Historically Black Colleges and Universities (HBCU) Global Health Consortium. Within the context of clinical transformation, the Consortium aims to enhance and improve the provision of HIV/AIDS services in Sub-Saharan Africa. Funded by the US President's Emergency Plan for AIDS Relief (PEPFAR) through the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau, Division of Global HIV Programs, this HBCU project is a multi-year initiative that partners the Consortium with

local Zambian hospitals in clinical practice transformation projects.

CHEMBIO DIAGNOSTIC SYSTEMS, INC.

"Chembio Diagnostic Systems, Inc. develops manufactures, and markets rapid tests for detection of sexually transmitted diseases, respiratory diseases, tropical and fever diseases globally. As a leader in small sample volume testing, we strive to innovate and push the boundaries of testing. Focusing on low resource settings, we have ensured both CE mark and WHO prequalification approvals. Our products include rapid tests for the detection of HIV 1/2 in a professional setting and Self Testing, and multiplex rapid tests for diseases like HIV, Syphilis, COVID-19, and ZDC using our DPP® platform. Support is a major foundation of our service and we have trained experts s to ensure that quality products also have quality support"

Chemonics
Deveopment works here.

Founded in 1975, Chemonics is an international development consulting firm. In more than 85 countries around the globe, our network of more than 5,000 specialists shares a simple belief: that the challenges we face today are best solved through the right partnerships – sharing knowledge, expertise, and experience to deliver results. Where Chemonics works, development works. Follow us on Facebook and Twitter or visit us at www.chemonics.com.

GILEAD
Creating Possible

Gilead Sciences, Inc. is a biopharmaceutical company that has pursued and achieved breakthroughs in medicine for more than three decades, with the goal of creating a healthier world for all people. The company is committed to advancing innovative medicines to prevent and treat life-threatening diseases, including HIV, viral hepatitis and cancer. Gilead operates in more than 35 countries worldwide, with headquarters in Foster City, California.

THE GLOBAL FUND

The Global Fund is a worldwide movement to defeat HIV, TB and malaria and ensure a healthier, safer, more equitable future for all.
The Global Fund raises and invests US$4 billion a year to fight the deadliest infectious diseases, challenge the injustice which fuels them and strengthen health systems in more than 100 of the hardest hit countries.

The Global Fund unites world leaders, communities, civil society, health workers and the private sector to find out what works and take it to scale – so the world makes more progress, more rapidly.
It's working. Since 2002, the Global Fund has saved 38 million lives and we won't stop until the job is finished.

Wondfo

Wondfo was founded in 1992, a pioneer in POCT industry through its dedication from China to the globe, has been focusing on the R&D, production, sales and service of point-of-care testing (POCT) products. Wondfo now has a wide range of RDTs products for infectious diseases, cardiovascular diseases, inflammation, drug abuse and so on, widely sold to 140+ countries and regions. Our products are extensively recognized by many international certifications such as CE, FDA and WHO Prequalification (HIV1/2). Everything we do is to protect the health of people all over the world and improve their lives.

Human
Diagnostics Worldwide

At HUMAN, our mission is to empower laboratories to fulfill their daily challenges and implement long-term IVD projects to improve patient care.
Offering a broad and comprehensive product portfolio with German quality standards, we provide reliable solutions that meet the most diverse local requirements. Worldwide service and supply capabilities as well as close cooperation with our long-standing distribution partners enable us to individually support healthcare professionals

in more than 160 countries. All above has made us a recognized global player in the IVD industry over the past half century. Discover HUMAN and see how our solutions help you achieve your objectives.

Johnson & Johnson

At HUMAN, our mission is to empower laboratories to fulfill their daily challenges and implement long-term IVD projects to improve patient care.
Offering a broad and comprehensive product portfolio with German quality standards, we provide reliable solutions that meet the most diverse local requirements. Worldwide service and supply capabilities as well as close cooperation with our long-standing distribution partners enable us to individually support healthcare professionals in more than 160 countries. All above has made us a recognized global player in the IVD industry over the past half century. Discover HUMAN and see how our solutions help you achieve your objectives.

MSD

MSD commitment to HIV: Over 35 years and counting…
Welcome to ICASA 2021 from MSD. Please join us at our exhibit booth and our symposium as we celebrate that for more than 35 years, MSD has been committed to scientific research and discovery in HIV, and we continue to be driven by the conviction that more medical advances are still to come. Our focus is on pursuing research that addresses unmet medical needs and helps people living with HIV and their communities. We remain committed to working hand-in-hand with our partners in the global HIV community to address the complex challenges that hinder continued progress toward ending the epidemic

Omega DIAGNOSTICS LTD

Omega is an international diagnostics testing business that is passionate about improving lives around the world by accurately informing health decisions. Drawing on 30 years' experience, we develop, manufacture and market pioneering diagnostic products, where there are few, if any, equivalent alternatives. These products enable health agencies and practitioners to make informed decisions that can transform their patients' long-term health.

Our Global Health division takes a proactive approach to disease management with a test that is developed for use in decentralised settings. VISITECT® CD4 Advanced Disease is a unique, instrument-free, same-day, rapid CD4 test benefiting patients living with HIV.

SAfAIDS
Knowledge for action: The power to make a difference!

Established in 1994 as a regional non-profit NGO, with an over 25-year footprint across the SADC region in SRHR, HIV, gender equality and social inclusion actions. SAfAIDS Regional Office is based in Zimbabwe and has Country Offices and Country Focal Points across 8 countries in the SADC Region. SAfAIDS Vision is an Africa where ALL people enjoy universal sexual and reproductive health and rights (SRHR), inclusion and viable livelihoods; free from disease or poverty and contributing to their human and social development. SAfAIDS' mission is to be a Trend-setter in Promoting Integrated Effective and Ethical Development Responses to SRHR, by enabling Gender Equality, Social Inclusion and Resilience for All.

Save the Children

SRHR HIV Knows no Border: Improving the SRHR-HIV Outcomes and Quality of Life among Young and Vulnerable People, Migrants and Sex Workers and others Living in Migration Affected Communities in Six Southern African Countries (2021 -2026). A program of the International Organization for Migration (IOM) in partnership with Save the Children International (SCI) and other partners are working together in the Southern African region for:

- healthy choices
- improved access
- enabling environment

Our primary target groups

- Migrants (internal and cross-border)
- Sex workers and their clients
- Young vulnerable people

The Female Health Company is the creator of the FC2 Female (Internal) Condom. The FC2 is soft, smooth, silky, strong, safe and fun. For over 30 years we have operated with one mission: to empower women and receptive partners with the tools and skills needed to enjoy safe, pleasurable sex. We support governments and partners around the world to offer free educational trainings and programming guidance on sexual and reproductive health and rights, promoting the FC2 Female (Internal) Condom for the prevention of unintended pregnancy and sexually transmitted infections (including HIV) and how to increase intimacy through safer sex.

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. UNFPA calls for the realization of reproductive rights for all and supports access to a wide range of sexual and reproductive health services – including voluntary family planning, maternal health care and comprehensive sexuality education. UNFPA launched efforts to achieve three 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, and ending gender-based violence and harmful practices.

UNICEF works in the world's toughest places to reach the most disadvantaged children and adolescents – and to protect the rights of every child, everywhere. Across more than 190 countries and territories, UNICEF does whatever it takes to help children survive, thrive and fulfil their potential, from early childhood through adolescence. Before, during and after humanitarian emergencies, UNICEF is on the ground, bringing lifesaving help and hope to children and families. Non-political and impartial, UNICEF is never neutral when it comes to defending children's rights and safeguarding their lives and futures.

Viatris Inc. (NASDAQ: VTRS) is a new kind of healthcare company, empowering people worldwide to live healthier at every stage of life. We provide access to medicines, advance sustainable operations, develop innovative solutions and leverage our collective expertise to connect more people to more products and services through our one-of-a-kind Global Healthcare Gateway®. Formed in November 2020, Viatris brings together scientific, manufacturing and distribution expertise with proven regulatory, medical and commercial capabilities to deliver high-quality medicines to patients in more than 165 countries and territories. Viatris' portfolio comprises more than 1,400 approved molecules across a wide range of therapeutic areas, spanning both non-communicable and infectious diseases, including globally recognized brands, complex generic and branded medicines, a growing portfolio of biosimilars and a variety of over-the-counter consumer products. With a global workforce of more than 40,000, Viatris is headquartered in the U.S., with global centers in Pittsburgh, Shanghai and Hyderabad, India. Learn more at viatris.com and investor.viatris.com, and connect with us on Twitter at @ViatrisInc, LinkedIn and YouTube.

ViiV Healthcare is a global specialist HIV company established in November 2009 by GlaxoSmithKline (LSE: GSK) and Pfizer (NYSE: PFE) dedicated to delivering advances in treatment and care for people living with HIV and for people who are at risk of becoming infected with HIV. Shionogi joined as a shareholder in October 2012. The company's aim is to take a deeper and broader interest in HIV/AIDS than any company has done before and take a new approach to deliver effective and innovative medicines for HIV treatment and prevention, as well as support communities affected by HIV.

For more information on the company, its management, portfolio, pipeline, and commitment, please visit www.viivhealthcare.com

OraSure Technologies empowers the global community to improve health and wellness by providing access to accurate, essential information. Together with its wholly-owned subsidiaries, DNA Genotek, Diversigen, and Novosanis, OraSure provides its customers with end-to-end solutions that encompass tools, services and diagnostics.

The OraSure family of companies is a leader in the development, manufacture, and distribution of rapid diagnostic tests, sample collection and stabilization devices, and molecular services solutions designed to discover and detect critical medical conditions.

OraSure's portfolio of products is sold globally to clinical laboratories, hospitals, physician's offices, clinics, public health and community-based organizations, research institutions, government agencies, pharma, commercial entities and direct to consumers.

IMMY focuses primarily on manufacturing rapid, high-quality fungal diagnostics. With products for Aspergillosis (AGM LFA), Cryptococcosis (CrAg LFA), Histoplasmosis, Coccidioidomycosis (Coccidioides Ab LFA), and Blastomycosis, along with mycobacteria specimen preparation reagents (MycoDDR), IMMY is setting the standard with accurate and affordable diagnostics for infectious diseases. It has been our goal to bring diagnostics closer to the patient by developing simple, rapid tests that can be used in any laboratory setting, on any shift. IMMY is bridging the gap between fungal infections and proper treatment by Saving Lives One Diagnostic at a Time.

UNAIDS leads the global effort to end AIDS as a public health threat by 2030 as part of the United Nations Sustainable Development Goals.

It provides the strategic direction, advocacy, coordination and technical support to catalyse and connect governments, the private sector and communities to deliver life-saving HIV services. UNAIDS provides the most extensive data collection on HIV epidemiology, programme coverage and finance and publishes the most authoritative and up-to-date information on the epidemic—vital for an effective HIV response.

UNAIDS draws on the experience and expertise of 11 United Nations system cosponsors and is the only United Nations entity with civil society represented on its governing body. UNAIDS has offices in 70 countries, with 70% of its staff based in the field.

Zoë-Life is a capacity-building and development organisation, working in the field of Public Health and Social Transformation. Developed by Zoë-Life, KidzAlive™ is a multicomponent, child-centred, capacity-building model of care that facilitates the provision of psychosocial and adherence services to children aged 2-12 years living with HIV and AIDS.

FEMNET is a Pan-African, feminist and membership-based network keen on influencing decisions by ensuring that the voices of African women are amplified and their needs, priorities and aspirations are prioritized in key policy dialogues and outcomes made at national, regional and global levels. FEMNET has strategically positioned herself as a convenor, organizer and facilitator on dialogues around critical issues including women's involvement in governance and leadership, promoting women's economic justice, advocating for women's sexual and reproductive health and rights, ending gender-based violence and harmful practices (such as female genital mutilation and child marriage) and strengthening the women's movement in Africa.

The World Health Organization contributes to a better future for people everywhere. Good health lays the foundation for vibrant and productive communities, stronger economies, safer nations and a better world. As the lead health authority within the United Nations system, our work touches people's lives around the world every day. In Africa, WHO serves 47 Member States and works with development partners to improve the health and well-being of all people living here. The WHO Regional Office for Africa is located in Brazzaville, Congo. Learn more at www.afro.who.int and follow us on Twitter, Facebook and YouTube."

- The AFRO Regional communication Manager (Mrs OKA) is copied here if additional clarification to be provided and she will lead the preparatory work on comm. for WHO participation to ICASA 2021.

- Also, as we'll participate to the hybrid booth- please kindly provide to our team the SAA comm. focal point's name and email who can assist us on the design requirement (format, number, duration etc….) of WHO's communication prior and during the event.

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 2023. The host country will be announced soon.

HISTORY OF ICASA

SOCIETY FOR AIDS IN AFRICA

ORGANIZERS OF THE ICASA 2021

REPUBLIC OF SOUTH AFRICA

info@saafrica.org
@ICASA2021
ICASA 2021
icasa2021.saafrica.org